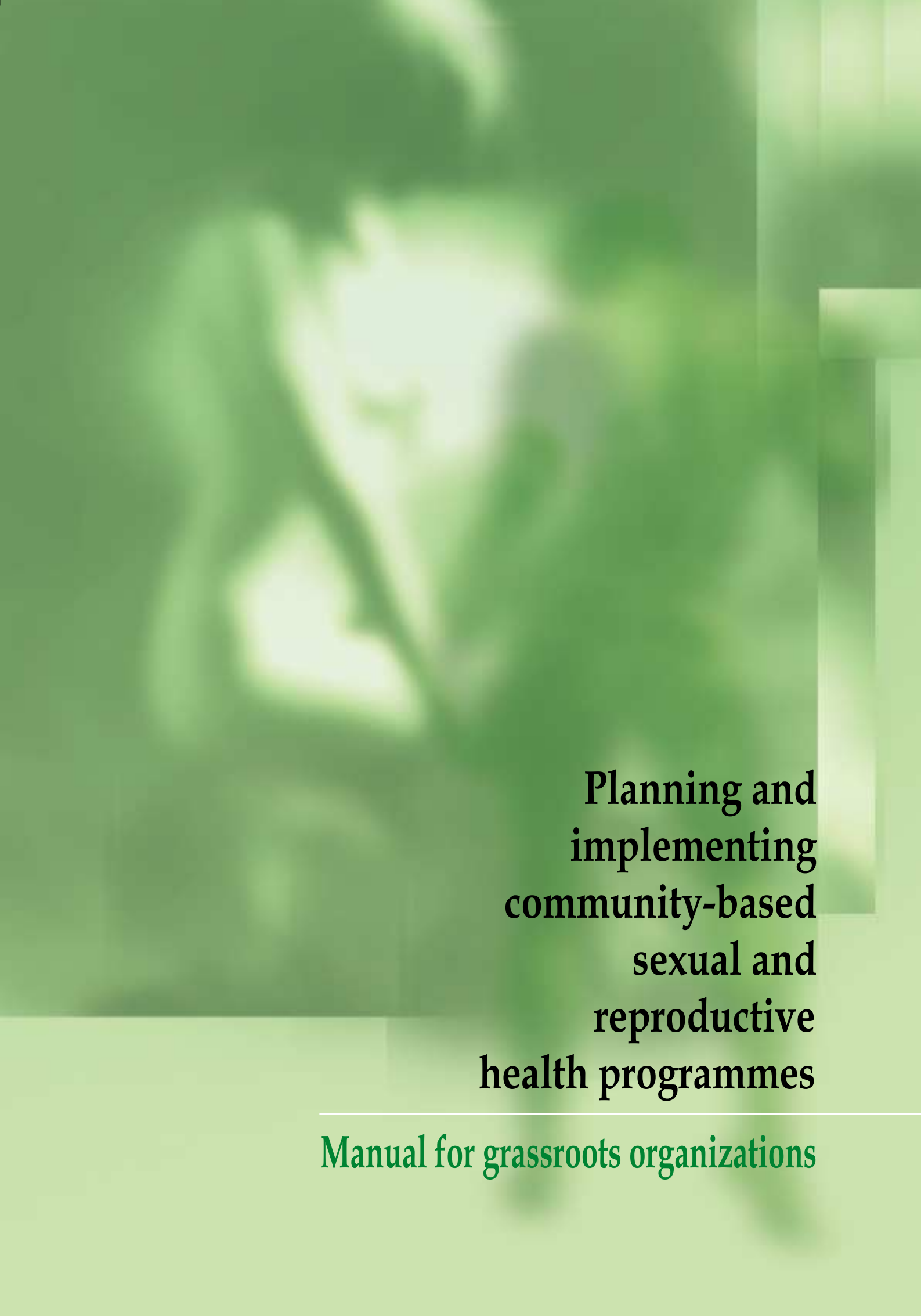


Planning and implementing community-based sexual and reproductive health programmes

Manual for grassroots organizations

Planning and implementing community-based sexual and reproductive health programmes

Manual for grassroots organizations

PLANNING AND IMPLEMENTING COMMUNITY-BASED SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES: MANUAL FOR GRASSROOTS ORGANIZATIONS

Rural Women's Social Education Centre, Chengalpattu, Tamil Nadu

Rural Women's Social Education Centre (RUWSEC), Chengalpattu, in Tamil Nadu, India, is an organization constituted of and by rural women from socially and economically marginalized communities, to address issues related to women's well-being through women's empowerment. The organization has been in existence since 1981, and has during the last two decades, carried out a wide range of activities- from community-based organization of women in 99 hamlets to provision of health services through a clinic, training support to NGOs, publications and research. The organization is now undergoing a process of restructuring, gradually moving out of the many hamlets where it has worked for two decades and focusing on innovative interventions, training support to other NGOs, advocacy and research.

The objective for putting together this manual is for sharing with other grassroots organizations the lessons RUWSEC has learned over the past two decades on planning and implementing community-based sexual and reproductive health programmes.

The basis of RUWSEC's work in the community is the promotion of information and education on health among women and men. RUWSEC has therefore invested considerable time and energy in conducting workshops and meetings for various groups: from community health workers, to women and men in the community, to community leaders including women members of the *panchayat*, to adolescent boys and girls, to young married couples and so on. We have tried to include here the material developed and used over the past two decades (as much as was possible) for conducting health education workshops.

The process of putting together the manual began in 2003. Once the outline of contents was drawn up, we began the difficult task of gathering and compiling material for the manual. We divided the topics amongst ourselves and small teams worked on each topic. We also had a system of review whereby teams would exchange the drafts that had been written with each other to plug gaps. The process of gathering RUWSEC's wealth of materials and compiling the drafts continued for more than a year. In June 2004, we were able to identify and work with a team (three persons) of consultants. The manual draft which was in Tamil and hand written was then translated into English, technical and other gaps filled, edited, and printed.

We do hope that you enjoy reading / using it as much as we enjoyed putting it together.

The RUWSEC Team

Acknowledgements

We warmly acknowledge the contribution of

- Ford Foundation for providing Financial Support
- Sundari Ravindran for all the RUWSEC materials that she has so carefully preserved over two decades
- Ranjani Murthy for her insightful comments
- Nirmala Selvam, N. Srilakshmi and Deepa Venkatachalam for their hard work and effort towards completing this manual
- Mr. S Jayaraj, Mr. Srinivasan and Mr. L Jayaraman for the artwork and printing

Contents

Pamphlets inserted *(17nos.)*

- Pregnant women who need special attention
- Danger signs during pregnancy
- Providing for a safe delivery
- Uterine prolapse
- Urinary Tract Infection
- Vaginal (white) discharge
- Modern parable
- Contraceptive pamphlets (10)

How to Use this manual

This manual has been designed to help NGOs, small grassroots organizations, community development groups, individual social workers or trainers to conduct training workshops for grassroots workers or organize community education programs at the field level.

The manual has two parts. The first part covers the concepts and approach to community development and highlights the social issues that impact the lives of women and men from marginalized communities. The second part covers issues on health, predominantly reproductive and sexual health.

The materials are organized in modules so that all information pertaining to that topic is approached holistically. Chapters within each module may be conducted as mini workshops or individual sessions taken from the module or chapter, may be used as part of an organization's ongoing activity when appropriate.

All modules have exercises at the end of the sessions, which provide participants an opportunity to develop ways to educate communities either through songs or campaigns or other community based activities that are easily doable and not dependent on external resources. The outcome of these exercises may be used as activities individually depending on the need for it.

Some modules have a lot of technical content that requires someone trained in that subject to be a part of the facilitating team. Examples Sexually transmitted infections, Lactation, etc.

Organizations or trainers preparing to use the manual are requested to read and assimilate all information provided in the entire module even if only one chapter or session will be used. This will give a holistic view of all aspects related to the session being used.

Each session indicates the materials required for the session and has samples of the same attached at the end of the session guide. In some sessions additional reference reading is indicated or given, as these are found useful in preparing a facilitator to deal with questions that may be asked but not directly covered in detail in the module. Facilitators are requested to go through these additional readings.

Before you prepare to conduct any session, first go through the entire module to understand the larger picture. Wherever there are exercises or demonstrations try to practice them first so you are comfortable with them when facilitating the session. Assemble the charts/make them and any other items you may need for the session well in advance. Go through the profiles provided as examples for the discussions and check whether you need to alter any to reflect the community that your participants will work with. The more realistic the profiles the greater the chances are that your group will come up with feasible solutions for the problems presented in the exercises.

In all the discussions ensure that issues of poverty, caste and gender are included so that participants understand their impact on health and explore ways to counter these in their attempts to promote and provide better health care in the community.

The annexure contains materials that can be copied and adapted for use when organizing or conducting surveys etc. The annexure also contains a section on Possible Tasks for grassroots organizations which is an excellent resource. All are requested to read through this information on what is possible at what level with what kind of support from government or other NGO partners. Some of the pamphlets developed by RUWSEC are inserted in the pouch inside the back cover. English translations can be found in Materials used for training under relevant topics.

We also recommend that you go through 'Basic Principles for Training' on Page # 56-57.

The sequence used to present the content:

The content is presented in modules and within modules in chapters and within chapters in sessions.

Each module contains an introduction to the module and lists the chapters that it covers. The time that is required to cover all sessions of a given chapter is provided in the module's introduction.

Thereafter the content is covered chapter by chapter. Each chapter covers a short introduction listing the sessions within that chapter. The time required to complete a session is also indicated.

The sessions are laid out in the following format for easy use:

Session Title

Session Objective

Training materials required for the session (these are listed here and provided as attachments at the end of the session. It is listed here so that they are collected before going through the methodology)

Methodology (This shows you how to conduct the session step by step. The materials you will use are indicated in (A1, 2 … or B or C…). You are requested to assemble that material, read through it, make necessary copies or charts or practice the demonstrations as indicated prior to conducting the session. Within the methodology you have timings given for covering the process.

Materials used for training /handouts include (These are materials listed earlier and also indicated in the methodology. You may need to make flip charts or use instructions for demonstrations as required in the methodology.) In addition always keep ready sheets of paper and pens for writing, markers or chalk for writing on the board as sometimes even if not indicated in the methodology you may prefer to write out points that come up in a large group discussion or may want participants to do an impromptu exercise. Also keep handy tape, pins and scissors.

Additional reference reading for facilitators (These are materials gathered for the facilitator to read and assimilate to provide a better understanding of the topic being discussed in the session. The additional readings may help in answering the questions that come up from the participants but which are not directly covered in the content of the session.)

Finally as a facilitator, try to ensure you are thoroughly prepared with the content and methodology of a given session so that you do not have to refer your manual during the course of a session. Referring to the manual now and then during a session distracts participants and also underlines a lack of conviction in the concept/practice/ idea that is being disseminated in that session.

PART 1

MODULE 1

RUWSEC'S PERSPECTIVES ON HEALTH AND ILLNESS AND IT'S APPROACH TO COMMUNITY-BASED WORK ON SEXUAL AND REPRODUCTIVE HEALTH

Overall Objectives:

- Describe the interlinkages between development, discrimination and health
- Explain sexual and reproductive health and rights
- Describe RUWSEC's approach to working in the community for the promotion of sexual and reproductive health as part of overall well-being

This module covers:

Chapter 1: Determinants of health and illness 14 hours 15 minutes

Chapter 2: Sexual and reproductive health as a gender and poverty issue 7 hours 10 minutes

Chapter One facilitates understanding of health not merely from a medical perspective but from the perspective of caste, class and gender. It provides an overview of India's health system, factors that impact health.

Chapter Two deals with Sexual and reproductive rights and health (SRRH) and specific ways in which poverty and powerlessness impacts SRH and Health Sector Reforms.

DETERMINANTS OF HEALTH AND ILLNESS

This chapter forms the foundation of this document. The understanding of the issues in this and the next chapter are crucial for analysis of the health issues covered in the later modules.

Understanding health, specifically sexual and reproductive health from the perspective of caste class and gender; the health care system, the global changes vis-a-vis the health sector facilitates a clearer understanding of the causes of health problems, barriers to health care in later modules and will also help participants to strategize activities / interventions for the socially and economically marginalized communities.

This chapter covers:

Session 1:	Understanding health and causes of Illhealth	3 hours 20 minutes
Session 2:	Difference in health status across different population groups	2 hours 40 minutes
Session 3:	Globalization, maldevelopment and health	2 hours 30 minutes
Session 4:	The Health care system and its contribution to health/ Illhealth	3 hours 40 minutes
Session 5:	Health as a Fundamental Human Right	2 hours 10 minutes

Session 1: Understanding health and causes of illhealth

Session Objectives: At the end of the session the participants will be able to:

A. Briefly explain health in a holistic manner as opposed to a purely medical approach and that we cannot protect our health only with health facilities, medicines and doctors

B. Describe the social determinants of health (caste, class, gender)[1] and their interactions with each other and impact on health

Training Materials required for the Session:

A. Piece of cloth, rope, chalk, chart /board, definition of health on chart, three narratives for discussion, 'For Good Health…' material on a chart

B. Copy of Murugan's story, Lalita's story**,** papers, charts, pens

Methodology :

Present the objectives.

A. Holistic understanding of health **1 hour 15 minutes**

Draw a line or place a long piece of cloth/rope on the floor. Mark one end 'very healthy ' and the other end 'not at all healthy'. Ask participants to stand along the line/cloth/rope based on how healthy they feel that day. After all participants have stood along the line, ask participants at different stages of the line, the reasons they chose the particular spot along the line and explore reasons why they were feeling healthy/not healthy. (15 minutes)

List the responses on a chart/black board and discuss. (10 minutes)

The responses may range from physical health problems (cold, cough); health problems due to social factors (my husband shouted (abused) at me this morning because the breakfast was late and that's ringing in my ears and given me a headache; feel really exhausted – I seem to have work all the time-it never ends; my child's school fees have to be paid soon and I don't have the money; etc

Sum up the responses saying that the participants felt healthy or not healthy for differing reasons. These were not only because of medical reasons but also because of various other social factors, by referring to examples from the responses. Sum up using the Alma Ata definition of health (A1). (5 minutes)

Divide participants into 3 groups, distribute narratives (A2). Participants discuss the narratives in the group and respond to the questions. (20 minutes)

In the large group discuss the responses. (10 minutes)

[1] *Not included race and ethnicity which are also determinants*

Some of the reasons that might come up are poverty, caste, lack of access to basic amenities, discrimination against women, lack of food, clothing, burden of work, lack of accessible health services, insensitive health system etc.

Consolidate the session with the material ' for Good Health…' (A3). (10 minutes)

Sum up with the following points: (5 minutes)

- We can protect our health / remain healthy not merely with hospitals, doctors and medicines.
- Health is a state of complete physical mental social well-being and not merely the absence of disease.

B. Social determinants of health **2 hours**

Introduce the activity. Explain that two narratives (B1) will be used to discuss the social determinants of health. (5 minutes)

Ask a volunteer(s) to read 'Murugan's story' or alternatively facilitator can narrate the story, followed by Lalita's story. (30 minutes)

In case of shortage of time, use only 'Lalita's story'. This story brings out the gender determinant of health which does not come through in 'Murugan's story'. The reason both narratives were included was to clarify the concepts of class, caste and gender but also to understand the difference between these factors. For example, in 'Lalita's story', if we were to control the factors of caste and class, the situation would change a lot but a rich, upper caste Lalita may also not have control over her fertility and autonomy of decision making etc.

After it has been read /narrated, ask participants what caused Murugan's death? This is a key question to initiate discussion. The question can be approached in many ways. One possibility is the 'But why' exercise: (15 minutes). This helps the participants recognize the complex chain of causes that led to Murugan's death.

Everyone tries to point out different causes. Each time an answer is given, ask the question "But why…?" or ask the participants to do so. This way everyone looks for still other causes. If the group examines only one area of causes, but others exist, you may need to go back to earlier questions and rephrase them so that the participants explore in new directions.

For the story of Murugan, the "But why….?" question game might develop like this:

Q: What caused Murugan's death?
A: Tetanus

Q: But why did tetanus attack Murugan?
A: Because he got a thorn in his foot

Q: But why did that happen?
A: Because he was barefoot

Q: But why was he barefoot?
A: Because he and his family were poor

And so on. Each response must be recorded on a chart.

Follow the same process for 'Lalita's story'. At the end of the activity analyze the causes of ill-health in both narratives from the perspective of class, caste and gender. (20 minutes)

Alternatively, ask questions as the narrative is being read. For example:

He had never stepped inside a school. When he was 9 years old, he began grazing cattle at the *mudalali/* landowner's.

But why had he never gone to school and started working instead?

Because they were poor. There was no school in the village.

His parents worked as agricultural labourers.

But why were they wage labourers?

Because they belonged to the Dalit caste, which is socially and economically very marginalized group. They did not own any land.

Thereafter explain that each of the ' Because…' responses on the chart will be discussed and marked as physical or social causes of ill health. Explain what physical and social causes are (B2). Explain P=physical or S=social. If the response is social, explore further if it is due to class, caste, gender. For example: 'Because he was barefoot ' – physical and 'because he and his family were poor' – social (class).

Analyze the causes for Murugan's death and Lalita's death. (30 minutes)

Summarize that

- Social causes are more numerous than the physical causes. It is very important that we recognize and discuss these social causes because they are often ignored or overlooked by professionals and authorities while planning and implementing health policies and programmes.
- Social determinants of health- class, caste, gender – determine the health status of individuals and groups. However it is important to remember that women are more disadvantaged than men in any given group. For example, a poor dalit man may be vulnerable to illness as compared to a rich man, because of poor housing, access to basic amenities like water and sanitation, food, work, access to affordable health care, education etc. However a poor dalit woman is more vulnerable because in addition to all the reasons given above, as a woman, she has lesser access to and control of resources, lack of decision making etc. Health differences between men and women in any given socioeconomic group (class or caste) are significant.
- Social factors influence risk, vulnerability, health seeking behaviour and access to health care and other long term consequences. Refer to the discussions for examples.

Explain to the participants that the next exercise /activity is to reiterate and clarify the concept of gender.

Divide participants into four groups. Handout a copy of the poem 'Beasts of Burden' (B3) to each group. Ask the groups to read and discuss the poem.

Thereafter in the large group, ask participants for their feedback and discuss the poem, encouraging the groups to share their interpretation.

Bring out the poverty, caste and gender issues and sum up using the material(B4) to highlight what it means to be a poor dalit woman. (40 minutes)

Materials used for training / handouts include:

A1 **Definition of health on a chart**

Health is a state of complete physical, mental, social well being and not merely the absence of disease.' – Alma Ata Declaration 1978

A2 **Narratives for discussion**

I. Ganesan's belongs to a dalit family that traditionally makes footwear. Ganesan who began working since he was 10 years old, is 54 years old now. He continues to work to survive and support his family. But he finds it increasingly difficult as his body is unable to cope. He frequently suffers from bodyache, knee pain, and his stomach gives trouble from time to time.

His eye sight is very poor and he feels breathless when he walks. He went to the doctor, who prescribed some medicines. The doctor explained the problem and the dosage but Ganesan did not understand the explanation. The health problems did not go away, instead, some new problems surfaced. On his last visit to the doctor, he was told to have nutritious food, rest well and sent home.

What are the reasons for Ganesan's health problems.

What is the cure for him / how can he get better.

II. Arputham has been married for 6 years and has four girl children, with the youngest child four months old. Her husband and inlaws want a son and harass and blame her for not begetting a son. Since marriage she has lost a lot of weight and constantly suffers from pain in the arms and legs, backache because of the work at home and in the fields. She feels weak all the time. The four girls also lack sufficient growth and frequently suffer health problems. The elder two girls stay home and look after the third and fourth siblings when Arputham goes to work.

What are the reasons for the health problems that Arputham and her daughters suffer from.

How can their health be improved.

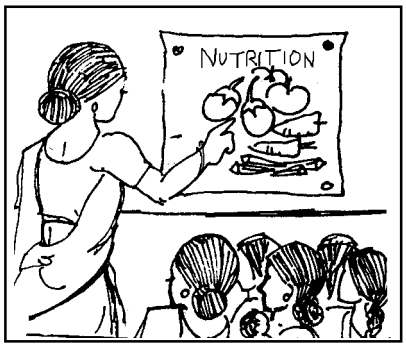
III. Raju was born in a well to do family. The family owns 40 acres of land and provides work to others in the village. He lives a life without a clue about hunger, poverty. He has a two storey *pucca* house in the village where he lives with his family. There is no dearth of clean water, food and all the work is done by the domestic help. Raju has no serious health problems and in case of any health problem or an emergency, one of the two cars he owns could be used to go to the 'big' hospital in town.

What are the reasons for Raju's good health.

A3 **For Good Health….. (**reproduce on a chart)

Please take these 5 medicines twice a day.

To safeguard health:



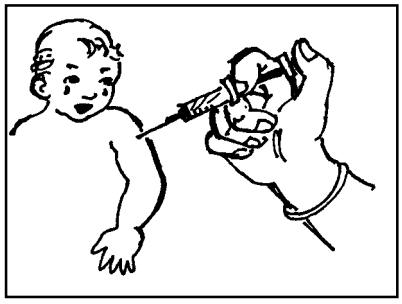
Health Education

Reasons for health problems should be explained /shared with community/people.

They should be motivated/encouraged to prevent these health problems

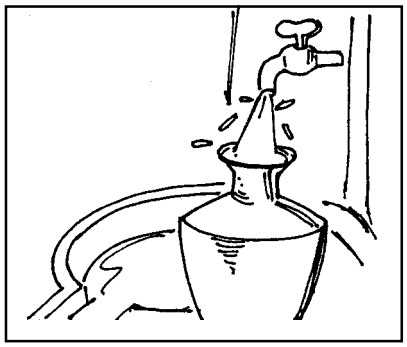
Local treatment /practices

Easy to use, at the same time harmless, useful treatment based on local knowledge and practices should be encouraged.



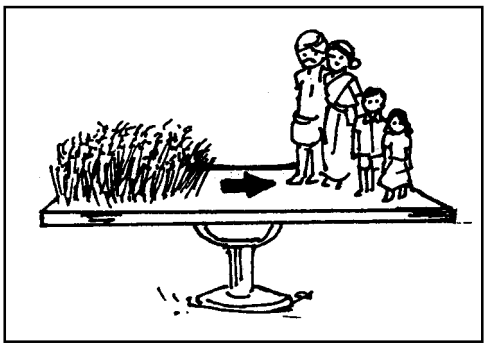
Prevention of Diseases

For prevention of communicable diseases children should be immunized before five years of age. Initiatives should be taken to prevent malaria and other infectious diseases.



Clean /safe drinking water and basic health

Clean drinking water, basic waste disposal systems are the birthright of each and every person.



Sufficient nutrition

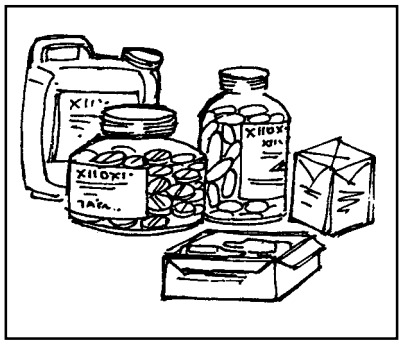
Sufficient food, necessary nutrition should be accessible to men and women. This is difficult to achieve if access to and control of land and food is unequal.

Mother and child care

All women should receive care from a trained provider during pregnancy, family welfare programme should reach those who need it; health status of children should be monitored.

Treatment

Prevalent diseases should be identified and treated properly. A health worker should be available in the village for this.



Essential drugs

Essential drugs should be easily made available to all.

Oh Goodness!

Wont it be expensive to do this?

For this we need,

Every year:

- 2/3 of the amount that people spend on cigarettes globally
- 1/2 of the amount that people spend on alcohol globally
- 1/15 of the amount that countries spend on defence.

B1 **I. Murugan's story**

Murugan was 12 years old. He had never stepped inside a school. When he was 9 years old, he began grazing cattle at the *mudalali/* landowner's, where his parents worked as agricultural daily wage workers. For the past three years he was grazing cattle, cleaning the cattle sheds, and doing other tasks that he learnt, thus able to barely survive.

Like on all other days, that day too he went to graze the cattle. The day was hotter than usual. So he let the cattle graze and at about midday he lay down in the shade of a tree and fell asleep. He would not have slept more than 10 minutes. But during that short time, two cows had strayed into the field and had begun eating the crops. Murugan got up with a start and ran to drive the cows out. While running, a thorn from a branch pricked his foot. He continued to run with difficulty and managed to gather the cattle. When he looked at his foot, he saw that the thorn was broken and embedded in the foot and it was very painful.

That evening he returned in pain with the cattle and tied them in the shed. He returned home and the pain was unbearable. He lay down crying with pain. His mother returned at 7 that evening and on hearing her son's problem said that he would get relief from the pain if he placed the area on his foot where the thorn had entered on the hot stove. Murugan did that. At around 10 pm, the pain worsened. The neighbours suggested that cow dung should be heated and tied around the foot. Murugan did that. Due to the pain and lack of sleep Murugan could not wake up the next morning. Murugan's mother requested him to go and graze the cattle that day and if necessary to take the next day off, as sowing was happening at the Mudalali's that day (possibly no one else would be able to fill in for the boy and take the cattle grazing). His father warned him as he left " You must certainly come and not take the day off because your foot is hurting".

Nobody understood this little boy's pain. The next day too he went to graze cattle. Murugan's fever increased and so did the swelling in his foot. By evening he returned with the cattle tied them in the shed and returned home.

That night he suffered a lot- he cried, tossed and turned. Everyone suggested that he should be taken to the doctor. There was no bus service and the health center was located at least 13 kilometres away. The Primary Health Centre built in that village had always been shut and never functioned.

Murugan's family was a very poor *dalit* family. They had nothing - not a single penny in hand- but debts that amounted to Rupees 3000. Because of extreme poverty his parents sent him to graze cattle when he was 9 years old so that he would at least get to eat two meals a day.

Murugan's father went to the *mudalali* to ask for money. Soon after he left to meet the landlord, Murugan began having spasms. Murugan's mother began crying inconsolably seeing the condition of her son and because of their helplessness.

Murugan's father returned empty handed. He borrowed some money –Rs 5 or 10 from the neighbours and on managing 100 rupees, pleaded with the *mudalali* for his bullock cart. Murugan's father tied the bullocks to the cart, lifted his only loving son onto the cart, and raced the bullocks. However not very far from the village, while on their way to the health center, Murugan died.

(Adapted from the book "helping health Workers Learn" – Werner and Bower, Hesperian Foundation, Pao Alto, 1982 pp. 26-3 to 26-5, as quoted in 'Training grass Roots Women for leadership in Health Development')

II. Lalita's story

Lalita was 34 years old when she died. She was a dalit woman and the daughter and wife of landless labourers. She herself was an agricultural wage labourer. She was married when she was 20. She had seven children. The last was only 5 months old when she found herself pregnant for the eighth time. She wanted to abort the baby but did not find the time to go to the abortionist. One day, during the fifth month of her pregnancy, she went to the well to get water as usual. When she bent down and attempted to lift two metal pots full of water, her uterus prolapsed and the fetus fell to the ground. She bled profusely for the next few days but did not go to the hospital, because her husband was traveling and she did not want to go without asking him.

After about a week she felt better and decided that she would go to the hospital and ask for a sterilization. She left her seven children with her mother in law, promising to return the next day. The hospital diagnosed her as suffering from tuberculosis and refused to operate. In her desperation she asked a health worker, who was under pressure to meet the sterilization targets, to arrange for the operation at a sterilization 'camp' being held elsewhere. She did not survive the surgery.

(Source: Experiences-Report of a meeting for rural women activists from Tamilnadu, Mahabalipuram, 13-15 August 1989 –Sundari Ravindran)

B2 Physical and social causes of illness (written on a chart /board)

To analyze the causes of ill health and how they are related, it may help to group them as follows:

- **Physical:** related to biology, caused by a living organism, such as a virus, bacterium, parasite or fungus or caused by some condition in the physical environment, such as a thorn
- **Social:** caused by human factors – the way people relate to or treat each other. These social causes can be divided into 3 sub-groups: Caste, Class and Gender.

Caste: having to do with social structure which implies who controls whom and how. (In this manual – caste to be read to include tribes)

class: having to do with money, land and resources who has them and controls them and who does not.

Gender: characteristics for men and women that are socially and culturally determined- that is, the different behaviour, roles, expectations and responsibilities all women and men learn in the context of their own societies.

B3 **BEASTS OF BURDEN (written / typed on paper –four copies)**

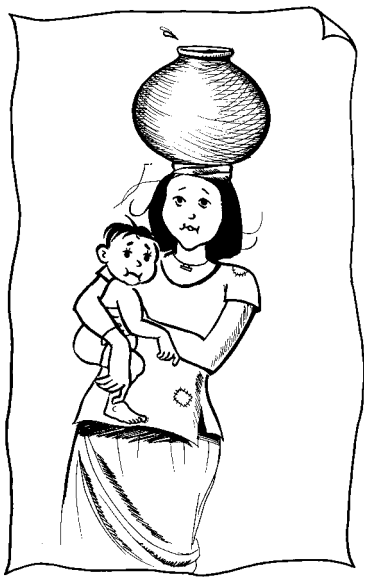
A Popular poem from India

Our master's farm is the biggest of all farms,
Where our men work, like beasts of burden

I'm carrying gruel for my hungry father
Toiling since morn
I'm learning to bear the burden
Of a child of my hips and
A pot of gruel on my head

For, some day not far off,
I'd have to walk on these field bunds
With a child in my belly and
A child on my hips
Carrying gruel for my husband
Toiling on this very farm

But tell me, if you can…
Who made this law
That our heads should always be lowered
And our backs bent, with burden?



B4 **Women and the Health care system**

When we say women in India, we are in fact referring to the vast majority of women who live in rural areas and are poor, and live under very difficult conditions.

Poverty:

The first of the characteristics of women is the absolute poverty in which they live. Most of them do either remunerated or unremunerated work. When they work for wages, their wages are really a pittance. The wages for men are also low but like everywhere in the world the wages for women are definitely much lower than for men. And in agricultural wage labor, it is usually half of what the men get.

As for living conditions, most of them live in mud huts with thatched roofs in rural areas. Water in the best of places is five minutes walking distance, and can be much farther away. The source is either a public tap which means that they are very fortunate, or a well which may run dry in summer. Usually it is a much farther walk to the pond or the river. There are literally no sanitation facilities whatsoever.

Fuel collection is one of women's most difficult tasks. Working all day, with scarcity of fuel and water, and having very little money to buy food, means what they can cook and what they can eat is going to be far below what is good or nutritionally the best for them.

When women work in rice cultivation, they work wet marshy lands, bending their backs, most of the time. They lift very heavy weights, both to carry water and to carry grain.

There are thus a number of illness causing factors already present here. If in addition they belong to a socially marginalized group, such as the scheduled caste or scheduled tribe in India, the disadvantages get compounded. It is going to be very difficult to explain what it means to belong to a low caste group, since caste is a very complex

social institution. But imagine the psychological effects of belonging to a very low status group in any society: when as a group, you are not human enough, are quite expendable. You wont feel the same kind of pain, you don't need the same kind of luxuries or privileges like everybody else, according to the status quo.

Gender based discrimination

It usually seems difficult to believe that in countries where we have women prime ministers, and we have female goddesses, we can talk about gender discrimination. But it exists for those even from the more privileged minority, but may not be manifested in the same ways.

Gender based discrimination in a poverty situation means that parents have to choose who they can make their investments on. And they will make their investments on their son, for many cultural, social and economic reasons. The girl child is not given the same educational opportunities as her male siblings. The girl child perhaps gets less food than her brothers. In case of illness, the decisions that the mother takes or the father takes about what kind of help to seek has been shown by many studies to be governed by gender of the child. A son has to be saved. Help will be sought for a daughter if they think the condition is really serious. But with the son, they will not take a chance. Studies show that often, the girl child arrives at the hospital after many days of illness, after trying home cures and traditional healers. It is not conscious discrimination. But it is a discrimination that nevertheless exists.

By about eighteen many girls are married. One of the reasons is a social one. Society dictates very strict sexual morality and parents are afraid to keep the girl at home very much longer. The other is that the older a girl gets, the more difficult it is to get her married. The more difficult meaning she is not as attractive, she is not as productive and so on. So they would try their best not to be left with the burden of a girl. And they are doing it in her interests. And although in many cases the girl enters her marital home as a productive member of the family, a dowry is paid to her husband's family by he parents, to compensate them for taking her in. This is tacit acknowledgement that she has no economic value.

The sexual division of labour means not only that women have a double burden but it means that they are doing certain kinds of work which may place them at greater risk of contamination. They work with water, are in charge of waste disposal, and are stressed from balancing the budgets: how to feed everyone with so little money? All these cannot but affect women's wellbeing.

Social attitude to women: the prevalent notions of how women should conduct themselves, also causes a lot of health problems. For example, in places where there are no toilets women have a very high incidence of urinary tract infections because they cannot use the open like everybody else. At all times, they have to wait, they have to find a suitable moment. The incidence of such infections is very high and unless we are sensitive to the conditions in which women live, we will never know that it exists, leave alone plan for preventive action.

To give another example, poor rural women also suffer from hyperacidity because they do not eat regularly and do not eat enough. They may not have the time, or may eat last after making sure everyone has eaten. They may develop peptic ulcers because they end up with a meal of rice with hot chilly to smother their hunger.

The other major aspect is ignorance about sex, a very poor self image, suspicion and a feeling of shame about their bodies. Women from many other cultures say the same. When there are gynecological diseases, either women don't know what is normal and what is abnormal and even if they suspect abnormality, they feel ashamed to talk about it. Ignorance about sex also means that women do not know enough about the whole process of conception, pregnancy and child birth. Even women with four or five children don't really know about the physiological processes involved. Pregnancy is not the result of a conscious decision to have a child. Women may often not be conscious of having missed a period till they develop symptoms of morning sickness. This may be because they are preoccupied with a number of day to day problems; or because, given their poor state of health, their menstrual cycle is erratic.

And the stress caused by this threat of pregnancy hanging over one's head – " Will I be pregnant this month? I hope not" is tremendous. It makes them feel that it is true what people say: it is a curse to be born a woman. "Why do I get to go through life like this?" This feeling is reaffirmed in many situations.

There is also the threat of infertility. Women's entire existence seems worthless if they are unable to bear children, given the social ideology under which we live. Secondary infertility due to infections of the reproductive system is known in the culture; people know you can become infertile after having one child or two children. And so they prefer to have all the children they want in quick succession, and perhaps after that they can start thinking about whether they want or do not want any more children.

A woman who had to wait eight years before she could get pregnant the first time, shared that people were saying that even if the family had bought a buffalo, they would have done better. They would have had an additional income. Feeding and taking care of her was in no way useful to the family: there were no children.

Women's vulnerability to sexual and domestic violence in male dominated societies. Wife battering, rape and subtle forms of psychological violence and repression that women experience are again an important element constituting gender based discrimination.

The characteristics of women described here may not be the same everywhere. But threads and parallels can be drawn in many situations.

(Pengalum Maruthva Amayppum:RUWSEC)

Additional reference reading for facilitator:

What is gender?

Sex: refers to the biological differences between men and women.

Gender: refers to the roles that men and women play and the relations that arise out of these roles, which are socially constructed, not biologically determined (Pan American Health Organization 1997)

Gender refers to those characteristics of women and men that are socially and culturally determined –that is, the different behaviour, roles, expectations and responsibilities all women and men learn in the context of their own societies. Because societies are different and because every society develops and changes in its practices and norms over the course of time, gender roles and relations are not fixed and universal. They differ in different places and in every society they change over time.

Gender roles are socially constructed. For example, the ideas that 'women's place is in the home' while men should be the breadwinners in common in many societies. Whilst it is often contended in this context that it is 'natural' for women to carry out domestic work such as cooking, cleaning and looking after children and for men to carry out waged work or produce goods to sell outside the home, these are not fixed roles but gender roles, which are produced by the society in which they emerge.

Gender roles and relations are held in place by ideology (underlying beliefs about the way society should be).

For example, males and females are expected to have different characteristics. Boys are often expected to be tough and discouraged from crying, while girls are expected to be soft, that is, more emotional. As adults, men are thought to be rational and intellectual while women are thought to be irrational and emotional.

Gender is relational; that is, gender roles and characteristics do not exist in isolation, but are defined in relations to one another and through the relationships between men and women.

Gender roles and relations are unequal and hierarchical. While gender roles and responsibilities are different in different societies, gender roles and relations are rarely equally balanced. Women and men generally do not have equal access to resources such as money, information, power and influence. In almost all societies what is perceived to be masculine is more highly valued and has a higher status than what is perceived to be feminine; masculine attributes, roles and behaviour are usually given greater social and economic rewards. Gender is thus one of the principal sources of power and inequality in most societies.

Gender relations are institutional because they form a social system which is supported by values, rules, routine activities, and divisions of resources in all forms of social organization, including families/households, communities, markets, states (and specific organizations such as health care systems).

Why is gender relevant to health?

Gender differences in women's and men's roles and responsibilities, and gender inequities in access to resources, information and power, are reflected in gender differences and inequalities in women's and men's:

- vulnerability to illness
- health status
- access to preventative and curative measures
- ability to adhere to treatment
- burdens/ consequences of ill health: care of self and other ill members
- quality of care

(Source:Guidelines for the analysis of gender and health: Gender and Health group, January 1999)

Session 2: Differences in health status across different population groups

Session Objectives: At the end of the session participants will be able to:

A. Be familiar with the reasons for power and powerlessness between groups and populations and impact on health status across different population groups

B. Understand the reasons for differences in health status among different populations at different levels

Training Materials required for the Session:

A. Tokens for star power game- gold=25, silver=25, red=25, green=25 (in case participants about 20), paper, pens, pencils

B. Four Cards with characteristics of people to develop profiles , Grid for analysis of causes for difference in health status at different levels on charts, paper, pens, pencils, chart /board, chalk

Methodology:

Present the objectives.

A. Reasons for differences in health status across population groups and at different levels 1 hour

Explain the Star Power Game to the participants (A1). Participants play the game. Ask the participants for their feedback about the game. (35 minutes)

Thereafter in small groups discuss the questions (A2) and record the responses. (15 minutes)

Discuss the responses in the large group clarifying the interaction between caste, class and gender and the resulting differences in the health status of different groups. (10 minutes)

B. Understand the reasons for differences in health status among different populations at different levels 1 hour 40 minutes

Divide participants into four groups. Ask each group to pick up a card (B1). Ask them to create a profile based on the characteristics given. Guide them to develop the characteristics into a complete profile with specific focus on vulnerability to health problems, access to health care etc. (20 minutes)

For example, in #I, the young woman may have health problems as a result of working in a garment factory. She may suffer from Urinary Tract Infection (UTI) as she is not allowed to use the toilet as frequently as she would like or back problems due to standing constantly. She may be exposed to sexual harassment. As a poor woman she may not be able to afford nutritious food which further compromises her health. She may not have access to health services due to non functioning or limited range of services at the PHC level. etc. The commute from home to the factory may be long and add to the burden of illhealth.

In the larger group ask participants to present their profiles (20 minutes). Write down the main health related issues on the board or the chart.

Guide the discussion to bring out the differences in health status across different groups/populations and explore reasons for this (15 minutes) Clarify that these differences in health status occur due to factor across different levels – factors at the individual, household, community, national and international levels. Explain what each level includes. Ask each group to use the grid (B2) for the profiles created by them to understand how health status is affected by factors at the individual, household, community, national, international levels. (15 minutes)

Groups present in the large group. Plug gaps and explain using the material on differences in health status and reasons (B4). (30 minutes)

Materials used for training / handouts include:

A1 Star Power Game

It is a simulation game depicting interaction across social classes in society. The game maybe used to reflect upon:

- power /powerlessness as a result of caste, class and gender: including the power to make decisions /rules/laws
- equality and equity : distribution and control of assets and resources and the impact on health

Divide participants into three groups. Give each participant in the group five tokens in a combination of four different colors. The tokens vary in value: gold is 50, silver is 25, red is 10 and green is 5. All members of the first group have gold and silver tokens each, members of the second group have a silver token each and members of the third group do not have either gold or silver tokens, but only red and green. One member of the second group maybe

given a gold token, and two members of the third group maybe given gold and silver, and silver alone, respectively. In other words, the first group is the 'rich' group, the second group 'middle class', and the third group is 'poor'. But there are one or two members in the middle class and poor groups who are better off.

Do not tell participants about the difference between the groups. After the tokens are distributed, ask participants to exchange tokens with each other by mutual consent.

They are not to talk to each other, nor show the tokens to be exchanged. After three minutes of such an exchange, ask participants to reassemble in their respective groups. Add the value of the tokens each of them has, and announce in the group. Regroup them according to the values of the tokens they have, into 'rich', 'middle – class' and 'poor' groups. Repeat the whole process (if desired) twice.

After this announce that henceforth all rules of exchange would be made by the 'rich'. The 'rich' group is requested to play its role. For example: Rules for the exchange of tokens maybe announced as:

- Members of the other groups have to go on their knees while they exchanged tokens with the 'rich'.
- For each token that a 'rich' person gave, others had to give two in return.

A2 **Questions for discussion** (Star Power Game)

- If the game compares with life in any way. How? Explore: distribution and control of assets and resources
- Who is powerful and who is powerless? What are the reasons for differences in power.
- Explore class, caste, gender. For example, ask participants to imagine men instead of 'rich' and women for 'poor' and upper caste and dalit /tribals respectively OR the rich as 'rich upper caste men', middle class as 'poor dalit men' and 'poor' as poor dalit women. The rules can be changed so that the 'rich upper caste men/women' make the rules for the other two groups but the 'poor, dalit men' can make the rules for the 'poor, dalit women'.
- Consequences of power and powerlessness on health: ask participants to reflect upon it.

B1 Four (or as many as there are groups) cards with sets of characteristics written on them. For example:

Card I – woman, 19 years, rural, dalit, poor, unmarried, works in a garment factory in the Export processing zone.

Card II - man, rural, owns land (rich), literate

Card III – urban, single woman with child (separated from husband), works in a bank, lives in Kalpakkam

Card IV – child- female, urban slum, mother works as domestic help, father alcoholic, violent

(These profiles/characteristics are merely guidelines. create profiles suitable to the context)

B2 Empty grid: Health status affected by factors at different levels (as many as there are groups) Refer B3

B3 **Health status affected by factors at different levels:**

Individual	**household**	**Community**	**National**	**International**
Biological: Birth order, genetic predisposition, sex Social: education, occupation, Age Gender	Caste, class characteristics; Education, Employed/ unemployed; house – location, condition; access to resources etc.	Caste, Infrastructure available, accessible – health education; employment, political participation, laws/ norms (within community groups)	Self sufficient or not re: resources, structure of health system, allocation for social aspects, how dependent on international market	Powerful vs powerless, pharmaceutical companies, outsourcing
[1] woman, rural, dalit, poor, limited education, works in factory in export zone	Family maybe dependent on her earnings – she cannot afford to leave her job, others in family may not have a job.	Dalit, poor, rural, lack of access to health care. For example, subcentre not functioning, PHC not suitable for her timings.	Lack of laws that would monitor and improve conditions in factories, provide benefits for workers including health and sanitation facilities. The export zone do not follow any of the regulations.	Cheaper labour in our country. Hence outsource work at a pittance. outsource work at a pittance. No accountability re: conditions in factories, workers etc.

[1] *Taking the first profile as an example although it is not a complete profile as given presently.*

B4 Health status is a measure of the quality of life of people. Where these basic necessities are available the quality of life can be said to be good and people are healthy. Where these are not available, the health situation is bad and life is a struggle.

Health status of populations is different in different countries and there are differences within the same country. For example, there is a large gap between the rich nations and health of all other nations. The top 25 countries are mainly North American and European (except for Japan). In India there is a large disparity between the states and within each state between communities. For example, the health status of Muslims, Dalits, Tribals is worse than the others. The health of women is worse than the health status of men. The main reason for this is unequal access and control of power and assets. Poverty is not the only reason for disparity – marginalisation and social exclusion are also important reasons. The poor are powerless and the powerless are poor. Because they are powerless, tribals, dalits and women are excluded from decision making. Because they are excluded they have less power and therefore are poorer. Also because they are excluded they have less access to basic social services. Because they have less access to social services they are sick more often and have even less income. Because they have less information, they are even more powerless.'

(Source: Health for All Now! The People's Health Sourcebook.)

Session 3: Globalization, maldevelopment and health

Session Objectives: At the end of the session, participants will be able to:

A. Describe what globalization means

B. Explain its impact on development and health

Training Materials required for the Session:

A. Skit prepared in advance with the dialogues etc. written on cards /slips of paper. Four – five persons (facilitators) to play the following roles –

1. Globalization 2.World bank (WB) 3. International Monetary Fund (IMF) 4. India
5. Poor+rural+dalit+woman

B. Paper, pens, chart /board with questions for discussion, materials on consequences and Impact of globalization,

Methodology:

Present the objectives.

A. What is Globalization **1 hour**

Ask participants if they have heard about globalization and ask them to share what they know about it.

Explain that the next activity is a skit enacted by facilitators. Each of the actors introduce themselves (A1). Important aspects of globalization are highlighted by the introduction.

The skit continues with interaction between the actors and with the audience –participants. Participants can become 'actors' and ask questions and clarify issues.

The 'woman' and other actors in the skit provide the leads. For example, she introduces the fact that she wanted to get some drugs for her old father but was not available in any government hospital and could not afford to buy it from the chemist. The other actors react to this by clarifying how they were involved for this situation. Similarly with agriculture, Public Distribution System (PDS), Health system etc.

The interaction between these entities clarify aspects related to globalization and briefly, the consequences in the area of health and related fields like agriculture, food, pharmaceuticals etc.

B. Impact on Development and Health **1 hour**

Divide participants into four groups and ask participants to discuss and respond to the questions (B1): (20 minutes)

Group 1: Agriculture+PDS+Food

Group 2: Education+Employment (labour)

Group 3: Health System including drugs /pharmaceuticals

Group 4: Environment

Each group presents their responses. (20 minutes) Discuss the responses and analyze the responses highlighting the role of globalization / economic policies in these changes. Summarize and highlight the consequences of the policies and conditions and their impact on development and health (A2). (20 minutes)

Activity ***30 minutes***

(15 minutes discussion+10 minutes presentation+5 minutes post presentation)

Divide participants into two groups. Ask each group to discuss the role that grassroots women's organizations and community groups could play to counter these policies that impact development and health.

Materials used in session:

A1 **Introductions**

Globalization: I am Globalization. I introduce economic and political policies to create a single global market. I mainly care about profits and the poor and marginalized are not my priority. The smaller companies who cannot compete oppose this. The rich and powerful in a free market are free to do what they want and the poor and powerless are pushed out.

I also create a homogenous global culture. Technology development, the creation and control of knowledge and information and the structure of social institutions are also shaped by me to favor domination by a few.

World Bank: Hello. I am an International bank. Like any bank I accept deposits and lend money, with interest of course. My depositors are the rich nations of the world, and lenders are the poor, developing nations, including India.

International Monetary Fund: Hi. You can call me IMF. I am an international financial institution floated by the powerful countries of the West to help manage the international financial situation.

India: I am a country with a billion people. Most of the people live in poverty and economic insecurity. There is a lot of gap between rich and poor, upper and lower castes, women and men. In the 1990s I was facing an economic crisis and to tide over this I introduced reforms – economic policies.

Woman (poor+dalit+rural): My name is Jamuna. I live in a dalit hamlet in Periyur, 45 kilometres from the state capital of Chennai. I work as an agricultural wage labourer and earn Rs. 30 for a day's work. Of course that is not all the work I do but that is all I get paid for…..

The skit maybe developed further like this:

World Bank: Hey India, IMF and I have decided that you have been taking loans from us for a long time. You say that this is so that your economic situation improves. But we have decided to introduce some conditions if you want to take the loan. How else can we be sure that you will repay us?

India: What are the conditions?

World Bank: Meet SAP.

Structural Adjustment Policies: Just call me SAP for short. I lay down conditions that the country has to follow for deferring their loan payments or giving them a fresh loan. First condition is that you should cut spending on health care, education, subsidies to farmers and poor. Privatize transport, power, health care.

Poor, rural dalit woman: What will happen to me? I have no money, to send my children to private schools. I have to sell all the agricultural produce to buy more pesticides which burn my skin. I have no work because of the machines; there is very little food at home and I have to eat last and the least. …

A2 **Consequences of policies:**

1. Retrenchment of workers in the public departments. Lack of employment guarantee, resulting in increase in poverty.
2. Reduction in subsidies and scrapping of social welfare schemes. E.g. reducing the amount of free drugs made available; reduce the items that are sold at subsidized rates through the PDS or reduce the quantity
3. Privatisation of Education, Health system
4. Increase in exports – export without any restrictions, with focus on earning money rather than on consumption.

5. Open Indian markets to imports, like milk, milk products, rubber, tea etc. Invite foreign companies to start manufactures/units in India. The local manufacturers unable to face competition from cheaper imports are closing units
6. Transformation taking place in terms of livelihood options and opportunities – in agriculture, fisheries, forestry, dairying, weaving
7. Privatize railways, air services

Impact on:

a. Agriculture+Food (PDS): Increased mechanization, decrease in employment, changing cropping patterns with priority to cash crops. Degradation and reduced fertility of the soil due to use of pesticides resulting in failed crops, increased debts, and poverty.

   Women are particulary affected. Large number of women are employed in the agricultural sector.

   Women's health suffers because of standing for long hours in the water in the fields while implanting/ sowing etc. The water/field contained chemicals from the pesticides which cause skin rash, itching etc. Women use fish, crabs etc from the fields and cook them. But the pesticides destroyed them and the quality of the soil. The employment (number of days) was reduced by half. Now women have to search for alternative employment, work much more to earn the same amount, travel farther and work in difficult/ unhealthy conditions to earn a living.

   The focus on cash crops meant that everything was sold, nothing was kept aside for the family's consumption. They then purchased rice and if and whatever was available through the PDS. Commodities available through PDS also decreased. This further burdened the woman who was primarily responsible for taking care of the food needs of the house.

b. Education and Employment: Privatisation of education has led to inability of the poor to access it. This has particularly impacted girls from socio economically marginalized communities. The quality of education through the existing schools in the rural areas is of very poor quality. Poor households incur further debt to educate their children. Higher school and college education is largely is out of reach of the majority of the poor marginalized communities and worse still for women. Lack of access to education /literacy impacts womens' health.

   Due to reduced employment opportunities in agriculture, many men, young women are employed by factories /companies especially in the export zones. These factories manufacture goods for export. Workers are exploited face violence in their workplaces. They work in extremely poor and hazardous conditions. They are paid low wages and have no employment security. Many of these factories violate all laws- violate workers' rights and violate laws for protection of the environment. Due to poverty and employment insecurity, workers continue to work even in these circumstances. All these factors impact health.

c. Health: The affordability and availability of health services is crucial to the well-being and survival of the disadvantaged, especially in a country with so much poverty and economic insecurity, driven by severe inequalities between rich and poor, upper and lower castes, women and men.

   At Independence, the Health Survey and Development Committee (Bhore Committee, GoI 1946) was emphatic that comprehensive health care should be universally accessed by all regardless of their ability to pay. Despite this, progress in health over the intervening decades has been very uneven and health inequalities across States, between urban and rural areas, and across the economic and gender divides have become worse. Stagnating Government health expenditures, the skyrocketing prices of drugs and rising cost of health services, and increasing unregulated privatisation of the health care sector as a result of the economic policies, have resulted in poor quality and increased costs of health care. Spiralling costs of drugs, and the continued absence of a regulatory list of essential drugs resulted in the market being flooded with irrational drugs. Rising cost of care is a critical concern for poor people. The rising cost of health care can have a range of possible impacts on the poor. These include cutbacks on other consumption such as food which directly impacts on health status; increased indebtedness; growing untreated illness; and growing gender biases in health seeking behaviour.

   Growing support for private health care providers included a variety of subsidies for corporate hospitals, such as urban land in prime locations in exchange for their providing a proportion of their services free to the poor. How ever there is increasing evidence of non-compliance with this condition and irrational use of medical technology. For example, irrational tests, scans, x rays, further increasing health costs. The poor

quality of care of the public health services and lack of or little accountability to patients by private services provides little choice especially to the poor. Inequity by economic class appears to have worsened, and the divide between rich and poor in terms of untreated illness and expenditures on health services has grown.

The health especially of poor women has been worst affected due to the impact on other areas of development too, as seen earlier.

(The Hindu: July 2001: Gita Sen, Aditi Iyer, and Asha George based on a research study)

d. Environment: Deforestation, industrialization, construction, pollution, usage of chemical fertilizers, social habits, , unsafe drinking water, irrational drawing and use of water especially from the rural areas, and transformation in practices of traditional occupations. For example, farming –changes in crop pattern and use of chemicals /pesticides; fishing using trawlers as a result there us destruction of marine life etc. Reduced tree /wood cover in the rural areas resulted in people, especially women having to go farther to relieve herself.

   Women are impacted much more than men. The cutting back on subsidies and welfare affects women due to their weaker economic position. They are usually more dependent on government benefits. They are expected to provide certain services at the community that used to be supplied by the government. They are expected to do this for little or no remuneration.

B1 Questions for discussion in the groups: (written on board / chart for display)

1. What was the situation 10 years ago and what is the situation at present.
2. Are the changes for the better or for the worse. What are the reasons? What are the consequences of these changes on poor dalit rural men and women.
3. What are the health consequences?

Session 4: The Health Care System and its contribution to Health / Illhealth

Session Objectives: At the end of the session participants will be able to:

A. Explain what is health care system (define in a simple manner) and its

contribution to increase social/economic and gender inequalities in health

B. Describe Strategies /Policies that need to changes to improve the health of the people especially the marginalized

Training Materials required for the session:

A. Poem-A Worker's speech to a doctor; charts, pens, Characteristics of the Health care system – charts will illustrations and text, discussion points.

B. Copy of 'The Modern Parable' charts, pens

Methodology:

Present the objectives

A. Understand the health care system and its contribution to increase social/economic and gender inequalities in health **1 hour 40 minutes**

Ask participants when was the last time they /or someone in their family or neighborhood was ill.

What was the problem and where was treatment/care sought.

For example: My name is Jaya. I was sick last week. I had fever and went to the PHC at Sadras for treatment. (20 minutes)

After all participants have shared this, it may be that health care maybe sought at home, in the village through a traditional practitioner, through the government system or the private system.

Explain that the health system comprises of private and public health services. The medical systems maybe allopathy, Siddha, Ayurveda, Homeopathy or others.

By health care system is meant the totality of formal efforts that a nation state may undertake to take care of the health problems of that country. There also sometimes exist formal parallel systems, but not organized by the

state. For example, private health care both for profit and non profit. This session focuses mainly on the formal health care system which is the conscious effort of a state and not the informal systems of health care nor the parallel systems, although various aspects are common to both. (5 minutes)

Read the poem ' A Worker's Speech to a Doctor' (A1) or ask participants to read it. Ask participants for feedback about the poem: Did they like it? What was it about? Can they relate to it. Record the responses. (10 minutes)

Thereafter divide participants into 4 groups and ask them to reflect upon their own experiences in using public / private Health facilities and create short skits to show the reality vis-à-vis health centers and providers. Two groups reflect public and the other two reflect private (If the group is mixed –that is, has both men and women, it would be useful to have separate groups of women to allow for issues that might be specific to women. In case of men-only groups, explore issues that their girlfriends/wives/mothers/daughters/ neighbors etc may have faced, or men of a poorer economic status. This is important as women's interaction and experiences with the health system may be different from those of men.

Do the health centers /providers treat users who are poor differently? How?

Do they treat users who are from marginalized castes like dalits or tribals differently? Encourage participants to share their personal experiences. (30 minutes)

Document the skits and the issues that they reflect. Discuss after each skit. If male only and female only groups, request the male only group to present the skit first, followed by the skit with a focus on women's experiences with the health system. Highlight the issues that are specific to users, especially women from poor and dalit/tribal communities. (30 minutes)

Pick up the different issues /aspects related to the health care system that came up in the skits. Use the illustrations (A2) and materials to initiate discussion about each of the following (30 minutes). Encourage participants to share experiences for each aspect:

- Budget sanction for health
- Health priorities and decision making
- Medical education
- Primary Health care
- Attitude of providers
- Community participation
- International context
- Comprehensive primary health care versus selective health care
- Interaction between women and the health system

B. Strategies /Policies that need to changes to improve the health of the people especially the marginalized 2 hours

Divide participants into two groups and ask each group to modify skits from previous session or create new ones to reflect and incorporate the aspects covered /discussed in the session that would be improve the quality of services. For example, aspects like community participation especially participation of women and marginalized communities regarding decisions related to health care services, involvement in monitoring quality of care etc (1 hour)

Group 1: Skit focuses on improving care /services for women (Poor /dalit /rural including adolescents, older and single women)

Group 2: Skit focuses on improving care/services for all users

Ask participants to read the story 'the Modern Parable' (B1) aloud. (1 hour)

Divide participants into small groups and ask them to discuss the questions and list their responses. Discuss in the large group and sum up that the factory's focus was on making profits, which was creating conditions that affected the health of many people. Unless the system itself was challenged and changed, people's health cannot be protected/promoted.

Similarly there is urgent need to look at the causes of ill health and challenge those existing systems towards creating a more just and equal society. Although hospitals and health services provide care, it may not be a lasting solution. People centred policies are necessary so that their well being is not compromised, as it happened in the Modern Parable, in the interest of profits.

We can act in the community to improve women's status in terms of improving information level, their self confidence, their ability to seek health. Those involved in policy making can do quite a lot about how resources have to be allocated and distributed. Researchers can focus their research on generating information necessary for better planning with the involvement of those affected. Those in decision making positions in health services can take bold initiatives to reorient service delivery to be more responsive and sensitive to people's needs.

Materials used for training / handouts include:

A1 A WORKER'S SPEECH TO A DOCTOR

We know what makes us ill
When we are ill, we are told
That its you who will heal us.

For ten years, we are told
You learned healing in fine schools
Built at the people's expense
And to get your knowledge
Spent a fortune
So you must be able to heal

Are you able to heal?

When we come to you
Our rags are torn off us
And you listen all over our naked body
As to the cause of our illness
One glance at our rags would
Tell you more.
It is the same cause that wears our bodies and our clothes.

The pain in our shoulder comes
You say, from the damp; and this is also the reason
So tell us,
Where does the damp come from?

Too much work and too little food
Make us feeble and thin
Your prescription says;
Put on more weight
You might as well tell a bullrush
Not to get wet.

How much time can you give us?
We see: one carpet in your flat costs
The fees you earn from
Five thousand consultations.

You'll no doubt say
You are innocent.
The damp patch
On the wall of our flats
Tells the same story.

— BERTHOLD BRECHT

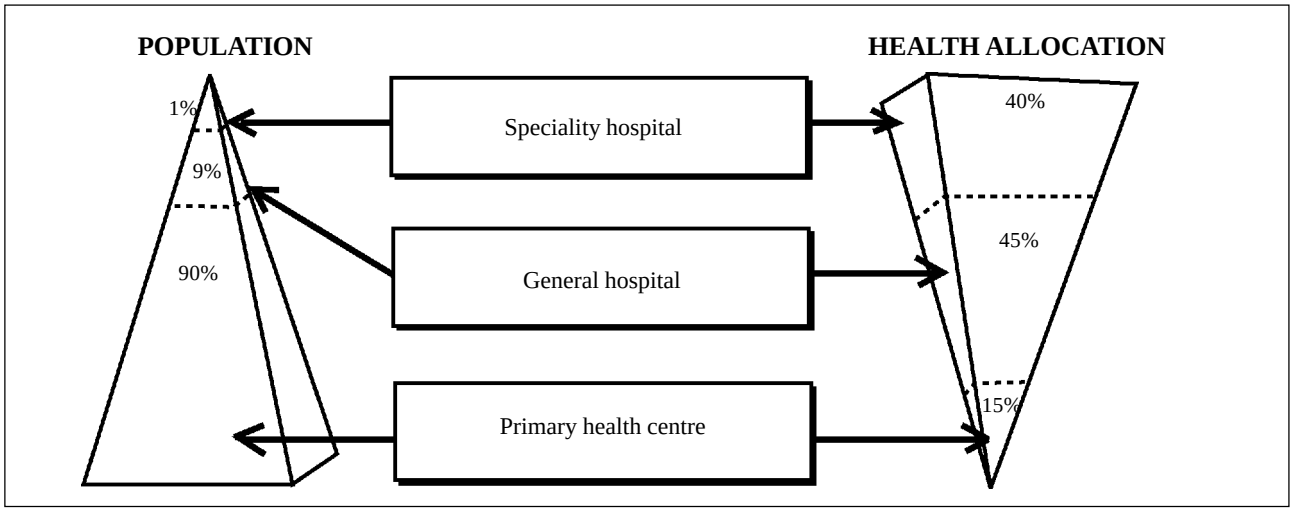
A2 Characteristics of the health system

(Illustrations and text on charts and points for discussion on cards /paper)

One of the features of the health care system that we have in India and in many countries like ours which had been colonized is that it is a superimposed model that developed as an organic component of the society. It came from another culture and it was different in many ways. It is different in the way they look at what is illness and what is health. It is different in the way causality is looked at. It still remains culturally alien to the vast majority of the people.

The health care system in India like the economy itself, is mixed with both a private and a public sector. We have a state sponsored, state financed public health system and an equally flourishing system of private health care. They complement each other and the worse the system gets, the better it is for the private health care.

Budget sanction for health



Discuss

Health services in the public sector is financed mainly from the budget of the Central Government. We do not have a wide spread system of social security. It exists in a small way for employees in the organized sector. Insurance again is not a very common phenomenon. Health services in the public sector is for the most part free. However recently user fees have been introduced in the public sector in some states.

The reality is also that the system is extremely corrupt and out of pocket expenses are common in the system.

The government has a political commitment to improving the health status of the population, without concomitant action. Only 3.1 percent of our budget is devoted to the health expenditure. We have a very small health budget, and most of it is spent on services in urban areas. We have 1 percent of the population with few specialized hospitals, 9 percent which use general service hospitals and 90 percent which use primary health services. Eighty five percent of health expenditure goes to hospitals for 10 percent of the people, 15 percent goes to primary health care for 90 percent of the people.

(In India the annual per capita health expenditure was only US 24$ in 2001 against the WHO stipulation of $45, of which only 1/6th is publicly financed.)

Health priorities and decision making

Joke – 'The health minister and his pain': How are some of the priorities shaped? (on a chart)

Doctor: " I am happy to say it is not your heart, Minister, but just indigestion. However, you know, we have no coronary care unit if it had been your heart".

Minister: "Mmmm, No coronary unit? We should definitely have a specialized coronary care unit for the country".

Discuss

Who makes the decisions regarding how much to spend?, what to spend on? Who should and can provide health care? What changes are required in the system? etc.

How are these decisions made? Are the users /people consulted, especially rural, poor, women from dalit/traibal and other marginalized groups? For example, the location of PHCs and sub centers.

It is the more powerful and those with a greater influence in the politics: it maybe the middle class, it maybe the elite, who shape the priorities in a country. The others don't know who to express their needs to, they don't even know that their needs can be expressed.

Professional interests also influence priority setting to a very great extent.

" A disease palace for doctors, or primary health centers"? The choice may be the former, because the argument may be, "if doctors don't see enough patients of a particular type, how will they develop their skills?". Fair enough, from one point of view. Primary health centers would not provide the kind of setting for training as a referral hospital would.

For example, in the state of TN there was a system proposed of recruiting health workers from the community as part of the government's health care system. And there was a strike by the doctors under the leadership of the local branch of the Indian Medical Association, saying that this would lead to the multiplication of quacks in rural areas and endanger people's health. The strike was so successful that after several years no government is talking of community health workers.

In another state there was a proposal that doctors of the traditional Ayurvedic system be trained in surgery because there were a number of Ayurvedic doctors in that state and many people sought help from them. There were strikes every time the proposal raised. And the argument is that these trainees will lower the standards of surgical services. It is a question of guarding one's territories.

Medical Education

Where do we do the teaching? We teach in 'disease palaces' and students follow the example and lifestyles of teachers.

The university trains doctors towards international standards and maybe this is the rule of the University. They have to do the best. The Ministry of health, after having trained doctors in the kind of 'disease palaces', wants them to serve in the rural areas. One of the results is that only those who do not have the money to start private practice opt for government service as a last resort.

Those who enter government service and are posted to rural areas find themselves in a very difficult situation. They serve three fourths of the population, they are not prepared or trained for the kind of services they are expected to deliver; they have too much work, and poor facilities for living and working. This is not what they studied medicine for. The one quarter of the population in urban areas has too many doctors, many of whom do not have an adequate private practice. Those who want better challenges, are leaving for other countries.

There are no initiatives for continuing medical education for the providers (nurses, health inspectors etc) at the subcentre and PHC level.

Primary health care

We cannot talk about the health care system without discussing primary health care. The principle of Primary Health Care enunciated in the Alma-Ata Declaration of 1978, is supposed to be practiced in many of our countries. What happens in reality?

The health expenditure is skewed in favour of hospitals. They get most of the health budget with very small percentage for primary health care.

This happens due to various structural reasons. You cannot wish away hospitals which already exist. You cannot close all of them down. The best you can do is to not increase the allocation to them, and perhaps cut costs to some extent. And then it means you have a distorted health budget. These changes are difficult with the best of intentions.

Primary health Care has come to mean second class, second rate health care for the poor and specialist hospitals for better care for the urban elite. For the ordinary people, we have a lot of preventive medicine and little curative services at the village level.

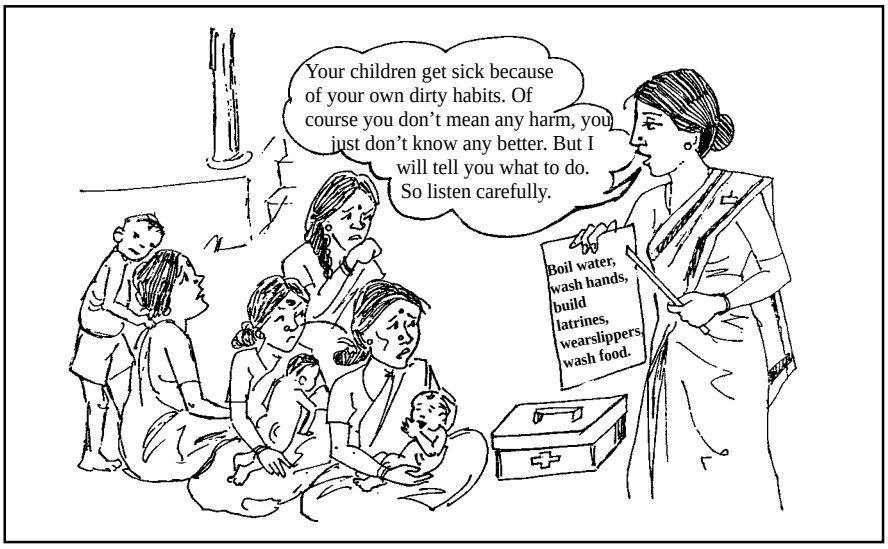
"I cannot understand why the people haven't responded better to our community health programme". Primary health care has come to stand for immunization, which is very good and a lot of 'be clean', and 'how to do' rather

than any relief from the pain and suffering people are experiencing. Even at the level of district hospital there are no facilities for blood transfusion, or emergency surgery. There is no blood bank or oxygen cylinders. The poor in the villages have to go a long way yet to get any of these, in the absence of good roads and means to transportation.

The characteristics of Primary Health Care as it exists maybe summarized as:

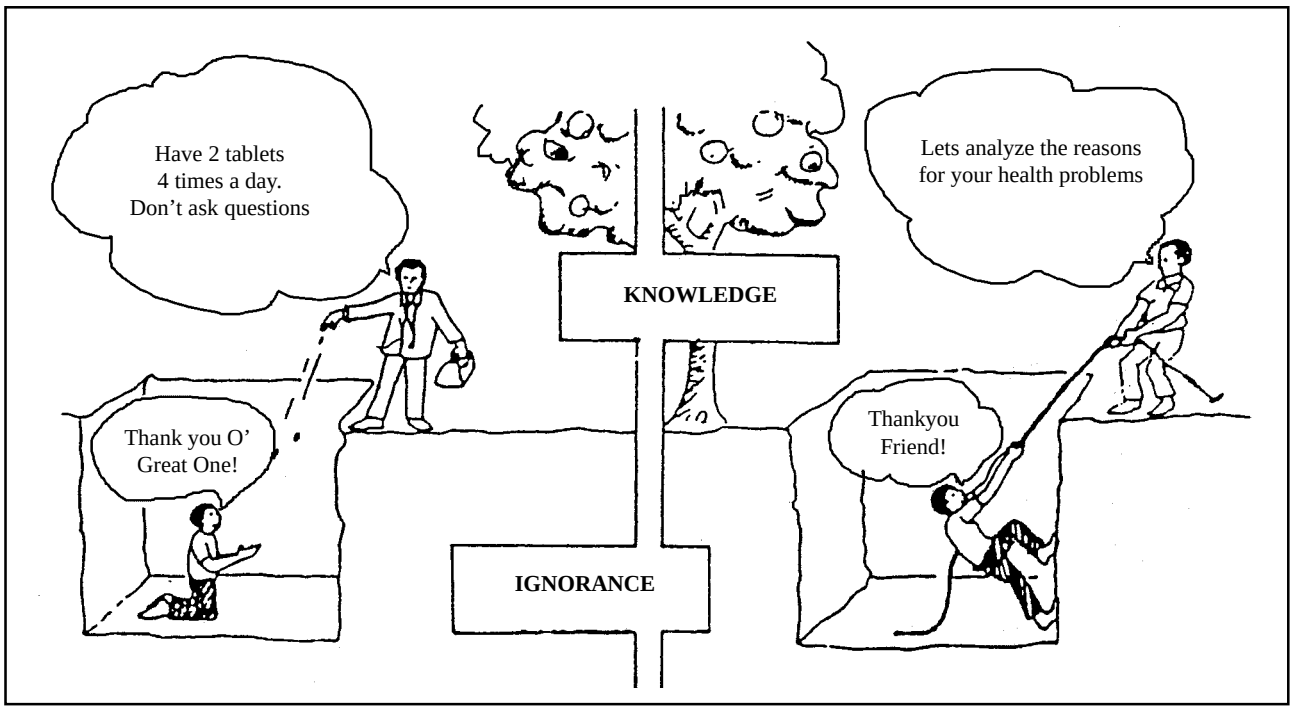
At the Ministry of Health level: weak, poor planning ability, insufficient funds; and the few non medical experts. At the tertiary level, we have disease palaces where doctors care for the city elite. At the district hospital level, it is isolated from the rest of the community. There is poor communication, the referral chain is poor. And at the primary care level, there is limited coverage, very few health workers and inadequate supply or even non availability of essential medicines.

Attitude of health providers



Discuss

These messages are given by nurses who come to give health talks. Although in principle Primary Health Care stands for working with the people, attitudes of health personnel have not changed. They continue to talk down to the people with little respect for their wisdom and no understanding of the conditions under which people live.



“Take two pills four times a day, don’t ask questions. Thank you, o great one.” It is not, “let me help you to know better”.

The attitudes of the doctors have not changed either. They ‘deliver’ health care.

Discuss

The meritocracy which is part of the hidden curriculum in medical colleges is to some extent responsible for these attitudes. Specialists know more than general practitioners, doctors know more than nurses, and those with training know best compared to the lay person. It is also reflected in the rigidly hierarchical nature of decision making with respect to the right kind of therapy or patient management, and in the strict demarcation allocating intellectual functions performed by doctors and routine, mechanical and manual work to nurses.

Despite the fact that the principle of Primary Health Care explicitly acknowledges that improvement in the health status can plainly be achieved with improvement in the quality of life of populations, doctors feel that they have an obligation to find a pill for every ill.

Community Participation

Community participation is the means through which the goals of Primary Health Care are sought to be achieved.

Participation as a way to control people: “How can we get them to do what we want. Why not through community participation?”. It is not participation of the kind where people are involved with what to do about a problem.

Often community participation consists of seeking people’s participation in terms of labor to build a health center; or some land or cash. In other words , participation to help implement decisions already taken on their behalf, “in their own interest”, by the authorities

International context

Another major variable influencing health care systems which should not be forgotten and that is the international context. One of the important actors is the multinational pharmaceutical industry which influences research, the kind of therapy that is promoted and availability of drugs. This is a very strong interest group which can shape the nature of health care delivery. One obvious way in which they have been known to intervene is when countries try to have an essential drugs programme, limiting the number of drugs that the country would import, and banning necessary products. Multinational pharmaceutical companies have worked behind the scenes to abort the essential drugs policy in Bangladesh, for example.

The second very important international force influencing the health care system is the population control lobby. They give funds for population programmes and in many countries these funds can be so disproportionate to what the country spends on other aspects of health. In Bangladesh, recent figures show that the funds received by the public and private sector for family planning programmes is far more than health budget taken as a whole. When the government is short of funds for health, and so much money is available for family planning programmes, it decides to receive the funds and use it as best as it can: for developing infrastructure, employing additional personnel and so on, which it believes will help the health sector as a whole. Personnel are employed and facilities set up from the family planning programme budget but are meant to deliver other services.

The government thus tries to arrive at a balance. But very soon, the donors are asking for results in terms of achievement of FP targets. And then the programme emphasis shifts to achieve, between answering and being accountable to the public: the latter cannot be ignored by any government in parliamentary democracies.

Comprehensive versus Selective health care

Another international force that has influenced the priority setting and resource allocation in health services is the Selective Primary health care lobby, which has spearheaded programmes such as Universal Child Immunization. Although the argument is not against immunizations as such, but this is a vertical programme which is supposed to be good for all countries, and all situations. It is not in response to local needs or based on local situations analysis. It is not part of an integrated programme. It has come from top down. In itself immunization may be a good idea but considering the resources that it consumes and the approach that it takes, one has to rethink.

For example, in the community where RUWSEC works, neonatal tetanus is almost non existent now, perhaps because of immunization, we don’t know. But neonatal mortality is very high because babies are dying of other causes. Nothing has been done about this because no one is even aware that there is such high infant mortality although immunization coverage of pregnant women is high. Resources continue to be heavily invested in the immunization progamme. Health budget is skewed in favour of selective health care.

Comprehensive health care 'addresses the main problems in the community, providing promotive, preventive , curative and rehabilitative services'. Selective health care addresses only specific areas of health as important which are identified by state, not by local planning. The focus in on quantity /targets as different from processes. This results in fragmented inputs and not integrated.

Interaction between women and the health care system

Last but not the least is the attitude to women in the health services system. Some manifestations of these attitudes are as follows: only those health problems of women that are related to pregnancy and childbirth are given importance; it seems to be totally unconcerned with what happens to her before, between or after her pregnancies. Studies also show that there is a strong bias against women in the teaching and practice of medicine. "It is widely taught, both explicitly and implicitly that women patients (when they received attention at all) have uninteresting illness, are unreliable historians and are beset by such emotionality that their symptoms are unlikely to reflect 'real' disease". *(Howell Mary C. What Medical Schools Teach About Women, The New England Journal of Medicine, 1947, pp. 304-307, as quoted in Sathyamala et al.)*

More often than not, women's gynecological complaints are dismissed as trivial; little research has gone into relieving and non-specific vaginal infections that most women suffer from.

Gender inequalities in society is reflected in the health services system also through the concentration of men in decision making positions and women in the lower rungs of the hierarchy. Although in India, unlike many other countries, there are a number of female medical professionals in responsible positions, they are still the exceptions rather than the rule.

To summarize, our health care systems are hierarchical and elitist; reflect dominant social attitudes to women; and have, in their attempt to integrate Primary Health Care into existing structures of inequality without fundamental reorganization, completely distorted its principles.

Interaction between women and the health system

Women's status influences their recognition of illness, the perception of how severe it is, the perception of what is causing it, and therefore their decision as to the type of medical help suitable: is this an illness you can go to hospital for, or do you have to go to a faith healer for it?

Then comes the distance, means of transportation and the cost. Even if the health services are free there is an opportunity cost involved and people have to be sure that it is worth it. Quality of care is an important factor in decision making. If what is available to you when you are reaching a district hospital after crossing incredible barriers is not satisfactory, this will be a very strong barrier against seeking medical help from that source.

From the point of view of third world women who characteristics have been described, formal health services are:

- physically distant
- economically unaffordable
- culturally alien
- socially alien
- socially dehumanizing
- technically inadequate
- organizationally inefficient

What does organizationally inefficient mean? For example, we have to wait till the chief doctor/medical officer is available to take some difficult decisions. "Does the woman have to go to the operation theatre?" is not something a junior doctor alone can decide. The decision chain is very hierarchical and the risks that juniors and about nurses and auxiliary staff will dare to take in an emergency situation are minimal because they have never been involved. This can cause considerable delay and can make the difference between life and death in case of emergency.

Many women die, not because the technology to save their lives is not available, but because of the inappropriateness and inadequacy of the health care system to cater to their problems.

(Source: Pengalum Maruthva Amayppum: RUWSEC publication)

B1 **Modern Parable**

There was once a factory which employed thousands of people. Its production line was a miracle of modern engineering, turning out thousands of machines- every day. The factory had a high accident rate. The complicated machinery of the production line took little account of human error, forgetfulness, or ignorance. Day after day men and women came out of the factory with squashed fingers, cuts, bruises. Sometimes a man would lose an arm or a leg. Occasionally someone was electrocuted or crushed to death.

Enlightened people began to see that something needed to be done. First on the scene were the churches. An enterprising minister organized a small first aid tent outside the factory gate. Soon, with the backing of the Council of Churches it grew into a properly built clinic, able to give first aid to quite serious cases, and to treat minor injuries. The town council became interest together with local bodies like the Chamber of Trade and the Rotary Club. The clinic grew into a small hospital, with modern equipment, an operating theatre, and full time staff of doctors and nurses. Several lives were saved. Finally the factory management, seeing the good that was being done, and wishing to prove itself enlightened, gave the hospital its official backing with unrestricted access to factory, a small annual grant, and an ambulance to speed serious cases from workshop to hospital ward.

But, year by year, as production increased, the accident rate continued to rise. More and more men and women were hurt or maimed. And, in spite of everything the hospital could do, more and more people died from the injuries they received.

Only then did some people begin to ask if it was enough to treat people's injuries, while leaving untouched the machinery that caused them.

(Tamil pamphlet inserted)

Questions for discussion:

- What is the message the story is trying to convey?
- Can you draw parallels between the modern parable and present day society's approach to the health problems of the population?
- What should/can be done by individuals, groups, community leaders, NGOs, researchers, policy makers etc.

Session 5: Health-a fundamental human right

Session Objectives: At the end of the session participants will be able to:

A. Briefly explain health from a rights perspective and get familiar with human rights

B. Explore ways of increasing accountability of the state in promoting, protecting and fulfilling these rights.

Training Materials required for the Session:

A. Copies of Lalita's story and Murugan's story (Session 1), papers, pens, cards for writing the UDHR or/and chalk for marking on the floor, explanation about UDHR on a chart.

B. Papers, envelopes, pens, information about Universal Declaration on Human Rights (UDHR)

Methodology:

Present the objectives.

A. Understanding health from a rights perspective **1 hour 10 minutes**

Divide participants in two groups. Refer to the narratives in the Session 1–'Murugan's story' 'Lalita's story'. Ask participants to recollect the stories and narrate them briefly. Thereafter ask participants what 'having the right to something' or 'violation of a right' means. Ask participants to share with examples. (20 minutes)

Give each group one narrative. Ask them to read the narratives carefully and discuss and list the rights that have been violated. Give an example of violation of rights from each narrative- for example, Murugan began working when he was 12 years old – his right to education has been violated. Lalita had seven children – her right to decide how many children has been violated. (20 minutes)

While the groups discuss the narratives, draw circles on the floor, with one right as per the Universal Declaration of Human Rights (UDHR) (A1) written on the floor with chalk or on a card and placed in each circle.

In the large group, each group presents their discussion in the following manner: One member of the group reads /narrates the story and other members of the groups occupy the circle(s) with the right (s) that has been violated as the narrative progresses, based on the discussion in the respective groups. The participants in the circles continue in their positions and the same process is followed by the next group. (20 minutes)

Sum up with a brief explanation of the UDHR (A2) and the different treaty bodies. Refer to the previous sessions on social determinants of health and clarify that right to health implies that various other rights like right to education, right to sanitation, right to life etc. have to be promoted, protected and fulfilled. (10 minutes)

B. Explore ways of increasing accountability of the state in promoting, protecting and fulfilling these rights 1 hour

Divide participants into 4 groups. Distribute papers, charts and pens to each group. Ensure that there is at least one person in each group who can write (either participant or co-facilitators). (1 hour)

Groups 1 and 4: Write a letter to the Prime Minister of India with a copy to the Chief Minister of the State. The letter may begin "We have the right to health/to be healthy". Participants should include in their letters whether or not at present that right is respected /ensured, protected, promoted or violated – how, why. The letter should also include action that the state needs to take to promote, protect and fulfill the right to health. Clarify that the rights at all levels are included, viz, individual-household, community, state/national and international.

Group 2: Are members and leaders in a community and hear about Lalita and Murugan, what would they do - evolve 3 strategies.

Group 3: Are members of an NGO and hear about Lalita and Murugan, what would they do- evolve 3 strategies.

Some responses for strategies maybe:

- Raising awareness about human rights
- Monitoring and reporting violations to the authorities. If violations by the state/authorities (for example, by the police) then report to independent committees like State Human rights Commission, National Human rights Commission, or even NGOs in case of the community reporting.
- Network with other NGOs/ groups to pressure the government / health system to protect/promote rights through public meetings /campaigns etc.

In the large groups the four groups present their 'letters' and strategies.

Sum up the activity highlighting the ways in which these rights are violated at various levels –household, community, and state, international. Connect the issues highlighted by Groups 1 and 4 with the strategies developed by Groups 2 and 3.

Conclude that the state is accountable to the people and is bound to :

Respect (ensure that the state does not violate)

Protect (take necessary steps so that other non state actors do not violate. (For example, individuals/groups, health services-private and public, pharmaceutical companies, factories, employers)

Promote human rights (take necessary steps to fulfill the rights. For example, by ensuring the necessary conditions to fulfill the rights – e.g. financial resources, infrastructure)

Conclude with the song 'O this government'. If not possible to sing it then read as a poem (B1).

Materials used for training / handouts include:

A1 **Human rights as per the Universal Declaration of Human Rights to be written on cards/in the circles.** (Add on if necessary)

- Everyone has the right to life, liberty and security of person
- Everyone is entitled to all the rights and freedoms without any distinction of any kind such as race, colour, sex, language, religion, political or other opinion, social origin, property, birth or other status.
- No one shall be held in slavery or servitude ……prohibited in all their forms
- No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- Men and women of full age….have the right to marry and to found family
- All are equal before the law and are entitled without any discrimination to equal protection of the law.
- Everyone has the right to freedom of movement ….and freedom of peaceful assembly and association
- Everyone has the right to a standard of living adequate for ... health and well-being of himself /herself and his /her family
- Right to food, clothing, housing, medical care and social services
- Right to security in the event of unemployment, sickness, disability, widowhood, old age.
- Motherhood and childhood are entitled to special care and assistance.
- Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.
- Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages……and higher education shall be equally accessible to all on the basis of merit.
- Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
- Everyone without discrimination has the right to equal pay for equal work.
- Everyone has the right to take part in the government of his/her country, directly or through freely chosen representatives. Everyone has the right of equal access to public service in his/her country.
- Everyone has the right to freedom of opinion and expression
- Everyone has the right to freedom of thought, conscience and religion….

A2 **Universal Declaration of Human Rights (UDHR)**

The UDHR was adopted by the UN General Assembly on 10th December 1948. It provides a 'common standard of achievement for all peoples for all nations.

The universal Declaration proclaims that human rights are based on the inherent dignity of every human being. The right to freedom and equality that are derived from the inherent dignity of the human person are inalienable and superior to powers of the state. They cannot be given or withdrawn by any ruler or legal system.

There are four major human rights (HR) treaties based on the UDHR:

- The International Covenant on Civil and Political Rights (ICCPR)
- The International Covenant on Economic, Social and Cultural Rights (ICESCR)
- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) focuses on women's rights
- The Convention on the Rights of the Child (CRC) focuses on the rights of children

The CEDAW and CRC are to be read along with the other treaties (ICCPR and ICESCR). For example in Lalita's story and in Murugan's story, the rights that were violated are based on ICCPR and ICESCR as well as CEDAW and CRC.

Each of the treaties has independent committees to monitor their implementation. These are called 'treaty bodies'. Governments /States that sign /ratify these treaties (India has ratified all four) and they are obliged to promote and protect rights as laid down in the treaties. They are supposed to amend their laws in keeping with the International Human Rights (HR) standards. The state is obliged to report periodically to the treaty body on how they put the provisions of the treaty into practice. In case of gaps in the law and /or gaps in implementation, or violation of rights, individuals and organizations can use the international HR norms to draw attention to the violation and advocate for changes.

B1 O this government!

O this government, O this government
We lost our property
We lost our livelihoods
Must we lose our rights?

Oh no Oh no
No hut no drinking water
The streetlights do not work
No medicines no education

No work and no respect
Is this a free nation?

Oh no! Oh no!

This is a crematorium where we are burnt!

Power of money and designation
Destroy the lives of common people
We will understand the schemes
And continue our struggle
Till we get our rights

We will form a *sangham*
Get rid of caste and creed

Court takes bribes
Upholds lies
Create divides to benefit them

Respect people
Justice, rights and equality…
When will it be time for equality.

(RUWSEC Songbook: Author unknown)

Sexual and reproductive health as a gender and poverty issue

This Chapter looks at the impact of poverty, caste and gender on sexual and reproductive health. It facilitates understanding of reproductive and sexual health and rights as envisaged at ICPD and the reforms that are taking place and their impact on sexual and reproductive health specifically for socio-economically marginalized groups.

This chapter covers:

Session 1: Sexual and Reproductive health: definition and determinants 3 hours 30 minutes

Session 2: A basic understanding of the structure of India's health system and consequences of health sector reforms 3 hours 40 minutes

Session 1: Sexual and Reproductive health: definition and determinants

Session objectives: At the end of the session participants will be able to:

A. Explain the meaning of sexual and reproductive health (SRH) and explore the determinants of SRH from the perspective of class, caste and gender

B. Explain sexual and reproductive rights and their bearing on sexual and reproductive health

Training Materials required for the session:

A. Development game, Definitions of reproductive and sexual health as per the International Conference on Population and Development (ICPD) on charts; board / charts to record participant responses; pens/ chalk, co-facilitators maybe required for each group during the game;

B. Situations written on cards for discussion; papers and pens/pencils, charts, glue, old magazines, sketch pens, paints, scissors, board/chart, pens/chalk

Methodology:

Present the objectives of the session.

A. Understand the meaning sexual and reproductive health and explore the determinants of SRH – from the perspective of class, caste and gender 1 hour 30 minutes

Divide participants in smaller groups if required. Introduce the Development game (A1). Continue the game for 30 minutes or till someone reaches the winning box (30 minutes). After the game, ask participants for feedback about the game: (20 minutes)

What were the issues /messages highlighted by the game? Reasons for some of the practices / behaviour referred to in the game.

How do these affect health and whose health is affected? How does poverty and caste affect health? How does gender affect health?

Sum up briefly the impact on health, especially sexual and reproductive health (SRH). At this point need not categorise as SRH (5 minutes).

Brainstorm: What is sexual and reproductive health? (10 minutes). Record the responses on a chart and summarize based on the definition of Reproductive and Sexual Health (A2) at International Conference on Population and Development (ICPD). (20 minutes)

B. Be acquainted with sexual and reproductive rights and their bearing on sexual and reproductive health 2 hours

Divide participants into four groups. Give one situation to each group (B1). Ask the groups to discuss the situation and develop it further as realistically as possible. (10 minutes). In the large group, each groups presents their narrative. (20 minutes)

For example, situation 1 could develop like this: Selvi and Babu are daily wage agricultural labourers and live in a village near Chengalpattu town. They have been married for 4 years but do not have any children. Her husband and his family have been harassing her for 3 years. She has been depressed because of the harassment and the fact that she is unable to bear a child. In the village, she does not attend any auspicious functions. She has tried all the local traditional remedies that were recommended.

Some months ago she asked the village nurse for help. The village nurse told her that she and her husband should go for a check up. When she told Babu, he was very angry and beat her because she dared to suggest that there was a problem with him. He was not willing to go for a check up.

During a visit to her parent's home she visited the hospital. The doctor did some tests and said she would need to come back for more tests and also asked her to bring her husband along. Selvi never went back to the hospital after that. She was afraid to ask her husband or his family, there was never any time, nor was there money to go to the hospital in town for the treatment. Babu's family now wants him to leave Selvi at her natal home and get married again.

Ask participants to discuss and list in each group- the cause of sexual and reproductive health problems; Consequences of the problems and barriers to health care. (15 minutes)

For example: In Babu and Selvi's situation it was not clear if the problem lies with him or her. Her husband was unwilling to go for a test.

Consequences: Selvi's physical and mental health suffers because she does not have children. She is blamed for not having a child and she blames herself too. Her status in the household and the village is low. Babu plans to leave her at her parents' home and remarry.

Barriers: The services for infertility are available at the hospital in town. Lack of information about the problem and cost of accessing treatment – especially for the poor as it means loss of one day's wages, extra cost for the travel. For Selvi, the family maybe reluctant also because of the various chores that need to be done at home.Selvi's lack of access to resources, lack of decision-making are all barriers to care.

In the large group discuss and list the issues on the chart/board (20 minutes). Highlight how class, caste and gender determine SRH and its consequences and impact access to care /treatment.For example, gender: In this situation, Selvi's status in the family and village. She is blamed for not being able to have a child, is considered inauspicious. No one thinks that Babu may have a problem. The health system too expects Selvi to 'bring' Babu for tests. The nurse does not try and talk to Babu or his family. Selvi does not have the power to make decisions nor does she have any money. Sum up the main points of the discussion, highlighting the impact of caste, class and gender on SRH. (10 minutes)

Ask participants in their respective groups, to identify from the situations developed by them, the rights that should be protected, promoted, fulfilled so that men and women enjoy Sexual and Reproductive Health. Ask each group to create a poster reflecting these rights. Distribute the materials for the poster. Participants present their posters in the large group. (30 minutes)

Discuss whether Sexual and Reproductive rights are human rights and reasons for that, the difference between sexual and reproductive rights. Conclude by referring to some human rights key to sexual and reproductive rights (B3) and the reproductive rights as envisaged in ICPD (B2) (15 minutes).

Materials Used for training/ handouts include:

A1 **Game Board :The Development Game**

Entrance fee
Birth of a girl child – Move 2 steps ahead
Female Infanticide – Leave the game
Joining school – Move one step ahead
Care for the girl child – Move one step ahead
Dropping out of school in the fifth class - Go back to the first box/square
Savings for children's education – Move two steps ahead
Women have the freedom to make decisions – Move four squares ahead
Control of women in the name of tradition – Go back to the first square
Savings are for girl's marriage – leave the game and start from the beginning
Earn yourself – move two squares forward
Control by men – remain in this square
Property rights – move one square ahead
Women in old age can help others – Move one square forward
Management skills –Move one square ahead
Unity is strength
YOU WIN THE GAME

Prepare as many boards or floor drawings as there are participants, so that everyone can play the game. The game maybe prepared on boards and dice can be used to play or alternatively, the boxes maybe drawn with chalk on the floor of the training area and dice or 4-5 sets of cards with numbers 1 to 6 written on them maybe placed in a bag for participants to pick up.

A2 **Definition of SRH** (on charts)

1. 'Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate

health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases'.

(International Conference on Population and Development — Cairo 1994; Programme of Action, para 7.2)

2. 'Sexual health means that people should be able to have safe and satisfying sex lives. Gender relations should be equal, responsible and mutually respectful. Sexual health encompasses behaviours essential to countering sexually transmitted diseases (STDs), including HIV/AIDS. Sexual health aims at the enhancement of life and personal relations, and sexual health services should not consist merely of counseling and care related to reproduction and sexually transmitted diseases'.

(FWCW Platform for Action, paragraph 94; ICPD Programme of Action, paragraph 7.2)

B1 **Situations to be developed and discussed**

Selvi and Babu are daily wage agricultural labourers and live in a village near Chengalpattu town. They have been married for 4 years but do not have any children.

Kala and Sekar have three girls. Kala is pregnant again but does not want to have another child as they are finding it difficult to take care of the three daughters.

Malar is 19 years old, single and is from a very poor dalit family in Kaaranai village. She has not got her period for 2 months.

Lakshmi is 48 years old, lives in Selayur, a very remote village. The nearest bus stop is 5 kilometres away. Her uterus prolapsed after aborting her sixth pregnancy.

B2 (Reproduce on a chart)

Facilitator connects the posters with Reproductive and Sexual Rights as envisaged in ICPD:

"…….Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed".

(International Conference on Population and Development — Cairo 1994; Programme of Action, para 7.3)

B3 **Human Rights Key to Reproductive Rights**

1. The Right to Life, Liberty, and Security
2. The Right to Health, Reproductive Health, and Family Planning
3. The Right to Decide the Number and Spacing of Children
4. The Right to Consent to Marriage and to Equality in Marriage
5. The Right to Privacy
6. The Right to be Free From Discrimination on Specified Grounds

7. The Right to be Free From Practices that Harm Women and Girls
8. The Right to not be subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment
9. The Right to be Free from Sexual Violence
10. The Right to Enjoy Scientific Progress and to Consent to Experimentation

*(Centre for Reproductive Rights **www.reproductiverights.org**)*

Session 2: A basic understanding of the structure of India's health system and consequences of health sector reforms on sexual and reproductive health

Session Objectives: At the end of the session participants will be able to:

A. Describe India's health care system

B. Explain in brief health sector reforms (HSR) and their consequences on sexual and reproductive health especially for socio –economically marginalized groups

Training Materials required for the Session:

A. Charts and pens/colors, structure map and information on charts, writing paper

B. ICPD-HSR aspects on chart for discussion, pens, paper

Methodology:

A. Structure of India's health system **40 minutes**

Present the objectives and introduce the activity.

Divide participants into smaller groups. If possible try and group persons who are from the same village or nearby villages. Ask each group to map the existing health facilities private and public, allopathic and non-allopathic in their areas –up to the nearest 'big' hospital. For each of these facilities, the groups detail transport facilities, distance, and cost of transport. (20 minutes)

In the large group the groups present / discuss existing facilities, services. Discuss the following questions and list the responses. (10 minutes)

- When you fall sick, where do you go? Why? (Government hospital/Private hospital/Indigenous medicine/ Quack.)
- For which type of health problems do you go to Government hospital/Private hospital/Indigenous medicine. Explore if any other. Why?
- Who seeks health care the most in your family? Why? Man/Women/Child (male/female)
- How much do you spend for health annually? For which specific health problem?

Following this, using the map of any one of the groups, explain briefly the structure of the public health system for the country and the State and norms for each level of the structure (rural) (A1).

Ask participants to discuss services, timings, locations provided at the sub center, the PHC, the CHC, the district hospital in their areas, with reference to the norms/standards that have been discussed.

Note the differences and common points in the large group. (10 minutes)

Activity ***50 minutes***

(20 minutes discussion+ 20 minutes presentation + 10 minutes post presentation)

Ask participants to go back into their groups and ask each group to evolve strategies to improve the public health system in their areas. For example, what will they do if the sub centers in their areas are closed, the Village Health Nurse (VHN) does not stay in the village, the PHC remains open only for two hours, no deliveries are conducted etc.

OR

If possible arrange an interface between health providers (Village Health Nurses and other Primary Health Centre staffs) and the participants and local leaders in Panchayat Raj Institutions (PRIs) in respective areas to discuss and strategize for possible improvement.

B. Health sector reforms (HSR) and their consequences on sexual and reproductive health especially for socio –economically marginalized groups **1 hour 10 minutes**

Ask participants if they are aware of any changes that have taken place in the last ten years in the health centers and details of the changes. In case of changes ask the group to share and list the changes. (Also refer to Session 3 for discussion responses) (10 minutes)

Who is behind these changes?

In case participants are not from a state with HSRs or are not aware of it, continue with the following activity.

Refer to the earlier activity about the health structure and services provided at each level. Recap the changes to improve the quality of care, range of services etc. that the participants had presented. (5 minutes)

Explain that reforms / changes have been introduced in the health systems of a large number of developing countries, including in India. These changes are the Health Sector Reforms or HSR. They were introduced in the 1990s to deal with the problems of poor quality of care, insufficient funding for health, inefficient delivery of health services, inequities and limited access to health services, lack of accountability and/or insufficient responsiveness to client needs'. (*Rights and Reforms Initiative: WHP: South Africa: unpublished*)

In the 1990s many developing countries were under enormous international pressure from donor and lending agencies to introduce market-style reforms in their public sector, including the health sector. (Refer the session on Globalization.) The countries were dependent on aid and loans from international agencies due to severe economic crises. The World Bank was the biggest lender for health and the main supporter of HSR. Thus HSRs were introduced in many countries all over the world. (10 minutes)

Explain using the chart with the content /aspects of HSRs, comparing it with the ICPD recommendations (B1). (15 minutes)

Divide participants into two groups. Ask participants to discuss each aspect of HSR and its possible impact on sexual and reproductive health. Explore who uses public health services and reasons. Explore the impact therefore of such reforms particularly for poor, for women, for dalits /tribals and other marginalized groups.

Encourage participants to share their personal experiences if participants are from states where reforms are taking place. (30 minutes)

Activity ***1 hour***

Divide into four groups.

Group 1 and 3 firmly believe in the ICPD agenda to promote sexual and reproductive health and rights.

Group 2 and 4 firmly believe in the need for reforming the health sector and therefore the health sector reforms.

Explain that Groups 1 and 2 Groups 3 and 4 debate / discuss every aspect and strategize to achieve reproductive and sexual health as per ICPD.

In the large group let the groups present and discuss the process and responses:

What happened in the groups? Was it possible to come to an understanding without compromising on sexual and reproductive health and rights?

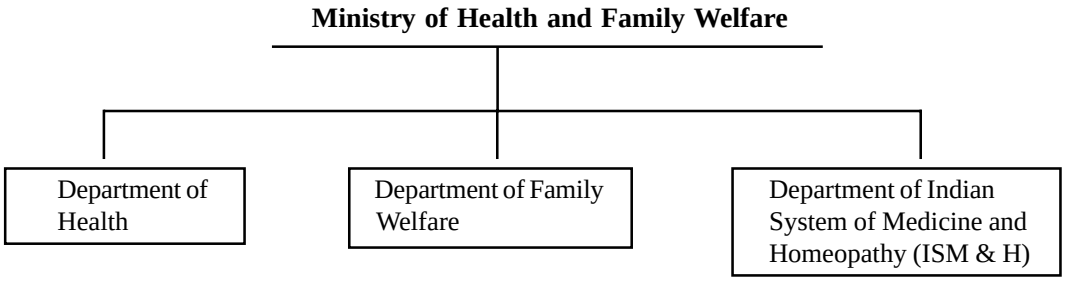
What were the decisions taken? What strategies were discussed?

What can grassroots organizations and community groups do?

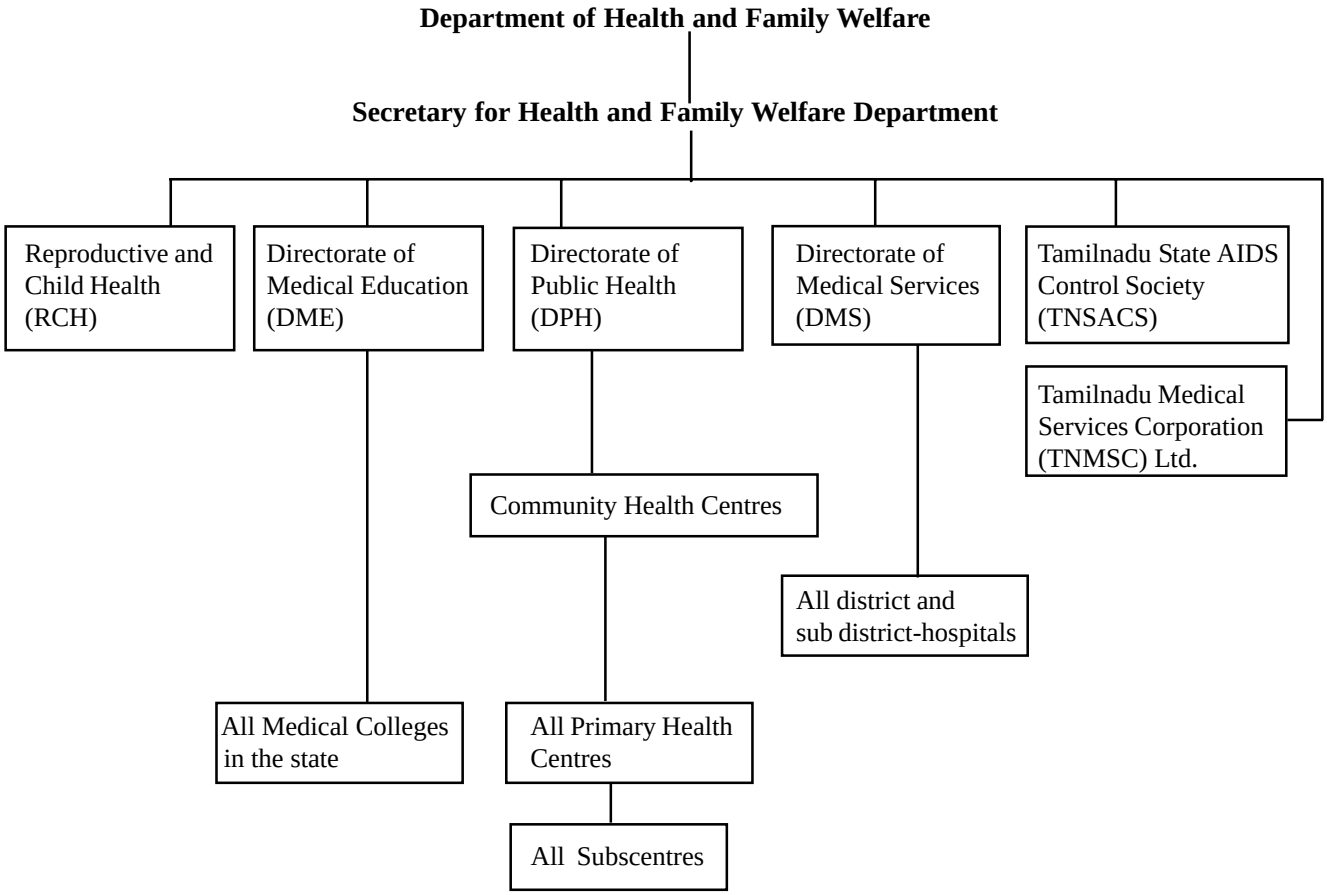
Sum up all the issues/points that came up during the session and conclude with examples of what organizations and community groups can do For example, raise awareness, strengthen capacities of marginalized groups and elected representatives in Panchayati Raj Institutions (PRIs), document and highlight impact of reforms on marginalized groups, especially women etc.

Materials Used for training / handouts include:

A1 Health structure



The state level structure in Tamil Nadu:



Explain:

Health is a state subject.

The Ministry of Health and Family Welfare at the Centre makes the policies and these are implemented by the departments. The Department of Health deals with the medical and public Health matters including drug control and food adulteration. The Director General of Health Services, New Delhi looks after the implementation of various national Health Programmes.

At the State /Union Territory (UT) level, there are Health Departments, which have the Directorate Of Health Services (DHS), similar to the Directorate General of Health Services at the Centre, and are responsible for implementation of various programmes of national and state importance and also for the Health Information System.

The States/Union Territories (UTs) are further divided into districts. The rural area of a district is divided into villages and urban area into towns and cities. The district chief Medical officer coordinates health functions of the district generally.

In Tamilnadu the Department of Health and Family Welfare is headed by the Minister of Health, followed by the Secretary. He/She is assisted by Joint Secretaries and Programme Officers who look after various programmes being implemented by the Department. The Department comprises several Directorates, some of which are indicated on the chart.

RURAL HEALTH STRUCTURE (on a chart)

Facility norms /standards, i.e. how many per how much population, location, staffing pattern, equipment etc exist. There are no norms for drugs and supplies.

District /Rural hospital is the main centre catering to both men and women. All services are provided by the Hospital at the town/ District level.

Community Health Centres (CHC):

Population: Cover 100000 -120000 population.

Location: Usually located in towns with a population of 20,000 and above. They serve as the first referral hospital

Infrastructure: They are usually 30-bed hospitals with Operation Theatre, X-ray, Labour Room and Laboratory facilities. Supposed to have a vehicle.

Staff: Each CHC is supposed to have four i.e. Surgeon, Medicine, Gynaecologist and Paediatrician supported by 21 paramedical and other staff.

Primary Health Centre (PHC):

Population: Cover about 30000 population

Location: generally located in Panchayats or mandal head quarters. PHC is the first contact point between village community and the Medical Officer.

Number of PHCs per CHC = 4

Infrastructure: Supposed to have a small operation theatre and male and female wards with a total of 6 beds. Equipment minimal lab and operating theatre devices.

Staff: One or two doctors supported by 14 paramedical and other staff. The activities of PHC involve curative, preventive, promotive and Family Welfare Services.

Sub-Centre:

Population: covers a population of about 5000 (3000 in hilly /tribal areas)

Location: Generally located in a large village, serves as the first link with the health system. It is the peripheral health institution available to the Rural Population.

Infratructure: Supposed to be one room plus buildings. Supposed to consist of kits for delivery etc.

Staff: Supposed to have two paramedical staff (1 male and I female) -multi purpose worker (Male) and one multi purpose worker (Female)/ANM / VHN.

(*Indian healthcare Sector : INGRESS: September 2003)*

B1 Health Sector Reforms and ICPD (Progamme of Action): a comparison of approaches

(Prepare the following table on a chart.)

Aspect	International Conference on Population and Development	Health Sector Reforms*
Financing	State should allocate resources to reach the goals of the ICPD POA. The international donor community to provide financial support to developing countries.	a. Introduction of user fees b. Social and private health insurance c. Privatize health care
Public-Private Interaction (PPI)	Integrate NGOs and local community groups into their decision-making and facilitate the contribution that they can make towards finding solutions to population and development concerns and, in particular, to ensure the implementation of the Programme of Action. Private 'for profit' sector in social and economic development, including production and delivery of reproductive health-care services and commodities, including appropriate education and information relevant to population and development programmes.	PPI for - Delivery and management of health services, mainly prioritized contraception delivery services

Aspect	International Conference on Population and Development	Health Sector Reforms*
Priority	Comprehensive reproductive health. IEC and services for Family planning, for prenatal care, safe delivery and postnatal care, Prevention and appropriate treatment of infertility, Abortion (not as an FP method), including prevention of abortion and the management of complications arising from abortions, Treatment of reproductive tract infections, sexually transmitted infections and other reproductive health conditions, IEC and counseling as appropriate on human sexuality, reproductive health and responsible parenthood. Referrals for further diagnosis and treatment as required for family planning services, complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancers and cancers of the reproductive system and sexually transmitted infections including HIV/AIDS.	Not comprehensive. Mainly includes Maternal and Child health, Family planning, prevention of sexually transmitted infections (STIs) /HIV /AIDS. No services for abortion, violence related health problems, adolescent sexual and reproductive health, infertility, and treatment of STIs, HIV/AIDS. No importance to provision of sexual reproductive health services for adolescents, elderly or those too poor to pay.
Integration of services	Focus beyond efficiency, on holistic care and client-oriented services. Integration of sexual and reproductive health services into primary care services, not just family planning and treatment of STIs.	Focus on efficiency and effectiveness.
Decentralization Community participation (CP) Accountability	To promote community participation and improve health service Community participation in needs assessment, planning, implementation, monitoring health services. CP and decentralization to further accountability of health institutions to health and SRH needs of of marginalized groups	To improve Resource mobilization and management Better meeting needs of the population CP in programme management and Service delivery, not in design of policies /allocation of budgets. Community only consulted, no decision-making powers. Recommends establishment of community participation structures, decentralization of health services, and community financing, as strategies for strengthening public health sector accountability. Seeks to strengthen accountability of the public sector through introduction of competition from private sector and user fees. Accountability of health workers than policy makers. No strategies for enforcement of accountability.

* 'Strengthening accountability to sexual and reproductive health and rights and community participation in the context of reforms', 'Sexual and reproductive rights in integration of reproductive health services in Asia': Ranjani K Murthy: Rights and Reforms Initiative, Women's Health Project: unpublished

APPROACHES TO WORKING IN THE COMMUNITY TO PROMOTE SEXUAL AND REPRODUCTIVE HEALTH

Module Two is organized differently from the previous Module. This module, based on the experiences of Rural Women's Social Education Centre, describes the process of leadership development for participation in health activities among women in the community.

The first chapter is a description of some ways in which the foundation may be laid for initiating the leadership training process. The second chapter deals with the concepts of leadership and the third chapter describes the content and methods for leadership training.

This Module covers:

Chapter 1: Laying the foundation for initiating the process of Leadership Training

Chapter 2: The Concepts of Leadership

Chapter 3: Content and Methods for Leadership Training

Annexure: Survey tools, health indicators developed by RUWSEC, possible tasks for grossroots womens organization, additional resources for initiating disucssions.

Laying the foundation for initiating the process of leadership training

Initiating the process of women's participation and leadership

We believe that women are the focal point for health development. This is because women have less access to health resources, though they are, for a number of reasons, in greater need of preventive and curative health service than most other sections of the adult population. Further, women themselves are an important health resource and their knowledge and skills in the area of health care and health maintenance are valuable.

Despite the fact that women as individuals are responsible for most of the informal health care provided within families women's participation in health activities at the community level is rare. This is a result of their general exclusion from decision-making and participatory processes within a community. This is especially true for women from the poorest and socially most deprived sections of the community.

We are interested in ensuring women's active involvement in health activities in the community, so that they are able to make health services more sensitive and responsive to their needs as persons and as women and mothers. Women's participation, however, cannot happen in a vacuum. Women have to be mobilised and mechanisms and channels for their participation need to be established. These could be women's health groups, or special groups or forums within existing women's or community organizations focused on women's reproductive health issues.

It may perhaps be possible for an external agent such as a women's organization or network to initiate the process of setting up such mechanisms. However, to sustain participation and to help extend its scope and coverage is a more demanding endeavour. What this calls for is the development of leadership among women in the community. The kind of leadership we envisage is characterised by:

- Awareness of health and related problems of women and deep concern about it
- Knowledge of alternative models and concepts of health care such as self-help and primary health care
- Vision of working to create a society free from inequities in access to all resources, including health
- Drive to initiate activities, and the will to sustain and carry them through

Guiding principles that inform our approaches and strategies

- Pursuing approaches which promote women's empowerment –enhancing information base, creating enabling conditions to make possible better self care and prevention and management of reproductive and other health problems
- Promoting equitable and mutually respectful gender relations
- Understanding of health as an equity and social justice issue and adopting strategies that involve the informed participation of the most marginalized sections of the community in demanding their right to conditions that make good health profile
- Recognizing that Reproductive Health (RH) is a woman's empowerment issue and cannot be achieved without gender and larger social equity
- Adopting interventions and approaches that uphold and promote women's reproductive rights

Carrying out a Situation Analysis

Initiating the process of leadership development in the community is a complex task. It demands extensive knowledge of various facets of the community, which have a bearing on the potential for developing women's leadership, and on popular participation in health development.

One of the first steps is to carry out a comprehensive situation analysis. This would aim at gaining insights into the health needs of the community, with special emphasis on women and children on the one hand; and on the complex factors influencing health status, on the other. Such a Situation Analysis would at the same time be an exercise that gives us the information necessary to appraise the potential for leadership development among women in the community and constraints and obstacles one may have to contend with.

Although it is the starting point, Situation Analysis is not expected to be a one-time exercise but an ongoing process of involvement with the community and its women. Secondly, the various aspects studied are not static but are constantly changing. Periodic review of the community situation is therefore imperative.

Getting started:

The first phase is a campaign phase, during which our purpose is to 'root' the idea of leadership development among women. An idea is on its way when enough people who matter are talking it over with one another. We seek to draw the attention of the community to the problems of high mortality in the country or region; to the widening of gaps in the health status of different sections of the population; to unmet health goals; and to get them to feel that they need to do something about it.

In addition to kindling the community's interests in the issue, the campaign also intends to mobilize community support and participation in the development of local leadership.

This will mean talking, not only to established community leaders, but also to people from different social groups and especially to women, explaining our focus on leadership development among women. After informal meetings over a few days, a public meeting may be arranged so that the message is conveyed to all members of the community. Role-plays, posters, film shows and simple songs may also be used to convey the message effectively.

Information needed:

Information sought for the situation Analysis may be grouped under the following heads:

- Health needs of women and children, and special health problems of the community
- Community health culture
- Community characteristics
- Women's status in the community

Health needs of women and children may be assessed through information on the mortality and morbidity levels, fertility rates, and major illnesses on the one hand; and information on utilization of health and family planning services, on the other.

Information on special health problems of the community such as tuberculosis, leprosy, parasitical infections and deficiency diseases may be sought from the local public health authorities.

The health status of women and children in a community is influenced by a number of factors, including what we call the community's health culture. We include within this beliefs and practices such as attribution of certain diseases to supernatural forces, food taboos, and practices surrounding pregnancy and childbirth. Other aspects of health culture of interest to us are traditional healing methods, traditional methods of fertility control, attitudes towards illness and healing, and notions about fertility and fertility control.

The first two of these have a direct bearing on health while the latter two affect health because they influence how women deal with their own and their children's illnesses, how they cope with high fertility, and what kind of professional help they seek, if at all they do.

The second factor that influences health status is the nature of the community itself: the resources at its disposal and its distribution across various social groups in the population, and between sexes within each social group, are a crucial factor. Included are both material and non-material resources: land, water, fuel, housing, sanitation, employment, wage levels, and education. Women's ill –health may be a direct consequence of their belonging to a poor community or to a marginalized subgroup of the community in some instances. And in others, it may be the outcome of gender-based discrimination even within a wealthy community, and in yet others, both factors may be operating. We need to know the situation that a particular community is in.

The third, and perhaps the most important of all factors influencing health is the way in which the community values its women. The family structure, the investment a family makes in its female members, the extent of autonomy women enjoy, the responsibilities and work load a woman shoulders, the presence or absence of social support, women's participation in decision-making within the family and community; the influence of all these on the health of women and their families has been established in a number of studies.

A description of the details to be examined under each of the four main heads discussed is presented in Table I :

Table 1
Information needed for situation analysis at the community level

Health Needs	• Age, Sex and cause specific information on deaths over the past 5 years • Information by age, sex on the number of pregnancies, children ever born and children survived • Common health problems as well as chronic and serious health problems, especially of women and children • Unmet need for family planning • Access to and utilization of health services, especially by women • It would be important to get such information by social class and caste or other stratification; other indicators of social status, e.g. education, occupation
Community Health Culture	• Beliefs, customs and habits that affect health • Attitudes and beliefs regarding fertility and its regulation/control • Traditional ways of coping with illnesses • Traditional healing practices • Traditional methods for control and regulation of fertility
Community Characteristics	
I. Resources: Material	• Land, water, fuel, food supply, housing conditions, waste disposal and sanitation etc. • Communication facilities, health posts, schools, markets • Availability of paid work and wage levels, by sex and by tasks • Wages in relation to cost of living • Population density or availability of physical space
Resources: Human	• Proportion of population literate/educated professionally trained • Leaders, healers, midwives and other health workers, people with special skills • Local organizations- formal or informal
II. Composition	• Age distribution, minority groups as a proportion of the population, distribution of population by nationality, race, religion etc
III. Structure	• Social stratification by race, ethnicity, religion or caste • Who controls whom and what: distribution of land, material and non-material resources (including access to information and to people in power; and mobility) • Distribution of power across social groups and between sexes within each social group
Women's status in the community	• Family structure • Cultural attitudes governing women's role in family and society • Age at marriage, existence of dowry or bride price, norms regarding choice of marriage partners, divorce, widow remarriage, social status of single, never married women • Women's access to and control over family's resources (food, money, property etc) • Extent of family responsibility shouldered by women; the extent of their work load • Availability of social support measures:space crèches, nutritional supplementation, credit etc. • Existence of mechanisms for women's participation in decision making in the community: representation in local government and other committees; membership in local organizations; participation in local women's organizations

The information needed for a comprehensive situation analysis is indeed vast. There are, however, ways in which this information may be obtained within a reasonably short period of time and at a low cost. The following section discusses some of these methods.

Some methods and techniques for gathering information for a local situation analysis:

The objective of information gathering for a situation analysis is to be able to get an overview of the context within which we will be intervening; and to have an idea of the nature and dimensions of the health problems in the community. We are therefore not looking for precise and accurate data as much as attempting to discern the broad contour of the issues involved. We give below some techniques for data gathering. Many of these techniques were inspired by data gathering techniques used for rapid rural appraisals prior to initiating rural development projects, but suitably modified for our purposes. These methods are informal and rapid, in contrast to those that are detailed and technically impeccable. They are suitable for collection of the kind of complex information that we are looking for on health status, health infrastructure and on determinants of health status. An array of methods may be used in conjunction, depending on the information sought. Which of the following methods may be used for each of the areas in which we need information is presented (Table II) at the end of this section.

I. Observing:

Observation is a method of gathering information in an unobtrusive manner. In observing, a person takes note of what he / she sees, hears, feels or experiences in a given situation. Keen observation demands that the observer be alert not only to the obvious but also to the subtle details in a situation. For example, when listening to a conversation between two people, one has to simultaneously register in mind the non-verbal communication or body language-the actions, gestures and expressions of the speakers as well as onlookers from the community.

Observation would be an ideal starting point for information gathering, before we go on to techniques such as interviewing which are high profile and draw a lot of attention to us. It would give us time to gain greater confidence and feel sure of our steps.

Observation is also a time and cost-effective method of gathering information. It yields two kinds of information:

- Direct evidence of living conditions, facilities available, environmental hygiene, crops being grown, women's activities and work load etc.
- Clues or symptoms, which provide indirect evidence of underlying perhaps invisible problems. For example: Frequency with which one encounters women and children who look malnourished; an impression that there are significant differences in health and socio-economic status across social groups; sensing hostility between groups in a public meeting.

These clues may need further investigation and probing, using other techniques before any conclusions can be reached. But they are vital for helping the analysis to proceed in the right direction.

The kind of observation that we are talking about consists of unhurried looking and listening aided by a checklist, and careful documenting of all the details. The observer(s) should stay in the community for at least three to four days, and watch the goings on during different times of the day, in the households, at work sites, in crèches, schools and health posts, and among different age groups, among men and women, across various social groups. Ideally there should be a team, which observes and discusses its findings at the end of each day, and follows up new leads. Subsequently, the maintenance of a field diary, recording all daily happenings would be a good practice.

II. Asking:

Talking and listening to people is perhaps the best way of learning abut the situation in a community. Apart from free, informal conversations with people, there are a variety of structured way in which one can ask questions and probe deep into an issue.

i. Guided interviews:

These are interviews based on a flexible checklist or a definite agenda instead of a questionnaire. The length of the interview and volume of information gathered depends on the willingness and disposition of the interviewee. No attempt is made to extract answers to all questions. Neither does the interviewer go through questions in a definite order or to interrupt the speaker to keep the discussion to the point. The idea is to start off a free conversation, asking certain key questions and gathering as much information pertaining to the agenda as possible. No written notes are made during the process but the interviewer may have to take a break between interviews to record the information.

A variation of this is the 'sonedo' method first used in Guatemala. It originally involved a pair of interviewers, usually an agriculturist and a social scientist, working together. The interviewing pair met each evening to exchange information and write up reports.

We can adapt this for our purposes, to have a pair constituted of a male and a female member, or members of two different racial / ethnic / caste groups. Each member may interview one specific section of the population: for example, the male member may talk to men, and the female member, to the women. This may put the interviewee at ease and facilitate the flow of information.

A further variation would be to have local person as one of the pair, but each person covers all aspects of the agenda. This is a good way to get the local people involved with the situation analysis, and to get to know their perceptions and perspectives on the local situation.

ii. Talking to key informants:

For information that requires specialized knowledge and training, or specific experiences, we can use the method of talking to key informants. For instance, we could get a good picture of practices related to pregnancy and childbirth as well as of maternal health problems common in the community, by talking to the traditional birth attendant. Key informants can also be those who shape or considerably influence public opinion in the community, such as leaders of local government or religious leaders. We may be able to get insights into notions about the role of women, or attitudes to fertility control, from talking to them. Talking to women leaders formal or informal, about factors that facilitated their rise to leadership, problems faced, the community's attitude to them and so on, may be a good way of learning what lies ahead of us in our attempts at leadership development.

It may perhaps be necessary to meet the same person more than once to get a good and reliable response. Care is needed in interpreting information gathered, as they are by definition, not representative.

iii. Talking to groups of people gathered informally:

There are many places or situations in a community where groups of women gather and have some time on hand to talk: public wells or ponds, work sites during breaks, places of worship, village shops, etc. It is relatively easy to start a discussion in such settings. Questions can be addressed to any one of them, but there is likely to be responses from several members. Some women may be more willing to talk than the others, and we may get a one sided view on some matters. This method may therefore be more useful in getting factual information pertinent to the community as a whole, such as availability of employment, types of work done, male and female wage rates, etc. Such details usually get a biased response in one-to-one interviews: for instance, wage payers tend to over quote, and wage receivers, under quote wage rates.

This method may also provide an appropriate context for asking some delicate questions such as habits related to hygiene, which when asked of individuals, may seem offensive. This may be used effectively to gather information on matters where collective memory may be more reliable: incidents of maternal and infant deaths in recent years and their causes, recent epidemics of communicable diseases.

Group interviews also provide the interviewer with the opportunity to size up respondents and to identify those who are articulate, those who seem popular and those with leadership potential in general.

III Participatory methods:

Methods described above need to be supplemented with participatory methods where the local people themselves define the problems rather than respond / give information on problems identified by others.

Participatory methods are based on three principles:

- That true involvement of the community depends on their learning of their conditions
- That learning starts with the familiar, the near at hand
- That facts have more interest when you have gathered them yourselves

One can go about participatory information gathering in a number of ways. Most of these would have one element in common, namely, organizing group meetings. Since our principal concern is promoting the participation of women, involving them right from the outset is a good strategy. The health worker can call for a meeting of local women at a time and location suitable to them. Separate meetings with women from different social groups and age groups may be necessary. Where there are women's local groups, we may contact the leaders and request for a meeting to be convened. Participants are encouraged to interact with each other actively, and care is taken to ensure that the discussion does not become a question – answer session between the facilitator and participants, a principle common to all participatory meetings. The facilitator has to be as unobtrusive as possible and not set herself as the authority figure in any way. She should refrain from commenting on participants' responses or correcting them from taking sides or giving any non-verbal cues of approval or disapproval.

Another participatory method used with some success with a literate group is to ask a select group of interested women to interview five (or a manageably small number) women each on a subject. The information thus collected is shared and compiled in a larger gathering including the interviewers and the interviewee as well as other women in the community. This is a step ahead of the other methods in that it initiates local women into purposive collection of information and compilation and analysis of it; in other words, equips them with the basic tools of research.

IV Sample surveys:

We do see a role for sample surveys in the community, in the process of information gathering, but a secondary one. These may be necessary for investigating specific aspects or problems: number of malnourished children, contraceptive prevalence, immunization coverage etc.

Face to face surveys have the advantage that they may help us learn about factors such as problems of individual households and differences in living conditions. They have, however, to be handled very carefully to get proper responses, and to avoid raising expectations of immediate action, which may turn to disillusionment and hostility when not fulfilled.

Some points to remember when planning a survey are:

- Discuss the need for a survey at a group meeting
- Keep it specific and focused on one or two issues rather than broad and general
- Find out how local people may be involved in it; as lay reporters of health events, investigators, in helping design suitable questions
- Keep questions to a minimum
- Ask only for information that makes sense to the respondents, and make sure they understand the purpose of the questions

V Using existing data:

For general information regarding population composition, number of births in a year, land ownership, educational status etc., use of existing records makes better sense than mounting a fresh survey, even if we are aware that such data are incomplete or not quite accurate. The general direction of biases in different kinds of data can be ascertained through informal methods we have earlier discussed. In any case we are more interested in magnitudes than on precise numbers. Examples of records that may be used are records of births and deaths, school enrolment registers, land records of beneficiaries of government programmes and so on.

Health data and health service statistics pertaining to the district and state to which the community belongs and other statistical data and reports for the macro level are very useful for cross checking information collected informally, and to examine any discrepancies and major deviations from the norm. Data such as maternal mortality rates, age specific death rates, age at marriage etc. are difficult to collect at the community level since they require a large sample. Use of district or state level statistics would be necessary in these cases.

In addition, grasp of the macro profile would enable us to place the social, economic and political processes observed in the community in the larger context of these in the area or in the country.

Table II below consists of techniques that may be suitable for collecting the different types of information for local situation analysis detailed in the earlier section.

Table II

Methods / Techniques suitable for information gathering for situation analysis

HEALTH NEEDS	METHODS/TECHNIQUES
Infant and child mortality rates by age and sex, maternal mortality rate, fertility rates	Existing data for the administrative unit
Common illnesses, chronic and serious illnesses, especially of women and children	Group interviews, talking to key informants Participatory group meetings
Utilization of health services	Health centre statistics
Unmet need for family planning (FP)	Sample survey, FP service utilization statistics
Community Health Culture	Observing, talking to key informants, group interviews Focus Group Discussions
Community characteristics	Observing, referring to existing records, guided interviews, and group interviews
Status of women in the community	Observing, talking to women leaders and community leaders, guided interviews, participatory group meetings with women

Factors influencing the potential for greater participation and leadership of women in health activities:

Before embarking on training activities or projects for leadership development in local women, it is important to be aware that quite apart from training factors such as effectiveness and relevance, several other underlying factors are likely to influence the success of this venture.

Among these are factors related to community characteristics, to women's status in the community, and to the structure and orientation of health services.

For example, the overall resource base of the community matters a lot. A very poor and isolated community with little access to resources will have health as a low priority as compared to other pressing socio-economic needs. The level of awareness is another important factor. If health problems are perceived to have biological causes alone, more medical facilities will be demanded and the need for local involvement will not be appreciated.

In hierarchically stratified communities where resources are concentrated in the hands of a few, appeals for participation may be viewed with suspicion and deemed as yet another way in which the poorer sections of the community may be exploited.

Whether the community has democratic institution for people's participation and decision–making or is subject to authoritarian leadership is yet another important factor. These factors will influence the extent of involvement in health development of members of the community in general. They are likely to have an even greater influence on the involvement and leadership of women because of women's subordinated status in most communities. Women usually have less access to resources than men, and greater responsibilities and work load, making any involvement in other activities sheer luxury. Their exposure to new ideas is usually more limited than that of men, and they may have difficulty in understanding the concept of women's leadership for health development. They form the lowest end of the lower rung in hierarchically stratified societies, which means that a great majority of women in such societies would never have been allowed to participate in decision making at the community level, leave alone allowed to lead.

Even where other community characteristics are favourable, the status of women is a crucial factor. The sexual division of labour leaves women confined to the home and children, and restricts their freedom of movement. This is true even in the case of women who are not poor and / or are hard pressed for time. Where male authority reigns supreme, it may find the very notion of women getting together to discuss and act through extra familial structures threatening, and confront it with hostility. Women's leadership role in health activities may be discouraged as culturally unacceptable, because it means that women are treading into the "public" domain hitherto reserved for men.

In societies where there is strict segregation of the sexes, the possibility that women in leadership position may have to interact with men who are not of the family, may be a deterrent. In such settings, women themselves have often internalized such values, and may be unwilling to break out of traditional restrictions, or afraid to do so.

The active presence of a women's group in the community can be a positive factor. We may work in collaboration with these organisations. Since there is already a forum for women, and there are women in leadership positions, what is required is just to motivate them to take interest in health development. This may not be difficult because issues related to maternal and child health and family planning are very much part of their lives, and closely intertwined with all their other concerns.

Much depends, however, on the nature of the local women's group. The group's membership may not be representative of the community, but composed exclusively of the well – off in the community. Or again, it may be controlled by the elite cooperating with us. If we work with such a group, we may alienate ourselves from women belonging to the poor and marginalized sections of the community. A comparable problem arises when the community is divided into conflicting social groups each with its own women's group.

Besides, there are factors within the health sector which may act as constraints. Mobilizing women's participation and leadership makes demands on the health sector that are completely different from what it is currently equipped for. It requires re-orientation, redefinition of roles and responsibilities, resource mobilization and considerable restructuring. If the health sector is consistently unable to meet the new and legitimate demands of local women, the latter may begin to feel frustrated and deem it not worthwhile to expend their time and energy on working for health development.

The concepts of leadership

What is leadership?

Leaders have been variously described, as those having a vision, commitment, and a passion for excellence; as people who think for themselves and are never willing to drift with the crowd; as persons who, when faced with a problem situation do not say "Why doesn't someone do something?" but, "What can we do?" and proposes a course of action.

Concepts of leadership and acceptable leadership styles are context and culture bound. Attempts at identifying the range of leadership styles have, nevertheless, come up with three broad categories of leadership into which a range of eight different leadership styles may be classified.

a) Authoritarian leadership

b) Consultative leadership

c) Enabling leadership

Different situations may call for different styles of leadership. An emergency situation may esquire that there is a strong leader who makes require that there is a strong leader who makes quick decisions and can influence other to abide by it. In a group situation such as in that of a newly formed women's group where members have no prior experience in participating in groups, the consultative type of leadership may be necessary. However, it is only the enabling leadership style that succeeds in developing maturity and responsibility among the people and helps them participate actively in decision making. The enabling leadership style is intended to move gradually to its ultimate objective, namely, help the group become self governing through collective leadership.

Leadership styles						
Authoritarian leadership		**Consultative leadership**			**Enabling leadership**	
Survival		**Security**			**Participation**	
Leader makes decision and announces it	Leader presents decision but 'sells' it to members	Leader presents decision and invites questions of clarification	Leader presents tentative decision subject to change	Leader presents situation, gets input, makes decision	Leader calls on members to make decision but holds veto	
Leader announces his /her decision with no feeling of responsibility to share the reasons	Leader announces his/her decision and shares the reasons behind it. which were prepared in advance (monologue)	Leader announces his/her decision, but responds on an impromptu basis with a rationale based on the questions of clarification from the members (dialogue with no expressed willingness to change decision)	Leader announces his/her 'tentative' decision and announces that (s)he is open to questions of clarification and discussion. (dialogue with willingness to change decision if necessary).	Leader identifies situation or problem and moves into a facilitating role to surface assumptions and suggestions. then moves out of facilitating role and makes a decision	Leader calls on group to identify situation and limitations, explore and make decision contingent on leader's veto power	Leader shares any 'givens' (e.g. funds available, the parameters etc.) and facilitates a decision among members on basis of limitations

One of the best descriptions of what collective leadership means is found in an article by Amilcar Cabral, the Guinea-Bissauan leader. (See Box)

> But to lead collectively is not and cannot be as some suppose, to give to all and every one the right of uncontrolled views and initiatives, to create disorder, empty arguments, a passion for meetings without results.
>
> In the framework of collective leadership, we must respect the opinion of more experienced people who for their part must help the others with less experience to learn and to improve their work.
>
> Combat the spirit of the 'big man', the traditional chief, boss or foreman among responsible workers.
>
> Combat the spirit of closed circles, an obsession with secrecy among some persons, personal questions and the ambition to give orders.
>
> Collective leadership must strengthen the leadership capability of (all) and create specific circumstances where full use is made of all members.
>
> Collective leadership means leadership made by a group of persons and not by one person alone or by some persons in the group.
>
> To lead collectively, in a group, is to
>
> - Study questions jointly
> - Find their best solutions
> - Take decisions jointly
> - Benefit from the experience and intelligence of each person
>
> To lead collectively is to
>
> - (give) the opportunity of thinking and acting
> - demand that people take responsibility with in their competence.
> - (require that people) take initiative
>
> To lead collectively is to
>
> - coordinate the thought and action of those who form the group
> - derive the greatest return in the accomplishment of the group's tasks, within the limits of their competence and in the framework of the activities and the interest of the organization.

(Cabral Amilcar, Unity and Struggle: Copyright 1979 by PAIGO. (as quoted in 'Training grassroots women for leadership in health development' :RUWSEC)

Another description compares collective leadership to a flock of wild geese in flight. The 'V' formation enables each bird, except the leader, to find an uplift in the slipstream created by the bird ahead of it. The lead bird quickly tires and its place is taken by another, while it moves back along the line to recover. Flying in formation, the birds can travel twice as far as a single bird alone. Sharing and caring are features of such a leadership.

Leadership for health action in the community: functions and requirements

'Leadership' here refers to the enabling and collective style of leadership. The role for local women leaders may be summarized as:

1. ***Health Education:*** Disseminating information of relevance to prevent and control diseases; enabling self – care for a number of common health problems; promoting discussion and reappraisal of beliefs and practices influencing health; helping women examine the factors underlying many of their health problems.
2. ***Advocacy:*** Playing an advocacy role in the community especially among the influential members, on issues related to women's health.
3. ***Mobilization:*** Mobilizing women to participate actively in health development, by spelling out their needs, and proposing measures or activities to help overcome obstacles to their fulfillment. This could be something as simple as ensuring regular immunization to more complex issues such as better wages to ensure adequate food supply. Further, to initiate activities and measures thus identified, and to carry them through.

To be able to fulfill their roles effectively, the local leader would need a wide range of skills and knowledge, and appropriate attitudes and qualities:

i Information requirements:

a) Information and analysis of local health problems and their underlying causes, both medical and non-medical

b) Knowledge of the 'Primary Health Care' approach which treats health as an issue of justice and equity; and a commitment to self – help as a philosophy

c) Prevention and simple curative measures that can be undertaken with respect to common health problems, pregnancy monitoring, and growth monitoring of children. Knowledge of first aid is another requirement

ii Social Skills:

a) Ability to communicate effectively

b) Ability to reach out to community members and to draw them out

c) Ability to work with groups agreeably and productively

d) Ability to identify and mobilise local talent and resources

e) Ability to inspire and motivate participation

f) Ability to network with other groups, sections within and outside the community

g) Ability to develop leadership in others

iii Qualities:

a) An analytical and enquiring mind that enables one to look for and gather the necessary information in a situation, to identify causative links

b) Creativity and imagination

c) Initiative

d) Openness and willingness to learn

e) Empathy and sensitivity

A LIST OF POSSIBLE HEALTH TASKS THAT LOCAL WOMEN LEADERS MAY PERFORM

1. Visit households in the community regularly, and inform the front line health worker of serious health problems. Also inform the health worker of births and deaths, especially maternal and infant and child deaths. Ensure that the front line health worker delivers the services he/she is supposed to and responds to the community's needs.
2. Encourage the community to keep water sources clean, and to arrange for safe disposal of waste.
3. Motivate the community to immunize children and pregnant women. Arrange for the health worker to immunise at a time and place suitable to the mothers, and help her complete it successfully.
4. Inform the public health authorities of any epidemics
5. Identify pregnant women, advise them on appropriate health care, arrange for them to attend ante-natal clinics.
6. Encourage women to critically examine traditional practices relating to pregnancy and child birth and to decide which of these would be beneficial to adopt, and which need to be necessarily avoided.
7. Identify danger signs in pregnancy and assist women to get immediate medical help.
8. Help those wishing to terminate their pregnancy to do so under appropriate medical supervision.
9. Persuade women 'at risk' and their families to ensure that delivery is assisted by qualified medical personnel.
10. Put together with the help of other women 'safe – delivery kits' , and distribute it to pregnant women.
11. Try to be present when a home birth takes place, and to assist in the observation of the 'three – cleans'.
12. Be able to identify danger signals during labour, delivery and postpartum and do one's best to secure immediate medical attention.
13. Explain the value of breast feeding soon after the baby's birth, and promote breast feeding in general.
14. Ensure proper cord-care for the baby.
15. Advise the mother on hygiene for herself and the newborn.
16. Promote the use of ORT for diarrhea.
17. Inform women about different contraceptive methods available and how they work. Help he women gain access to the methods of their choice.
18. Follow up women who have newly adopted a method of contraception and provide the health worker with feedback on their problems.
19. Provide first aid in case of emergencies.
20. Be able to treat simple health problems with home remedies and simple and safe drugs.

The process of leadership development

Let us begin with a basic question – " Is it possible to develop leadership in a person? Is not leadership on inborn quality?"
It is often believed that leaders are born, not made. This may well be true for some kinds of leadership. In every community or society there are natural leaders who seem to command the respect and following of their people. Unfortunately, there are too few who are endowed naturally with exceptional leadership qualities.
What we seek to do is to draw out and develop the best in each individual, and equip her with certain essential skills necessary for self – governance. Each person may have differing capabilities and strengths, but together, they could form an able collective leadership.

Another point of clarification: when we refer to leadership development and leadership training, we are talking of two different things.

Leadership development is the process of drawing out from a person, her / his latent leadership qualities and skills, by creating suitable conditions. Leadership training is one component of the process of leadership development.

Leadership training refers to learning systematically about the technical principles behind effective leadership. It also consists of learning to apply these principles to acquire mastery over leadership skills already possessed, and to learn new leadership skills.

The natural leader may not need leadership development. But leadership training has to be directed also at natural leaders because it would considerably enhance their intuitive skills.

It is not easy to learn to be a leader, or to teach another to be one. There exists no simple formula for leadership development. We shall attempt below to draw on a wide variety of experiences with leadership development and with consciousness raising to empower marginalized groups, to describe the process that seems suitable for leadership development.

1) The development of leadership qualities in a person usually takes place within a context which makes the person concerned, anxious to take the initiative to lead. You have to make a person feel strongly about a cause, and the obligation to do something about it. In the present context, this means that women will have to feel outraged by the injustice inherent in the prevalent health situation and are deeply moved by the suffering of their people towards the need for action.

2) You have also to give her hope. Learning about, seeing and meeting dedicated people committed to the same cause inspires her. It makes her feel part of a common endeavour, and gives her hope that the goal can indeed be achieved. A climate for involvement is created through arranging for meetings with dedicated health leaders, visits to projects and even through reading and learning through slides and films about attempts to improve the health situation in other countries.

3) In the next stage, the person has to be given the confidence to lead. She has also to be equipped with the necessary skills and information so that she has something to be confident about. This is a many dimensional process, the contents of which have been already indicated.

4) She has to be given opportunities to exercise her leadership skills. Instruction and action have to proceed side by side. This is achieved in our situation through participation and leadership in the local health forum for women. She is at first assigned simple tasks, and gradually more and more demanding ones.

5) She has to feel part of a larger cause, and in fact as an important contributor to it.

6) So as not to be discouraged because of initial hurdles and setbacks, she needs someone she can consult with. She also needs new stimuli and fresh challenges time and again, and has to be updated with new information, ideas and approaches to avoid stagnating.

Leadership is something that has to be carefully nurtured. Leadership development is an intensive process that cannot be achieved by one – time training and seminars. It involves long-term involvement between the facilitator and the women concerned.

Leadership training programmes are only a small part of a long – drawn process. They are useful for learning specific skills or information from experts which then have to be reinforced and further developed.

Contents of leadership training

Training contents may be classified as:

a) Self awareness

b) Learning about issues related to reproductive health, child health, fertility control, and about the primary health care approach

c) Discussing leadership styles, and concept of collective leadership

d) Learning to communicate

e) Learning to work in groups

f) Learning to lead groups

a) Self Awareness

Leadership development is essentially a deeply human process, involving a heightened understanding of one's self as an individual and as an entity shaped by different factors of socialization. In the case of a traditionally exploited and subjugated group such as women, self awareness consists not only understanding one's strengths and weaknesses but of locating these in the context of the women's gender based subordination in society and drawing the connecting links between the two.

The Principle is to move from the familiar to the unfamiliar, from personal experience to understanding and critically reviewing the community context, inequities within the community and society. They begin to see women's subjugation as a part of an inequitable social structure and yet different from it because women in every strata experience it.

This is followed by an analysis of the health care system, emphasizing the need for women's participation in making good health accessible to all. They realize the need to be in positions of leadership and develop the confidence that they will be able to do training and guidance.

At later stages of leadership training self-awareness should ascend to in-depth analysis of one's traits. Much of its success depends on the individual's maturity and capacity for honest self – appraisal. What we can hope to do through leadership training is only to initiate the process and provide the individual with tools for critical self – appraisal.

b) Learning about reproductive rights issues and about the Primary Health Care approach

Subsequent to the initial motivation of women of the need for involvement, they should be given information on the health problems of women and children in the community, and how these may be related to several factors, social, economic and cultural. Information from the local situation analysis becomes a vital resource here.

The stage is now set for equipping women with specific information and skills related to health. The starting point is learning about their bodies, about menstruation, conception, pregnancy and childbirth. Traditional beliefs relating to these need to be discussed and clarified. Another area relates to fertility and its regulation and control.

Skills may include how to identify pregnancies at risk; and how to recognize danger signals in pregnancy and childbirth so that medical help can be speedily sought. Other include simple preventive measures, simple cures for common ailments and first aid. The range would differ according to local needs and ability.

In all instances, communication should be two-way. What the women have to say on each of the problems has to be listened to and understood; and supplemented with the information that the facilitator wants to convey. Action for tackling the issue or problem concerned would evolve on the basis of the common understanding reached as a result of the sharing between the women and the facilitator.

This has been covered in Modules 1 (Chapters 1 and 2) and Modules 3-5.

c) Discussing leadership styles and the concept of collective leadership

Women are initiated into discussion on leadership styles through suitable exercises such as talking about leaders they know of in the community. Questions such as who they consider a leader; what in their view are the qualities of a person for leadership would be useful. The concept of collective leadership is then introduced to them. They are encouraged to discuss the strengths of collective leadership as well as essential preconditions for it to succeed. The extract from Amilcar Cabral's writings on collective leadership as well as the illustration of collective leadership through the example of a flock of geese flying in formation may be good discussion starters.

d) Learning to communicate

This is important, not only because it is one of the basic tools to be mastered for effective leadership. Learning to express oneself, to articulate what one feels, is an empowering experience for women, who have remained in the background and learned to be silent observers rather than active participants. It makes the task of learning to communicate all the more difficult for the ordinary woman. She has to break through mental blocks, and overcome her initial diffidence to venture into unexplored domains. The process of learning to communicate may proceed from the simple to the complex in the following steps:

- Speaking up as a member of a group
- Expressing one's ideas and opinions coherently to an audience – public speaking
- Debating
- Enacting, role playing
- Advocacy or selling an idea.

e) Learning to work in groups

This involves the development of skills and attitudes necessary for a person to function as a productive member of a group. These skills are based on a grasp of group dynamics.

The starting point of the learning process is to be put in a group situation for completing a given task or for working towards a common purpose. Issues related to group functioning may be highlighted through specifically formulated exercises focussing on, say, group consensus, conflict resolution, cooperation, etc. This would give a broad understanding of how groups tend to behave.

In the next stage, the focus is on analysing the structure and characteristics of a specific group to which one belongs. For example, one may analyze the group's functioning in terms of:

- The participation patterns of members: the high contributors; the others
- The leadership styles and spheres of members of the group
- Roles taken by different members: who plays positive roles, who plays negative roles
- Decision making patterns
- Group atmosphere
- Norms and ground rules

An understanding of the stages in a group's development is also necessary for effective group participation and leadership. For instance, every group after the initial stage of coming together, passes through a period of conflict and competition for position, after which it settles down to sustained activity for a time, and may gradually lose momentum until such a time as a new stimulus is received. The process starts afresh, with specification of new goals, emergence of new leadership, and so on.

f) Learning to lead

Apart from learning to communicate and to participate effectively in groups, leadership requires other, more specific skills.

Some of these skills such as chairing meetings and facilitating discussions are often taken for granted, and no specific training is provided to perform these tasks. We list below a variety of leadership tasks, starting from the simplest.

- Chairing meetings
- Writing reports / meeting minutes
- Planning and organizing for specific tasks
- Team building for carrying out these activities
- Managing resources
- Mobilizing resources
- Liaisoning and networking with other groups

Although the principles behind these tasks may be "taught" in training sessions, the best and often the only way to learn is to actually perform the tasks in a real life situation.

1. Chairing meetings and writing reports and minutes: These are simple skills that can be learned through observing the facilitator's practice of the same, and by being given opportunities to apply these in the context of their own groups. A simple checklist of do' s and don'ts can be evolved to help the trainees.

2. Planning and organizing for specific activities: Training in planning specific activities, let us assume that we have identified the need to inform mothers about use of ORT for treatment of diarrhea, and to teach them to prepare oral rehydration solution. Training in planning and organizing specific activities starts here. The women are actively involved throughout the planning process, which follows the sequence below:

Specification of objectives: How many women do we propose to reach within what period of time?

Obstacles: What may be the obstacles to the adoption of ORT? (Beliefs regarding fluid intake? Lack of time?)

Strategies: How can we reach out to the women? What activities shall we undertake?

Organization: Who will do what and when? Who will ensure that the task is performed?

Evaluation: How will we know whether or not we have achieved our objectives?

The objectives are set, obstacles identified, and strategies are evolved by the trainees with the help of the facilitator. Responsibility for carrying out different activities is assigned to trainees with the facilitator playing an advisory role and pitching in only when things seem to go out of hand and the trainees ask for intervention. After the task is completed, both the process and the outcome are analyzed in detail to see what went wrong or what was overlooked.

3. Team Building: In the course of carrying out specific tasks, team building roles are performed by one person or another spontaneously. Team building involves being sensitive to the feelings of all the members, ensuring that every one feels 'included' and part of the activity. It requires identifying trouble spots: reasons why a member is hostile, or unwilling to participate; sources of intra group conflicts, and so on. It means that every member is motivated and enabled to participate in carrying out the group task, in working towards the common objective. These are essentially skills in group management. Team building skills are acquired with experience, through conscious attempts after the completion of each activity, to review the group's behaviour in the course of performing it.

4. Resource Management and Mobilization: Resource management consists of taking stock of available resources. Money, people, materials, equipment and facilities; and ensuring that these are well utilized. This is in fact a formidable task, and requires training and technical support over a protracted period of time. Simple budgeting and accounting skills may be relatively easy to learn, and can be included in leadership training.

Similarly, writing project proposals and applying to funding sources, writing for technical help and support to specialized agencies, or requesting donation of space or equipment from charitable organistion, are simple skills that a leader can learn. They are basically communication skills, and the leadership training can in addition explain the modus operandi. This would help in mobilizing external resources.

5. Networking and Liaisoning: Networking and liaisoning with other community groups, agencies and government departments operating in the area is in important task before the local leader in her attempt to make the most effective use of all available resources for the benefit of the community, to avoid duplication of work or working at cross purposes to another organization, to benefit from the experiences and insights of others and to pursue a truly integrated approach to health development. The need for networking and possible ways for doing so should be included in the curriculum for leadership training.

Some areas to be explored may be:

- What do we hope to achieve through networking
- Who to liaison with, and why
- What are the mechanisms through which this can be done
- Who would initiate it
- What would be its character formal or informal
- How to create a climate for cooperation and coordination
- In the mechanism (body, forum, meeting) set up for liaising
- Past experiences with networking and liaisoning: what have been the obstacles and problem areas

Approaches and methods for Leadership Training

A. Basic Principles

A major determinant of the success or otherwise of a leadership training effort is the attitude of the facilitator. It is this that will determine the kind of methods and materials chosen.

Some basic principles are:

a) Believe in the human material before you. Do not be afraid of making big demands upon it. At the same time enable participants with skills to meet these demands

b) Give people several chances. Never dismiss anyone as incapable. The fault may be yours, your inability to communicate with them

c) Learn to get profound ideas across in simple language

d) Learn to care about participants as people

e) Learn to respect people's innate wisdom and common sense

f) Try to find a point of contact with the person you are trying to get across to : Search for "Where do we agree" and extend that area of sympathy wider and wider

B. Methods and Techniques

Leadership training efforts are important not only for what they say but for how they say it. Participants emulate and absorb a great deal of the behavioural pattern of facilitators. There should be no contradiction between what is professed and what is practiced: there is no way you can convey the importance of popular participation through one-way communication in lectures.

a) Participatory in nature: Training methods have to be enabling and empowering. They have to build the participants' confidence in their capacity to think and analyze. They should also encourage trainees to cooperate rather than to compete to gain the facilitator's approval.

Training methods have to be participatory. They should encourage the participation, of as many as possible; be able to draw information out from the trainees' own experiences; and be able to encourage them to think critically and figure things out for themselves.

The scope allowed for participation should be genuine. It just won't do if for example, after asking for trainees' perceptions on a problem and listening to it, the facilitator imposes his / her own ideas as the "correct" answers. The participatory training process treats the trainees and the trainer as partners in the process of learning, each having an important contribution to make.

b) Sensitive to participant characteristics: Choice of learning techniques and methods for leadership training at the community level have also to be based on an understanding of trainees' characteristics, ways in which they relate to each other and communicate ideas, and way in which they learn. Local women leaders may have low literacy levels, and further, may be unaccustomed to organized learning in a classroom setting. Their attention span may be limited. Trainees may also have difficulty in understanding abstract concepts, and further, in moving from the particular to the general.

Training methods have to take into account the fact that for many of the trainees this may be the first experience in participating in a group outside the family structure. As women, they may never have been given a chance to think for themselves or speak their mind or larger issues. They are likely to be hesitant to speak up, and may never express an opinion or contradict the trainer. The shy and less exposed among them may withdraw into the background, allowing the more vocal women to dominate the show. The trainer needs to patiently draw out each one of them.

c) Examples of participatory training methods: These include

- Group discussions based on a variety of discussion starters such as stories, case studies, poems, posters, skits or films
- Role playing
- Simulation games and exercises
- Group and team exercises and tasks
- Techniques that allow maximum room for individual participation, such as brain – storming
- Open ended probing of issues in the whole group, where the facilitator asks only questions that demand deeper probing

The following sessions include exercises/discussion starters based on the contents of this chapter:

Session 1: Self Awareness	2 hours 15 minutes
Session 2: Vision of a new society	3 hours 15 minutes
Session 3: Learning about leadership styles	2 hours
Session 4**:** Learning to communicate	2 hours 45 minutes
Session 5: Learning to work in a group	3 hours
Session 6: Learning to lead	8 hours 45 minutes

Session 1: Self Awareness

Session objectives: At the end of the session participants will be able to:

A. Reflect about themselves

B. Reflect upon their lives as women (in case of male volunteers/ staffs, understand and reflect upon their lives of women)

Training Materials required for the session:

A. Cards to write on, pens

B. 'Thus God Judged Women' story, charts, pens, old magazines, glue, scissors, colours/ paints

Methodology:

A. Reflect about themselves **45 minutes**

Explain the activity. Participants have chanced upon a magic shop. At the shop participants can exchange three qualities in themselves that they do not like for three that they want to have.

Facilitator (s) are the shop keepers. Participants write the three qualities that they want to change and on the reverse side of each card – the exchange quality.

In the large group participants share the qualities they want to change and reasons. Ask participants for feedback about the exercise and sum up that the purpose was to reflect upon strengths and weaknesses and to be aware of these for self development.

B. Reflect about their lives as women (in case of male volunteers/ staffs, understand and reflect about the lives of women) **45 minutes**

Read the narrative 'Thus God Judged the Women' (A1) or ask the participants to read aloud. (10 minutes)

Ask participants for their feedback about the narrative: What is the narrative about? What does it imply? (15 minutes)

Ask participants to draw a circle on the paper given and demonstrate how to divide the circle into 24 sections- 12 in each half. Thereafter ask them to number them as in a clock. These numbers are the 24 hours of the day. Participants fill these circles with activities of a typical day for them. (30 minutes)

In the large group some participants can share. Discuss if men too have the same schedules. What are the differences and reasons for them. Discuss the consequences for health.

Activity ***45 minutes***

Divide participants in to four groups. Ask each group to create a poster to depict differences due to gender roles between men and women.

Group 1: Children and adolescents

Group 2: Adults-men and women

Group 3: Older men and women

Share and discuss in the large group. Ask participants if this can change and ways to change starting from their own homes. Each participant shares one way/strategy. Summarize the main issues from the session.

Materials used for training /handouts include:

A1 **Thus God judged the women**

Once upon a time very long ago, God needed someone to help him with something he wanted to have done. He turned to the women, who already had their hands full even in those days. Just then they were sitting making milk jugs and water basins and mats to cover the huts. God summoned them. "Come here! I shall send you on an important mission." The women replied, "Yes, we are coming , but wait a moment, we shall just finish our work here." After a while, God summoned them again. "Wait a moment, we are nearly done. Let us just finish our mats and jugs" said the women. The men did not have to milk, build houses, fetch wood and water as the women did; their only duty was to put up a fence and protect the livestock.

So since at the moment they had nothing else to do, they came running at God's call and they said, "Send us instead, Father,". Then God turned to the women and said: " Hereafter, women, your chores will never be done. When one is completed, the next one will be waiting for you. Hence, the men may rest since they came at once when I called. But you women will have to work and toil with neither pause nor rest till the day you die".

And so it has been ever since.

(Garri Folk tale from North Kenya)

Session 2: Vision of a New Society

Session Objectives: At the end of the session the participants will be able to:

A. Explain ways of handling power or authority and explore ways for women to attain greater authority

B. Think about the future in a creative and constructive way

Training Materials required for the session:

A. Role play instructions and briefs on cards, charts, pens, paper

B. Charts, markers, tape, Instructions and questions for each group.

Methodology:

Present the objectives.

A. Be acquainted with ways of handling power or authority and explore ways for women to attain greater authority **5 minutes**

Explain the role play and ask for five volunteers to take parts in the role play and another set of five volunteers to act as coaches for individual role players. Explain the instructions for the role play (A1). After the role play, discuss the aspects observed, barriers to women being in leadership positions etc. Participants share their personal experiences.

What approaches in relation to power can women use if they are to aim at long term, substantive changes that will directly affect their development? List the main issues and points from the discussion and summarize.

B. Think about the future in a creative and constructive way **2 hours**

Explain that the aim of this exercise is to help people think into the future in a creative and constructive way. So often we look for the root causes of problems in society and we can be critical. But in order to have a liberating and transforming consciousness, we all need to have a Vision of the future. The vision must be concrete.

Divide the participants into smaller groups- as many groups as the areas of life to be explored (B1). If a topic is not chosen/ not relevant, then just leave it out. Each group should be at least 3 members but not more than 7. Groups present in the large group followed by discussion.

Materials used for training / handouts:

A1 **Instructions about the role play -**

a. The role players and their coaches will have five minutes to study and prepare for their roles. They must not reveal their roles to anyone else.

b. The role play activity comes in two parts. Part I will last 20 minutes. A five minute break will then be called during which time the players and their coaches may plan further strategies. Part 2 will be for another 20 minutes.

1. Arrange the seats of the players and coaches in two circles, with the players occupying the inner circle. The coaches should be seated in the outer circle directly across the players to whom they are assigned, so they can easily observe their partners.

2. Ask the players and coaches to leave the room while preparing for their roles. Instruct the rest of the participants to observe the following aspects of the role play:

a. The roles of the different personalities

b. The strategies used by the personalities to influence the group

c. The strategies that were effective in influencing the group

ROLE PLAY INFORMATION SHEET

For all role players:

Players should not know about each other's roles, only about their own role.

Players should read their parts carefully and play their roles conscientiously.

You should put yourself in the role and character you are given.

You should be natural, but emphasize behaviour aimed at fulfilling your role without overacting.

ROLE BRIEFING SHEET

Write out the descriptions of individual roles below on cards. Assign one role to each volunteer. You must add to or revise the details of the roles as appropriate to your situation, but keep the general direction of the roles.

ROLE BRIEFING SHEET

Your are Banumathy a social worker with the Ministry of Social services and Development. You have been working for some months with the women in a village an hour away from the state capital. During your work, you and many of he poor women with whom you work realize that in order to obtain more favourable consideration for the health concerns of such women, you need some political representation on the Health advisory committee constituted by the District Collector. The committee has only three representatives and now all these are occupied by prominent representatives of various social and medical sectors in the district. You are speaking on behalf of the women to request an additional seat on the advisory council for a representative of your women. You are prepared to present many arguments to support your position.

ROLE BRIEFING SHEET

Your are Duraisamy the District Collector where the women live who are requesting women's representation on the advisory committee. While you sympathize with the cause of Ms. Banumathy and the women's group, you do not want to displease the other influential members of the committee whose representation is important for the committee. You prefer to leave the issue as it is. Nevertheless, you called the meeting today to get the opinion of different sectors.

ROLE BRIEFING SHEET

You are the owner of the biggest private hospital in the district. You are currently on the advisory committee. You do not think it is necessary for women to have a representative on the committee since their concerns can be represented by the current members. You are also worried that they may endanger the interests of the business sector if they are represented on the committee.

ROLE BRIEFING SHEET

You are Dr. Ezhumalai a cardiologist with a successful practice in the capital and with political ambitions. You think the professional sector which knows what it is doing should have more than one seat on the council. Therefore you do not support an additional seat for a women's sector representative although you do support an additional seat for a professional person.

ROLE BRIEFING SHEET

You are Sagayam, a health activist and leader from a nearby town in the district. You have been involved in various projects to help poor women. You agree that the advisory committee should have a women's representative. You are not too sure it is wise to fight the persons in power, although you would like to support Ms. Banumathy's efforts.

B1 **Topics for discussion** (to be written on separate cards).

1. Work in Agriculture

a) What are the laws on ownership and distribution of land?

b) Who are the major producers in agriculture? Why? What changes are needed in their conditions, in order to increase their productivity?

c) Should emphasis be on cash crops or food? Small or Large farms? Individual small holdings, co-operative, or collective farming?

d) Is it important that rural people live in villages?

e) What kinds of tools and technology would be most helpful?

f) What kind of organizations do farmers and agricultural workers need?

g) What should be the priorities in the budget for the department of agriculture?

2. Work in Industry

a) What type and structure of Industry is there? Why? How can it be changed?

b) Who should decide what is produced and how should it be decided?

c) Who should own the factories, processing plants, etc.?
Who should determine the conditions of production?

d) In what way should the workers participate
- In sharing the profits?
- In ownership of the factory?
- In decision-making ?

e) Should profits be shared – within each industry?
- Between different industries?

f) What are the advantages and disadvantages of State ownership?

g) What needs to be done to prevent a few people exploiting others?

h) What is the relationship between industry and the life o the community as a whole?

3. Health

a) How could you develop a good balance between promotion of health, prevention of disease and curative medicine?

b) Do you agree that the good health of the community depends more on pure water supply, latrines, balance diet, and adequate income, than on medical services? If so what are the implications?

c) What can be done to encourage community responsibility for health?

d) What could be done to overcome the problem that nearly all trained medical personnel (doctors and nurses) want to work in big hospitals, towns or cities and that the rural areas get neglected?

e) What kind of health workers do we need to train to bring basic health education and services within reach of every village?

f) How could we make sure that most the those given the opportunity to do nursing or medical training are committed to serve the needs of people rather than to getting prestige and money for themselves?

g) What could be done to prevent the illegal sale of medicines for private profit?

4. HOUSING (Urban)

a) What could be done to provide adequate housing in rapidly growing cities?

b) Should low cost housing be owned and subsidised by the city or town council?

c) Should there be rent control? Should rent be a fixed percentage of income?

d) As nearly all housing projects built by city councils turn out to be too expensive for the poor, would it be better to provide 'site and service' schemes? (i.e where people get a plot roads, water, sewage, and electricity etc., but have to build their own houses). What help would people need? How could this be organized?

e) What about ownership? Should people be allowed to own their own houses? Just one house Or as many as they want to?

5. Money: Wages, Credit, Foreign Investment etc.

a) Should there be minimum wages?

b) Should there be any kind of control limiting the amount of money one person can make?

c) What range should there be between minimum and maximum incomes?

d) Is there any way to ensure adequate incomes for subsistence farmer? Or is it more important to ensure that essential services such as education, medical services are free and available to all ?

e) How could we ensure that everybody has the opportunity to save money, and to borrow money for worthwhile purposes?

f) Is it possible in rural areas to work towards an 'interdependent community' where there is work for all as people produce and sell the goods needed by their neighbours and buy the goods made by their neighbours?

g) What effect does the present system of imports and exports have on employment? How does the import and export policy affect the rich? The poor?

h) What really needs to be imported for the overall development of the country?

i) Who produces most of the goods exported? Do they benefit from the foreign exchange earned by these exports? Is there too much emphasis on cash crops for export and the importing of luxury goods?

j) What are the advantages and disadvantages of encouraging tourism?

Does it bring much benefit to the ordinary people? Who does benefit?

k) What are the advantages and disadvantages of encouraging foreign investment?

6. Education (Children)

a) Should primary education be free? Compulsory?

b) Should there be exams?

c) What changes need to be made in primary schools to prepare people to contribute to genuine development, get away from 'certificate fever' and 'white collar ambitions'? What changes in subject taught? What changes in general organization of the school?

d) What can be done to develop initiative, creativity responsibility and communal concern in the children?

e) Should there be changes in secondary education? How should selection to Secondary schools be made?

f) What arrangements should be made for technical training? Are village polytechnics (trade schools) a satisfactory solution? Could an effective system of apprenticeship be worked out? What could be done to develop managerial skills, so that people with technical training e.g building and masonry can organize their own work and not depend on 'ready-made jobs'?

7. Specialized Training and Higher Education

a) What kind of specialized training should be given priority, (e.g teacher training; adult educators, etc.)

b) How should candidates be selected?

c) How should university students be selected?

d) Should students be given grants or loans to pay for their fees?

e) Should graduates be better paid than other workers?

f) How can the work of the university be related much more closely to the needs of the community?

8. Adult Education

a) Should adult education be a priority? Why? How should a system of basic education for all be organized?

b) What should it include?

c) How can adult education be linked to development human and communal?

- In production, in agriculture
- In social and political organization
- In health care, etc.?

d) How should religious education for adults be organized? What should it be focused on? Who should do it? How should the educators be trained?

e) Should adult education programmes also deal with cultural values? In what way?

9. Family relationships

a) What type of family relationships and loyalties would we like to see in the future?

b) Is the 'nuclear family unit' (father, mother and children) the ideal model?

c) How can we retain what is good in the Indian concept of extended family?

d) How can we deal with the pressures put upon the family (both nuclear and extended) by modern life, urbanization, migrant labour etc.?

e) In what ways are role expectations of women and of men changing? Can anything be done to encourage the positive changes and discourage the negative ones?

f) What needs to be done to help make marriage a satisfying relationship for both men and women?

g) What could be done to encourage communication between different generations? In a rapidly changing society how can we help to make the 'gap' in outlook a less painful experience?

h) What could be done to help make old age a happy time?

10. Political Participation

a) What do you consider priorities of good government? Is it important for as many people as possible to be genuinely involved in decision –making? If so why?

b) If participation is important how can it be organized effectively

- At local level (village or town)
- At district and provincial level
- At national level?

c) Is political education necessary? If so how can it be done effectively?

d) What types of (community meetings), decision making procedures etc. would be helpful?

e) What can be done to make sure that political leaders remain accountable to the people they represent?

f) What could be done to prevent – individuals or groups entrenching themselves in power and refusing to give it up?

- Corruption
- Other abuse of power?

g) What could be done to make sure that government policy is effectively carried out by government officials who are capable, honest and have a spirit of service to the public?

11. Religion

a) What role would we like to see the religious institutions playing in society?

b) What structures would be needed to encourage communication between

- People in different roles within one religious institution
- People of different religions.

c) What human needs are being met by different religions and religious institutions and what changes could be brought about in them to meet these needs more fully?

d) In what ways can religion enrich the whole quality of life for people, and what can we do to see that it fulfils this role wherever possible.

e) Does preaching and teaching today give most people trust in God and concern for one another and hope for the future?

12. New Society

Recreation & cultural values

a) What aspects of traditional Indian culture and custom do we value and wish to keep? Which aspects do we feel are negative and should be changed?

b) Which Western values (or values of the scientific technological society) do we value and wish to keep?

c) How could people be helped to make choices about cultural values in life? In what way could this be done in adult education programmes?

d) What could be done by governments, religious and other voluntary groups, to foster values which lead to the happiness of the whole community and discourage negative attitudes?

e) In what ways could creative expression in art, music, dance, drama and other forms be encouraged?

f) What could be done to make life interesting and enjoyable for all (old and young, men and women) in rural areas? In urban areas?

g) What were the high points of celebration of life, community, in traditional society? Should anything be done to retain or adapt these in modern life?

h) What new forms of recreational facilities need to be provided in rural and urban areas?

i) Is it important to encourage active rather than passive recreation? How?

(The activity can be sucessfully adapted for use with rural women. This is done by redefining the activity to be "what would I like my village to be like?". Certain sections that are too macro in context are dropped and other questions suitably modified. Hope A. and Timmel, S. "Training for transformation." Book 3 Mambo Press. Gweru, Zimbabwe, 1984 PP. 61-66)

Session 3: Learning about Leadership Styles

Session Objectives: At the end of the session participants will be able to:

A. Explain different leadership styles

B. Explain the concept of collective leadership

Training materials required for the Session:

A. Stones, chairs, cloth for blindfold,

B. Chart with questions (role play), Poem on Collective Leadership by Amilcar Cabral

Methodology:

Present the objectives.

A. Different styles of Leadership **50 minutes**

Ask for 8-10 volunteers from the group. Introduce the activity. Mark a start and end point. There should be at least 30 feet distance between the two points. Participants have to go from starting point to finishing point. Participants form pairs. One of the pair is blindfolded. Place obstacles on the floor /ground (a chair, stones, cloth etc). Place as many sets as there are pairs. The partner who can see has to guide the blindfolded partner across the path without touching the obstacles. The pair that reaches the end first and successfully, without touching any obstacles, wins the game.

Give a couple of minutes to the participants if they want to discuss anything – strategies etc. Thereafter signal the start. The remaining participants stand along the path and observe the pairs. (30 minutes)

After the game, in the large group, discuss how the pairs felt. How did the 'blind' partner and the 'sighted' partner feel. Ask observers-participants for their feedback (20 minutes). Sum up that the game could be used to understand leadership better. How the partner who could see lead the other may be different for different pairs. In some pairs the sighted partner just drags the other, in others he/she may explain the obstacles (share) so that the 'blind' partner is prepared for them and it may be easier and more reassuring for him/her (care).

B. The concept of collective leadership **1 hour 15 minutes**

Explain that the activity is a role-play on different leadership styles. This exercise helps a group to see how the behaviour of the leader affects the group he or she is working with (A1).

This can either be prepared ahead of time, and rehearsed (in which case it will be skit and not a role play) or people who are familiar with the exercise can play roles of the two different leaders and volunteers can be called from the group to play the other roles.

Clarify to all the volunteers that they are taking part in a role-play in which particulars roles will be played by the participants. If they enter into a serious decision-making process and later find that others are acting roles, they may feel it has been manipulated, and resent this.

Ask for about six volunteers for each of the two plays. Each should be asked to act out a meeting of some group with which they are familiar, e.g. A school or development committee or women's group. Give a task to make a decision on some matter of general interest to the whole group, (but not too absorbing an interest.) If the group become too absorbed in the subject matter, they will not be able to reflect objectively on the leadership styles later.

1. Ask the first leader to act the part of a very dictatorial chairperson. (S)he calls for ideas, but does not listen to people, squashes their suggestions, imposes his or her own point of view on the group etc.
2. Give other members of the group specific roles:
   a. Ask one to support whatever the chairperson suggests
   b. Ask another to suggest several different possibilities
   c. Ask another to support this speaker,
   d. Ask another to interrupt and oppose the chairperson etc

Give these instructions either orally to individuals before doing the play, or in writing on slips of papers for each volunteer.

3. Arrange the chairs (or sit on the floor) in an open circle in front of the group or ask participants to sit on the floor in front of the group, so that everyone can see and hear well. Remind the actors to speak clearly and make all their gestures quite visible.
4. The chairperson starts the play and each person participates in the roles (s) he has been given
5. When the situation has become clear to the audience, stop the action and asks the second group of six to come to the chairs.
6. This is a different committee in a different place, but their task is similar. Give similar instructions about their roles to most of the members, but this time ask the chairperson to be very passive (or laissezfaire – 'let them do as they choose'.) This leader shows little interest, makes no suggestions, does not respond to suggestions of the group, does not help to reach decisions or resolve conflict.
7. Stop the play when the situation has become clear.
8. Display a chart with the following:
   a. What did the 1st leader do in the group?
   b. How did the group react?
   c. What did the 2nd leader do in the group?
   d. How did the group react?
9. If the group is fairly big divide participants into smaller groups to discuss the questions for a few minutes before gathering up all the answers in the whole group.
10. Discuss all the points/issues that emerge in the group and after that has been done, ask another question:
    What does a good facilitator do in a group?

(Note : Here the group is asked to focus on what the facilitator does e.g. listens to each speaker with concentration', etc., not just the general moral virtues such as 'the leader is kind and just'.)

11. Finally ask for a volunteer who can re-act to play the part of a democratic chairperson as effectively as possible.

(Role Play on different leadership styles: Hope and Timmel, opcit Book 2, pp.54-05)

Conclude the session with the reading of 'Collective leadership by Amilcar Cabral' followed by a brief reiteration of points that emerged in the session. (15 minutes)

Materials used for training /handouts include:

B1 **Collective Leadership by Amilcar Cabral** (Refer pg # 51)

Session 4: Learning to communicate

Session Objectives: At the end of the session participants will be able to:

A. Explore if they truly listen to others and develop the skill of listening (even when we disagree)

B. Practice skills to express ourselves better

C. Use communication skills in a real life situation

Training Materials required for the session:

A. Charts/boards, pens /chalk

B. Charts / boards, pens / chalk

C. Time schedule on chart, role play directions, roles written on cards, charts /board, pens /chalk

Methodology:

Present the objectives.

A. Explore if we truly listen to others and develop the skill of listening (even when we disagree)

30 minutes

The exercise 'LISTENING PAIRS' helps develop the skill of listening (even when we disagree) and helps find out if we truly listen to others. Use this exercise after a group knows each other fairly well.

Ask each person to find a partner with whom they know they disagree on a specific subject. Then ask them to discuss this subject, but after each one has spoken, the other summarizes to the speaker's satisfaction what has just been said, before they may give their own response or point of view. In this exercise each pair chooses for themselves the topic they will discuss. *Or*

Ask each person to choose a partner and give a controversial topic for them to discuss. Again after each one has spoken, the other summarizes to the speaker's satisfaction what has just been said. Only then may (s) he give her or his own response or point of view on the subject.

Possible topics may be: Family planning, divorce, Women's Liberation, Socialism / Capitalism, abortion etc.

In the large group discuss what difficulties they experienced in listening and what they can do to improve communication in the group. List these on chart/ board and sum up with inputs from participants.

B. Practice skills to express ourselves better **45 minutes**

The purpose of the activity is to learn to express oneself, to articulate what one feels.

Ask participants to sit in a circle. Participants pass a ball/other object as long as the facilitator plays music / claps his/her hands. When this stops, the person with the ball/ object picks a chit from the basket and talks for a couple of minutes on the topic given.

Choice of topics is important and should be selected in keeping with the capacity and interest of the participants. Alternatively be flexible to participants choosing their own topics / issues to talk about.

For example: topics could begin with family, village, an incident that I can never forget etc.

Participants share how they felt while talking, if they faced any difficulty and reasons for that. Ask them how these can be overcome. List on a board / chart and summarize.

C. Use communication skills in a real life situation **1 hour 30 minutes**

This simulation (C1) also functions as a discussion starter and as a means for clarification of the multiple problems that affect motivation and participation of women in community education programs. After the participants finish the task, they discuss the simulation and list not only problems that affect participation, but also recommendations for solutions to these problems.

1. Divide all participants into small groups.
2. Appoint one person as a secretary and one person as a monitor for each group.
3. Appoint one or more community leader(s) for each group depending on the number of participants.
4. Hand out instructions to the secretaries, monitors, and community leaders.
5. Head out role cards to the community members in each group. With these cards hand out name tags so that the community leader can identify each community member by name.
6. Write the time schedule on a blackboard or newsprint and explain that all groups have approximately 30 minutes to complete Task I. Be sure everyone begins Task I at the same time.
7. After Task I is completed, as well as the discussion after the task, one monitor and one secretary from each group describes to all participants the problems and recommendations they have recorded from their community. Then all participants list the problems they observed that affect motivation and how the community leader can facilitate problem solving for community members.

The last part (7) of the simulation is very important. This helps participants understand the significance of the simulation. The discussion at the end helps clarify the objectives of the simulation and what people have learned from the simulation. Be sure to allow enough time for adequate discussion at the end of the simulation where recommendations can be made.

Materials used for training /handouts include:

C1 Motivation and participation among women in the community

A group of women were gathered together, all of them seemingly talking at once. One was complaining about her husband's refusal to let her leave the house; another was describing her child's illness; two other were arguing loudly with each other. Some were asking questions, listening, taking notes. At a certain point, the voices died down, as one of them, standing at one side, asked for quiet. "What then, can we say are some of the reasons why people in the community find it hard to come to the meetings?"

These women are community leaders engaged in starting nutrition education programs in their respective communities. They have been concerned that many women are not attending meetings. This morning, they have been participating in a simulation designed to help them better understand problems of motivation. Each women has been acting out a different role: some have played the part of women in the community who have a variety of reasons for not wanting to participate in the nutrition project. Others have played the role of the community leader interviewing these women concerning their problems and trying to persuade them to attend. Others have been the 'secretary' and 'monitor', whose roles are to observe the interaction.

Now they have gathered together to discuss what they have done during the activity, to identify the complexities of the situation, and to discuss solutions. By playing out a 'real-life' situation, they have all come closer to understanding the problems involved in motivating people to participate in educational projects. In the course of their 'game', they have also learned much about participation itself.

Notes for the participants

The following are the general learning objectives for this simulation learning activity.

a. To identify problems in a community that affect women's motivation and participation.
b. To clarify the relationship between the community leader and community members and how this relationship influences participation.
c. To examine how the community leader can instill motivation in community members.
d. To make recommendations on how the community leader can help facilitate problem solving in the community.

Time schedule for the simulation: Total time – 1 hour and 30 minutes (approximate)

a. General explanation — 10 minutes
b. Task I — 30 minutes
c. Small group discussion — 20 minutes
d. Report out and general discussion of all participants — 30 minutes

This time schedule will be written on the wall so that participants will have an idea of their time limitations.

Directions for the Monitor

Your job is to lead the simulation in your group and to keep notes on what you observed during the simulation.

1. Read the simulation
2. At the end of Task I bring your community together to discuss what happened.
3. All members of the community should read their role and the back of their card to the rest of the community.
4. The secretary should read his / her notes on what was observed during the interviews.
5. You should read your notes on what you observed during the interviews.
6. After each person has read his / her role, the group should discuss:
   a. How people felt during the simulation?
   b. What problems they were aware of ?
   c. How the community leader tried to motivate people?
   d. What recommendations they would make to a community leader who had to confront and help people resolve similar problems?
7. Your community should have a list of recommendations as to how a community leader can encourage motivation in a community and how the community leader can help solve problems that inhibit motivation.
8. You and the secretary will then present the result from your community to the participants. At the end of the simulation your community should have produced:
   a. A list of problems that prevent community participation among women
   b. A list of recommendations for community educators to help community members resolve these problems and to encourage motivation.

Directions for the Secretary

Your job is to observe and to record what you see happening in your community. At the end of Task I, you will report back to your community on what you observed during the simulation. You should not participate in the conversations between the community members and the community leader. You should keep to your role as an outsider whose job is to listen, to observe, and to record. While you are observing the interviews or meetings between people in the community and the community leader, keep note of the following:

1. What seem to be the problems for people in this community?
2. What are the needs of the community people?
3. How does the community leader interact with community members?
4. What seems to be preventing motivation or participation among women in this community?
5. How does the community leader encourage people to participate?
6. What methods does the community leader use to help people solve their problems?
7. What are the results of the conversations between the community women and the leader?

Directions for community Leaders

You are a leader in the community who has decided to teach the women about nutrition. Many children in your community have illnesses such as stomach problems, skin diseases, and diarrhea. You have consulted a nurse and you think these illnesses are related to poor diet, poor eating habits and poor habits of cleanliness. You have decided that before you can get people to change their habits, you must find out what these habits are and you must get people motivated to change them. As the community leader, you have one general objective.

To get all the women you visit to come to a community meeting.

Task I (30 minutes)

You have 30 minutes to visit each woman in your community. Your objective is to have each woman individually agree to come to a meeting at your home to discuss nutrition. Many of the women have specific problems that may prevent them from coming to the meeting. Thus, they may seem poorly motivated. It is not clear to them that nutrition is a problem in this community. You must try to convince them (as many women as possible) to come to this meeting. Remember you have 30 minutes to convince them. Record the results of your visits on the check list provided.

Note: The original simulation had three tasks. Tasks 2 and 3 are given in the Appendix along with role cards for community members.

Community member roles are written out on cards with instruction on both sides of each card.

Roles for members of the community

Card 1 Selvi (Side 1)

Your family is very poor. Very have nine children and your husband works on one of the rubber plantations tapping rubber trees. At present two of your youngest children are sick and you are very worried about them. You have very little time except to go to the market, wash, clean and take care of your sick children.

You are usually very friendly and like to spend time going to the market and talking to friends there. You enjoy visiting people but right now are too worried about you children to be your usual good – spirited self.

Card 1: Selvi (Side 2)

(Do not show this side of the card to the community leader)

While the community leader is meeting with you, you must make a decision and tell the leader what you decided.

Yes: You will go to the meeting if the community leader can get you some medicine for your children or you can find a nurse or doctor who can tell you what is wrong with them.

No: You will not go to the meeting if the community leader cannot promise some help for your sick children.

Card 1 Dhanammal (Side 1)

You are an older member of the community. Although you have seven children, only two are now living at home with you. You are usually shy and do not like to start conversations. People in the community know you as a dependable person who does what you say you will do. You have been responsible for helping many people in this community.

Card 1 Dhanammal (Side 2)

(Do not show this side of the card to the community leader)

Yes: You will agree to go to the meeting if the meeting is conducted in the local language, Tamil. Because you do not speak any other language and because you are shy, you do not want to go to the meeting unless someone will help you understand what people are saying.

No: You will not agree to go to the meeting if it is conducted in any language other than Tamil or if there is not someone there who can translate what people are saying.

Card 1 Amudha (Side I)

You are an outgoing person who because of your somewhat aggressive personality have acquired a few enemies in this community. You like to tell other people what to do. You also feel that you do not want to waste time at a meeting unless there is some money in it for you. In other words, you would like to participate in something that would be of economic benefit to you and your family.

Card 1 Amudha (Side 2)

(Do not show this side of the card to the community leader)

Yes: You will agree to go to the meeting if you are sure that Selvi will have no power or leadership at the meeting. You had a disagreement with her a few months ago and friends have told you that she is spreading rumours about you. You want as little contact with Selvi as possible.

No: You will not agree to go to the meting if Selvi leads the meeting or if you have to talk directly to her.

Card 1 Bhavani (Side I)

You are a quiet woman who is dominated by your husband. You are conscientious and a very hard worker though your family has very few resources. Most of your family is dead so you have your husband and your five children for support. You are interested in going to meetings and involving yourself in women's activities in the community but do not want to cause trouble between you and your husband; you think he will disapprove.

Card 1Bhavani (Side 2)

(Do not show this side of the card to the community leader)

While you are talking to the community leader, you must make a decision and tell the community leader what you decided.

Yes: You will agree to go to the meeting if the husband of the community leader will convince your husband that this meeting may eventually lead to some economic benefit to your family. Your husband feels that this meeting will be a waste of time and take you away from your family responsibilities.

No: You will not agree to go to the meeting unless you husband agrees to your going. This will happen if the husband of the community leader talks to your husband.

APPENDIX

Additional tasks and role cards for simulation 2: 'Motivation and participation among women in the community'.

Task II: 30 Minutes

You have 30 minutes to have all the women at this meeting make a list of all the foods they eat in one week. After they make this list, they must figure out a way to record how many times each member of their family eats a particular food and how much of this particular food they eat. The general objective then is to have all the participants make a food chart and agree to fill it out in their homes for one week.

Task III: 30 Minutes

You have 30 minutes to convince each member of your community to agree to change one food habit or dietary pattern on their food chart. This change of eating habit may be a change in the content of the food, the number of times the food is eaten, the addition of some foods that are missing from the chart. Some of the nutritional problems this particular family has will be written on one side of the community member's card. Your objective is to try to have the person agree to change one eating habit or dietary problem.

Roles for Members of the Community

Card 2: Selvi (Side 1)

You decided to come to the meeting because your children are not healthy again. You are back to your old cheerful self and have looked forward to the next meeting with your friends. You think that something in the food your children ate caused their illness. It is important to you that you improve your family's diet.

Card 2 Selvi (Side 2)

(Do not show this side of the card to the community leader)

During this meeting you must make a decision and tell the group what you have decided to do:

Yes: You will agree to fill out the food chart if you do not have to buy any materials. You must be sure that all the materials needed to fill out this chart will be provided by the community leader.

No: You will not agree to fill out the food chart if you have to buy any materials.

Card 2: Dhanammal (Side 1)

(Do not show this side of the card to the community leader)

At this meeting although you are very quiet, you are interested. Because you mother is old and sickly she has decided to come and to live with you. She will be moving into you house next week, and until she has adjusted to her new surroundings, you will be very busy.

Card 2: Dhanammal (Side 2)

During the meeting you must make a decision and tell the other participants and the leader what you have decided:

Yes: You will agree to fill out the food chart if it does not require that you know how to read and to write. You do not know how to read and to write and feel very shy about it in front of the other women at the meeting.

No: You will not agree to fill out the food chart if you have to know how to read and to write to do it. You are willing to make check marks or something similar.

Card 2: Amudha (Side 1)

At this meeting you spend a lot of time joking. This leaves the impression that you are not very serious about nutritional problems in the community. But, in fact you feel very uncomfortable in the presence of Selvi.

Card 2: Amudha (Side 2)

(Do not show this side of the card to the community leader)

During this meeting you must make a decision and tell the group as well as the community leader what you have decided:

Yes: You will agree to fill out the food chart if this group or the community leader can convince you that it is important. You and your family have usually been very healthy, so that you do not think that there are any severe nutritional problems in your family or in the community.

No: You will not agree unless you can understand and be convinced that there will be health or economic benefit to your family if you fill out this chart.

Card 2: Bhavani (Side 1)

You are happy to attend the meeting and participate. You are not sure why the topic is nutrition and diet. You would like to know why this topic was chosen and how people can change their eating habits if they do not have enough money to buy food.

Card 2: Bhavani (Side 2)

(Do not show this side of the card to the community leader)

During this meeting you must make a decision and tell the group as well as the community leader what you have decided:

Yes: You will agree to fill out the food chart if you can convince your husband that it will improve the health of the family and lead to economic benefits. Your husband does not understand how your family can eat better food without an increase in income.

No: You will not agree to fill out the chart unless the group and community leader can give you definite reasons how this chart will help the nutrition of your family.

Card 3: Selvi (Side 1)

You were only able to fill out the chart for 4 days because one of your children became sick again. The child has very bad diarrhea. It seems from a food chart that you maintained the problem is not in the food the children eat but in the water they drink. Either the source of your family's drinking water is polluted or the water you store in your home becomes contaminated.

Card 3 Selvi(Side 2)

(Do not show this side of the card to the community leader.)

During your conversation with the community leader you must make a decision and tell the community leader what you have decided to do:

Yes: You will agree to change one behaviour with regard to your family's water drinking habits if the community leader can explain how and why this change of habit will improve your family's health.

No: You will not agree to change one behaviour with regard to your family's water drinking habits if you do not have confidence in what the community leader explains to you.

Card 3: Dhanammal (Side 1)

You have filled out the entire chart. It seems from the results of the chart that there is one outstanding problem in your family's diet. There is no fruit in your family's diet. As a result of this absence of fruit your family is prone to get colds or flu (according to the community leader).

Card 3: Dhanammal (side 2)

During your conversation with the community leader you must make a decision and tell the community leader what you have decided to do:

Yes: You will agree to buy fruit for your family to eat if the community leader can convince you that the fruit will not harm your family's health. Your mother convinced you a long time ago that your family had acquired a food taboo. This taboo prohibits your family from eating fruit especially fruit with the color red or orange. You are not convinced that this is true but your mother is very influential in the family and at present she is living with you.

No: You will not agree to eat fruit unless the community leader can convince you that eating fruit will not cause harm to your family.

Card 3: Amudha (Side 1)

You filled out the chart but much of the information on it is not true. You have exaggerated the amount of food your family eats because you wanted to have a better chart than Selvi. Even though the chart has misinformation, some problems are still evident; for example, the children are not getting enough milk or dairy products and the children are eating too much sugar, candy and not enough protein.

Card 3: Amudha (Side 2)

(Do not show this side of the card to the community leader)

During your conversation with the community leader you must make a decision and tell the community leader what you have decided to do:

Yes: You will agree to change some food habits if you understand why these changes are necessary and if you are convinced that your children will not become too thin if they stop eating so much sugar. Also you want to know how you will get your children to eat foods that they do not like and stop eating foods that they like. You also want to be sure that Selvi's family has dietary problems too.

No: You will not agree to change your family's food habits unless the conditions above have been met.

Card 3: Bhavani (Side 1)

You have not filled in any of the food chart even though you told the group you would. You feel very embarrassed and would rather not have to explain your negligence to the community leader.

Card 3: Bhavani (Side 2)

(Do not show this side of the card to the community leader)

During your conversation with the community leader you must make a decision and tell the community leader what you have decided to do:

Yes: You will agree to fill in the chart if no one else in the community can see it. Your husband and you do not like the idea of other people in the community seeing what your family eats. You thought you would have to bring your chart to a community meeting. Your husband, in particular, feels that it would be bad luck if people saw your family's food chart.

No: You will not agree to fill in the chart unless the community leader can promise that no one but she will see the contents of your family's food chart and that the community leader will not talk to other people about what your family eats every week.

(From Cash, Kathleen. 'Designing and using simulation for training: technical note No. 20, Centre for International Education, University of Massachusetts, Amherst, 1983, pp 18-25 and appendix)

Session 5: Learning to work in a group

Session Objectives: At the end of the session participants will be able to:

A. Develop skills and attitudes necessary for a person to function as a productive member of a group.

B. Describe the communication and decision patterns in groups

C. Describe the technique for collective decision making and priority setting regarding major health problems in the community or in any situation where different members of the group express different priorities and a procedure for rating these is needed

Training Materials required for the session:

A. Enough stiff card for fifteen 6 inch squares and envelopes. (You will require as many squares as number of participants, in this case there are 15 participants)

C. Flannel board, strips of paper, cloth, cut out symbols

Methodology:

Present the objectives.

A. Develop skills and attitudes necessary for a person to function as a productive member of a group
1 hour

The game can be played by a group of 5 persons with the others observing or by all participants, in which case you will require as many squares as number of participants.

Rule (depending upon number participants) squares from a piece of card or stiff paper (12 centimetres or 6 inch squares would be a suitable size). Rule each square into a pattern (A1), and mark each shape with the appropriate letter. (Measurements should be made as accurately as possible). Cut out the shapes, and sort them into sets of the same letter. Put each set in an envelope marked with the same letter. Explain that the participants have to assemble the squares as a group using the pieces given. Divide participants into groups of five. (If 15 participants there will be 3 groups of 5 members each). Read the instructions.

This exercise is used to reflect upon co-operation, sharing , working as a group etc. For example, in each group there maybe some who are able to assemble their squares quickly. Once they have their squares put together, they may close these with their palms and watch on as others in the groups struggle with their pieces. They may not offer any help or even consider pulling down their own squares, exchanging their pieces with others, trying to reassemble five squares for the group. This may hold the group up until the person(s) dismantle it. Groups that work together may finish first. The other groups may not make much progress.

In the large group, discuss what happened in groups. Encourage participants to verbalise their feelings. What does the exercise say about sharing. Was the initial reaction to try and get your own square. Ask participants to draw parallels with life. Sum up the activity highlighting the main points/issues that emerge.

B. Communication and decision patterns in groups **1 hour**

Introduce the activity. One group forms the outer circle and the other the inner circle. Members of the inner circle carry out a group discussion on any specified topic. Divide participants into two groups. (5 minutes)

Brief members of the outer circle to observe the following:

Who talks?

For how long?

How often?

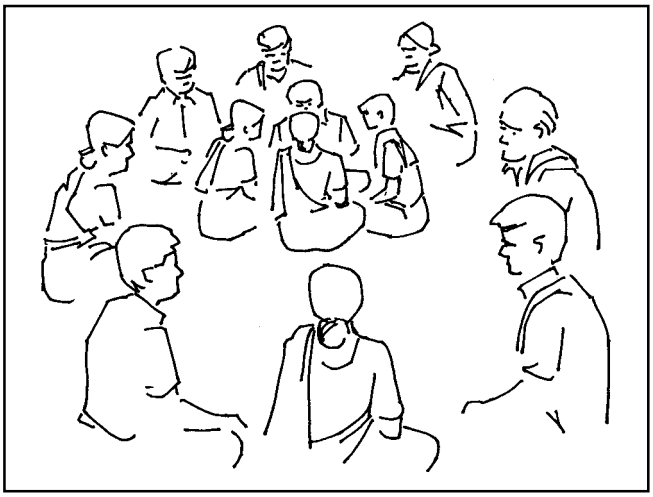
Who do people look at when they talk?

- Other individuals, possibly potential supporters?
- Scanning the group?
- No one?

  The ceiling?

  Who talks after whom, or who interrupts whom?

  What style of communication is used?
- Long statements
- Questions
- Tone of voice
- Gestures etc.



After a specified time (maybe about 20 minutes), the groups change places, and the group which had carried out the discussion now observes, while the other group discusses (20 minutes). Thereafter both groups discuss separately and a group representative presents their observations (10 minutes). Sum up with the main issues that come up in the presentation and discussion (5 minutes).

C. Collective decision making and priority setting regarding major health problems in the community
1 hour (or 1 hour 30 minutes depending on method chosen)

This can be don e in several ways, some simpler and some more complete.

Divide participants into smaller groups. Ask them to discuss and list the most common and most serious health problems in their villages /area. (10 minutes)

In the large group list them on the board / chart using the grid (C2), how common and how serious the participants feel each problem is. Then mark from 1 plus (+) to 5 pluses (+++++) in each column.

Ask participants to add the plus marks for each problem. By considering both how common and how serious a problem is, participants get an idea of its relative importance in the community.

Sum up by asking participants which problem appears to be most important (the problem with the maximum plus marks), followed by the next and so on. (1 hour)

Discuss that a more complete way to look at the relative importance of problems is to consider four questions for each problem. Use the chart (C1) to discuss. Use and add plus marks for results. OR

Use cut out symbols which gets everyone involved and is a more fun way (1 hour 30 minutes). Discuss what symbols can be used for the four questions. For example: common –sad face; serious –skull; contagious- face with arrows; chronic-long arrows. Each of these symbols could be in a different colour (C2).

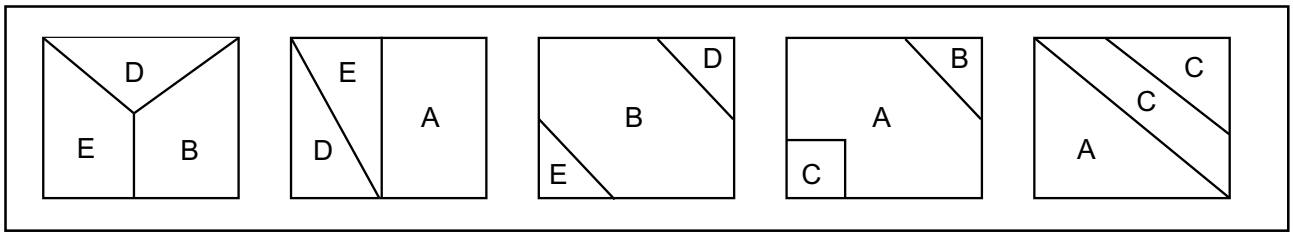
Divide the participants into smaller groups. Divide the task and guide the groups to prepare the symbols.

During discussion list each problem on a strip of paper or cloth. Attach these strips to the flannel board. Discuss each problem and ask participants to place the symbols that they think fit each problem (C2). There maybe difference of opinion especially if health workers come from different areas. They discover that problems and needs vary from village to village. Health workers can use these methods with persons who cannot read. To show the problems, they can use simple drawings instead of words. Once the drawings are explained people rarely forget what they represent.

(From Werner and Bower op cit pp.314 to 316).

Materials used for training /handouts include:

A1



Write up the following instructions on a chart:

- On the starting signal -Open envelopes and take out the contents
- The exercise continues till each person has a square
- You may pass a piece of square but not take one without the consent of the others in the group
- No talking or any other kind of communication is allowed

  You may at any time decline to take any further part.

C1 To be written on a chart:

A more complete way to look at the relative importance of problems is to consider the following questions for each problem:

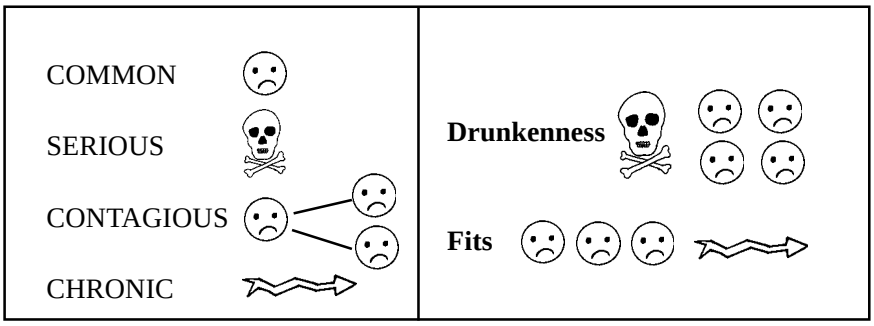
a) How COMMON is the problem in the community?

b) How SERIOUS are the effects on individuals, families, communities?

c) Is it CONTAGIOUS? (does it spread to other people?)

d) Is it CHRONIC? (does it last a long time?)

C2 A grid on a chart or blackboard.



Session 6: Learning to lead

Session Objectives: At the end of the session participants will be able to:

A. Develop problem solving skills

B. Be acquainted with the Force Field analysis as a tool for diagnosis and planning a strategy for change by working through a problem

C. Use a systematic approach to plan and implement

D. Be acquainted with the process of participatory evaluation

E. Develop skills for managing resources

Training Materials required for the Session:

B. charts, pens, Force Field diagram on chart, pencils and paper.

C. 5" x 3" cards, masking tape, felt pens, thumb tacks, charts, sample grid on chart, flash cards, board/cloth

D. Felt Pens, masking tape, charts, copies of the CIPP Evaluation grid

E. Copies of the village case study for each participant and two pages of regular bookkeeping journal paper for each participant or the group, pencils

Methodology:

Present the objectives.

A. Problem solving skills **45 minutes**

Introduce the activity 'problem drama' and explain that a problem situation from real life will be dramatized, for example, a parent unwilling to send the daughter to school.

Stop the drama at the point where the problem and some underlying reasons have been presented. Invite participants to propose ways in which the situation could end, and actually join in completing the play. This can be repeated for different situations identified by the participants.

Discuss and sum up each situation, highlighting the problem and ways of resolving it.

B. Be acquainted with the Force Field analysis as a tool for diagnosis and planning a strategy for change by working through a problem **3 hours**

Introduce the Force –Field Analysis as a tool for diagnosis. Describe with a diagram on a chart (B1) the model of Force Field Analysis as one way of planning for change.

Explain the steps in the process of planning for change. The Force Field concept reveals that the present level of performance of organizational or individual behaviour is determined by the balance between the forces that are diving and those that are restraining that particular performance. The known forces can be identified and listed.

Illustrate principles in overcoming resistance to change and reinforcement to planning for change. Explain that: (B2)

The level of performance can be raised in several ways:

a) Increasing the driving forces

b) Reducing the driving forces

c) A combination of the two

d) By the development of new driving forces.

An increase in the driving forces places the restraining forces under tension and the performance tends to return to the present level when the increased effort in the driving forces is reduced.

On the contrary, a decrease in the restraining forces enables the present effort to lift the level of performance. The key to change, however, is to start by reducing the restraining forces, a technique rarely used.

Demonstrate the concept of driving and retraining forces by diagnosing a problem. For e.g. How can our group increase its membership?

Ask the group to identify some of the retraining forces. Write these down in the diagram on the chart. They can be written down along the arrows in the diagram.

1. Review the two lists and underline those forces which seem to be most important right now, and which you think might be able to affect constructively. Which are assumptions? Which are facts? Which are beyond

your influence and ability to affect? There may be one specific force which stands out, or there may be two or three driving forces and two or three restringing forces which are particularly important.

2. For each restraining force you have underlined, list on chart some possible action steps which you might be able to plan and carry out to reduce the effect of the force or to eliminate it completely. Brainstorm or list as many action steps as possible, without worrying about how effective or practical they would be. You will later have a chance to decide which are the most appropriate.

3. Do the same with each driving force you underlined. List all the action steps which come to mind which would increase the effect of each driving force.

4. You have listed possible action steps to change the key forces affecting the problem of a desired change. Review these possible action steps and underline those which seem promising.

5. List on the chart the steps you have underlined. Then under each action step, list the materials, people and other resources which are available to you for carrying out the action.

6. Review the list of action steps and resources, and think about how effective or practical each of them would be. Select the most appropriate steps based on all the factors listed and discussed.

C. Systematic approach to plan and implement **2 hours**

Explain that to avoid confusion and waste of time the group should use a systematic procedure such as the 'The Programme Evaluation and Review Technique (PERT)' or any other step by step approach with an aim of moving rapidly through the steps with as much consensus as is possible in (C1).

Ask participants to identify an activity to be implemented. For example, Motivating leaders in Panchayat Raj Institutions to attend a meeting to strategize about audit and monitoring of health centers to improve quality of health services. This is only a sample. Discuss with the participants and decide upon an activity.

1. In the group brainstorm all the steps which need to be taken to implement their activity. Write these boldly with a felt marker on flash cards, spread on a table/ on the floor or pinned on a board / cloth.
2. Arrange all the activities in the order in which they will be performed and as they are related to each other. The group may discover that they left out quite a number of essential steps and that many activities must be done concurrently.
3. Write missing steps on flash cards and add to their appropriate places.
4. Write the time when each activity is expected to be completed on the cards (best written boldly with a different colour marker). The group checks again the activities which precede each step e.g. booking, ordering or procuring of necessary resources before an activity.
5. Assign the roles. Indicate the names of people to perform each activity. This includes assigning monitoring and evaluation roles.
6. Review the decisions undertaken to find out any important activities or steps omitted.
7. Record the decisions future reference and guidance using the format.
8. Fit into a comprehensive action plan. Eliminate those items which do not seem to fit into the overall plan, and any new steps and resources which will round out the plan, and think about a possible sequence of action.
9. The final step is to plan a way of evaluating the effectiveness of your action programme as it is implemented. Think about this now, and list the evaluation procedures you will use.

D. Participatory Evaluation **2 hours**

Explain that the purpose of the activity is planning for participatory evaluation. The activity demonstrates the process of involving group participants in evaluating their activities together and generates questions for evaluation that could be used in training their groups to do similar exercises.

Explain the concept and purposes of participatory evaluation and asks the group to list steps they would take to involve a group in evaluation. (D1)

1. Explain the elements of the CIPP Grid – C-Context, I-Input, P-Process and P- Product evaluation.
2. Divide participants into smaller groups and ask each group to discuss each of the four elements and list as many items of project or activities which need to be evaluated in respect to their elements.
3. Groups read their lists in the large group and with the other groups providing additions.

4. Select one aspect as an example and lead participants to list questions which need to be answered to evaluate the aspect.
5. The 4 small groups meet separately to generate questions for each item listed. Ask groups to list ways or methods of collecting information needed to answer the question asked.
6. In the large group, share and improve on the strategies discussed.

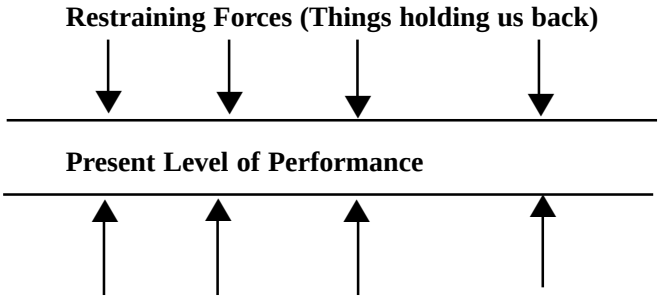
E. Managing Resources **1 hour**

Explain that the purpose of the activity is to develop skills in simple accounts. Distribute the Handouts (E1) to all participants or divide participants into groups and distribute one copy per group.

a. Ask each participant or the group to record the amount of cash received (income), and the amount of cash given out (expenses). If possible, participants do this on regular book keeping journal paper.
b. After they finish, show them on the blackboard or on a chart, the correct accounts.
c. Ask each participant or group to find their errors and correct them. Slowly go around to each participant or group and see what problems they had.
d. Give time for questions and answers, and give simple instructions for any general mistakes the group is making.

Materials used for training / handouts:

B1 **Steps in the process of Planning change** (large drawing on a chart)



B2 **Chart 2:**

(From: IPPF; 'planning and Management of Community projects: A manual on programme Development, Leadership training and management of group projects, IPPF Africa region: 1983; as given in RUWSEC 'Training grassroots women..')

C1 **A table like this one might be useful on a chart to record the decisions for future reference and guidance**

Activities	Date of Completion	Assigned to	Monitoring and Evaluation
Venue or place of implementation may be indicated; concurrent activities listed together	Time indicated if it is important	Names listed	Names of persons to make sure decisions are implemented and take action if they are not.

(D N Nturibi –Adapted from- From the field –World Education, New York, 1980
From IPF Africa Region op cit p.45)

D1 CIPP Grid

Context What needs to be done?	**Input** How should it be done?	**Process** Is it being done?	**Product** Did it succeed?			
			Were the right beneficiaries reached? (Impact)	Were their needs met? (effectiveness)	Were the gains sustained? (sustainability)	Did the process that produces the gains prove adaptable for effective use in other settings? (Transportability)

E1 Village Case Study

The following case study is given to each participant as a handout. Alternatively, distribute one copy per group.

September

1.9. 03 Meena and Kamala, group members, contribute Rs 150 each.

12.9.03 A grant of Rupees 2500 is received from Oxfam to buy materials for the village water project.

23.9.03 Sekar and Eshwari , group members, contribute Rs 200 each.

24.9.03 A grant of Rs 5000 is given to group from the Block development office. It can be used for loans only, of no more than 500 rupees per person for purchase of farm tools.

27.9.03 Raji and Pushpa receive loans of Rs. 500 each.

29.9.03 10 bags of cement are bought by the group at Rs. 250 each.

October

3.10.03 A local mason is paid Rs. 2000 for work done on the group building.

5.10.03 Loan of Rs. 250 given to Neela

5.10.03 Raji repays Rs. 200 for her loan.

7.10.03 Loan given to Sarla of Rs. 750.

18.10.03 Rs. 500 paid to people for breaking stones

23.10.03 Rs. 300 paid for tea, snacks etc for a meeting with the local minister

November

3.11.03 Raji repays Rs.200 for her loan.

3.11.03 Pushpa repays Rs 250 for her loan.

5.11.03 Neela repays Rs100 for her loan

6.11.03 Cement and Iron bars bought at the cost of Rs.1000

6.11.03 Seeds bought for a widow at Rs. 500

28.11.03 Widow pays back Rs. 200

Reproductive Health Indicators for monitoring community – based reproductive health programme

POPULATION GROUP	INDICATOR	MODE OF DATA COLLECTION	PERIODICITY OF DATA COLLECTION
Adolescents 13 – 19 years	Proportion who have had at least 7 yrs of schooling (male / female)	House hold survey	Baseline followed by once in 3 yrs.
	Proportion married (female)	- do -	
	Proportion who have had one or more children (female)	- do -	
	Number of deaths / year (male / female), and proportion of deaths caused by suicide / violence	- do-	
	Proportion who have reproductive health problem (by cause), and proportion seeking medical help for it	- do-	Base line survey followed by six monthly updates by health worker
	Proportion who smoke or drink or use other addictive substances (e.g pan parag, ganja)	Self administered questionnaires responding (yes or no to a list of statements on gender norms and values	- do-
	Proportion who believe in gender equity / justice (male / female)	Self administered questionnaires responding yes or no to factual information	In workshops on gender conducted for adolescents
	Proportion who are aware about their bodies (male / female): (at least the following) puberty, menstruation, sexual intercourse, pregnancy and delivery, and contraception		In sex education workshops conducted for adolescents.
Pregnancy and birth	Proportion of pregnant women who report that the present pregnancy was not planned / wanted (by age, parity, education, occupation)	Interviews with the women concerned	Base line survey followed by six monthly updates by health worker.
	Proportion receiving additional food during pregnancy (by age, parity, education, occupation, landowning status of household and family type-nuclear or joint)	- do -	- do-
	Proportion having a pregnancy carried to term and resulting in a live birth (by place of delivery and type of attendance, age, parity, education, occupation & landowning status of household)	- do-	- do-

POPULATION GROUP	INDICATOR	MODE OF DATA COLLECTION	PERIODICITY OF DATA COLLECTION
	Proportion suffering from a health problem during pregnancy or following delivery (or miscarriage), and proportion seeking medical help for it (by place of delivery and type of attendance, age, parity, education, occupation & land owing status of household)	-do -	-do-
	Number of maternal deaths, cause of death and place of death (by place of delivery and type of attendance, age, parity, education, occupation & landowning status of household).	-do -	-do-
Abortion and contraception	Contraceptive prevalence rate # (by method, age, parity, education, occupation sex composition of children) # includes withdrawal and rhythm methods.	Interviews with women in the reproductive age group and their husbands	Baseline survey followed by six monthly updates by health worker
	Proportion of women / men who are using a method of their own choice (by method, age, parity, education, occupation)	- do-	-do-
	Women with less than 2 years spacing between the last two deliveries or terminations of pregnancy (by age, parity, education, occupation, sex composition of children)	-do-	-do-
	Proportion of women developing an infection (RTI) following an abortion (by type of personnel conducting age, parity)	-do-	-do-
	Proportion of women / men developing an infection (RTI) following sterilization (by type of facility, age, parity in the case of women)	-do-	-do-
Reproductive health problems	Prevalence of a reproductive health problem including STDs (by sex, condom use, age, parity, education, occupation and landowning status of household)	Interviews with all women, and with their partners in the case of married women below 45 (assumed to be sexually active)	Base – line survey followed by six – monthly updates by health worker.

POPULATION GROUP	INDICATOR	MODE OF DATA COLLECTION	PERIODICITY OF DATA COLLECTION
	Proportion of those with a RH problem seeking health care; proportion of these where both partners do so (by type of care, sex, age, parity, education, occupation and landowning status of household)	- do -	-do-
	Proportion of those with a RH problem in whom the problem recurs (by type of help, sex, condom use, age, parity, education, occupation and landowning status of household)	-do-	-do-
	Proportion of women above 40 who have had a pap smear	-do-	-do-

Survey Tools

Health Status of Women –Baseline survey

Village: Name of staff:

Card Number: Date of study:

Name of Head of the family: Verified by:

I Profile

1.1 Name

1.2 Age

1.3 Name of the husband:

1.4 How long have you been married:

II Details about pregnancies

2.1 How many times have you been pregnant? If you are pregnant now please include that

2.2 How many children (include older children)

Total: Boys: Girls:

2.3: When was the last child born?

2.4 Details about earlier pregnancies

2.4.1.

Number of pregnancies	Prolonged labor - more than one day and one night	Excessive bleeding	Delay in placental delivery	Fits after delivery *(janni)*	Fever after delivery	Any other details
1						
2						
3						
4						

If yes tick and if 'no' mark a cross.

2.4.2 What kind of delivery did you have?

Number of pregnancies	Full term delivery	Preterm delivery	Normal delivery	Stitches	Forceps delivery	c-section
1						
2						
3						
4						

If 'yes' mark a tick, if 'no' mark a cross

2.4.3 Details about the children born

Number of pregnancies	Child born		Child		Current status of the child	
	Male	Female	Born	Born	Alive	Dead
1						
2						
3						
4						
5						

If 'yes' mark a tick, if 'no' mark a cross

2.4.4 Care during pregnancy and delivery

Number of pregnancies	During pregnancy	Delivery took place			
	Immunization was done tests	Underwent	At home attended by a trained birth attendant	At home attended by other	In a health facility
1					
2					
3					
4					
5					
6					
7					

If 'yes' mark a tick, if 'no' mark a cross

2.4.5 Details about children that were born live but died thereafter

Birth order of the child	Boy? Girl?	Age at the time of death	Reasons

2.4.6 Did miscarriage happen? Yes/No

If yes during which pregnancy? In which month?

_____pregnancy _____month

_____pregnancy _____month

2.5 Did you do an abortion? Yes/No

If yes, fill the details in the following table

Order of pregnancy	Traditional method, on my own	Traditional method done by another	Tablets	Injection	Health facility	Reasons for abortion

III Current health status

A. Common health problems

3.1 At present are you undergoing any treatment for a health problem Yes/No

If yes, explain your health problem

3.2 Have you been hospitalized in the past one year? If yes, for what reasons? How many days were you in hospital?

3.3 In the past one year have you been bed ridden for a week or more for any health problems?
If yes explain the problem? What kind of treatment did you undergo?

3.4 Do you have a lot of worries/problems at home? If yes, what are the causes/reasons for the problems.

IV A. Gynecological problems

If 'yes' mark a tick if 'no' mark a cross

Health problems	Do you have this problem now	Did you have in any time last month?	In the past six months how many times have you had the problem
1. Excessive bleeding during menses			
2. Bleeding in between two periods			
3. Menses at short intervals			
4. Delayed Smelly vaginal discharge excessive vaginal 'white' discharge, enough to wet the inskirt			
5. Sour smelling string like discharge			
6. Urinary Tract Infection			
7. Intense hip pain and pain in the lower abdomen			
8. Swelling or lump in breasts			
9. Pain during sexual intercourse			
10. Prolapse			
11. Cannot hold urine (incontinence)			
12. Any other (note)			

3.5. (Ask women who have vaginal discharge). Does your husband have any related health problem? If yes give details.

V. Use of contraceptives

5.1 Do you or your husband use any contraceptives currently? Yes/No

5.2 If yes, what method (if yes mark a tick)

Abstinence

Pills

Copper T

Diaphragm

Nirodh

Tubectomy

Vasectomy

Laparoscopy (women)

5.3 If they do not use any, then ask:
What are the reasons for not using any contraceptives

5.4 Are you interested in temporary methods (health worker explain the methods). If yes what methods?

5.5 How many children do you desire?

Total: _____

Boy _____

Girl_____

5.6 If you have decided not to have children, what method are you going to use?

Household survey

1.1 Name of the head of the family

1.2 Village/Block:

1.3 House number:

1.4 Card number:

1.5 Caste SC/other

1.6 Religion: Hindu/Christian/ Muslim/others (Mark)

Information about family members:

2.1 Sr.No.	**2.2 Name**	**2.3 Relation-ship with head of the family**	**2.4 Age/Date of birth**	**2.5 Male/ Female**	**2.6 Marital status**	**2.7 Education**	**2.8 Reasons for dis-continuing**	**2.9 Occu-pation**

D E T A I L S	2.3 Head Wife Son Daughter Brother Sister Mother Father Others (Specify)	2.6 Married Unmarried Widow/Widower Separated	2.9 Owns land Works on own land Lease for a week Agricultural labour Padivelai Household work Others (Specify)

3.1 Details of Deaths in the family in the past 5 years

3.1 Sr. No.	**3.2 Name**	**3.3 Relationship with the head of the family**	**3.4 Age of the dead**	**3.5 Male/Female person**	**3.6 Reasons for death**

Economic Status of the Family

4.1 Property 4.1.1 Have/Do not have.
If yes, how many acres?

4.2 House
- 4.2.1 Patta House Yes/No
- 4.2.2 Type of house – Thatched/ tiles/ Concrete
- 4.2.3 Separate Kitchen: Yes/No
- 4.2.4 Is there a way for the smoke to go out o f the kitchen: Yes/No
- 4.2.5 Electric light: Yes/No

4.3 Water

Source	**Summer season**	**Other seasons**
Well Tap Lake/pond Pumpset		

1. Own
2. Common
3. Others

4.4 Health facilities
1. Toilets at home
2. Common toilets
3. Use backyard of the house
4. Outside

Health status of children below 5 years - baseline survey

Village: **Name of health worker**

Form Number: **Date of study:**

Reviewed by:

I. Basic Deetails

Desription/Details	**Child 1**	**Child 2**	**Child 3**
1. Name of the child 2. Father's name 3. Mother's name 4. Age of the child 5. Boy, or girl? 6. Parity of the child? 7. Any disabilities 8. If yes what kind of disability 9. From Birth or when did it happen			
Details	**Child 1**	**Child 2**	**Child 3**
10.1 Does the child go to balwadi 10.2 If below one year is the child being breastfed? 10.3 Is the child being given complementary food daily 10.4 If yes what food. If no, what is the reason?			

II Details of immunization

If yes mark a 'tick' : if no mark a 'cross'

Details	**Child 1**	**Child 2**	**Child 3**
2.1 TB vaccination			
2.2 If not what is the reason			
2.3 Polio drops 3 times 4 times (with booster) 1 or 2 times did not give			
2.4 If all vaccines were not given what was the reason			
2.5 Chicken pox vaccine			
2.6 If not given, what was the reason			

III Present Health Status

3.1 At present does the child suffer from any of the following problems?

(Make a note only if the problem exists on the day of the visit/survey/study)

Health problems	Child 1	Child 2	Child 3
1. Fever			
2. Severe cold			
3. Continuous cough			
4. Diarrhoea			
5. Dysentry			
6. Indigestion			
7. Worm infestation			
8. Stomach ache			
9. Pain in the eye (boil in the eye)			
10. Ear ache, fluid secretion from the ear.			
11. Toothache, rotten tooth			
12. Itching, skin rash			
13. Night blindness, Kannil poo vizhadal			
14. Kwashiorkor or Marasmus			
15. Injury			
16. Any other (specify)			

3.2 In the past one year was the child affected by any of the following serious health problems?

Health problems	Child 1	Child 2	Child 3
1. Chicken pox			
2. Small pox			
3. German measles			
4. Malaria			
5. Primary complex			
6. Typhoid, fever			
7. Dog bite, other poisonous bites			
8. Jaundice			
9. Any other (Specify) Note: Did chicken pox occur after vaccine			

3.3 Medical care/attention

What kind of medical care did you access for these problems

Health problems	Child 1	Child 2	Child 3
3.3.1 For how many days has this problem continued			
3.3.2 Did you try any treatment (at home) (vaithiyam)			
3.3.3 If yes what treatment			
3.3.4 Did you access medical care? If yes what type of care/treatment? A. Traditional healer B. Primary Health Centre C. Government Hospital D. Private clinic run by Government doctor E. Private doctor F. Private clinic/hospital			
3.3.5 If not why?			
3.3.6 What steps were taken by the health worker			

3.4 In the past one year did the child have to be admitted to a clinic/hospital. If yes, specify reasons

	Yes/No	Reason	How many days in the hospital
Child 1			
Child 2			
Child 3			

This info was maintained and followed up by the health worker. The information from each of these forms and from the other such surveys was compiled by the health worker every month. These were shared at RUWSEC and were the foundation for follow up interventions by the health worker and community.

Survey of the health status during pregnancy and delivery

Village : **Name of Health worker:**

Form Number: **Date of the survey:**

Name of the Family head: **Reviewed by:**

I History of previous pregnancies

1.1 Name of the pregnant woman:

1.2 How many times have been pregnant before:

1.3 Any previous pregnancies (or) abortion, miscarriage took place how long ago?

2 years or more ( )

Two years not yet completed ( )

During the previous pregnancies did you have any of the following problems?

1. Miscarriage Yes/No
2. Abortion Yes/No
3. Swelling of hands, legs and face Yes/No
4. Complicated delivery
5. Cesarian
6. Infection (*Janni}*
7. Premature delivery
8. The baby was born dead
9. The baby died within the first month
10. Any other (specify)

II Health Status during present pregnancy

2.1 Date of the last periods

2.2 Date of delivery

2.3 Where does the woman plan to have the delivery

2.4 have you thought/considered using any contraceptives after delivery (temporary or permanent)? Yes/No

If yes, which method?

2.5 Present health status	**Months**										
Details/Descriptions	3	5	7	8				9			
				Week 1	2	3	4	Week 1	2	3	4
1. Nutritious diet											
2. Is she having iron tablets. Y/N											
3. If Y then where did she get them ANM/outside											
A. If tablets not being taken – what is the reason?											
4. Weight											
5. Immunization											
6. Swelling of hands, legs, face											
7. Anemia											
8. Hemoglobin level											
9. Blood pressure											
10. Bleeding											
11. Blood group											
12. Urine test											
13. Does the ANM visit and do a check up every ,month											
14. If miscarriage took place, record in which month it happened											
15. Is the foetus okay?											
16. Is the delivery kit ready? Y/N											
17 Did she experience any other health problem during the pregnancy?											

III Health status during delivery

3.1 Date of delivery: Time:

Place: Delivery conducted by:

3.2 Position of foetus in the uterus

Normal Breech Transverse Twins

3.3 Details about the baby

Male ( ) Female ( )

Healthy ( ) Was born dead ( ) Died within a day after birth( )

Colostrum given ( ) Eye drops were administered ( )

3.4 Details about the mother:

Safe delivery	Yes/No
Forceps (*Ayutha case)*	Yes/No
Cesarian	
After delivery	
Excessive bleeding	Yes/no
Infection	
Fever accompanied by severe shivering	
Uterine prolapse	
Pain during urination	
Perineum tear	Yes/No
If yes, has the tear been stitched	

IV One week after delivery

4.1 Did she undergo sterilization? Y/N

4.2 If perineum tear has been stitched or in case of sterilization has the area with stitches healed

4.3 Has the infant's navel healed

4.4 has the child been given a vaccine against TB

4.5 Does the mother/infant have any other health problem. If yes, describe/give details.

4.6 Is she having iron tablets (Yes/No

4.7 Does the ANM visit /Check

4.8 What method have you considered for spacing before having the next child

Abstinence

Pills

Copper T

Nirodh

Diaphragm

Any other (Specify)

SURVEY FORM -SINGLE WOMEN

Village: **Caste: SC/BC/Others**

Card Number: **Religion: Hindu/Muslim/Christian/Others**

Name of the head of the family:

Date on which the survey took place:

PART –1

1.1 Name
1.2 Age
1.3 Married/Unmarried
1.4 If married age at marriage:
1.5 If unmarried what is the reason?
1.6 The husband is alive/dead
1.7 If the husband is dead when did he die?
1.8 If living separate from husband, how long? What is the reason?
1.9 Have you undergone tubectomy? Yes/no
1.10 If no, why?
1.11 Whom do you stay with at present?
1.12 How many children do you have? (Only for married women)

Total births: Boys: Girls:
Children alive: Boys Girls:

PART-2

2.1 Are you economically sound/okay? Yes/No. Explain.
2.2 At present do you have any health problem? Yes/No. If yes what kind of health problem? Explain?
2.3 Who supports you to the maximum extent? Explain.
2.4 When you have problems whom will you share it with?
2.5 Were there any incidences where you have faced problems that undermined your dignity. Can you share it with me?
2.6 What have you thought about your future? What kind of help/support would you need to manage?
2.7 Do you wish to share any thing else with me?

Health status of women above 50 years

Village:
Street:
Plot no.:
House No:
Name of the head of the family:

Name of the health worker:
Date on which the survey was done:
Verified by:

Profile

1.1 Name

1.2 Age

1.3 Age at menarche:

1.4 Marital status: married/separated/widow

1.5 Husband's name

1.6 How long have you been married

1.7 At the time of marriage

Husband's age:

Wife's age:

1.8 Married to someone who is related? Yes/No

II Details about motherhood

2.1 How many pregnancies have you had?

2.2 Children born: Boy:_____ Girl:_____ Total:_____

2.3 Total number of children(including older children)

Boy:_____ Girl:_____ Total:_____

2.4 H ave you had nay miscarriage?

2.5 Have you undergone an abortion?

2.6 Have you done sterilization? Yes/No

If yes, when did you undergo: _____

III. Health problems of women

S.No.	Health Problems	Do you have the problem at present Yes/No	For how long have you had the problem	Did you go for treatment? If yes, where? If no, reasons
1.	Irregular menstruation			
2.	Smelly Vaginal discharge			
3.	Excess vaginal discharge so that the inskirt is wet			
4.	Sour smelling stringy discharge			
5.	Vaginal discharge with blood			
6.	Blisters /itching/pain (in vagina)			
7.	Long term pain in the hip			
8.	Pain in lower abdomen			
9.	Swelling or lump in breast			
10.	Pain during sexual intercourse			
11.	Bleeding after sexual intercourse			
12.	Prolapse			
13.	Cannot hold urine (incontinence)			
14.	Any other? Give details			

3.1.2 Women who have problems (2-5), does the husband have related health problems? If yes, what kind of problems?

3.1.3 Is the husband undergoing treatment for this? If yes, where? If no, why?

III. Health problems of women

Current health status

If there was a health problem on the day of the survey, document the problem here.

Sr. No	Health problem	For how long have you had this problem	Did you do any treatment? Yes/No. If yes, where? If no, why?
1	Head ache		
2	Fever		
3	Cold, cough		
4	Mouth ulcer		
5	Tooth ache		
6	Hip pain		
7	Stomach pain		
8	Ulcer		
9	Body pain		
10	Joint pain		
11	Chest pain		
12	Anemia		
13	Skin problems		
14	Wound		
15	Yellow fever		
16	Blood Pressure		
17	Diabetes		
18	Breathlessness		
19	Fits		
20	Others (detail)		

3.2.2 In the past year have you been hospitalized? If yes, for what reasons? For how long? What kind of treatment?

3.2.3 In the past one year have you ever been bed-ridden for a week or more? If yes for what health problem? What treatment did you undergo?

3.2.4 Do you have worries/problems in the family? What are the causes/reasons for these worries/problems?

Survey: Substance Use

Month: Village: Name of health worker:

1. (a) Information on current health status and common problems

Sr. No.	Card No.	Date	Name	Age	Married Y/N	What problem?	For how long	Action taken by health worker	Did you undergo treatment? If yes, where? If no, why?

2. (a) Information about persons who drink, smoke and consume pan parag and such other

Sr. No.	Card No. No.	Date	Name	Age	Married Y/N	What habits			
						Alcohol	Cigarettes	Panparag	Any other

1. Never used
2. Used once or twice
3. Used rarely (once in 6 months)
4. Not so often (once a month)
5. Often (several times a month)
6. Habitual (daily)
7. Cannot live without it (addict)

2(b) Continuation

Sr. No.	Card No.	Date	For how long have you had this habit				Do you wish to stop this habit?			
			Alcohol	Beedi	Panparag	Others	Alcohol	Beedi/Cigarettes	Panparag	Any other

3 (a) Reproductive health problems

Sr. No.	Card No.	Date	Name	Age	Married Y/N	What problem?	For how long?	Action taken by health worker	Using condom Yes/No

3 (b)

Sr. No.	Card No.	Date	Did you undergo medical treatment?	If Yes, where? If no, why?	Did you follow the advice of the practitioner Yes/No	Were completed you cured by the treatment? Yes/No

3 (c) Continuation

Sr. No.	Card No.	Date	Did your wife have any infection due to this?	Did your wife seek medical assistance If yes, where? If no why?	Was the advice of the medical practitioner followed Yes/No	Was there complete cure by the treatment? Yes/No

Possible tasks for grassroots women's organizations

I. Education concerning prevailing health problems and methods of preventing and controlling them

A. Health Promotion

1. Seek out information and materials on basic hygiene, proper nutrition, common health hazards and how individual and group behaviour influence ad promote health, from CHW and / or first health facility.
2. Disseminate information gathered through informal gatherings, distribution of leaflets/pamphlets, posters, community notice-boards etc.
3. Arrange for community/ women's meetings with Community Health Worker (CHW) /First health facility personnel for information on health resources available at different levels.
4. Mobilize women and other community members to undertake positive health actions such as hygiene, recreation, etc.
5. Mobilize women to attend functional literacy classes and provide moral support and other possible support (such as minding their children or helping in household tasks).

B. Prevention of Diseases and maintenance of health

1. Seek information on:
   - Prevention of locally endemic diseases.
   - Prevention of accidents including burns and fractures.
   - Correct MCH practices.
   - Correct use of essential drugs, from CHW /First health facility, for dissemination among its members and in the community.
2. Organize training programmes for mothers on basic first aid.
3. Seek out and make known essential information on who has to be contacted for what in the health sector and in the local bureaucracy.
4. Undertake activities in the community for creation of a healthy community, via for example:
   - Improving and securing living conditions (better housing, obtaining the legal rights to house-sites or settlement area, better sanitation).
   - Improving wages and working conditions, especially of women.
   - Improving means of communication and transportation.
   - Campaigning against harmful practices detrimental to health such as food taboos or over and improper use of drugs.

C. Education to deal with diseases

1. Seek out information and organize meetings with CHW and other health personnel on:
   - Symptoms of easily diagnosable prevalent diseases.
   - How to deal with these and when to seek help.
2. Assign one or more persons from their group to assume special responsibilities for health within the community, and to treat common sicknesses with simple home cures or other drugs.
3. Assign persons to make house visits in their neighborhood to ensure all is well, advise on health matters and aid them in finding the necessary help.
4. Develop a reporting system whereby serious illnesses such as TB and leprosy, or communicable diseases are immediately brought to the attention of the women's organization, which has assigned one of its members the responsibility to notify the health authorities and help the sick person find appropriate and sustained help.
5. Organize workshops from time to time on how to deal with specific common diseases with the help of CHWs and health authorities. (Conduct role-plays and socio-dramas to communicate messages simply and effectively).

II. Promotion of food supply and proper nutrition

A. Promotion of food supply

1. Organization of meetings with the help of CHW / volunteers from intermediary women's organizations / other resource persons to analyse the obstacles to improving food supply in the community. For example:
   - Poor land quality
   - Inequality in land distribution
   - Improper use of land: cash crops for export replacing staples for local use and so on.
2. Undertake actions on the basis of the above analysis, with appropriate technical and professional help.
3. Organize demonstration /education for women with the help of CHW on preparation of balanced meals with locally available and inexpensive foods.

4. Promote the creation of co-operatives for better production and marketing of food, with the help of agricultural extension agents.
5. Organising kitchen garden projects.
6. Improving water-supply facilities.
7. Set-up co-operative fair price shops to sell food and essentials at nominal prices.
8. Organising co-operative canteens in busy work seasons so that the quality of food supply does not deteriorate because there is no time to cook.
9. Seek out information on time and energy saving means /devices that will make food preparation easier and quicker and seek financial technical support for their adoption.
10. Encourage and promote the participation of men in food preparation /preservation tasks.

B. Promotion of nutrition and prevention of protein energy malnutrition (PEM) in children under 3 years of age

1. Designation of trainees for CHW and health volunteer courses
2. Organize with the help of CHW, meetings to educate mothers and surrogates on
   - Relationship between the health of a child, its growth and development and the type and amount of food he /she receives.
   - Knowledge and ability to prepare suitable food from locally available food stuffs for children of different ages.
   - Appropriate feeding practices and hygienic measures for the child, when ill and normal.
   - The relationship between child spacing and nutrition.
   - Understanding the weight chart.
3. Seek knowledge and skills from CHW and carry out weighing of children and enter these in the growth charts.
4. Assess nutritional status of children through use of an arm circumference / tape and interpret findings.
5. Through the above, identify children needing attention and refer to CHW for advice and help.
6. carry out house visits to see if new and better practices are being adopted, discuss problems involved, and to call for group meetings to tackle these; keep track of children needing special attention, as a priority.
7. Provide the necessary support to mothers of children at risk, to improve nutritional practices.
8. Seek help to set up feeding centers / day-care centers, etc. and check nutritional status of recipients.
9. Actively campaign against food taboos that are detrimental to infants' health and nutrition; promote breastfeeding.
10. Undertake if possible, large-scale production of weaning foods and make available to the mothers at subsidized rates.

C. Treatment and rehabilitation of PEM

1. Through nutritional assessment activities, collection of data on prevalence of PEM.
2. Identify children who need treatment and rehabilitation, and refer them to CHW.
3. Home visiting of children recovering from PEM at least twice a month.
4. Ensuring that the child is fed according to recommendations of CHW.
5. Weighing child at least every two weeks and recoding her/his progress in the growth chart.
6. Distribution of food supplements, demonstration of their use.
7. Immediate referral of child showing no progress or developing concomitant illnesses to CHW.
8. Distribution of iron tablets and Vitamin A to all children suffering from PEM, explaining their use and ensuring their administration.
9. Setting up feeding schemes, day care centers if necessary and managing them.
10. Ensure proper access to higher health referrals.
11. Arrange for help with household chores / childcare by other members when mother is away with child for treatment from higher levels of health care.

D. Treatment and prevention of nutritional anemia in pregnant women

1. Carry out educational activities to:
   - Change any discriminatory attitudes in the family with regard to food distribution for girls and women.
   - Increase awareness pf the special nutritional needs of women, especially during pregnancy.
   - Explain the dangers of anemia, how to prevent them and how to recognize symptoms.
2. Nominating volunteers to be trained in recognizing anemia who would
   - Visit houses of pregnant women.
   - Refer cases to CHW.
   - Follow up distribution of supplies of iron / foliate tablets and ensure they are being taken.
   - Refer unresponsive cases to the CHW / first health facility.
3. Take action to ensure that the pregnant women gets adequate rest and that her working conditions are safe.

4. Initiate schemes /measures if possible, that ensure adequate food and care for pregnant women. (Example: paid maternity leave, medical support, help in household tasks etc.
5. Campaign actively to correct taboos and misconceptions regarding the use of certain foods during pregnancy.
6. Initiate programmes and measures to improve women's access to and control over resources and income. (Fair wages, employment opportunities, equal right to property and land etc.)

E. Promotion and protection of nutrition in pregnant and lactating women

1. Carry out educational activities to:
   - Change any discriminatory attitudes in the family with regard to food distribution for girls and women.
   - Increase awareness of the special nutritional needs of women during pregnancy and lactation.
   - Impart knowledge about which local foods can be taken to enhance and protect the nutritional status of pregnant women.

   (Others as in D- 3,4,5)

III. Adequate supply of safe water and basic sanitation

A. Promotion of personal and community hygiene

1. Seek information from CHW and sanitary inspectors about the relationship between unhygienic practices and ill health.
2. Organize workshops for members and other groups in the community, to
   - discuss current practices which are unhygienic and analyse the reasons why they persist.
   - Identify short term and long term measures needed to tackle the reasons / problems identified, and evolve a plan of action (e.g. digging rubbish pits for dumping rubbish; (short term) campaigning to break misconceptions and social taboos regarding defecation and excreta disposal, reducing women's work load so that they have time to implement better hygiene and encouraging men to participate in fetching water, cleaning, washing etc. (long term).
3. Work along with other community groups and committees in implementing the above actions.
4. Undertaking projects specifically designed to reduce women's workload; in addition, campaigning for men to share in household tasks so that better family hygiene becomes a shared responsibility.
5. Make periodic visits to houses and communal areas and advise and demonstrate as appropriate regarding proper hygiene. Encourage women's organization members to set examples that would motivate others in following hygienic practices.
6. Arrange for demonstration of suitable community sanitary facility and usage; the type of facility maybe chosen according to water availability , community's financial capacity and cultural and social practices.
7. Promote and motivate and actively participate in:
   - construction operation maintenance and financing of community / sanitary facility;
   - cleaning of premises.

B. Supply of drinking water

Problem identification

1. Discuss with members problems with water supply, collection, utilization and storage; identify problem areas that need intervention.
2. Invite appropriate resource persons (CHW, sanitary inspectors, leader of a local committee responsible for water supply) to a meeting to discuss problems identified, and seek assistance in dealing with them.
3. Participate in community meetings where water and sanitation is discussed. Coordinate plans and activities. If community does not have such meetings, initiate them through the organization.

Construction

4. Select member (s) for taining in design, construction, operation and maintenance of simple technology, low cost water supply systems.
5. Participate in planning design, site locations of simple technology low cost water systems. Emphasise women's issues, location, design of pumps /taps etc.
6. Contact the concerned departments / sectors and seek financial assistance (according to the financial position of community) for construction.
7. Assist or organize voluntary community labour and materials contribution.

Organization and maintenance (O & M)

1. Select member (s) for training in construction, organization and maintenance of water system used in community.
2. Organize demonstrations on operation and simple maintenance of small community simple technology water systems, e.g. how to operate pumps, how to change washers, cleaning out water storage vessels and tanks.
3. Assist in or implant an O & M plan for improving water supply, through nomination of volunteers to carry out different tasks.

4. Campaign against wastage of water.
5. Help organize a system of financing running costs and in procuring tariffs, etc. from community members.
6. Organize a caretaker service either by employing someone or providing volunteers; develop a system of regular and routine maintenance checks.
7. Develop an early warning system to responsible persons to report any breakdown to the system, e.g. leaking taps, burst pipes, drying up of wells and pools.
8. Carry out evaluation of outcome of activities especially with reference to the benefits it has brought to women.

C. Protection of water sources and surveillance of drinking water quantity

1. Organize meetings for members (and other community groups) with the help of CHW, sanitary inspector or water engineer, to give technical information and practical advice on the protection of water sources and surveillance of drinking water quality.
2. Organize members to conduct an observationa; survey through house visits and visits to communal water sources to determine
   - how well protected the water sources are;
   - how water is stored and supplied by households, and its implications for drinking water quality.
3. Pool together the information gathered, and jointly work out a plan of action to protect and monitor water quality. Example
   - installation of hand pumps, well-cover, clean buckets for well;
   - maintenance of cleanliness around water sources;
   - cleaning up silt from wells, ponds etc.
4. Conduct educational activities to motivate community members to participate in above plans. Arrange, if possible, with the help of sanitary inspector, for community members to see for themselves what the quality of drinking water in their villages is (by viewing through microscopes to see particles, organisms etc.)
5. Mobilize resources and seek external assistance if necessary to carry out the above plans.
6. Ensure that ground water supplies are located away from areas where water is or can become unsafe for drinking;discourage grazing of animals in water catchment areas.
7. Ensure the installation of surface water intake in location safe from contamination.
8. Locate and maintain waste disposal facilities where they are not liable to contaminate water.
9. Carry out periodic sanitary surveys to ensure installations are protected.
10. participate in surveillance of water quality by
    - collecting water samples for analysis and sending to first health facility or to the appropriate person;
    - early warning to appropriate authority when water tastes bad, becomes discolored or looks contaminated with matter.

D. Excreta Disposal

1. Discuss with members prevalent practices and attitudes in regard to excreta disposal.
   - what needs to be changed
   - reinforcing good practices
   - contamination
2. Seek advice on most appropriate local method for home and communal use from CHW, first health facility, and others.
3. Discuss viable options and prepare a plan of action
4. Discuss plans with appropriate local authorities –collaborate and coordinate activities.
5. Organize demonstrations for members and other groups in the community on
   - how to construct and install suitable sanitary facilities in the home and for public;
   - how to use and maintain them.
6. Encourage organization members to take the initiative to build sanitary facilities thereby encouraging others to do so.
7. Seek financial assistance from governments / NGOs and mobilize community contributions in cash, kind or labour for construction of community sanitary facilities.
8. Ensure that someone (or persons) from the community is delegated responsibility for maintaining, repairing and upgrading public sanitary facilities.
9. Organize campaigns to reiterate messages and promote family and community action to encourage proper excreta disposal.
10. Evaluate the activity (with appropriate technical help) to find out how far the idea has been accepted and adopted; how well the sanitary facilities are used and maintained; and whether there have been any significant reductions in communicable diseases.
11. Identify constraints and plan action.

E. Linkage with other related sectors

1. Motivate and encourage members and community to
   - Regularly clean household and public places of harborage and breeding of disease vectors.
   - Deposit solid wastes in allocated areas.
   - Clean and clear drains and gutters around house, near public places.
   - Improvements to dwellings in association with vector control and water / sanitation upgrading.
   - Utilise waste water for irrigation, planting of family gardens, flushing of toilets.
   - Make use of resources recovered from waste disposal (e.g. composting, biogas)
2. Organize community action to construct and clean drains, disposal of solid wastes, especially where there is a piped water system.
3. Organize a campaign to control disease vectors. (flies, mosquito and rodents).

IV. Maternal and Child health Care, including Family Planning

Antenatal care

A. Early diagnosis of pregnancy and screening for risk cases

1. Organize discussion and study meetings for members
   - to learn about their bodies and about life cycle events: puberty, conception, childbirth, menopause.
   - To discuss and share feelings and perceptions about these.
   - To view critically the beliefs and taboos regarding menstruation, pregnancy, childbirth etc and to appraise their validity.
2. Conduct meetings for women in the reproductive age group, to emphasise importance of attending antenatal clinics, and to teach detection of risk factors using defined criteria, including nutritional and socio-economic family history.
3. Carry out a household survey and keep a register of all females aged 15-49 by involving members, and other community based organizations. Record menstrual history, health problems, history of previous pregnancies and related problems, and general health condition.
4. Update register at least once a month for new entrants with missed periods, for visit to Antenatal clinics, immunization etc through house visits.
5. Encourage women in the community to report missed periods and other health reproductive problems to members maintaining register.
6. Nominate TBAs and volunteers in the community for training in antenatal and postnatal care and postnatal care and in midwifery.
7. Ensure that antenatal clinics are conducted regularly by CHW at places and timings convenient to the pregnant women; encourage women concerned to attend these clinics by providing the necessary support (minding children, helping in household tasks etc.)
8. Try as far as possible to extend the scope of antenatal clinics to treat all women with Gyn-Ob problems so that their overall health status improves, and helps reduce 'risk' if they get pregnant. Encourage women reporting problems to attend and assist in finding help.
9. Maintain a list of 'at risk' women. Make regular house visits to them, and talk to husbands and family members about the need for specialized care for the women during childbirth. Try to convince them to let her deliver in a health facility.
10. Discuss with the pregnant women 'at risk' about their health, help her find specialized care at childbirth by giving her the moral and social support necessary.

B. Health education during pregnancy

1. Organize regular meetings of pregnant women to share their feelings and apprehensions, and their health problems; with the help of CHW, TBA or trained volunteers, advise them on
   - process of normal pregnancy and childbirth
   - rationale for antenatal care
   - Hygiene and nutritional requirements during pregnancy
   - The importance of birth spacing
   - Available services and when and how to utilize them.
2. Discuss with members about existing beliefs and practices in regard to pregnancy and pregnant women; (with the help of trained members), appraise which of these are beneficial and need to be reinforced, and which need to change.

   Plan health education sessions accordingly.
3. Also have a discussion and exchange between TBAs, members and CHW /trained midwives about their maternity practices, and rationale for these. Encourage appraisal of what practices need to be changed.
4. Organize special classes for women during the last four weeks of pregnancy to teach and demonstrate

- what to prepare and how to prepare for labour and childbirth;
- non strenuous physical and breathing exercise classes;
- care of newborn;
- how to breastfeed;
- personal hygiene during immediate post partum period.
- Periodically assess success of activities and revise them as needed.

C. Basic antenatal care

1. Reinforce health education activities in A and B to motivate women to seek antenatal care and attend regularly.
2. Enquire in the meetings for pregnant women and through house visits whether they are attending antenatal care clinics regularly;
   - find out what problems they have in doing so and see how these can be solved;
   - ensure that the advice given in ANC clinics is followed and drugs taken.
3. Detect 'risk cases' on the basis of a simple checklist, and ensure they get specialized care from CHW or health facility as required.
4. Organize and establish ANC clinics in the community once or twice a month.
5. Select volunteers to be responsible for organizing the clinics and assisting TBA,CHW or nurse during clinic sessions.
6. Check that all pregnant women are immunized.

D. Detection and management of abnormal pregnancy

1. Organize health education sessions with the members to teach and demonstrate how women can detect abnormalities and problems, self care and availability of referral services.
2. Encourage and help women in self-care activities. Example: group meetings, discussion and self examination sessions, home visiting, distribution of information materials.
3. Appoint someone –preferably with training – to use antenatal register as a tool for monitoring pregnant women's health.
4. Give priority to high risk women, i.e. displaced families, poor, landless, frequently ill.
5. Organize community antenatal clinics with trained TBAs and CHWs where appropriate procedures can be carried out for the diagnosis of abnormal pregnancies.
6. Monitor food supply and availability to pregnant women.
7. Organize a system for transfer of cases with severe and urgent complications, e.g. eclampsia during pregnancy.
8. Ensure rapid means of communication for management of severe and urgent complications.

Delivery and postnatal care

A. Management of normal delivery and detection of complications

1. Conduct educational activities for members and other women about normal delivery and detections of complications.
2. Discuss with members (include TBA / CHW) traditional beliefs and practices in childbirth, and usual practices in management of complications.

- which beliefs and practices are beneficial?
- Which are harmful and must be discouraged?
- Are all practicing TBAs safe?
- Are health sector services satisfactory?
- What alternative services and facilities do women want for delivery of normal pregnancies and detection of complications?

3. Carry out antenatal health education activities mentioned in A and B.
4. Attend to basic requirements for preparing home for delivery with clean cloth, clean water, bowls, clean and sterilized TBA kit, sanitary towels, and essential drugs.
5. Help contact TBA/CHW when labour starts. Nominate volunteers to ensure delivery is conducted hygienically and assist if necessary.
6. Give support –psychological, in kind, or money to woman and family if needed; or through social support such as care of children or performing household tasks.
7. If there is no trained TBA or professional health worker in easy reach, select suitable women TBA for training.
8. Ensure registration of birth to authorities and enter birth, outcome, in appropriate place in register of women and in birth register.
9. Complete reporting forms for health sectors (if required).

B. Management of risk cases in labour and complicated cases

1. Carry out educational activities. See I A, B, C and motivate and assist 'at risk' women and their families plan the delivery in health center or hospital.
2. Provide a rapid contact system to appropriate person in organization /TBA /CHW, to inform when problems arise and onset of labour.
3. Keep closer observation on high risk cases during final 7 days, to ensure rapid transfer when necessary.
4. Select volunteers for training in midwifery and management of abnormal cases, risk cases and complications to act as standbys in case of absence of TBA /CHW.
5. Arrange referral and transfer f high risk cases to first referral health facility.
6. Arrange for suitable relative /s to accompany (especially if blood may be needed).
7. If transfer not possible, ensure that trained TBA /midwife is available to attend and ale to give whatever assistance possible under the circumstances.
8. Complete required reports, registers etc.

C. Management of newborn after delivery (also refer Promotion of food supply…)

1. Organize health education classes and demonstrations for pregnant women near-term on the care and needs of the newborn. (See Health education during pregnancy).
2. Allocate responsibilities to a committee of members to provide technical, physical (if necessary), and psychological support to the mother during labour, delivery and care of the newborn.
3. If delivery normal-advis emother and family regarding care of cord, breastfeeding, diet for mother, rest, sleep etc.
4. Organize revolving funds to provide small loans for purchase of essentials for newborn itself if necessary.
5. Ensure that in the register for women 15-40 years mentioned in 'Early diagnosis of pregnancy…(# 3) is completed with details about births, maternal or perinatal deaths.
6. Report birth (death) to authority responsible for vital registration.

D. Basic care of the newborn and mother during post partum period (refer also 'Promotion of food supply and Immunisation

1. Health Education classes of women and if possible, their families; demonstrations during pregnancy on establishment of lactation, food requirements of mother and hygienic practices in the post partum period.
2. Organize home visits by trained TBAs or other volunteers to monitor recovery of mother and child and to detect signs and symptoms of post partum complications (risk factors).
3. Arrange immediate care of trained TBA / CHW or health facility, in case of any complications.
4. Arrange a small group of women to visit the mother and baby to give psychological support, and offer food and gifts. Give priority to low-income and emotionally disturbed women. it maybe possible to blend this task into existing traditional practices.
5. Devise and implement measures appropriate o the community to encourage women to breastfeed especially poor working women.
6. Organize day-care centers to assist working mothers in the care of other children.
7. Encourage mothers to have proper nourishment in the days immediately after delivery.
8. Encourage mother to attend postnatal clinic (usually six weeks after delivery) and to take the baby for examination and screening for abnormalities and immunizations. Organize postnatal clinics in community /work site if necessary.

Child care (including school age children)

A. Basic child care-monitoring of growth and development, screening for risk cases, management of disease or maldevelopment (See also I, II, V, VII)

1. Organize educational activities for members and other groups about
   - nutrition requirements during growth;
   - importance of child spacing for child health
   - normal development;
   - need for growth monitoring and immunizations;
   - availability of services.
2. Nominate volunteers to be trained to carry out a community survey and prepare a register of all children under five, noting details regarding immunization, birth defects, chronic problems, sicknesses and other relevant factors such as length of breastfeeding, parity of mother, etc.
3. Arrange for an under fives clinic to be held in the community by CHW once or twice a month; assist CHW by undertaking weighing of children and helping complete growth charts, etc.
4. Update register at least once a month for newborns and to note new problems, follow up etc.
5. Make house visits to sick children and ensure medical advice is being followed.

6. Organize day care and food programmes for children of working mothers
7. Organize immunization of children
8. Organize feeding centers and other nutrition supplementary programmes for malnourished children by seeking assistance from social welfare /other relevant sectors.
9. Organize a system of reporting urgent or serious cases of illness to a member, or CHW and for transporting the case to the referral health facility

B. Prevention of main causes of child mortality (communicable diseases, gastroenteritis, malaria, respiratory tract disease, malnutrition, accidents etc

1. organize, (with necessary help from health workers /CHWs/ other health personnel) workshops for members intended to analyse
   - death and morbidity among children, causes and extent;
   - the nature of mortality causing sickness-i.e. communicable /chronic, preventable by immunization /by better sanitation better nutrition etc.
2. Work out a plan of action on the basis of the above analysis, on ways of preventing main causes of child mortality, e.g:
   a. organizing immunization campaigns;
   b. improving water supply and sanitation;
   c. improving food supply and nutrition;
   d. providing adequate social support for mothers;
   e. improving women's status;
   f. eliminating /reducing causes of accidents and training mothers in first aid;
   g. improving family income etc.
3. Encourage mothers to space children and limit family size.
4. Procure simple medications (drugs category A2-ref VIII) and supply it to mothers regularly; arrange for essential drugs to be in constant supply with CHW.
5. Monitor the progress of children 'at risk' –whose progress according ti the growth chart is not satisfactory, who suffer often from sickness, who have chronic problems etc. and help families to take immediate action in case of problems.
6. Plan with families of 'at risk' children with regard to how their health can be improved and what practical assistance the family needs; help them find such assistance.

C. Detection and management of social and family problems affecting child health (including disease in the family, child abuse, alcoholism etc)

1. Organize a meeting of the members to discuss social and family problems that affect child health (growth and psychological development).
2. Determine how the organization could help in the detection of cases or families with problems
3. Discuss among members how they can help each other in ameliorating problems e.g. day care centers, relief for mother /father, economic support etc.
4. Provide counseling for family problems, referral of cases needing special care.
5. Organize and / or sponsor local seminars on prevalent social problems affecting child health and mobilize community support to prevent and iameliorate those problems.
6. Follow up recommendations or suggestions arising from meetings /seminars.

V. Family Planning

A. Providing information on the benefits of family planning, and services available

1. Acquisition of knowledge about the relationship between family size and health of mother and child, other family members, through information materials, CHW, FP workers.
2. Seek information about available methods for child spacing, sterilization and abortion and the pros and cons of each method.
3. Discuss amongst members how FP message can best be understood and accepted by community.
4. Disseminate information and appropriate information materials through meetings, home visiting, informal get togethers, etc. emphasis on high risk groups.
5. Seek the help of supportive men in the community to organize FP information meetings for men, or if acceptable, joint meetings of couples with FP workers /other trained personnel..
6. Organize private counseling, advisory services for young people if there appears to be a need, i.e. high adolescent pregnancy rates, young people not using FP clinics.
7. Select volunteers for training in FP motivation, follow up of clients and distribution of contraceptives.

B. Identification and management of clients for FP

1. Discuss among members including TBAs and CHWs the merits, demerits, problems etc. of existing birth spacing and limiting services (traditional and modern) and services for infertility.
2. Invite FP service providers to participate in discussions and to outline a plan for improving the quality and acceptability of existing services.
3. A survey of existing knowledge, attitudes and FP practices in community may also /instead be undertaken.
4. Set up community based (if none exists), FP advisory, information, counseling and contraceptive supply service, possibly through trained and experienced members of the organization, trained TBA, etc.
5. Assist in identification of men and women in need of means for birth spacing / limiting or infertility management.
6. Develop a system to
   - follow up clients, arrange for initial check ups and provision of regular supplies;
   - assist other method users to find services
   - counsel about side effects or complications;
   - arrange for medical attention in case of problems;
   - follow up and reassure safety of method. If method not suitable, encourage trying an alternative.
7. Help childless couple go for medical examination to check for infertility; arrange for counseling if necessary.
8. Carry out regular assessment and periodic evaluation of performance of organization and outcome of activities – based on objectives and targets which were determined prior to the starting of activity, e.g. community perception of the services now given; number of couples using a reliable method compared to a certain time before, the average number of months methods are used continually.

VI. Immunization of women and children

A. Motivation / education of pregnant women, mothers and other family members

1. Organize educational activities /information gatherings to impart knowledge of
   - Which childhood diseases are preventable by immunizing children
   - Possibility of protecting women and newborn children against tetanus by injection during pregnancy;
   - Appropriate hygienic practices during home delivery to prevent neonatal tetanus.
2. Follow up with home visits to motivate mothers /family members.
3. Make a list of women and children to be immunized.
4. Consult with the community about the suitable days and times for immunization and notify health authorities.

B. Immunization of pregnant women and children

1. Provide support, reassurance and advice to mothers in case of fever etc. after immunization.
2. Help with reaching the immunization site.
3. Remind mothers of the dates for subsequent doses and ensure that all doses are administered.
4. Report cases with side effects or complications.
5. Sustain immunization activities on a regular basis, and ensure all children and women are covered.
6. Mobilise women and children to be immunized on the schedule dates.

VII. Provision of Essential Drugs

A. Acquisition of drugs

1. Contacting CHW and First Health facilities, and obtaining drugs in group A2 regularly.
2. Ensuring that CHW has an adequate and regular supply of essential drugs in group A1 from first health facility.
3. Carry out educational activities to enable
   - Recognition of general symptoms of common diseases;
   - Knowledge of what conditions can be safely self-treated and how.
4. Ensure that prescription drugs are sold through qualified pharmacists; and not across the counter, but only on producing prescriptions, by monitoring drug outlets and pharmacies.
5. Register complaints regarding improper drug sale practices with the concerned authorities.
6. Campaign against unnecessary and inappropriate use of drugs and tonics by community members and encourage rational drug use.
7. Be vigilant about drugs administered to pregnant women and very young children and discourage drug intake without medical advice.
8. Discourage use of contraceptive pills without sufficient information or medical check-up.

ADDITIONAL RESOURCES FOR INITIATING DISCUSSIONS

The village fair price shop

This skit is about the malpractice in a village fair – price shop. The fair price shop of a village receives supplies of essential food stuffs like rice, sugar, cooking oil and coarse cereals from the Government and it is meant to sell these at controlled prices. Each household in the village is eligible for a fixed quota of the supplies according to the number of members it has.

The skit portrays how most often the real culprits act behind the scenes, leaving those who act on their behalf, more out of compulsion than by choice, to face all consequences. Attacking the mere figureheads doesn't solve the problem because some else would soon take their place. One has to direct one's confrontation at the powerful men acting behind scenes.

Scene – I

The house of an influential upper caste landlord in a village. Subban and his educated son Sundaram are waiting in the courtyard. Subban is a *dalit* farmer who has been cultivating this landlord's farm on lease for more than 30 years and is a trusted servant. His son Sundaram is a modern young man, dressed in trousers and shirt, while his father still wears the traditional dhoti and has only a towel on, no shirt. Sundaram is one of the few *dalits* to complete high school. The two meet the landlord to ask for a favour. There is a vacancy for employment in the village fair price shop and Subban requests that his son Sundaram be given a chance. The landlord promises to consider the matter and the two men return hopefully.

Scene – II

Sundaram is now employed in the fair price shop. The job means a lot to him since it is his first break after five years of unemployment.

Stocks of rice and sugar arrive and Sundaram make an entry in the stock register. Shortly after this, the landlord's manager – of – affairs pays Sundaram a visit. There is to be a wedding in the landlord's family the following fortnight; Sundaram should deliver the bulk of the supplies of rice and sugar to the landlord's house.

Sundaram tells the manager he is afraid. He is told not to worry, the need of his obligation to the landlord's family and the possibility that he would lose his job.

Eventually, Sundaram delivers the rice and sugar stock to the landlord's house.

Scene III

The Fair Price shop has a board outside saying "Stocks exhausted". Many women who have come to buy provisions seem agitated. They are talking loudly to each other. Hadn't they seen stocks arrive just a few days ago? When few households had bought their rations, how could they be exhausted?

Sundaram is nervous but tries to overcome his nervousness by being offensive. He asks the women to get lost and not crowd the shop. There were no supplies left and he could not help it.

A young woman in the crowd – the only woman to have gone to school in the village – demands to see the stock register. All the other women cheer her and repeat the demand. Sundaram loses his temper. He is a Government employee and is answerable only to his superiors, he claims. He is not willing to offer explanations to a bunch of loud – mouthed women.

The women get together to discuss the matter. Many suggest writing a petition to complain to the higher authorities. Sundaram's mother is among the crowd. Hesitantly, she asks the others what they expected to achieve by this, except Sundaram losing his job. Did they believe that replacing Sundaram would solve the problem?

There is a lot of confusion among the women now. If they complained about Sundarm, a poor family would lose its income. If they didn't their own families would continue to suffer because food stuff was not available at controlled prices ……. What was the way out? How could they ensure that food supplies did not get delivered to the rich households?

(Subverting Patriarchy: Workshops for rural women:1983 –TK Sundari Ravindran)

Water ! Water!

This skit portrays how a woman is treated by the land owning castes. It shows the lack of support for her cause from within her community for several complex reasons.

Scene I

Valli, a poor *Dalit* woman goes to fetch water from the pumpset irrigating the fields of an upper caste landowner. There is no water in the well in the *dalit* settlement. While others prefer to walk a long way to another water source, Valli dares to venture into the fields nearby.

While Valli is filling her brass pots with water, the landowner chances to come by. He is very angry and abuses Valli. Valli is rather cheeky and defies him saying he wouldn't lose a fortune by lending her two pots of water. The landowner slaps her hard and snatches away her pots.

Scene II

Valli comes back home seething with impotent rage. She complains amidst sobs to her husband about the landlord's behaviour. Her husband is in a state of shock. He is not used to the idea of a confrontation with the landlords. When he realises what the loss of two brass pots means to the family's scant resources, his anger gets directed at Valli. He accuses her of being quarrelsome and unwomanly. He is afraid she has ruined him by evoking the wrath of the landlord. "You lazy slut!" – he says. " Are your feet so delicate that they cannot take the two mile walk to the pond?" and slaps her.

Valli's husband is concerned about the brass pots lost to the landlord. He meets some influential *dalit* elders and requests them to negotiate with the landlord on his behalf. The elders agree to take up his cause for a small fee(!) and Valli's husband has to reluctantly part with five rupees – a whole day's wages for him.

Scene III

Dalit elders outside the landlord's house. The landlord comes to the door.

Elders: (bowing down) Sami (Meaning Master), we bow before you

Landlord: (loudly and rather arrogantly)- what brings all of you here at this hour? Hurry up and don't waste my time.

Elder 1: (hesitantly) Sami, it's nothing important; we came to see you about a problem in our Cheri (in every village, the *dalit* live in a separate settlement traditionally known as Cheri, but now called 'colony').

Elder 2: It is about Kasi's wife Valli.

Landlord: You came about Kasi's wife I see …. I meant to call you about this matter. You elders – Do you have no say in the community? Haven't you taught your women to behave? Shame on you! If I were you I wouldn't dare to expose my face for shame.

Elders: (together) Yes Sami, this woman will be the ruin of Kasi. She's got a wagging tongue, she does. Never learnt to obey, nay, not even her husband! We came to apologies for their behaviour. We will not let such an incident occur again, Master.

Landlord: You apologise! Your apology isn't worth two pence, you thankless bastards. We give you work and take care of your livelihood and look how we are repaid! No, we have to teach that woman how to behave – So that others learn too. She'll have to pay a fine. Fifty rupees, shall we say? Go tell Kasi to come and beg forgiveness and pay up.

Elders: Sami, have mercy. You are our protector. Scold us, take us to task, punish us …..But we are poor – where will Kasi go for fifty rupees?

Landlord: Good for nothing paupers! You should have thought all this before letting your women talk back to the landlord. Learn to keep your women in their proper place.

(After a while) – OK since you plead so much ….. Kasi must pay a fine of twenty five rupees as soon as possible. I hope you'll take the responsibility for it.

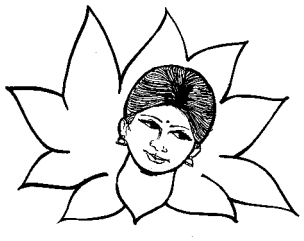
Elders: Of course, Sami. Thank you for being so merciful.

Landlord: Here, take this and go have a drink (Throws a few coins at them which they take and make their exit)

Thus, not only does Valli not get back her brass pots, her husband has to pay a fine. As to Valli having been slapped by the landlord, whoever remembers it?!

(Subverting Patriarchy: Workshops for Rural Women: 1983: TK Sundari Ravindran)

I am a Woman



(Can be used to start a discussion on status of women in society)

I am a woman

I am proud to be a woman

I am a woman

I am proud to be a woman

I am forced to my raise voice against the way this society perceives me, and women like me. I raise my voice against the way men use women, collectively and as individuals. I raise my voice against the way in which women are considered as inferior, the society even forces women to perceive themselves as inferior.

I am a woman. I am clever like other women. I can think. I have my own views/thoughts. I can satisfy my personal desires and I am not a fool nor stupid that I have to depend on men.

I am not only creative, I have certain goals and I can achieve them.

I and women like me, possess the conviction and power of being women.

I or other women, when we lose our confidence in protecting ourselves or in fulfilling our basic desires it does not mean that we are just attractive but foolish women who need to depend on young men who smoke and are immersed in alcohol.

Should we let women be constantly considered inferior and treated badly. Why are women mis- potrayed by the media? Why is it that everytime I go for a movie, and watch the advertisements, and see how women are portrayed, why do I hold myself tight and why do I gnash my teeth and feel disgusted?

Why does the society continue to accept these negative views about women and force me to be part of it. Why does the state permit these kinds of advertisements that suppress and sideline the rights and the respect that each woman deserves. Why do men and women keep silent when they see such portrayals in movies and magazines and not oppose them. Are we brainwashed to such an extent that we accept as truth whatever we see. Or is it that there is no use in discussing this?

I am a woman

I am proud to be a woman.

I am a human being with capacity to do many things, self-respect, and self pride. Then why do men always behave like jackals- whistle, tease and laugh at me and other women? Why do they always behave like animals and sexually harass us.

Sexual harassment in any form makes a woman feel low, lose her dignity. This behaviour stems from the perception that women with their slim bodies, kindness, and beauty are toys and pleasure giving objects for men.

Women are to be possessed, experienced and thrown away. When this does not happen men abuse her. Like other women I am not a piece of meat or someone to be enjoyed, to be loved till you find a slave. I am no piece of meat to be treated as a slave to satisfy the long list of demands and to be abandoned. I am a woman.

I am proud to be woman.

I am a beautiful woman beyond the norms of beauty that the world expresses. I feel proud to be so. There is a woman inside me who has physical power, tolerance and tenacity. Being a woman is my beauty and makes me complete. It is not limited to the way I walk, apply make up or the way I look. Then why are women made to parade in swimming costumes and treated in a degrading manner. Why do big airways select only those women who are beautiful and slim?

Why do women allow themselves to participate in these incorrect practices? Why don't women oppose those people who demand soft, attractive, slim and sexy women for jobs?

Why don't women realize that this is also sexual harassment? Why is the importance of women and their capability based on physical characteristics alone? Why does she perceive herself as others do?

I am a woman

I am proud to be a woman.

Like other women I am happy about my body , because it is special and different from a man's body. Like other women I am happy to be a woman and feel proud about my natural qualities. I have all the right to feel proud about my femininity and sexual characteristics.

We wear clothes, dress up and comb hair for ourselves. It is not for the pleasure of others. Because we are proud to be ourselves, to be women. When a women is raped, why does the society say even today that she was dressed provocative manner and that she desired it. – why do the society say so still now? Why do men who are involved in such violence blame women? When an eight-year-old girl was brutally raped, why do other women too believe in similar reasons?

Will men be blamed when they dress in a provocative way? No. When such a man invites a woman to fulfill his sexual urge is he blamed? I do not think so.

Then why are the women blamed for being harassed ? Why does this sexual harassment cause a woman to be without any support, to feel guilty, and make her feel small and shrivelled? The society treats women with discrimination otherwise why would all this happen.

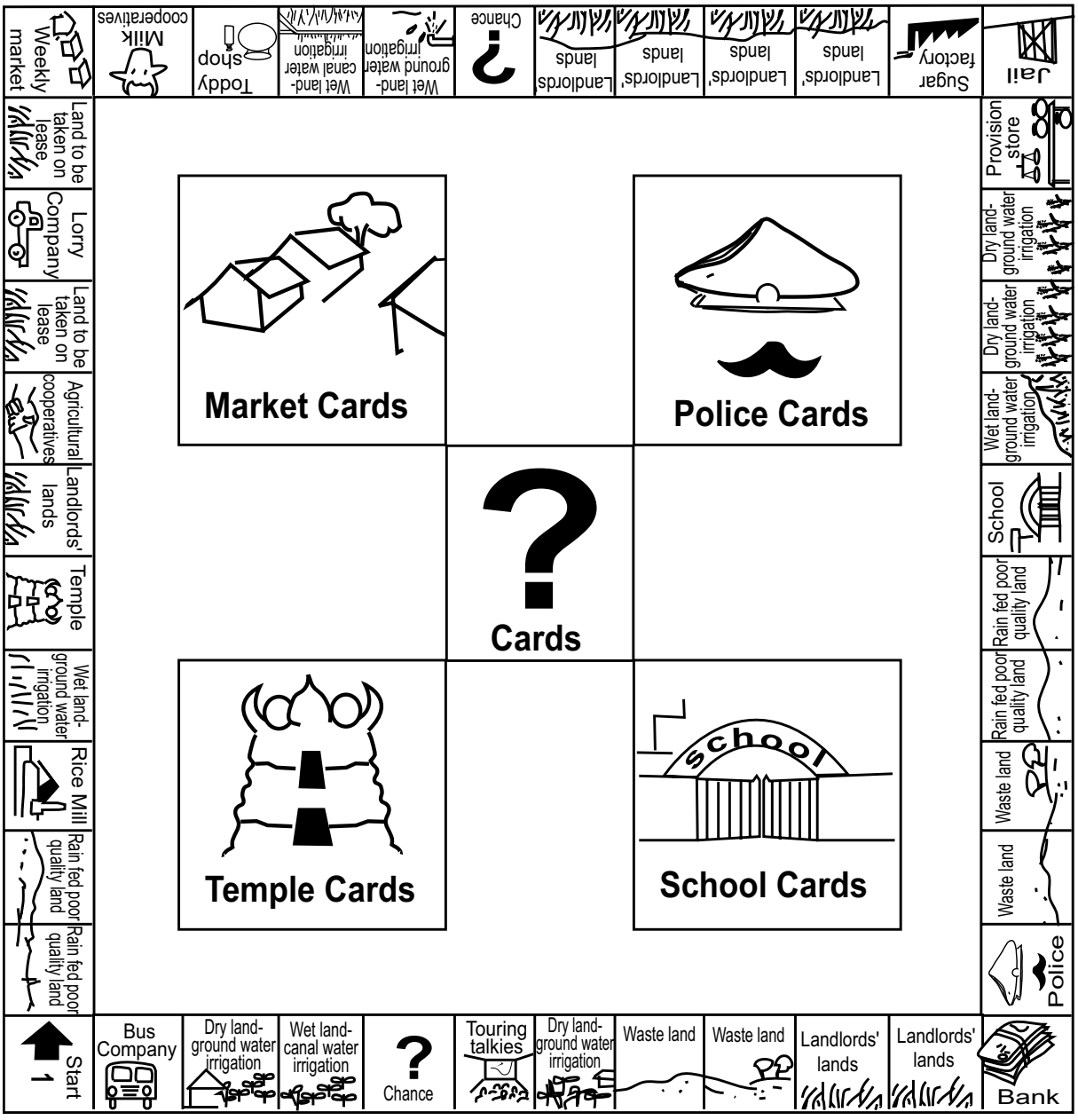
I am a woman

I am proud to be a woman.

Even if the world exploits me, cheats me, makes me feel inferior, treats me in the lowest manner, as an object to be stared at, insults me, I am proud to be who I am.

The Game of Life

This is a board game similar to "Monopoly" or "Trade" with the difference that it has true –to – life rules and regulations and depicts a rural setting.



Materials to be prepared

1. The Playing Board

There are in all 44 columns on the board. These are as follows:

- Different kind of rural properties (7 places in all): Toddy shop, Provisions stores, Bus Company, Rice Mill, Lorry Company, Sugar factory, Touring movie talkies.
- Different categories of agricultural land (17 places in all): 'wet land with ground water irrigation sources : (2) 'wet' land with canal irrigation (2) 'dry' land with ground water irrigation: (4) rain fed poor quality land: (3); waste land (unprepared, uncultivated land which belongs to the government, and is sometimes encroached upon and cultivated); (2).
- Landlords' lands (2 different landlords, sharing 7 places between them but not equally).
- Land to be taken on lease : 2 places
- Other places (11); start ; chance (2); weekly market; Temple; School; Bank, Police and Jail.

Land values, terms of lease and price of other properties are to be stated according to what prevails in one's area.

2. Money:

Rupees in the denominations 50,000, 10,000, 5,000, 1,000, 500, 100 & 50.

3. Property cards :

These have to state cost of property, rent payable and in the case of land, produce per harvest. There are also two cards of lands leased out by the landlord, stating cost, rent and amount payable by lessee annually (i.e every time he completes one round on the board), as well as number of bags of grain per harvest.

4. Chance cards : Ten

1. Lottery prize income Rs. 100 /-
2. New tax of Rs. 50% on your property.
3. Sickness in the family: Pay Rs. 200 /- for medical expenses.
4. Expenses for children's education Rs. 100 /-
5. Pay the doctor Rs. 100 /-
6. Son sends Rs. 250 /-
7. Go to jail on the false charge.
8. Local parish priest give you Rs. 50/-
9. Continuous rains unable to go to market this turn.
10. Pay a fine of Rs. 50/- for a social offence.

5. Market Cards :

Nine in all, 3 each stating, 'High Prices', 'Medium prices', and ' Low prices'.

6. Police Cards: Eight

1. Tiff with the landlord. Fine Rs. 100/-
2. Antagonised the local cop. Stay one turn in the lock – up.
3. Involved in a wage strike, and keep getting accused on false charges. Rs. 500/- penalty and three turns in Jail.
4. Fine for straying cattle Rs. 50/-
5. Involved in a local caste fight Rs. 200/- penalty and two turns in jail.
6. Accused for stealing the landlord's bullocks – Pay Rs. 500 /- or stay in jail for three turns.
7. Unable to repay loans Rs. 50/- fine.
8. Drunken brawl – pay Rs. 50/-.

7. Temple Cards : Six

1. Pilgrimage Rs. 700 /-
2. Make gruel for the local deity Rs. 300/-
3. Festival give Rs. 50/-
4. Rs. 400 /- expenses to fulfill a vow.
5. 'Chithirai' Car festival – Spend Rs. 50/-
6. Going to the family deity's temple for your Child's naming ceremony Rs. 800 /-.

8. School Cards : Four

1. Studied up to class 5. Receive Rs. 500/-
2. Studied up to class 8. Receive Rs. 1000/-
3. Studied up to matriculation. Receive Rs. 1500/-
4. Successfully completed technical training. Receive Rs. 5,000/-

Number of Players:

The game can be played by six or more players. It also needs a facilitator cum banker besides this.

Rules of the Game:

To start the game, the players take turns to throw a pair of dice. The two players with highest scores become landlords, and the others are labourers. The banker then distributes Rs. 50,000 each and their property cards to the landlords, Rs. 1000 each to each one of the labourers.

The players place their respective tokens at the 'start' column. The landlords are the first to play, and are followed by the labourers according to their scores in the initial throw of dice.

The play, the pair of dice and thrown, and the token is moved to the corresponding column. The player has the option to purchase the property on which she lands, if it has not already been purchased. She would receive a rent from any subsequent player who lands on her property. To buy a property, the player has to play the banker the amount stated the receive a property title from her in turn. The rent to be collected would be stated on her card. The two landlords do not have to pay any rent to others.

Land to be leased in from the landlords can be had on landing on the corresponding column, by paying a fixed sum stated in the landlord's property card. The lessees do not receive rent from other players who land on his land. The rent accrues to the landlord.

On landing on the landlord's land, a sum of Rs. 150/- has to be paid as rent to the person concerned.

Temple, Chance, Police and School and special columns. When a player arrives on any one of these, he draws a corresponding card from the pile shuffled and placed at the centre of the board and does as indicated in the card. The police cards do not apply to the landlords.

Weekly market is another special column. On crossing this or arriving on it, owners of land draw a market card and sell their bags of grain at low, medium or high price as stated in the market card. The number of bags of grain they have for sale is given in their property cards. The current high, medium or low prices for the grains will be stated by the banker.

On arriving at the Jail a player Rs. 500 /- as fine to the banker, or loses three turns. This does not apply to the landlords.

A player unable to pay her rent, or requiring money for investment can mortgage her property and borrow money from the bank at the prevailing rate of interest. Every time a player completes one round on the board, she has to pay interest on the money she borrowed. Also, if a player arrives at the Bank column, she plays an additional 10% interest on money borrowed.

It is up to the banker to decide when money borrowed should be reclaimed, and to auction the property if the player is unable to pay.

Personal loans from other players can also be taken at terms and conditions specified by them.

When a player has no property and is repeatedly unable to pay dues, she can declare herself insolvent and quit the game.

Proverbs

This exercise maybe used to understand the status of women in society and maybe used to understand how women's status affects her health.

Requirements: Colored Ribbons. Attach the cards to the ribbons.

Ask a volunteer to stand in the center of the circle of participants.

The exercise is in two parts.

1. Ask participants to think of proverbs that refer to women, that state 'norms' on how women should behave or should not behave –both complimentary as well as derogatory.

Distribute the ribbons to the participants. Participants should share the proverb aloud and tie the ribbon on the volunteer- if possible on the specific part of the body that the proverb may refer to.

2. If the proverb is complementary the tied ribbon can remain on the volunteer.

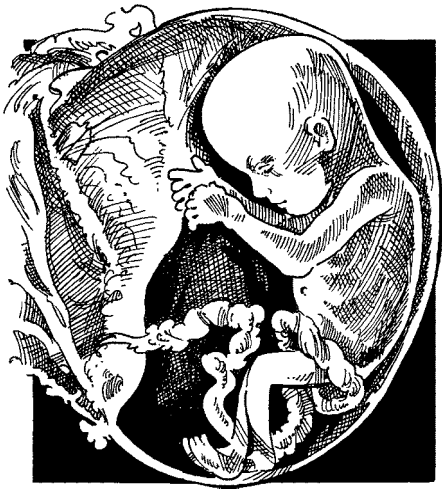
   If the proverb is derogatory, the participants should think of a positive, progressive alternative, share it with the group and untie the ribbon.

Some examples of proverbs (translated from Tamil):

- 'Dawn does not break with the crowing of the hen'
- 'The rod should not be spared in bringing up a girl'
- 'If a woman laughs she loses all, as an unfurled tobacco leaf'
- '(Eating) small quantity is correct for women'
- 'You can trust a hissing snake but not a smiling woman'
- 'She is responsible for creation and destruction'

A tomb in the uterus

This narrative maybe used to discuss the status of women in society.



I am going to take you to Ponvayal village. The village is fertile with paddy crops, jasmine fields, green trees, and waterfalls. The village is under the control of landlords and there are many families as bonded slaves. One of them is Paravthi's family. She is a pregnant woman. One day the child in her womb began to speak. You too listen to what the child had to say….

Oh my god! Oooof ! I feel suffocated. How many days should I keep myself shut in the uterus? How long should I keep my hands and legs bent. For how long do I have to float in the amniotic fluid? How long do I have to keep myself shrunk. I can't even stretch my hands and legs! But I will come out in a few days. My mother was telling the dai and I heard it! When I become free, and come out, I want to kiss my mother a thousand times first. Pity, how long she had to keep me in her stomach. She caresses me with love when she walks breathlessly, taking care of me in the womb. I really pity her. In these 300 days she has never said that her stomach is paining and made me come out of her stomach. Apart from that whatever she eats and inhales she gives me my share! But she is just skin and bones. One day the doctor who tested her said that she was anemic. I did not understand. I wanted to ask her what it meant. When she came out I wanted to talk to her! Softly I called 'Mother' 'Mother'.

My mother was leaning against a wall and stitching her torn clothes. She turned around! She was very sad! I could see the signs of poverty on her face.

Again I called Mother! Mother! Softly. She was surprised and she caressed her stomach.

I said: 'Mother, I am the baby in your womb'.

Son! She caressed me gently. Why, mother, can't I be your daughter. No dear, you should be born as a son. I have faced a lot of problems born as a girl. Your sisters also suffer.

What are you saying mother?!

Look there, your elder sister is wearing a white saree and fetching water from the well. One month after marriage, her husband died and she is a widow. Her life is dark. Mother, can't she marry again?

No! No! She slapped her forehead.

Mother, do not cry. I will console you.

Once mother was consoled she continued. The person who is washing clothes near the well is your second sister. She is married but stays here.

Why mother?

The *streedhan(dowry)* we gave was not sufficient. Her husband drove her away. I wanted to ask her what *streedhan* was but her sobs made me stop.

After a period of silence she continued. Mother, how many siblings do I have? Totally eight, you are the ninth.

Oh how she must have struggled with eight children. Why so many mother? I could not control myself and asked her directly.

What to do!? Your father is an alcoholic. The doctors who came to the village explained about family planning. He did not opt for the operation and did not allow me to go for it either. He drinks daily and beats me. How many days we have starved without a morsel to eat!

Your sisters and I work daily and eat just enough to fill a fourth or half the stomach. When I look at your two elder sisters I really feel bad.

It hurt me. I could feel the sorrow of my mother. But my father does not understand.

I could hear someone moaning in pain in the corner of the room. She is my youngest 2 year- old sister, suffering from fever for five days.

Why did you not take her to the doctor mother? We cannot afford to go to the doctor. We need bus charges to go to the government hospital and we don't receive proper care. I provide them home based care.

Without a planned family my mother is suffering. I feel like getting out and crying.

When I wanted to call out to her, I could hear a crowd shouting at the entrance. They were dragging a boy. I think the boy's hair must not have been oiled for long. He did not wear a shirt. and wore torn trousers. He had a round object in his hand. The crowd must have hit him badly. His eyes were swollen with tears.

Mother struggled to get up, she ran and hugged him.

Hey lady! If you cannot feed him why don't you kill him. Why do you make him steal a bun and eat it. They scolded mother and went away.

Mother hugged him and he fell asleep on her lap. My mother's tears felt hot on me.

Mother, who is he? He is your third brother.

Enough mother, all this is making me cry.

Hey! You…

I looked in the direction of the shout. A man with red eyes like those of an animal, came near my mother.

Hey, I asked for money in the morning to drink and you did not give me any. Did you make my dry fish sambar? He screamed at my mother.

You get out! She had fire in her eyes and she screamed.

You Bitch! Are you asking ME to get out. He kicked my mother's stomach.

I felt as if I had been struck by thunder. My mother screamed and fell down. I felt like hitting that man.

He left.

Both my sisters came running and gave my mother some water. Thank goodness, nothing happened to my mother.

Why do you speak with that man! My sisters consoled my mother and went away.

I called Mother! Mother!

My son, that man….before my mother could finish, I said he is not my father. He is an animal.

Mother, I thought within a few days I will be free and come out of the womb and kiss you a thousand times. But now I don not want to see the world. I do not want to increase your troubles.

Moreover I am not a boy as you think, I am a girl. So I am going to die.

My son! Do not leave this mother and go away. Mother started to scream and cry. I wanted to wipe my mother's tears.

Mother in another life, I would be born to you. I took the cord and wound it round my neck. My eyes started to close. My mother's crying gradually faded.

The next day the villagers said that Parvathi had delivered a beautiful but dead baby girl.

(Source: Indriya Pengal Nilay: RUWSEC: author unknown)

Floods!

This activity is used to understand decision making in groups.

Requirements: (List of things at home): matchbox, mat, lamp, water pot, grinding stone, pot to cook rice, pot for sambar, book, plate, ladle, box, cycle, spade, school certificates, buffalo, axe, land document, jewels, cash, goat, rice, hen, wood, TV, tumbler, plough, knife, clothes, bag.

These could be listed on charts with little symbols for each item. You will need as many charts as there are groups.

Explain to the participants:

Consider the training hall/space is your house. There are lots of things in your house. It is raining continuously. Just now you heard that the river that runs through your village is going to break its banks and immerse the whole village. You have to leave the house immediately.

What are the things that you will carry with you?

Divide participants into groups of four or five. Each group represents a family- can choose a name.

Explain that the groups have ten minutes to decide. After ten minutes the groups will present in the large group

Distribute the charts with the list of things at home.

For discussion after all the presentations:

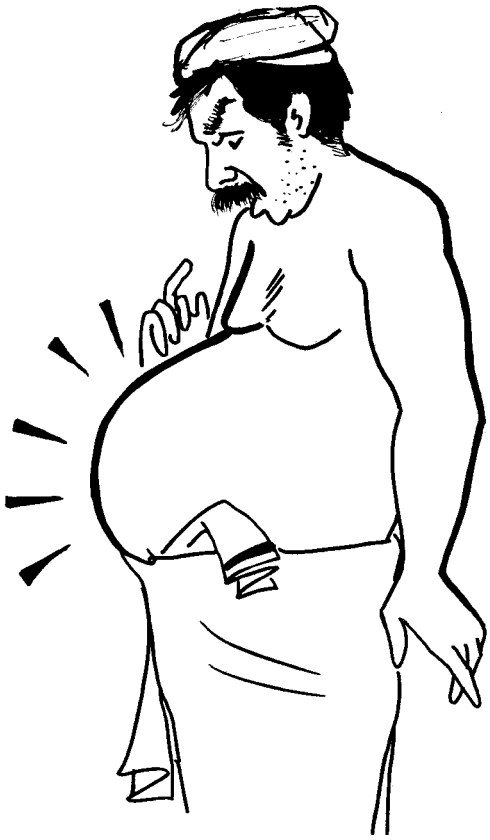
- How did you feel when you were in the group.
- Who participated in decision making? Who did not –kept silent? What were the reasons for this?
- Who took the lead –who made the decisions- did he/she ask everyone's opinions?
- Where there any problems when the decision was taken in a group?

Note:

There are many problems in decision making. Some participate wholly and do not take into consideration others views. Some do not participate and stay silent. A few people's decision may not be the decision of the group. The democratic way is to get everyone's views and arrive at a decision.

Posters for discussion

The following can be used to initiate discussion on Gender.



PART 2

KEEPING HEALTHY AND BEING A DISCERNING CONSUMER

Overall objective:

- Provide participants with the necessary knowledge and understanding of how to keep healthy through personal care and environmental hygiene and sanitation.
- Provide participants with the necessary knowledge and skills to be discerning consumer of health services

This module has been designed to provide participants with a basic understanding of their bodies and how to maintain personal as well as environmental hygiene to keep healthy. Most problems arise first out of a lack of understanding of our bodies especially the organs one cannot see and the poor personal hygiene that many in the poor or marginal communities practice. It is possible to maintain personal cleanliness even in very poor conditions. Second the poor value given to personal cleanliness spreads to unclean surroundings and low values placed on environmental hygiene resulting in many problems that are unaddressed by the Panchayat Raj Institutions (PRI), village groups and the government. Government needs local bodies to demand and maintain measures for good environmental hygiene that can reduce the incidence of disease in the area. This module can be conducted as a 2-day workshop or conducted on two weekends as per the needs of the organization and the community they are working with.

This module has two chapters:

Chapter 1: Keeping ourselves healthy	7 hours 15 minutes
Chapter 2: Being a discerning consumer of health care services	4 hours 30 minutes

Keeping ourselves healthy

This chapter has two sessions. The first covers the discussion of key organs within the body and their function and the second covers discussion on ways to improve personal and environmental hygiene in order to keep healthy and avoid illnesses.

Session 1: Our bodies – organs and their functions — 2 hours 30 minutes

Session 2: Care of ourselves and care of the surroundings/Environment — 4 hours 45 minutes

Session 1: Our bodies – organs and their functions

Session objectives: At the end of the session participants will be able to:

A. Name the organs in the body and briefly describe their function and how to keep them healthy

B. Briefly explain how the digestive system, respiratory system and the muscular system work and how to keep these in good condition

Training Materials required for the session:

A. Charts - 2 each of the male body and female body outlines, 2 sets of cutouts of internal organs, crushed paper ball

B. Flash cards with the respiratory, digestive and muscular systems (picture and how it works content)

Methodology:

Introduce the topic.

A Body Organs and their functions — 1 hour 15 minutes

Divide participants into two groups. Let them form two circles with enough space on the floor to draw a full body outline. Ask one group to draw the female body outline and the other to draw the male body outline. (Can also be done by mapping the body outline of a member of the group, lying on the floor.) Distribute the cutouts of the different organs (one set for the male and the another set for the female) to be placed in the appropriate places of the body outlines (10 minutes).

Go around and observe once they have placed the organs in the body outlines, call them together to form a large group that encircles both body outlines. Let participants comment on the placements and correct if there are any mistakes (10 minutes).

Now explain to participants that they will have a chance to speak out as a body part/organ. Explain how they need to introduce themselves as an organ. F*or e.g:* 'Heart' - they need to introduce themselves as *"I am the heart, I am about the size of your fist, I work continuously pumping blood. If I stop, you will have a heart attack"*. The participant should end up saying *"Some people make it hard for me to work and then I find it hard to carry on!!!"*

Have participants pass the paper ball in clockwise direction in the circle while you clap and when you stop they stop. Whoever has the paper ball then is asked to speak up as an organ you name. When participant finishes ask the other participants what conditions make it hard for the organ to work Let them come up with the answers like:*Too much of fat deposit in the arteries so it is difficult to pump, to much stress so the nerves tighten and don't allow the heart to work etc.* Then ask,What can we do to keep our heart healthy ? Let participants come up with e*at healthy fibre rich food, be active physically, be happy etc.*..Plug gaps then carry on the exercise to complete all the organs heart, lungs, stomach, liver, kidney, urinary bladder, pancreas and intestines. For details about the ovaries and uterus in the female body and the testes and penis in the male body, refer later chapters (See training materials A1 to A10 for basic content- 55 minutes).

B. Digestive system, respiratory system and muscular system – how they work — 45 minutes

Divide participants into 3 groups and give each group one of the three flash cards (B1 to B3) to view and discuss how the system works and what to do to keep in good condition. In the large group they can then present the content on how the system works and how to keep the system in good condition. Plug gaps.

Activity — ***30 minutes***

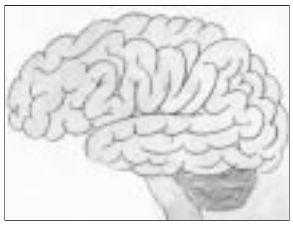
Divide participants into two groups. Ask them to compose a song to educate people on

a. How to keep the body organs working in good condition

b. How to keep the digestive, respiratory and muscular systems working in good condition

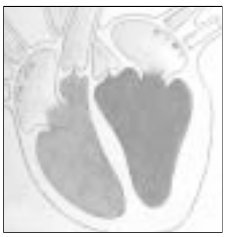
Materials used for training/handouts:

A1 Brain



I am the pale grey organ called the brain. I am about the size of a small cauliflower. I am well protected inside your skull.
I control your body and house your mind.
Everything you do or say can happen only if I work. I am a vital organ.

A2 Heart



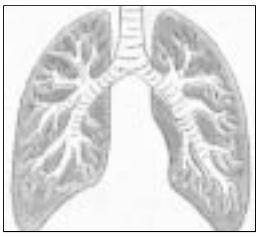
I am the heart. I work non-stop to pump fresh blood to all parts of the body. In a day the blood I pump goes around the body about a 1000 times.

I am made of muscle called cardiac muscle that never gets tired I sit inside the rib cage behind the lungs.

When you exercise or feel tired your nervous system stimulates the heart to beat faster.

I need the blood vessels through which the blood flow to be kept clear so I can work easily. If they are clogged with fat deposits then I will have to struggle and may stop. If I stop you will die. I am a vital organ.

A3 Lungs

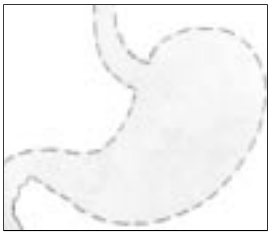


I am the lung. I have a sponge like body. I deliver oxygen to your blood and remove the carbon dioxide from the blood. The ribcage protects me.

On average, the maximum amount an adult male lung can hold is 5.7 litres and in an adult female I can hold a maximum of 4.2 litres.

I need my air sacs, of which I have millions, clean all the time. If you inhale smoke or pollutants you can clog my air sacs and I won't be able to do my job that is deliver oxygen to you and rid you of the carbon dioxide. Like the heart I work non-stop too. I am a vital organ.

A4 Stomach

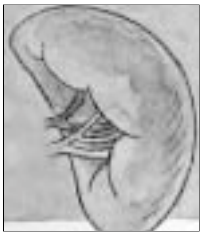


I am a muscular sac called the stomach. I churn food with digestive juices. This creamy mixture I squirt into the small intestine to distribute the food for the body.

I am the widest part of your digestive system because I can store the food that you eat allowing you to consume a large meal quickly and digest that slowly. As soon as food enters me I release enzymes that start breaking down protein in the food. My lining also secretes strong hydrochloric acid that kills harmful microbes in the food which can enter your body.

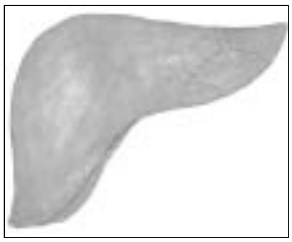
You cannot survive without me I am a vital organ. I am joined at the top by a long tube to your mouth and at my lower end I am joined to the small intestine. Too much of alcohol, very pungent or oily food make me slow and hurt my walls.

A5 Spleen



I am a fist-shaped organ called spleen. I clean your blood of bacteria, viruses and other debris, destroy old red blood cells and fight infection. This keeps your blood clean and helps protect you against infection. I make blood cells (before birth I produce red and white blood cells but after a baby is born I produce the white blood cells throughout your life). I sit in the left hand side of your body, between your stomach and diaphragm
It is possible to live without a spleen as most of my functions can be taken over by other organs. However, people without spleens are more vulnerable to all kinds of infections.

A6 Liver

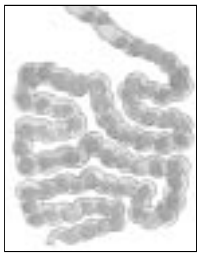


I am the liver and am the largest internal organ in your body. I get rid of toxins found in your blood. I produce bile which breaks down fats in the food you eat. I also regulate the sugar levels in your blood. I am essential for life. Without me you will die within 24 hours. I sit below the lungs.

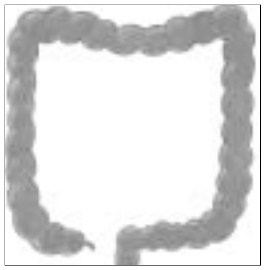
A7 Pancreas

I am a pistol shaped gland called the pancreas. When you eat, I secrete the digestive juices through a duct into the first part of your small intestines. I produce insulin and glucagon, two hormones that regulate sugar levels in the blood. If something happens to me and I am removed you can survive if you take insulin and glucagon everyday to regulate your blood sugar levels. I am situated behind the stomach.

A8 Intestines

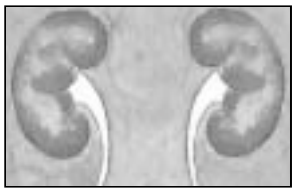


I am a 5 metre long coiled tube called the small intestines. Most of the nutrients in the food that you eat pass through the lining of my walls into the blood. The liver and pancreas deliver digestive juices to the top part of me. These juices help me break down fat, protein and carbohydrate in the food that has been churned out by the stomach. Food that is not digested I pass on to the large intestine.



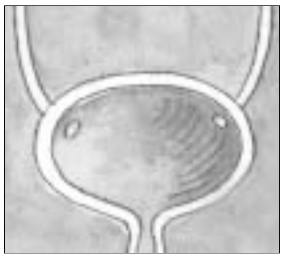
I am a 1.5 metre long tube called the large intestine. Bacteria that live in me produce the smelly compounds that produce smelly gas. One third of your faeces are made up of the bacteria that live in me. Food waste products stay in me between 10 hours and several days they are excreted as faeces. Too much fat in the food makes me slow. Too little fluids and too little fibre in your food make me sluggish and constipated.

A9 Kidneys



I am the dark red bean shaped organs called kidneys. I clean your blood by making urine from the waste products found in your blood. When you drink lot of water I produce a lot of urine to stop your blood from becoming too thin. This also keeps me flushed and clean. I rid your blood of the excess salt and so keep the salt levels in the blood constant. I am located in the middle of the back.

A10 Urinary Bladder



I am a stretchy sac called the urinary bladder. I store the urine produced by your kidneys. I can usually hold about 300 to 500 millilitres of fluid comfortably. When I stretch beyond a certain point, the nerves in my walls transmit a message to your brain that I need to be emptied. When you leak, my muscles contract, forcing the urine out of me into a tube called the urethra which takes it out of your body. Urine made in your kidneys is transported to me via two tubes known as ureters.

If you hold urine in me too long, then I can become infected with the bacteria. If you don't keep your private parts clean I can get infection that can travel up the urethra. Drinking plenty of water and passing urine whenever I let you know I am to be emptied will keep me in good health. I am located in your pelvis.

B1 The digestive system

Food provides us with fuel to live, energy to work and play, and the raw materials to build new cells. All the different varieties of food we eat are broken down by our digestive system and transported to every part of our body by our circulatory system.

The Digestive Tract The main part of the digestive system is the digestive tract. This is like a long tube, some nine metres in total, through the middle of the body. It starts at the mouth, where food and drink enter the body, and finishes at the anus, where leftover food and wastes leave the body

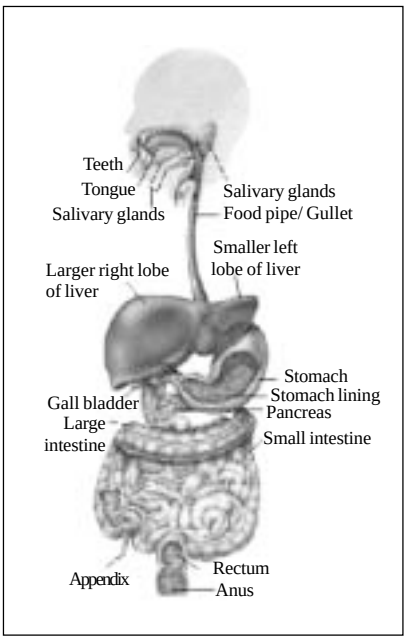
Mouth Teeth bite off and chew food into a soft pulp that is easy to swallow. Chewing mixes the food with watery saliva, from 6 salivary glands around the mouth and face, to make it moist and slippery.

Oesophagus (Food pipe) The oesophageus, or gullet, is a muscular tube. It takes food from the throat and pushes it down through the neck, and into the stomach. It moves food by waves of muscle contraction.

Stomach The stomach has thick muscles in its wall. These contract to mash the food into a sloppy soup. Also the stomach lining produces strong digestive juices. These attack the food in a chemical way, breaking down and dissolving its nutrients.

Pancreas The pancreas, like the stomach, makes powerful digestive juices called enzymes which help to digest food further as it enters the small intestines.

Gall Bladder This small baglike part is tucked under the liver. It stores a fluid called bile, which is made in the liver. As food from a meal arrives in the small intestine, bile flows from the gall bladder along the bile duct into the intestine. It helps to digest fatty foods and also contains wastes for removal.



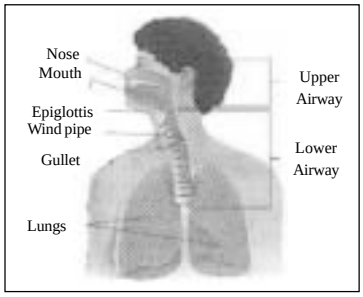
Small Intestines This part of the tract is narrow, but very long - about 20 feet. Here, more enzymes continue the chemical attack on the food. Finally the nutrients are small enough to pass through the lining of the small intestine, and into the blood. They are carried away to the liver and other body parts to be processed, stored and distributed.

Liver Blood from the intestines flows to the liver, carrying nutrients, vitamins and minerals, and other products from digestion. The liver is like a food-processing factory with more than 200 different jobs. It stores some nutrients, changes them from one form to another, and releases them into the blood acccording to the activities and needs of the body.

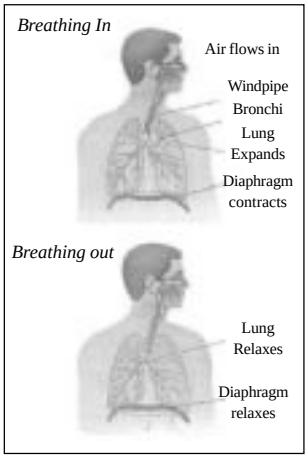
Source: http://www4.tpgi.com.au/

B2 The respiratory system

The respiratory system is the system of the body that deals with breathing. When we breathe, the body takes in the oxygen that it needs and removes the carbon dioxide that it doesn't need



First the body breathes in the air which is sucked through the nose or mouth and down through the trachea (windpipe). The trachea is a pipe shaped by rings of cartilage. It divides into two tubes called bronchi. These carry air into each lung, where oxygen we breathe is released into the blood and carbon dioxide from the bloodstream is removed from the body when we breathe out.

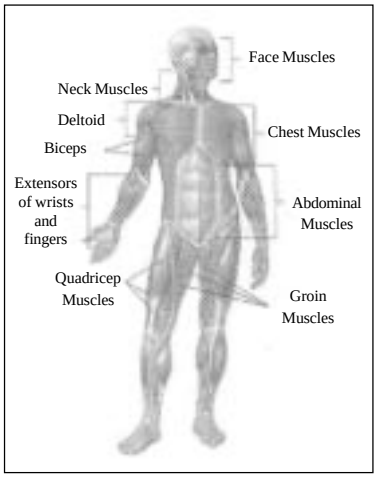


The diaphragm is the muscle that controls the breathing process. As the diaphragm flattens it causes the chest to expand and air is sucked into the lungs. When the diaphragm relaxes, the chest collapses and the air in the lungs is forced out.

Source: http://www4.tpgi.com.au/

B3 Muscular system

Almost half the body's weight is muscle. Muscles are the part of our body that allow us to move. They are made up of special tissues that can contract, or shorten, when they receive a signal from the brain. The muscles are attached to bones by stretchy tissue called tendons. When the muscles contract, they pull on the tendons which pull on the bones and cause our limbs to move.



There are more than 640 muscles, and they hardly ever work alone. Muscles can get shorter and pull, but they cannot push. So most muscles are arranged in opposing teams. One team pulls the body part one way, then the other team pulls it back again. As each team pulls, the other team relaxes and gets stretched. Muscles band together to form muscle groups which work together.

Voluntary muscles, such as your arms and legs can be controlled by your thoughts.All this muscle action is controlled by your brain, which sends and receives signals through your nervous system.

Muscle actions can be voluntary or involuntary. Involuntary muscles, such as the heart, diaphragm and intestines, are automatically controlled by the brain. You don't have to think about making them work. For example the heart beats between 60 and 80 beats every minute without you having to think about it.

Source: Andrew McGann http://www4.tpgi.com.au/

Session 2: Care of ourselves and care of the surroundings/environment

Session Objectives: At the end of this session participants will be able to:

A. Briefly explain how we can take care of ourselves physically and emotionally

B. Briefly explain how we can take care of our surroundings / environment

Training Materials required for the session:

A. Charts -4 each of the male body and female body outlines, markers, snake and ladders game –A1,A2.

B. Chalk, Game B1-B2 – 'What will you do'.

Methodology:

Present the objectives for the session.

A. Taking care of ourselves **1 hour 45 minutes**

Divide participants into four groups. Distribute the charts (each group should be given two charts with the outline of male and female body etc. Any 5 common health problems must be discussed and the part of the body that is affected should be marked with colour. For example, if violence is common then both physical and psychological impact –may color the outline, in case respiratory problems are common among children, then a dot can be marked in the chest area etc.

Five most common health problems among each of the following:

Group 1: children –girls and boys

Group 2: Adolescents- girls and boys

Group 3: Adult men and women

Group 4: Old men and women

Ask groups to discuss and list:

1. both physical and psychological health problems
2. perceived causes
3. consequences for self and others in the family

Discuss the responses in the large group. Then let participants return to their groups and discuss how the problems mentioned can be prevented, cured. When a response is found they can color that dot a different color and document it. Let the groups present in the large group, followed by discussion and plug the gaps.

Ensure that habits like alcoholism, smoking, food practices, work related problems are explored too. (45 minutes)

Introduce the game (1hour) on keeping healthy using the snakes and ladders board. Divide participants into four groups and give each group a copy of the board (100 squares in a board) reproduced on a chart as in (A1). The size of the game board should be big enough for participants to write in the individual squares. Show them the sample game board (A2).

Ask participants to reflect on the previous exercise and what they learnt in the previous session including their own experiences to develop a game board (fill in the squares) to educate community groups on being healthy. Ask them to use colors and paints/illustrations (in the squares) if they wish to. Explain that the groups try and include practices /habits/behaviours and solutions.

Groups display their boards, plug gaps. If time permits it can be played at the end of the session or played during the next training session.

If participants are health workers /NGO staff they can make individual boards that can be used in the village meetings and workshops etc.

B. Hygiene and Sanitation **2 hours 30 minutes**

Divide participants into four groups and ask

Group 1 and 2 to map a house (based on the house of one person in the group) on the floor with chalk. (can also be done on a chart) and

Group 3 and 4 to map a model village and identify health issues at the village level and perceived reasons for these. Unsafe waste disposal (sanitation facilities); lack of safe drinking water, health problems, pollution, deforestation, cutting of trees etc

The groups should present in the larger group the perceived reasons/causes for illness and health problems. Note the main points reasons/causes for illnesses both at home and at the village level.

Discuss: 1. health problems at the house and village level that have to do with the surrounding, structure of houses, environment (plastics) etc 2. consequences. Small groups present in the large group.

After each presentation guide the discussion to explore if the perceived reasons are correct and clarify what the actual causes may be (45 minutes).

What can/should we do to prevent these?

Ask participants to go back to their earlier groups to make / suggest necessary changes that will prevent the problems, at the home and outside- what can be addressed by them and what can be addressed by others, by whom? (25 minutes).

Introduce the game 'What will you do?' (B1 and B2) to the participants (1 hour). The game explores reasons for common problems; the barriers to preventing and treating these problems and roles and reactions of different individuals /groups /organizations in the community to these problems.

Divide participants in small groups to play the game.

Note: the facilitator should prepare as many boards as participant-groups.

At the end of the game, discuss in large group what the participants understood from the game. Discuss what were some of the causes/reasons for illnesses and some barriers to achieving these and list on a chart/board. The discussion could explore the reasons for lack of basic infrastructure, lack of access to care, apathy on the part of officials, policies and priorities(20 minutes).

Activity ***30 minutes***

Ask the participants to work in three groups reflecting on the above exercise to

Group 1: As PRI what strategy they will use to improve sanitation and hygiene in their panchayat

Group 2: As Village community groups what would they do to improve the hygiene and sanitation in their village

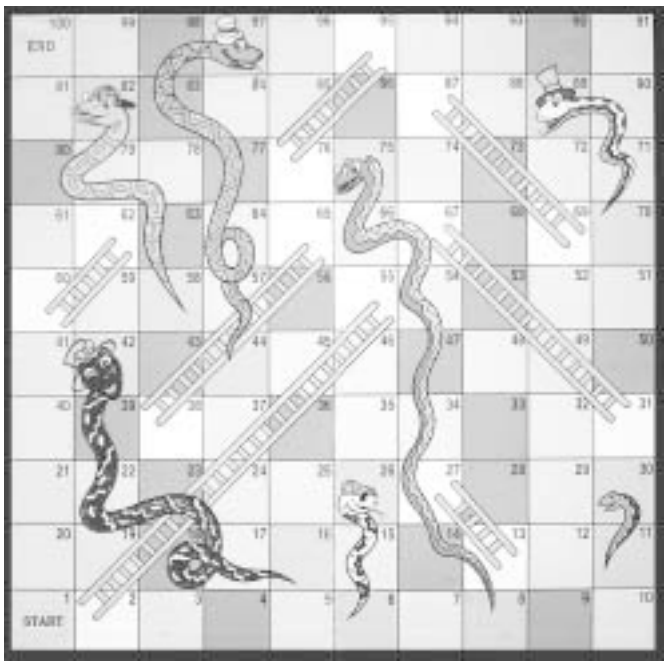
Group 3: As family what would they do to improve hygiene and sanitation in their home and surroundings

In the large group when they present, let participants comment and refine strategy/plans. Collect notes for duplication and distribution if possible.

Materials used for training/ handout include:

A1 **Snakes and ladders game to be developed by groups: Reproduce A2 on charts**

A2 **Sample :** Snakes and ladders game to be developed by facilitator



Start the game like in normal dice games with a throw of six and then roll the dice to get the number to move

Ladders on the board for

2 Eat brightly coloured food and vegetables GO TO # 55 Good eyesight
13 children have completed their vaccination on schedule GO TO # 27 Children protected from infections
31 Couples complete treatment for STIs together and practice safer sex GO TO # 67 cures and prevents recurrence of STIs
38 Eat fibre rich food GO TO # 65 Helps clear the bowels smoothly and keep body healthy
60 Drink at least 8 to 10 glasses of water daily GO TO # 62 Flushes the kidneys and urinary bladder and clears the body of toxins
76 Clean, happy and caring environment GO TO # 95 Healthy happy family and home
69 Exclusively breastfeed your baby till 6 months of age GO TO # 87 best for baby and mother, saves lives.

Snakes on the board for

26 blaming women for not bearing a boy child GO TO # 6 sperm is responsible for the sex of baby

30 Eating food with dirty hands GO TO # 11 leads to contamination and infection

42 Do not treat foul smelling vaginal infection GO TO # 16 can lead to pelvic inflammatory disease

75 Smoking beedis and cigarettes GO TO # 8 damaging for the lungs

97 Open overflowing drains and dustbins GO TO # 44 spreads disease and unhealthy environment

82 lifting and moving heavy objects frequently after delivery or during periods GO TO # 58 may cause uterine prolapse

89 Beating pregnant wife GO TO # 70 Great damage to health of woman and fetus

B1 Hygiene and Sanitation ('What will you do?' game)

To be prepared:

1. Dice –1
2. A game board with the illustration given. Preferably should be large.
3. 7 coins
4. Star cards- ✵

A. Panchayat president
B. PHC doctor
C. Health visitor
D. Block Development Officer BDO
E. Block MLA
F. Collector
G. A member of a social service organization
H. Youth group leader of the village

How to play the game:

- Six or seven persons can play the game at a time. One person is required to facilitate the game
- One dice should be rolled and whoever gets the highest should begin the game
- Each person should have a coin and move the coin on the board based on the number rolled.
- Whichever space the coin is in, the question given should be answered by that person. The facilitator should note the response
- If anyone reaches the space with the 'Star', he/she has to pick up a card with the star symbol on it and has to act out a part/role. This should be done after the completion of the first round, ie after all 5 or 6 persons have played.

For example, if Panchayat president is mentioned on the card, the remaining players will go to him as the Panchayat president to resolved their problems. He/she has to pretend /behave like a panchayat president. Further explanation-

A player rolls a three and gets the star on the # 3 space; lets take it that (s)he becomes the panchayat president; the next player gets a four and reaches the space with the problem about putting medicines in the well, if (s)he thinks it necessary (s)he can go to the panchayat president and ask her/him to put the medicines; the president can also respond to that (as it happens in reality) – a chance to discuss. Similarly another player can go to the president about children dying….

START
1 The well in your area is not covered So the water is not pure. What can be done?
2
3
4 People are aware of putting medicines in the well. It is cheap. But no one has taken any step. Why? What can be done?
5 No safe water. Children suffer from diarrhea, many die. How can we solve this problem?
6
7 People wash cattle in the lake where others bathe. Consequences?
8
9
10 Many people have skin problems. Reason? How can it be controlled
11
12 Village does not get safe water. Who is responsible? Consequences?
13
14 Last year many died of cholera, jaundice. Give reasons.
15 If there are pipes will the water problem be resolved or not. Explain
16
17 4 steps ahead
18
19
20
21
22 Boil and drink water. Is this feasible? Why?
23
24 Go back two steps
25
26 The nadars (higher caste) has complained several times to the panchayat president about water facility. But that was of no use. What will you do next?
27
28 When asked, the BDO [Block development office] said next year. There are no funds. What next?
29
30 Some people say that if people decide, they can change the situation. What do you think?
END

Being a discerning consumer of health care services

This chapter helps participants to explore ways to help people become discerning consumers of health care services by helping them to seek medical help and how to overcome barriers to receiving appropriate medical care. It discusses the rights of the client and the need to be aware of unnecessary drugs and treatment procedures. The chapter's three sessions can be conducted as the one day workshop.

This chapter consists of :

Session 1: Recognizing when to seek medical help and overcoming barriers to receiving appropriate medical help 1hour 30 minutes

Session 2:The Rights of the Client 1 hour 30 minutes

Session 3: Being aware of unnecessary drugs and treatment procedures 1 hour 30 minutes

Session 1: Recognizing when to seek medical help and overcoming barriers to receiving appropriate medical help

Session Objective: At the end of the session participants will be able to:

A. Recognize when to seek medical help

B. Identify ways to overcome barriers to receiving appropriate medical help

Training Materials required for the session:

A. Blank grids for the exercise on seeking medical help, markers

Methodology

Present the objectives.

A. Seeking Medical help **40 minutes**

Divide participants into 3 small groups. Give them 2 blank grids (A1) that have only the title column written and ask them to discuss common health problems or health condition for that group and what is the common practice with relation to that ailment and when do they seek medical help. They should fill the grids for one groups' problems only. For example, group 1 will do it for children using a separate grid for boys and separate grid for girls. (15 minutes)

Alternatively you could split the participants into 6 small groups and give each a grid to fill.

Group	Common health problems/condition	Normal practice	Seek medical help
Children	Cold and cough	Do nothing or if possible give sukkhu coffee	Only if it does not stop for a month and becomes very bad

Group 1: Children (separate for boys and separate for girls)

Group 2: Adolescents (separate for boys and separate for girls)

Group 3: Adults (separate for men and separate for women)

In large group discuss the responses. Ask participants to give reasons for why people respond to health problems the way they have listed out. Discuss barriers to seeking help/treatment and also different treatment for males and females. (25 minutes)

B. Overcoming Barriers to receiving appropriate medical help **15 minutes**

In large group ask participants to share their experiences on how to overcome barriers to receiving appropriate medical help. Record responses and consolidate.

For example, users who are poor are treated as if they are fools and are not given any information regarding their health problems. This is especially true for women. Poor dalit women are considered unclean and injections are given through the blouses – without lifting the sleeve (reference RUWSEC's observations). Costs, timings, lack of privacy, drugs etc. should also be discussed.

Activity ***15 minutes***

Divide the groups and ask participants to do the following:

Group 1: List things they would do to educate others to seek medical help in time.

Group 2: List things they would do to mobilize the panchayat to improve heatlh services for their village, e.g. motivate Village Health Nurse (VHN) to come when she is supposed to visit their village.

Materials used for training/ handouts include:

A1

Group	Common health problems/condition	Normal practice	Seek medical help

Session 2: The rights of the client **1 hour 30 minutes**

Session Objectives: At the end of the session the participants will be able to:

A. List the basic 10 rights of the client

B. Examine the ways in which the rights of clients are compromised for the poor, marginalized communities and women in particular

C. Develop a plan to educate the public on their rights as a client/patient

D. Develop a plan to mobilize support to motivate the health services to provide services respecting the rights of clients/patients

Training Materials required for the session:

A 10 Rights of the Client (chart)

Methodology

Presents the objectives of the session

A. Rights of the Client **1 hour**

Lead a large group discussion (30 minutes) on client's rights by asking participants what they feel they have a right to when they seek health services. Write the answers on the board or a flip chart. Then present the Rights of the Client/patient A1(one by one with discussion).

Divide participants into two groups and ask them to discuss ways in which the rights of clients are compromised (use examples of situations they had come up with in the earlier session) Group A Rights 1-5, Group B Rights 6-10. In large group note against each right how it is compromised and post chart on the wall.

Activity ***30 minutes***

Divide participants into two groups and ask them to do the following:

Group 1: Develop a plan to educate the public on their rights as a client/patient.

Group 2: Develop a plan to mobilize support to motivate the heatlh services to provide services respecting the rights of clients/patients.

Let the groups share the plans and let others comment and contribute. Fill gaps and request copy for typing/ duplicating for distribution to all participants

Materials used for training/handouts include:

A1 **Rights of the Client/patient**

1. **Dignity** – to be treated with courtesy and without discrimination
2. **Information** – to learn about the benefits and availability of services, the cost of services, the complete information of what he/she is ailing from if ill, information in a language that the client can understand.

3. **Safety** – to be able receive treatment/ services that are safe and effective, in a safe and effective environment, services that do not expose the client to risk of infection
4. **Choice** – to decide freely from the options provided

   If family planning (FP) client then to chose which method, when to use and when to change or discontinue. If seeking treatment to decide if there is an option between oral medication or other possibilities including surgery. To decide which system of medication they will prefer once illness or disease is diagnosed
5. **Confidentiality** – to be assured that any personal information will remain confidential
6. **Access** – to avail services at convenient locations
7. **Comfort** – to feel comfortable when receiving services
8. **Continuity** – to receive supplies for as long as needed
9. **Opinion** – to express views on services being offered
10. **Privacy** – to have a private environment during counseling or services

Session 3: Being aware of unnecessary drugs and treatment procedures

Session Objectives: At the end of the session the participants will be able to:

A. Be aware of drugs and other prescriptions by the health providers.

B. Self medication – being aware of safe and effective use.

Training Materials required for the session:

A Situation cards for discussion, materials on 'drugs', 'common practices', 'rationality of drugs'

B Material 'Dos and Donts', small papers chits

Methodology:

Present the objectives.

A. Unnecessary drugs and other prescriptions by the health providers 45 minutes

Divide participants into small groups and distribute the situation cards to them (A1) for discussion and to be enacted as role plays.

The participants in smaller groups should discuss reasons for these practices – whether they are necessary/ unnecessary and the consequences of such practices. After presentation and discussion in large group, ask groups to go back and modify role play. Two groups where the health provider counsels against and two in which the user refuses unnecessary prescriptions.

Ask what conditions are needed for this to happen: e.g. information about basic drugs and treatment procedures.

At the end of the discussion sum up and explain what drugs are (A2) and about reasons for irrational use (A3) of drugs referring to the points from the discussion. (45 minutes)

B. Self medication – being aware of safe and effective use 1 hour

Explain the following exercise will help participants discuss what type of medicines people can take for some common health problems / when is it necessary /not necessary and what are the alternatives?

Give small paper chits to participants and ask them to write common health problems that they would like discussed in the session. Fold the chits and place them in the center of the training area. Now ask participants to stand in a circle and select an object (it may be a note book or even a duster) that they can pass round while you clap hands.

The person holding the object when the clapping /sound stops should pick up a chit and say what he/she does in case of such a problem. What medicine is taken or what treatment procedure is followed. Ask groups to provide inputs and plug gaps. List the various remedies that are suggested in addition to the allopathic drugs and other procedures.

Select a few very common practices and explain as given in (A4):

Briefly explain the Dos and Donts for drugs (use A5 for reference but use local language to explain).

Then conclude that people generally consume medicines even for minor problems. Constant self-medication leads to problems like allergy, stomach ulcer and kidney problems. Pregnant women and lactating mothers should take medicines only after consulting the doctor, self-medication in pregnant women cause excessive bleeding during delivery and affects the growth of the child.

Materials used for training/ handouts include:

A1 Situation cards for discussion

1. For joint pains/ache, tiredness people go to the nearby shop and buy tablets and consume it .In villages general medicines are available in the provision store (Saridon, Anacin, Crocin etc)
2. Pregnant women to get immediate relief buy medicines for headache, fever, nausea, giddiness and joint pains. They are not aware of the consequences of it. Certain medicines affect the growth of the embryo.
3. Some doctors to gain popularity prescribe heavy dosage medicines; though people get quick relief in the long run their health is affected.
4. Some patients compel the doctors for saline/drips and injections. There is a common belief among the villagers that the above will give quick relief for tiredness and weakness.
5. Unnecessary scans and laboratory tests are prescribed.

A2 About drugs in general

Drugs are chemical substances which affect living organisms. Such substances, also known as medicines, are used to detect, cure and prevent diseases, and relieve symptoms. Many drugs are synthetic forms of naturally occurring substances, that is, chemical copies of the original. Some are obtained from botanical or animal sources, for example, belladonna used for some gastrointestinal problems is derived from the deadly night shade; opiate drugs including morphine are derived from certain types of poppy. Many vaccines, thyroid hormones and insulin (until recently) are obtained from animal sources. Some hormones are produced in the laboratories. The process involves altering certain micro-organisms at the genetic level and thereby changing the products of cell activity. For instance, the hormone insulin which is produced naturally by humans can now be manufactured by genetically-engineered bacteria. Most drugs are produced by pharmaceutical companies through chemical processes. They are marketed only after testing for safety and efficacy. Testing is done on animals and human volunteers. Drugs cannot be marketed without the approval of the Food and Drug Administration (FDA), also called the Drug Controller/Commissioner in some states. The highest drug control authority in India is the Drug Controller of India.

A3 Rationality of drugs

Rational Drug Therapy is described as "Ordering the right medicine for the right patient at the right time and in the right amount with due consideration of costs" . Rationality is also to be looked at within a particular medical system. In this book, we are concerned with rationality within the allopathic medical system only. (Rationality of use of two or more systems is a knotty if unresolved issue. A recent hearing of the Supreme Court (1996) prohibits prescribers trained in one system to prescribe medicines of another system in which the prescriber is not trained.)

Rational drug therapy means the use of drugs which are efficient, safe, low-cost and easy to administer. It requires that health practitioners have adequate medical knowledge and appropriate skill for correct diagnosis and treatment. They would also be required to have time and concern for their patients.

Irrational use occurs owing to:

1. *Lack of knowledge*: Or when prescribers have no scientific knowledge. This happens in the case of so-called quacks or when doctors have not kept abreast of current developments in medicine. (It is indeed debatable whether any formally trained doctor with a medical degree who does not have knowledge to treat even simple problems, or treats common problems irrationally, should be considered a 'quack'; likewise, should a well-trained village health worker knowing how to prescribe for specific conditions be considered 'practising' medicine unethically and illegally?). Lack of knowledge also occurs when patients treat themselves without sufficient knowledge about the drug. Most Over the counter (OTC) drugs have instructions for use in English - a language understood only by a minority of the Indian population. Moreover, very often instructions are couched in technical jargon (and often in small, unreadable print) which cannot be understood by lay persons. In addition, people tend to recommend drugs based on their personal experience.
2. *Inaccurate diagnosis*: This occurs due to lack of interest, lack of time, over-crowded Outpatient Departments (OPDs), inadequate health personnel and lack of diagnostic aids.
3. *Lack of objective drug information*: It is doubtful whether a majority of doctors in India are in the habit of referring to standard textbooks or standard medical journals. So they probably tend to take the easy way out by relying on information supplied by medical representatives and drug companies which can be very biased and selective. Also, doctors are led to believe a lot of new products are being marketed every day. Many of these are not new discoveries which radically alter the course of treatment. Therefore to say that it is difficult to keep up with new knowledge is not quite correct. Thirdly, absence of compulsory recertification

of medical degrees and continuing education programmes is another drawback in updating whatever relevant new knowledge that does come out.

4. *Aggressive drug promotion influencing doctors*: As mentioned in the earlier chapter, there are more than 100,000 formulations (at five products per company for the estimated 20,000 manufacturing units in India) in the Indian market, many of which are similar except for different brand names or for a few unnecessary additional ingredients. Pharmaceutical companies therefore indulge in aggressive marketing to promote the sale of their brands. Sometimes, it results in unethical marketing practices such as bribing doctors with diaries, calendars, posters, gifts and even foreign trips and vacations
5. *Over/under-prescribing by doctors*: Over-prescribing occurs when doctors prescribe too large quantities, for too long duration, too many at the same time for the same problem, or sometimes even unnecessary drugs. This causes wastage of money, drugs, adverse reactions due to drug interaction, and saddest of all, is that the patient's condition does not improve, and in fact may have deteriorated. Doctors over-prescribe because they may not be able to diagnose the patient's condition and hope to "hit or miss" with a wide range of drugs. They may also be influenced by the pharmaceutical companies which supply doctors with excessive samples. In addition, doctors may not be able to resist the clamour of patients' demand for more medicines, lest they lose their practice to a competing private practitioner.Under-prescribing occurs, among other reasons, due to lack of knowledge on the part of the prescriber, non-availability of drugs as in the case of long-term, regular treatment necessary for the treatment of diseases like tuberculosis and leprosy, and patients' inability to purchase drugs.
6. *Cut-Practice*: Another reason irrational and often expensive treatment occurs is due to the presence of cut practice, that is, kickbacks offered by specialists, pathologists, X-ray clinics, CAT scan centres, etc., to prescribers who refer patients to them.

* Prescribing antibiotics for ailments like diarrhoea or viral infection where they are useless, thus causing antibiotic resistance by the body when needed for dangerous diseases.
* Prescribing combination products where one medicine is sufficient..
* Prescribing unnecessary expensive vitamins or tonics, virtually regardless of the condition being treated.
* Prescribing expensive new drugs in preference to established, less expensive ones.
* Ordering of unnecessary investigations.

(Source: www.locost.org)

A4 **Common practices** (The following are samples)

Head-ache: One should know the reason for headache before going in for treatment. For example hunger, constipation, tension, anger, shock, lack of sleep and anxiety leads to headache. If your activity is diverted you can get relief from headache. Without analyzing the reason for headache intake of painkillers leads to health problems. Constant headache should be referred to doctor immediately, as migraine and eye problem can also cause headache.

Women hesitate to seek care they go in for self-medication. Self-medication can cause ulcer, boils in the body and affect kidneys.

On rare occasions people can take paracetamol, children below 12 years can be given ½ a tablet.

Cold and cough: The reason for getting cold and cough is due to water consumption. If we drink water in a new place, drink unclean water, winter season and climatic condition can also cause cold and cough. When there is less immune power in the body one may get cold and cough. Cold and cough can also be a symptom for a major health problem. In take of tablet for this may lead to ulcer and allergy. In this regard can drink hot water and take rest. If the colour of the phlegm is yellow or green it may be due to any kind of infection. Refer doctor immediately.

Menstrual cramps: Cramps during menstruation is normal this happens due to the contraction and expulsion of the spongy uterine lining. One should not take tablets for this. Intake of tablets is risky. The following are the risks.

- Causes hindrance to the normal secretion of the hormones.
- Affects the ovaries and uterus functioning.
- Postponing the menstrual period by consuming tablets leads to problems in the uterus and kidneys.
- Usage of medicines in the long run causes addiction towards particular medicines. Less workload and taking rest will give relief to this.

A5 Guidelines for safe and effective drug use

Do not	Do
Pressurise your doctor to prescribe unnecessary drugs.	Know the name and the correct spelling of the drug you are taking. It is advisable to know both the brand name and its generic name.
Take drugs on the advice of friends who have had similar symptoms.	Check the product label before purchase to ensure that the expiry date is valid at the time of consumption of the drug.
Offer anybody drugs prescribed for you.	Read the package labels and inserts of all drugs so as to familiarise yourself with the contents of the product.
Change the dose or timing of any drug without the advice of your doctor.	Follow dosage instructions correctly.
Continue a drug which is causing adverse reactions.	Contact your doctor as soon as possible.
Take any drug if you are pregnant or breast-feeding, unless prescribed by your doctor, who is aware of your condition.	Shake all liquid suspensions of drugs thoroughly to ensure equal distribution of the ingredients.
Withhold from your doctor, information about your previous drug experiences. It is important that your doctor be informed about the beneficial and undesirable drug effects you had experienced in the past.	Use a standarised measuring device for liquid medications to be administered by mouth. The household teaspoon varies greatly in size.
Take drugs in the dark. Identify every dose of medicine carefully in adequate light to be certain you are taking the drug intended.	Follow your doctors's instructions on dietary and other treatment measures designed to augment the actions of the prescribed drugs. This makes it possible to achieve desired effects with smaller doses. A common example is to reduce salt intake during drug treatment for high blood pressure.
Keep different medicines on the bedside table. You are likely to be confused and take the wrong one, even with the light on.	Inform your doctor if you intend to take over the counter (OTC) drugs, got from the pharmacy or other source without prescription, while on prescribed medication.
Discontinue taking a prescribed drug abruptly without the doctor's advice.	Inform your surgeon, dentist, anaesthetist,pathologist of all drugs you are taking or have been taking prior to any surgery.
Take drugs which have expired	Keep a written record of all drugs (and vaccines) you have taken during your pregnancy and reasons for their use and those which you experienced allergic or adverse reactions.
	Determine if you can operate a machinery or engage in hazardous activity while on prescribed medication.
	Determine if alcoholic beverages can be taken while on prescribed medication
	Determine the course of action if you miss a dose of the prescribed drug.
	Discard all outdated drugs. This will prevent used of drugs that have deteriorated with time.
	Store all drugs away from the reach of children to prevent accidental poisoning and away from heat, light, in airtight containers in a dry place.
	Keep all appointments and follow-up medical examination to determine the effects of drugs and the course of your illness.

(Source: www.locost.org)

OUR BODIES, SEXUALITY AND REPRODUCTION

Overall Objective:

- Provide participants with a basic understanding of our bodies' sexual and reproductive anatomies, an overview of sexuality, sexual norms and behaviour and an understanding of menstruation and menopause; and conception and contraception.

A large majority of people grow up with unanswered queries regarding their own as well as the opposite sex's sexual and reproductive anatomy. This is because in most societies and cultures discussions on sex and sexuality are taboo leading to an association of shame or embarrassment with relation to one's own sexual and reproductive anatomy. This ignorance creates problems when women, men or adolescents need help to sort their feelings or seek treatment for infections in the 'private parts' or need cooperation and consideration in their sexual relations. A lack of understanding of the reproductive anatomy also gives rise to many myths and rumours that again lead to problems when not addressed in time. This module attempts to clarify basic issues on sexual and reproduction issues.

RUWSEC firmly believes in the conviction from women's experiences that they cannot become successful agents of social change without first having control over their bodies and their lives. Women are brought up to view their bodies with suspicion shame and contempt which results in poor body image. A healthy attitude towards their bodies would help them develop self respect and this would be the first step towards working in the community and initiating changes there. Control over their bodies is the first step in control over fertility and their sexuality.

Health education and awareness-raising programmes that empower women with a sound information base, and through programmes aimed at enhancing their self-image and self-confidence, enable women to initiate self-help at home and also be aware of when to seek medical help.

The lack of knowledge makes men and women prey to existing misconceptions and beliefs about their bodies and impacts their health and their lives. However unequal gender relationships mean that women are more severely affected than men. For example, women are blamed for the sex of the child. In many families birth of daughters is enough reason to abandon the woman, and get the man remarried. After a vasectomy for some months there is still a chance of getting pregnant as the sperm remain in the man's body so the couple need to use another contraceptive method to avoid pregnancy. Lack of this information results in the woman being blamed for extra marital affairs and is subject to emotional and physical violence.

Another example is the negative perception of menstruation –that it is bad, something to be ashamed of. In case of reproductive and sexual health problems, either men and women don't know what is normal and what is not and when they suspect abnormality, they feel ashamed to talk about it. Women and men need to have access to information, education about their bodies and processes as the first step towards achieving good sexual and reproductive health and exercising their rights.

This module consists of the following chapters:

Chapter 1: Male and female sexual anatomy and reproductive systems, and changes in these through adolescence, adulthood and older years — 7 hours

Chapter 2**:** Sexuality, sexual norms and behaviour — 4 hours

Chapter 3: Menstruation, menopause, conception and contraception — 5 hours 45 minutes

Anatomy and reproductive systems of women and men and changes in these through the life cycle

Men and women need to be more comfortable with their own bodies especially of the sexual and reproductive systems to be better able to take control of their sexual lives. The sexual and reproductive aspects of people's lives play a key role in their state of well being. Lack of knowledge leads to problems in this area that often give rise to other social problems within families especially for women who do not have much power to negotiate and make decisions which impact their lives.

This chapter provides basic knowledge and understanding of the sexual and reproductive anatomy of women and men and also discusses the changes in these through the life cycle beginning from the foetus stage. The knowledge gained here will help dispel many myths and misconceptions and help participants become familiar with aspects of their own sexual and reproductive system without embarrassment. There is only one large session split into mini sessions and takes a total of 7 hours to complete.

Session 1: Sexual anatomy and reproductive system of women and men and changes in these through adolescence, adulthood and older years

Session Objectives: At the end of this session participants will be able to:

A. Identify and describe different parts of the female sexual and reproductive anatomy

B. Identify and describe different parts of the male sexual and reproductive anatomy

C. Explain the stages of sexual (physical and social) development in males and females

Training Materials required:

A Flips charts/writing board, markers/chalk, prepared charts A1, A2, A3, A4, A5 training reference

B Flips charts/writing board, markers/chalk, prepared charts B1, B2 B3 B4, training reference

C Flips charts/writing board, markers/chalk, prepared charts on 'Stages of Sexual Development in women and men (physical)' and 'Socio-sexual Development through the Life Cycle'

Methodology:

Present the objectives for the session.

A. The Female Sexual Anatomy **2 hours**

Divide participants into groups. Give each group a blank flipchart and ask them to draw the outline of the female body. Alternatively the groups can map the body of one member in the group on the floor. Then ask participants to map /mark the sexual and reproductive organs. Go round and observe.

Then display chart (A1) that has the picture of the external female genitals and ask the participants to volunteer to identify the parts. If the participants had mapped them earlier, consolidate what they already know. Also ask participants what are the functions of these body parts. State that while people may have discussed the internal reproductive organs before, the external genitals get ignored, although they play an important role in the sexual life and provide protection to the internal genitals. Explain that the external genitals are also the first sites for sexually transmitted infections, so proper care for these body parts will then reduce incidence of infections. Use content given in (A3) to provide information in local language.

Then show the picture of the internal genitals on a chart (A2) and follow the same process as before. Explain using the reference given in (A4). Explain the breasts as a sexual body part with the content given in (A5).

Activity ***10 minutes***

Divide the participants into two groups and ask them to name the external and internal female genitals in *simple local spoken language*. Have one group work on the external while another group works on the internal genitals. Let them share in the large group, comment and change as necessary.

B The Male Sexual Anatomy **2 hours**

Divide participants into groups give each group a blank flipchart and ask them to draw the outline of the male body. Alternatively the groups can map the body of one member in the group on the floor. Then ask participants to map /mark the sexual and reproductive organs. Go round and observe.

Then display the chart (B1)and ask the participants to volunteer to identify the external genitals. Also ask participants what are the functions of these body parts. Listen to their responses and then explain using content given in (B2) of the training materials

Then ask participants to identify and name the internal parts. Also ask participants what the functions of these body parts are and then explain using the reference given in the content for (B3) in the training materials.

Activity ***10 minutes***

Divide the participants into two groups and ask them to name the external and internal male genitals in *simple local spoken language.* Have one group work on the external while another group works on the internal genitals. Let them share in the large group, comment and change as necessary.

C Stages of Sexual Development in males and females **2 hours**

1. Stages of Sexual Development in women and men (physical)

Divide them into two groups and ask participants (working in groups) to describe in their own words the different stages of sexual development (physical characteristics only) in males and females. Give them the grid with the development column empty as in (C1) and let the groups fill up the column. Have one group work on the female and another work on the male.

After 5 minutes call them back and let them present. Use the grid in (C2) to then fill gaps and explain, answer any queries as you progress through the grid.

State that the size of the breasts or the penis does not determine their functioning/ effectiveness. They play a specific role along with the other parts of the body regardless of size.

2. Sociosexual Development through the Life Cycle

Now ask participants to share what they have observed about the socio-sexual development of males and females through the life cycle. Listen to what they share and at the end ask whether foetuses display any such sexual characteristics too. Many would be surprised by that but will be more interested to learn that sexual responses are natural and not necessarily something we consciously make although one can learn to control the social actions related to that natural response. Display (C3) and explain. Ask participants if they have any clarifications, if yes deal then clear their doubts and move on to the activity.

Activity ***40 minutes***

Divide participants into groups to discuss

How does this knowledge affects the way they will perceive things in their daily life in relation to the care and upbringing of young children, understanding and dealing with adolescents, needs of the adults, needs of the aging adults. The participants can be divided into groups to discuss how the sexual and reproductive lives of male and females are impacted keeping the discussions around the local cultural practices, gender bias and poverty issues that they need to deal with at each of these stages in life.

Group 1: Discuss regarding young children (Boys, Girls)

Group 2: Adolescents (Boys, Girls)

Group 3: Adults upto 50 years (Men, Women)

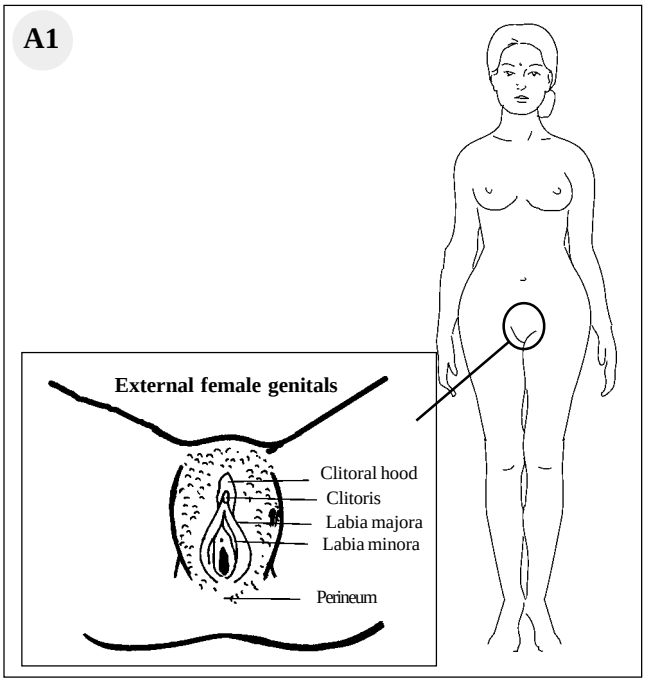
Group 4: Elderly 50 and beyond (Men, Women)

After participants return to the large group and present their groups points, lead a large group discussion (5 minutes) on an community education, and an education on the contents discussed so far can help men and women, boys and girls - young and adolescents improve and alter social norms and behaviour and make life easier and better for all people respecting their individual rights.

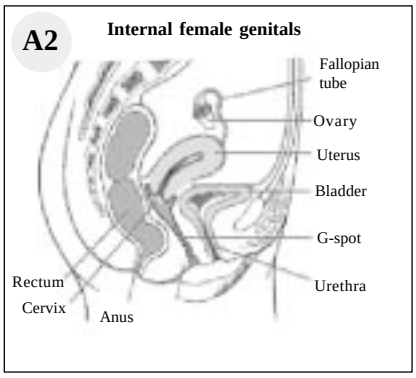
Materials used for training / handouts include:

A1 (Outline figure of female body with external genitals)

A1



A2 Internal female genitals (cross section view)



A3 **External female genitals**

(Explain in simple local language the parts given here. The colloquial terms used in your area can be added later, in the activity)

The external female genitals are: the mons pubis, the clitoris, the labia majora, and the labia minora. Together, along with the opening of the vagina, they are known as the vulva. This structure, which becomes covered with hair during puberty, protects the internal sexual and reproductive organs.

The clitoris is an erectile, hooded organ at the upper joining of the labia that contains a high concentration of nerve endings and is very sensitive to stimulation. The clitoris is the only anatomical organ whose sole function is providing sexual pleasure.

The labia majora are two spongy folds of skin, one on either side of the vaginal opening, that cover and protect the genital structures. The labia minora are the two erectile folds of skin between the labia majora that extend from the clitoris on both sides of the urethral and vaginal openings. The perineum is a network of muscles located between and surrounding the vagina and the anus that support the pelvic cavity and help keep pelvic organs in place.

A4 **Internal female genitals**

(Explain in simple local language although the parts can be named as given here and can have colloquial terms given to refer to them later in the activity of naming the parts in simple local language.

The internal female genitals are: the vagina, the cervix, the uterus, the fallopian tubes, and the ovaries.

The vagina is a muscular, highly expandable, tubular cavity leading from the vestibule to the uterus. The vagina is the structure penetrated during vaginal intercourse, and it also serves as an exit channel for menstrual flow. During vaginal intercourse, contact with this structure provides sexual pleasure in some women. The anterior vaginal wall is more densely innervated and more highly sensitive to stimulation than the posterior vaginal wall.

The Grafenberg spot, or G-spot, is a small area (about 1 to 2 cm) on the front wall of the vagina (closest to the bladder and urethra), about halfway between the pelvic bone and the cervix, that is especially sensitive to sexual stimulation in some women and may be the source of a small amount of fluid ejaculated at orgasm. If stimulated, this area becomes engorged. The G-spot has no known function for women except as a source of sexual stimulation. After stimulation of the G-spot, some women report temporary difficulty urinating, which may be due to the swelling that creates pressure on the urethra.

The cervix (the lower part of the uterus that protrudes into the vaginal canal) has an orifice that allows passage for menstrual flow from the uterus and passage of sperm into the uterus. During vaginal intercourse, contact with this structure may provide sexual pleasure in some women.

The uterus is a hollow, thick-walled, pear-shaped, muscular organ located between the bladder and rectum. It is the site for implantation of the fertilized ovum (egg), the location where the fetus develops during pregnancy, and the structure that sheds its lining monthly during menstruation. The upper portion of the uterus contracts during orgasm.

The fallopian tubes (*oviducts*) are a pair of tubes that extend from the upper uterus, extending out toward the ovaries (but not touching them), through which ova (eggs) travel from the ovaries toward the uterus and in which fertilization of the ovum takes place. The fallopian tubes contract during orgasm.

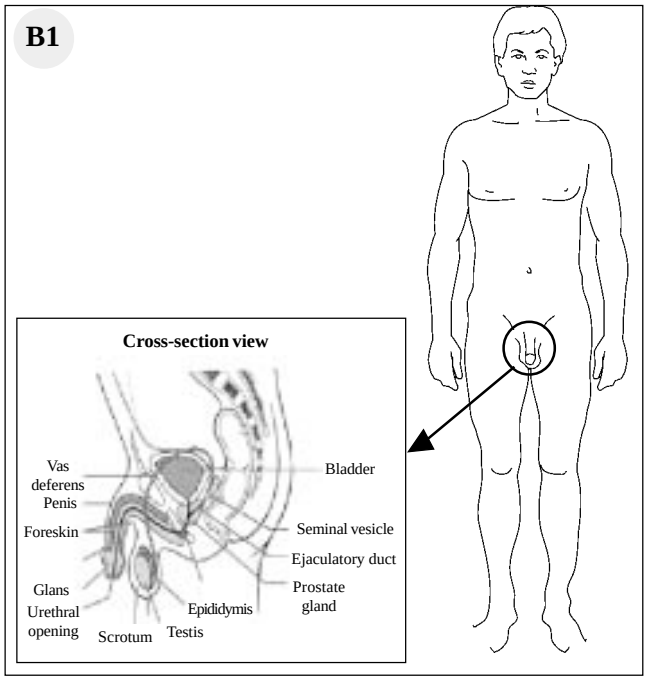
The ovaries are two organs located at the end of each fallopian tube, that produce ova (releasing one per month from puberty to menopause). The ovaries produce *estrogen* and *progesterone*, the hormones responsible for the development of sex characteristics. These hormones are also responsible for elasticity of the genitalia, integrity of the vaginal lining, and lubrication of the genitalia. *Testosterone* is also produced—although in smaller amounts than is produced in men and is responsible for sexual desire.

A5 **The breasts**

For both women and men, the breasts may provide sexual pleasure. In both sexes, the nipples may be highly sensitive to stimulation. The main difference between female and male breasts is the amount of fatty tissue within the breast.

For women, the breasts provide optimal nourishment for infants. Also for women, the glandular composition of the breast is very sensitive to hormonal changes in the body consistent with the menstrual cycle. Consequently, a woman's breasts may vary in sensitivity or tenderness from one part of the month to another, or from one cycle to another.

B1 (Outline of male body with the external and internal male genital organs clearly drawn)



B2 **External male genitals**

(Explain in simple local language the parts given here. The colloquial terms used in your area can be added later, in the activity)

The external male genitals consist of the penis and the scrotum.

The penis is a cylindrical structure with the capacity to be flaccid or erect. The penis provides passage for both urine and semen. It can be a source of pleasure in response to sexual stimulation and is the organ that penetrates the mouth, vagina, or anus during penetrative sex. The head of the penis, the *glans* (*glans penis*), is the part of the penis that is most sensitive and has the most nerve endings. The glans is covered by the foreskin, or *prepuce*, in men who are not circumcised.

The scrotum is a pouch of skin hanging directly under the penis that contains the testes. The scrotum protects the testes and maintains the temperature necessary for the production of sperm.

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B3 **Internal male genitals**

The internal male genitals are: the testes, the epididymides, the vasa deferentia, the seminal vesicles, the prostate gland.

The testes, the paired, oval-shaped organs that produce sperm and male sex hormones, are located in the scrotum. They are highly innervated and sensitive to touch and pressure. The testes produce *testosterone*, which is responsible for the development of male sexual characteristics and sex drive (*libido*).

The epididymides are the two highly coiled tubes against the back side of the testes where sperm mature and are stored until they are released during ejaculation.

The vasa deferentia are the paired tubes that carry the mature sperm from the epididymides to the urethra.

The seminal vesicles are a pair of glandular sacs that secrete about 60% of the fluid that makes up the semen in which sperm are transported. Seminal fluid provides nourishment for sperm.

The prostate gland is a walnut-sized, glandular structure that secretes about 30% of the fluid that makes up semen. The alkaline quality of the fluid neutralizes the acidic environment of the male and female reproductive tracts. A muscle at the bottom of the prostate gland keeps the sperm out of the urethra until ejaculation begins. The prostate gland is very sensitive to stimulation and can be a source of sexual pleasure for some men. ©2004 EngenderHealth

C1 (Prepare grid as given in C2 but leave column 2 and 3 blank except for the heading (Female development and Male development respectively)

C2 Stages of Sexual Development in women and men (physical)

STAGE	FEMALE DEVELOPMENT	MALE DEVELOPMENT	AGE RANGE
1	• No breast budding • No pubic hair growth	• Prepubertal, small penis and testes • No pubic hair growth	<10 years
2	• Small breast buds • Fine, delicate, fuzzy pubic hair growth	• Testes grow • Scrotal skin becomes redder and coarser • Sparse, fine hair develops at the base of the penis	10–13 12–14
3	• Enlarging breast buds • Increased pubic hair, mainly in the center and not extending out to thighs or upward; dark and coarser	• Penis lengthens, with small increase in diameter • Scrotum and testes continue to grow • Pubic hair increases in amount and becomes darker, coarser, and curly	
4	• Noticeable growth of pubic hair in a triangle, the shape it will take in adulthood • Underarm (axillary) hair growth visible • Breasts form mounds • Menarche	• Penis and testes continue to grow • Pubic hair increases in amount and becomes darker, coarser, and curly	13–15
5	• Breasts fully formed • Pubic hair is adult in quantity and forms an upside-down triangle, a shape common to women	• Penis is at its full adult size • Pubic hair is at its adult color, texture, and distribution	14–17

(Adapted from: Swanson, J. M., and Forrest, K. A., 1984, *Tanner Stages of Male and Female Reproductive Development in Men's Reproductive Health*, Springer Series: Focus on Men, vol. 3, Springer Publishing Co., pp. 55–57; and Gennex Health Care Technologies, 1999, "Puberty and Its Stages," A Forum for Women's Health, The Estronaut Site. *Source: EngenderHealth. NY)*

C3 Sociosexual Development through the Life Cycle

Age	Characteristics of Sociosexual Development
Before birth	Male fetuses have erections, female fetuses have sexual responses.
Months 6–12	Genital self-exploration and masturbation occur.
2 years	Children show an awareness of biological sex and understanding of sexual identity.
3–5 years	Children begin to conform to society's messages about how women and men should act, and show an understanding of gender roles.
5–12 years	Children may begin to show romantic interest, and first signs of sexual orientation or preference toward females or males, depending on cultural norms.
8–12 years	First physical signs of puberty appear (slightly earlier for women than for men). Girls menstruate at around 13-15 years of age, boys begin to produce sperm by ages 14–18.
40–65 years	The process of reproductive system aging begins. This occurs slightly earlier for women (can be as early as the mid-30s) and ends earlier (mid- to late 50s) than for men. It is characterized by altered patterns and lowered estrogen, progesterone, and testosterone. Sexual function continues, with responses altered

Sexuality, sexual norms and behaviour

This chapter discusses concepts of sexuality, sexual norms and sexual behaviour in a broad sense. It provides participants with an opportunity to examine their own views and values on these aspects of sexual and social life and highlights the sexual rights of individuals irrespective of caste, gender or creed.

There is just one session that is split into mini sessions dealing with different aspects of the topic under discussion. The total time is 4 hours for this chapter.

Session1: Sexuality, sexual norms and behaviour — 4 hours

Session Objective: At the end of this session the participants will be able to discuss:

A. Sexuality

B. Sexual norms and behaviour

C. Sexual rights

Training Materials required for session:

A slips of paper / small cards, pens, pins, grid for discussion

B Story 'Only for Seeta?', pens, paper; Materials B2, B3 and B4

C Pens, papers, material on sexual rights

Methodology:

Present the session objectives.

A. Sexuality — 1 hour

Ask participants to reflect, to remember the first time they heard / read about sex. When did that happen? What did you hear/read? How did you hear/read about it? Who told you? After participants have shared sum up saying that people learn about sex, sexual norms, sexuality, and sexual health from various sources. These may include parents, friends, teachers, radio, newspapers and television, work colleagues, community elders, the health system, traditional health care providers Add on any others to the list.

Divide participants into triads. Give each triad slips of paper or small cards and ask them to write what comes to their mind when they think of the term "sexuality". *Note: participants are not sure about the word you may use the word sex at first and explain sexuality thereafter. In many groups the word sex is used to imply sexuality and encompasses all.* After 15 minutes, display the chart (A1) ask the triads to share by coming up to the board and pinning the slips of paper in the appropriate column. Discuss in large group the different words that have been discussed and noted. Conclude that sexuality is more than just sexual acts or reproduction. It includes our desires, feelings, what we do, our values and attitudes Sum up with (A2).

B. Sexual norms and sexual behaviour — 1 hour 30 minutes

Divide the participants in two groups. Give each group a copy of the story ' Only for Seeta' (B1). Ask groups to discuss the story and respond to the questions. In the large group discuss the responses and sum up with the grid (B2) to highlight and add on to the discussion about different norms for men and women. Encourage participants to add other categories if they desire.

Sum up saying that the sexual behaviour for men and women are different because they are guided by sexual norms which are determined by the gender relationships between men and women. Gender relationships are not equal and are reflected in sexuality too.

Sexual norms and behaviour – acceptable and unacceptable sexuality. Choose three corners in the training area – 'acceptable', 'unacceptable', 'not sure'.

What behaviours are unacceptable and acceptable in our society? Read from the list in (B3) and ask participants to move to their corner of choice. Facilitate a discussion after each point to understand reasons why acceptable/ not acceptable/not sure? Are they acceptable for some and not for others? If the norms/values are uniform in all cultures, communities? Can these change?

For example, violence – if it is unacceptable, probe if it is really 'unacceptable'. Facilitate a discussion to understand violence –its acceptance as a means of 'control' of women, gender values and socialization etc. there are some communities/societies without violence. Clarify issues like homosexuality, premarital sex vis-à-vis norms.

Conclude with appropriate examples that various social institutions - family, religion, schools, media, law, community groups, state, political groups regulate sexuality, sexual behaviour, through norms and values attached to what is acceptable and what is not. Summarize and explain what sexual behaviour and sexual practices and sexual norms are (B4).

Activity ***30 minutes***

Divide in two groups and ask participants to reflect on all the activities so far and ask:

Group 1: To present role play /s on how sexual norms and behavior could affect health.

Group 2: To present strategies /plans that need to be initiated to achieve sexual and reproductive health.

In large group, note points from the presentations, clarify points and plug gaps.

Possible responses :

Sexual norms are different for men and women and therefore affect them differently.

For example, patriarchal norms which deny women the right to make decisions regarding their sexuality and reproduction expose them to avoidable risks of morbidity and mortality, be it through sexually transmitted infection resulting from coercive sex, or abortion as a result of non use of contraception leading to a pregnancy (B5).

The practice of unsafe sex by men who are aware of the health risks but continue to indulge in such practices because of existing gender norms about desirable male sexual behaviour.

Non biological factors which compound women's vulnerability because of the way society expects women and men to behave. For a majority of women, high risk activity can simply mean being married. Norms which accept extra-marital and pre-marital sexual relationships in men as 'normal', and women's inability to negotiate safe sex practices with their partners, are factors that make it difficult for women to protect themselves from sexually transmitted infections.

Some of the strategies could include:

- learning about the sexual and reproductive functions of men's bodies and women's bodies and being able to discuss sex in a positive way, avoiding secrecy
- providing the opportunity for women and men to express anxieties about issues related to sexuality such as sexual violence, infertility, masturbation, painful sex, possible illnesses or infections, or problems in relationships
- ensuring access to sexual health services or advice to help with problems so that women and men know how to protect themselves and their partners from HIV and other infections.

Summarize and conclude stating what sexual health and rights are. This should cover most of the points presented by the groups.

C Sexual rights **30 minutes**

Ask participants to share what they think are sexual rights. Listen to their responses and then explain sexual rights as given in (C1). Clarify statements as you go.

Activity ***30 minutes***

Divide participants into two groups. Let each group work on one each of the following:

Group 1: Compose a verse to educate people on sexual rights.

Group 2: Compose a verse to educate people on the consequences for women and girls when their sexual rights are violated and how that will affect the family too in the long term.

In the large group let them share the compositions. Correct where needed and then collect for duplicating and distributing to all participants.

Materials used for training / include:

A1 (Prepare a chart as below)

Sexual organs	Sexual acts	Sexual preferences	Sexual feelings

A2 'Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.'[2]

B1 **Only for Seeta?**

Why are you glaring at me?

She looked at the husband who had slapped her. Even a normal look was a glare to him.

They were married seven years ago. They now have two chidren –both boys. The years were not without fights and arguments. But he was never suspicious of her before. Today was the first time.

So tell me,what happened in Room number 4004 of the Taj Hotel.Don't hide anything.

As long as she had been a clerk he had trusted her. Since her Managing Director had made her his personal Secretary, the storm had started brewing in her life.

Suspicion! Suspicion! Suspicion! Suspicion about everything.

Why don't you answer, bitch?

He raised his hand to hit her. He saw the challenge in her eyes for the first time and dropped his hand.

Seeta:What do you expect me to say? The truth is that there was a meeting of Branch Managers from Mumbai, Calcutta, Delhi and Chennai. I had to take notes of the proceedings.

That is all?

Seeta: What do you mean?

How was the bed in the Taj?

Seeta: What?Did you even think before asking me that?

Were all the managers men?

Yes.

You were the only woman?

Yes.

Then what is wrong in my asking the question!

Seeta: All managers are womanizers! All women who work in offices are having sex with their colleagues?! Is that what you are saying? We have been married for seven years, and I have two children and I don't have to earn a living by dropping my clothes at the Taj.

Just because you talk like this, does not imply that you are 'pure'.

Seeta:Its your perception that I am 'Bad'.

Seeta did not argue like this with Ram.

Seeta: Which Ram? Which Seeta?

That was the last straw. Her anger boiled over and her heart was shattered.

Seeta: Of course and then Seeta jumped into the fire without a word. You expect me to jump into the fire- to do agnipariksha? Lets talk about you, about your affairs with other women. In spite of knowing all this I have stayed here with you. That is true agnipariksha. Why are women alone blamed? Arent men to blame too? Is the agnipariksha only for Seeta? Not for Ram? The world not changed after all this time?

Seeta: You first go through the test (agnipariksha) and then you can be part of this family. She left with her two sons.

Many centuries ago, that Seeta took her two sons and went to the forest. Today this Seeta left and moved on…

For discussion:

1. Have things changed for Seeta (women)?
2. Are the norms different for Seeta and Ram?
3. How are they different. Give examples pertaining to sexuality.
4. Why are they different?

B2 The following chart must be prepared prior to the session by the facilitator. This is only a sample.

Aspects of Sexuality	Women	Men
Act	Submissive	Aggressive
Sexual Object	Sensuous, temptress	–
Sexual feelings	Should not discuss openly	Can discuss
Sexual expectation	Has to be a virgin	Need not be a virgin
Sexual relations	Single partner/monogamous	Multipartner/ polygamous
Sexual knowledge	Ignorant	knowledgeable
Motive for sex	Duty to bear children	Pleasure , adventure
Sexual urge	not to be expressed nor acted upon (loose character)	expressed (strong/normal)
Position	Inferior	Superior (controls)

B3

Unacceptable	Acceptable
Homosexuality, multiple partners, violent, premarital sex, sex during menstruation, coerced/forced sex, anal/oral sex, masturbation	Heterosexuality, does not hurt someone else, sex within marriage, consensual sex, vaginal sex

The points above are only guidelines and not exhaustive. The facilitator can/should add on to the list.(Tables sourced from Report: Short Course on Gender Health and Development, Trivandrum 2001)

B4 Sexual behaviors are actions (touching, kissing, and other stimulation of the body) related to the expression of one's sexuality. Activities related to sexual _expression that are performed habitually or repeatedly can be referred to as sexual practices (although some use the terms "sexual behaviors" and "sexual practices" interchangeably). Sexual behaviors and practices are what people "do" sexually with others or with themselves.

Sexual Norms are norms/rules – the dos and don'ts related to sex and sexuality. These norms are reflected in gender roles, relationships, marriage, partnerships, friendships, and family. Societal norms often determine sexual practices, marriage customs, punishment for unapproved sexual behaviors, and attitudes toward prostitution, homosexuality, contraception, sexual taboos, and sexuality education.

Sexual orientation is the erotic or romantic attraction (or "preference") for sharing sexual expression with members of the opposite sex (***heterosexuality***), one's own sex (***homosexuality***), or both sexes (***bisexuality***).

In the majority of cultures around the world, only heterosexuality is considered acceptable. All societies have values that guide private and public behavior. These values are *formal*—that is, defined by religions, governments, and other official entities shaping a society's laws. However, *informal* values—those reflecting a person's day-to-day behavior—may not be consistent with the culture's formal values.

For example, while some societies may have strict taboos on homosexual behavior and may deny the presence of homosexuality, although there is evidence that homosexual identity or orientation exists in nearly all societies and cultures. Under these circumstances, homosexual practices in that society may be suppressed or kept within a private subculture. Equally, while a society may publicly prohibit sexual activity outside of marriage, many people may practice sex with a person who is not their spouse. In some cultures, it may be understood informally that this is common—even acceptable—while in other cultures, norms—and even laws based on these norms—may make these behaviors acceptable for one sex and not the other. For example, in some cultures it is acceptable for men to have multiple sexual partners or sex with a person who is not their spouse, whereas a woman in the same culture who has sexual relations outside of marriage may be stigmatized, punished, or socially ostracized—even if the woman has been raped.

Many other types of sexual taboos exist—some of these are nearly universal, while others are more rare. For example, many cultures have laws or taboos regarding sex or marriage with close family members (such as fathers with daughters or mothers with sons), but cultures vary in what they consider to be "too close" a relation (for example, some cultures allow first cousins to marry, while others do not). Many cultures have taboos regarding sex during menstruation, pregnancy, or lactation, while others do not. Such norms 'control', and suppress women and other marginalized groups / communities – for example homosexuals).

B5 (Refer: Part 1 Module 1-Chapter 2 for more information on sexual health and rights if not already covered)

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[3]

C1 Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

(Source: WHO Draft working definition, October 2002)

When sexual and reproductive rights are abused or ignored, women and girls may be placed at risk of violence, sexual abuse, rape, sexually transmitted infections such as HIV/AIDS, unintended pregnancy, abortion complications, abandonment, harmful practices.

For example, women are more vulnerable to diseases of the genital tract than men, both biologically and socially. Biologically, the vagina is a more permeable organ than the penis. Socially, lack of power within sexual relationships can make it difficult—if not impossible—for women to negotiate safer sex with their partners. Lack of economic power can also lead to vulnerability as some women are forced to enter into prostitution or multiple or temporary partnerships in hopes of bartering sex for economic gain or survival, including food, shelter, and safety. In many cases, women are at risk simply because they are economically dependent on their partners for survival and support.

Menstruation and Menopause, Conception and Contraception

Menstruation is the sign of womanhood. The blood that comes out during menstruation can create a new being and protect him/her. The power of woman to give birth to a new life was unanimously respected and practices where celebrations were held when the girl began to menstruate, were followed in different communities. A woman undergoes a lot of physical changes in her life and menopause is also an important phase in her life. Many myths and misconceptions prevail about conception and contraception. The lack of knowledge and understanding gives rise to many social problems and some unhealthy behaviours. This chapter provides participants with the necessary information about each of these to dispel the many myths and misconceptions that surround them.

The chapter consists of the following sessions:

Session 1: Menstruation	3 hours
Session 2: Menopause	1 hour
Session 3: Conception	1 hour 30 minutes
Session 4: Contraception	1 hour

Session 1: Menstruation

Session Objectives: At the end of this session the participants will be able to explain:

A. What exactly is menstruation

B. What should be done during menstruation

C. What kind of care should be taken during menstruation

Training Materials required for this session:

A Picture –charts, content on menstruation, care during menstruation, charts, pens, colours, glue etc for posters

B+C Picture –charts, content on care during menstruation, materials for menstrual cloth: some pieces of cloth torn from an old sari for demonstrations, string /naada.

Methodology:

Present the objectives for this session.

A. What is menstruation **1 hour**

Ask participants to share what they know about menstruation. Listen to their answers. Then explain (A1).

Show the picture of the uterus (A2) and explain how this egg travels from the ovary through the fallopian tube to the uterus where if not fertilized it is washed away with the uterine lining during menstruation.

Some women and most young girls experience cramps at the start of their monthly cycle and even sometimes during the periods. Ask participants why this is so? Listen to their response and then explain (A3).

Ask participants what causes or triggers menstruation to happen. Listen to their responses and then explain with content given in (A4).

Ask participants if any of them had prepared their daughters for the first menstruation in advance to the event. If yes what did she tell her daughter or how did she explain?

State that it is important to prepare a young girl in advance for her first menstruation which is referred to as menarche. It is also important for girls to think positive thoughts about their bodies and about menstruation too and about taking special care of their bodies during this time. A change in the way we value this very important aspect of womanhood will affect our attitude and our attitude in turn will affect the way we conduct ourselves. Therefore the messages that we give the young girls should be positive and constructive to their well being.

B. What should be done during menstruation ? **30 minutes**

Ask the participants what they do during menstruation for sanitary protection (wearing a cloth or napkin to absorb the bleeding).

Listen to their answers and acknowledge and appreciate their input. Then state that in order for everyone to get a uniform understanding they will first practice how to fold and fasten the cloth napkin and then they will discuss what girls and women can do/should do during their periods and what they should not do during their periods.

C. Care during menstruation **40 minutes**

Divide participants into 4 groups. State that the participants must fold the cloth to be used during menstruation and describe how to use it. If a doll is available then demonstrate. Give a piece of cloth and strings/nada to each group. (10 minutes)

After each of the group has presented, the facilitator should sum up with the points given in (B1) with the help of the pictures (5 minutes)

Local practices **(25 minutes)**

Ask participants what are the local practices that they observe during menstruation? Divide participants into groups and ask

Group 1 : To work on the dos and donts that accompany menstruation, regarding mobility, clothes, interaction with boys etc.

Group 2 : To work on the should eat or should not eat regarding food items and what are the special foods that are given to a young girl when she comes of age?

Group 3 : Personal hygiene dos and donts; difficulties they face in washing and drying the cloths or in maintaining privacy.

Group 4 : To create a narrative/story about menstruation that could be used to share information with other women and young girls to prepare them for menstruation.

State that during menstruation a girl or woman should eat well and also take some rest. She should not carry heavy loads or even push heavy objects so that she does not strain her pelvic floor muscles that can lead to prolapse later in life.. She should bathe daily and keep herself clean. After bath use a fresh cloth not a damp one to avoid getting infected. She should avoid taking bath in the pond or stream, as she may be prone to infection. During these days it is better to bathe using water from a bucket. She needs to wear clothes that comfortable and that give her enough support so her cloth does not slip out of place and soil everything. She can do normal housework like sweeping and mopping the floor etc. Mothers have an important role to play in supporting their young daughters especially for privacy and cleanliness.

Activity ***45 minutes***

Ask the groups to do the following using the ideas generated in the earlier exercise:

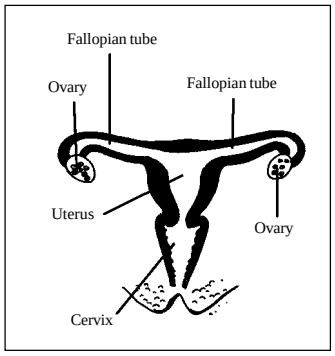
Group 1: Develop a song to proclaim the joy of womanhood, the importance of good nutrition during menstruation, the importance of keeping one's self clean and importance of not lifting or pushing very heavy objects during this time.

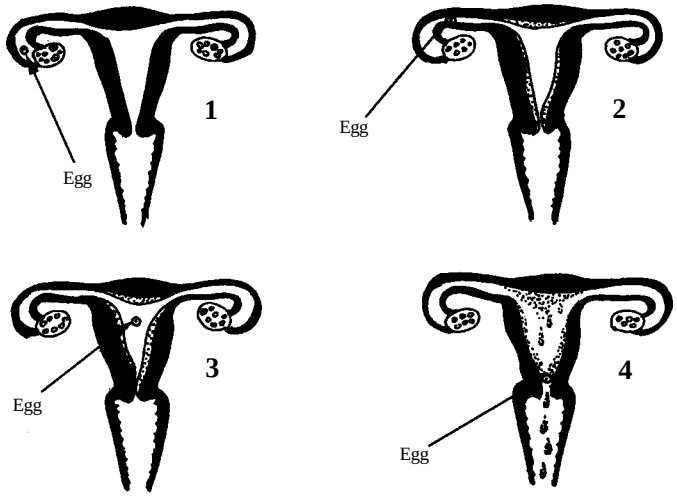
Group 2: Make a poster of what a girl can do, should eat, and what she should not do during menstruation.

Materials used for training /handouts include:

A1 The womb since puberty (around 12 to 15 years of age) begins preparing every month for holding and nourishing a foetus till its birth. Every month the uterine walls grow a spongy lining waiting to hold and nourish a fertilized egg. When no fertilization takes place, the egg that was released that month from the ovary dies, this sends a signal to the womb that the preparation for a baby has been in waste and the uterus (womb) begins to shed the lining it had formed. This lining with the blood comes out through the cervical opening and out through the vagina. This is the menstrual blood. This process of preparation and cleansing of the womb will continue unless it has a baby to hold and nourish or until menopause (45 to 55 years). There is nothing dirty or shameful about this although the majority of girls and women are brought up by culture to think so.

A2 **Process of menstruation**



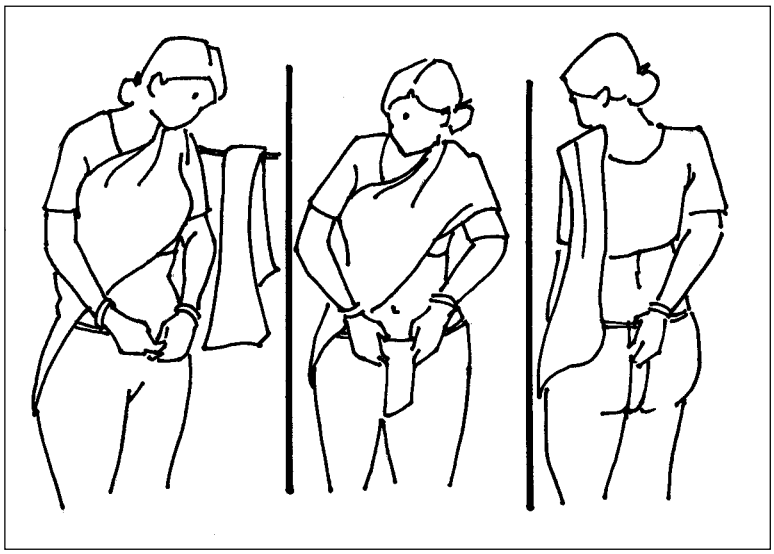


A3 Menstrual cramps and pain is because of the uterus shedding the lining it had created from its walls. For some these cramps are severe and may cause a great deal of discomfort but for most women it is something that they manage without much discomfort.

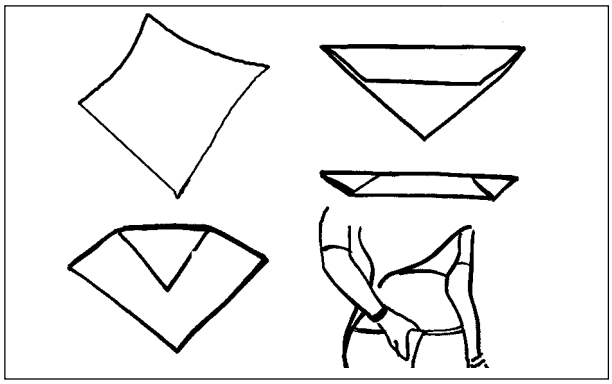
This process of preparation and cleansing follows a cycle and different women have different menstrual cycles some have short 21 day cycles, some 28 days some 32 or 35 days. The first day of bleeding is taken as the first day of the cycle. The bleeding too differs. This monthly flow of blood lasts for some women for only two or three days, for some it lasts about 5 days and for some women it lasts for about 7 days. All these are normal as each woman is different. Only when the pattern changes for a woman and she is worried or disturbed by it she needs to have it checked. When fertilization takes place, the womb does not bleed but grows to meet the demands of the growing baby that it nurtures till its birth.

A4 Menstruation is influenced by the female hormones estrogen and progesterone. Estrogen and Progesterone are made by the ovaries. They regulate the changes that occur with each menstrual cycle and prepare the uterus for pregnancy. Estrogen is known as a 'female hormone' because it plays a key role in shaping the female body and preparing it for uniquely female functions such as pregnancy. Estrogen is vital for the development of breasts and hips. In addition, the vagina, uterus, and other female organs depend on the presence of estrogen in the body to mature.
Also, estrogen stimulates skeletal growth and helps maintain healthy bones. It also helps protect the heart and veins. The main function of progesterone is to stimulate the growth of a cushion lining in the uterus where the fertilized egg can grow and develop into a baby and help the breast make milk. An imbalance in the hormones causes delays or other disturbing problems for women. Infection in the womb can also cause problems with altered bleeding patterns.

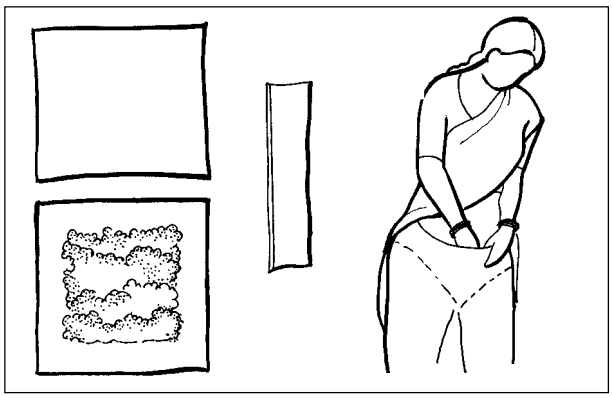
B1



1. During menstruation it is essential to use a cloth to absorb the blood that come out. For that a cloth needs to be placed covering the vagina so that it is covered and the blood that comes out is absorbed.
2. Generally a thin string is tied at the hip and used to place the cloth covering the vagina. It is tied in the same way as the langoti (Komanam) for boys.



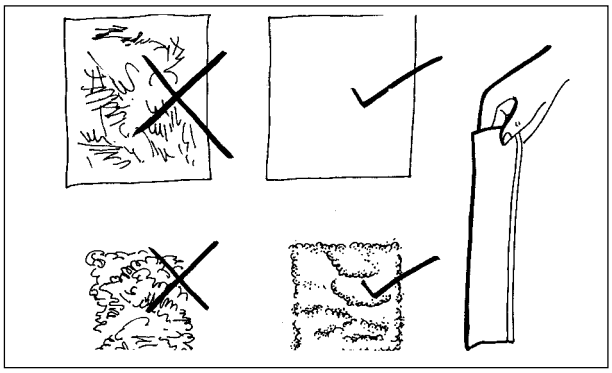
3. It is important to understand how the cloth should be placed. Fold the cloth as shown in the picture and place it in a way so that it covers the vagina and tie it, the string should be tightened well. If panties/underwear are worn over this it offers more protection.



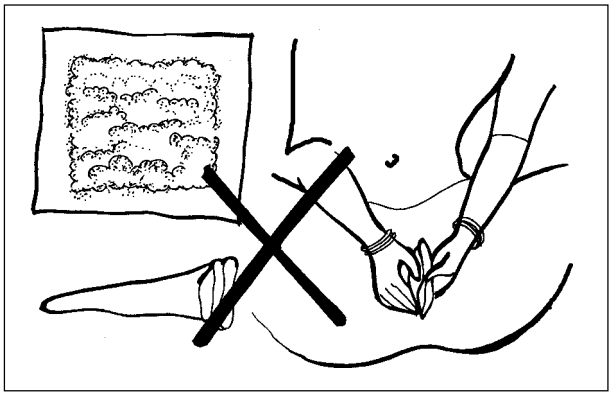
5. Use of folded cloth is suitable for young girls. Clean cotton wrapped in clean cloth may also be used. Panties maybe worn to keep this in place.

7. During menstruation many girls suffer from odour from the vagina. This may be caused because of use of unclean cloth. The cloth must be cleaned every day and before new cloth is placed the vagina and the surrounding parts must be washed with soap and lukewarm water. It is important to clean the hair (pubic). The odour may be caused because of not cleaning these parts or because of not changing the cloth daily.

9. Do not dry the cloth on stones or on grass. By doing that the cloth may get infected by germs. When the cloth is reused these germs enter the vagina and reach the uterus. This can lead to various illnesses

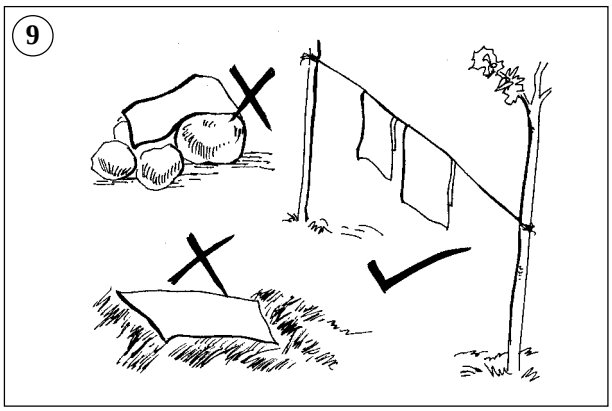


4. This cloth should be very clean. If unclean cloth is used it may lead to various health problems.



6. During menstruation cotton wrapped in cloth and rolled to resemble a finger and inserted in the vagina. But this is not suitable for women who are agricultural workers and young girls. It may cause discomfort.

8. The cloth used during menstruation needs to be washed before using it again. It should be soaked in boiling water and washed with soap. If there is no soap, soak it in boiling water and put it to dry.



Session 2: Menopause

Session Objective: At the end of this session participants will be able to explain:

A. What is menopause

B. Symptoms of menopause

Training Materials required for this session:

A +B Materials about menopause

Methodology:

Present the objectives for this session.

A. What is menopause **45 minutes**

Ask participants to share their thoughts about what menopause means. Let everyone get a chance to contribute to the meaning. Then explain using content in (A1).

Ask participants to think about why menopause happens. Let participants give you their views. Guide them to think about how menstruation is caused and therefore think of how menopause may be caused. Then state that to understand menopause it is important to understand the physiology of hormones in a woman. Recap what was covered in the menstruation session and add using content in (A2).

B. Symptoms of Menopause **15 minutes**

The symptoms of menopause are caused by changes in estrogen and progesterone levels. As the ovaries become less functional, they produce less estrogen/progesterone and the body subsequently reacts. Some women experience no symptoms, while others experience mild to sever symptoms. This variation is normal. A gradual decrease of estrogen allows the body to slowly adjust to the hormone change, but in some women a sudden decrease in estrogen level occurs, causing severe symptoms. This result is often seen when menopause is caused by surgical removal of uterus (surgical menopause).

Ask participants what they think are signs of menopause. Ask one volunteer at a time to mime the symptoms and the group to guess. Then explain using the content in (B1).

Activity ***15 minutes***

Ask all participants to sit in a circle. Say that they will now create a story about a woman who has reached menopause. They will try to incorporate all that they remember from the session and any additional information they might like to add. Each person must add only one or two sentences and then the next person will continue and so on till the end.Start the story:

I am 49 years old and my periods are irregular since one year. ……

Record the narrative and clarify any doubts and plug gaps at the end.

Materials used for training / handouts include:

A1 Menopause, which normally occurs between the ages of 40 and 55, is a natural event in a woman's life. During menopause ovulation (egg production) ceases, eliminating the possibility of pregnancy, and menstruation becomes less frequent and eventually stops. In India, menopause begins early. In some women, menstrual activity stops suddenly, but usually it tapers off, both in amount and duration of flow, and frequently the menstrual periods become more closely or more widely spaced. This irregularity may last for 2 or 3 years before menstruation finally stops.

A2 Estrogen is known as a 'female hormone' because it plays a key role in shaping the female body and preparing it for uniquely female functions such as pregnancy. Estrogen is vital for the development of breasts and hips. In addition, the vagina, uterus, and other female organs depend on the presence of estrogen in the body to mature. Also, estrogen stimulates skeletal growth and helps maintain healthy bones. It also helps protect the heart and veins Estrogen may also affect a woman's sexual desire. Prior to menopause, the ovaries make more than 90 per cent of the estrogen in a woman's body. Other organs including the adrenal glands, liver, and kidneys also make small amounts of estrogen. That's why women continue to have low levels of estrogen after menopause. Progesterone is the second most important female hormone made by the ovaries. This, along with estrogen regulates the changes that occur with each menstrual cycle and prepares the uterus for pregnancy. A smaller amount of progesterone is produced by the adrenal glands. The main function of progesterone is to stimulate the growth of a cushion lining in the uterus where the fertilized egg can grow and develop into a baby and help the breast make milk.

B1 Symptoms of menopause

The changes you can feel are:

- Flushing of skin and hot flashes- A reduction in estrogen is associated with Hot flashes, caused by an increase of blood flow in the blood vessels of the face, neck, chest and back.
- Mood changes and decreased libido (sex drive) are due to partially from the hormone decrease, but may also result from having to deal with hot flashes and vaginal dryness.
- Irregular menstrual periods.
- Thinning of the tissues of the vaginal wall causes vaginal dryness.
- In addition to these, some changes may go undetected for many months or years by increasing the risk for osteoporosis (loss of calcium from the bones, causing bone fragility), which sometimes isn't detected until a bone fracture occurs.

Session 3: Conception

Session Objective: At the end of this session the participants will be able to explain:

A. What is conception and how it takes place

B. Who is responsible for the sex of the baby

Training materials required for this session:

A + B Content and charts

Methodology:

Present the objectives of the session.

A What is conception and how does it take place **30 minutes**

Ask participants to explain in simple language what they understand by the term conception. Ask one to volunteer and explain how conception takes place using the picture. Plug gaps and sum up explaining that

Conception means to become pregnant. Explain how it takes place using picture and content in (A1).

B. Sex of the foetus **40 minutes**

Ask participants who they think is responsible for the sex of the baby. Listen to their responses and then explain using content in (B1). **(**15 minutes)

Ask them whether knowing this will help women in their communities and if yes how?

Ask them what the current practice is when a woman repeatedly has a girl child. Listen to their responses. (5 minutes)

Ask volunteers to enact a role play on dealing with a family which is blaming the woman for having only girl children and therefore trying to marry the man again in the hope of getting a male child. (5 minutes discussion+ 10 minutes presentation+ 5 minutes post presentation)

Activity ***20 minutes***

Ask participants to

Group 1: Prepare a chart on how conception takes place.

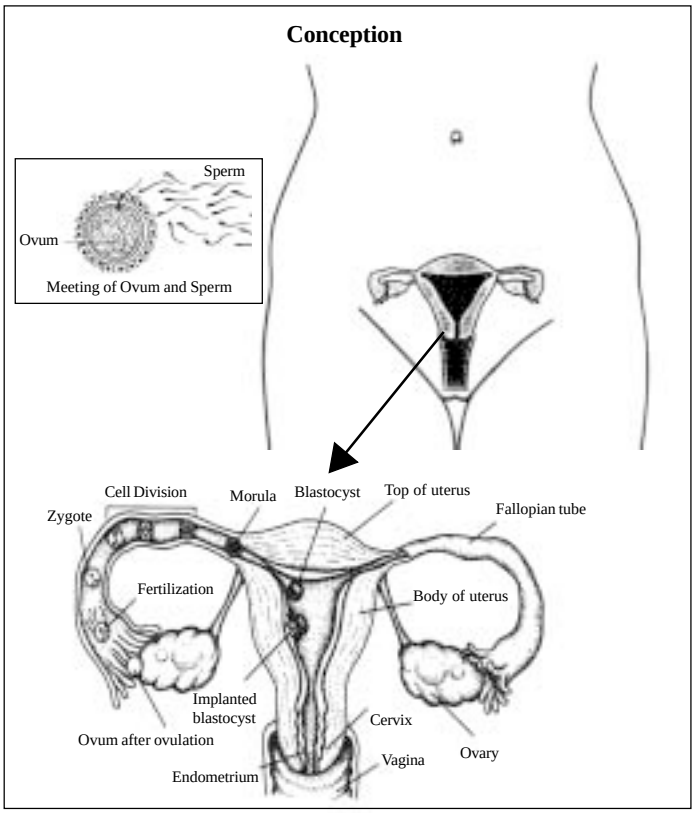
Group 2 : Prepare a skit or song to educate people that the sperm from the man is responsible for the sex of the baby to be born and that women should not be held responsible.

Materials used for training / handouts include:

A1 **How conception takes place**

Conception takes place once a sperm from the man's body meets and fertilizes an ovum (egg) in the woman's body when the couple have sexual intercourse.The fertilization normally takes place in the fallopian tube when the ovum is travelling to the uterus in the woman's body. At conception the fertilized egg will attach itself to the lining of the uterine walls (endometrium) where it will grow. The womb's lining is thereafter not shed during pregnancy so a woman does not menstruate during this time.

B1 The sex of the baby to be conceived is determined by the sperm. There are two types of sperm. One type has X chromosome and the other type has Y chromosome. On the other hand all ova have only X chromosome. When a sperm with X chromosome fertilizes an ovum a female baby is conceived. When a sperm with Y chromosome fertilizes an ovum a male baby is conceived.



Session 4: Contraception

Session Objective: At the end of this session the participants will be able to explain:

A. What is contraception

B. Explain the contraceptive action and the method used

Training materials required for this session:

B Picture of contraception, Matching game

Methodology:

Present the objective for the session.

A. What is contraception **5 minutes**

Ask participants what is contraception. Listen to their responses and explain:

Contraception means to stop conception from taking place. In other words " to contracept means to not allow conception".

B. How does contraception happen **30 minutes**

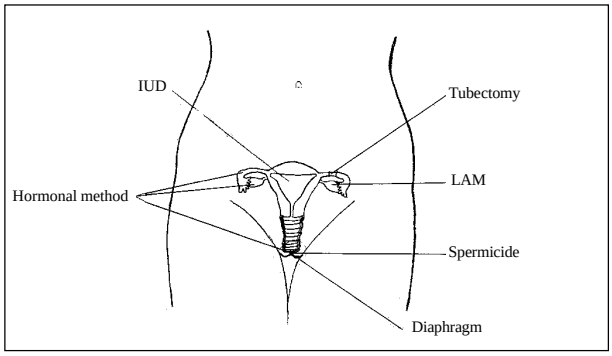
Ask participants to explain how contraception happens. Listen to their responses and explain using content and pictures in (B1).

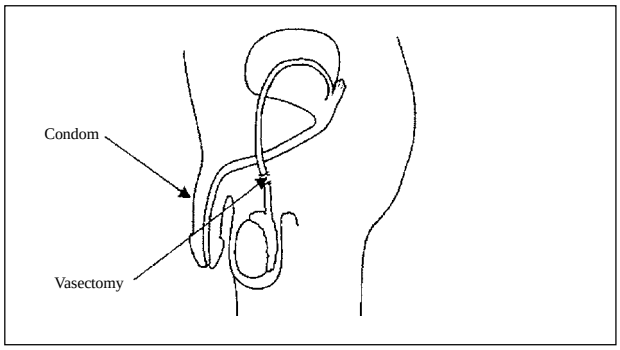
Activity ***25 minutes***

Divide participants into 3 groups and ask them to form circles separately. Give each group (B2) a set of shuffled cards (face down) which have text on them. Explain that when you say start all groups will try to arrange the cards they have to show Contraceptive action and contraceptive device/method used. 15 minutes. At the end go round and see which group has it all correct. If any incorrect sets are there then seek clarification to help them correct the response. Sum up explain the contraceptive action and the method used so that all participants are clear and can explain to others too.

Materials used for training/handout include:

B1





Explain that sperms must be deposited in the vagina in order to be able to swim up to reach a fertilize an ovum. If there is a barrier to that happening then it means that the barrier is a form of contraception.

In case the sperm is deposited in the vagina and it does manage to swim up, the presence of an IUD, for example, in the uterus does not allow the sperm to survive the journey it has to make and therefore the sperm die or are incapable of fertilizing the ovum. This is also a form of contraception.

When sperm are deposited in the vagina but the secretion in the vagina is so thick that the sperm cannot swim in it, they die or are incapacitated it is also a form of contraception.

B2 **Matching game :** make the statements for each separately so that each set will have 7 cards for contraceptive action totally with title and 6 7cards for contraceptive method including title separately. Make 3 or 4 such sets.

Contraceptive action	**Contraceptive device/method**
sperm are not allowed to join the seminal fluid	Male sterilization
sperm are not allowed to enter the vagina	Condoms, Diaphragm and Withdrawal method
sperm are not allowed to enter the cervix	Cervical cap
sperm cannot meet an ovum in the fallopian tube	Female sterilization, hormonal methods that suppress ovulation, Lactational Amenorrhea Method (LAM)
the environment in the vagina is not conducive to the survival of the sperm	Spermicides, hormonal methods
the walls of the uterus do not support the embedding of fertilized egg	Hormonal methods, IUD

Contraceptive action matching game: Nirmala Selvam, Chennai 2004

MATERNAL AND INFANT HEALTH

Overall Objective:

- Provide participants with the necessary knowledge and understanding of care during pregnancy, postpartum and lactation period in order to improve the nutrition and maternity care of women with the help of their husbands and extended family support
- Provide participants with the necessary knowledge and understanding of care of the new born and young infants
- Provide participants with the knowledge and understanding of the importance of proper nutrition to avoid problems

In order to improve the health of the women another important aspect is to educate, increase awareness among the men, husbands, partners, family members on how they can take care of their daughters, wives, women in general which in turn will ensure better health for her, for themselves as a couple, their children and their family as a whole. Educators may help people assess their social expenditure habits so as to put health needs as a top priority, especially for women and children. Involving men and others in the community in the care of their wives and women in general, will go a long way to challenge existing gender norms and relationships and specifically promote better understanding about various factors that contribute to a healthy mother and child.

This module covers the health care needed by women during pregnancy, delivery, postpartum and lactating periods. It also looks at the problems that lead to maternal mortality and morbidity in communities. It covers key issues in the care of newborns and young infants. It provides an understanding of what and why such care and nutrition is needed and will help communities to plan what they need to do and why,- for example, it will help those who need to campaign for better living conditions or health care services know what they should be able to receive from the government health services. The module also provides some guidelines, for example, in the case of nutrition, to identify and make maximum use of whatever is available locally, and from low cost sources.

This module includes:

Chapter 1: Antenatal care – physical and emotional care for each stage during pregnancy 11 hours 45 minutes

Chapter 2: Postnatal Care – physical and emotional care, expectations during this stage and healthy life styles 6 hours 15 minutes

Chapter 3: Breastfeeding (Lactation) 14 hours 30 minutes

Chapter 4: Maternal Morbidity and Mortality 9 hours 10 minutes

Chapter 5: Newborn and Infant care 7 hours

Antenatal Care - physical and emotional care for each stage during pregnancy

Often it is during the antenatal period that a woman gets her chance to go for a health check. In most Indian households, a health check up annually or biannually is unheard of, people generally go to visit the doctor when they are ill and get to a difficult situation. Pregnancy is the only normal condition during which they find it necessary to visit a health care person. This is the time not only to ensure that a complete check is done to make sure that the pregnant woman and the growing baby have no problems but also the time when one can try to get the husband to accompany the wife and be educated on his role and responsibilities and how he can ensure that the wife and baby are provided necessary care.

This chapter includes the following sessions:

Session 1: Physical and emotional changes and needs during pregnancy	3 hours 45 minutes
Session 2: Routine antenatal care (ANC) checks and the safe delivery plan	4 hours 30 minutes
Session 3: Maternal nutrition during pregnancy	3 hours 30 minutes

Session 1: Physical and emotional changes and needs during pregnancy

Session Objectives: At the end of this session participants will be able to:

A. Explain the physical and emotional changes a woman goes through during pregnancy

B. Explain why and how husbands can play a positive and responsible role during pregnancy including the role of other care givers in family have to play to improve care during pregnancy.

Training materials required during the session:

A Empty grid on charts for groups to work on

B Filled out grid copy for trainer's reference

Methodology:

A. Physical and emotional changes and needs during pregnancy **2 hours 30 minutes**

Present the objectives of this session and then initiate large group discussion on what generally happens when a woman becomes pregnant – include first signs and family/cultural social practices in behaviour towards pregnant woman (10 minutes).

Introduce the topic of pregnancy and changes in the woman and very briefly mention some areas to be filled so participants understand what you are wanting them to cover in the discussions. (5 minutes)

State that they should in their groups discuss the changes –physical, emotional, sexual in keeping with gender and other socio-economic issues. For example, taboos regarding nutrition, malnourishment – affordability and accessibility, health consequences during the trimesters because of violence – physical, psychological, sexual; lack of decision making power regarding having children, how many and when; woman's burden of work – productive and reproductive; childcare responsibilities perceived as 'woman's work'; anxiety/fear etc which may be because of lack of information/clarification due to lack of accessible and affordable health services and a lack of infrastructure like toilets and others that impact the health of the woman. Guide discussion using leading questions, use the grid to contain discussion within each trimester separately.

Alternatively use a general discussion to state what we will cover in this activity and then split the participants into three groups and give each of them a trimester to discuss and fill the grid (A1) leaving the last column blank. Bring them back into the large group and then discuss the results, correct mistakes and fill gaps using the filled grid (A2) provided to you and finally move on to discussing the last column of the grid that covers the husband and other family members' role in care. Ask the group whether pregnancy is solely a women's issue and what role do the husbands have in this. Brainstorm to list the current practices (separately) and then brainstorm and discuss to list (fill in the last column of the grid) the expectations from the husband and expectations from other family care-givers. Sum up this discussion with a focus on the basic things that husbands can and should do for their pregnant wives. Post the filled grid on the wall (1 hour).

Ask the participants whether they feel that care during pregnancy as practiced in their communities needs to be improved/can be improved. List the ways in which they feel it needs/can be improved. Post the list on the wall (10 minutes).

Activity ***1 hour 15 minutes***

Divide participants into 5 groups and state that they will in groups discuss and draw out action plans or activities.

Group 1: Educate couples on what to expect during a pregnancy and how to manage the changes and care required (this could be in the form of a folk song)

Group 2: Educate families on why husbands need to play an active supportive role in the care of their pregnant wives (this could be in the form of a folk song)

Group 3: Establish and encourage SHGs to plan for and support pregnant women

Group 4: What they can do to:

- Actively do things at home to improve conditions for the pregnant member in the household
- Ensure that the husband turns up for counseling on pregnancy care and is not made to feel he is a weak man to make time for and help his pregnant wife
- Ensure that the husband also presents himself along with his pregnant wife for a clinical check up and treatment if either or both have any infections as the untreated infection (no matter what it is) may affect the growing baby in the womb or during delivery.

Group 5: Ensure that the government health service is activated to provide the mandatory services for all communities include how this will be done and who will take the initiative

Materials used for training / handout include:

A1

Trimester	Physical changes	Emotional changes and sexual health	Care- husband's role in providing care and family support and care needed
1			
2			
3			

A2 (3 grids – 1st, 2nd and 3rd trimester)

First trimester		
Common Physical changes	**Common Emotional changes and sexual health**	**Care- husband's role and family support to be included**
Is not menstruating Has fullness, bloating or ache in pelvic cavity May be constipated Has vasocongestion (a lot of blood flow in that area causing the blood vessels to swell in congestion) in genital area May be nauseated, may vomit Is tired Has increased vaginal secretions Breasts feel tender, areola becomes darker and nipples sometimes tingle May need to urinate frequently May lose or gain a little weight during the first month or two	Feels anxiety, hope while awaiting pregnancy test results There may be anger/ fear if she did not want to be pregnant. If out of wedlock helplessness/fear if failure of contraception – unplanned pregnancy or if pregnancy is a result of coercive sex /rape Anxiety over sex of foetus Mood swings more pronounced and vary widely Focus is on body changes May fear miscarriage Motherhood feelings are sorted out that is this may be a planned or unplanned pregnancy, if unplanned then is she ready to face the outcome? How she feels about having the baby and what does she plan to do to cope with the way it will affect her once her baby is born May need more gentle caresses from spouse or may not feel interested in sexual intercourse but yet at the same time may need reassurance of physical desirability Some women do not desire sex at all during their pregnancy. Desirability also varies from woman to woman, from couple to couple depending on the closeness in their relationship and also depends on whether the pregnancy is a source of joy or a source of worry for the couple May fear sexual intercourse might cause miscarriage Finances may affect attitudes about approaching parenthood Time seems short	As a husband whose wife is pregnant: Try to understand and cope with the pregnant wife's mood swings, need for physical closeness and caring Make time to take her for the ANC check up and learn as much about what he needs to do to ensure that she stays healthy and has a normal safe delivery If not sharing household chores must now take on the heavier household chores especially those that involve lifting of heavy things Ensure that she is treated with gentleness, avoid violence in any form physical or mental and ensure that she is well fed Ensure that she gets enough rest and does not carry heavy loads Ensure that you do not smoke in her presence as it will also affect the health of the growing foetus Try to give enough time and attention to her needs If you or your wife have anyinfections go for your tests together and take treatment simultaneously to be cured and practice healthy habits to stay uninfected.

Second trimester		
Common Physical changes	**Common Emotional changes and sexual health**	**Care- husband's role and family support to be included**
Fetal movements are noticeable Nausea is usually gone Breasts are usually less tender A dark line (linea nigra) between the pubic bone and the naval may appear (Chlosoma) darkening of the skin around eyes and nose may appear (it will disappear after the birth) May have nasal congestion Pelvic joints are relaxing May have leg cramps Gums or nose may bleed Voice may change due to effects of hormones Steady weight gain every week	May feel more dependent Sexual desire and activity may change and fluctuate at times disinterested in sexual activity and at other times increased desire More day dreaming and dreaming at night pregnancy becomes more enjoyable Sense of growth and creativity may develop Feel more sensitive Time seems short	As a husband whose wife is pregnant: Be understanding and supportive of her feelings Help in taking care of heavy household chores Help in taking care of older children if any Ensure she eats a well balanced diet and has frequent meals to be well nourished Ensure that she has adequate rest and is kept stress free Prepare a delivery plan and ensure that the person who will take care of the delivery is well trained Arrange for someone to be responsible when you are not reachable during an emergency If your wife is in the high risk group make the necessary plans and arrange for funds for emergency obstetric care as a precaution Ensure that the health care staff, your wife and the family/neighbour have your contact numbers or know where to reach you in an emergency Make sure that the surroundings in your home are clean and there is adequate water supply/stored in case of emergency If you are a smoker than refrain from smoking at home and try to reduce or stop smoking as smoking adversely affects the health of your unborn child, wife and you too.
Third trimester		
Expanding uterus High levels of the progesterone hormone may also cause indigestion and heartburn Varicose veins in the legs, hemorrhoids, and swollen ankles sometimes develop During the final months may develop small red elevations on the skin on the upper part of the body Stretch marks may develop on the abdomen, thighs and breasts Feel the need to urinate frequently Uterine contractions increase towards the end of the pregnancy Breasts feel full and may leak a clear fluid even before the delivery Steady weight gain every week Can feel move very frequently	Emotionally may be waiting for the pregnancy to come to an end and may find waiting frustrating, worrisome or depressing Feel very dependent and vulnerable May feel worried about the outcome of the pregnancy Tired easily The enlarging size of the abdomen needs adjustment in the sexual relationship in terms of positions and needs as desires change	As a husband whose wife is pregnant: Accompany your wife for her ANC check up as much as possible Spend sometime talking with your wife and when possible try to bond with your unborn child by touching her abdomen when baby moves and by talking to it try to ensure that you are available around the expected delivery date or ensure that there is someone loving and caring who will be there with your wife when she goes into labour Learn the danger signs and how to deal with them Learn the signs of labour and what needs to be done to ensure a safe delivery Purchase all the items for the delivery kit Set aside sufficient funds to pay for transport and the delivery at an institution or home Have someone help or help wife prepare the house for the new addition to come in the family If you have older child/children then give them enough attention and also explain that they will soon have a baby sister/brother to play with to look after too Plan for someone to be around and take care after the delivery too Learn how to support your wife for breastfeeding and understand that she will require support and understanding Be patient with her mood swings and a decline in sexual desires during this period and immediately postpartum

Session 2: Routine antenatal care (ANC) checks, danger signs and the safe delivery plan

Session Objectives: At the end of the session participants will be able to:

A. Explain what is routine/mandatory ANC check –up, its importance and the consequences for not attending an ANC clinic and identify barriers to access ANC services

B. Explain the danger signs during pregnancy

C. Explain what is a safe delivery plan (DP) and why couples need to plan the DP together and if possible with the health service/care provider's help

D. Explain how to help couples prepare a DP and make arrangements to ensure that the arrangements are actually made and do not stay at just the planning stage

Training Materials required for the session:

A Unfilled Copies of the ANC card used by the government and other local social service organization

B RUWSEC pamphlet material on women who require special attention during pregnancy

C Danger signs

D Family profiles

Methodology:

Present the objectives for this session

A+B. Routine ANC checks and women who require special attention **1 hour**

Open the topic with a question on what is the mandatory routine schedule for ANC checks. Let participants come out with their answers. Then sum up with the ANC schedule as prescribed in the health centre. Include some details of the process, what tests are done routinely and that the women should ask for the records of the test. (10 minutes)

Ask participants to share their experiences of ANC checks, then walk the group through the routine schedule for ANC checks that include immunization, danger signs and women who need special attention (B1) and screening/ treatment for STIs too besides clinical examination. During ANC besides routine urine and blood tests all pregnant women should try to go for a VDRL/ RPR test to rule out syphilis. If test found positive, partner will also have to undergo tests or/and given treatment simultaneously with the woman for the infection, any genital sores or abnormal discharge should be tested and treated.(50 minutes)

Activity ***1 hour***

Break up the large group into three and give each group one of the following tasks (10 minutes preparation, 8 minutes presentation by each group, 15 minutes post presentations discussion of 5 minutes each and then summing up by facilitator)

Group 1: Present the ANC check – examination, advice/counsel for nutrition and personal care and husband's active support required during the period.

Group 2: If the health facility is non functional or quality of care is lacking how would they address the issue of no or poor quality service so that the community receives what it is supposed to receive from the government.

Group 3: Explore and discuss barriers to ANC as a consequence of gender inequity and poverty. For example, work burden resulting in lack of time, lack of resources and access to it, distance and costs involved, status of woman in family and her power to make decisions, prevailing practices (mother in law /husband may say there is no need. They may feel that it was not done for mother –in-law/ mother, so no need now), lack of access to information/education (village nurse may not be making visits; not providing any information), timings of PHC not suitable, lack of transport, 'out of pocket' expenses, lack of health services, attitude of health providers: treatment of poor, especially women from marginalized groups etc.

Let participants present in the large group plug gaps and sum up. Then state that they will now discuss the danger signs during pregnancy and then what is a delivery plan and how to help couples prepare one.

C. Danger signs **45 minutes**

Divide participants into two groups and distribute the copies (C1) of the pamphlet on danger signs. Let them discuss and then present as a short role play the signs and symptoms of danger and what to do at that time. Sum up the activity asking every one to repeat the danger signs orally. State that this is another reason for couples to be prepared with an emergency obstetric plan which is much like the delivery plan but takes into account an emergency situation especially for high risk pregnancies and for those whose pregnancy turns dangerous to the woman's health suddenly.

D. Delivery plan **1 hour**

Now discuss with them what is a delivery plan. Explain that it is a simple way of preparing oneself for the forthcoming delivery and ensure everything is arranged and everyone involved knows what to do, when and how at the required time. It includes choosing a doctor or dai or institution or ANM to conduct delivery, financial arrangements, arrangements for someone to take care of the pregnant woman before, during and after delivery.

Then have them in small groups prepare a delivery plan -. A good idea would be to give each group a different profile (D1) of a couple/family that needs to be ready for delivery – profiles could each have different scenarios and also something special in each case to pay attention to when making their delivery plan. Ask the groups to present the profile and the delivery plan and let others comment. Note the delivery plans may include mini plans to be carried out in order to achieve the larger delivery plan (this could be even ideas for earning/making extra money to meet their impending expenses) (30 minutes group work and 5 minutes each group (4 groups) presentation + 10 minutes discussion)

In the large group discuss why it is important for the husband to be actively involved in all these plans (10 minutes) In the absence of the husband (in the case of single mothers or migrant workers) other care givers in the family to be involved in all these plans.

Note to facilitator: Please assemble a delivery kit to show your participants. Or do a simple exercise to help participants remember the items in the delivery kit. Assemble all items for the delivery kits and baskets as many as the number of groups who will participate. Add items like pen, band-aid, stone etc (as many as the number of groups). Let participants select items to be put in the delivery kit. For each item they select they need to explain why the item is essential for safe delivery.

Activity ***45 minutes***

Let participants in 4 small groups draw out an action plan to

Group 1: Educate the couple on danger signs and what to do in case the woman suffers any of those conditions (write a song).

Group 2: Educate the couple/community on the importance of timely ANC checks. Educate and support the couple or family to find ways to draw a delivery plan and actively carry out the plan so they are prepared in every sense for the delivery.

Group 3: Strategy to activate the health service to provide proper ANC counseling so that people are well prepared for the delivery also.

Group 4: Discuss and list out who has access to the emergency transport fund through the Panchayat Raj Institution (PRI). How to mobilize community help for transport and financial support in case of an emergency.

Note to facilitator: Get enough copies of the ANC schedule from the local subcentre or PHC and follow that schedule in the training.

Materials used for training / handout include:

A1 ANC/Maternity Card (government sector/ free social service organization clinic's ANC/Maternity service card)

B1 **PREGNANT WOMEN WHO NEED SPECIAL ATTENTION**

Conception and giving birth happen naturally. But some women face health problems during pregnancy. These women need constant/regular medical checkup/examination.

Women who had a cesarean section and had stitches for their earlier/previous delivery

Women who are very short

Women who have physical disability in their legs and hips

Women who had bleeding during pregnancy and/ excessive bleeding during their earlier pregnancy

Women who had delivery complications in their earlier delivery for example: delay in placental delivery, birth of a dead child or pre-mature delivery.

Women who have 5 or more number of children

Women who have their delivery below the age of 18 years or above the age of 35 years.

When the growth of the belly/stomach does not match with the months of the pregnancy

Women who are very lean
(Tamil pamphlet inserted)

C1 Danger signs during pregnancy

If you come across these signs seek medical attention immediately. In case of any delay there is a risk for both the mother and the child.

1. Bleeding during pregnancy – bleeding in any month during pregnancy is dangerous. Do not believe that "P*ai nirambi padugirathu*" / 'The uterus is overflowing and bleeding' or 'This is common among the women in our family' and ignore.
2. Normally there maybe vomiting/nausea during the initial three months of pregnancy but if this continues even after three months it is not okay.
3. If a pregnant woman is not able to get up from bed for days together or in case of symptoms of jaundice seek medical care immediately.
4. DO NOT IGNORE THE FOLLOWING:
   i) Continuous headache and severe THROBBING pain in the head *(mandai edi)*
   ii) Blurring of eyesight, lack of clear vision
   iii) Symptoms of eclampsia- fits
5. Swelling in the face and hands
   i) If the face of the pregnant women is swollen as shown in the picture
   ii) If there is swelling in the hands as shown in the picture
   iii) If there is swelling in the legs when she gets up in the morning

The above are dangerous, medical examination (tests) are essential in case of such conditions.

6. During the sixth or seventh month of pregnancy the mother can feel the movement of the child. If the movement stops all of a sudden it is not okay.
7. If the head of the baby is not down, if the head is up, or if the child is facing sidewards (horizontal) the delivery process is risky and the delivery should happen in the health center. These types of deliveries should not happen at home.
8. It is risky if the pregnant women suffers sudden stomach pain.
9. If there is constant fever or any other health problem seek medical attention immediately. The health problem of the mother may affect the child or may cause problems/complications during delivery.

Do not forget, if you come across the above-mentioned complications do not waste time and seek medical attention immediately.

(Tamil pamphlet inserted)

C2 Providing for a safe delivery

When talking about a woman who has delivered it is commonly said "survived after delivery" (PETRU PIYAITHAL). Even today motherhood continues to be very difficult for women (PERUM GANDAM)

What is the reason for this?

Today in spite of progress/advancement in medicine, in our villages out of 100 deliveries 80 deliveries happen at home in the absence of a medical supervision. In case of risks/complications on many occasions either the mother or the child dies before reaching the health care services.

If we really analyze the reasons for this we realize that they can easily be avoided.

How?

Generally for a delivery to be safe, one should follow certain practices/principles. Out of these the important ones are "three basic cleanliness".

1. The hands of the person who conducts the delivery should be clean
2. The umbilical cord should be cut with the help of a sterile knife

3. After delivery the women should be made to lie down on a clean cloth or a mattress. The environment and the surroundings should be clean

If we follow the above practices the spread of infections to the mother and the baby can be minimized.

Preparation

People generally feel "that is all! Okay, we will do it" – but wait/listen " Even God does not know when it will rain and when a baby will be born" – Proverb. The above mentioned three points about cleanliness should be followed without fail.

Two or three months before the delivery certain preparations should be made at home. We should not wait till the last minute. We have to collect 8 things for this.

1. Soap

This is important, as it is needed to wash the hands of the person who conducts the delivery. When you buy soap from the shop cut a fresh piece and safeguard it from rat bites and keeps it in a safe place.

2. Two small sticks

To clean the nails keep two sharp sticks.

Take two sticks of one ' jaan' * length. Sharpen the edges; the person can clean her nails before conducting the delivery.

3. Three thick strings *(Naadas)*

From a used old cloth cut three parts. Wash it using soap, put it in a bowl add water and boil it. After the water starts boiling take out the cloth, squeeze out the water and dry it in sunlight. While drying it in sunlight after hanging the cloth put a clean cloth on the top of it so that no dust or dirt sticks to the cloth. After it dries cut this into three strips of one ' Jaan'*(*NADA*) and keep it safe. Out of these three two will be used to tie the umbilical cord.

4. Blade

To cut the umbilical cord buy a new blade from the shop cut it into two parts. Check that there is no rust on the blade if you have one at home. Put this blade in boiling hot water and let in remain for 6 minutes. Dry it immediately after you take it out of the water.

5. Cotton

Buy a small packet of cotton from the shop and roll it into small balls, three or four balls will be sufficient.

6. Plastic bag

After you buy a sari or some things from the shop clean the bag and keep it safe. The five things explained above (soap, sticks, threads, blade, cotton) should be put inside the plastic bag. Heat an iron rod or knife and seal the opening of the bag. Keep this bag safe and had it over to the Dai when she comes to attend the delivery. Ask her to clean her hands and use the things provided by you and stress that she should tie the cord with thread before cutting the cord.

7. Plastic or rubber sheet

During delivery the women should be made to lie down on this sheet. Buy a one-meter rubber or plastic sheet. After delivery this can be cleaned and used for the baby. If you buy once this can be cleaned and used again.

8. Clean cloth

After delivery the women and the baby should be wiped using the cloth. For that you need 2 pieces of cloth. You can take an old sari or dhoti wash it using soap and dry it in sunlight, protect it from dust. After it dries keep the rubber sheet and the cloth safely.

The things that are essential for delivery are ready now. Please use this for a normal delivery. Do not hesitate to spend money for this preparation. By using this complication/risks can be avoided and lives can be protected.

(One jaan= the length between the thumb and little finger spread out to the maximum)*

(Tamil pamphlet inserted)

D1 Family profiles examples

Family profile 1

Ravi (40) is a landless labourer working on a small farm in the village. His wife Valliamma (36) years also works along with the neighbours for another landowner. She does the washing of utensils and clothes in that house.

They have one daughter (Kasthuri) aged 14 months born after 12 years of marriage,. Valliamma is three months pregnant and is also anaemic. She had gone the last time to her mother for her delivery but now her mother is no more and she has no home help except for her aged mother-in-law who is also weak. Ravi had had some infection in his genital area which was treated many times to return again and finally he and Valliammal received treatment together for that infection as well as syphilis a year before she had conceived Kasthuri. Valliamma had two miscarriages (in second month of pregnancy) in the first ten years of her marriage, (the second miscarriage was just before she received treatment along with her husband for the genital infections).

Family profile 2

Mohan is 23 years old and works in a nearby rice mill. His wife Shanti (17) is pregnant. They just discovered this. They are living on their own as Shanti belongs to another village far away and Mohan's father a widower has moved to another place for a live in job after his wife died. They live in a small one room hut. There is no toilet , they have to use the open spaces/fields. Water is a scarcity, there is a hand pump 100 metres away and the couple manage to survive on just 2 pots (*kodams)* and 1 bucket of water which is used for cooking, bathing and cleaning and washing purposes. Shanti is just 4 feet 9 inches tall and is slender in build.

Family profile 3

Selvi is 27 years old. She got married at the age of 19. She and her husband work as agricultural laborers. They live with their 3 daughters aged 7, 5 and 4 years, and her in-laws. Selvi's husband and inlaws blame her for having 3 daughters and ruining the family. Her husband shouts at her constantly and beats her. There is a lot of pressure on her to have a son. She is very nervous. What if she has another daughter? Will he leave her? And marry someone else? What will happen to her and her daughters.

Family profile 4

Theresa (21) and her husband (26) have been married 4 years and have 2 children – a boy and a girl. She is pregnant with their third child. This is the second month. They live in the *dalit* hamlet in Elampakkam village. Theresa's inlaws – father-in-law, mother-in-law, two brothers –in –law (one works as an electrician and the other is studying) live with them. She works in a nearby garment factory from 8 am till 5 pm. Her husband is unemployed. She has to do all the house work- fill water, clean, cook before she goes to work every morning. Similarly after returning home she has no rest. Cook, clean and feed the children. She eats last, whatever is left over – usually just rice. She adds water and chilly to it and has it. Sometimes she is so tired she can barely eat.

Note to facilitators: Prepare profiles based on the community the participants are working with or come from. Keep the background as realistic as possible. Prepare a set of at least 4 such profiles each with a different set of problems so that you can give one to each group for group work.

Session 3: Maternal nutrition during pregnancy

Session Objectives: At the end of this session the participants will be able to explain in simple language:

A. The importance of good nutrition for the pregnant woman

B. Common sources of main nutrients and consequences of deficiencies

C. How to improve/increase a pregnant woman's food intake

Training Materials required for this session:

A Five Foods song

B Chart showing Common sources of main nutrients and consequences of deficiencies

C1 Profiles of Shanti and Selvi: C2 Sample of a day's diet for the pregnant woman

Note to Facilitator: Prior to the session identify locally available sources of micronutrients. It is also very important to identify health problems as a result of nutrition deficiencies. For example, enlargement of the thyroid gland or goitre, especially in adolescence or pregnancy may indicate iodine deficiency.

Methodology:

A. Importance of good nutrition for the pregnant woman **45 minutes**

Start the session with a song on the five foods (A) or any song that tells women to eat healthy food.

Present the objectives and ask the participants about the practices that are prevalent in the community. Listen to their answers and then state that let us look at what pregnant women need and why (5 minutes).

B. Common sources of main nutrients and consequences of deficiencies **45 minutes**

Explain the foods a pregnant woman needs to ensure in her diet. (20 minutes)

- A pregnant woman will need to consume an equivalent of an additional meal everyday. She can increase the amount of food by consuming 4 to 5 small meals spread across the day.
- She should consume a variety of foods e.g. rice, wheat, grains (sources of energy), pulses (source of proteins), green leafy vegetables (source of vitamin A, vitamin C, folic acid, calcium and iron), other vegetables, fruits (source of vitamins and minerals), milk, milk products (source of calcium) available to the family
- She should increase daily consumption of seasonal vegetables and fruits . She should also consume animal products e.g. meat fish, eggs, (source of protein and B complex) if feasible and acceptable
- She must consume the iron and folic acid tablets that is given to her by the health care provider
- Using iodized salt in the preparation of her food will also ensure that she has an adequate intake of iodine.

Explain that in the absence of variety, the woman should eat more of whatever is available to her at least to give her energy. Discuss how deficiencies of micronutrients like iron, folic acid, other minerals and vitamins could lead to problems for the pregnant woman and her unborn baby (20 minutes). Use (B) chart given in training materials.

Sum up stating that to avoid these deficiencies, a pregnant woman's diet should include food items that are good sources of the various micronutrients needed by her body for her own as well as for the health of her unborn child.

C. Improving/increasing a pregnant woman's food intake **1 hour**

Now ask participants how they can (as a small group exercise) increase the food intake of the women to meet the extra energy requirements. Show them the sample meal plan (C1).

Give them the profile of Shanti and Selvi (C2). The participants can draw up the meals that these women-Shanti and Selvi might have in keeping with their family situation. Give reasons why they can or cannot eat certain things and include reasons outside the home (market/ PDS) why they may not be able to get the various items for their meals. (40 minutes)

Explore reasons for availability, affordability, accessibility for women. Women may not eat a lot of greens for example, because it takes longer to clean etc and in their very busy day, don't have the time. The amount of work, in relation to calories expended; in the case of Selvi if she is in a state that has disincentives for women more than two children. These are issues that need to be addressed when counseling families to improve the nutrition of pregnant women.

Activity ***1 hour***

Divide participants into 4 groups and ask:

Group 1: To compose a verse on the importance of good nutrition for the pregnant women and a verse on the amount of food and diversity of food she needs to consume.

Group 2: Identify ways to grow the local foods in common community land or around one's house or on the roadside.

Group 3: To compile rich sources of local and easily available low cost food that we can choose from to prepare food for the pregnant woman.

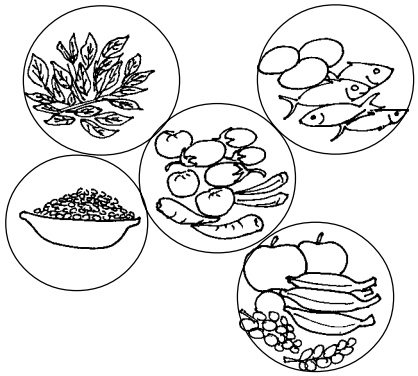
Group 4: To spell out what a family needs to do to help a woman get the foods she requires, what a community can do to educate all members on the importance of nutrition during pregnancy so that they have healthy mothers and therefore healthy babies and therefore a healthier future for their community.

Have the groups return to the large group and present. Let the other participants comment and contribute where information is lacking. Collect the complete verses to type and or use a recorder to record the song on tape for play back later. Collect the extra meal plans that the groups come up with and check for nutrition balance before copying it for all to carry and disseminate.

Materials used in the training/ handout include:

A **There are 5 basic foods *(ADIPADAI UNAVU 5 UNDAAM)***

Five basic foods
Basic foods are five
There are more nutrients in them
Nutrients in them are high
Let us eat one each daily
And live healthily (Basic foods…)
Let us eat lentils
To keep body fit and grow
Let us eat fish, eggs and nuts
Let us make a conscious choice
To live healthily (Basic foods….)
So many greens and fruits
Let us eat one daily
Let us eat different vegetables
Let us live healthily (Basic foods…)



B **Common sources of main nutrients and consequences of deficiencies**

MICRO NUTRIENTS	COMMON SOURCES FOR THE NUTRIENT	CONSEQUENCES OF MICRONUTRIENT DEFICIENCY
IRON	pulses, legumes, fish, whole grains, green leafy vegetables, dry lotus stems are a good source of iron too and so are cauliflower and turnip greens besides others. Dried fish and beef are also good sources of iron. *Note : reduce the consumption of tamarind as it inhibits the body's ability to absorb iron from the food.*	Anemia and it leads to maternal death and even perinatal death.
Folic Acid	Paruppugal (lentils), karamani and other dried beans, dark green leafy vegetables (*thandu keerai*, *karivopillai* (bay) leaves etc), cluster beans *(kothuvarankai*), ladies finger (*vendakka*i), beans, bananas, whole wheat chapattis or dallia *(broken wheat/rice)*-, beef or mutton liver, and eggs etc.	Leads to birth defects (neural tube defects), lowers immunity and also causes anemia. Birth defects caused by folic acid deficiency is of two types. One type is a partial or complete absence of the baby's brain with the result that most of these babies are stillborn or die soon after birth. In the other type the babies may lack feeling in their legs and later develop problems with walking. In addition, these children may develop problems with their bowel and bladder control. They may also have learning problems, and some may have mental retardation.
Vitamin C	Indian gooseberries (*amla*), guavas, limes, oranges and papayas are the most valuable sources of this vitamin. Fish among animal sources contains some vitamin C, pulses soaked and then allowed to germinate are a good source of this vitamin too.	Vitamin C deficiency leads to poor absorption of iron which in turn leads to anemia.
Vitamin A	Ripe papaya, mango and orange, ripe tomatoes, carrots, sepangkelazhhangu keerai, murungai keerai, methi, mullangi keerai, turnip/beet/carrot keerai, bathuva, pasalai keerai, (*keerai =greens*) mutton liver.	Vitamin A deficiency can cause anemia.
Vitamin B12	This is mostly found in animal origin food items like mutton liver (contains the most), meat especially buffalo meat, eggs, prawns and dairy products.	Anemia
Iodine	Iodized salt	Dietary iodine deficiency during pregnancy hinders development of the fetus and results in newborns with extreme forms of brain damage and physical impairment and infants who show severe forms of mental retardation. The mental retardation resulting from iodine deficiency during pregnancy is irreversible. Iodine deficiency in pregnancy is also associated with neonatal deaths, still-births and miscarriages.

C1 Nutrition during pregnancy: sample of a day's diet

Example of a day's requirement of at least 1800 calories for the pregnant woman

Early morning Milk or tea

Breakfast: 2 idli or dosai or 1 cup cooked pongal

Mid morning: Payasam made with pachcha paruppu +jaggery (provides iron, calcium and protein) 1 banana or 1 cup *sathu maavu kanji*

Lunch: 75 gms raw rice with 1 cup cooked dal, 1 cup cooked keerai and 1 cup cooked vegetables and 1 guava

Mid afternoon: 1 glass buttermilk and 1 mango (or papaya 2nd trimester onwards)

Early evening: Ragi murrungakeerai adai or rice roti with murrungai keerai

Dinner: Rice, cooked beans or (rajma or channa) and 1 cup cooked cabbage and ½ cup cooked ladies finger / *vendakai* or other vegetable

Night before going to bed 1 cup milk or sathu maavu kanji

Note: Use tomatoes instead of tamarind for sourness as tamarind inhibits the absorption of iron by the body and iron is very necessary

Avoid coffee and if possible tea also but if not possible tea is ok. (Another good option is prepare Kothumalli (Herbal) tea powder and substitute for normal tea).

The participants can be told how to prepare *sathu maavu* as the ingredients are easily available and nutritious

Kelviragu/ Ragi flour – ½ kg

Wheat flour– ½ kg

Groundnuts – 100 gms

Pottu kadalai / roasted gram– 100gms

Pasi paruppu / Moong Dal– 100gms

Cashew nuts– 100gms

Kaikuthal / hand pounded rice -100gms

Elaichi/ cardamom –for Rupee 1

Jaggery as per taste

The above ingredients should be powered and can be stored. Take two spoons of this mix with either milk and jaggery or buttermilk and salt or can be made into *kanji /*gruel.

C2 Profiles for discussion

Family profile 1

Mohan is 23 years old and works in a nearby rice mill. His wife Shanti (17) is pregnant. They just discovered this. They are living on their own as Shanti belongs to another village far away and Mohan's father a widower has moved to another place for a live in job after his wife died. They live in a small one room hut. There is no toilet , they have to use the open spaces/fields. Water is a scarcity, there is a hand pump 100 metres away and the couple manage to survive on just 2 pots (*kodams)* and 1 bucket of water which is used for cooking, bathing and cleaning and washing purposes. Shanti is just 4 feet 9 inches tall and is slender in build.

Family profile 2

Selvi is 27 years old. She got married at the age of 19. She and her husband work as agricultural laborers. They live with their 3 daughters aged 7, 5 and 4 years, and her in-laws. Selvi's husband and inlaws blame her for having 3 daughters and ruining the family. Her husband shouts at her constantly and beats her. There is a lot of pressure on her to have a son. She is very nervous. What if she has another daughter? Will he leave her? And marry someone else? What will happen to her and her daughters.

Post Natal Care (PNC) – physical and emotional care, nutrition, expectations during this stage and healthy life styles

The period immediately after delivery till 6 weeks is known as the postpartum period and the entire period till 6 months is known as the postnatal period. Care during this period is crucial to the health of the mother and the infant. In this chapter we will discuss the care for the mother and care for the infant will be covered in the chapter on Infant health.

Communities everywhere have different cultural practices some of which are good and some of which have adverse affects on the health of both mother and infant. RUWSEC has collected information on some postpartum practices in the communities they have served (read Postpartum local community practices reference collected by RUWSEC).

Although it is universally accepted that during pregnancy a woman should eat more, very little knowledge exists at large about the woman's need for more calories and nutrition during the postnatal and lactating period with the result that they are often underfed during this time leading to health problems sometimes immediate and generally long term. Women especially poor women begin work immediately- both in the home and outside. This causes health problems due to lack of proper care and rest. This is further compounded by poor nutrition. All this speaks of a crying need to educate husbands, women, and families in particular of the care of self, of the mother during the postpartum/postnatal period.

This chapter discusses the physical and emotional changes in the postpartum period, nutrition and care during the postpartum period, husband's and families role in the providing care during the postpartum period. It also covers some complications during the postpartum period.

The chapter includes the following sessions:

Session 1: Changes and care during postpartum period 3 hours 30 minutes

Session 2: Postpartum physical check up 3 hours 45 minutes

Note to facilitator: Please read the entire module on Maternal Health and in particular all the references given for postpartum care that include local practices (which you could use for discussions on whether the practices contribute to good health care or whether they contribute to health problems for the woman). Please also read the Nutrition session for Pregnancy and during lactating period along with the additional references, it will help in guiding participants when discussing nutrition.

Session 1: Changes and care during postpartum period

Session Objectives: At the end of the session the participants will be able to:

A. Explain the physical and emotional changes a woman goes through immediately after delivery and during the postnatal period

B. Give importance to proper nutrition during postnatal period

C. Explain why and how husbands can play a positive and responsible role during postpartum including the role other care givers in family have to play to improve care of the woman during this period

Training materials required for the session:

A1 Blank grid

A2 Filled grid

Methodology:

Present the objectives for the session.

A + B. Changes, care and nutrition during the post partum period. 2 hours 30 minutes

Ask participants to share (10 minutes) their experiences during their own postpartum period. Then state that during this session they will discuss what normally happens during the postpartum period and what should be the nutrition and care that a woman in this period of her life should get. They will discuss ways in which the husbands need to take responsibility and also discuss the family support required during this period.

Display the blank grid for Postpartum chart on the board or on a chart (A1).

Take the first two columns one by one and using a guided large group discussion (first ask participants to help fill the contents and then fill the gaps using the filled chart as reference) fill the first two columns. (30 minutes)

Now divide participants into two groups and give them one of the following tasks (50 minutes: 20 minutes to discuss and prepare their presentation, 5 minutes each to present and 10 minutes for comments and clarifications and 10 minutes for facilitator to sum up).

Group 1: Assess the current local community practices with regard to nutrition during the postpartum period. Refer (A3). Do the local practices help improve the health of the woman? If yes how? If not why?

Is there an anganwadi centre that caters to the women from these hamlets? If Yes, is it functional ? State in simple language the nutritional needs for the postpartum women.

Group 2: Assess the current practices regarding the restrictions forced on postpartum women (take related sections from the "postpartum local community practices" gathered by RUWSEC), also include here the expectations of the local communities from the postpartum women with regard to her work unpaid and paid at home and outside home during this period.

Do the practices help improve the health of the woman? If yes how? If not why?

State in simple language the care needed for the postpartum women.

Call them back in the large group and ask the groups to present. Let others comment. Use the statements to fill column 3 and maybe some of 4 in the grid. Ask whether the participants know about the governments' support to postpartum women at the anganwadi centre for food supplements. If not inform them that they need to check with the local sub centre and anganwadi center for that provision. State that postpartum women need more food to help replace the nutrients lost during pregnancy and child birth and for maintaining her own health during lactation. She also needs to have plenty of fluids to keep her body flushed of toxins and quench her thirst.

Discuss in the large group the role husbands and other family members have to play in the postpartum care of their wives /women and fill the column on the grid with their answers.

Fill the gaps using the filled grid (A2) for reference and clarify doubts. Post the final filled version on the wall for reference.

Activity ***1 hour***

Divide participants into 3 groups. To each group give one of the following tasks *(* 30 minutes to prepare, 10 minutes each to present and 10 minutes for clarifications and summing up)

Group 1: Develop a skit or verses for a song that covers the changes that happen for a women when she has delivered a baby, the nutrition and care that she needs during this time, and the husband's role or role of other members in caring for the mother and the baby.

Group 2: Develop a daily meal plan for the woman (sample for a week) from locally available foods including some of the good nutrition practices already existing such as *laddoos and kozhambu* etc. The daily requirement is more than that required for pregnant women.

Group 3: Plan a campaign to create awareness in the community to treat postpartum women better: create support through the mahila mandals, encourage women to save earlier through SHGs for the period so that they do not have to work immediately/encourage SHGs to set up a fund for this, access maternity funds from labour department, activate the government services to provide appropriate postpartum care.

Materials used for training / handout include:

A1

Postpartum checks	**Physical and emotional changes**	**Nutrition needs and physical care**	**Care- husband's role and family support**

A2

Postpartum checks	Physical and emotional changes	Nutrition needs and physical care	Care- husband's role and family support
Check for delivery of placenta. Check whether the postpartum bleeding is not turning to hemorrhage (about ½ ltr). Check to avoid or treat eclampsia (Coma and convulsions during or immediately after pregnancy, characterized by edema, hypertension, and the presence of excessive amounts of protein in the urine). Tears that need stitches. Check for any uterine infections if problems in urinating. Fever and other warning signs (refer chart on warning signs during the postpartum).	Will lose as normal the extra fluid collected by the body through frequent urination and sweating. Bloody vaginal discharge that changes to brown, then whitish over the couple of weeks after delivery. A tender vaginal area. Painful contractions that continue after delivery - as the uterus returns to its original size. Breast engorgement - as milk production begins. Extreme fatigue and soreness are common in the first few weeks. At first urination may be difficult because of slack muscle tissue or other factors. Try to urinate the first few times. If painful while having a bath and pouring warm water water over the perineum to start the flow. Difficulty and pain in the perineum when trying to pass stools due to pressure for bowel movements. Thirsty during breastfeeding. Breasts may feel tenderness or engorged at times. If improper positioning for breastfeeding may feel pain while trying to feed baby. Some women suffer from postpartum depression (read additional reference: Caring for Mother postpartum) Sexual activity differs from woman to woman and from couple to couple but since the perineum will be sore and the woman would feel tired due to lack of proper rest and sleep she may feel disinterested in resuming sexual inter course and may nor may not appreciate other forms of non intrusive sexual activities.	Avoid constipation by eating fresh fruits and vegetables and whole grain cereals and drinking plenty of water. Continue to eat healthy balanced diet like during pregnancy and increase the quantity to one more meal or a snack to add more calories and replace loss of nutrients. (refer sessions nutrition during pregnancy and nutrition during breastfeeding). Maintain good personal hygiene it will keep away infections. Rest and sleep whenever possible. Do not carry heavy loads. Try to do your pelvic floor exercises to avoid weak pelvic muscles later that may cause a prolapse. Use clean cloth for absorbing postpartum bleeding (lochia). If requiring contraceptive method although you will breastfeed exclusively, speak to your care provider to help you have an IUD inserted around 6th week postpartum if have not done so immediately after delivery or better still motivate your husband to use a condom when you resume sexual intercourse. If you had been treated for infection during pregnancy then you and husband must return for follow-up check and practice infection preventive measures.	Try to be with wife or immediately after delivery at least. Show concern for her physical and emotional state. Speak and reassure her in gentle tones. Avoid violent speech or behaviour at any cost. Arrange for someone who cares and who does not upset your wife to take care of her. Ensure that trained person has checked her after the delivery and everything is alright. Arrange for the registration of the birth if you have to do it, normally the institution or the trained birth attendant will carry this out but you will need to collect and preserve the birth certificate. Arrange for your wife to have good nutrition and if culture demands otherwise, explain that you want her to be healthy and continue to see that she has enough to eat and is rested. Appreciate that she is sore from the trauma of birth and do not pressurize her into resuming sexual intercourse, express your feelings in a non intrusive way if acceptable to her. Keep her happy at all times and help her breastfeed the baby by learning how to handle the baby to burp the baby after feed. Spend time trying to take care of your new born as well as older children if any. Just as in pregnancy continue to do any heavy lifting work so that she does not have to do it. Insufficient rest and lifting of heavy loads may cause uterine prolapse and other health problems, early in the postpartum during bleeding it may cause hemorrhage.

A3

Some Post partum care –practices prevalent in the community where RUWSEC works

Salava kuzhambu – (cleans the uterus)

Period of use: from day 3 till 9/11/13/15 till the day 'the hair is washed'- bleeding stops.

Ingredients

Dry ginger, Pepper, Vaal milagu, Kaduurni, Nutmeg –Jaadikai, Maasikai, Black cumin, maavalingapattai, adimathuram and akravarampattai To be fried to golden brown, to powder and filter with a cloth. One handful given to the dai, 2 handfuls to the woman. The remains in the cloth after filtering is made into a 'kuzhambu' – gravy. Other ingredients/vegetables added are: Broad beans – avarakkai, Brinjal and drum sticks which are tender (pinj) are added to the kuzhambu to avoid constipation.

For the first three days only black coffee, *varki, rusk,* bread, biscuit (Marie) used to be given. Nowadays *idli and idiyappam* is given. It is believed that this is to promote normal bleeding. If the woman eats (especially spicy and heavy food) '*udiram thangidum'*- bleeding stops/remains inside**.**

Earlier on 3rd day-2 meals, 4th day –1 meal i.e. every alternative day 2 meals on odd days followed by one meal on even days, to be eaten before 7 pm. This practice is largely discontinued now. If the woman feels hungry/feels like eating anything, 'paddy is heated in a hot pan and pops to give nellu pori'. **A** small piece of Aesofoetida is given after all meals, every day.

Not to eat – Mango- to prevent maandam /cramps. If the child has "karuppu noyi" blue baby the mother should not eat garlic and turmeric for a month. Should not eat any varieties of dhal, fruits, coconut. Basically no intake of protein in the diet

Water is given to drink only after the meal. Even if the women feels thirsty she is not given water to drink. There is a belief that it will cause puss cells and lead to infections. This practice continues for a month.

Not much chilly dhania is used. The food restrictions continue till 3 months after delivery. Fish that has less fat content is given i.e. varieties like karapodi, suthumbu kara podi, pachi kutty, podi era and velli odan are fed to mother. Women should not eat root vegetables as it has gas content. 15 days after delivery – mutton (*aat kaal* soup) and two pieces of *aatu* curry (mutton). Chicken not allowed as high fat content

Believe - Should not eat in front of others – to prevent 'evil eye' / *nazar lag jaayega*

After 3 months the women can include garlic, turmeric, water and all varieties of kirai (only in the morning diet)

The women is given hair wash on alternate days. Oil is heated using the following ingredients: javari odu, kalaka veru (local herbs). The women do not get involved in any activity so she is given less food – belief.

Prasava nadagaya leghiyam

Readily available in traditional medicine *naatu marundu* shop – Rs 50-70 for one container – used as a health supplement. It contains Ghee, *Tipli*, wheat and pepper – to prevent joint pain and general health.

Bathing (from the first day till 9/11/13/15-till bleeding stops)

Herbal bath (antifungal) , relaxes the body, free from itch to clear the uterus.

Eucalyptus, *Nocchi* leaves, Neem leaves, *Taidaali*, Nona leaves are added to water and boiled. The woman is assisted by two others to press her lower abdomen and this water while its still very hot, is thrown on the stomach with great force 3-5 times. One glass of this liquid is kept aside at the beginning for the mother to drink. After the bath Incense/ *sambhrani'* is lit. The woman is not allowed to sleep after the bath during the day.

Water is boiled with *kadukkai.* This water is used to clean 'the vaginal area' and legs etc after urination or excretion.

In case Perineum tear *Avinjili* leaves, *Kappa* turmeric, rock salt are boiled and cooled and applied on the tear. This numbs the pain.

Session 2 : Postpartum physical check up

Session Objectives: At the end of the session participants will be able to:

A. Explain the need for postpartum check up and list what needs to be checked
B. Explain the danger signs during the postpartum period
C. Explain the pelvic floor exercises to tone the pelvic floor muscles and avoid complications such as uterine prolapse later
D Postpartum contraception

Training materials required for this session:

A Pictures of delivery, including delivery of placenta
B Warning/ Danger signs
C Pelvic floor exercises
D Postpartum contraception (refer Lactation chapter) + chart for initiating time for methods

Methodology:

Present the objectives

A. Postpartum check up and list what needs to be checked **1 hour**

Ask one of the participants to recap from the earlier session the checks during the postpartum period.

Reiterate that postpartum care should respond to the special needs of the mother and should include: the prevention and early detection and treatment of complications and disease, and the provision of advice and services on breastfeeding, birth spacing, immunization and maternal nutrition. Use (A1) to quickly sum up the key elements in postpartum care.

Using the pictures (A2) explain that the delivery of the placenta takes place in the third stage of labour. Explain that the placenta supplies the baby with nutrients during the pregnancy by absorbing the nutrients from the blood. The placenta has a maternal surface which is attached to the mother and looks a bit like liver. This is localized to one area of the uterus and thins out at the edge becoming the membranes. The baby develops inside these membranes or sac. There is therefore a fetal surface and a maternal surface. The placenta does not always come out in one piece and this may give rise to bleeding, infection or the need for a curette after delivery.

Sometimes in normal deliveries the abdomen is gently massaged to help the uterus expel the placenta but this can be done only if the uterus is felt like a hard round mass, *if the uterus feels as soft and flaccid* DO NOT MASSAGE AS IT MAY CAUSE THE UTERUS TO INTROVERT AND IS FATAL FOR THE WOMAN. When the placenta is delivered usually in about 20 minutes to 30 minutes, check to see if the placenta is complete (A). If pieces of the placenta seem to be left behind in the uterus and there is hardly any bleeding then the woman should be taken to a hospital for immediate attention.

B. Danger signs **1 hour**

Explain that the bleeding after delivery is normal although if the woman bleeds almost half a litre of blood it is dangerous and she should be rushed immediately to the hospital or she may die.

Now display the chart showing warning signs during postpartum period (B) and taking each warning sign discuss it with the participants. Let participants share any experiences they had related to that warning sign and how it was managed. Go through the entire list in the same manner and ask one of the participants to sum up what has been covered.

C. Pelvic floor exercises **30 minutes**

Now ask participants to share what they know about pelvic floor exercises (C). First explain what pelvic floor means. Then explain that consciously trying to contract and release the muscles in the pelvic region helps to tone the muscles and keep them in good condition. These exercises after delivery help the uterus and the muscles in the pelvic region tone up and revert to pre pregnancy stage, it will help the woman avoid uterine prolapse along with other precautions such as not carrying very heavy loads soon after delivery and later when there is a need to carry a heavy object use the correct position for carrying the weight needs to be followed.

Ask participants to try to exercise their pelvic floor muscles by simply contracting and releasing the muscles without inserting fingers or anything. This will help them understand how it feels.

D. Postpartum contraception **45 minutes**

Now explain that fertility returns to normal around 6th week postpartum once the uterus has returned to normal position and size. A woman who is not breastfeeding or one who is not breastfeeding regularly keeping all three LAM critieria is at risk of getting pregnant and therefore must use another method of contraception to delay another pregnancy. All breastfeeding women should avoid hormonal methods as it interferes with breastmilk production. The best options are LAM (for first 6 months), condoms, diaphragms, spermicides and IUDs during this period. They could use any one of the methods mentioned along with practicing LAM. Explain that however only the condom provides dual protection that is protection from pregnancy as well as from most sexually transmitted infections.

The methods are discussed in detail in the “breastfeeding and contraception” session in chapter 3 of this module on Maternal Health. However ask participants to state what they know about postpartum contraception and discuss the timing for starting any of the postpartum methods. Use the chart (D) on when methods can be initiated postpartum

Activity ***30 minutes***

Divide participants into two groups and give them the following task

Group 1 : To develop a few verses to educate the husbands/in laws/community about danger signs during the postpartum period.

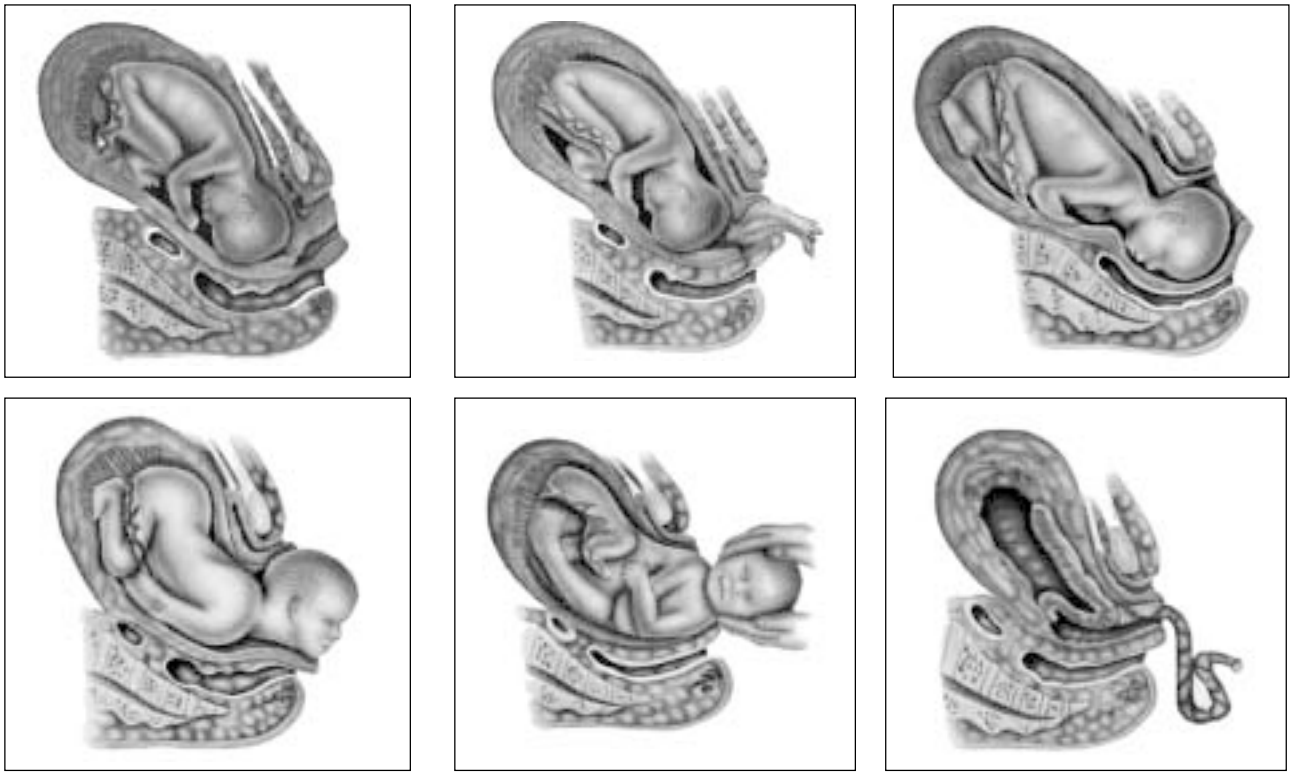
*Group 2 :*To develop a plan to explain to women's groups about the need for proper check up during the postpartum period and to explain how to do the pelvic floor exercises to tone the muscles and avoid prolapse.

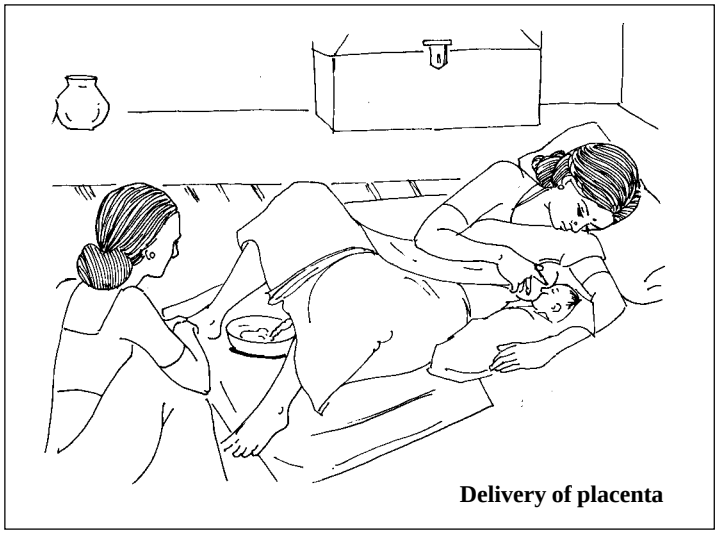
Materials used for the training / handouts include:

A1 **Key elements of postpartum care**

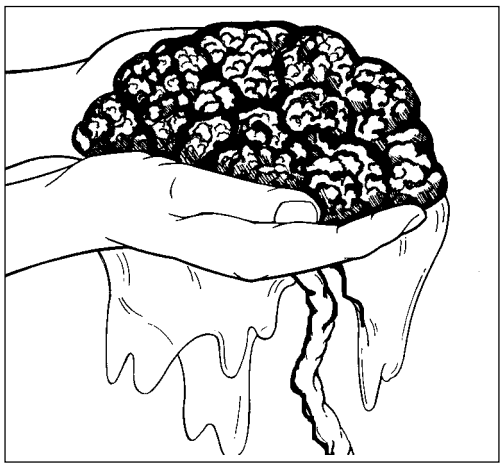
6-12 hours	3- 6 days	6 weeks	6 months
blood loss, pain, BP, advice/ warning signs	breast care temperature/infection lochia (the normal uterine discharge of blood, tissue, and mucus from the vagina after childbirth) mood	recovery anaemia contraception	general health contraception continuing morbidity

A2 **Delivery including that of placenta**





Delivery of placenta



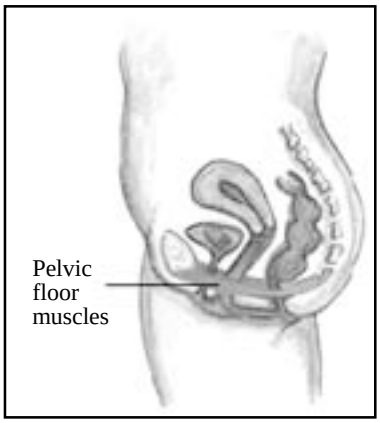
B **Warning Signs during Post Partum : signs that health workers should look out for/ask about or women themselves may report about**

Warning signs	Possible problems
Fever	Uterine infection Bladder /kidney infection Breast infection-mastitis Other illness
Burning with urination or blood in the urine	Bladder infection
Inability to urinate	Swelling or trauma of urethral sphincter (a muscle which surrounds, and by its contraction tends to close, a natural opening; as the sphincter of the bladder)
Swollen, red, painful area on leg (especially the calf) that is hot to the touch	Thrombophlebitis- development of blood clot in blood vessel (do not massage)
Sore, reddened, hot painful area on the breast(s) in addition to fever and flu like symptoms	Breast infection-mastitis
Passage of large red clots, pieces of tissue, or return of bright red vaginal bleeding after the flow has decreased and changed to brownish pink or yellow	Retained fragment of placenta Uterine infection Overexertion
Foul odour to vaginal discharge, vaginal soreness or itching	Uterine infection Vaginal infection
Slight opening of cesarean incision;may be accompanied by foul discharge and blood	Infection of cesarean incision
Feeling depressed, uncontrollable crying, inability to sleep or eat, extreme anxiety or agitation	Past partum depression

C **Pelvic Floor Exercises (Kegel Exercises)**

Pelvic floor exercises help prevent prolapse by strengthening the muscles that support the pelvic organs. The exercises are easy and quick to do but it's important to do them correctly, Start by locating the muscles you need to exercise. There are a few different ways to do this:

1. Place one or two fingers in your vagina and squeeze your muscles until you can feel your vagina tighten around your fingers. These are your pelvic muscles.
2. Imagine you're trying to stop the flow of urine mid-stream. The muscles you tighten (contract) are your pelvic floor muscles.
3. The other way to identify the correct muscles is to imagine you are trying to stop yourself from passing gas. The muscles you squeeze to do this are your pelvic muscles.



Once you've identified the correct muscles you're ready to begin. The exercises can be done while lying down, sitting or standing, with your knees together or slightly apart.

Set 1 - Slowly tighten your pelvic floor muscles and count to four, then let the muscles relax for a count of four. As your muscles get stronger gradually increase the count to 10. Try to repeat this 10 -15 times.

Check that you're not tightening the muscles in your legs, abdomen or buttocks, as it's important to use only your pelvic muscles. Remember to keep breathing.

Set 2 - Now tighten and relax your pelvic muscles as quickly as you can, again 10 - 15 times.

As a preventive measure, try to do the exercises two or three times a day. If you have a prolapse, you may be advised to increase the number of times you do the exercises, but don't overdo it. Excessive exercising of the pelvic muscles can cause muscle fatigue and make the exercises less effective.

You can do the exercises anywhere, anytime, but studies show that when women do them at home, they are more likely to do them correctly. Some women find it helps to set aside specific times to do the exercises, such as before getting out of bed in the morning and before going to sleep at night.

D Initiation of postpartum contraception

LAM	Immediately keeping all three criteria for 6 months duration only
IUD	Within 48 hours after delivery or anytime from 6th week postpartum after ruling out pregnancy
Condom	On resumption of sexual relations
Spermicide	On resumption of sexual relations
Diaphragm	After 6th week postpartum
Sterilization	For the woman immediately after delivery or anytime after six weeks postpartum after ruling out pregnancy. For the man anytime but must use a condom or another contraceptive for 3 months after sterilization to ensure that sperms left in the ducts after the procedure are flushed out or not capable of fertilizing an ovum

Additional Reference Reading for facilitators:

1. Training for TBAs :An illustrated guide: WHO

2. Postpartum care of the mother and newborn: a practical guide (Department of RHR :WHO: Maternal and Newborn health)

It is usually a joyful event when a woman gives birth to a baby she wants. Despite the pain and discomfort, birth is the long-awaited culmination of pregnancy and the start of a new life. However, birth is also a critical time for the health of the mother and her baby. Problems may arise that, if not treated promptly and effectively can lead to ill-health and even death for one or both of them. Nonetheless, the postpartum period is often neglected by maternity care. The lack of postpartum care ignores the fact that the majority of maternal deaths and disabilities occur during the postpartum period and that early neonatal mortality remains high.

In the postpartum period, women need:

Information/counseling on- care of the baby and breast feeding :

- what happens to their bodies - including signs of possible problems
- self care - hygiene and healing
- sexual life
- contraception
- nutrition

Support from :

- health care providers
- partner and family: emotional, psychological
- health care for suspected or manifest complications
- time to care for the baby
- help with domestic tasks
- maternity leave
- social reintegration into her family and community
- protection from abuse/violence.

Women may fear:

- inadequacy, isolation
- loss of marital intimacy and constant responsibility of caring for the baby and others

Maternal health during postpartum

The postpartum period, or puerperium, starts about an hour after the delivery of the placenta and includes the following six weeks. Postpartum care should respond to the special needs of the mother during this special phase and should include: the prevention and early detection and treatment of complications and disease, and the provision of advice and services on breastfeeding, birth spacing, immunization and maternal nutrition.

Postpartum haemorrhage is the single most important cause of maternal death. It kills 150 000 women each year and nearly nine out of ten of these deaths take place within four hours of delivery. A woman who is anaemic is usually less able to cope with blood loss than a woman who is well nourished. During the first hours after the birth, the care-giver has to make sure that the uterus remains well contracted and that there is no heavy loss of blood. If the bleeding is particularly severe blood transfusion may be the only way of saving a woman's life.

Puerperal infections such as sepsis are still major causes of maternal mortality in many developing countries. Fever is the main symptom and antibiotics the main treatment, though prevention by ensuring cleanliness and hygiene at delivery is obviously the best course of action.

Eclampsia is the third most important cause of maternal mortality worldwide. A woman suffering from eclampsia or severe preeclampsia the first days postpartum should be hospitalized. The treatment of choice is magnesium sulphate.

Other common postpartum complications include urinary tract problems such as infections, urine retention or incontinence. Many women also experience pain in the perineum and vulva for several weeks, especially if there was tissue damage or an episiotomy during the second stage of labour. The woman's perineum should be regularly inspected to make sure it is not infected.

Psychological problems in the postpartum period are also not uncommon. These problems can be lessened by adequate social support and support from trained care-givers during pregnancy, labour and postpartum period.

The nutritional status of the woman during adolescence, pregnancy and lactation has a direct impact on maternal and infant health in the puerperium. Women's intake postpartum should be increased to cover the energy cost of lactation. The three main vitamin or mineral nutritional deficiencies in the postpartum period are iodine deficiency disorders, vitamin A deficiency and iron deficiency anaemia. The main causes of micronutrient malnutrition are inadequate intake of foods providing these micronutrients and their impaired absorption or utilization. Preventive and treatment measures include ensuring regular intake of appropriate foods, food fortification, giving supplements to pregnant and lactating women and infants and children.

Mothers need help and advice on how to breastfeed. Supplementary feeds should be avoided. During the postpartum period women need counseling on contraception.

The postpartum period is an important opportunity to counsel women, their partners and their families about the decision to carry out an HIV test if the opportunity was missed during pregnancy. If a test is positive, counseling needs to be given on possible treatment or preventive measures. In many resource-poor settings, the risks of diarrhoeal disease or malnutrition due to improper or inadequate preparation of artificial milk outweigh the risk of contracting HIV through breastfeeding. Maternity services should take the necessary preventive measures to protect health care workers and mothers against infection.

All mothers should be immunized with at least two doses of tetanus toxoid to protect both themselves and their newborns. The third dose is given 6 months after the second and the last two doses are given after at least one year or during a subsequent pregnancy.

Postpartum services should be based on the needs and health challenges outlined above, incorporate all the essential elements required for the health of the mother and her newborn, and should be provided in an integrated fashion. Skilled care and early identification of problems could reduce the incidence of death and disability, together with the access to functional referral services with effective blood transfusion and surgical capacity. With regard to timing of postnatal visits, there seem to be "crucial" moments when contact with the health system or caregiver could be instrumental in identifying and responding to needs and complications. These can be resumed in the formula (which should not be interpreted rigidly) of "6 hours, 6 days, 6 weeks and 6 months".

There is a need to provide a solid infrastructure for the provision of a service which is comprehensive, culturally sensitive and which responds to the needs of childbearing women and their families. Elements of this infrastructure include policy, service and care provision, tool development, training and human resource issues, health protection and promotion and research.

Breastfeeding (Lactation)

Breastfeeding saves lives. Both the mother and infant benefit from breastfeeding. This chapter on breastfeeding covers the benefits of breastfeeding for the mother and child. It provides participants with the necessary knowledge and understanding to appreciate the importance of breastfeeding, how it works and the importance of correct position and attachment for breastfeeding to be a painless enjoyable experience for baby and mother. It educates participants on the nutrition needs of the lactating woman. It addresses prevalent cultural practices that compromise breast feeding; common problems that may arise during breastfeeding and how they can be resolved; how exclusive breastfeeding can be carried out by working mothers in a supportive environment.

This chapter has six sessions:

Session 1: Why breastfeeding is important, when to begin and why. How does breastfeeding work and how to help women with problems 4 hours

Session 2: Definitions of colostrum and exclusive breastfeeding, and when to start complementary foods 2 hours

Session 3: How working women can exclusively breastfeed their babies, how to express & store breastmilk and how to feed the baby using a cup 2 hours 30 minutes

Session 4: Maternal nutrition during lactation 2 hours

Session 5: Breastfeeding as a contraceptive method (LAM) 2 hours

Session 6: Lactation counseling and community education 2 hours

Note to facilitators: Please note this chapter is only the preliminary and it would be desirable for organizations to have their facilitators undergo formal training on breastfeeding and complementary feeding through trained or approved trainers from organizations like BPNI which is a key resource organization for breastfeeding training and promotion in India. In the absence of that training, facilitators are requested to read, observe and practice helping families prepare for breastfeeding, help and support women who experience breastfeeding problems. This practice will then help the facilitator conduct the sessions better.

Essential reference reading for facilitators is "Breastfeeding and Complementary Feeding – A guide for Doctors" BPNI 2000

Session 1: Why breastfeeding is important, when to begin and why. How does breastfeeding work and how to help women with problems

Session Objectives: At the end of this session participants will be able to explain in simple language:

A. Why breastfeeding is important and When to begin breastfeeding and why
B. Anatomy of the breast and how breastfeeding works
C. Correct position and attachment at the breast for breastfeeding

Training materials required for the session:

A Benefits of breastfeeding
B Anatomy of the breast and physiology
C Pictures – Correct and Incorrect positioning at the breast for feeding, doll,

Methodology:

Present the objectives.

A. Why breastfeeding is important and When to begin breastfeeding and why 30 minutes

Ask participants Why is breastfeeding important? Use two flip chart sheets or draw a line to divide the writing board in two halves and write Benefits for mother on one side and Benefits for baby on the other column. Guide participants to fill up the columns (A). Now picking up on benefits, ask participants when should mothers begin to breastfeed and why. Let participants volunteer answers and quickly sum up that breastfeeding should start preferably within half an hour to one hour of birth and explain the reasons for this relating to the benefits for the mother in expelling the placenta and the baby's activeness during that period. Also explain that a delay in initiating breastfeeding will cause problems for the baby and the mother. For the baby it will cause problems due to artificial feeding and nipple confusion if bottle fed, for the mother it will cause engorged breasts leading to blocked ducts and mastitis later.

B. Anatomy of the breast and how breastfeeding works 1 hour 30 minutes

Now explain to the participants that in order to understand breastfeeding it is important to know the anatomy and physiology of the breast and how breastfeeding works. This knowledge will help dispel many myths and doubts too.

Draw the outline of the female breast large on the board and mark the external features. Ask participants to supply you with the local terms for those parts. Then using a different coloured chalk or marker, mark the inner anatomy (B) and then name all the parts the outer then the inner parts. (external:areola, nipple; internal: milk secreting cells, milk ducts)

Taking one part at a time, starting from the outer to the inner most ask what the function could be and then explain the physiology.

Explain that the breast consists of milk producing and secreting glands within a mass of soft supporting tissue and fat. The size of the breast does not increase or decrease the number of milk producing and secreting glands in it as all women have the same amount of glands.

Explain briefly how the breastmilk is produced/secreted. When the baby suckles at the breast, messages/impulses are sent to the brain; the brain releases hormones; these hormones work continuously to produce the milk. If the baby suckles more, the breast will make more milk. If the baby stops suckling or if he never starts, the breast stops making milk.

These hormones also make the uterus contract hence mothers are encouraged to breastfeed within ½ hour –1 hour after delivery as it helps delivery of the placenta [afterbirth]. These hormones also suppress ovulation. (Refer Lactational Amenorrhea Method (LAM) later in the chapter for details)

Effective working of these hormones depends on:

- Physical factors: suckling by the baby, including correct attachment at the breast
- Psychological factors: the mental health of the mother. For example, thinking of the baby lovingly – the sight and sound of the baby promote secretion of milk. Anxiety, stress, depression, lack of confidence (if mother feels breasts too small for example), hinder the process.

Now ask participants to explain in their own language what they understood and or point out to each part and ask them to state what it is and what is its function and how does it function.

Note: Participants must be clear on the anatomy and physiology of the breast in order to fully understand why the correct positioning is important for breastfeeding successfully.

C. Correct position and attachment at the breast for breastfeeding **1 hour 15 minutes**

Then ask participants whether all mothers especially first time mothers find it easy to succeed at breastfeeding. Listen to their answers and then sum up saying that for some women breastfeeding is not that easy, they complain of pain in the nipples when feeding and some feel their breasts do not have enough milk etc. But all mothers can learn how to breastfeed successfully.

Then using a baby doll show how to position baby for feeding. Explain using your fist the open mouth attachment at the breast and show pictures to make this clear. Go through the key points to be followed for correct attachment at the breast. Then show or have your co-facilitator show the different positions of holding a baby that a mother can use – lying down, sitting or standing for breastfeeding. Explain the important points to be noted to ensure that the baby is held in a correct position to facilitate ease in breastfeeding.

Get participants to practice how to hold baby pass the doll around so your participants get a chance to demonstrate the way to hold baby. Post on the wall the important points to remember the position and attachment to the breast for breastfeeding (C1).

Now ask participants to reflect on the anatomy of the breast and then explain what happens when the attachment at the breast is not correct. Explain what physical problems incorrect attachment and position can cause for the mother and the baby.

Ask participants whether they or women they know have had other problems that interfered with breastfeeding successfully. Guide the answers to focus on cracked /sore nipples and engorged breast or other issues like being tired or angry or frustrated (C2).

Activity ***45 minutes***

Divide participants into 3 groups and ask

Group 1: To refine the song on breastfeeding (C3) to ensure the message is complete on the importance of breastfeeding and the timing of when to initiate breastfeeding.

Group 2: To draw up a plan on how to educate couples and women in the family on the correct position and attachment for breastfeeding. They can use the important points for checking whether the attachment and position are right to become two verses of the song on breastfeeding.

Group 3: To plan a campaign on importance of breastfeeding.

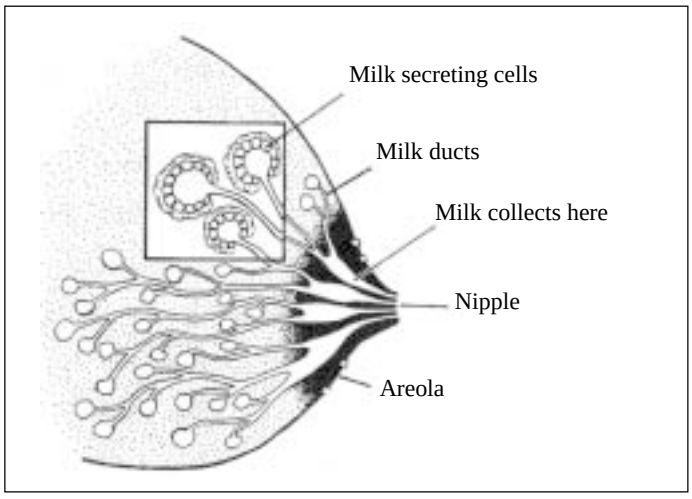
Have the groups return to the large group and present. Let the other participants comment and contribute where information is lacking. Collect the correct complete verses to type and or use a recorder to record the song on tape for play back later.

Materials used for training/ handouts include:

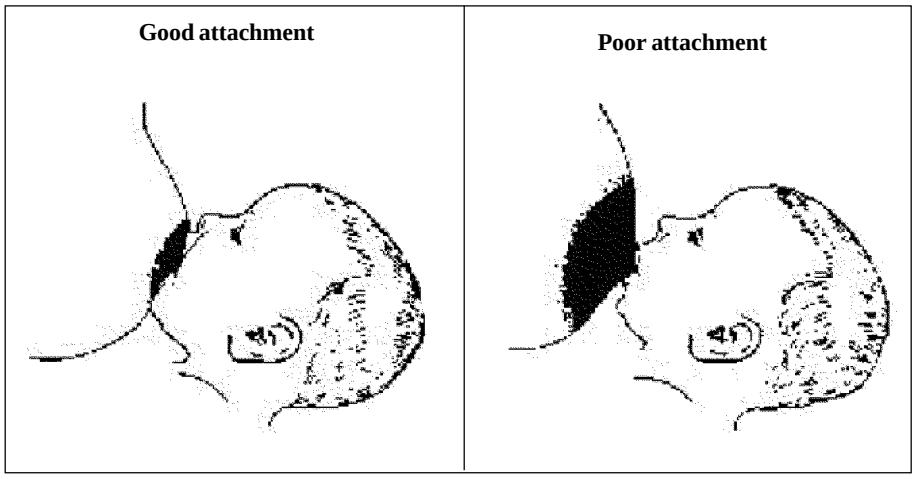
A **Benefits of breastfeeding**

For babies	For mothers
It enhances emotional bond between child and mother, providing warmth, love and affection more than just food alone	It promotes early involution of the uterus due to the oxytocin release
Breastfed babies have been shown to have a higher intelligence	Reduces anemia due to reduction in postpartum bleeding and reduced blood loss due to delayed return to menstruation
Breastfeeding provides clean, nutritious food for the infant in the right temperature	Obesity is less common among mothers who breastfeed as it helps her regain her normal figure
Breastfeeding enhances brain development	It has a protective effect against breast and ovarian cancers
Breastfed babies are less prone to asthma and other allergic disorders	Exclusive breastfeeding has a contraceptive effect for 6 months postpartum
Breastfeeding protects the child against several infections including diarrhea, and respiratory infections and many chronic problems like hypertension, diabetes and heart disease etc.	Mothers who exclusively breastfeed their babies are better adjusted to their children as far as rearing and behavioural adjustments are concerned
Breastmilk contains the right kind of proteins, fats lactose, vitamins, iron, minerals, water and enzymes in the amounts necessary for the infant	
Iron in breastmilk is better absorbed and breastmilk contains more water soluble vitamins like A, C, E and D	

B **Outline of breast**



C1



Correct positioning is very important for breastfeeding success. Incorrect positioning leads to inability to hold a good attachment at the breast which would result in pain during breastfeeding and a unsatisfied infant struggling to get enough milk.

The following signs indicate a good body position for breastfeeding:

- Baby's head and neck is straight
- Baby's body is close to mother with whole body facing the breast
- Baby's whole body is supported
- Baby is relaxed

Attachment at breast is important and correct position facilitates correct attachment for feeding.

- Baby's chin is close to the breast
- Baby's tongue is under the dark portion that surrounds the nipple and the nipple is against the roof of baby's mouth
- Baby's mouth is wide open and the lower lip is turned outwards
- Less of the dark portion surrounding the nipple is visible below the baby's mouth than above it.
- Nose should be free
- There should be no pain in the nipple area during breastfeeding

If one or more of the above signs are not present, then the baby is poorly attached for breastfeeding.

C2 Cracked or sore nipples are caused when baby is incorrectly attached at the breast so suckles only on the nipple. Correct baby's attachment to latch on the breast for suckling. For cracked or sore nipples do not apply any cream or medication. A little of the milk that comes at the end of a feed needs to be applied on the sore/cracked nipples to heal them. Do not use soap and water to keep washing the breast and nipple it will strip it of natural oils and make the condition worse. Wash in plain water.

Fullness of the breast is a frequent problem. The engorged breast is tight, shiny (because of edema) and very painful. Also the milk may stop flowing. An engorged breast if not attended to creates a vicious cycle that worsens the condition. This is because the baby cannot feed in the correct position because of a tight and painful breast and also the mother avoids feeding because of pain; which leads to inadequate emptying of the breast, decreased production of milk and sometimes infection.

The common causes of engorged breasts are:

- Other feeds given before breastfeeding,
- Delayed initiation of breastfeeding,
- Long intervals between feeds,
- Early removal of the baby from the breast
- Inadequate emptying of the breast
- Bottlefeeding
- Restrictions on breastfeeding

Engorgement of the breast can be prevented by:

- Avoiding prelacteal feeds,
- Rooming in of the baby,
- Unrestricted and exclusive breastfeeding on demand
- Feeding in the correct position.

Once engorgement occurs:

- The baby should be breastfed frequently followed by expression of breastmilk.
- If pain and tightness of the breast are severe, expression of milk may help relieve pain and allow breastfeeding.
- Warm compresses may also help alleviate pain.
- If suckling is impossible, expressed breastmilk may be given using a cup and frequent expression continued until the mother feels comfortable and there is no engorgement. Engorged breasts may cause a mild fever (milk fever) in the mother, which subsides spontaneously within a day or two.

C3 Mother's milk is the best

In mother's milk
There are a lot of nutrients
Sufficient feed of mother's milk
No germs are present

Mother's milk is pure
Easily available dear
To control spread of diseases
Feed children with mother's milk

Mother's milk
Easy to digest for the baby
For the growth of the brain
Give colostrum to the baby
To strengthen relationship
Between the mother and child
Feed breast milk
For growth of children
Feed breast milk

(Source : THAAI PALE SUTHAM AMMA : RUWSEC)

Session 2: Definitions of colostrum and exclusive breastfeeding, and when to start complementary foods

Session Objectives: At the end of the session the participants will be able to explain in simple language:

A. What is colostrum
B. What is exclusive breastfeeding
C. When to start complementary foods while continuing breastfeeding

Training Materials required for the session:

A What is colostrum
B What is exclusive breastfeeding

Methodology:

A. What is colostrum **20 minutes**

Ask about the infant feeding practices prevalent in the community immediately after birth for the first few days. Then explain what is colostrum and why is it necessary to feed that to baby? (A). Check participants' understanding by asking them to explain in simple language what is colostrum and why it is important to feed the colostrum to the baby.

B. What is exclusive breastfeeding **40 minutes**

Ask participants and then explain what is meant by exclusive breastfeeding. Explain also that breastmilk is designed by nature to be a complete nourishment for the human baby and there is no need to add water or anything else to the baby's diet for the first six months of its life. Explain that within each feed the consistency and composition of breastmilk changes from the start of the feed to the end of the feed at a breast and this happens for all women. The breast milk that comes at the beginning of a feed is thinner and than the milk that comes later in a feed which is richer in fat and looks whiter. The milk that comes in the beginning has more water and immuno factors and satisfies the thirst while the later milk satisfies the newborn's hunger and provides much of the energy. Therefore it is important not to take the baby off the breast too quickly. The newborn needs both to sleep well and grow healthy. Breastmilk is therefore a complete nourishment for the infant 0-6 mths of age and therefore babies no other food or liquids during this period of their lives. [B]

C. When to start complementary foods while continuing breastfeeding **15 minutes**

Now that they understand what breastmilk contains and that it is a complete nourishment for the baby explain when to start complementary foods while continuing breastfeeding also explain why. Explain that for all babies breastmilk alone will not be able to provide enough nourishment for the growing baby. The baby will also need to begin on a thicker texture of food to gradually reach normal food within the year as the chewing and swallowing reflexes develop. All babies should be given complementary (in addition to breastmilk) food once they complete six months of age. What the foods are is explained in the infant health nutrition session.

Activity ***45minutes***

Divide participants into 3 groups and ask

Group 1: To compose verses on what is colostrum and what is exclusive breastfeeding.

Group 2: To compose verses on the composition of breastmilk and how it changes during a breastfeed to satisfy the needs of the baby.

Group 3: To compose a verse on when to start complementary foods and why.

Have the groups return to the large group and present their parts of the breastfeeding song. Let the other participants comment and contribute where information is lacking. Collect the correct complete verses to type and or use a recorder to record the song on tape for play back later.

Materials used for training / handouts include:

A **Colostrum**

During the first few days after the delivery, a woman produces special milk which is thick, sticky and light yellowish in colour. This milk is called colostrum. Although colostrum is secreted in small quantities, it is sufficient to meet the caloric needs of a normal newborn in the first few days of life.

Colostrum contains large quantities of proactive substances and growth factors and has more proteins, minerals and Vitamins A and K than mature milk. It is easily digestible contains anti-infective elements to protect new born against infection and provides the first immunization against diseases that a baby may encounter after delivery. Being rich in growth factors it stimulates the baby's immature intestine to develop to be able to digest and absorb milk and to prevent the absorption of undigested protein. If a baby is given any other milk or food before colostrum, it should be known that it can damage the intestine and is a potential cause of allergies. Colostrum also has a mild purgative effect, which helps to clear baby's gut of meconium [the first very dark stools] and helps to prevent jaundice by cleaning the bilirubin from the gut. It is rich in Vitamin A, so its prevents eye diseases. It is also rich in Vitamin K, which prevents bleeding in the newborn.

B Exclusive breastfeeding means the infant receives only breastmilk and no other liquids, not even water or complementary foods.

Babies should be exclusively breastfed for six months because:

- Babies grow normally for 6 months on breastmilk alone
- It contributes to better intelligence development for the baby
- Babies have lesser chances of infection, asthma, allergies and eczema
- It helps in birth spacing and provides 98% protection for a woman who meets all three of the following conditions:
  - Baby is exclusively breastfed
  - Baby is less than 6 months old
  - Menstruation has not resumed
  - It reduces the risk of breast and ovarian cancers and anemia in the breastfeeding woman
  - Water supplementation even in hot weather is unnecessary and leads to reduced desire to suckle and is a source of infection as well.

Session 3: How working women can exclusively breastfeed their babies, how to express & store breastmilk and how to feed the baby using a cup

Session Objectives: At the end of the session the participants will be able to explain in simple language:

A. How working women can exclusively breastfeed their babies

B. How to express and store breastmilk

C. How to use a cup or simple katori to feed baby expressed breast milk

Training Materials required for the session:

A How working mothers can breastfeed their infants

B1 Breast model, B2 Expression of breastmilk instructions

C Using a cup to feed expressed breastmilk

Methodology:

Present the objectives

A. How working women can exclusively breastfeed their babies **45 minutes**

Ask participants what can working mothers do to be able to exclusively breastfeed their infants for the first six months of baby's life. Listen to their responses and then sum up using content in (A1).

Ask participants why should women learn to express, store and feed expressed breastmilk. Listen to their responses and then sum up using content in (A2).

B. How to express and store breastmilk **30 minutes**

Ask participants whether they have ever expressed breastmilk and what was their experience. Explain that just like breastfeeding, expression also has a technique that helps women express painlessly. Use the breast model (B1) to show technique of hand expression of breastmilk. Show pictures on expression and explain step by step the method of how to express breastmilk (B2). If any of your participants had said that she had expressed breastmilk then ask how she had done so and how she had stored the milk till it was fed to the baby. If she has done it the way you will be explaining then praise her efforts and state that you will now explain again to the rest of the participants how to do it painlessly. Even if she had not done it the correct way, praise her for having tried to express and feed the baby breastmilk.

Explain that breastmilk can be stored in a clean steel katori covered with a clean lid at room temperature for up to 8 hours in a cool clean dry place in the house. Explain that it should not be stored in a glass or coloured vessel or a vessel that has grooves because when stored in glass certain good factors get stuck to the glass and so are lost for the baby, coloured plastics may be toxic, vessels with grooves in them are difficult to clean and so may contaminate the milk stored in them. Explain that the expressed breastmilk should not be heated up like you heat up other food items as it will destroy some of the protective properties of breastmilk.

C. How to use a cup or simple katori to feed baby expressed breast milk **30 minutes**

Demonstrate using a clean plain steel cup/katori/kinnam with water and a baby doll to show how to hold the cup for feeding baby expressed breastmilk. Emphasize the point that the milk should not be poured into baby's mouth. [C]. Pass the cup with the water around and ask participants to demonstrate how to hold the cup to the baby's mouth.

Explain that working women can learn how to exclusively breastfeed their babies for 6 months and continue to breastfeed till 2 years and beyond.

Activity ***45 minutes***

Divide participants into 3 groups and ask.

Group 1: To compose a verse on how working women can ensure that their infants are exclusively breastfed.

Group 2: To compose a verse on how to express and store breastmilk and why it should be heated.

Group 3: To compose a verse on how to feed a baby expressed breastmilk with a cup (they should use appropriate actions to accompany this verse of the breastfeeding song).

Have the groups return to the large group and present their parts of the breastfeeding song. Let the other participants comment and contribute where information is lacking. Collect the correct complete verses to type and or use a recorder to record the song on tape for play back later.

Materials used for training / handout include:

A1 **If the mother goes out of the home to work how can she breastfeed ?**

If she is going to be away from her baby and cannot come back to feed her baby or cannot take baby with her, then she could do the following:

- Breastfeed baby before she leaves for work and as soon as she can when she returns from work. Baby would need a feed every 3 or 4 hours so she can express enough to last the time that she is away. (in the first few months babies feed more frequently but by the time they are around 3 months of age they have a set routine and generally feed every 3 to 4 hours)
- The baby would need around 100ml (i.e. about ¾ cup) of expressed breastmilk per feed. If she can store for each feed separately then that will be ideal
- Breastmilk can be expressed and stored safely in a clean cup for 8 hours at room temperature even in a hot climate (and for 24 hours in refrigerator). Use a clean plate to cover the cup.
- The caregiver should not heat expressed milk.
- Mother should also try to breastfeed as much as possible when she is at home and at night.
- When she is away and her breasts feel full, she needs to find a quiet private spot and express her milk so that her breasts do not get engorged and her milk supply is maintained

A2 **Why should a woman learn how to express her breastmilk?**

There are many situations in which expressing breastmilk is useful and important. It is a good idea for all mothers to learn how to express their breastmilk, so that they know what to do if the need arises.

The following are situations when expression of breastmilk will help:

- To establish lactation, to feed a low-birth-weight or sick newborn

She should start to express milk on the first day, within six hours of delivery if possible. She may express a few drops of colostrum at first, but it helps breastmilk production to begin, in the same way that a baby suckling soon after delivery helps breastmilk production to begin

She should express as much as she can as often as her baby would breastfeed. This would be at least every three hours, including during the night. If she expresses only a few times, or if there are long intervals between expressions, she may not be able to produce enough milk

- To keep up her milk supply to feed a sick baby

She should express as often as her baby would feed, at least every three hours.

- To build up her milk supply, if it seems to be decreasing after a few weeks

Express very often for a few days (every ½ to 1 hour) and at least every 3 hours at night.

- To leave milk for a baby while she is out at work.

She should express as much as possible before she goes out to work, to leave for the baby. It is also very important to express while at work to help keep up the supply

- To relieve symptoms, such as engorgement, or leaking at work. She should express as much as necessary to relieve symptoms

B1 **Breast model**

If you do not have a model, this is how you can make one:

Materials required: 1 skin colored sock, 1 roll of cotton wool, 1 shirt button, brown/dark brown sketch pen, skin color thread and needle.

Procedure:

Roll cotton into a ball [fist size or larger]. Take a very thin layer of cotton and spread it over the button.

Shake out the sock well, hold the heel of the sock and insert the button. Place the button in the center of the heel and stitch in place. Insert the rolled cotton and place it under the button. [The top of the cotton roll has the button to project like a small nipple]. Shape the cotton so that the bottom is flat and rest is rounded to resemble a breast. Remove hand, fold loose ends and stitch at the flat end of the breast.

Mark the areola around the outer part of the button. Stitch a circle lightly around the button outside and pull thread lightly so that this part projects. Knot and cut thread. Color the areola and nipple with sketch pen.

B2 **Expressing breastmilk, and feeding expressed breastmilk**

For expression of milk the mother should wash her hands thoroughly and sit or stand comfortably holding a clean container near the breast. The thumb and the first finger should be placed on the areola above and below the nipple opposite each other (Fig. 1).

The thumb and the finger should be pressed inwards towards the chest wall, then the areola behind the nipple should be pressed between the finger and thumb so that the lactiferous sinuses beneath the areola are compressed. (Fig. 2)

Pressure should be alternately given and released till the flow of milk starts. If the procedure is painful, the technique is wrong. The fingers should not be slid along the skin nor should the nipple itself be squeezed. Pressing or pulling the nipple cannot express the milk. Pressure should be given on all the sides to ensure expression from all segments of the breasts (Fig. 3). The breast should be expressed for at least 3 to 5 minutes until the flow slows, then express the other side and repeat alternately. To express milk adequately it takes 20 to 30 minutes. It is important not to attempt expression in a shorter time.

Fig. 1

Fig. 2

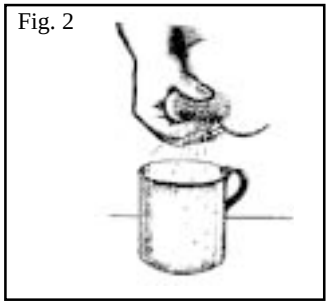
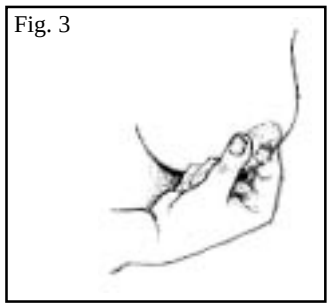


Fig. 3



C **How can a baby be fed using a cup**

Even newborns can be fed using the cup if for some reason they are not able to suckle at the breast

The following steps will help you cup feed an infant without much difficulty. Practice will make it easy

- Hold the baby sitting upright or semi-upright on your lap
- Hold the small cup of milk to the baby's lips
- Tip the cup so that the milk just reaches the baby's lips
- The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert and opens its mouth and eyes.(A low birth weight will take the milk into its mouth with the tongue A full term or older baby sucks the milk, spilling some of it.)
- DO NOT POUR the milk into baby's mouth. Just hold the cup to baby's lips and let the baby take it herself/ himself.
- When the baby has had enough, it will close its mouth and will not take anymore. If it has not taken the calculated amount, it may take some more next time, or you may need to feed the baby more often.
- Measure the baby's intake over 24 hours – not just at each feed.

Bottle feeding increases chances of contamination and therefore infection. Bottle feeding causes nipple confusion, should a mother decide to breastfeed again then the baby may not want to suckle at the breast.

Session 4: Maternal nutrition during lactation

Session Objectives: At the end of the session the participants will be able to explain in simple language:

A. The importance of good nutrition for the lactating woman

B. The effect of maternal nutrition on breastmilk

C. An example of how a lactating woman can improve/increase her food intake

Training materials required for this session:

A Nutrition during lactation

B1 Picture on the source of energy for breastmilk

B2 Effect of maternal nutrition on breastmilk

Methodology:

Present the objectives.

A. Nutrition during lactation **30 minutes**

Ask the participants about the practices that are prevalent in the community. Listen to their answers and then state that let us look at what lactating women need and why. [10 minutes]

Explain that lactating women need more food than pregnant women (A1) [5 minutes]

Show the picture on the source of energy for breastmilk (A2) and explain the importance for the lactating women to be adequately fed to maintain and replenish the energy and micronutrient stores in her body. Answer queries [15 minutes]. Explain that some of the energy to produce breast milk comes from the fat that the mother acquired during pregnancy see shaded part around mother, the remaining must come from her food so she requires additional food to cope with the demands on her body for energy .

B. Effect of maternal nutrition on breastmilk **30 minutes**

State one of the common reasons people switch to artificial feeding is because they state the woman is too weak and therefore the baby will not be well nourished if fed by her. Ask participants what they think about that statement. Listen to their responses and then explain showing the picture (B) the effect of maternal nutrition on breastmilk. Explain that there is no difference in quality and content of breast milk in well nourished or malnourished mothers. Severely malnourished mothers in famine conditions may require that mother to be treated for nourishment .

Now ask participants whether any of them had a baby recently and if yes how did they feel about their hunger during the lactating period and whether they had enough food for themselves. Divide participants into small groups and ask them to plan how they can increase the food intake of the women to meet the extra energy requirements. They can draw up a comparative chart of what is eaten and what can be eaten and how they can do that in the exercise. Then sum up with the example (C) given in the reference material. (45 minutes)

Activity ***1 hour***

Divide participants into 3 or 4 groups and ask

Group 1: To compose a verse on the importance of good nutrition for the lactating women.

Group 2: To compose a verse on the amount of food and diversity of food she needs to consume.

Group 3 and 4 : To compile composition of an extra meal based on the sample provided in the reference material they should use foods that are locally and cheaply available. Also include a discussion of how they can access the anganwadi centre for the first six months after childbirth for food supplement for the mothers.

Have the groups return to the large group and present their parts of the breastfeeding song, and an extra meal plan Let the other participants comment and contribute where information is lacking. Collect the correct complete verses to type and or use a recorder to record the song on tape for play back later. Collect the extra meal plans that the groups come up with and check for nutrition balance before copying it for all to carry and disseminate. This can be used in a campaign to promote and disseminate information about extra nutrition within the existing resources for lactating women.

Materials used for training / handouts include:

A1 **Nutrition during lactation**

The nutritional needs of a breastfeeding woman are even greater than during pregnancy. For this reason her food intake should be increased and also be varied. A lactating woman must to continue to eat the foods she was eating during pregnancy but should increase the amount to add one more meal.

For example, *in addition to the three meals and a snack* she consumes each day she requires to have an extra meal of about 60g of rice, 30g of *dal*, a handful of cooked vegetables, half a banana and a teaspoon of oil. This can be an additional meal or divided into a meal and a snack.

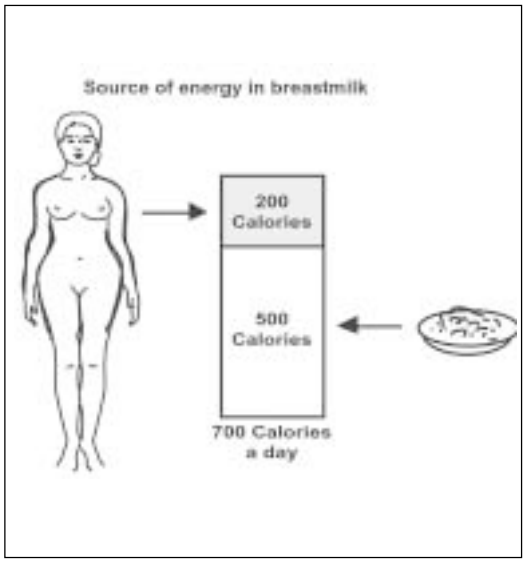
Note facilitators need to emphasize that while the amount given is "ideal" not all families can afford but it is important to learn that the lactating women needs extra food more than she had during for pregnancy.

C Diet of a lactating mother can be improved through dietary diversification. It is essential that lactating mothers consume the following:

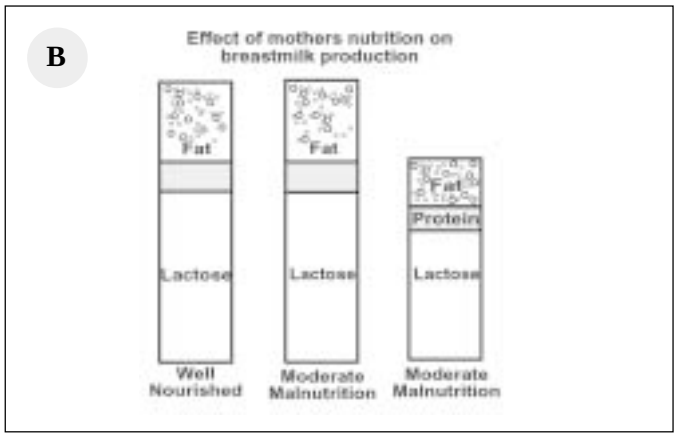
- Locally available green leafy vegetables (which contribute vitamin A, vitamin C, folic acid, calcium and iron).
- Other seasonal vegetables (which contribute vitamin C and minerals).

- Yellow vegetables and fruits e.g. yellow pumpkin, mango, papaya (which provide vitamin A).
- Seasonal fruits e.g. guava, amla (which contribute vitamin C).
- Milk and milk products, if feasible (source of calcium).
- Animal products (source of protein and B-complex vitamins), if feasible and culturally acceptable.
- Iodized salt *(source of iodine)*

A2



B



The figure (B) shows that the lactose, protein and fat content in the breastmilk of well nourished mothers and moderate nourished mothers remains the same. Difference is seen in "severely malnourished mothers' breastmilk where all three are less in the breastmilk. Severely malnourished are those in famine conditions. *[Source: Breastfeeding counseling: a training course –WHO & UNICEF 1993]*

Session 5: Breastfeeding as a contraceptive method (LAM)

Session Objectives: At the end of the session the participants will be able to explain in simple language:

A. How exclusive breastfeeding can be used as a contraceptive method- Lactational Amenorrhea Method (LAM)

B. Contraceptive choices for women who are breastfeeding

Training materials required for the session:

A LAM chart

B Contraceptive choices for breastfeeding women

Methodology:

A. How exclusive breastfeeding can work as a contraceptive method **1 hour**

Explain that suckling at the breast stimulates the production of a two hormones, one of which suppresses ovulation. (A1) This hormone is produced during and immediately after a feed. The high level of the prolactin hormone needs to be maintained without letting it fall, as once it falls the woman will then begin to ovulate. Explain that prolactin is produced more at night than during the day and that is why the gaps between breastfeeds should not exceed 4 hours during the day as for some women the level falls around 4 hours and no one knows which women fall in that group.

Use (A1) and the prepared LAM algorithm (A2) to explain the criteria for LAM to work and emphasize that ***even if one of the criteria is not met then breastfeeding cannot work as a contraceptive.***

Explain that working mothers who feed their babies on their expressed breastmilk cannot use breastfeeding as a method of contraception as expression of breastmilk does not stimulate the production of the hormone in the quantities that is required for ovulation to be suppressed.

B. Contraceptive choices for breastfeeding women **30 minutes**

Explain that for postpartum mothers who are breastfeeding but are not comfortable using LAM there are some limitations in choice of methods. Show (B) the choices available and explain.

Activity ***30 minutes***

Divide participants into 2 groups and ask

Group 1: To compose a verse to explain how breastfeeding can be used as a contraceptive method. The second verse should reiterate the criteria for LAM.

Group 2: To compose a verse on contraceptive choices for breastfeeding women.

Have the groups return to the large group and present their parts of the breastfeeding song. Let the other participants comment and correct/complete. Collect the verses to type and or use a recorder to record the song on tape for play back later.

Materials used for training / handout include:

A1 **How exclusive breastfeeding works as contraceptive method – criteiria for LAM**

Exclusive breastfeeding helps maintain a high level of prolactin in the woman's body which in turn not only helps in the production of breastmilk but also suppresses ovulation with the result that the woman does not have her periods (menstruation).

Breastfeeding causes Lactational Amenorrhea - a natural contraceptive method referred to as LAM. However, *it can work as LAM only when all three of the following conditions are fulfilled:*

- Baby is less than 6 months of age.
- Baby is breastfed exclusively (preferably not more than a four hour gap between feeds during the day and not more than six hours gap during the night between feeds*).
- Menstruation has not returned.

If maintained then it provides 98% protection against another pregnancy. If even one of the above is not fulfilled then breastfeeding cannot be expected to work as a contraceptive method.

(Prolactin is secreted in greater quantities at night than during the day and is dependent on the suckling stimulus. Some authors state that the prolactin levels needed to suppress amenorrhea are maintained through this suckling for about 4 to 6 hours. This can vary in women so to be safe the mother should try to avoid a gap of more than four hours between breastfeeds during the day if she wants to use it as a contraceptive method.)*

B Contraceptive choices for a woman who is breastfeeding her baby

A woman can be counseled on how to use breastfeeding as a contraceptive method she needs to know the three conditions that ensure it works. However, some women may want to use more than only LAM to feel safe, they could opt for LAM + IUD/withdrawal/ Condoms/Spermicide/diaphragm (if available). Condoms provide dual protection and couples who had been treated for a STI during pregnancy should be encouraged to continue to use the condom during the postpartum period too.

A breastfeeding woman, who wants to use a contraceptive method, could choose from the following options:

Preferable methods - First Preference (these methods do not adversely affect lactation)

1. LAM (Lactational Amenorrhea Method effective for six months only if criteria are met)
2. Condom
3. Spermicide
4. Diaphragm [not available]
5. IUD
6. Natural methods such withdrawal
7. VSC – Vasectomy for men & tubectomy for women (use only if couple is very sure they do not want to have any more children and have been counseled on the possibility that reversal may not help them have another child)

Alternative Methods - Second Preference

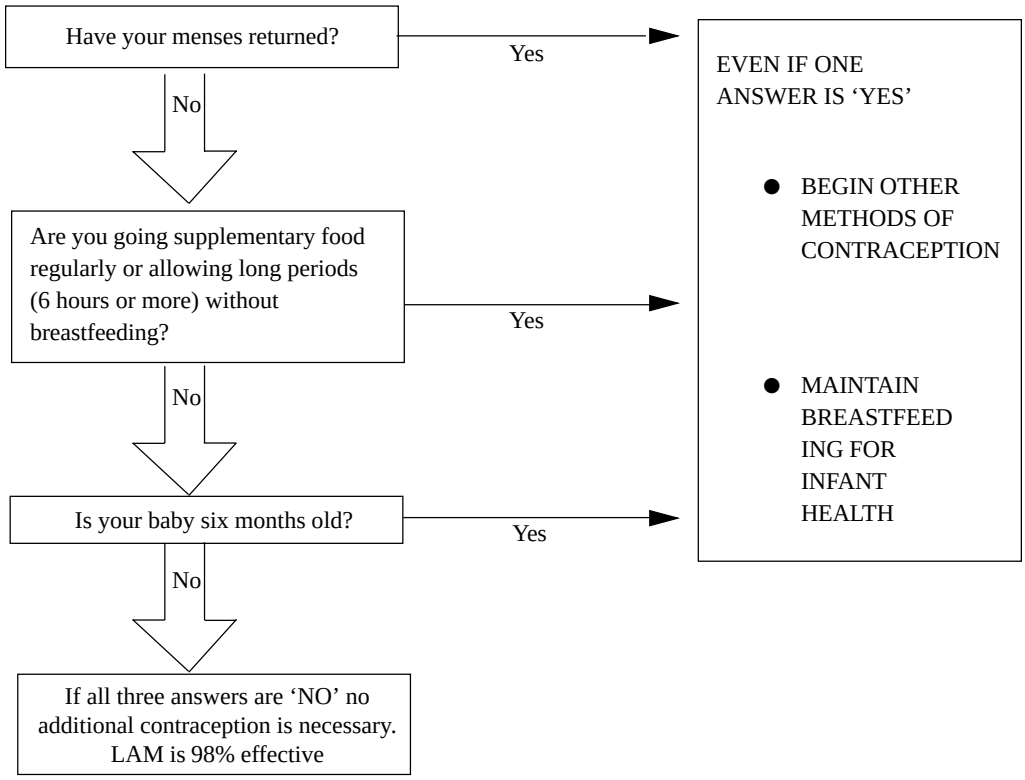
1. POPs (progestin only pills) [not available]
2. Progestin only injections - DMPA, Net En [available only in private sector]
3. Norplant [not available in India]

Last option Third Preference (estrogen in Combined oral contraceptives [COCs] reduce the body's ability to produce milk)

1. COCs combined oral pills

A2 **LAM History Checklist**

[Adapted from LAM algorithm, Institute for RH, Washington D.C. 1994]



Session 6: Lactation Counseling and community education

Session Objective: At the end of the session participants will be able to:

A. Educate the community through a song on breastfeeding

B. Counsel a couple to breastfeed their infant

Training materials required for the session:

A Portions of the song on breastfeeding that has been gradually made through the sessions on Lactation

B Case studies for counseling couples

Methodology:

Present the objectives.

A. Summarizing messages on breastfeeding **30 minutes**

Summarize the lactation chapter and bring together the learning from all the sessions into practice in the roleplays and community education songs/campaign.

By now you will have gathered a whole song on breastfeeding that had started out from the song that was originally used by RUWSEC staff sometime ago. Have the whole song written out to share with all participants. This will reinforce the messages. If time permits then have someone sing and teach the song so that they can then sing it for educating the community.

B. Counseling for breastfeeding **1 hour 30 minutes**

Divide participants into groups and give each group a case where they need to educate the couple or individual (to be presented in a role play). Facilitators please note that your target population is poor, there is a prevalence of gender related violence and discrimination both in terms of feeding infants all well as the nourishment of the women, try to ensure that the role-plays and post discussion address these issues as well in their attempt to resolve issues. At the end have everyone sing the breastfeeding song that they have developed during the course of the sessions.

Materials used in training /handouts include:

B **Case studies:** Ask participants to focus (for the purpose of applying content related to the breastfeeding session) on the breastfeeding component in their role-play showing counseling/education.

1. Vanita is 7 months pregnant. This is her first pregnancy and her mother–in-law from the semi urban town in the neighbouring state now lives with them. Vanita works as a cleaner in a nearby village. She wants to be able to breastfeed her baby but is not sure she can because she is very slim and feels her breasts are small. Her mother in law also thinks that her breasts won't have enough milk.
2. Meena and Ravi are first time parents they have a 6 weeks old baby. Meena is trying very hard to breastfeed her baby and is continuing to do so despite the pain she has in her nipples and that baby insists on feeding very frequently. They are worried that she may not have enough milk.
3. Jayanti has a 4 month old daughter. She is pregnant and her mother in law has asked her to stop breastfeeding as it may harm the child in the womb. Jayanti wants to know if she should stop breastfeeding.
4. Lakshmi's delivery date is fast approaching. Her sister delivered a baby girl two months ago. She did not feed the colostrum to the baby as she was told that would lead excess fat in the baby. They gave her donkey's milk. Lakshmi heard that her sister cannot eat certain foods as they are not good for the baby.

Note to facilitators: Prepare case studies to reflect the population that you are working with. The above are only samples.

Maternal Morbidity and Mortality

This chapter explains what is maternal morbidity and mortality and discusses them through case studies to help participants reflect on real situations and devise ways to reduce maternal morbidity and mortality in their communities. It clarifies the understanding of abortion and miscarriage and seeks to educate the participants on the types of miscarriages/abortion, why they happen and how to avoid such situations. It also provides opportunity to participants to examine reasons why women go for abortion especially for illegal or backstreet abortions.

The chapter has the following sessions:

Session 1: Maternal mortality and morbidity 2 hours 30 minutes

Session 2: Abortion and miscarriage 3 hours 30 minutes

Session 3: Understanding the reasons why women go for illegal/backstreet abortion 1hour 40 minutes

Session 4: Female feticide and female infancticide – the link to maternal morbidity and mortality 1 hour 30 minutes

Note to the facilitator: Please read the attached reference texts before you begin preparing for your session. It will give you a better understanding about the issues to be covered and will help you deal with questions that may come up during the sessions.

Session 1 Maternal mortality and morbidity

Session Objective: At the end of this session the participants will be able to:

A. Reflect on the factors that make maternal death more likely and consider how these factors can be removed or reduced in their own areas through effective community based health care

B. Explain the different types of maternal morbidity

Training materials required for this session:

A Case studies on Janaki and Saraswati

B Sample poster to create awareness

Methodology:

A. Factors that lead to maternal death. 1 hour 30 minutes

Introduce the objective for this session. Then prepare the participants for their group activity. (20 minutes preparation+ 15 minutes each group presentation + 5 minutes each group post presentation discussion). Divide participants into two groups and give group 1 the story of Janaki (A1)and group 2 the story of Saraswati (A2) with supporting information. You will need sufficient floor space in the room or verandah to do this activity in two groups or you may do the exercise with the large group one after the other which means it will take an extra 30 minutes). Let the participants reflect on the story given to them. Use mapping technique for the story to be explained and to make analysis easy at each stage. In order to do that read the story carefully and break up the story into pieces (write out each part on a A4 size sheet/card that can be set out on the map in a sequence. A good idea would be to also have blank flash cards of a different colour that can be used later as an alternate step for any stage in the story that could have changed the outcome in the story . Guide the groups to walk the path of 'Janaki' or 'Saraswati' respectively.

Then discuss:

The factors social and others that make such maternal deaths likely.

How these factors can be removed or reduced in their own areas.

How they will promote safe motherhood practices in their area.

After the discussion use the 'path to maternal mortality' (A3) to sum up the analysis and discussion.

B. What is maternal morbidity? 30 minutes

Explain that Morbidity means a state of being ill or in a diseased state of health, a chronic state of ill health.

State that maternal morbidity is categorized into 3 types.

Direct morbidity: results from complications of the pregnant state- pregnancy, labour and postnatal: can be temporary conditions or short term complications (sepsis, hypertensive disorders, haemorrhage.) and chronic conditions or long term complications (fistula, uterine prolapse, pelvic inflammatory disease or urinary and /or faecal incontinence).

Indirect morbidity: results from diseases like anemia, malaria, tuberculosis aggravated by pregnant state.

Psychological morbidity: includes postpartum depression and other mental health problems related to pregnancy and childbirth.

Ask participants what are the effects of these on families. Listen to their responses and then sum up that an ill mother cannot take care of her family, herself and with time will not only develop serious conditions but will eventually succumb to her morbid state if left untreated. If she is a working mother then her ability to continue to provide for her family will decrease and cease causing even more financial problems. Women in such conditions may conceive and beget children who are stunted or have some abnormalities.

Activity ***30 minutes***

Divide participants into three groups

Group 1: Identify ways in which a family and couple will be affected when a woman is chronically ill.

Group 2: Identify ways in which to educate the communities to take better care of women.

Group 3: Create posters that can be used for a campaign in the community to prevent MM. Show sample poster (A4).

Group 4: Identify ways to mobilize Panchayat Raj Institutions to put pressure on government to ensure better better maternity care and safe abortion services at the periphery level to reduce maternal mortality (MM) and morbidity.

Materials used in the training / handout include:

A1 The story of Janaki

Janaki died during labor in a district hospital. The reason for her death was given by the doctor as 'antepartum hemorrhage due to placenta praevia'.

An investigation committee looking into maternal deaths found that when she arrived in the hospital she had severe bleeding and was in shock. She was given very little blood. She had to undergo a c-section which was carried out 3 hours after her admission. Janaki died during the operation.

The committee said that Janaki death was avoidable if blood transfusion had been more readily available and if the services were better equipped to deal with emergencies

Other information:

- It took Janaki 4 hours to reach the hospital from the time she started bleeding heavily as there was no transport.
- It was not the first time she suffered from bleeding. There had been two minor bleeding episodes during the same month but they had stopped spontaneously. But Janaki was not warned about this and no action was taken.
- Janaki was not very healthy. She suffered from anemia caused by malnutrition.
- She did not have access to any type of prenatal care during pregnancy.
- Janaki was 39 years old. Five of her children are still living, three of them are males. Janaki did not really want another child. Because of her age and number of children previously her pregnancy carried higher risk.
- She had no access to any family planning education or services.
- She was a housewife and her husband was a poor agricultural laborer.
- She was illiterate and she lived in a remote village.

The exercise involves analysis of the reasons for Janaki's death. Any incident of MM from the participants area can be used for this analysis. A volunteer from the group could be Janaki. The main reasons for death could be cited on a road drawn/marked on the floor. In the case of Janaki, poor socio economic development, excessive fertility, high risk pregnancy, life threatening complications led to mortality in the absence of improved status of women, FP services, community based maternity services, accessible first level referral services. For example as Janaki walks along the path marked 'poor socio-economic development – participants can be asked what could be the exit path – in this case 'raising the status of women'.

A2 **The story of Saraswati**

Saraswati died while giving birth. It was her fifth delivery. She was not from a far off village but lived in the city itself. She initially set out on time to go to the hospital. But …….(This can be done using a village scenario and based on local incidences)

- by the time they found a vehicle to go to the hospital
- by the time they struggled to get her an admission card
- by the time she was admitted
- by the time her file was made up
- by the time the nurse/midwife was called
- by the time the midwife finished eating
- by the time the midwife came
- by the time the husband went and bought some gloves
- by the time the midwife examined the woman
- by the time the bleeding started
- by the time the doctor was called
- by the time the doctor could be found
- by the time the doctor came
- by the time the husband went to buy drugs, IV, Drip etc
- by the time the husband went to look for blood bags
- by the time the hematologist was called
- by the time the hematologist came and took blood from the poor tired husband
- by the time the day and night nurses changed duty
- by the time the midwife came again
- by the time the doctor was called
- by the time the doctor could be found
- by the time the doctor came
- the woman died!

(Adapted from : Safe Motherhood series – Foundation Module WHO/FRH/MSM/96.6)

Factors influencing delays could include:

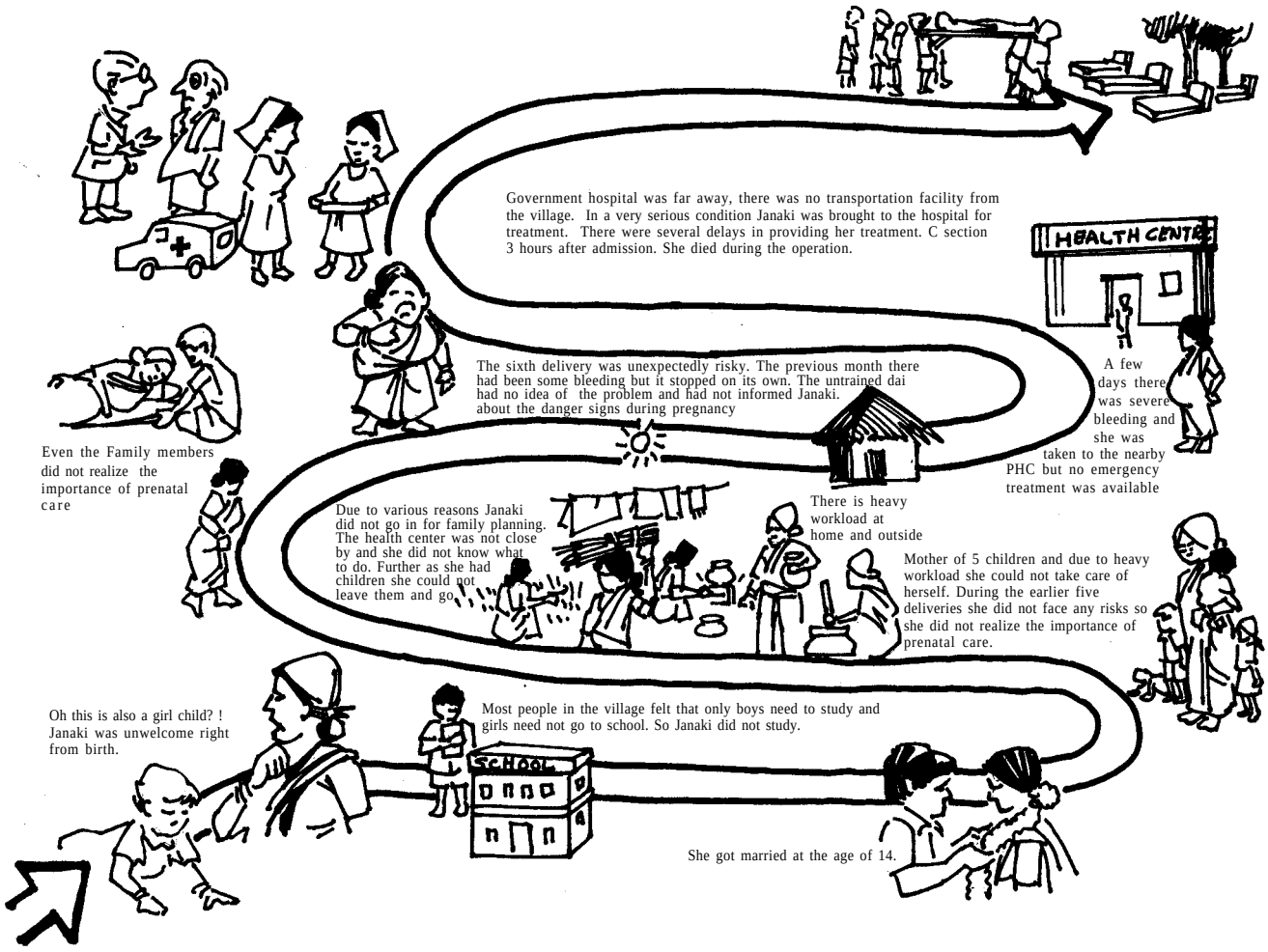
- transport
- bureaucracy
- procedures/routines are useful but not when they get in the way of prompt attention
- availability of staff
- lack of supplies/equipment
- laboratory services

Why did Saraswati die?

- Identify the factors which influenced the delay in Saraswati receiving treatment she needed ?
- Which of these factors could have occurred here in our hospital/facility/community ?
- What action needs to be taken to prevent another Saraswati dying ?

A1

Path to Maternal Mortality



Causes of maternal mortality

- Negligence right from birth.
- Early marriage
- Lack of education
- Frequent birth of children
- Excessive burden of work
- Indifference to women's health in society
- Medical facilities that are not accessible
- Desired family planning methods are not easily available to women at the time of need

To avoid maternal mortality…

- Right from birth female children should be given healthy diet and should be provided care and attention.
- Girls should be educated
- Early marriages should be avoided
- It is necessary to be informed about the family planning methods
- Everybody should realize the importance of antenatal care
- A trained Dai should conduct deliveries
- Desired Family planning methods should be easily accessible.
- Medical care should be easily accessible.

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- Medical care should be easily accessible.

A4

Let us prevent Maternal Deaths

- Every year in Tamilnadu about 10000 mothers die during pregnancy or delivery. Most of these deaths can be prevented.
- The risks that lead to the death of a majority of women:
  - ❖ Excessive bleeding during delivery
  - ❖ Damage to the uterus
  - ❖ Fever during pregnancy
  - ❖ Anemia
  - ❖ Jaundice and other communicable diseases
- Our country has the medical technology/skills to prevent and treat these problems. Then why so many deaths?

To prevent maternal deaths…..

- **Safe drinking water and basic health care can prevent jaundice and other communicable diseases.**
- **Basic health care should be easily accessible to women.**
- **A trained birth attendant should provide delivery care.**
- **Primary Health Centres must provide special care to women during pregnancy and delivery.**
- **Towards healthy development of women, feed her healthy diet and provide care right from birth.**
- **The low status of women in society must change.**

Let us prevent Maternal Deaths

International Day of Action for Women's Health

Rural Women's Social Education Centre
Chengalpattu

Session 2: Abortion and miscarriage

Session Objectives: At the end of the session the participants will be able to:

A. Explain the difference between abortion and miscarriage and the health consequences of abortion/ miscarriage – physical and psychological

B. Explain the reasons for miscarriage / abortions

C. Identify ways to prevent abortions / miscarriage in the future

Training Materials required for the session:

A1 What is abortion and miscarriage, (A2) Cards about types of miscarriage.

B1 Reasons for miscarriage -small cards to write on, paper sheets, sketch pens and ribbons

B2 Charts with the case studies for illegal abortions written on them, blackboard, chalk

Methodology:

Present the objectives of the session.

A What is miscarriage and what is abortion? 2 hours 30 minutes

Ask participants what they understand by the terms abortion and miscarriage. Listen to their answers then clarify the terms using the content given in (A1).

Ask participants if the terms are clear to them. Ask one of them to explain in her/his own words.

Types, symptoms of miscarriage and types of abortion (1 hour)

Draw 5 circles in a circle and write one of the following points in each of the circles:

- Inevitable miscarriage
- Complete miscarriage
- Incomplete miscarriage
- Missed miscarriage
- Habitual miscarriage

The facilitator claps while the participants go around. When the clapping stops, the participants stand in one of the circles. The circle that the Facilitator calls has to be vacated. One of these participants reads the card given by the facilitator (A2).

Consequences of miscarriage and abortion (1 hour)

Ask participants to share their experiences or knowledge about the consequences of abortion and miscarriage. Fill gaps in their knowledge using the following information to explain

(Note to facilitator - Read additional reference and include points from there)

A woman who has had frequent abortions and/or miscarriage may have physical and psychological problems.

Physical:

- Excess bleeding.
- Intense, unbearable stomach pain.
- Back, hip pain, pain in the limbs.
- Severe anemia. Due to excess bleeding, lack of nutrition, weakness, giddiness. As a result cannot do hard work-physical labor.
- Fibroids, cysts, lumps in the uterus.
- Infections may be cause because of abortion done in a non-sterile condition, or because of the non-sterile equipment used.
- RH problems –white discharge, STIs, UTI.
- Possibilities of the cervix tearing, prolapse.
- Increased risk of breast and ovarian and cervical cancer (read attached reference on physical health risks of abortion).
- Increased risk of ectopic pregnancy in future (read attached reference on physical health risks of abortion).

Psychological:

- If a woman has experienced miscarriage there is constant fear that the next pregnancy may also end. Due to this there may be lack of appetite, sleep, even low self esteem at the inability to have a child.
- Souring of relations between the husband and wife if frequent abortions take place.
- Feelings of guilt, lack of interest, attempt suicide.

B. Reasons for abortion and miscarriage **1 hour**

Each reason for abortion and miscarriage should be written separately (B1) on the cards. A volunteer from the participants stands in the center of the room/space surrounded by the participants. The facilitator asks the group to cite the reasons for miscarriage followed by abortion. Each reason given is jotted on a white sheet and is tied with the ribbons to the different parts of the volunteer in the center. Subsequently the facilitator distributes the cards with the reasons. These are read in the group by each participant and the reason that coincides with the one tied to the volunteer is then untied.

Through this exercise myths and superstitions about abortion and miscarriage are cleared and the participants gain clear understanding of the reasons for abortion and miscarriage.

Illegal and legal abortions (45 minutes)

Ask to share narratives that they might have heard or experienced about illegal and legal abortions.

Divide participants into 2 groups. Provide the case studies (B2)for discussion. Discuss in larger group and note the points on the chart or black board. Add on the points that are left out.

Prevention of miscarriage (30 minutes)

Ask two volunteers from the participants one to enact a pregnant woman and the other to enact a counselor.

The woman shares symptoms of miscarriage based on experience of self or others. Counselor counsels her based on the information given by the woman.

- Women should go for regular check ups.
- If anemic should take necessary steps –consume iron tablets and other food like drumsticks, okra, greens-leafy vegetables.
- Abstain from sex after miscarriage till next menstrual cycle, to avoid immediate pregnancy. The uterus needs time to go back to its normal state. Should be careful and try to prevent conception for three months after miscarriage
- During pregnancy women should avoid medication without the doctor's advice
- Rest is necessary. Therefore even if work is unavoidable, prevent carrying heavy things.

Apart from the above, it is important to know that the following myths are NOT reasons for miscarriage:

- Eating papaya
- The woman is possessed by a ghost or spirit
- Frequent sex

Activity ***1 hour 50 minutes***

Divide participants into three groups and give each group one of the following tasks (15 minutes to prepare the task, 15 minutes to present, 15 minutes for discussion after presentations).

Group 1: Prepare a song or skit that covers information on what is miscarriage and abortion and the health consequences of using abortion as a method of controlling the size of family, the need for having an abortion only through a well trained person. Rest and care for the woman who has undergone miscarriage or abortion.

Group 2: Plan how to educate women's groups, families, men in the community on the severe health consequences of abortions.

Group 3: Plan a campaign to reduce abortions in the community by increasing contraceptive services and where services are lacking campaign for trained service providers for contraceptive and legal abortions.

Plug gaps and conclude the session with a summary of the ways that incidence of abortion can be reduced

Materials used in the training / handouts include:

A1 Miscarriages are when the body sheds the fetus on its own within 7 months without external interference. Miscarriages could happen due to the pregnancy being unviable physically or when the mother's womb or mother's physical health is unable to carry the pregnancy through to its term. Miscarriages are also called spontaneous abortions meaning that they happen naturally and are not induced for termination of pregnancy.

The biological definition for abortion and miscarriage is - The expulsion or removal of an embryo or fetus from the mother prematurely; this can be done as an artificial procedure, but it often happens naturally when the mother's body expels the embryo/fetus because it has died, has genetic or developmental defects, or because of infection or illness in the mother. Natural abortions are typically called "miscarriages". Medically-induced abortions (legal), which can be completed with surgery or with hormone drugs, are done because the embryo/ fetus is unwanted, deformed, not likely to live, or endangers the mother's life or health. However in an all India study done recently on abortion (AAP-I) regarding the reasons for seeking abortion, only 25% were for reasons given above and the rest were unwanted pregnancy, economic reasons and unwanted sex of the fetus.

The term Abortion is therefore the induced termination of a pregnancy due to various reasons, carried out by a trained medical practitioner or otherwise.

Abortion should (legally recognized) preferably be done within 3 months. Only trained physicians should perform an abortion. They have to apply for and receive special certification from the government (for skills as well as facilities). Abortion is done by vacuum suction and Dilation & Curettage (D&C) method.

A2 The card should contain the following details:

Inevitable abortion or miscarriage: intense stomach pain, excess bleeding, cervix is open, the skin that covers the fetus maybe torn, the fetus sometimes comes out fully.

Complete: Sometimes some parts of the uterine matter may remain in the uterus.

Incomplete: Such spontaneous abortions which are not premeditated are called miscarriages.

Habitual: if a women miscarries two or three times or more, it is considered habitual. It can be prevented by medical diagnosis and treatment.

Missed miscarriage: When the fertilized egg or fetus is unable to grow further due to a physical abnormality in the cell division stage and dies, the body expels the products of the pregnancy. This is a missed miscarriage or missed abortion.

B1 The following points/reasons should be written on the cards:

Reasons for miscarriage:

- Developmental defects: lack of development of the uterus; subdivided uterus.
- Lack of favorable conditions for the fetus in the uterus.
- Low implantation of placenta.
- In case of a problem with the egg or the sperm, aborted by the body within 50 days.
- Lump in the uterus, ovaries, cancer, STIs, anemia and high blood pressure, urinary infections, typhoid, jaundice.
- Shock – electric and psychological.
- Blood supply to the fetus is blocked by underdeveloped blood vessels.
- Reduction in thyroid.
- Accident or severe impact on the stomach/uterus (due to violence).
- Frequent pregnancies.
- Use of narcotic substances in the first trimester.
- Medication for other problems.

Reasons for abortion:

- If the pregnancy is dangerous for the physical and psychological health of the mother.
- If the fetus has a serious disability.
- Pregnancy as a consequence of rape – women with mental health problems, girls below 18 years
- Failure of contraception – temporary or permanent. For example, pregnant after undergoing sterilization or in spite of using condoms, OCPs, IUDs.
- When the previous child is very young and there is not sufficient gap between the previous child and the present one (for spacing), When there are adult/grown up children.
- To control family size- the number of children, unwanted pregnancy.
- Son preference – when trying to beget a boy and find out that is a girl (sex selective abortion)

- Due to economic circumstances
- Superstitions- for example, it is inauspicious for a baby to be born in a particular month ('Chitrai' month), inauspicious things that happen in the family when the woman is pregnant is sometimes believed to be caused by the unborn child, or if there is some function or ceremony in the same month as that of the birth of the child.

B2 **Case study**

Chitra from Melayur village near Palani got preganant by her boyfriend. She worked as a nurse in the private hospital at Ottanchateri. She was scared that if her employers found out that she was pregnant out of wedlock, they would dismiss her.

There was a lot of opposition to her boyfriend from her family because he belonged to a lower caste. When she informed her family that she was pregnant, they were shocked and asked her to abort. They threatened that if she did not do so then the entire family would commit suicide.

Chitra was helpless and saw no way out and decided to go for an abortion. Last March she underwent an abortion at a private clinic. Within four days she got an infection and had fits. She was taken back to the clinic where she had the abortion. They referred her to Palani General hospital, but they too could not do anything for her. She was taken to the private clinic where she was employed. The doctors tried their best but could not save her.

Points for discussion:

- What were the circumstances that caused Chitra to reach such a situation?
- Who is responsible for her death?
- If such a situation was to happen to a friend or relative, what would be your advice?

Additional reference reading for facilitators:

A List Of Major Physical Consequences Related To Abortion

Death

The leading causes of abortion related deaths are hemorrhage, infection, embolism, anesthesia, and undiagnosed ectopic pregnancies.

Breast cancer

For women aborting a first pregnancy, the risk of breast cancer almost doubles after a first-trimester abortion and is multiplied with two or more abortions. This risk is especially great for women who do not have children. Some recent studies have refuted this finding, but the majority of studies support a connection.

Cervical, ovarian and liver cancer

Elevated risks of cervical, ovarian and liver cancer have also been linked to single and multiple abortions. These increased cancer rates for post-aborted women are apparently linked to the unnatural disruption of the hormonal changes which accompany pregnancy and untreated cervical damage.

Uterine perforation

The risk of uterine perforation is increased for women who have previously given birth and for those who receive general anesthesia at the time of the abortion. Uterine damage may result in complications in later pregnancies and may eventually evolve into problems which require a hysterectomy, which itself may result in a number of additional complications and injuries including osteoporosis.

Cervical lacerations

Significant cervical lacerations requiring sutures occur in at least one percent of first trimester abortions. Lesser lacerations, or micro fractures, which would normally not be treated may also result in long term reproductive damage. Latent post-abortion cervical damage may result in subsequent cervical incompetence, premature delivery and complications during labor. The risk of cervical damage is greater for teenagers, for second trimester abortions.

Placenta Previa

Abortion increases the risk of placenta previa in later pregnancies (a life threatening condition for both the mother and her wanted pregnancy) by seven to fifteen fold. Abnormal development of the placenta due to uterine damage increases the risk of fetal malformation, perinatal death, and excessive bleeding during labor.

Handicapped newborns in later pregnancies

Abortion is associated with cervical and uterine damage which may increase the risk of premature delivery, complications of labor and abnormal development of the placenta in later pregnancies. These type of reproductive complications are the leading causes of handicaps among newborns.

Ectopic pregnancy

Abortion is significantly related to an increased risk of subsequent ectopic pregnancies. Ectopic pregnancies, in turn, are life threatening and may result in reduced fertility.

Pelvic inflammatory disease (PID)

PID is a potentially life threatening disease which can lead to an increased risk of ectopic pregnancy and reduced fertility. Of patients who have a chlamydia infection it the time of the abortion, 23% will develop PID within 4 weeks. Studies have found that 20 to 27% of patients seeking abortion have a chlamydia infection. Approximately 5% of patients who are not infected by chlamydia develop PID within 4 weeks after a first trimester abortion. It is therefore reasonable to expect that abortion providers should screen for and treat such infections prior to an abortion.

Endometritis

Endometritis is a post-abortion risk for all women, but especially for teenagers, who are 2.5 times more likely than women 20-29 to acquire endometritis following abortion.

Immediate complications

The nine most common major complications which can occur at the time of an abortion and are life threatening are: infection, excessive bleeding, embolism, ripping or perforation of the uterus, anesthesia complications, convulsions, hemorrhage, cervical injury, and endotoxic shock. The most common "minor" complications include: infection, bleeding, fever, second degree burns, chronic abdominal pain, vomiting, gastrointestinal disturbances, and Rh sensitization.

Increased risks for women obtaining multiple abortions

Women who have multiple abortions face a much greater risk of experiencing these complications. This point is especially noteworthy since approximately 45% of all abortions are repeats.

Increased risks for teenagers

Teenagers are also at much high risk of suffering many abortion related complications. This is true of both immediate complications, and of long-term reproductive damage.

(Adapted from information provided by the Elliot Institute, PO Box 7348, Springfield, IL 62791)

As is clear from the document above, surgical abortion carries many physical risks, which are compounded for repeat and late term abortions. Many women may have damage to their reproductive systems without realizing it, only to find years later that they are infertile or worse. Surgical abortion can make subsequent pregnancies more dangerous, thus contributing to overall maternal mortality for wanted pregnancies. The increased risk of breast cancer, though well documented, is not usually disclosed to women seeking abortions. Any woman considering abortion should take into account the possibilty of becoming injured in any of the ways documented above.

Session 3: Understanding the reasons why women go for abortion especially illegal/backstreet abortion

Session Objectives: At the end of this session the participants will be able to:

A. Analyze a case study to identify the social reasons for abortion besides the technical/medical reasons.

B. Identify ways that the death of the woman in the case study due to abortion could have been avoided.

C. Educate community on the need and ways to avoid such maternal deaths.

Training Materials required for this session:

A. Copies of the story of Pattu and 2 blank charts for each group (at least three groups)

Methodology:

Introduce the topic and then the objectives of the session.

A. Analyzing the reasons for illegal/backstreet abortion, identifying ways that the death could have been avoided **1 hour**

State that the participants will do an exercise to understand why women do what they do sometimes that lead to their health being severely compromised to be fatal in some cases as in the narrative that they will be provided. At the end of the exercise the participants will need to analyze the story and come up with options that could have saved the woman's life.

Divide participants into small groups give the story of Pattu (A) to discuss and list on one chart various reasons that lead to Pattu's untimely death. On another chart ask participants to list out how to avoid such a situation from happening in their community.

Activity ***40 minutes***

Divide participants into two groups and give them the following tasks (20 minutes preparation, 10 minutes each presentation and 5 minutes each for review and winding up)

Group 1: To develop a song that includes verses on Abortion/miscarriage, reasons, consequences for women's health, prevention. What people need to do to avoid such maternal deaths in their communities due to abortion-right to safe abortion.

Group 2: To develop a campaign to educate the community leaders about the adverse effects of abortion/ miscarriage on women's health, plan to how to revive the supply of contraceptives and services through the government health centres.

Call participants to the large group and ask them to present their tasks. After each ask for comments and clarifications, correct mistakes if any and reiterate the points that they may have missed. Collect the song and campaign strategies for typing and for distribution to all participants.

Materials used for training/ handout include:

A **The story of Pattu**

Pattu lived in Pushpavanam village by the sea shore in Nagapatinam district of Tamil Nadu. Her husband was a fisherman and he owned a "Catamaran". The family's economic condition was reasonable.

Pattu was his second wife . He was 40 years old when he asked for Pattu's hand in marriage. She was 15. Her parents happily relented and got her married to him.

Four months after marriage Pattu was pregnant. To reach the health center from the village, one had to walk 8 kilometres on the sand/shore to reach the main road, from where one could get a bus. There was no one to accompany her to the health centre. Her husband was busy at sea.

How could a young woman go to the health center on her own?

Pushpavanam village had never been visited by the village health nurse. Village elders and leaders gave a petition that the village needed a subcentre /a nurse. But who would pay attention to the needs of poor fisherfolk.

Pattu's first child was born dead. Two girl children were born one after the other and finally a boy was born. Everybody said the family's prayers had been answered . All deliveries took place at home.

In the meantime Pattu's health deteriorated. Once healthy, she was n ow just skin and bones. She often felt faint.

She was aware that she should go to the health center for treatment but the situation at home was not very good. As she was the second wife, her husband's relatives did not even speak with her. She was treated as an outsider, with enmity. She heard rumours about her husband having affairs with other young women.

When the boy was only 4 months old, she became pregnant. She was afraid that her son's health would be affected if she had another child so soon.

She decided to go for an abortion and went to an old lady who performed abortions.

No one else was aware of it. After a week she developed a fever due to infection. Pattu did not reveal anything to anyone. Her condition worsened. Her husband was at sea, people at home did not know what to do. How could they take Pattu to the health center without asking him? Who would take responsibility for the expenses?

Pattu experienced a lot of pain and died the same night. She was 26 years old.

Points for discussion:

Who was responsible for Pattu's death? Discuss this from the perspective of –family, culture, society, gender, education/literacy, government, patriarchy/male domination and list on black board/chart.

Understand/analyze causes underlying women's choice to have a safe abortion – infrastructure in the village.

Session 4 – Female foeticide and female infancticide - the link to maternal morbidity and mortality

Session Objectives: At the end of the session participants will be able to:

A. Briefly state the reasons for female foeticide and female infanticide

B. Briefly describe the consequences of abortion as a result of sex selection and identify ways to overcome this unfortunate practice

Training Materials required for this session:

A "Amma why do you hate me"*Amma ennai en verukkirai* (for introduction of the topic)

B Case studies (to analyze consequences of abortion as a result of sex selection

Methodology:

Present the objectives of this session and introduce the topic by reading the material 'Amma why do you hate me' (A1). Lead a large group discussion and let participants express their views as well as give reasons for female feticide (45 minutes).

Activity ***45 minutes***

Divide participants into 3 groups and give each group a case study (B1) as given below to reflect on and present their discussions after that in the large group. (15 minutes for group discussion, 5 minutes presentation and 15 minutes post presentation discussion and sum up with B2).

Materials used for training / handout include:

A1 **Amma why do you hate me**

In 1987 September, at the SAARC summit that took place in Delhi, it was decided that 1989 would be celebrated as the year of the girl child.

In countries like India, Bangladesh, Pakistan and in several other Asian countries like China, there continues to exist a feeling of hate against girl children.

If a girl child is born, "Oh! A girl child?"they mourn.There is a proverb in Telugu ' Bringing up a girl child is similar to watering the neighbor's plant and making it grow'.

In our country approximately120 lakhs of girls are born each year. Of these, 15 lakhs i.e .12.5% children do not even have the good fortune of celebrating their first birthday. Another 8.5 lakhs og girl children leave this world and are forgotten before they can reach out to their 5th year.

You will be shocked to learn about the steps taken in our country to prevent birth of the girl child or kill them.

As a result of medical advancement we have got an important test – Amniocentesis. In this test within 3 months of conception, amniotic fluid is drawn with a needle and it can be found out if the fetus has any possible defect/ problems.

If the problem is treatable then necessary steps can be followed, otherwise the child maybe aborted.

In our country this test is used to find out if the child is male or female. If they find that the fetus is female, immediately it is aborted.

There are plenty of doctors, nursing homes to do the amniocentesis test and abortion.

Somehow to prevent the girl child from being born, our people are resorting to this. They are willing to spend money, 1000 to 2000 rupees for the test and abortion.

Even poor rural folk in the villages, where there are no facilities for amniocentesis, courier the amniotic fluid to the nursing homes in the towns/cities, to find out if it's a boy or girl.

It was found that in Mumbai city alone, in 1987, 40000 female fetuses were aborted. As a result of the protests against this evil by women's groups, the Maharashtra government in 1988 passed a law banning this test and abortion carried out as a consequence.

In Delhi there are regular advertisements in the dailies about centers where amniocentesis is carried out –"Boy or Girl. Do you want to know?"

Even worse than female feticide is female infanticide. It was published that people belonging to a particular caste in Tamilnadu carry out this practice.

That is Rajasthan there exist such *Kalyug Kamsan* is a well known secret. In this family in the past 40 years 36 girl infants have been killed soon after birth. Hence there are no girl children in his family. Further two girls born were killed by giving them poison mixed in milk – this case was being looked into by the Rajasthan High Court some years ago.

In Mumbai city it was heard that girl children born at the KEM hospital were thrown in the garbage dump outside the hospital.

Even in families where female infanticide does not take place, girl children are thought of an 'unwanted guests'- this is the bitter truth that we have to accept. Differentiation between the male and female child is prevalent.

Girls who are naturally more healthy than boys at birth, without parental care and attention, suffer from tetanus, diarrhea, measles and soon disappear from this world. Due to the negligence of parents, female mortality is higher than male mortality till the age of 4.

Although it is said that the situation in Tamilnadu is not so bad, even here there is a difference in the mortality rates between boys and girls.

What is the reason for higher mortality rates among girls?

Breast milk is the most important diet for the new born child. The child is protected from illness/disease because of breast milk. In several studies carried out in Punjab, Haryana, the mothers feed their child very little breast milk for very few days.

As they desire to have a son immediately, they stop breastfeeding in 2-3 months.

Hygienic practices in bottle feeding are not followed (bottle should be sterilized). As a result the child is exposed to disease. This is also a reason for female mortality. For the male child, they maybe willing to spend much more than their capacity to provide him nutritious food. It is true that families do not pay much attention to the diet of the girl child.

Even today in most families the men in the house eat first, while the women eat the left overs. This practice persists.

Even in the case of immunization for the girl child, parents are not very keen.

Among migrants from UP staying in a colony in Delhi, when the male child suffers from fever, cold, cough, diarrhea, the parents take him to the doctor but do not feel the need to take the girl child. Usually 'home remedies' are used to treat her.

The difference in mortality rates between boys and girls is higher in rural areas than in urban areas. An important reason is that if the child falls sick it is easier to access health care immediately in the urban areas. But people in the rural areas have to come to the cities/towns for this- resulting in higher expenses and more inconvenience.

Therefore in most villages if the girl falls ill the parents do not pay much attention. In Punjab, in the economically developed district of Ludhiana, according to a survey most mother interviewed felt that it was okay if they didn't have even one girl but they should certainly have 1 or 2 boys.

What are the reasons for this?

- Parents believe that if a boy is born he will take care of parents in their old age
- But the parent's duty ends when the girl grows up
- Even for girls who have good jobs dowry has to be given. Further her earnings go to the marital home.

Unless girls are considered equal in society – till such a day arrives, laws against female infanticide alone cannot prevent it.

(Source:Ruwsec pamphlet – originally sourced from a Tamil magazine Kalki)

B1 **Case Study I**

Emerging from the scanning room, Rajathi is crying uncontrollably: it is a girl. Certain that she will not be able to face her husband and mother in law, she decides to go back to her parents village and abort the fetus. Some of the women in the village will help her; their methods will be crude and will probably put Rajathi's own life at risk, but her mind, conditioned/pressured by traditional social values that look upon female children as a 'burden' on the family, is made.

"Of course, I will abort the fetus", says Rajamma a local woman will perform the abortion as she has done for many others, charging less than what private hospitals charge.

Rajathi undergoes the abortion but a two weeks later complains of severe pain in the lower abdomen, she has fever and is also extremely depressed.

Discuss

What factors lead to Rajathi undergoing an abortion ?

Why did she choose to go to Rajamma instead of the hospital ?

What do you think has happened to Rajathi since she had her abortion ?

How could this affect her health and future pregnancies if any?

What can be done to avoid such incidences in the families in the community?

Case study II

Frail and anemic, Poomani had tried to abort her five month old fetus but her husband, Selvam who had lost both his legs in an accident had prevented her. His overriding concern was that if she died owing to complications arising from an improper abortion there would be no one to look after him and their eight year old son and six year old daughter; the family survives on Rs 15 a day that he earns as a farm labourer. But Selvam asked tearfully, "What will I do if this too is a girl? The expenditure we incur on a girl all through her life is enormous (there are 6 occasions on which ceremonies are to be performed for a girl). For the marriage, which entails a huge expenditure, we have to give at least 10 sovereigns of gold, a TV set, sofa, cot, cupboard, mixie, grinder. How can I afford all this?"

Discuss

What factors lead to Poomani trying to abort her fetus ?

Do you think her husband hates the girl child or is he too a victim of the unfortunate customs of society?

How could the unwanted pregnancy affect the emotional state of the couple and how could such a pregnancy be avoided

What can be done to educate people to change the customs of dowry and unnecessary expenditure in the family with regard to girls ? (thoughts : the grand celebration that is carried out when a girl comes of age was performed in olden days to inform the community at large that she is ready to be married and reproduce. But in today's world is that practice relevant ? Do people still need to beg and borrow to meet that expense? Why should the girl's family bear the expenses of her delivery after her marriage? Don't all these customs cause families to reject the female fetus or commit female infanticide?)

Develop a plan and activity to educate the community to avoid such situations and change their attitude towards female children.

Case study III

A woman doctor who has been practicing in Usilampatti town offers scan facilities, said she performed four or five abortions a day. She says (about sex specific abortions) that she offers the poor a place where the abortion can be conducted without health risks to the mother. Otherwise the poor people will be at the mercy of quacks.

Discuss

What are the reasons for these practices- Infanticide, Feticide, Differential feeding and care during infancy

Is what the doctor doing in keeping with the law ? Why ?

Is the law effective ? What maybe the reasons for this – discuss. How can it be implemented better? What strategies can be initiated to monitor and implement the law better.

Other factors that influence decisions to abort the female child or may also influence female infanticide. For example two child normal.

Case study IV

Maran and Pushpam have three daughters. The youngest born just a month ago. The Local VHN had come to talk to Pushpam to adopt some form of contraception. Pushpam's mother-in-law jover hears the conversation and after the VHN goes,starts an argument and cursing Pushpam saying that her son is handicapped with a woman who gives birth to only daughters. Pushpam in turns tells her husband that he has to put a stop to all this harassment from his mother. She tells him that the VHN told her that it is the sperm that is responsible for the sex of the child so it is not the woman's problem. He does not want to believe that but cannot help thinking about it. He talks to his friend who in turn decides to talk to a doctor in the city where they work. The doctor explains and also tells Maran that there is no guarantee that the next child would be a son.

A week later the VHN returns but the mother-in-law sees her and shouts at her asking her to go. Maran interferes and then talks to the VHN. The VHN explains that she is happy that he has thought about it enough to go and check out the fact with a doctor. She tells him that he can check out with the doctor again about the dangers of

frequent pregnancies and abortions. She cautions him that aborting because it is a female foetus will lead to poor health conditions for the wife and that he may ultimately lose her and have to look after the daughters on his own. Also aborting female foetus is against the law and if anyone reports it to the authorities he and the doctor who did the operation may have to face going to jail. Maran thinks about all this. He again confides to his friend and then they visit two doctors in the city who confirm the same fact and also tell him about the ACT(B2). They then request a friend of Maran, who is also a local leader to talk to Pushpam's mother-in-law, which they do.

Discuss:

What were the positive features in it?

What could have happened if the VHN had not talked to Maran or if Maran was not willing to discuss or listen to the VHN.

What can women's groups do to enlist the local support and expertise to address the problem of sex discrimination and female foeticide ?

B2 **The Prenatal diagnostics (Regulation and Prevention of Misuse) Act of 1994**. Under the act, prenatal diagnostic scans are permitted solely to detect genetic abnormalities at the prenatal stage. The act forbids sex determination tests. The Act states:

No person shall conduct …any pre natal diagnostic techniques …for the purpose of determining the sex of the fetus.

No person conducting pre natal diagnostic procedures shall communicate ……the sex of the fetus by words signs or any other manner.

In Tamilnadu the Gazette Notification states:

Every clinic shall prominently display on its premises a notice in English and in the local language or languages for the information of the public, to the effect that disclosure of the sex if the fetus is prohibited under law. However, not a single prosecution has been initiated till date.

CHAPTER-5

Newborn and Infant Health

In developing countries like India, the infancy period has been recognized to be a hazardous one. Malnutrition, repeated episodes of diarrhoeal and respiratory infections, poor personal and environmental hygiene, low income levels, illiteracy and, distance, slow and non-affordable access to preventive and curative health services, all contribute to this grim picture. The National Family Health Survey-2 has found the prevalence of under nutrition to be very high in India. Of all the children under 3 years of age 47% were underweight and 18% were severely underweight.

This especially impacts the girl children negatively. Undervalued in a society that craves for sons, discrimination begins early. Infant girls are breast fed for shorter period and may not be provided health care as promptly as would sons. In poor families, given the resource constraints, the health of a son receives priority. The mother may not be able to afford variety of foods and may feed the child what others eat at home. This may also be because of heavy work burden and lack of time and energy to prepare separate food for the child. Further if the girl is 'unwanted' the mother [or caregiver] may not be permitted to spend money for the infant's care. The first two years of life are the most vital in a child's growth. The nutrition provided in this phase of life, lays the foundation of health and healthy feeding habits. Widespread ignorance and misapprehension largely result in high incidence of malnutrition and illness in this age, compounded by infections due to poor personal hygiene and environmental conditions; Unsafe drinking water and poor sanitation.

This chapter contains

Session 1: Newborn care 3 hours

Session 2: Infant Nutrition 2 hours

Session 3: Growth Milestones 2 hours

Session 1: Newborn care

Session Objective: At the end of the session participants will be able to:

A. Describe the needs of newborns

B. Identify any problems and provide necessary care

Training materials required for this session:

A What newborns need during the postnatal period

B Pictures and text for newborn care from the dai training book

Methodology:

Present the objectives

A. Postnatal practices - needs of the newborn **30 minutes**

Divide participants into 2 groups and ask each group to discuss and list what happens when a child is born. One group will discuss male child and the other female child. What are the prevalent practices? Are they different for a boy and a girl? Under what circumstances do these practices differ? What does the mother, father, family do? What does the birth attendant or the health provider do? (10 minutes)

Ask the groups to enact a role-play to reflect the points discussed. (10 minutes each)

List points on a chart/board and sum up activity by reading the points in order i.e. what comes after what. Sum up the activity with content from (A).

B. New born care immediately after delivery **2 hours**

State that immediately after delivery it is very important for some things to be done in order to ensure that all is well with the newborn and to treat any abnormal situation immediately. New born care immediately after delivery must be done systematically so that no item is missed out. Using the handout show the illustration in (B) and ask participants to explain. Fill gaps using the content given in (B).

Although some of the points given in this section may already have been brought up in the earlier activity, it is good to go over each of them using illustrations (B).

Activity ***30 minutes***

Divide participants into 2 groups

Group 1: Write a song on the things that should be checked in the newborn.

Group 2: Create a Mime show on what must be done to take care of the new born.

Materials used for training / handout include:

A **In the postnatal period newborn infants need:**

- Easy access to the mother
- Appropriate feeding
- Adequate environmental temperature
- A safe environment
- Parental care
- Cleanliness
- Observation of body signs by someone who cares and can take action if necessary
- Access to health care for suspected or manifest complications
- Nurturing, cuddling, stimulation

Protection from :

- Disease
- Harmful practices
- Abuse/violence

Acceptance of :

- Sex
- Appearance
- Size

Recognition by the state (vital registration system)

The newborn's health and well-being can also be affected by a variety of conditions. The most common causes of death and disability in the postnatal period include prematurity, neonatal sepsis, respiratory infections, neonatal tetanus and cord infections, congenital anomalies, and birth trauma or asphyxia. Babies that are preterm or have a low birth weight are more prone to low body temperature, more likely to succumb to infection, more often need to be resuscitated, and are more difficult to feed. Mothers and health workers can help avoid dangerous heat loss by making sure the room is warm and that the baby is kept next to its mother.

Infections are still a major threat to newborn infants in developing countries. Like puerperal sepsis in the mother, the extent can be reduced dramatically by making sure that the birth takes place in hygienic conditions and that those present observe basic rules of cleanliness such as hand washing.

Jaundice is quite common in newborns and usually clears up without treatment, but it can be especially dangerous in preterm or low birth weight babies. Ophthalmia neonatorum is a discharge from the eyes that occurs within the first two weeks of life but can be prevented by application of ointment or eye drops in the first hour after birth.

The establishment and maintenance of breastfeeding should be one of the major goals of postpartum care. Breast milk provides optimal nutrition for newborn infants, protects them against infections and allergies and promotes mother-infant bonding. The baby should be given to the mother to hold immediately after delivery, to provide skin-to-skin contact and for the baby to start suckling as soon as s/he shows signs of readiness - normally within ½-1 hour after birth. In institutions babies should be kept with their mother and unrestricted breastfeeding should be allowed.

6-12 hours	3- 6 days	6 weeks	6 months
Baby: breathing warmth feeding cord immunization	feeding infection routine tests	weight/feeding immunization	development feeding

(Source:WHO)

B **Postnatal care** (prepare the pictures on chart /flipchart with the text)

IF THE NEWBORN DOES NOT CRY

Show the picture: The newborn does not look alive but looks lifeless.

For discussion

- After birth if the newborn does not cry, what should the birth attendant check for?

If the newborn does not cry, check her/his breathing. After birth if the newborn does not breathe nor cry, the body of the child may turn blue or white. The heartbeat may be mild or may not be heard and the newborn looks lifeless.

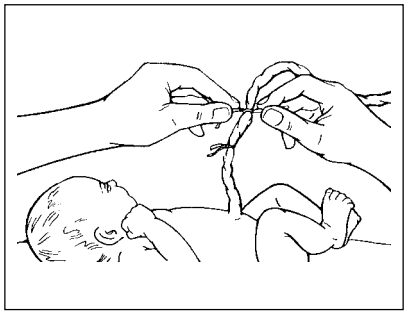
- After birth if the newborn does not cry or breathe what should the birth attendant do?

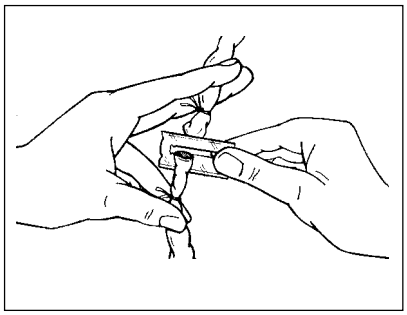
The phlegm in the newborn's mouth and throat should be removed. If there is no change in the condition of the newborn after this, he/she should be given mouth to mouth resuscitation.

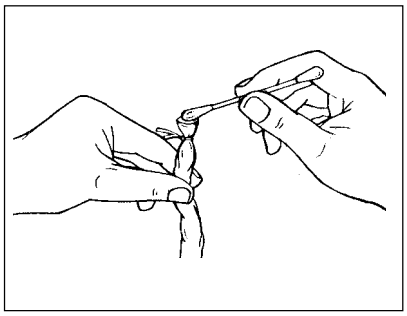
Note to facilitator: In the same manner cover the rest of the content given below

Cord care

Show the picture:







The birth attendant/ health provider ties the cord with a clean thread. She cuts the cord with a new blade.

She applies antiseptic to the edge of the cord with a cotton bud

- Why is it important to cut the cord in the correct manner?

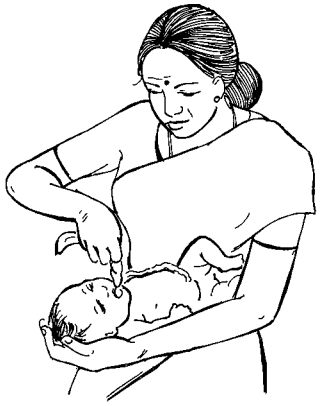
Cutting the cord in a clean and correct manner can prevent risky infections

- To prevent infections, what care should be taken while cutting the cord and caring for it?

Hands should be washed properly. The attendant should then remove the string/nada from the delivery kit and tie it at two thumb distance from the umbilicus. The second string must be tied at three finger space form the first one.

The cord should not be left long. This may be prone to infection. There is no need to clean the entire cord with antiseptic. It is sufficient to apply on the edge.

HOW TO REMOVE THE PHLEGM FROM THE MOUTH



Show the picture:

The birth attendant cleans the phlegm in the mouth and throat. The fingers of the birth attendant should be wrapped with a clean cloth or cotton.

For discussion:

- What is the importance of cleaning the phlegm in the mouth of the newborn?

The phlegm may block the air pipe so the newborn cannot breathe or cry.

- When does the birth attendant clean the mouth of the newborn with the help of her fingers wrapped in cotton or cloth.

  In case of such a condition , if the newborn cannot breathe or cry, the newborn's mouth should be cleaned using a cloth or cotton wrapped around a finger.

- In what other ways can the phlegm be removed?

The newborn's head should be placed slightly lower than the body, the face should be turned towards the birth attendant. The phlegm can be removed using suction.

HOW TO GIVE MOUTH-TO-MOUTH RESUSCITATION

Show the picture:

If the newborn does not cry, mouth-to-mouth resuscitation must be done

For discussion:

- After birth when can one give mouth-to-mouth resuscitation?

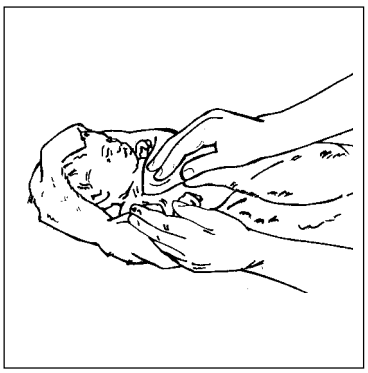
After removing the phlegm from the mouth and throat of the newborn, if the newborn does not cry, the birth attendant should carefully give mouth to mouth resuscitation to the newborn.

- What steps should the birth attendant follow for mouth-to-mouth resuscitation?

A rolled cloth should be kept beneath the neck of the newborn and the newborn should be laid down. The birth attendant should hold the head of the newborn and give mouth-to-mouth resuscitation. Place a clean cloth over the mouth and nostrils of the newborn and blow the breath in the mouth of the newborn. After each breath, check the movement of the chest. After doing this two or three times, the birth attendant should take care so that she does not feel breathless and tired.

KEEPING THE BABY WARM

Show the picture:



The newborn is wiped with a dry and soft cloth.

The newborn is wrapped in a soft cloth so that the heat is retained in the body.

Colostrum is fed to the newborn

For discussion:

- If the newborn is not kept warm what could be the consequences?

The newborn is delicate, so to protect him/her from cold , ensure that the newborn's body is kept warm, or the newborn may get sick and die.

- After birth, why should the newborn be kept dry?

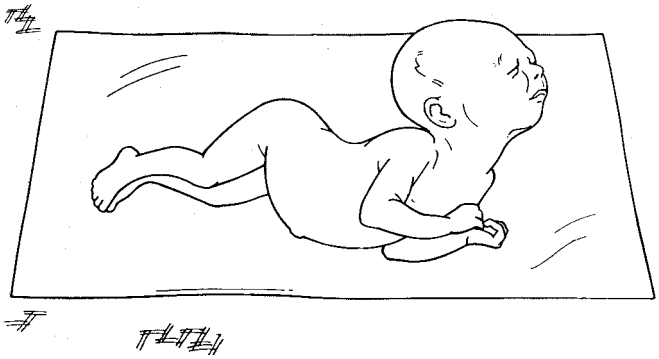
After birth the newborn's body is wet, so there are more chances of the newborn being affected by cold. The newborn is wiped with a clean cloth so as to dry the body.

- What are the methods to keep the baby warm?

After drying the body, the newborn is wrapped in layers of cloth. The air circulates through the layers and the body of the newborn is kept warm. This warmth is soothing for the baby. Cover the baby and keep the baby warm.

Apply oil lightly, place the body- hands and legs of the newborn in plastic covers/bags, ensure that the newborn's body is in contact with the mother's body to keep the newborn warm.

HOW TO IDENTIFY IF THE NEWBORN HAS TETANUS



Show the picture:

The body of the newborn is like a wooden log or the body of the newborn is bent like a bow or when an eight day old newborn is unable to open her/his mouth.

For discussion:

- What do these symptoms show?

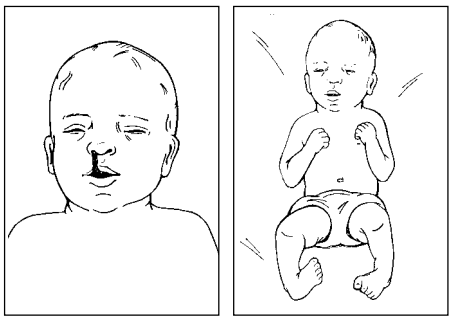
If the newborn cannot suckle the breast milk or suck the colostrum or when the newborn avoids sucking milk, this may be the first symptom of tetanus. How can you identify if the newborn has tetanus?

If the newborn has tetanus the mouth of the newborn is shut tightly and he/she appears to be smiling.

- What is the first symptom of tetanus?

The newborn who has tetanus gets fits, at which stage the newborn bends his or her body and resembles a bow.

HOW TO CHECK FOR DISORDERS IN A NEWBORN



Show the picture:

Newborn with a cleft lip

Newborn with a disability in the leg

For discussion

- Why is it the important to identify birth disorders in the newborn?

  In addition to the disorders visible to the naked eye, there may be other disorders too. There may be other risky disorders that are not visible. Some may even endanger the life of the newborn.
- List out the other disorders you know

  Small lumps in the back of the head or the backside, shapeless ears, small or big head are the other birth disorders, which are not seen in the picture.

If the mother gets vaccinated for German measles at the right time, certain disorders can be avoided. Mothers should avoid consuming unwanted medicine and x-rays during the first three months of pregnancy. This also helps avoid birth disorders in newborn.

If the mother takes any injections or tablets to abort the fetus and if abortion does not take place, there are chances of birth disorders in the newborn.

HOW TO CHECK IF THE NEWBORN HAS PNEUMONIA

Show the picture:

The chest is sunken and difficulty in breathing, and the newborn avoids drinking breast milk.

For discussion:

- How to identify if the chest is sunken ?
- While breathing if the chest of the newborn is low and the stomach is bulgy, and if the chest sinks in.
- When the chest is hard and sunken, why do these newborns avoid drinking breast milk?

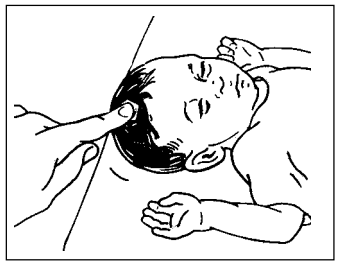
When the chest is hard and when the breath inhaled forms a depression below the chest and above the stomach. If the newborn finds it difficult to breathe and the chest is hard and sunken, the newborn becomes tired and cannot suck the breast milk

- If the chest of the newborn is sunken what is the reason?

After birth the chest of the baby is soft and a little depressed. If the chest is hard and the chest is sunken it shows that the newborn has pneumonia.

HOW TO CHECK IF THE NEWBORN IS DEHYDRATED

Show the picture:



The mother can touch the soft part in the center of the head of the newborn and identify if the child is dehydrated..

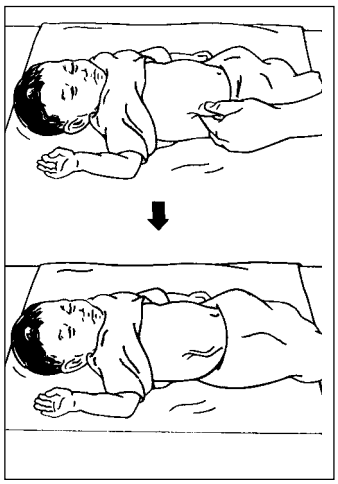
The mother can pinch the skin in the stomach of the newborn. After pinching it takes time to come back to normalcy.

For discussion:

- How to check if there is elasticity while pinching?

Normally after pinching the skin, it immediately comes back to normal state.

- While pinching if there is less elasticity what does it look like



When the newborn has loose motion, when the skin is pinched, it takes time to come back to normalcy. This indicates that there is less water in the newborn's body.

- When the newborn has loose motion how will the soft part on the head be?

In Newborns who have loose motion the soft part on the head forms a depression

HOW TO CHECK THE NEWBORN'S WEIGHT AND MEASURE THE LENGTH IN CENTIMETERS

The baby must be placed on a weighing machine and the weight recorded. If baby is below 2.5kg the baby is said to be underweight.

To measure the length, draw a straight line on the floor or smooth flat surface, lay the baby on the smooth flat surface along the line and mark the head top edge on the flat surface. Have someone gently hold baby in place while you stretch the legs and mark the edge of baby's feet on the line. Lift baby out and measure the distance between the two marks this will give you the baby's length.

Session 2: Infant nutrition

Session Objective: At the end of this session the participants will be able to:

A. Explain the importance of proper nutrition for infants from 0 to 24 months of age

B. Identify foods that can be introduced to infants after 6 months of age

C. Explain how often and how to feed a baby (according to its age)

Training materials required for this session:

A Starting complementary foods – types of foods to include

B Appropriate type of complementary food, list of major Indian foods that can be fed to the infant

C. How often and how to feed the baby

Methodology:

Present the objective.

A. Starting complementary feeding **30 minutes**

Ask participants if they remember what is recommended for babies from birth to 6 months of age. Explain that after the age of 6 months breast milk (HIV positive women must consult their doctor before delivery to discuss

infant feeding guidelines), alone cannot supply all their nutrition requirements. The baby's digestive system is developing. The jaw and the gums and teeth too are developing to support the mechanics of eating semisolid and solid food that the infant needs as its nutritional requirements grow. Babies when they start on complementary foods generally roll it around in their mouth and quite often push food out of the mouth as they learn the mechanics of chewing and swallowing. So the foods that are introduced should not only support their nutrition requirements but also be fed in a form that supports their ability to chew and digest the food.

Ask participants when do people normally start feeding babies semisolid foods. Listen to their responses and then explain using (A).

Ask participants if they remember what is recommended for babies from birth to 6 months of age. (5 minutes) Reiterate that all babies need to be exclusively breastfed from birth to 6 months of age. State that HIV positive women must consult their doctor before delivery to discuss infant feeding guidelines.

Ask participants what types of food are generally fed to infants. Let them share. Discuss the appropriate practice as given in (B) filling gaps in knowledge and providing time for participants to ask questions. (30 minutes).

Ask participants about how much and how often to feed baby. Then share information given in (C) (20 minutes).

Activity ***30 minutes***

Divide into 2 groups

Group 1 : To develop a song on when to feed complementary foods and how to introduce the foods.

Group 2 : To develop a chart on the types of food (local food names) to be included in baby's diet.

After groups present their items comment and provide inputs to plug gaps to sum up the activity.

Materials used for training / handout include:

A Additional foods or complementary feeding is usually started after 6 months of age. Till 6 months, exclusive breastfeeding provides sufficient nutrition to the child. If introduced before this age then breast milk might be replaced, thereby depriving the child of optimal nutrition and exposing her/him to the risk of diarrhea and other infections. After 6 months age additional semisolid food is required to complement breastfeeding for the increased energy, protein, minerals, and other nutritional requirements of the child. Initially only one or two semisolid feeds should be introduced. Gradually the number of feeds and variety is increased. After 9 months age minced, chopped, or pounded food can be introduced. By one and half years age the child should be given the normal food cooked at home.

B The desirable complementary food should be: -a) semisolid in consistency but not watery, b) inexpensive and easy to prepare, preferably from food available at home, c) easy to digest, freshly prepared and clean, d) high in calorie density and provide proteins, iron, and vitamins A and C, the nutrients which are usually deficient.

A cereal based semisolid food is usually the first food to be introduced. This can vary from "ragi" (a food used in South India), "suji kheer", or "moong dal" cooked, mashed, and strained. A "mashed banana" is also an excellent first complementary food available all over India. "Khichri" and "dalia" are other popular and appropriate complementary foods. Curd, rice, kheer, and porridge are other foods that can be used to introduce the child to semisolids.

Main Categories of Indian Foods Which Can be Used

Cereals: Rice, Wheat, Jawar and Millets. Cereals contain 7 to 12% protein and about 75% carbohydrate. They form an important source of energy, iron and protein in the Indian diet and also supply a certain amount of fat, which is referred to as invisible fat.

A thick creamy porridge made from cereals in water/milk/milk water mixture can be used. The porridge should be thick (too thick for not to be given through a bottle) and concentrated but soft. Some oil or fat (or sugar) is added to help swallow and digest. Care should be taken to ensure that the porridge is not watered down or made unduly thin which will further compromise the energy content.

Legumes: Lentils, bengal gram, red gram, horse gram, moong dal, arhar, rajma, and lobia, etc. Their protein content is 20-25%. The immature legumes do not have much protein in contrast to the dry legumes that are a much richer source. They are also a good source of vitamins and minerals. When eaten with cereal staples, they are just as nutritious as animal foods (meat, fish, milk) but are much cheaper. Recently, Soya been has become quite popular in urban areas and it contains 40% protein.

Foods from animals like eggs, meat, and fish are all nutritious. They are rich sources of energy and provide high quality protein, vitamin B12 and iron and are easily digestible. Eggs should be initiated in a half boiled or full

boiled and mashed form. Meat of all origins needs to be properly cooked, chopped very finely, pounded or mashed before it can be given to a child. However, socio-culture beliefs of vegetarianism and high cost limit their use.

Milk and Milk Products: All types of milk provide high quality protein, mostly in the form of casein, in contrast to human milk, which has mainly lactalbumin. The fat content of buffalo's milk is almost double that of human or cow's milk. Milk is rich source of riboflavin and calcium, and has some amount of vitamin A and C. However, it is poor source of iron and goat's milk does not have vitamin B 12. Milk can be used to cook the porridge or added to other complementary foods to enhance their energy content and soften them. Several milk product like curd, cottage cheese (panir), khoya, etc. are available and can be used in addition to or in place of milk.

Oil or fat helps to increase the energy density of the food and helps in absorption and metabolism of Vitamin A. It can be used during initial cooking of the food or after it is ready, and helps in swallowing and digestion.

Sugar or jaggery (gur) is added to improve taste and to provide additional energy and minerals.

Vegetables & Fruits. Vegetables help to increase the vitamin (especially A, B and C) and minerals (especially iron) contents of the complementary foods. The dark green or yellow vegetables are particularly good sources of vitamin A. Tubers and starchy roots like potato, sweet potato and colocasia (arbi) are rich in carbohydrates. These should be well cooked and properly mashed and are best given along with the cereals.

Fruits add to variety and taste. They can be given after mashing either alone or with cereals. The fruits like banana, mango, papaya, pear, plum, peaches are good sources of vitamin A and citrus fruits provide vitamin C besides minerals. But fruits contain no proteins and are not a good source of energy. A lot of money should not be spent on expensive fruits.

C How often and how to feed the baby

Feeding amount and frequency is an important factor that affects a child's nutritional status. Given the small stomach sizes, young children need to be fed frequently during the day to ensure adequate food consumption. Start with 1 to 2 teaspoonfuls and gradually increase the amount of food. Over 3 to 4 weeks increase to 50 to 60 g or half a cup (or one banana). Feed 2 to 3 times a day till about 9 months age, after which the feeds can be increased from 3 to 6 times a day. The fewer the feedings, the higher the caloric needs per feeding. Continue breastfeeding and preferably give semisolids after breastfeeding.

Gradually add tubers and starchy roots to improve variety and taste. Fruits can be added after mashing alone or with cereals, they are not a good source of energy but provide vitamin A and C. All foods from animals are nutritious, but the high cost limit their use.

Feeding from the family pot. Family foods, that is, the foods that the rest of the family normally eats can provide all the nutrition for the baby without any additional expenditure. Giving the family food in a mashed form, without or before adding hot spice or extra salt, and adding something extra like oil and green leafy vegetable is best. Foods such as rice, dals and vegetables can be easily modified in this manner. Traditional Indian foods also provide a good opportunity to mix cereals and legumes to improve nutritive value. Foods like idli, dosa.

Practice active feeding: The mother, father or other caregiver should actively encourage and help the child to eat himself/herself, while ensuring that the baby gets enough food. This helps in developing coordination and motor development. Hand feeding should not be looked down upon. This is a traditional method of feeding throughout the country. What should be stressed is that the hands should be clean and the nails short and scrubbed.

Mealtime should be a pleasant time for both the caregivers and the children. It is not only what to feed but how to feed the child and is equally important for growth and development of the child. Caregivers should enjoy actively feeding the child to make feeding an opportunity for interaction and psychosocial stimulation. Interaction between the two should assure the child that s/he is loved and cared for.

Following is a list of optimal behaviors that would help the caregivers to promote active feeding in the child:

- Caregiver should sit with the child and feed the child.
- Caregiver should understand child's signals and needs relating to hunger and satiety and respond appropriately.
- Caregiver should encourage the child to eat by showing interest and offering more helpings.
- Talking and naming the food being given to the baby and describing its texture, taste and smell stimulates the child to stay interested and helps in eating adequate amounts of food.
- Caregivers should be discouraged from threatening, forcing or showing anger at children who refuse to eat. These actions result in children eating less.
- Children should be allowed to eat from a separate bowl. This would allow the caregiver to monitor food intake and not allow the competition from older siblings for food from a common plate.

- Children over 1 year of age should be assisted in feeding and adequately supervised while eating. Children eat slowly and get easily distracted. If not supervised adequately, other siblings or even animals may take the food away or food may be spilled on the ground.

Session 3: Growth Milestones

Session Objectives: At the end of the session participants will be able to:

A. Briefly describe the Growth milestones for infants 0-6months of age and 7-12months of age

B. Describe the immunization schedule for infants

Training materials required for the session:

A Magic child story

B Chart on complementary foods

C Empty grids and filled grid on growth milestones

D Immunization schedule

Methodology:

A. Growth milestones **1 hour 15 minutes**

(15 minutes) Divide participants into smaller groups and give each group a copy of the story (A1) ''The magical child' to read In the larger group, discuss the story. Use chart (A 2) based on complementary feeding to explain the amount of food that babies need as they grow.

Divide participants into groups and ask participants to discuss about the development of young infants 0-6 months of age and 7-12 months of age. Give them a sample grid (A3) each.

Review the physical, mental and social abilities and interests for younger infants aged 0-6 months and infants aged 7 –12 months using filled grid in (A3)

B. Immunization schedule **15 minutes**

Ask participants to explain the immunization schedule for infants and young children.

Display the immunization schedule (B) and explain the importance for each immunization. Explain that it is important to ensure that the vaccines are given in time as scheduled for them to be effective.

Activity ***30 minutes***

Divide participants into 2 groups and ask them to devise a way of educating the community about

Group 1: Growth milestones.

Group 2: On the immunization schedule and the need to adhere to it strictly.

Materials used for training / handout include:

A1 **The magical child**

Maya kulandaiyin marama valarchi

Thousands of years ago the King who ruled Tirunelveli had a son. As he was the only son of the King he was given special care and attention to the child. But the king was concerned. The child looked exactly like he was when he was born. The child had not grown sufficiently. At one year of age the child could not sit nor stand. The king was very upset that the child was not active and kept lying on the bed. His chief minister advised him and the King a prize of one thousand gold coins to any person who might find a solution to the problem. This information was widely disseminated.

Many vaidhus/healers came and saw the child but they could not identify the reason for the child's lack of growth. One day a Magician came to the palace and claimed that he had a solution. The King and the Chief Minister were taken aback. He went closer to the child and observed him. He asked the King what the child was being fed. The King was insulted but because he wanted the child get well, he responded that he had bought a good cow from a foreign land, transported it to the palace by sea. The child was fed the cow's milk diluted with water. When the Magician heard this he understood everything. He waved his magic wand ' *Om reeem neem kleem'* and created a one and a half year old child. The child was so lovely! He looked well developed and healthy. The Minister and King were surprised to see the child and when the King wondered about the reasons behind the child being so healthy, the child answered:

When I was born I was also like the King's son. I was very small. I was breast fed from the day I was born. After 3 months I began to turn over and at 4-5 months I began crawling. My mother continued to feed me only breast milk till I was 6 months old. I began sitting in the 6-7 month Thereafter my mother began feeding me porridge made from ragi , fried gram and rice, mashed idlis, idiyappam, bananas, boiled eggs. Gradually she introduced food items one by one so I could get used to it and gradually increased the quantity of food and would give me about ½ cup extra. She would feed me 2-3 times a day as I could eat only little at a time. She continued to breastfeed me. When I was about nine months old my mother used to keep aside some food for me while cooking which was not spicy /sour. She fed me little rice, greens/ *keerai,* lentils and ghee/butter which were softened. I began walking a little bit when I was one year old. She still continued to breastfeed me. The quantity of food I ate increased. I also ate some fish, vegetables, minced meat etc. When I was born I was only 3 kilos. Do you realise how many vitamins are responsible for my growth.

The King was really taken aback when he heard this. He repented that in spite of all the riches because of ignorance he had fed cows milk alone to the child.

We should not think that all these things can only be given by King-like rich people. We can give whatever is available and affordable in the village, like my mother did, along with breast milk. Then all children would be – Healthy! said the 'magical' child.

The magician waved his wand again and made the child disappear and collected his reward of 1000 gold coins.

Mothers who have heard this/read this, alongwith breast milk give other food for your child's growth from the 7th month onwards

From the 7th month onward soft foods like banana, idiyappam, idli.

From 8th mashed rice, boiled eggs.

From the 9th month – whatever is cooked at home can be given to the child without spice (chilly).

Do share this information with other mothers too.

A2 **Use equivalent measures in teaspoon, or cup/katori to the gram measures given in the table.**

Balanced Diet for Infants and Children

Food Groups	Infant (6-12 months) Amount/day (g)	Children (1-3 years) Amount/day (g)
Cereals and Millets	45	120
Pulses	15	30
Milk (ml)	500	500
Roots and Tubers	50	50
Green Leafy Vegetables	25	50
Others Vegetables	25	50
Fruits	100	100
Sugar	25	25
Fats/Oils (visible)	10	100

A3

0-6 months	**Physical development**	**Mental development**	**Social development**

7-12 months	**Physical development**	**Mental development**	**Social development**

0-6 months Physical development	Mental development	Social development
Learns to localize sounds and turns to see. Gains control of hands - learns to bat, then reach and grasp objects. Discovers feet - brings feet to mouth and explores with feet. Begins to sit with support. Large muscle play may include rolling, scooting, rocking, bouncing.	Explores world with eyes and ears and begins to explore with hands and feet and mouth. Enjoys creating effects in the environment by own actions. Begins to recognize familiar people, objects and even events - then to anticipate them. becomes aware of novelty and strangeness in people, objects and events. Develops definite preferences for certain people, objects and events. May imitate simple movements if in own repertoire. Does one thing at a time.	Special interest in people (faces and voices especially). Begins to smile at faces, voices and mirror image. Quits crying when sees face or hears voice. Begins to seek attention and contact with people. Distinguishes among familiar people and has preferences. Begins to coo and gurgle, babble and laugh aloud, play with sounds. listens to voices and may imitate sounds already in own repertoire
7-12 months **Physical development**	**Mental development**	**Social development**
Begins to sit alone. Begins to creep and crawl onto or into things Begins to pull to a stand, cruise (walk holding furniture), and walk alone (10-16 months). Interest in moving about and practicing motor skills. Develops "pincer" (thumb and finger) grasp and begins to hold objects with one hand while manipulating them with the other. With objects wants to bang, insert, poke, twist, squeeze, drop, shake, bite, throw, open/shut, push/pull, empty/fill, drag along. Enjoys bath play - kicking and splashing.	Interest in appearing and disappearing (objects and people) - develops 'object permanence' (looks for object out of sight at approximately 11 months). Interest in container/contained relationship likes to empty cupboards, drawers, and containers of objects. Interest in letting go and dropping objects (will use string to pull back vanished objects). Interest in exploration and likes many objects to explore. likes to operate simple mechanisms (open/shut, push/pull) and create effects. Remembers people, objects, games, actions with toys - shows persistence and interest in novelty. Beginning interest in picture books	May fear strangers or react to change - plays best with familiar person nearby. Watches and may imitate others. sensitive to social approval and disapproval. Interest in getting attention and creating social effects. Enjoys simple social games 'peek-a-boo,' 'bye-bye' babbles and plays with language - may try to imitate sounds. Recognizes own name and may begin to point to named objects or obey simple commands.

(Source: Adapted from Vincent Iannelli, MD-about.com pediatrics guide)

Note that these lists indicate average development - the age range at which the 'average' child can he expected to achieve a particular skill or develop a specific interest. The ages in the text are only approximate. Children develop skills at uneven rates - any one child may be 'above average' in one skill and 'below average' in another skill. For an individual child, the parent is the best judge of the child's abilities and interests at any point in his or her development. Be sure to talk to your health provider or anyone else who is informed about early childhood development if you have any concerns about your child's development.

B **Immunization Schedule for Infants**

AGE	IMMUNIZATION	DISEASE PREVENTED
At Birth	BCG	Tuberculosis
1 ½ months 2 ½ months 3 ½ months	DPT, Polio DPT, Polio DPT, Polio	Diphtheria, Whooping Cough, Tetanus, Poliomylitis
9 months	Measles	Measles
18 – 24 months	DPT, Polio first booster dose	
4 ½ - 5 years	DPT, Polio second booster dose.	

References:

'Garbam mattrum Peru Kaal Paramarippu': RUWSEC
Adapted from:Training of traditional Birth Attendants: an illustrated guide for TBAs : World Health Organization, Geneva.
BPNI Infant and Young Child Feeding - Update – 6

SEXUAL AND REPRODUCTIVE HEALTH ISSUES FOR WOMEN AND MEN

Overall Objective:

- Provide basic knowledge and understanding on sexual and reproductive health issues that affect women and men and explore ways to prevent health problems as well as be able to seek appropriate treatments when necessary

Myths and misconceptions due to lack of information and an inherent embarrassment to discuss sexual and reproductive issues, compounded by insensitive health services, leave many women and men coping miserably with problems in their sexual and reproductive lives.

This module, through it's seven chapters, provides to a large extent technical information or update that is crucial to the understanding of sexual and reproductive health problems and provides participants the opportunity to explore ways to deal with them effectively to pave the way to a better healthier sexual and reproductive life. The exercises can be modified to focus on particular social issues that impact on the sexual and reproductive lives of people, however what is prevalent in one community may not be prevalent in another so facilitators need to tailor the exercises when there is a need to narrow the focus to particular issues prevalent in the local area of the participants.

Chapter 1: Menstrual Health Problems	5 hours 15 minutes
Chapter 2: Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) in women and men and HIV/AIDS	17 hours 30 minutes
Chapter 3: Urinary Tract Infections (UTI)	3 hours
Chapter 4: Uterine prolapse	2 hours 50 minutes
Chapter 5: Cancer : Breast, Cervical and Prostate	5 hours 30 minutes
Chapter 6: Contraception	4 hours 15 minutes
Chapter 7: Infertility	3 hours 15 minutes

Menstrual health problems

This chapter deals with problems related to menstruation and menopause. It covers the clinical conditions of health problems in these two, otherwise normal, features of a woman's life. Some of the health problems experienced by women may be attributed to poor hygiene and general health conditions or social practices prevalent in some communities, while some could be clear medical problems that need professional attention.

This chapter has the following two sessions:

Session 1: Problems during menstruation 2 hours 45 minutes

Session 2: Health problems associated with menopause 2 hours 30 minutes

Session 1: Problems during menstruation

Session Objectives: At the end of the session participants will be able to:

A. Describe the problems during menstruation (what is menstruation is already covered in an earlier module)

B. Describe self care practices

Training materials required for this session:

A. Flip charts, markers and content on A1, A2, A3

Methodology:

Present the objectives for this session.

A. Problems during menstruation **1 hour**

Ask participants to share the physical problems that women face during menstruation or before and after menstruation. List all of the problems that the participants state on a chart and post on the wall.

Sum up that some women experience severe pain with severe bleeding throughout the cycle, others experience it during the first two days, others during the middle 3 days. The pain maybe severe, in the lower abdomen, hips, back. This pain maybe accompanied by dizziness or nausea. This pain does not start for some years after the onset of puberty. Between 19-21, progestrone levels increase a lot and hence in this age, there is increase in the incidence of stomach pain. The pain usually disappears after 35 years.

Stomach pain/cramps in single girls/women disappears after marriage. The reason for this is not clear. But changes due to sex may be the reason. There are two kinds of stomach pain/cramps – constant and pain that occurs at intervals. The constant pain is not severe but the pains at intervals maybe severe with dizziness, nausea. For most women there will be breast tenderness and may be some dull pain in the lower abdomen just before or on the first two days of menstruation (periods). Some women have irregular cycles or scanty bleeding or no bleeding for many months. Some women bloat and have other problems.

Dysmenorrhea

Many women experience symptoms of dysmenorrhea (painful periods). Explain what is dysmenorrhea and its two stages and the possible solutions to this problem. Read attached content (A1) on dysmenorrhea . On the chart that you had posted with the participants' contribution tick off or circle the symptoms that go with dysmenorrhea. (20 minutes)

Premenstrual syndrome (PMS)

Discuss in large group the problem of PMS. Read content (A2) on PMS. On the chart that you had posted with the participants' contribution tick off or circle the symptoms that go with PMS (20 minutes).

Amenorrhea

In the large group now discuss issues related to amenorrhea (irregular periods). Explain what is amenorrhea and the possible causes from (A3) on amenorrhea. On the chart on the wall circle out those problems that the participants had listed that are symptoms of amenorrhea. (20 minutes)

B. Care during menstruation **15 minutes**

Ask participants to outline how women need to care for themselves during menstruation. (*This has already been covered in detail in Part 2, Module 2, Chapter 1).*

State that the following are essential:

- Wear clean underclothes.
- During menstruation, the cloth should be washed and dried outside. She should not use the same cloth throughout the day.
- Should bathe daily with clean water. During menstruation should avoid bathing in lakes or ponds as the mouth of the uterus is open and the chances of infection increase.
- In case of pain/cramps a hot water bottle may be used for fomentation and rest may also help manage pain.

Activity ***1 hour 30 minutes***

Divide participants into five groups and give the following: (20 minutes preparation, 10 minutes each presentation and 20 minutes discussion)

Group 1: To plan a community based workshop/meeting to discuss problems of women /adolescent girls with dysmenorrhea in the community and the impact it has on their daily lives. How can these women be helped (at home, in the village, health center). The group can 'enact the workshop'.

Group 2: To discuss problems of women/adolescent girls suffering amenorrhea in the community and the impact it has on their daily lives. How can these women be helped (at home, in the village, health center). The group can 'enact the workshop'.

Group 3: To discuss problems of women suffering from PMS/adolescent girls in the poor marginalized community and the impact it has on their daily lives. How can they be helped.

Group 4: To make a poster to show how to take care during menstruation (include needs of adolescents too).

Group 5: To plan strategies that enable women to take care during menstruation. (for example: water supply/ toilets, awareness/information, challenge existing practices regarding diet/mobility etc)

After they present in the large group ask participants to volunteer to sum up what they have learnt in the session

Materials used for training / handouts include:

A1 **Dysmenorrhea**

Dysmenorrhea, is the term for painful periods or menstrual cramps. Although menstruation is often painless, many women suffer from discomfort or pain in association with periods at some time during their reproductive years. There are two types of dysmenorrhea:

Primary or spasmodic dysmenorrhea: in this variety no disease or other medical cause can be found for the pain and other symptoms. Primary dysmenorrhea frequently affects women in their teens and early 20s, who have never had a baby.Features of primary dysmenorrhea: include backache, diarrohea, dizziness, headache, nausea, vomiting, and a feeling of tenseness. Severe pain occurs only in minority, but there is no doubt that it can be incapacitating. The pain is colicky (cramping) in nature, usually starts on the first day of the period. It may last for several hours or continue throughout the first and second day. Often the menstrual flow is scanty at first, and then the pain becomes easier when the flow is properly established.

The symptoms are caused by prostaglandin, a natural hormone produced by cells in the uterine lining. The level of prostaglandin increases in the second half of the menstrual cycle. When a woman's period begins, the cells in the uterine lining release prostaglandin as they are shed. Women with severe primary dysmenorrhea have significantly higher prostaglandin levels in their menstrual fluid than do other women.

The only good thing that can be said about primary dysmenorrhea is that usually the symptoms don't last very long. Some women experience symptoms for up to one or two days, but rarely longer. Secondary dysmenorrhea is caused by a physical condition. Women who suffer from it tend to be older than those with primary dysmenorrhea. Some conditions that may be responsible for secondary dysmenorrhea are

1. Endometriosis (uterine tissue that grows outside the uterus, in the ovaries and other locations). Endometriosis is the most common reason for secondary dysmenorrhea.
2. Adenomyosis (uterine tissue growing into the uterine wall).
3. Endometrial polyps (growths in the uterine lining).
4. Fibroids (growths in the uterus).
5. Narrowing of the cervix (the entrance to the uterus) as it opens into the vagina.
6. Pelvic inflammatory disease (PID).
7. Use of an intrauterine device (IUD).

Features of secondary dysmenorrhea: The type of pain experienced is very variable. It may precede the onset of period for about a week. The pain is often a dull ache felt equally on both sides of the lower abdomen and back, sometimes extending down the thighs.

Tests and treatments:

Primary dysmenorrhea: A pelvic examination and/or other tests like an ultrasound examination are done to be sure there's no other causes for the symptoms.
If everything is normal, then generally analgesics like aspirin, ibuprofen, or naproxen are recommended. The most widely used medical treatment is to use the birth-control pill. It acts by stopping the ovulation and decreases prostaglandin levels. Regular exercise can also help minimize pain and cramping.

Secondary dysmenorrhea : in these cases the underlying cause must be treated. To find the cause, the doctor may

- perform a pelvic exam.
- ask about the problem and general health.
- do X-ray and ultrasound examinations.
- advise dilation and curettage (D & C), a minor surgical procedure to open the cervix and remove tissue for microscopic testing

A2 Premenstrual Syndrome (PMS)

PMS consists of various physical and/or emotional symptoms that occur in the second half of the menstrual cycle, after ovulation. It is characterized by premenstrual discomfort in the lower abdomen and back, and in the breasts. All these features precede the period by a week or ten days. Fortunately, a woman obtains relief when her menstrual period begins. Another feature of PMS is a symptom-free time for several days every month, in the first half of the menstrual cycle.
Features: these include physical features like acne, backache, bloating, sore breasts, and headache. Emotional symptoms might include changes in sexual desire, difficulty concentrating, irritability.
Women may gain upto a kilogram of weight or more in the latter part of the menstrual cycle due to water retention in the body. Emotional stress often contributes to the symptoms.
The only saving grace in this problem is that few women experience all these symptoms! Most have a few that recur each month.
The symptoms of certain medical conditions can resemble PMS. These conditions include allergies, depression, diabetes, dysmenorrhea (painful periods), endometriosis, fibrocystic breast disease, and thyroid problems.

Causes: There's still some disagreement about what causes PMS, but it definitely seems to be linked to hormones. A relative lack of the hormone progesterone is suspected along with increase in a water retaining substance called anti diuretic hormone.

Treatment: The assessment of the emotional and work related stress is very important. Many women find that a balanced diet and healthy snacks are helpful, as are avoiding caffeine and reducing salt intake. Simple reassurance often does wonders, but often it is necessary to treat the symptoms with various drugs
Diuretics ("water pills") can reduce bloating.
Analgesics like ibuprofen, aspirin ease headache or cramps. Combined oral contraceptives also called the birth control pill may be useful for some women.

(Source for A1 and A2: http://health.indiamart.com/womenshealth/menstrual-disorder/dysmenorrhea.html)

A3 Absence of menstruation (amenorrhea)

Amenorrhea is the lack of menstrual flow and can be a normal occurence or a sign of malfunction or disease. In primary amenorrhea, menstruation does not begin when expected (by the age of 16). Secondary amenorrhea occurs when the normal established menstrual cycle is shut down for 6 or more months due to a condition other than pregnancy, breastfeeding or menopause.

Primary amenorrhea: Primary amenorrhea is the absence of the menstrual period by the age of 16. Treatment of amenorrhea may range from hormonal supplementation for developmental abnormalities of the reproductive system to surgery for tumors of the pituitary.

Secondary amenorrhea: Secondary amenorrhea is the cessation of menstrual flow for a period of 6 months or more in the absence of pregnancy, breastfeeding or menopause. Extreme weight gain or loss, certain medications, as well as anxiety can be the root cause of amenorrhea. Treatment can range from behavior modification for excessive excercise to medication to surgery in the presence of disease.

Symptoms associated with amenorrhea depend on the cause and may include the following:

- Headache
- Breasts produce milk in a woman who is not pregnant or breast-feeding an infant)
- Visual loss (in rare cases of pituitary tumor)
- Marked weight gain or weight loss
- Dry vagina
- Increased hair growth in a “male” pattern (hirsutism)
- Voice changes
- Breast size changes

Common Causes

Primary amenorrhea

- Normal delay of onset (up to age 16)
- Lack of an opening in the membrane at the entrance of the vagina (hymen)
- Drastic weight reduction
- Congenital abnormalities of the genital system (underdeveloped ovary and fallopian tube)
- Chromosomal abnormalities
- Extreme obesity

Secondary amenorrhea

- Pregnancy
- Anxiety over pregnancy may cause a missed period, thereby increasing the anxiety even further
- Drastic weight reduction
- Vigorous athletics
- Obesity
- Emotional distress
- Menopause (normal for women over age 45)
- Endocrine disorders such as thyroid disease or pituitary disease/tumor
- Drugs such as busulfan, chlorambucil, cyclophosphamide, oral contraceptives, phenothiazines, and non-oral contraceptives (such as Norplant and Depo-Provera)
- Dilation and curettage (D and C)

Home Care

Treatment depends on the cause:

- For amenorrhea caused by normal delay of menstruation onset, have patience until age 16.
- For a missed period that may be caused by pregnancy, consult your doctor to confirm pregnancy.
- For a missed period caused by drastic weight loss or obesity, proper diet is recommended.
- For a missed period resulting from excessive exercise, use moderation and cut back to a more conservative program.

Contact the health care provider if there is no satisfactory explanation for a missed period.

(Source http://www.nlm.nih.gov/medlineplus/ency/article/003149.htm)

Session 2: Health problems associated with menopause

Session Objective: At the end of the session participants will be able to:

A. Describe common problems associated with menopause

Training materials required for the session:

A Charts and markers

Methodology:

Present the objectives.

A. Common problems women associate with menopause **1 hour 30 minutes**

Ask participants to share what menopause means. If the session on menopause has not been covered, it can be covered before dealing with the specific objectives of this session. (10 minutes)

Divide into three groups. Ask each group to discuss and note on the chart:

What changes take place during menopause that impacts the health of the woman: physical, psychological, and sexual. (15 minutes discussion+ 10 minutes presentation by each group+ 15 minutes post presentation discussion). Discuss the consequences of cessation of menstruation (if any) and which are as a result of social, economic and other factors/changes during that age /period.

Activity ***1 hour***

Divide participants in two groups and ask each group to create and present a role play on interaction between a woman and her barriers to access health care and strategies for community based support and care that can be provided for older women.

Group 1: Present the situation of a woman who wants to access health services and her experiences.

Group 2: Present the possible strategies that can be initiated in the community to provide care and support for older women.

Highlight the barriers to health care – from home till she reaches the health center, lack of comprehensive care, affordability, distance etc. and how to overcome these. Also highlight the strategies that might address some of the issues of health access and others pertinent to older women.

Reproductive tract infections and sexually transmitted infections in women and men and HIV/AIDS

Reproductive Tract Infections (RTIs) pose grave threats to women all over the world. RTIs also include Sexually Transmitted Infections (STIs), infections due to surgical procedures like unsafe deliveries, abortion, insertion of IUDs and also as a result of infections due to increase in the organisms found naturally in the genital tracts. RTIs especially STIs are experienced by men also but the prevalence and consequences for women is much more severe –resulting in morbidity and mortality. Over 50% of STIs in women are asymptomatic as a result of which diagnosis is difficult. These infections remain undiagnosed and untreated resulting in serious health problems including infertility, cancer.

Attitudes towards gynecological problems are secretive (shame) and tend to 'blame' the woman- This problem affects men and women but is called a '*pomblai noi'* 'woman's disease'. This attitude is a major barrier to seeking care, to providing care and is reflected even in interventions and programmes planned and implemented (by the health system).

Women and men need to know what these infections are, their symptoms as well as know that some of them have no symptoms but the person may still be infected if any one of the sexual partners are infected.

This chapter provides the information related to each of these infections to increase the knowledge and understanding about these infections and how they can be prevented or treated.

The content has been spread across four sessions as follows:

Session 1: Overview of what are RTIs and STIs, how are they spread and how can the transmission be prevented — 4 hours 30 minutes

Session 2: STIs and RTIs — 5 hours

Session 3 : STI Case studies — 4 hours

Session 4 : HIV/AIDS — 4 hours

Session 1: Overview of what are RTIs and STIs, how are they spread and how the transmission can be prevented

Session Objectives: At the end of the session participants will be able to:

A. Explain in simple terms what are RTIs and STIs

B. Explain what is white discharge, what causes it, how it can be treated and how to prevent it.

C. List STIs and RTIs

D. Explain how STIs are spread and how to prevent transmission of STIs

E. Explain how to use a male condom

Training materials required for this session:

A Prepared chart on content

B1 RUWSEC pamphlet material on Vaginal discharge, B2 content on yeast & bacterial infections

C Prepared Chart listing STIs

D Prepared charts on content

E Penis models (or bananas) and several condoms, E1 instructions on using the condom

Methodology:

Present the objectives for this session.

A. What are RTIs and STIs — **30 minutes**

Ask participants what they understand by reproductive tract infections and what they understand about sexually transmitted infections. Explain using content given in (A1).

B. Vaginal (White) discharge — **1 hour 30 minutes**

Divide participants into four groups and distribute the pamphlet (B1) on Vaginal (white) discharge. They should read and discuss it. (10 minutes)

In the large group ask the following questions one by one and let participants respond. Correct any mistakes and fill gaps in their knowledge.

What is white discharge?

When is white discharge a symptom of a disease?

When is white discharge not a problem?

When is white discharge problematic and why?

Symptoms and prevention

What tests should be done? Treatment.

*Note to facilitator: Read content on yeast and bacterial infections given in (*B2) *as they are common white discharge problems and are RTI not necessarily STIs. This maybe useful to answer any questions / provide clarifications that may come up during discussions.*

C. List of STIs **30 minutes**

Ask participants if they can list diseases or infections that can be transmitted through sexual contact. If your participants are health workers they may be able to list some but others may not be able to. Display the list of the STIs on the board and read out to the group and explain that some have symptoms and some have none as given in the content in (C1).

D. Prevention of transmission through safer sex practices **1 hour**

State that before they learn more about some of the common STIs, they will concentrate on how to prevent transmission.

Ask participants to share any experience or knowledge on how STIs transmission can be prevented. State that the best way is to practice safer sex. Ask participants what is meant by safer sex.

Explain that safer sex includes practices that reduce the risk for contracting sexually transmitted infections (STIs), including *HIV* (the virus that causes AIDS). These practices reduce contact with the partner's body fluids, including ejaculate from a man's penis (semen), vaginal fluids, blood, and other types of discharge from open sores. Safer sex reduces but does not totally eliminate risk. For example, using a condom correctly and every time for vaginal, oral, or anal sex greatly reduces, but does not totally eliminate, the risk for transmission from open genital sores that touch body parts not covered by the condom.

Ask what could be the risky behaviours. Listen to their answers then explain unprotected anal and vaginal sex with an infected person carry a high risk for disease transmission. Anal sex is especially risky because it can result in tiny tears or cuts in the rectum. Viruses can enter the body more easily through these breaks in the skin than through intact healthy skin. Unprotected oral sex carries a lower risk, but is not risk-free. The use of drugs or alcohol can increase the risk for getting an *STI* or HIV/AIDS because people under their influence may be less careful about practicing safer sex.

Let participants share what they think could be some forms of safer sex, then add to their views from (D1).

E. Condoms **1 hour**

Male *condoms* are cheap and effective. There are many types of condoms of different thickness and shapes to suit individual preferences. Condoms should be fresh and can only be used once. Check the expiry date on the back of the package, or, if there is a manufacture date, do not use if more than five years old. Never use condoms that are stiff, sticky, or have been exposed to extreme temperatures, or if the package is damaged or the seal is broken. If lubrication is used, it should be water-based. Never use oil-based substances, such as petroleum jelly, butter, and vegetable oils. Condoms must be put on before penetration, and must be used correctly every time sexual intercourse occurs

How to use a male condom

For this part of the session you will need at least 3 penis models, plenty of condom supplies, waste newspaper, and some tissues to wipe hands, a copy each of the instructions (E1) on how to use the male condom.

In the large group ask participants to volunteer to show(using the penis model or bananas) how to put on the condom. Carefully observe the volunteer's demonstration and if everything is correct then appreciate him/her. If no one volunteers then state that you will show them (using a penis model or bananas) how to use a condom. Proceed with the demonstration on the penis model. Once the condom is put on explain that since it is a wooden model/ banana unlike the erect penis it cannot turn flaccid but on the real penis after ejaculation the condom must be carefully removed while the penis is firm to prevent spills.

Now split the large group into three or four small groups (as many as you have penis models/bananas) Give each group a penis model (or some bananas) and plenty of condoms. Ask participants to practice the instructions on the model.

Materials used for training / handout include:

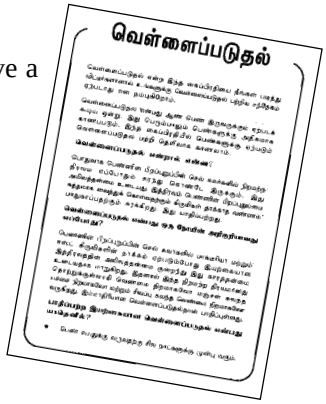
A1 Reproductive tract infections (RTIs) are defined as any infections of the reproductive system. They include sexually transmitted infections (STIs) and other infections of the reproductive system that are not caused by sexual contact. These other infections may be the result of the overgrowth of the bacteria and other organisms that normally live in the vagina. RTIs also include infections that result from inadequate infection prevention practices by health care providers, infections related to procedures such as unsafe deliveries and abortion or IUD insertion.

Although RTIs affect both women and men, research shows that women are more susceptible to infection and often less likely to seek treatment than men. In addition, complications can be more serious in women and infections can be transmitted to the offspring of pregnant women.

The symptoms associated with STIs and other RTIs vary from none to severe. You cannot always tell if a person has an STI, and people without symptoms often transmit the infection to others unknowingly. If you believe you have an RTI or have been exposed to or at risk for STIs, you should talk to a health care provider as soon as possible. STIs are infections passed from person to person by sexual contact.

B1 **Vaginal (White) discharge**

VELLAIPADUTHAL


வெள்ளைப்படுதல்

If you read this pamphlet on '*white(Vaginal) discharge*' we believe that you will have a clear understanding about it.

Vaginal discharge occurs both in men and in women. It is more common among women. This pamphlet provides a clear picture about white discharge in women.

What is white discharge?

Generally in women a colorless fluid is secreted at all times in the vagina. It is acidic. This fluid protects the reproductive organs of the woman and prevents the entry of bacteria.

When is white discharge a symptom of a disease?

When the bacteria and yeast in the vagina cause infection, the naturally acidic vaginal secretion becomes less acidic and more alkaline. As a result this colorless secretion gets infected and comes out as white, yellowish green or reddish white. This type of 'white discharge' is problematic.

When is white discharge not a problem?

- The white discharge a few days before a girl attains puberty/menarche
- Before menstruation (periods)and two -three days after menstrual periods
- Discharge during pregnancy
- Discharge during sexual stimulation/pleasure

White discharge that is problematic

As stated above white discharge that is infected by bacteria and yeast in the vagina and changes color is a problem.

Why does white discharge become problematic?

- As a result of increase in microorganisms in the vagina.
- Bacterial infections following deliveries, abortions conducted in unhealthy conditions
- Bacterial infection following insertion of IUD in unhealthy manner/conditions
- Due to sexually transmitted infections (STIs)

Symptoms

Women are greatly affected by this white discharge but in spite of that are not aware about it. hey are not aware of the consequences of vaginal discharge. Problematic white discharge has some common symptoms.

- Continuous vaginal discharge
- White in colour and watery
- White colour curd- like discharge
- Yellow or green colour discharge
- Odour like decayed hay
- Burning sensation while passing urine
- Itching sensation in the vagina and becomes reddish in colour

- Pain during sexual intercourse
- Boils (*pungal or koppalangal*) boils in the vagina and causes pain

What are the reasons for these types of white discharge?

When the naturally occuring microorganisms in the vagina increase because of the following reasons:

- Anemia, lack of nutrition
- Suffering from infections like tuberculosis, jaundice, diabetes
- Due to the lubrication in the vagina
- Due to long term use of contraceptive pills or contraceptive injections
- Tension, stress, excessive workload, lack of sleep and intake of excessive antibiotics
- Due to use of wet cloth or unclean cloth during menstruation which causes increase in bacteria
- Mainly poor women in the villages have to use old cloth again and again; they have little option but to use the washed cloth before it dries completely
- Due to wearing nylon undergarments
- Due to use of detergents and antiseptics (dettol)
- Having sexual intercourse with an infected person
- After miscarriage the uterus is not cleaned and following surgeries
- Following deliveries, abortions and surgeries in unhealthy, unsterile conditions
- In the medical department, insertion of copper-T and other such devices in unhealthy conditions and due to negligence during the process
- When an infected person takes bath or washes clothes in pond, there are chances that others may be infected. This is something we have arrived at based on our experiences

Why is white discharge more common among women than men?

- Biologically there are differences between men and women. Specifically men's reproductive organs are long, with small narrow opening which reduces the chances of infection. But women's reproductive organ is broad, the chances of infection are higher. Especially following miscarriage, abortion, delivery and contraception women are prone to infection.
- Further there is a feeling that it is wrong/incorrect to talk about these things openly and therefore restrictions are prevalent. As a result women's opportunities to learn about this is less.
- Lack of gender equality is the main reason for this. Specifically woman is unable to negotiate condom use by the man to promote safe sexual practices.
- Access to medical services is lesser for women than men. This is due to lack of time, restrictions on spending, low wages, family responsibilities. Due to such reasons women are unable to pay attention to their well-being.
- Even when women approach the medical system, its approach, shortage /absence of drugs, priority to family planning methods etc. affect the health of a women.

Prevention

- Keep the vagina clean
- Use cotton panties
- Wear clean under garments
- Use of dry cloth instead of wet cloth during menstruation
- Change the menstrual cloth regularly
- After passing stools washing from front to back. Prevent coercive sex
- Avoid sexual intercourse with infected partners. In case it is unavoidable use a condom. Do not use the clothes belonging to a person with the infection
- Avoid bathing and washing clothes in ponds especially during menstruation

What should be done? Tests

- The vaginal fluid should be tested
- Blood tests (VDRL) can be done

Treatment

- Apply non sour curds twice a day in the vagina for 10 -15 days. This will reduce the burning and itching sensation
- *Kizhanelli* leaves should be taken with roots, cleaned and nicely ground on a stone that does not have remnants of chilly, take a pebble size ball mixed with goats or cow's milk for 7 days in the morning on an empty stomach
- Take a flake of garlic (do not remove the skin) remove the hard part at the end and insert it in the vagina. Follow this at night for 3 days. If there is no cure continue the practice for 4 - 10 days, only at night. Do not use the same garlic again
- If there is no cure it is better to consult a doctor and follow the advice of the doctor

Common types of vaginal (white) discharge

Reasons	**Symptoms**			**Effects /consequences**
Types of infection **Fungal infections:**	**Colour**	**Smell**	**Other symptoms**	
The naturally occurring microorganisms (yeast infections) in the vagina cause infection and cause problems	White in colour like curd	Wet hay like odour	Itching and burning sensation in the vagina. Burning sensation while passing urine. Boils in the vagina and pain.	It can spread into the uterus and ovaries. Cause menstrual problems. Chronic back pain. Bulginess in the vaginal walls and cervix.
Sexually transmitted infections: Spreads through sexual intercourse from a man to a woman. This does not affect men but affect women widely in anus, vagina and intestinal region	Greenish yellow in colour. At a later stage it is grayish white colour	Smells like fish	Watery or frothy Itching sensation or boils in vagina and vaginal passage. Burning sensation while passing urine or swelling of the vaginal wall.	Can cause urinary tract infection. Can spread to uterus and ovaries.
Asymptomatic infections Indigestion, spread of bacteria, may be due to infection in the vagina that is asymptomatic	White or yellow in colour. At times may be bloody	Fish or sour curd	Swelling in hip joint. Swelling in glands. Wounds in vaginal walls and sometimes may cause pus. Itching sensation in vagina. Pain while passing urine.	Can cause urinary tract infection. If the infection increases it may cause cancer in the cervix.

B2 Non sexually transmitted infections

Non STI vaginal infections with unusual vaginal discharge

	Vaginal Yeast Infections (Candidiasis, Moniliasis)	**Bacterial Vaginosis (BV)**
Basic facts	Vaginal yeast infection is an RTI. It is not an STI. Yeast infection occurs when the normal environment in the vagina changes. Sometimes the reason for this is unclear. Yeast infections can also occur with antibiotic use. A woman can develop a vaginal yeast infection if she has conditions that affect the immune system, such as diabetes, HIV infection, or lupus. If yeast infections occur repeatedly, it may be a good idea for her to get a test for HIV infection and one for diabetes (if available).	BV is an RTI. BV is not an STI, although it is more common among sexually active women and women with a new sexual partner. The infection develops when the normal environment in the vagina changes. Sometimes the reason for this is unclear.
Symptoms	Redness and burning sensation in the genital area Vaginal pain during sexual intercourse Burning sensation during urination Internal or external genital itching Clumped discharge resembling cottage cheese Bread-like, "yeasty" odor from the genital area Breaks in the skin when there is significant inflammation Irritation of the cervix.	Itching or tingling in the genital area. Unusual vaginal discharge.

Non STI vaginal infections with unusual vaginal discharge

	Vaginal Yeast Infections (Candidiasis, Moniliasis)	Bacterial Vaginosis (BV)
Complications	Other than extreme discomfort from skin irritation in severe infections, there are no complications from vaginal yeast infections.	If left untreated… BV can increase the risk of HIV transmission. In pregnant women, BV can cause early labor and delivery.
Prevention	Clients should avoid sex until treatment of the infection is completed. To prevent recurrence of these infections, women should avoid, using scented soaps, and wearing synthetic underwear. Using a condom during vaginal sex might prevent recurrence.	To prevent BV, women should avoid using scented soaps. Using a condom during vaginal sex might prevent recurrence.
Content sourced from Engender Health : http://www.engenderhealth.org		

C1 List of common STIs

The following diseases can be transmitted by sexual contact:

Chlamydia

Gonorrhea

HIV infection/AIDS

Hepatitis B

Hepatitis C

Herpes

Human papillomavirus (genital warts)

Pelvic inflammatory disease

Syphilis

Trichomoniasis

These infections may lead to symptoms in the reproductive organs themselves as well as the skin around the vagina, penis, or anus. Some STIs also cause systemic symptoms that cause problems in other parts of the body.

Some STIs (for example chlamydia, gonorrhea, human papilloma virus (HPV), hepatitis B, and genital herpes) often cause no symptoms. Therefore, although the person has an infection, he or she may have no symptoms and may not realize that he or she is infected. STIs without symptoms can be transmitted to others and can cause serious complications.

These infections may lead to serious complications, especially if they are not treated. In addition, STIs increase the risk of acquiring or transmitting HIV, the virus that causes AIDS. For your comfort and safety, as well as that of your sex partners, all STIs should be treated promptly.

If a person thinks that he/she might have an STI, he/she should be checked by a health care provider as soon as possible and if positive seek treatment for self and partner simultaneously.

D1 Some forms of safer sex

The most reliable way to avoid transmission of STIs, including HIV, is to abstain from sexual intercourse—vaginal, oral, or anal sex—or to be in a long-term, mutually monogamous (sexually exclusive) relationship with an uninfected partner.

Very low or no risk

- Kissing
- Massage
- Masturbation
- Sexual stimulation using your hand on another person
- Oral sex on a man who is wearing a condom
- Oral sex on a woman who is wearing a dental dam or plastic wrap

Low risk

Vaginal and anal sex using a latex or polyurethane male or female condom. Using condoms is the most effective way of preventing sexual transmission of HIV/AIDS or other STIs. While it is believed that the use of condoms is

highly effective in reducing the risk of STI transmission, the degree of risk reduction varies depending on the STI. For STIs that cause genital ulcers, such as syphilis, herpes, and chancroid, and for HPV infection, the degree of protection that condoms provide is lower since these infections are transmitted through contact with genital skin and mucosal surfaces. This contact can occur in areas that the condom does not cover. However, consistent and correct use of condoms can still significantly reduce the risk of transmission of these STIs.

It is probably safe to have sex without a condom when both partners are free of STIs (including HIV) and they are not having sex with other partners. Remember, it is necessary to have an HIV test 6 months after engaging in risky sexual behaviors to be sure that you are HIV-negative. In addition, some STIs do not have symptoms for a long time so it is impossible to know for sure if you are infected unless you are tested. However, getting a partner's sexual history can be difficult and unreliable. People may not be honest because of fear or shame. Sometimes a partner may have an STI or HIV but is unaware of it because he or she does not have any symptoms.

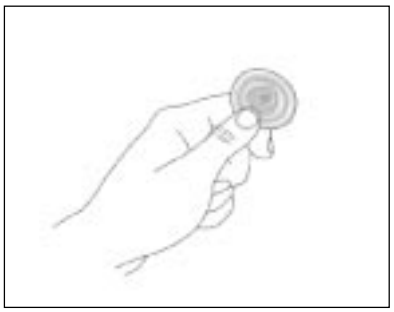
E1 Instructions on how to use the condom

Although many people mistakenly assume that all men know how to correctly use condoms, incorrect use is common and is a major cause of condom failure.
Remember:

- Do not use grease, oils, lotions, or petroleum jelly (vaseline) to make the condom slippery. These substances can make the condom break. Use only jelly or cream that does not have oil in it.
- Use a new condom each time you have sex.
- Only use a condom once.
- Store condoms in a cool, dry place.
- Do not use a condom that may be old or damaged.

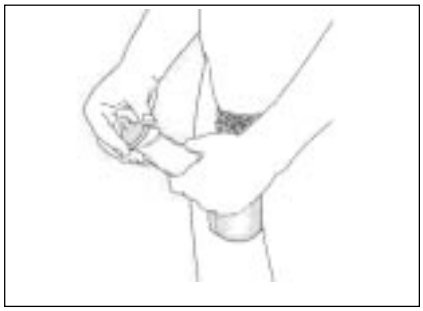
Do not use a condom if:

- The package is broken.
- The condom is brittle or dried out.
- The color is uneven or has changed.
- The condom is unusually sticky.



Before Intercourse:

1. Carefully open the package so the condom does not tear. (Do not use teeth or a sharp object to open the package.) Do not unroll the condom before putting it on.



2. If you are not circumcised, pull back the foreskin. Put the condom on the end of the hard penis. Note: If the condom is initially placed on the penis backwards, do not turn it around. Throw it away and start with a new one.

3. Pinching the tip of the condom to squeeze out air, roll on the condom until it reaches the base of the penis.

4. Check to make sure there is space at the tip and that the condom is not broken. With the condom on, insert the penis for intercourse.

After Intercourse:

5. After ejaculation, hold onto the condom at the base of the penis. Keeping the condom on, pull the penis out before it gets soft.

6. Slide the condom off without spilling the liquid (semen) inside. Dispose of the used condom.

(Source Engender Health, New York)

Session 2: Common STIs and RTIs

Session Objectives: At the end of the session participants will be able to:

A. Explain the symptoms, diagnosis and treatment for common Sexually Transmitted Infections (STIs) such as chlamydia, gonorrhea, syphilis, trichomoniasis and Pelvic Inflammatory Diseases (PID)

B. Explain the common symptoms and possible causes

Training materials required for the session/ handout:

A Prepared charts on content for each infection

B Flip chart, marker pens, Prepared chart on content

C Materials to prepare games: charts, sketch pens, scissors, old newspapers, glue

Methodology:

Present the objectives and state that in the previous session we covered white discharge which is also one of the symptoms of some STIs but not necessarily caused by STI. In this session we will cover some of the common STIs and PID which if not recognized and treated appropriately can cause serious damage to the reproductive organs and also lead to fatal conditions in the long term.

A. Common STIs and RTIs **3 hours 30 minutes**

Ask participants whether they or anyone they know had genital sores and if yes how were they treated. Did it reoccur? *Let those willing to share do so do not compel anyone to reveal such information about themselves and also try to discourage use of names or identifiable description of persons to underline the need for confidentiality of cases.*

Most STIs present with either abnormal discharge or with genital sores or swelling. We will first cover the common STIs where vaginal discharge is a symptom in women and urethral discharge in men. These include chlamydia, gonorrhea, Trichomoniasis. Many men and women who have STIs also suffer from genital sores that are common in syphilis infection. Explain one by one using prepared charts (A1) on the content for each STI and PID.

B. Common symptoms of STIs/RTIs **30 minutes**

Divide the board or flip chart into two columns and on one write symptoms and on the other write possible causes. Explain that they are going to examine some of the common symptoms for both RTIs and STIs and try to identify the possible causes. After participants have through a brain storming session listed out the common symptoms they have experienced or know about, they are then encouraged in the light of their recent learning to figure out the possible causes for such symptoms. Then present the completed table (B1) that lists some of the most common symptoms of RTIs, together with possible causes.

Explain that there are other infections or conditions that may be responsible for the symptoms listed, so if a person is experiencing some of these symptoms it does not necessarily mean that he/she has a reproductive tract infection (RTI). It is important to remember that many women and men who have an RTI, especially one that is transmitted by sexual contact, often do not experience any symptoms at all.

RTIs may lead to serious complications—especially in women—if they are left untreated. In addition, RTIs increase the risk of acquiring or transmitting *HIV,* the virus that causes AIDS. A person experiencing any of the symptoms listed in (B1) should talk to a health care worker as soon as possible.

Activity ***1 hour***

Divide into two groups. Each group has to create an exercise /game to present the symptoms of RTIs and STIs. Group 1 will facilitate the game for Group 2 and vice versa.

(Discussion 20 minutes+ facilitation/presentation = 15 minutes each+ post presentation 5 minutes). Provide the groups with some charts, sketch, scissors, old newspapers etc.

Materials used for training / handout include:

A1

STIs		**Gonorrhea**	**Chlamydia**
Basic facts		STI transmitted during anal, oral or vaginal sex Many men and women who have this infection have no symptoms, but they can still pass the infection to others.	
Symptoms	**In men**	Urethral discharge Swollen and/or painful testicles	
	In women	Unusual vaginal discharge Lower abdominal pain (pain below the belly button; pelvic pain) Abnormal and/or heavy vaginal bleeding Vaginal bleeding after intercourse	
	In men and women	Burning or pain during urination	
Complications		If left untreated... In women, gonorrhea can spread to the uterus (womb) and fallopian tubes, causing pelvic inflammatory disease (PID), which can make it difficult for her to become pregnant, cause infertility, or increase her risk of ectopic pregnancy (pregnancy outside the uterus). In pregnant women, gonorrhea can cause early labor and delivery and can be passed to the baby, causing serious infections. In men, gonorrhea can cause pain and swelling in the testicles, leading to infertility. Gonorrhea can get into the bloodstream, leading to an infection throughout the body, often causing pain and swelling in the joints.	If left untreated... In women, chlamydia can spread to the uterus (womb) and fallopian tubes, causing pelvic inflammatory disease (PID), which can make it difficult for her to become pregnant, cause infertility, or increase her risk of ectopic pregnancy (pregnancy outside the uterus). In pregnant women, chlamydia can cause early labor and delivery and can be passed to the baby, causing serious infections. In men, chlamydia can cause pain and swelling in the testicles, leading to infertility.
Prevention		An infected client should inform all sexual partners he or she has had in the last month about the infection (if possible) and encourage them to come to the clinic for more information and treatment—even if a partner does not have any symptoms—to avoid reinfection. Remind clients that if a sexual partner does not get treated, the client can get the infection again. An infected client should avoid sex (1) until treatment is completed (for seven days if one-dose therapy is used) to make sure he or she does not pass the infection to others, (2) until after any partner completes treatment (or for seven days if one-dose therapy and is used) so he or she does not get infected again. If abstinence is not possible, the client should use a male or female condom during anal, oral, or vaginal sex	

Content sourced from Engender Health's mini course on Sexually Transmitted Infections

STIs	**SYPHILIS**
Basic facts	Syphilis is an STI transmitted through direct contact with the sores the infection causes on themouth, lips, vagina, penis, anus, or rectum *Primary Syphilis.* Initially causes sores that will heal on their own, but the infection will still be present and can progress to- *Secondary syphilis:* Rash, sore throat, muscle aches, tiredness, and swollen lymph nodes *Tertiary syphilis:* No symptoms for many years; eventually can affect every part of the body; at this stage, can damage the heart and nervous system and can cause death.
Symptoms	Blisters or ulcers (sores) on the mouth, lips, genitals, anus, or surrounding areas
Complications	If left untreated, the sores syphilis causes will heal on their own, but the infection will still be present and can progress and cause serious problems. If left untreated, syphilis can damage the heart and nervous system and can cause death. Syphilis can be transmitted to a baby during pregnancy, causing stillbirth or the death of the baby shortly after delivery. Transmission to a baby can be avoided if the woman is treated early in pregnancy. If a pregnant woman tests positive for syphilis, she and any sexual partners must receive treatment as early in the pregnancy as possible. Repeat testing should be done close to delivery, if possible.

STIs	SYPHILIS
Prevention	An infected client should inform all sexual partners he or she has had in the last three months about the infection (if possible) and encourage them to come to the clinic for more information and treatment—even if a partner does not have any symptoms—to avoid reinfection. An infected client should avoid sex (1) until the sores are completely healed after treatment to make sure he or she does not pass the infection to others, and (2) for seven days after any partner completes treatment so he or she does not get infected again. If abstinence is not possible, the client should use a male or female condom during anal, oral, or vaginal sex, making sure all sores are covered.

Content sourced from Engender Health's mini course on Sexually Transmitted Infections

	TRICHOMONIASIS
Basic facts	***Trichomonas vaginalis*** is a microscopic organism that causes the disease trichomoniasis, which can be sexually transmitted from person to person.
Risk factors	The primary risk factors for trichomoniasis include: Engaging in unsafe sex Having sex with more than one partner Having sex with someone who has multiple sex partners
Symptoms	Both men and women may be infected with trichomoniasis. Many people who are infected have no symptoms. *Symptoms in women include:*Unusual and increased vaginal discharge (bubbly, pale green, or gray) with an unpleasant odor, Itching, burning, or redness of the vulva and vagina *Symptoms in men include:*Discharge from the penis, Burning with urination
Can it lead to other health problems	Trichomoniasis itself is not known to lead to serious complications. However, when left untreated, it can increase the risk for acquiring or transmitting HIV infection, the virus that causes AIDS. Heavy discharge can cause moderate skin irritation on the external genitals and inner thighs. Trichomoniasis is associated with an increased risk of inflammation of the fallopian tubes
Prevention	The chance of becoming infected with trichomoniasis can be reduced by avoiding risky sexual behaviors. Use latex or polyurethane condoms during sex Limit the number of your sex partners If you have recently been treated or are being treated for trichomoniasis, you must make sure your sex partner(s) also receives treatment in order to prevent getting infected again. Sex partners should receive treatment even if they do not have any symptoms.
What is the impact of the infection on pregnancy?	Recent evidence indicates that trichomoniasis may be associated with low birth weight in babies born to women with the infection, and with early labor and delivery in pregnant women.
Is there a treatment or cure	Trichomoniasis can be easily treated and cured with antibiotics—usually a one- or seven day course of a drug called metronidazole (Flagyl). This treatment can cause side effects such as mild nausea, vomiting, and metallic taste in the mouth. In order for the treatment to work it is important to take the medication as prescribed. It can also cause a bad reaction when mixed with alcohol; avoid drinking until 24 hours after you finish taking the medicine. Metronidazole should not be used during early pregnancy. It is important to make sure your sex partner(s) also receives treatment in order to prevent getting infected again. Avoid having sex while being treated to reduce the chances of getting the infection again or transmitting it to someone else
	PELVIC INFLAMMATORY DISEASE (PID)
Basic facts	PID is an infection of the internal reproductive organs in women, involving the uterus, allopian tubes, ovaries, and surrounding pelvic tissues. These tissues become inflamed, irritated, and swollen. The most common causes of PID are *chlamydia* and *gonorrhea,* although other types of bacteria also play a role. PID is one of the leading causes of *infertility* in women. PID is caused by sexually transmitted infections (STIs) that have been left untreated, most commonly *chlamydia* and *gonorrhea.* Other types of bacteria also play a role.
Risk factors	The primary risk factor for PID is infection with an STI—in particular, *chlamydia* and *gonorrhea.* Risk factors for these STIs include: Engaging in *unsafe sex* Having sex with more than one partner Having sex with someone who has multiple sex partners

	PELVIC INFLAMMATORY DISEASE (PID)
Symptoms	The primary symptom of PID is lower abdominal or pelvic pain. In mild cases, there may be only slight cramping. In severe cases, the pain may constant and very intense. Physical activity, especially sexual intercourse, may greatly increase the pain. Other symptoms of PID include: Abnormal vaginal discharge Abnormal and/or heavy vaginal bleeding Bleeding between periods Fever/chills Nausea/vomiting Women with PID may have no symptoms or the symptoms may not be those usually seen with episodes of PID.
How is it diagnosed	PID is usually diagnosed using several criteria, including symptoms, signs, and results of a pelvic exam and lab tests. These include: Abdominal tenderness Tenderness of the cervix, ovaries, and fallopian tubes during the pelvic exam Fever Abnormal cervical or vaginal discharge Lab tests of cervical discharge that show the presence of *chlamydia* or *gonorrhea*
Can it lead to other health problems	The complications following PID can be very serious and can lead to death. They include: Tubo-ovarian or pelvic abscess: Local collection of pus in the ovaries and fallopian tubes or the pelvis can occur in severe cases of PID. These require hospitalization and intravenous antibiotic treatment, and may require surgery. *Infertility*: After PID, scar tissue can form around the pelvic organs. This scar tissue can cause blockage and distortion of the fallopian tubes so that the egg cannot get through the tube and into the uterus. After one episode of PID, a woman has an estimated 15% chance of infertility. After two episodes, the risk of infertility increases to approximately 35%, and after three, the risk is nearly 75%. Chronic pelvic pain: Besides causing infertility, the scar tissue associated with PID may lead to pelvic pain or discomfort because of the distortion of the pelvic organs. Surgery may be required in severe cases. Ectopic pregnancy: An ectopic pregnancy is a pregnancy that occurs outside the uterus, most commonly in the fallopian tubes. Because PID can cause partial blocking or distortion of the fallopian tubes, the chances of an ectopic pregnancy are increased. Ectopic pregnancy is a very serious condition and must be treated surgically and immediately.
Prevention	Infection with PID can be prevented by avoiding risky sexual behaviors. *To reduce your risk:* Use latex or polyurethane condoms during sex Limit the number of your sex partners If you have symptoms suggestive of an STI or think you may have been exposed to one, you should seek medical attention immediately. If you have recently been treated or are being treated for an STI, you must make sure your sex partner(s) also receives treatment in order to prevent getting infected again. Sex partners should receive treatment even if they do not have any symptoms.
What is the impact of the infection on pregnancy?	A woman with a history of PID may have difficulty getting pregnant. Prior PID can also place women at increased risk for ectopic pregnancy (a pregnancy that occurs outside the uterus, most commonly in the fallopian tubes). It can lead to serious complications. Once detected, it must be treated immediately with surgery. Women who are pregnant and suspected of having PID, should be hospitalized and treated with intravenous antibiotics to reduce the risk of serious illness, loss of pregnancy, or premature delivery.
Is there a treatment or cure	PID can be treated and cured with a combination of antibiotics. Sometimes, hospitalization and intravenous antibiotics are necessary. If infection spreads beyond the reproductive tract and deeper into the abdomen, or if an abscess forms, surgery may be necessary. In order to reduce the inflammation and scarring, anti-inflammatory drugs like steroids may be prescribed. If left untreated, the complications of PID may be very serious and may need immediate medical attention. Signs of improvement must be carefully monitored within 3 days of beginning treatment. If symptoms do not improve, hospitalization is usually required. Follow-up examination and testing is recommended after completion of treatment. It is important to make sure your sex partner(s) also receives treatment in order to prevent getting infected again. Avoid having sex while being treated to reduce the chances of getting the infection again or transmitting it to someone else.

B1

Symptom	Possible Causes
Unusual vaginal discharge*	Bacterial vaginosis, chlamydia, gonorrhea, herpes, PID, trichomoniasis, yeast infection
Penile discharge	Chlamydia, gonorrhea, trichomoniasis
Abnormal and/or heavy vaginal bleeding	Chlamydia, gonorrhea, PID
Bleeding after intercourse	Chlamydia, gonorrhea, PID
Burning or pain during urination	Chlamydia, gonorrhea, herpes, trichomoniasis
Pelvic pain (pain below the belly button)	Chlamydia, gonorrhea, PID
Swollen and/or painful testicles	Chlamydia, gonorrhea
Itching or tingling in the genital area	Bacterial vaginosis, herpes, trichomoniasis, yeast infection
Blisters or sores on the genitals, anus, or surrounding areas	Herpes, syphilis
Warts or bumps on the genitals, anus, or surrounding areas	Human papillomavirus
Persistent vaginal yeast infections	HIV infection/AIDS
Yellowing of the eyes and skin (jaundice)	Hepatitis B, hepatitis C

** Although women may normally have some vaginal discharge, an RTI can lead to changes in normal vaginal discharge (such as changes in color, consistency, amount, and odor) in addition to vaginal itching, burning, or pain.*

Note: These common symptoms may also be caused by other ill health conditions so it is best to consult a doctor for treatment instead of self-medicating.

(Source: Engender Health's online course on Sexuallly transmitted infections. http://www.engenderhealth.org)

Session 3: Impact on women's health

Session Objectives: At the end of the session participants will be able to:

A. Analyze the problem that the person in the story has and identify what needs to be done and how to go about it especially from the perspective of poor rural dalit women

Training Materials required for the session:

A Case studies 1 to 6, paper and pens

B Notes on observations of risk of infections, consequences and its impact on the health of women

Methodology:

Present the objective of the session.

A. Woman and STIs/RTIs **1 hour**

Ask participants why is it that women are more prone to infection than men are? Listen to their response and then explain using content in (A1). Check whether participants understood this and find out if they can relate it to real life experiences. State that they will now do a few case studies to identify the problem and what needs to be done to help women who are infected or at risk.

B. Case studies **3 hours**

Divide participants into groups and give each one a case study (B1)to read and work on. Each case includes instructions.

Discuss and summarize using the pamphlet - why is 'white' discharge more common among women than men include the observations in (B2).

Note to facilitator: Read reference on bacterial and yeast infections (previous session training materials) especially for case 1 and case 4 respectively to answer participant queries in post discussion.

Materials used for training / handout include:

A1 **Special Concerns for Women**

Although STIs affect both women and men, research shows that women are more susceptible to infection and are less likely to seek treatment than are men. The potential complications of untreated RTIs are more serious in women, and infections can be transmitted to the offspring of pregnant women as well.

Although the rates of infection vary tremendously among and within countries, reports indicate that STIs are the second most important cause of health life years lost in women of childbearing age (after pregnancy-related problems).

It is important to recognize that *women are biologically more vulnerable to diseases of the genital tract than are men since:*

The lining of the vagina is a mucous membrane more permeable to infection than the skin on the outside of the penis.

Women's genitals have more surface area through which infection can occur.

Lack of lubrication during intercourse or changes in the cervix during the menstrual cycle can facilitate more efficient transmission of infection to women.

Younger women are particularly vulnerable because their cervical tissues may be less mature and more readily penetrated by organisms (e.g., chlamydia and gonococcus).

Older women are more likely to get small abrasions in the vagina during sexual activity because of the thinning of the tissues and dryness that occur with age.

Women who already have an infection (particularly one that causes genital lesions) are more likely to get or transmit HIV, and since women are often asymptomatic when infected with an STI, they are often not aware of this increased risk.

Although women are often perceived as being the "end of the line" of infection since they are less likely to pass on infection, many women are at risk for infection, particularly when their primary partners have other partners. Social and economic vulnerability amplify women's risk for infection. For example, many women lack economic resources and are fearful of abandonment or of violence from their male partner. Therefore, they have little control over how and when they have sex, which in turn hampers their ability to protect themselves from infection.

B1 **Case studies**

1. Sheila is a 22 years old with one child. She complains of slightly bitter smelling white discharge. She has been feeling itchy in her genital region. They live in a small hut closer to the town but there is very little water available, need to walk some distance to fetch water for daily use. Also there is not enough space to dry clothes except in front of her house where there is sufficient sunlight.

   What does Sheila need to do about her condition? What infection do you think she has? What changes does she need to do in her daily life to keep free of such infection.

2. Sunil, 31 years old, works as a driver. He had married late in life. His wife Radha 22 years is 3 months pregnant with their first baby. Sunil had had some problem of small boils in his genital area 2 months ago for which he had used some herbal application to cure. Radha has heard from the women's group about the STIs. She is afraid to ask her husband to go for a check up but knows it is important for them to get treated especially now since they are to have a baby.

   What can Radha do? What do you think Sunil is suffering from? What do the couple need to do?

3. Mohan works as a truck mechanic since 10 months, he accompanied his pregnant wife to the clinic for ANC. This is their second pregnancy. The first pregnancy ended in a miscarriage at two months they were then living in a remote village far from any health service centre. He has a burning sensation when passing urine.

   You are the health worker here at the centre. What will you do? What do you think Mohan is suffering from?

4. Vasanti is an attractive young 17 year old. She lives in a joint family in the village. She is the eldest for her parents and while the elders are out working she looks after the young children her own sisters and brother as well as a three of her cousins. She has been at different points in time having sexual relations with one of her male cousins since the time she was about 15 years old. Since the last 5 months she has been feeling very tired and weak, she has begun to have smelly white discharge and itching in her genital region and is

now worried and come to you, the health worker in the village. She is also worried that others will come to know her problem and relationship.

What do you think Vasanti is suffering from? What does she need to do? How can she prevent this situation in future? If you were a school health educator how would you educate adolescents on STIs and RTIs.

5. Anjalai had very smelly discolored vaginal discharge for some months. She also had severe pain in her abdomen. She could not take it any longer and decided to visit the hospital. The doctor diagnosed gonorrhea, put her on a prolonged course of antibiotics and asked about her husband who is suspected of having infected her. The husband refused to see the doctor and was in fact furious. Anjalai suffered repeated infections as a result and eventually stopped seeing the doctor after it. After a lapse of three years, her infection was so advanced that the hospital she approached carried out a hysterectomy (she was told it was the only way out). It is six months since the surgery. Anjalai feels better but asks everyone who she thinks can help, whether or not she is in danger of infection now she has got rid of her uterus.

   What were the factors that led to hysterectomy?

   Would the situation have been different for a man? How? Why?

   For Anjalai's cure what are the various factors that need to be addressed?

   Note to facilitator: Even though Anjalai has had a hysterectomy, she can still get STIs in the vagina and external genitalia if she does not pracice safe sex.

6. A clinic visit: what happens at the health center.

Role 1: A woman who suspects she has STI.

You have severe abdominal pain. Your husband has been working in the city and has returned home recently. You went to the PHC nearer your village but they referred you to the hospital at Chengalpattu. You could not come earlier because there were so many things to do at home. The hospital is 20 kilometres away, you have to go to work in the fields or would lose a day's wages.

You could not tell your mother in law what you suspect, and you are also shy about discussing it with the doctor/ nurse.

Role 2: Nurse- its another very busy day.

You feel that most of these women who come with these pains are given tablets but they do not have them regularly, do not come back for follow ups and their husbands/partners are not willing to come.

What were the reasons the woman could not access care earlier? Ask group to focus on the health system: quality of care: including attitude of providers, availability of services, accessibility etc.

In case government camps (for RTIs) are held in the area, ask participants to discuss and present why women do not attend these camps which are free and held in more accessible locations.

What are the factors that need to be addressed for women like her to find cure their health problems

Session 4: HIV/AIDS — 4 hours

Session Objectives: At the end of this session participants will be able to:

A. Explain what is HIV and what is AIDS
B. Explain how someone gets infected with HIV
C. Identify the risk factors for HIV infection
D. Explain how to protect oneself from HIV infection
E. List some symptoms of HIV infection and AIDS
F. Explain whether infection with HIV leads to other health problems
G. Describe the impact of HIV infection on pregnancy
H. Explain how is HIV infection diagnosed
I. Explain whether there is a treatment or cure for HIV infection or AIDS
J. Describe how can HIV affect women and children? Is the problem of HIV and AIDS different for women than it is for men

Training materials required for the session:

A Prepared flip charts on content for A1, A2,

B Prepared list of statements -B1 and B2- prepared flip chart on content, 'yes' and 'no' cards

C Papers and pen, prepared chart on the content

D Prepared flip chart on the content, chart papers and markers

E Prepared flip chart on content

F Prepared flip chart on content

G Prepared flip chart on content

H Prepared flip chart on content

I Prepared flip chart on content

J Prepared flip chart on content

Methodology:

Present the objectives.

Then lead discussion on each of the questions given in the content. Encourage participants to contribute as much as possible or explain in their own terms the content that you are disseminating to them.

A. What is HIV and what is AIDS **20 minutes**

Ask participants what is HIV infection. Listen to their answers and then clarify using the content in (A1).

Ask participants what does AIDS mean. Listen to their answers and then clarify using the content in (A2).

B. How does someone get HIV infection? **20 minutes**

Post two cards - YES and NO on opposites sides of the room. Ask participants to stand at the center and explain that when you read a statement (B1), they go to the yes corner if they agree or the no corner if they disagree. Follow each statement with clarifications/discussions.

When all the statements are done, have participants go back to the large group and sum up using (B2)

C. Risk factors for HIV infection **10 minutes**

Ask participants to share what they think are the risk factors for HIV infection. Listen to their responses and clarify using content in (C).

Activity ***1 hour***

Divide participants into 2 groups and ask them to discuss all the ways in which they are exposed to the risk of HIV infection.

Group 1 : The workplace or in the hospitals where they seek treatment for any infection or illness.

Group 2 : The home environment and in the community at large (this could include ear piercing, tattooing, back street abortions, rape, incest etc).

After they have presented and discussed in the large group ask them to go back to their small groups and prepare a chart to educate to people in to community to beware of the many ways they are exposed to risk of HIV infection. Let them present in the large group, correct mistakes and post on the wall.

D. Protecting oneself from HIV infection **20 minutes**

Discuss in the large group- How you can protect yourself from getting HIV infection. List answers on the flip chart/board. Fill gaps and sum up using content from (D).

Activity ***30 minutes***

Ask participants in 3 small groups to do each of the following:

Group 1 : Write a song to tell people how to protect themselves from HIV.

Group 2 : Make a poster of the ways in which a person can protect himself/herself from HIV infection.

Group 3 : Make a plan / strategy to implement infection prevention standards when providing services at the health centers or hospital.

E. Symptoms of HIV infection and AIDS **20 minutes**

Discuss in the large group -What are some symptoms of HIV infection and AIDS? Fill gaps and sum up using content in (E).

F Does HIV lead to other health problems **15 minutes**

Discuss in the large group -Can infection with HIV lead to other health problems? Fill gaps and sum up using content in (F).

G. Impact of HIV infection on pregnancy **10 minutes**

Discuss in the large group-What is the impact of HIV infection on pregnancy? Fill gaps and sum up using content in (G).

Activity ***30 minutes***

Ask participants to work in two small groups to role play

Group 1 : Counseling a pregnant woman who has recently been diagnosed with HIV and is concerned about her child.

Group 2 : Counseling on why it is important to maintain good health and take all the regular tests during pregnancy and complete treatment simultaneously with partner when infected with STIs/HIV Plug gaps and sum up.

H. How is HIV infection diagnosed **10 minutes**

Discuss with large group - How is HIV infection diagnosed? Fill gaps and sum up using content in (H).

I. Is there a treatment or cure for HIV infection or AIDS **10 minutes**

Discuss in large group-Is there a treatment or cure for HIV infection or AIDS? Fill gaps and sum up using content in (I).

J. Impact of HIV on women and children **40 minutes**

Use the narratives in (J1) to discuss how can HIV affect women and children? Is the problem of HIV and AIDS different for women than it is for men.

Divide participants into 2 groups and ask them to explore ways in which HIV/AIDS affects women and children and the reasons for them in these narratives and in other ways that may not be covered here (30 minutes). After the presentation fill gaps and sum up using content in (J2).

Materials used for training/ handout include:

A1 HIV is human immunodeficiency virus, the organism that causes AIDS. HIV is found in the blood and other body fluids (particularly semen, vaginal secretions, and breast milk) of persons infected with the virus. A person can be infected with HIV and not know it. It is currently believed that most people infected with HIV will develop AIDS. However, they can be infected with HIV for many years (often more than 10 years) before they develop AIDS.

A2 AIDS (acquired immunodeficiency syndrome) is a condition caused by advanced HIV infection. It occurs when a person's immune system is weakened due to HIV infection, which limits the body's natural ability to fight other infections and diseases. Living with AIDS is like living with any other chronic disease. Sometimes a person with AIDS suffers from infections and feels sick. At other times, a person may feel fine and participate in normal activities.

B1 Cards - write each point from 'how HIV is transmitted' and 'cannot get HIV from' given in (B2) on separate cards and mix them up.

B2 HIV infection is spread through the blood and other body fluids (primarily semen, vaginal secretions, and breast milk) of infected individuals. How HIV is transmitted:

- Sexual contact (primarily unprotected vaginal or anal intercourse). Transmission through oral sex can occur, but the risk is much lower.
- Blood and other body fluids, by:
- Sharing needles, Intravenous (IV) drugs, and drug related equipment such as syringes and needles
- Receiving transfusions of infected blood or blood products and/or transplant of an infected organ
- Using contaminated skin-piercing instruments (needles, syringes, razor blades, tattoo needles, or circumcision instruments)
- Becoming injured from contaminated needles or other sharp objects

- Getting splashed with infected blood or other body fluids onto mucous membranes (such as eyes)
- Perinatal modes (passed from mother to infant during pregnancy, childbirth, or breastfeeding)

Some individuals may not have any symptoms and not know that they are infected with HIV. However, they can still transmit the virus to others. You cannot tell if a person is infected with HIV just by looking at him or her.

However a person cannot get HIV from:

- Ordinary social or casual contact
- Shared clothing
- Touching
- Shared food, dishes, or eating utensils
- Dry kissing
- Hugging
- Shaking hands
- Toilet seats
- Insect bites
- Massaging another person
- Sexually stimulating a partner using your hand (Although a risk may exist if blood, semen, or vaginal fluids come in contact with broken skin.)
- Masturbation
- Tears, saliva, sweat
- Living or working with an HIV-infected person

C Certain behaviors place people at risk for HIV. People are not at risk simply because of who they are. The primary risk factors for HIV include behaviors and circumstances such as:

- Engaging in *unsafe sex*
- Having sex with more than one partner or with a partner who has or has had more than one partner or who uses or has used IV drugs
- Sharing needles, IV drugs, and drug paraphernalia
- Receiving a blood transfusion or treatment with contaminated blood or blood products
- Getting a tattoo or piercing with contaminated equipment and supplies
- Having a job (such as a health care worker) that exposes one to blood or other body fluids

Having an STI also increases the risk for transmitting or acquiring HIV. For example, STIs that cause ulcers provide an entry point for the virus to enter the blood and body.

D Your chance of becoming infected with HIV can be reduced by avoiding high-risk behaviors. Abstinence is the only sure way to prevent getting HIV through sex. Your risk of HIV infection from sex is low if you have been in a long-term monogamous relationship *with an uninfected* person. The best way to prevent HIV infection is to abstain from unsafe sexual and drug using practices.

- Use latex or polyurethane condoms during every act of sex
- Use male or female condoms along with your chosen contraceptive
- Limit the number of your sex partners
- Avoid sharing needles, IV drugs, and drug paraphernalia
- Avoid having sex with partners who have risky behaviors
- Avoid using skin-piercing instruments that have not been disinfected
- In addition to the suggestions listed above, health care workers should practice standard precautions at all times
- Remember: You cannot tell if someone is infected with HIV just by looking at him or her.

E Persons infected with HIV infection may not have any symptoms. It can take 10 years or more between initial HIV infection and the diagnosis of AIDS. Now, with advances in treatment, this time lag may even be lengthened further. Once symptoms begin to develop, they may include:

- An unexplained loss of weight lasting at least one month
- Diarrhea for several weeks or more

- A white coating on the tongue
- Enlarged or sore glands in the neck, armpit, and/or other parts of the body
- A cough that persists for more than one month
- Persistent fever and/or nightsweats
- Persistent vaginal yeast infections

Since these symptoms may be caused by other diseases, a test must be done to confirm the presence of HIV.

F HIV weakens the immune system, making a person infected with HIV susceptible to many infections that the body is normally able to fight off. These are often referred to as opportunistic infections or *AIDS-defining illnesses*. Many conditions may be especially severe, difficult to treat, and recurrent in individuals with HIV infection.

G Babies born to mothers with HIV infection can contract the HIV virus during pregnancy, labor, delivery, and breastfeeding. It should be noted that all infants born to women who are HIV positive will test positive for HIV at birth because of the presence of the mother's antibodies in their blood. Antibody testing after the age of 18 months can more accurately determine infection.

There are now some treatment options (HIV antiviral drugs) that can greatly reduce the rate of transmission of HIV from mother to child. If you are a pregnant woman infected with HIV, you should talk to your health care provider about options for preventing transmission.

Because the HIV virus can also be transmitted through breast milk, HIV-positive mothers are advised not to breastfeed their newborns. However, in areas of the world where infant and childhood infections are common and can be fatal, the risk of HIV transmission must be weighed against the risks associated with not breastfeeding. In India, women are counseled about exclusive breastfeeding as chances of HIV infection when exclusively breastfed are almost similar to that of artificial feeding. Mixed feeding (breastfeeding + other top feeds or foods given to the baby) is very dangerous and the baby will surely get infected. Mothers who opt to breastfeed must make sure that they do not get any nipple sores or any cut where body fluid can be exchanged with the baby as this will cause HIV to be transmitted. Poor women cannot afford the very expensive method of exclusive artificial feeding for the baby and in addition the artificial milk does not have live antibodies that breastmilk has to protect the baby from several other childhood illnesses so in that condition if she can make sure that she exclusively breastfeeds and can take care not to have any cuts or sores that may touch the baby's body then she can breastfeed her infant.

H There are blood tests to determine if a person is infected with HIV. Diagnosis of HIV infection is made by detection of antibodies to HIV on the same blood sample by a test called an ELISA and confirmation by another test—the Western Blot. Because these tests look for antibodies rather than the actual virus, it is possible that during the time between when infection occurs and when antibody levels are high enough to be detected, an HIV test will be negative even if the person is actually infected with HIV. This "window period" varies from one person to the next. Therefore, persons who think that they might be infected should wait 2-6 months since their last possible exposure before getting tested.

There are other blood tests that can look for the actual presence and amount of virus in the blood. However, these tests are very expensive and are used primarily in treatment decisions for persons already known to be HIV-infected.

Counseling before and after testing is an integral part of the HIV testing procedures. During counseling, vital information is made available that can help those who test positive prevent subsequent transmission to their partner(s), prevent acquiring other STIs, identify links to social and health resources, and receive guidance for maintaining health. For those who test negative, counseling information can be critical in helping to prevent infection. Testing can make a critical difference in the lives of those who test positive, as knowing they have HIV empowers them to take appropriate action in planning their lives and in getting the services they need.

I Currently, there is no cure for HIV infection or AIDS. However, with the combined use of new antiviral drugs (known as combination therapy) as well as drugs to prevent opportunistic infections, many people with HIV infection and AIDS have extended and improved the quality of their lives and delayed the progression of HIV infection to AIDS. These drugs can cause a number of side effects that may require that a person switch to other drugs or stop taking them. In addition, combination therapy requires taking a large number of pills on a complicated schedule. These drugs **a**re also very costly and unavailable to many people in industrialized countries as well as in many parts of the world, where the majority of individuals with HIV infection and AIDS live.

J1

1. Saraswathi, 23, is HIV-positive; so are her two children aged four and two. Her husband, Rajan, died last year at the young age of 26 of acquired immune deficiency syndrome (AIDS). She got infected by Rajan, who had tested positive for human immunodeficiency virus (HIV) even before marriage. Yet he got married as it gave him, and his family, social acceptability. After Rajan's death, her in-laws told her to take her children and leave. They blamed her for their son's death.
2. Sasikala is 14 years old. She had to drop out of school to take care of her father. He had been sick every now and then. Recently he underwent tests and was found to have AIDS. He could not go to work. Her mother had also tested positive. They were poor and her mother worked in the PHC as the ayah. She was the only earning member in the household of 2 sons, one daughter. Sasikala's younger brother Raja went to the nearby government school but he wanted to discontinue as other students and even the staff used to insult him, call him 'AIDS' and wanted him to leave school.

J2

The risk of becoming infected with HIV during unprotected vaginal penetrative sex is two to four times higher for a woman than man.

- Women's limited access education, income earning opportunities.
- Low status of women and double standards in norms governing sexual behaviour for women: women are not expected to discuss issues related to safe sex as they may fear violent reactions from partner.
- Biological factors in women (include vulnerability of young, adolescent women) therefore the practice of early marriage puts them more at risk. Male to female transmission is more efficient as women have a bigger surface area of mucosa exposed to seminal fluid than does man. There is higher concentration of HIV in semen than in vaginal secretions. There is evidence that dried and fragile genital membranes and reduced vaginal secretions of post menopausal women increase their vulnerability to HIV.
- Women in commercial sex work (csw) and as women (monogamous) whose partners who have sex with csw (women being forced into CSW due to poverty) who find it difficult to insist on condom use
- Migration.
- Violence (rape/ child sexual abuse); sexual violence may lead to damage to the genital/anal mucosa because of lack of lubrication.
- STIs –untreated and especially if ulcerative (in developing countries more women have STIs than men. Many STIs in women are asymptomatic and therefore not recognized. Stigma attached to STIs and other health seeking barriers-time, money, decision making, lack of services.
- Women are more likely to need blood transfusions as a consequence of child bearing role, exposing them to another mode of transmission.
- Reluctance to access treatment- sociocultural norms make it difficult for women to protect themselves from HIV and once diagnosed gives rise to intolerance, implying that the woman has had multiple sexual partners.
- Women are blamed for the deaths of their spouse (who may have passed on the infection to them), violence against them in the family increases when they disclose that they have been infected, evicted from homes, abandoned by husbands or partners and denied custody of children.
- They are not given jobs, children are not allowed to attend schools.
- As traditional caregivers, in the absence of treatment, care is the main and most important component. The responsibility for this falls on women. The burden of reproductive and productive work is enormous for her. Women and girls may also have to give up studies and paid work to stay home to take care.
- Women may want to have children but not get infected but using condoms prevents pregnancy.

Urinary tract infection

Urinary Tract Infection (UTI) occurs in both men and women. Women are more vulnerable to UTI biologically and socially –especially poor rural women who may not have access to basic facilities like water and toilets. Highly optimistic estimate of sanitation coverage in rural India is only 14%. In the absence of toilets the incidence of UTIs is higher.

Demand for sanitation and water come more from women than men as sanitation in rural areas i.e. use of open areas in closely linked with woman's dignity. Women are not expected to use these spaces except 'very privately'. This would imply that they have to wait till the 'appropriate time –late evening or early morning. At present this problem is pressing due to the diminishing tree/scrub cover in many areas. Women have to go farther looking for 'covered' spaces which are getting harder to come by. Women in violent situations are often not allowed to go out alone even to relieve themselves. Decision regarding whether or not to build a toilet depends on the funds available to the family and on whether it is perceived as priority by the men who are invariably the decision makers.

In a study carried out by RUWSEC, it was found that majority of schools in the rural areas do not have any toilets and in case of toilets, no running water.

With more and more young women employed in 'export zone'–factories, it is alarming that many of these factories lock the toilets and the young women cannot use them except at lunch time or only with the permission of the supervisor in an emergency. For example, from a study conducted by RUWSEC among young women working in factories- 'There is a token system to go to the bathroom. There are only a few tokens. If any person takes a token only after she returns that token, can others go to the toilet. However we cant go too often. We can go only during lunchtime. If we go very often, then the work stops and stocks up with the person. (They) shout, so we don't go at other times.'

It is essential to understand the conditions that women live and work in to be able to plan effective action to tackle the problem.

This chapter provides the basic information and understanding on Urinary tract infections with a focus on women. There is only one session covering all basic information regarding UTIs.

Session 1: Urinary Tract Infection — 3 hours

Session Objectives: At the end of this session participants will be able to explain:

A. What is a urinary tract infection (UTI)?
B. What are the symptoms of UTI?
C. Why does UTI happen?
D. What should be done?
E. When should medical help be sought?
F. What will the doctor/health care provider do?
G. What can be done to avoid UTI?
H. Issues at the community level that expose people to UTI and find ways to create support for sanitation and other basic facilities

Training materials required for this session

A1 Picture for Urinary tract

A2 RUWSEC pamphlet material on UTI

Methodology:

Present the objectives of the session.

A. Urinary tract infection (UTI) — 1 hour 30 minutes

Ask: What is a urinary tract infection? Let participants offer their views, then using picture (A1), explain that the urinary tract consists of various parts that produce, store and get rid of urine. It consists of the two kidneys, the two ureters (tubes that connect the kidneys to the urinary bladder), the bladder and the urethra(the tune through which urine comes out of the body). When blood passes through the kidneys, the waste products from the blood are removed, making up the urine which flows through the ureters into the urinary bladder and then pushed out through the urethra. The urinary tract can be infected by bacteria in two ways:

- By bacteria entering the kidneys from the blood and travelling down.
- By bacteria entering the urethra and travelling upward.
  Ask if any of the participants have suffered from UTI and ask if some of them would like to share their experiences. They could share when they had UTI, how/why did they get it; what happened, how did they feel; what treatment did they take. (5 minutes)

Divide the participants into three or four groups. Distribute the handout (A2) and ask each group to read it carefully. (20 minutes)

In the large group ask the participants if they were able to understand the information in the handout and state that the group will discuss each of the points in detail.

Ask participants: What are the symptoms of UTI?

Ask the groups to discuss it among themselves and select any one group to explain. Follow the same for all the remaining points, referring to any points from the participants' experiences shared earlier (60 minutes for discussion and clarifications)

Why does UTI happen?; What should be done?; When should medical help be sought?; What will the doctor do?; What can be done to avoid UTI?

Use content(A2) to explain and plug any gaps in information.

Activity ***1 hour 30 minutes***

Divide participants into 3 groups. Read out the situation to the participants.

Arputham is 28 years old and lives in Melaiyur village with her husband and daughter who is 10 years old. Her family is very poor and both husband and wife work as agricultural daily wage workers. Arputham's daughter goes to the government school 4 kilometres away.

Their day begins very early and ends late. Both mother and daughter take care of all the housework and most importantly like all other women in the village, use the fields before the village stirs. Similarly at night too. Arputham has been feeling a burning sensation and pain while passing urine since a few days. She feels like urinating constantly too but does not happen when she tries. She knows that it is *Nirsurukku (*UTI) and both she and her daughter have suffered from it before. She is worried as she cannot afford to miss work.

She has come to you to understand why she and her daughter get it? How can it be prevented?

Group 1 : Will do a role play providing counseling to Arputham.

Group 2 : Will create a poster series about UTI –causes, prevention, treatment and consequences if ignored (based on the situation narrated by Arputham) to benefit the community.

Group 3 : Will role play a 'fact finding team' that visits the village, health centre and school to understand and address issues that can have a more long term solution. For example, toilets maybe required but are not the priority and decisions regarding this made by the men, information that could help prevent the problem.

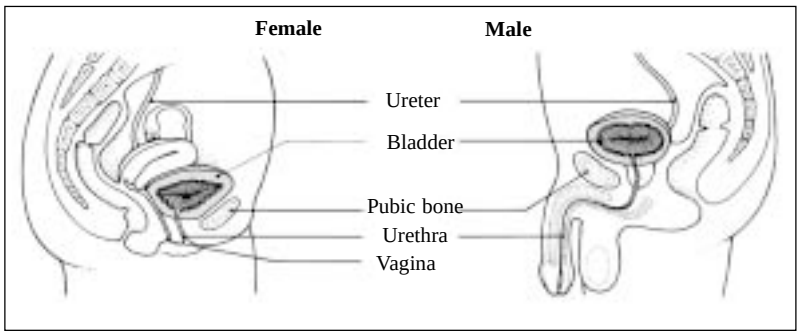
After the presentations sum up the session saying that women are more vulnerable to UTI biologically as well as due to social norms/attitudes to women.

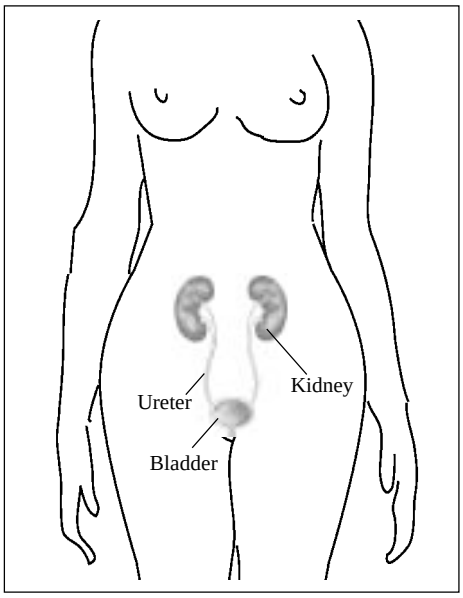
Women in areas without toilets suffer from UTIs more that in other places because they cannot use the field whenever they want. They have to wait either till very late or very early – which implies that women cannot relieve themselves as and when they desire because they 'must not use the open like the men'. Decisions regarding building a toilet and such facilities are invariably made by men and may not be a priority and/or because of reasons like 'who will clean the toilets/ water etc. This may be particularly true in poor households due to lack of resources to build toilets. Another aspect that maybe discussed are the present sanitation schemes / programmes initiated by the state and the issues regarding them.

The tasks of all the three groups together should cover:

- information about UTI
- awareness about the problem at the community level
- need to and strategies to improve medical care
- advocacy/lobbying for changes that may help address the problem in the long term

A1 Materials used for training / handout include:





A2 Urinary Tract Infection (UTI)

SIRUNIR THADAI THOTRU

Urinary tract infection is also called as '*Nirsurukku*. It would be correct to say that there are no women who have not suffered from UTI at least once or twice in their lifetimes.

What are the symptoms of UTI?

- While passing urine there is a burning sensation and pain.
- Feel like urinating constantly, but the flow of urine is limited. Urine is passed minimally, in drops.
- May get an uncontrollable feeling to pass urine urgently.
- Some times this may be accompanied by fever, pain in the lower abdomen or lower back. The urine appears cloudy. At times urine may appear bloody.

Why does UTI happen?

UTI can happen because of various reasons.

Due to Bacteria:

Bacteria is always present around the anus. Sometimes these bacteria enter the urinary bladder through the urethra. In the bladder these bacteria multiply and affect the inner lining of the bladder, which causes a burning sensation and pain.

The biological structure of women's bodies makes them more vulnerable to UTIs. In women the urethra, the vagina and the anus are very near each other. During sexual intercourse or while washing up after passing stools or wearing very tight panties may push the bacteria to the urethra. This is the reason why women suffer more often from UTI than men.

Other reasons:

- In a person with sexually transmitted infections and reproductive tract infections, the bacteria responsible for these infections can also affect the urinary system.
- Due to Allergy
- Due to soaps that are used to wash the under garments/inskirts or the bathing soaps may also cause allergy and lead to UTI.
- During sexual intercourse rubbing unclean body parts with the urethra may be another reason if either or both parties do not maintain good hygiene. Among several newly married women this is the cause of UTI.

What should be done?

1. Act immediately: This can cure UTI and avoid medical intervention.

2. Keep drinking water continuously:

If you drink 2 glasses of water immediately it will flush out the bacteria with urine. Keep a jug of water beside you and drinking water again and again. Drink at least 8 glasses of water in the day preferably warm to speed up the process. And wash and keep body clean.

3. Hot water massage:

If there is unbearable pain, fill hot water in one or two glass bottles and massage the back, inner thighs. Or cover the bottle with a towel and place it on the back or place it between the thighs and lie down.

4. Drink cooking soda solution:

Add a tea spoon of cooking soda in a glass of water or a glass of fruit juice and drink it. Drink this four times at one hour intervals. The acidity of the urine reduces due to the cooking soda. This prevents the bacteria from multiplying. It also prevents the burning sensation in the urinary passage. Although this solution tastes bad it provides relief from UTI.

Caution: People who have blood pressure problems and heart problems are advised against this treatment.

5.If necessary pain killers can be taken:

If the pain is intolerable, tablets that provide pain relief can be taken.

6. Drink water continuously, without fail:

Drink one glass of water or more every twenty minutes without fail. Drinking this much water may cause frequent urination. The bacteria in the bladder automatically come out this way. One should drink water like this for at least three hours.

7. Lie down and take rest:

Take rest with hot water bottles and water jug near you. You will find relief from UTI within three hours.

When should medical help be sought?

- If UTI continues for more than a day
- If you are pregnant
- If blood is mixed in urine
- Men and children get UTI rarely. In case of infection they should be taken to the doctor immediately

What will the doctor do?

- The doctor may ask you to undergo a urine test. If you have got UTI because of bacteria or other germs, the doctor will prescribe antibiotics. Otherwise you may require counseling/information regarding home remedies and preventive methods

  If you have vaginal 'white' discharge in addition to UTI, you will have to undergo lab tests
- If the UTI continues even after consuming antibiotics or if the infection occurs frequently, further tests may be required. Do not ignore the problem nor avoid treatment. This may result in bacteria affecting the kidneys

What can be done to avoid UTI?

- Drink at least 3 – 4 litres of water daily. You may feel this is a lot but if you follow this it is possible to flush out the bacteria from the bladder immediately.
- When you feel like passing urine, do not control it unnecessarily.
- If you feel that you get UTI generally after sexual intercourse, clean your vagina before and after sexual intercourse and ask your husband to do the same.
- Always keep your vagina clean. But do not apply powder or use 'Dettol' to wash it. It is sufficient to wash with clean water.
- Avoid using nylon and tight panties. Wear cotton panties.
- Some people get UTI when they drink too much coffee or tea. If you find that this is the reason for UTI, then give up this habit.

(Source: RUWSEC pamphlet –Tamil version inserted)

Uterine prolapse

This chapter provides the necessary knowledge and understanding on uterine prolapse to help women prevent it's occurrence or recognize the signs and symptoms and get treated appropriately. The grassroot experience of RUWSEC in dealing with dalit women with uterine prolapse gives an additional insight to the problems women from marginalized communities face and the measures that are needed to help them.

The chapter has just one session:

Session 1: Uterine Prolapse 2 hours 50 minutes

Session Objective: At the end of this session the participants will be able to:

A. Explain what is uterine prolapse
B. List causes of uterine prolapse
C. Describe signs and symptoms of uterine prolapse
D. Briefly describe treatment for uterine prolapse
E. Explain how to prevent Uterine prolapse
F. Describe the barriers to care and the needs of and support for women who are suffering from uterine prolapse

Training materials required for this session:

A Picture of uterus (refer earlier chapters), A1 RUWSEC pamphlet material on uterine prolapse; A2 Pictures on stages of prolapse

E Reference from PNC chapter on pelvic floor exercises

F1 Story of Pushpa

F2 Background reading on barriers to care and treatment (RUWSEC)

Methodology:

Present the objectives of the session

A. What is Uterine Prolapse 40 minutes

Divide participants into groups and distribute copies of (A1). Let them read and discuss.

Now show a picture of the uterus to explain where exactly the uterus lies in the woman's body. Ask them to make a fist and tell them that when not pregnant the uterus is the size of their tightly closed fist.

Ask participants what is prolapse. Ask if any of them or anyone they know have had a prolapse and if yes how did they feel during that time, when did they seek treatment and what was the treatment they received and how they feel after having the treatment. Let them share. Using (A1) explain and clarify any doubts.

B. Causes of Uterine Prolapse 20 minutes

Now ask participants why does prolapse happen? Let them explain. Ask one of the participants to read out the perceptions of village women the reasons they give for the prolapse (A1). Allow participants to comment. Then using the information given in the pamphlet explain the causes.

C. Symptoms of Uterine Prolapse 20 minutes

Ask participants to describe the symptoms of uterine prolapse. Listen to their answers then using (A2) state that : With mild prolapse, a woman may not have any symptoms, even though the opening to her uterus (cervix) may be sagging down into her vagina.

With moderate prolapse, also known as stage 1 when a woman begins to actually feel it, a woman may have a heavy sensation in her lower abdomen, or she may feel as if she are sitting on a ball. She may feel low back pain and lower abdominal discomfort. The pain and discomfort may get worse after she has been standing a long time. She may feel pain when she has sexual intercourse.

With stage 2 of the prolapse, the uterus may feel like a large lump in the vagina or may even be visible from the outside at the opening of the vagina.

With stage 3 the uterus slips out and hanging between the thighs of the woman putting her in great discomfort and in grave danger of infections and pain.

Some women with prolapse experience urine leakage when they lift, cough, or laugh. Others have difficulty urinating and difficulty moving the bowels is common.

D. Treatment **15 minutes**

Ask participants to describe the treatment if any of them have undergone this problem. Ask one participant to read out from (A1). Ask participants how they can avoid prolapse listen to their answers and fill gaps.

E. Pelvic floor exercises **15 minutes**

Ask participants what is meant by pelvic floor exercises. (Refer: Module 3- Chapter 2: Postnatal Care (Pg#) Explain what is the pelvic floor and help them to identify the muscles. Ask someone to explain the exercises. Fill gaps. Let all participants sitting in their places try to do the exercise for a few counts. Ask them how it feels. Explain that these exercises should be done from the teenage years to help keep the muscles well toned. They are compulsory after delivery. Ask how many of them had done the exercises after delivery and whether they knew anything about it during that time.

F. Barriers to Care and treatment **30 minutes**

When women have a uterine prolapse many do not seek treatment immediately but continue with it till it becomes a serious condition. Read the story of Pushpa given in (F1). Ask participants to identify what the barriers to care and treatment could be. Discuss barriers. Refer (F2).

Activity ***30 minutes***

Divide participants into two groups and ask them what can be done to overcome these barriers and to prevent the problem. They can discuss the following:

Group 1 : A strategy or program for Health education – to limit the risk of prolapse, including pelvic floor exercises after delivery.

Group 2 : Ways to increase availability of wider range of temporary contraception to promote spacing and avoid frequent pregnancies and ways to improve accessibility to treatment.

Materials used for training / handout include:

A1 **Uterine Prolapse**

Uterine Prolapse is a major reproductive health problem. Old age and middle age women face this problem. We should be informed about the reasons for prolapse and how to avoid it and follow the procedures to avoid prolapse. Women who have first stage prolapse can follow the instructions given in this pamphlet and do simple exercises to control the problem.

Uterine prolapse means the uterus changes its position/ or comes down from its original place. Before we understand prolapse we should be aware of the location and the functions of the uterus in the human body.

Structure of the uterus

The uterus is pear shaped and without conception it's the size of one's fist. The uterus can be divided into three parts.

a) The top part which is in the shape of a basket (turned upside down) and forms the 'roof'.

b) Flat – hollow space in the center – triangle shaped middle region.

c) What is called cervix in English - a narrow lower region.

To the top region of the uterus are attached two fallopian tubes one on each side and the ends of the two fallopian tubes have ovaries. The cervix is attached to the inner vaginal opening.

The location of the uterus

Uterus is situated inside the pelvis of the woman. Urinary bladder, uterus and large intestine are situated one behind the other in a woman's body. The uterus is in the center. The muscles and ligaments of the pelvis hold the kidneys, uterus and the large intestine.

What is prolapse?

We saw in the earlier pages that the muscles and ligaments hold the uterus. When the muscles and ligaments become weak the uterus moves from its position or the uterus comes down. When the muscles and ligaments lose elasticity, the uterus comes near the vaginal passage. That is known as uterine prolapse.

Based on the location of the uterus having slipped down due to weakness of the muscles and ligaments, prolapse can be described in three stages:

1st stage: When woman sits/squats or bends down she can feel her uterus near the mouth of the vagina.

2nd stage: In this stage the uterus is always (even when standing) felt near the vulva / outer entry to the vaginal canal.

3rd stage: In this stage the uterus comes out of the vagina and hangs between the thighs of the woman.

What are the reasons for prolapse?

- During complicated delivery the muscles and ligaments that hold the uterus are stretched and become weak. When the baby is big and the women push for long hours or if labour is prolonged the muscles and ligaments holding uterus become weak and prolapse happens.
- Applying fundal pressure during delivery leads to weakness in uterus.
- Early delivery (</=18 years) lack of growth /weakness or late delivery (=/>35 years) the muscles and ligaments may become weak.
- In case of delay in delivery of placenta (health care personnel press the lower part of the stomach of the women) which leads to weakness in muscles and ligaments holding the uterus.
- Lack of nutrition, workload, lack of rest after delivery, carrying heavy loads of weight leads to uterine prolapse.
- During menopause the secretion of estrogen hormone is reduced and weakens pelvic muscles and ligaments, leading to prolapse.
- Activities that put pressure on lower part of stomach may lead to prolapse. For example, excessive manual labour or wearing iron belt *(ERUMBU KACHAI KATTUVATHU*).
- Excessive weight puts pressure on the pelvis and leads to weak pelvis.
- In some women cysts in the pelvis may lead to prolapse.

The above reasons and lack of nutrition, weakness in the muscles and ligaments that holds the uterus, damage to the pelvic muscles during child birth, carrying heavy weight after delivery are the reasons for uterine prolapse.

In 1998 RUWSEC conducted a camp on prolapse and a training session. Thirty two women participated in the camp and they were asked to explain the reasons for prolapse. Of these, majority of the women said heavy manual work and constant childbirth were the reasons for prolapse. This is the reason for prolapse for majority of the women living in villages.

The reasons for prolapse from the perspective of poor village women

A 45-year-old mother who has one child:

We are very poor. My husband and I were both bonded labourers those days. It was soon after delivery I had to carry a bundle of firewood on my head. That's when it happened.

A 42 year old woman with three children:

After the birth of my third child I started doing all kinds of work the very next day. I boiled paddy and stood near the stove for a long time. When I tried to lift the large vessel from the stove I lost balance and fell down and my uterus prolapsed that day.

Four women who had early marriages said that early marriage and immediate childbirth were the reason for prolapse.

Five women said that their first delivery was risky and after that they had prolapse.

Some said that after abortion and after tubectomy they had prolapse.

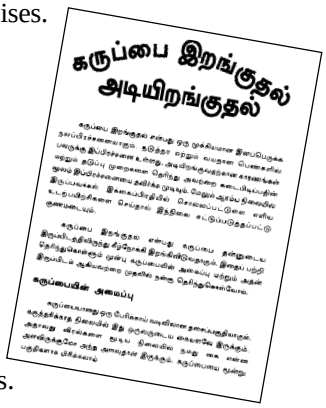
Majority of them said that carrying heavy weight after delivery caused prolapse.

Symptoms

- Women feel something in the vagina. When a woman does hard manual labour she feels something is pressurizing in her vagina.
- She feels some hinderance during sexual intercourse (painful).
- In the 3rd stage she may find it difficult to walk. She may find it difficult to perform her normal activities.
- She may find it difficult during urination and passing motion. She cannot control urine and feels like passing urine constantly during the night.
- Some women have hip pain and lower back pain.
- In the 3rd stage due to constant rubbing with the thighs small boils occur on the uterus, which lead to discharge of pus and blood.

How can uterine prolapse be avoided?

- To speed up the delivery should not apply fundal pressure before the cervix opens.
- Women should take sufficient rest before and after delivery. Avoid carrying weight after delivery.
- Should avoid conception at an early age and middle age. Should use contraceptives for spacing.
- Women with excessive body weight should try to reduce their weight by doing exercises.
- Before and after pregnancy exercises should be done to strengthen the pelvic muscles.



Treatment procedures

In case of symptoms of prolapse, refer to the doctor immediately. Some treatment procedures are as follows:

1. Women who have 1st stage prolapse may insert round shaped rubber (pessaries) in the vagina; this prevents the uterus coming down.

2. Doing some simple exercises can cure weakness in the muscles and ligaments.

Estrogen maybe replaced and treatment may be given to strengthen the pelvic muscles.

In the last stage may have to undergo a hysterectomy operation, as the chances of infection due to prolapse are high.

Kegel Exercises

Conception and delivery and excessive weight cause weakness in the pelvic region and weakness in the muscles and ligaments. This can be avoided by doing regular exercises. If these exercises are done right from adolescent period prolapse can be avoided.

Women after delivery should do this exercise compulsorily. Identify the pelvis and do this exercise because if done incorrectly it may weaken the pelvis.

How to identify the pelvic muscles?

Before doing this exercise women should be asked to go to the toilet and urinate. They should be asked to hold the urine and pass urine. This should be repeated. This helps to understand that the muscles, which are used to control passing urine, are the pelvic muscles.

Exercise to strengthen the pelvic muscles

The bladder must be emptied before doing this exercise. This exercise can be done lying down, sitting or standing.

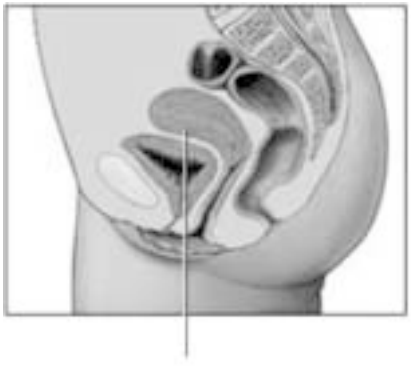
1. Woman should try and hold their pelvic muscles and count till 10.

2. Woman should try and relax pelvic muscles and count till 10. This exercise can be done for 10 counts, thrice a day (morning, afternoon and night).

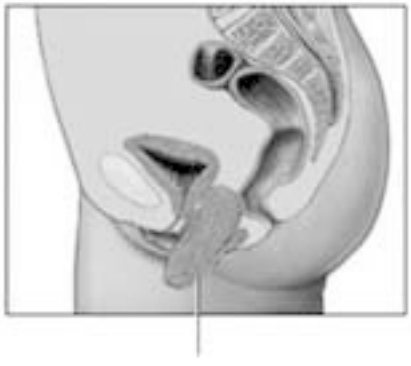
If a woman does this exercise for 4 – 6 weeks they will find a change and if they continue this for 3 months she would find a considerable change in her body.

The above exercise is not suitable for women who suffer from urinary incontinence.
(Source: RUWSEC pamphlet- Tamil version inserted)

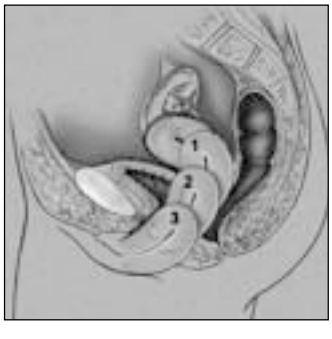
A2



Uterus



Prolapsed uterus



3 stages of prolapse

E Reference from PNC chapter on pelvic floor exercises (Page No. 164)

F1 My name is Pushpa. I am 30 years old and have three children. I had delivered my first child in my husband's home, because my mother was too poor to bring me home for delivery. I had no rest even for a week. One day I had to carry a huge basket of cow dung. As I bent down and lifted it up from the floor to put on my head. I felt something give way inside.

I went to the hospital then. They said that I would get better with drugs and no surgery was required. I did not get any better. So I stopped taking the drugs and did not go again.

It is almost impossible now with three children, husband and old in laws to take care of and the hospital is so far away. *(Adapted from Women's experiences…': RUWSEC)*

F2 **Women's Experiences** (to be used as reference for discussion)

RUWSEC's observations on women living with Uterine Prolapse in Chengalpattu, Tamil Nadu, India

Generally uterine prolapse is a problem faced by older, post-menopausal women because of the weakening of the muscles and ligaments. However in developing countries, especially among rural women, this may not hold true. Prolapse may occur even in the early twenties among chronically malnourished women who perform heavy manual labour soon after their first or second deliveries. Women have to perform chores like lifting heavy pots of water –(on an average a woman may have to carry and transport about 10-15 such pots a day), use of heavy pounding instrument to pound rice or millet also adds to the weakening of the pelvic floor. Prolapse may also be caused by violence against women, following surgery, or trauma to the pelvic floor. First delivery at a young age, frequent childbearing are also reasons that the uterus could prolapse.

In women living with prolapse for many years, the condition worsens gradually and becomes more difficult to live with this condition. Women with prolapse in their early twenties may experience the uterus projecting out of the vagina by their late thirties. Women suffer from various associated health problems:

The most common are difficulty in standing and sitting; an obstructed and blocking feeling, obstruction while passing urine and motion; back ache, lower abdominal pain, profuse and smelly or itchy white discharge; urinary tract infection; heavy menstrual bleeding.

Women with severe (third degree prolapse) develop sores on the uterus because it rubs against their sarees and thighs, increasing the incidence of cervical cancer.

For poor women who depend on agricultural/manual labour, it may result in loss of livelihood. They are unable to lift heavy things at home as well as at work. A lot of work in agriculture, construction etc. require the lifting of heavy loads. For example, in the villages that RUWSEC works in, harvesting gets the highest wages but requires carrying bundles of paddy on one's head. At home women with severe prolapse are unable to carry out their tasks like fetching water, firewood, squatting to wash clothes etc.

Women experience strained relations with their spouses because they avoid sexual intercourse, and others endure the pain whenever it happens. Women face violence and are forced to have sexual intercourse by the husbands. They are battered because of their inability to carry out household work.

To prevent the problem it is necessary to promote health education – to limit the risk of prolapse, including pelvic floor exercises after delivery; improve availability of wider range of temporary contraception to promote spacing and avoid frequent pregnancies.

There are several barriers to medical care for prolapse. Women maybe reluctant to seek treatment; their families may not provide the support; high costs for undergoing treatment, ranging from loss of wages to costs of hospitalization in case of surgery, drugs etc. Apart from this their husbands are reluctant to pay the additional expenses –for visiting the women, food for the companion who would stay at the hospital.

Lack of familial support: Husbands and families may not allow the woman to go for treatment because her absence from home would cause inconvenience to them. Lack of support to take care of their children when they are in the hospital and lack of support when they return home to help with work at home. Poor quality of care (including delays and long waiting lists in the few public facilities that provide surgical services). Some ways of improving access is by providing counseling for the woman and her family so that they understand the problem and possible ways of providing support to her; Creation of community support groups/networks that provide support to the woman – for example, accompany women to hospital, provide support to take care of her children in her absence and help with domestic tasks; Promotion of availability/accessibility of services- arranging for subsidized treatment, including surgery.

(Women's Experiences of Utero vaginal prolapse: a qualitative study from TN: TK Sundari Ravindran, R Savitri, A Bhavani: RUWSEC)

Cancer

Cancer maybe described as a category of diseases in which there is abnormal growth of cells. Nutrition – the lack of it predisposes a person to cancer. Other risk factors like early sexual initiation and high number of deliveries make women in developing countries like India particularly vulnerable.

The most important aspect for treatment of any cancer is early detection. For early detection people need to be informed about risk factors and symptoms. Health providers need to be trained in conducting tests or referring people to the appropriate facilities;

Testing for cancer, even the pap smear which is supposed to be low cost technology to detect cervical cancer is not available except in limited facilities. This results in mortality from cancer that is avoidable.

Grassroots organizations, community groups must work towards disseminating information to the community; lobby with health facilities and the government to provide facilities for screening and treatment through the public health system more effective. At present treatment of cancer is beyond the means of most people in this country.

This chapter has one session that provides basic information on three reproductive cancers - ovarian, breast and prostate cancers.

Session 1: Cancer **5 hours 30 minutes**

Session Objective: At the end of the session participants will be able to explain briefly:

A. Breast Cancer and how to do a self breast examination

B. Cervical Cancer

C. Prostate cancer

Training materials required for this session:

A1 Flip charts prepared in simple local language on the content

A2 Breast model and instruction for self exam

B Flip charts prepared in simple local language on the content

C Flip charts prepared in simple local language on the content

Note: It maybe useful to have a chart with internal organs of the body to clarify the organs referred to in this chapter.

Methodology:

Present the objectives of this session.

A. Breast Cancer **1 hour 30 minutes**

Ask participants what they know about breast cancer. Clear the misconceptions that cancer is caused by a virus. Explain about breast cancer using information given in (A1) while allowing them to question in between to clear their doubts.

Ask participants if they have any query and then move on to how to do a breast self exam. Use the breast model, the pictures and instructions in (A2) to demonstrate.

B. Cervical cancer **1 hour**

Ask participants what they know about cervical cancer and do they know of anyone personally who has suffered it. Let them share experiences. Then explain in detail (B1) giving participants enough time ask questions in between.

Ask participants if they have any more questions and then move on to Prostate cancer.

C. Prostate cancer **1 hour**

Ask participants what they know about prostate cancer and do they know of anyone personally who has suffered it. Explain in detail (C1) giving participants enough time ask questions in between.

D. Barriers to care **30 minutes**

Ask participants to list out the many barriers to care and treatment for cancer. The list may include:

- Poor people cannot afford treatment for cancer as it is very expensive
- Cancer can be cured in early stages but people lack information and generally postpone treatments which worsens the disease

- Cancer patients should be fed with nutritious food but due to lack of money they are unable to afford it
- Treatment facilities for treating cancer are usually available only in the bigger cities and towns.

Activity ***1 hour 30 minutes***

Divide participants into three groups and ask

Group 1: To develop a skit at a health facility about prostrate cancer.

Group 2 : To develop a pamphlet to disseminate in the community about cervical cancer.

Group 3 : To develop and present a session on breast self exam. (Use the breast model: refer Chapter on Lactation: Module 3, Chapter 3).

Materials used for training / handouts include:

A1

Breast cancer is malignant abnormal cell growth in the breast. Cancer is not caused by a virus or bacteria. If left untreated the cancer spreads to other areas of the body. Fibrocystic changes (e.g., formation of cysts, scar tissue) may cause benign (i.e., noncancerous) lumps in the breast. It is important for women to become familiar with their breasts and report changes (e.g., lump, nipple discharge, asymmetry) to their health care provider.

Risk Factors

Most women who develop breast cancer have no identifiable risk factors other than their being women. The condition is 100 times more common in women. The growth of breast cancer tumors is often affected by the presence of estrogen and progesterone. The following risk factors result from exposure to these hormones:

- Age (over age 50)
- First pregnancy after age 30
- Long-term (more than 5 years) hormone replacement therapy (HRT)
- Menstruation before age 12
- Menopause after age 50
- Nulliparity (never gave birth)

Other risk factors include the following:

- Family history of the disease (mother or sister with premenopausal breast cancer)
- Genetic link
- History of breast biopsy or radiation to the chest
- Moderate alcohol use (2 to 5 drinks daily)
- Obesity
- Personal history of the disease – women with a history of breast cancer are 3 to 4 times more likely to have a recurrence
- Race
- Sedentary lifestyle

Approximately 5% of breast cancer cases have a genetic link that results from an inherited mutation in genes. Patients who inherit these genes have an increased risk for developing premenopausal breast cancer and are more likely to have family members with the condition. Patients concerned about the genetic risk for breast cancer should speak to their doctor about genetic testing.

Cause

The cause of breast cancer is unknown.

Signs and Symptoms

The most common sign of breast cancer is a lump or mass in the breast. Any change in breast tissue should be reported to a physician or other health care practitioner. Other symptoms include the following:

- Dimpling of the breast
- Lump in the underarm
- Nipple discharge, pain, or inversion (turning inward)
- Skin irritation (e.g., redness, scaling) of the breast or nipple
- Swelling

Diagnosis

Diagnosis of breast cancer is made through a process called triple assessment, which includes

- clinical examination,
- imaging procedures (e.g., mammogram, breast ultrasound), and
- *biopsy* (surgical removal of tissue for microscopic examination) of a mass detected by physical examination or mammogram (x-ray of the breast).

Breast self-examination should be performed about 1 week after the menstrual period ends every month. Health care providers can instruct patients in the correct method of performing this examination.

During clinical breast examination, the health care provider examines the breasts (including the nipples and areola) for retractions, skin changes, and discharge. Then, the breasts and underarms are palpated (felt with the fingers). Health care providers should teach patients how to perform breast self-examination while doing a clinical examination.

During a *mammogram*, the breast is compressed between two plates for a few seconds and x-rays are taken. The procedure uses low amounts of radiation. Compression causes some discomfort.

Ultrasound may be used to determine if a mass detected by examination or mammogram is a cyst or a solid lesion. Ultrasound uses high-frequency sound waves to create an image of the breast on a computer screen. *Needle aspiration* may be performed if ultrasound reveals a suspicious lesion.

If a diagnosis of breast cancer is made, the cancer is staged to determine the course of treatment.

The doctor will counsel the patient and the family and then the patient can decide about the treatment with the doctor. Treatment is expensive and the cure rate depends on the stage of the cancer when is first discovered in the body of the particular patient.

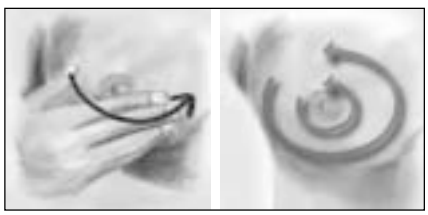
A2 Breast self examination (BSE)

Women of all ages should perform self-examination since breast problems can occur at any age. The best time of the month to perform self-examination is after menstruation. For women who are post-menstrual, with irregular periods or who have had hysterectomy, a suitable time should be chosen - for example the 1st day of the month.

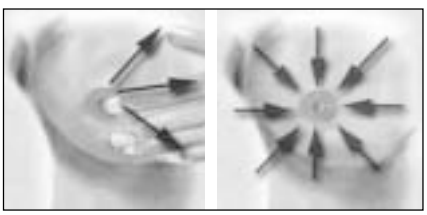
There are two basic ways of conducting a BSE: Visual and Tactile exam

Visual examination:
Look for changes in each breast- any change in one breast without a similar change in the other, including Shape, Size, contour or symmetry, Skin discoloration or dimpling, Bumps/lumps etc. (Note: Lumpiness is normal before menstrual cycle) Stand in front of a mirror and look for changes in your breasts (from both a frontal and profile view) in different positions: with your arms raised, arms at the side, with your hands on your hips and shoulders turned in.

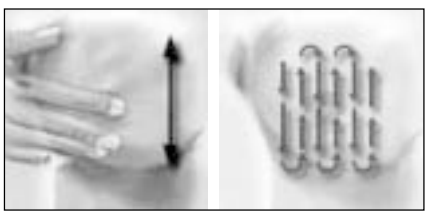
Tactile Examination:
Lie down. Place a small pillow or folded towel under your left shoulder and your left hand behind your head. Your shoulder should be raised high enough for your left breast to be center on top of your chest, falling neither to the center nor toward the armpit, using the pads of your three middle fingers.



Spiral examination



Wedges examination:



Linear examination:

Follow any of the patterns in the pictures always using a circular rubbing motion without lifting your fingers. Feel your breasts for any changes. Check surrounding areas - around the breast and underarm.

(Adapted from UCMS, Delhi)

B1 Cervical cancer develops in the lining of the cervix, the lower part of the uterus (womb) that enters the vagina (birth canal). This condition usually develops over time. Normal cervical cells may gradually undergo changes to become precancerous and then cancerous.

Cancer of the cervix is the second most common cancer in women worldwide and is a leading cause of cancer-related death in women in underdeveloped countries. Worldwide, approximately 500,000 cases of cervical cancer are diagnosed each year.

Causes and risk factors

The cause of cervical cancer is unknown. Infection with two types of human papilloma virus (HPV), which is transmitted sexually, is strongly associated with cervical and vulvar cancer and is the primary risk factor. Evidence of HPV is found in nearly 80% of cervical carcinomas. Human immunodeficiency virus (HIV) infection reduces the immune system's ability to fight infection (including HPV infection) and increases the likelihood that precancerous cells will progress to cancer.

Sexual activity that increases the risk for infection with HPV and HIV and for cervical cancer includes the following:

- Having multiple sexual partners or having sex with a promiscuous partner
- History of sexually transmitted disease (STD)
- Sexual intercourse at a young age
- High number of deliveries

Women who smoke cigarettes are twice as likely to develop cervical cancer. Chemicals in cigarette smoke may increase the risk by damaging cervical cells.

Regular screening with a Pap smear effectively lowers the risk for developing invasive cervical cancer by detecting precancerous changes in cervical cells. Women who do not receive regular Pap smears have a higher risk for the condition.

Signs and symptoms

Early cervical cancer is often asymptomatic (does not produce symptoms). In women who receive regular screening, the first sign of the disease is usually an abnormal Pap test result. Symptoms that may occur include the following:

- Abnormal vaginal bleeding (e.g., spotting after sexual intercourse, bleeding between menstrual periods, increased menstrual bleeding)
- Abnormal (yellow, odorous) vaginal discharge
- Low back pain
- Painful sexual intercourse (dyspareunia)
- Painful urination (dysuria)

Cervical cancer that has spread to other organs may cause constipation, blood in the urine (hematuria), abnormal opening in the cervix (fistula), and ureteral obstruction (blockage in the tube that carries urine from the kidney to the bladder).

Prevention

Avoiding sexual activity that increases the risk for HPV infection, not smoking, and having regular Pap smears can help prevent most cases of cervical cancer. Using barrier contraception (e.g., condoms) and limiting the number of sexual partners may prevent HPV infection

Treatment

Test are done in the health centers – PAP-smear test and testing the cells in the cervix.

Women between the age group of 30 –60 years should go in for voluntary check-up.

Laser treatment and hysterectomy is done based on the condition of the women.

C1 **Prostate Cancer**

Adenocarcinoma of the prostate is the clinical term for a cancerous tumor on the prostate gland. As prostate cancer grows, it may spread to the interior of the gland, to tissues near the prostate, to sac-like structures attached to the prostate (seminal vesicles), and to distant parts of the body (e.g., bones, liver, lungs). Prostate cancer confined to the gland often is treated successfully.

The prostate gland is located in the pelvis, below the bladder, above the urethral sphincter and the penis, and in front of the rectum in men. It is made up of glandular tissue and muscle fibers that surround a portion of the urethra. The gland is covered by a membrane (called the prostate capsule) that produces prostate-specific antigen.

Prostate cancer occurs in 1 out of 6 men. Reports of diagnosed cases have risen rapidly in recent years and mortality rates are declining, which may be due to increased screening.

Risk factors

A family history of prostate cancer increases the risk. Other possible risk factors include the following:

- 55 years old and older
- Diet high in saturated fat
- Exposure to heavy metals (e.g., cadmium)
- Sedentary lifestyle
- Smoking

Signs and symptoms

Early prostate cancer usually is discovered during a routine digital rectal examination (DRE).

Symptoms are often similar to those of benign prostatic hyperplasia. Men observing the following signs and/or symptoms should see their physician for a thorough examination.

- Blood in the urine or semen
- Frequent urination, especially at night
- Inability to urinate
- Nagging pain or stiffness in the back, hips, upper thighs, or pelvis
- Painful ejaculation
- Pain or burning during urination (dysuria)
- Weak or interrupted urinary flow

If any of these conditions are present a man must go to a urologist to rule out other illness and also test for prostate cancer.

Contraception

Contraception is an important component of reproductive health. It provides the possibility of regulating the timing, frequency of pregnancies, with significant benefits, especially for women. However, there is often a limited range and supply in the government system, in addition the people are unable to make a fully informed choice about the methods of contraception that are available in the market.

This chapter has two sessions:

Session 1 **:** What is contraception 45 minutes

Session 2 **:** Contraceptive methods and barriers to contraception 4 hours 10 minutes

Session 1: Contraception

Session Objective: At the end of the session the participants will be able to:

A. Explain what is contraception

B. Explain the male and female reproductive system (using the RUWSEC pamphlet)

Materials required:

B1 RUWSEC pamphlet material on contraception, B2 & B3 Picture posters of the male and female reproductive systems, (Refer part 2 module2)

Methodology:

Present the objectives for the session.

A. What is Contraception **5 minutes**

Ask participants what is contraception. If they have attended the contraception (concept) session earlier they can recap. Listen to participants' responses and sum up that Contraception means 'to stop conception from taking place'. It can be done through natural or artificial methods.

B. Male and Female reproductive systems **40 minutes**

Divide participants into 4 groups and distribute a copy each of the pamphlet (B1) on contraception. Give them about 10 minutes to read through the material provided.

In the large group ask a volunteer to explain the male reproductive system using the picture (B2) let participants comment and then fill gaps using (B1). Sum up stating that the mature sperms from each of the testes are stored in the respective epididymis which is a fine thin spiral tube that then straightens out to form the vas deferens that carry the sperm to the ejaculatory duct via the seminal vesicle and prostate gland. The seminal vesicle provides the fluid and base for the sperm to survive in while the prostate gland provides the nutrition for the sperm. The sperm, fluid from the seminal vesicle and the fluid from the prostate gland together form the semen that comes out during ejaculation. The testes also produce the male hormones. Tell participants that it is important to understand that the passage of sperms, as it is useful when trying to counsel clients for vasectomy later.

Ask a second volunteer to explain the female reproductive system following the same facilitation process using the material on contraception. Use pictures (B2 & B3) to explain.

Materials used for training / handouts include:

B1 **What does contraception mean**

Karuthadai endral enna

Contraception helps a woman to achieve desired number of children at the desired time. Contraception is the prevention of conception. Contraceptives function in the following ways.

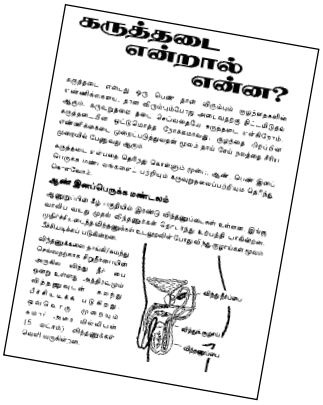
Contraception is a simple means of controlling the birth of children to protect and promote the health of the mother and child.

Prior to understanding contraception we need to understand the Reproductive systems of men and women and conception.

Reproductive system of man

There are two testes below the penis of men. Here sperms are formed right from adolescence. The matured sperm comes out through the sperm tubes during sexual intercourse. The mature sperm are stored in a sac below

the bladder. The seminal fluid that comes out each time during ejaculation contains very large quantities of sperm. Every time around half a million sperms come out.



Reproductive system of woman

The vagina in women is canal shaped, and ends in the cervix. The uterus is pear shaped and is like a thick skin. There are two ovaries one on each side of the uterus, the fallopian tubes connect the ovaries to the uterus. This is essential to bear a child. After puberty, every month, two weeks after the menstruation an egg matures and comes out of the ovaries, travels via the fallopian tube to reach the uterus. One month the egg comes out of the left ovary and the next month the egg comes out of the right ovary.

Conception

When the sperm from man fertilizes the egg from the woman, conception takes place. As a result of sexual intercourse, many sperms enter into the vagina of the woman but only one sperm fertilizes the egg and conception takes place. This generally happens in the fallopian tube.

The sperm remains alive in the uterus only for 48 hours; likewise the matured egg remains alive for 12 – 24 hours. Only if fertilization takes place during this period, conception takes place.

After the fertilization of the egg by the sperm they move to the uterus from the fallopian tube. Then the embryo implants/attaches to the inner lining in the uterus and grows. Every month the uterus prepares itself for the growth of the embryo.

If conception does not take place within 48 hours, the inner lining of the uterus dissolves and comes out. This is menstruation. Generally menstruation continues for 3 – 5 days.
Contraception means to prevent conception. Contraceptives function in the following ways.

- They prevent the formation of egg in the ovaries
- Prevent fertilization of egg by the sperm
- Prevent the egg from reaching the uterus
- During sexual intercourse prevent the passing of sperm through semen
- Even if fertilization happens prevent implantation in the inner lining of the uterus

Contraceptives can be classified as

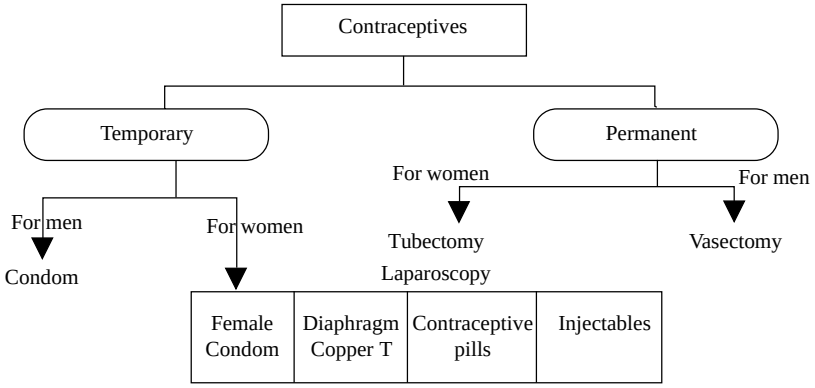
1. Temporary methods
2. Permanent methods

1. Temporary methods:

This is to postpone the birth of the first child or to provide two-three years spacing between one child and another, which promotes the health of the mother and the child.
Temporary methods can be used in place of permanent methods too by couples who do not wish to undergo a female surgical method or non scalpel vasectomy [NSV].

2. Permanent methods:

These maybe used by couples who prefer not to give birth to anymore children, after the birth of two or three children.



(Tamil version inserted)

Session 2 Contraceptive methods and barriers to contraception

Session Objective: At the end of the session participants will be able to:

A. Explain in detail about each of the modern contraceptives available for couples.

B. Explain the natural methods of contraception that couples can practice

C. Barriers to contraception

Training materials required for the session:

A1-A9 Samples of modern contraceptives; Material (from RUWSEC pamphlets) on each of the contraceptive methods;

B Copies of Notes on natural methods (LAM) from the Lactation chapter; Sample on Characteristics of good quality FP services

C Narratives for discussion, Sample chart on barriers

Methodology:

Present the objectives for the session.

A. Modern contraceptive methods **1 hour 30 minutes**

Divide participants into 9 small groups or pairs, give each pair or triad one contraceptive method (A1-A9) and its sample and let them read and discuss the contraceptive method. Write the title of each of the nine pamphlets on small pieces of paper, fold them up to use for lots. Ask one of the participants to come forward to select a folded paper from among them and select that method to be presented first and so on in order to complete all nine. Or you can start with the two male methods of contraception and move on to female methods, using the same facilitation process as done in the earlier session, cover each method. When presenting they may use an advertising format or story format or enact as a role play to present the information on the method of contraception. After each presentation comment and fill gaps if any.

B. Natural methods **30 minutes**

Ask participants what they know about natural methods of contraception. Refer to the notes given in the Lactation/Breastfeeding chapter of the Module on Maternal and Newborn health for information on LAM. State that other than LAM and the withdrawal method all other natural methods can be used only by women who have regular menstrual cycles.

Ask one of the participants to explain LAM and the criteria for LAM. Let participants comment and then fill gaps using the notes given for LAM in the Breastfeeding chapter of the Module on maternal health.

Fill gaps using content given in (B1) and in that manner complete all the methods one by one.

Summarize the session stating that all methods are good depending on how correctly they are used by the couple. *They do not protect from STI or HIV. Among all methods whether modern or natural the only method that provides safety from STI and HIV is the Condom.*

C. Barriers to contraception and Characteristics of good FP services **1 hour 30 minutes**

Divide participants in two groups and give one narrative (C1) to each group. Ask the groups to discuss and continue the narratives. (15 minutes discussion+ 10 minutes each presentation + 15 minutes post presentation).

In the post presentation discussion, guide it so that the issues are discussed at each level – individual, household, community (including health services), state (include policies, schemes). A sample is provided in the grid in (C2).

Activity ***40 minutes***

Divide participants into 4 groups and ask them to discuss and list some characteristics of 'good quality' FP services. List the points presented by all the groups and plug gaps (C3).

Materials used for training / handout include:

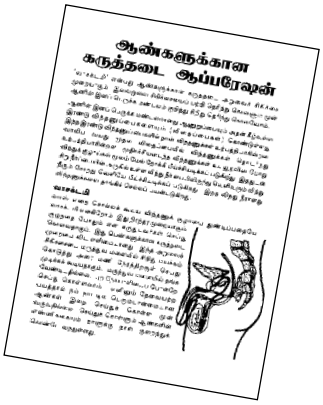
Modern contraceptives *(Notes included in the materials below do not appear in the original pamphlet. Tamil versions inserted)*

A1 Vasectomy

Vasectomy is the permanent sterilization method for men. Before understanding about vasectomy we should understand man's reproductive system.

In the man's reproductive system there are two testes. Sperm are produced in the testes. The mature sperm come out along with the semen through the penis during sexual intercourse. The semen helps to carry the sperms.

Vasectomy



Cutting of the sperm tube is called vasectomy. This is a permanent method and may be chosen if one decides to avoid childbirth or stop childbirth. Sterilization in men is easy but sterilization in women is very complicated. In hospitals they perform vasectomy within half-an-hour under local anesthesia. The man need not stay in the hospital after the surgery. But due to fear of the procedure and consequences, men do not come forward for this. The number of men who undergo this procedure has been decreasing gradually.

How does it work

1. The tube, which carries the sperm, is cut off so that the sperm does not come out during sexual intercourse and thus avoids conception. After this operation erection takes place and semen is ejaculated normally but no sperm comes out.
2. This can be carried out even through the out patient department of a hospital and the required time is just 20 minutes.
3. Doctor gives an injection on the outer skin of the testes to avoid pain and conducts the surgery by making a small incision using a special device and using this the sperm tube is held.
4. The doctor cuts it and the ends are tied up to avoid joining.

The incision is stitched and is bandaged and the person can go home within an hour.

Advantages

- It is a simple surgery
- After the surgery the person can go home within half an hour
- This does not create any obstacles nor make any difference to sexual activity or sexual pleasure
- It increases sexual pleasure in the absence of fear of conception

Instructions for care after surgery

1. Take rest and do not carry weight for 2 or 3 days.
2. Till the stitches heal keep the area dry .
3. After the operation the sperm will be present in the tube for two or three months so it is better to use another method (condom) during sexual intercourse. Due to lack of awareness about this problems arise in the family.

4. If there is fever, pain and swelling in the area of operation consult the doctor immediately.

Tests that need to be done before the surgery

Do you have diabetes ?	**Heart problems or high blood pressure>**
Do you have any STIs?	**Hernia in testes?**

If one has any of the above problems the operation should be carried out only after these problems are treated.

There are no side effects after the surgery. Sexual pleasure does not decrease and erection is normal. 'Masculinity' does not decrease. There is no problem during the sexual intercourse. This is simpler and better than the surgery for women.

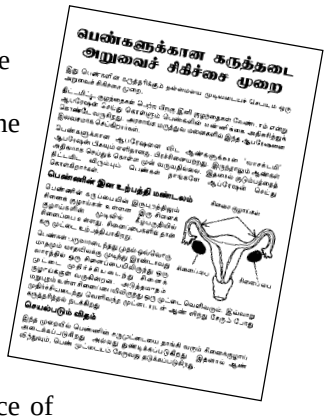
Like tubectomy after a surgery this can be reversed but the cost of surgery is very high. The chances of conceiving are reduced and hence only those who decide to stop having children may choose this method.

A2 Tubectomy

This is to avoid conception and childbirth. When a woman decides to stop the birth of children she can opt this method. The number of women who go in for operation is increasing day by day. This operation is conducted free of cost in the Government hospitals.

Vasectomy is simpler, safer and has no side effects but men do not come forward so women go in for sterilization. Women who decide to control the size of their family opt for sterilization.

Women's reproductive system


பெண்களுக்கான கருத்தடை அறுவைச் சிகிச்சை முறை

There are two ovaries on each side of the uterus connected by the fallopian tube. The eggs are formed in the ovaries. After puberty every month, in the second week since the last menses, one egg is released from the ovaries- one month from the left and one month from the right. When the egg meets the sperm fertilization takes place.

How it works

In this method the fallopian tube which carries the egg, is closed or cut off. It prevents fertilization of the egg by the sperm.

When can this be done

Generally it is believed that tubectomy should be done after delivery or after abortion, but this is not necessary. It can be done after menstruation, in the absence of pregnancy. There are no risks or complications in this surgery and hence is a safe method.

This is done in two ways:

1. Tubectomy – cutting the fallopian tube or blocking the fallopian tube.
2. Laparoscopy

1. Tubectomy:

This surgery is done in a fully unconscious state. A 2 or 3 inch, in other words thumb-sized incision is made across the navel and the fallopian tube is pulled out knot is tied or cut and stitched. After this surgery the women should take bed rest for at least a week and should not carry to much weight for some time.

2. Laparoscopy:

In this method the instrument, which has a mirror and lens, is used to perform the surgery.

Below the navel a half inch incision is made and the tube is inserted into the stomach so that the doctor can view the fallopian tube clearly Then the fallopian tube is burnt or cut or pressed /closed and the incision is stitched. After this surgery the women needs to stay for 6 – 8 hours in the hospital The pain as a result of the surgery is less and after two or three days the woman can resume her routine work.

This method needs trained and well-experienced doctors because if the fallopian tube is not identified correctly then it could have dangerous consequences.

Unlike tubectomy, amongst women who have undergone laparoscopy there have been instances of women getting pregnant. This happens when the fallopian tube is not cut but clip is put around it.

Advantages

There is no fear of conception.

Unlike contraceptive pills it does not cause any risk to breast-feeding and unlike the diaphragm does not cause any inconvenience during sexual intercourse.

Women who have the following problems cannot use this and can ask their husbands to go for vasectomy:

1. Women with psychological problems and who have psychological problems after delivery.
2. Those who experienced fits (epilepsy) before and after delivery.

Those who had excessive bleeding.

3. Those who suffer from the following problems

(A) Jaundice (B)Anemia (C)Tuberculosis, Asthma, high blood pressure, thyroid, diabetes, cancer (D) skin problems or infection in surgery area (E) cysts in the abdomen.

Generally women put on weight or reduce weight after this surgery but there is no medical evidence. After sterilization by undergoing a surgery they can conceive again but it is very expensive and there is no guarantee that everyone can conceive.

Post surgery

1. Two weeks after the delivery one can have sexual intercourse
2. After surgery one should take complete rest for a week and healthy diet for a month.
3. Till the stitches heal one should be careful and keep them clean to avoid infection. Should eat vegetables fruits and milk. Need not follow any food restriction.

Changes in the body

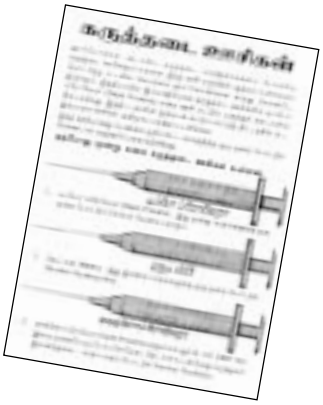
The egg in the ovary cannot reach the end of the fallopian tube that is the only change. The egg will be in the body. There should be no problems in the menstrual cycle and sexual activity.

Note: When tubectomy takes effect: Tubectomy begins to prevent pregnancy as soon as the surgery is performed. But if the surgery is done during the middle of the menstrual cycle (day 10 to day 20), use another contraceptive method until you have your next period.

A3 Injectables

There are hormonal contraceptive injections/injectables similar to the pills. The injectable as long as it lasts continuously secretes artificial hormones in the body. It is available in India by the name of Depo provera. This is available in medical shops but it is not available through the government's family planning programme.

If women use this injection during that specific period conception can be avoided.



There are three different types of injectables available at present

1. Depo Provera- Should be used once in three months.
2. Net en- Should be used once in two months.
3. Cyclo Provera and HRP 102 have other ingredients in addition to those in Depo Provera and Net en. These have to be injected monthly.

How does it work

The hormone based injectables function like contraceptive pills.

- They control the release of the egg from the ovaries
- Thickens the cervical mucus so that sperm cannot enter into the uterus
- The injection should be taken in the same week after menstruation. Depo provera should be injected three months after the first, Net- en two months after the first injection and Cyclo provera and HRP 102 every month. The subsequent should be injected on the same day in the subsequent months.

Who should not use this

1. Pregnant women
2. Women who are breastfeeding
3. Women who have symptoms of breast or cervical cancer.
4. Women who have excessive bleeding
5. Generally Women who cannot use contraceptive pills should not use this

Advantages

This very effective method can be stopped when the woman wants to conceive. Unlike Pills and other methods injectables need not be remembered everyday. It prevents anemia.

Side effects

1. Contraceptive injections cause changes in the menstrual cycle. 60% of the women do not get their periods.
2. Some have excessive bleeding or less bleeding.
3. Studies reveal that contraceptive injections cause more chances of cancer but it have been proven otherwise now.
4. Increase in body weight
5. There may be problems like vomiting, giddiness and tiredness. Any medicine containing hormones will cause this.
6. After stopping the injection there are chances that there is no egg formation in the ovaries for 4 to 9 months, so there are lesser chances of immediate conception. For some conception may not take place at all.
7. Apart from the above if there are any health problems it is better to consult a doctor. For example problems like migraine, blurred vision, depression, should go to doctor immediately.

Attention

Among the contraceptive injections Depo Provera was banned in America for one or two years. The reason being this was given to Rhesus monkeys and these monkeys developed breast cancer and uterine cancer.

As it was banned in America countries like India and other countries banned this. The recent research conducted by WHO concluded that there is no relationship between Depo Provera and cancer. Net en was used in India on a trial basis. Women who were given this injection were not informed about it's side effects nor were they provided any tests. Many women's groups filed a case in the high court against the callousness of ICMR. As a consequence Net en was banned.

At present Depo Provera is recognized and available in medical shop and private clinics. The cost of this injection is Rs.150. Before using this check whether this is suitable for you. It is better to go for a medical check-up before using this method.

Note: When the injectable takes effect: To be sure the injectable is working, wait to have sexual intercourse, or use another contraceptive method, such as condoms or spermicide, for at least 24 hours after the injection.

A4 Intra Uterine Devices

IUDs are small devices that are fixed in the uterus. This prevents pregnancy. In our country some IUDs are made of copper and some are made of artificial hormones and others are made of plastic. In our country Copper – T is widely used.

Copper – T:

It is T shaped as in the English alphabet. It is used for spacing. The types of Copper – T are 308, 380A, MLCU – 375. 380A- this can be used for 10 years continuously.

Copper –T can also be used as an emergency contraceptive – refer pamphlet on emergency contraceptives for details.

How it functions:

As copper –T is fixed in the uterus there is a protection and it prevents fertilization of the egg in the uterus. Even if fertilization takes place the embryo cannot implant in the inner lining of the uterus. So there are no chances of conception.

Who can use this?

Women who need spacing can use this. Once fixed it can remain for 3 years. After three years it should be changed. MLCU – 375 can be used for 5 years and 380A can be used for 10 years. After this period it should be changed.

How and where it is fixed

Copper – T is inserted in the government hospital free of cost. Only a trained medical practitioner can insert this. Generally this is inserted on the 5th day after menstruation because during menstruation the cervix is open wide and there is no chance of pregnancy. Special equipment is needed to insert this into the uterus. There is a long stick with the help of which the doctors insert it and after it is inserted it forms the T shape. While inserting it women may feel some pain. Some women do not have any side effects but others women feel tired, pain in the hip and lower back and weakness in the legs.

Women should be escorted when she goes for insertion of copper – T and if possible should rest the whole day.

Who should not use it and when should it not be used:

1. Those who have problems in the uterus and fallopian tube.
2. Those who have bleeding between menstrual cycles without known cause.
3. Those who have vaginal discharge and STI's.
4. Those who have wounds and cysts in uterus and cervix.
5. Those who have a history of ectopic pregnancy.
6. After a cesarean section and after miscarriage.
7. Women who have irregular menstruation, menstrual cramps and are anemic.

Side effects

1. Women complain of excessive bleeding and irreregular menstruation after inserting copper – T. This should regularize in a few months. If the problem persists for a long time then should seek medical attention.
2. Irritation/burning sensation in the vagina, smelly vaginal discharge, sudden bleeding – women who have these problems should remove copper – T immediately
3. Contraceptives are not 100 % safe if you do not get periods after using contraceptives refer to the doctor immediately

4. Chances of ectopic pregnancy are higher when using copper – T. this is very risky as the fallopian tube could rupture as the embryo develops.

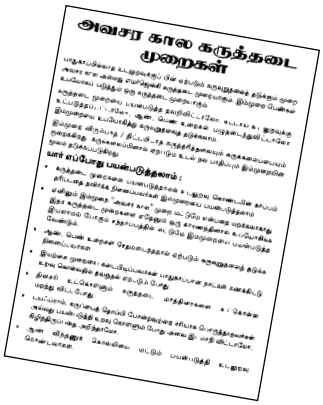
If the woman does not get her periods it is necessary to do a pregnancy test. If this is delayed it may cause risk to her life.

A5 Emergency contraceptives

Emergency contraceptives are used for prevention of conception after unprotected sex. Emergency contraceptives are available for women. Emergency contraceptives are used to prevent conception in case contraceptives are forgotten to be used, forced sex, damage to male/ female condoms.

This method can prevent unplanned or undesired pregnancy and minimizes health problems due to abortions.

Who can use them and when:


அவசர கால கருத்தடை முறைகள்

- These can be used when no contraceptives were used during sexual intercourse and want to avoid pregnancy.
- It is important to remember that this is to be used in an 'emergency'. For some reason if other contraceptives could not be used.
- In case of damage to male/female condoms and to avoid the possibility of pregnancy as a result.
- While practising natural method if the safe period is miscalculated.
- When oral birth control pills to be consumed daily are forgotten.
- While using diaphragm or cervical cap if it is not fixed in the correct position or during intercourse if it moves out of place, or if it tears.
- In case spermicide alone is used during sexual intercourse.
- In case of rape/forced sex to prevent pregnancy.
- There are two types of emergency contraceptives available in the market.

1. Hormone pills

2. Intra uterine devices

1.Hormone pills

An extra dose of oral contraceptive pills is emergency contraceptives. These pills are made out of the combination of estrogen and progestin hormones. The contraceptive pills that are available in India namely Mala – D and Ovirol – G are used as emergency contraceptives.

How to use them:

The emergency contraceptives should be consumed in two dosages. The first dosage should be within 72 hours of sexual intercourse and the next dosage 12 hours after taking the first dosage. The dosage and time duration of these emergency pills are as follows.

Name of the pills	Time duration and	When to consume
	1st dosage	2nd dosage
Mala – D	Within 72 hours of sexual intercourse 4 pills at a time	12 hours after the first dosage 4 pills at a time
Oviral –G	2 pills within 72 hours of the sexual intercourse	2 pills 12 hours after the first dosage of the pills

This should be within 72 hours after sexual intercourse i.e. 3 days. If it is more than 3 days then this method cannot be used/ there is no guarantee.

How it works:

- It stops the egg coming out of the ovaries or slows down the release of egg .
- It slows down the movement of sperm and egg in the fallopian tube and avoids fertilization.
- Even if fertilization takes place it prevents the implantation in the inner lining of the uterus.

Advantages:

- Easily available and very effective
- Can be used without the advice of the doctor

After consuming the tablet:

- There may be a delay in menstruation or early menstruation
- There may be excessive bleeding or less bleeding during menstruation
- If menstruation does not happen after 3 weeks or in case of any symptoms of pregnancy consult the doctor immediately

Side effects:

- Some may suffer from giddiness, nausea, fainting. It is recommended to have a glass of milk or biscuits and after half an hour consume the pills. To avoid vomiting, tablet like *Avomin* can be consumed and after one hour emergency contraceptive pills can be taken.
- Some women have heavy/sensitive breasts or irregular periods and headaches. This usually becomes normal after a few days.
- Some believe that emergency contraceptives cause infertility and cancer but this is wrong. **They must not be used continuously as regular contraceptives. This may result in serious consequences.**

2. IUDs – Copper – T

Five days after unprotected sex copper – T 308A can be inserted to prevent pregnancy. Normally copper – T is used to postpone pregnancy and spacing. This can also be used as an emergency contraceptive.

Within 120 hours (within 5 days) after unprotected sexual intercourse the copper – T can be inserted with the help of a doctor. This is effective for 3 – 5 years. Those who want to avoid pregnancy can continue with the same or remove it after the next menstrual period.

How it works:

- Avoids the movement of sperm and the egg and prevents fertilization
- Avoids the embryo from implanting onto the inner lining of the uterus

This can be inserted in government and private health centers following the advice of the doctor.

Side effects:

- Those who have reproductive tract infections, use of copper – T the chances of increase in the infection are higher.
- IUD use may cause some bleeding which generally stops within 1 or 2 days. However if it continues the doctor must be consulted.
- All women report delay in menstruation and heavy bleeding after inserting copper – T. This should get okay in a few days but if the delay lasts a long time (several months) consult the doctor.
- In case of burning sensation in the vagina or smelly vaginal discharge and sudden bleeding, the doctor should be consulted at the earliest. Sometimes the Copper T has to be removed.
- Sometimes pregnancy may take place in spite of the IUD. If menstruation is missed, consult the doctor immediately.
- There are chances of ectopic pregnancy in some persons after copper – T usage. This is very risky because during the process of fetal growth the fallopian tube may burst. Therefore as mentioned above in case of a missed period it is extremely necessary to do a pregnancy test. In case of delay there maybe grave danger to life.

In India Mala – D, Oviral G are used world over as regular contraceptives. But as emergency contraceptives there are very few who use them, because of lack of sufficient information and misplaced opinions about them. On an average 67 lakh abortions are conducted every year in India and about 15 – 20 000 women suffer as a result of abortion related health consequences. If the emergency contraceptives are used properly this can be avoided.

Caution:

Emergency contraceptives should be used only in 'emergencies'. These are not to be used regularly. If used regularly the side effects increase and the efficacy decreases.

Emergency Contraceptives	
Type	How to use
Hormone tablets	Consumed within 72 hours after unprotected sex
Copper – T	Between 72 hours – 120 hours after unprotected sex, copper T maybe inserted

The emergency contraceptives can be used within 3 days after unprotected sex. Within 72 –96 hours, i.e. 3-5 days after unprotected sex, copper – T maybe used. Beyond this time frame emergency contraceptives are not effective.

One point that we need to understand clearly is that this does not cause abortion. Therefore already pregnant women who use this cannot abort. Further this should not be used as abortion pills.

A6 Contraceptives that are fixed in the cervix

Generally there are two different types in use.

1. Diaphragm

2. Cervical Cap


கருப்பையின் முகவாயில்
பொருத்தப்படும் தடுப்புகள்

These two temporary methods can be used by a woman on her own. But they are not available widely in our country. Many women's groups feel and that these should be available in our country.

1. Diaphragm:

It is in the shape of a cup and it is made out of latex rubber. The edges corners provide grip and remains in position.

If this is fixed in the cervix of the woman the sperm from the man will not enter into the uterus. Moreover the spermicide used in the diaphragm destroys the sperm so conception can be prevented. Let us understand more about spermicide as it is used in both diaphragm and cervical cap.

Spermicide:

These are available in the form of tablets, cream and paste. Prior to sexual intercourse, the spermicide should be applied in the vaginal passage of the woman or inserted in the vaginal passage of the woman. Sometimes spermicide alone is used. But it is most effective when used with diaphragm or cervical cap.

The spermicide destroys the sperms or prevents their movement towards the egg.

How to use the diaphragm

1. The size of the diaphragm varies according to the build of the woman. The woman should be tested and the appropriate size is confirmed and the doctor should fix the first time. After that the woman can fix it on her own and no medical care is needed.
2. Diaphragm should be used every time during sexual intercourse. If more than two hours have passed since fixing the diaphragm it is advisable to apply the spermicide again.
3. Spermicide should be applied inside the cup region and also on the sides. Then it should be folded in half and inserted through the vagina till it reaches the cervix. Check whether it fully covers the cervix.
4. The diaphragm should not be removed till 6 hours after sexual intercourse.
5. After taking out the diaphragm it should be cleaned in luke warm water, dried and should be kept safely in its box. Soap should not be used to clean the diaphragm.
6. Diaphragm can be used during menstruation too.

Who should not use it:

1. Women who are allergic to latex rubber
2. Women who have prolapsed uterus

3. Women whose uterine, cervical muscles and ligaments are weak due to frequent childbirth.
4. Women who do not know how to fix the diaphragm properly

Side effects

There are not many side effects. If the size of the diaphragm is not correct; if it is small it can be painful and there maybe problems in passing urine. The problem can be solved by checking with the doctor and getting a bigger sized diaphragm.

Due to latex allergy, or intolerance to spermicide, there maybe irritation, pain and swelling in the vagina. Diaphragm is not advisable for women who have these problems.

Poor women may not have the privacy that is required to insert the diaphragm, or the facility to store in a clean and dry place . Women should decide how effectively they can practice this method and then start following the method.

2. Cervical cap

Cervical cap is like an inverted funnel. The top part is closed and the bottom part is open and wide.

How to fix it:

1. One third of the closed part should be filled with spermicide.
2. The cervical cap should be held between the thumb and the forefinger and the closed region should be slightly folded and pushed into the vagina.
3. Use the finger to fix into the cervix. If you feel the inserted cervical cap it is like the tip of a nose. The lower part should be nicely pressed.
4. The cervical cap should be taken out 6 hours after sexual intercourse and should not be left for more than 48 hours.
5. The cervical cap should be cleaned using soap and clean water. It should be dried and can be reused .

The side effects are similar to that for the diaphragm.

Advantages

- Using spermicide in diaphragm and cervical cap reduces the chances of cervical cancer.
- Certain bacteria/virus that transmit infections sexually are destroyed by the spermicide so that the spread of STIs in women is controlled.

Note: How to remove the diaphragm:

- *Wash your hands. Use soap, if possible*
- *Place your finger behind the front rim of the diaphragm. Then pull the diaphragm down and out of the vagina. Be sure your fingernails are short enough to avoid tearing the diaphragm*
- *You may remove the diaphragm while you are in any position that is comfortable for you (standing, squatting, sitting on the toilet, lying on your back, etc.).*
- *Check the diaphragm for tears or holes of any size before or after each time you use it. To look for holes, you can hold the diaphragm up to the light, or fill it with water to see if there are leaks. If the diaphragm has a tear or hole, do not depend on it to prevent pregnancy.*

A7 Contraceptive pills

Contraceptive pills are in use for a long time in India. These are made out of artificial hormones. These are available in various brand names in India- Mala – D, Mala – N, Beryl x-rays, Ovirol – N, Choice and Primolar. Mala – D and Mala – N are widely used in India. Let us understand more about them. Mala D is used by young women to postpone the first pregnancy, for spacing thereafter. It is a simple and safe method and the woman can conceive after she stops taking the pills.

It is easy to consume daily. Each strip has 28 pills, of which 21 are white in colour and 7 are orange in colour (or any other colour). The 21 white pills are contraceptive pills and the 7 are iron tablets.

How it works

The contraceptive pills contain two hormones namely estrogen and progestogen.

ESTROGEN

This prevents the formation of egg in the ovaries, preventing fertilization by the sperm so that conception does not take place.

PROGESTOGEN

This causes the cervical mucus to become impenetrable and makes it difficult for sperm to reach/enter the uterus.

Normally every month the inner lining of the uterus is formed and this holds the embryo. Consumption of the contraceptive pills, specifically the progestogen hormone present in the pills prevents the formation of this inner lining so that even if fertilization takes place the embryo cannot implant itself in the inner lining of the uterus.

Normally to postpone the first pregnancy, or for spacing between subsequent children, contraceptive pills are used. Many women feel that it is not advisable to use this method continuously for more than 3- 4 years.

Who should not take pills?

- Women who are breastfeeding. In case of doubtful or unconfirmed pregnancy.
- Women who have irregular bleeding or bleeding without known cause.
- Women with High blood pressure, diabetes, jaundice and/or tuberculosis.
- Those who have problems in the liver.
- Those who have symptoms of cancer.
- Women who have certain types of anemia.

Note: should not be taken by women who are taking medicines for seizures, convulsions or rifampicin, an antibiotic used to treat TB.

Tests that should be done before consuming this:

Prior to long term use of contraceptives the woman should ask the doctor to perform tests to check for the following:

- High blood pressure
- Diabetes
- Types of anemia
- Symptoms of cancer
- Pregnancy

How to use this

- Consume this on the fifth day of menstruation. It is better to consume this after dinner and before going to sleep.
- Should continue to consume the tablet at the same time daily.
- While consuming the last seven tablets the woman gets her periods.
- Even if the pill is missed, it can be taken the next day at the earliest. She can continue the remaining pills at the same time. It is okay if two pills are consumed on the same day.
- If the pills are not consumed for 3 days continuously, the pills must be stopped till menstruation. Start with a new strip of pills.
- Use other contraceptive methods when not taking pills.
- If consumption of the pill is irregular, there is delay in menstruation, there maybe chances of pregnancy, consult the doctor immediately.

Side effects

Some women face some side effects due to consumption of contraceptive pills. These are normal and minimize in the long run. Some of the side effects are very harmful and the woman should stop taking the pills and consult a doctor immediately if she experiences the following:

A. Unexpected sudden bleeding, giddiness and vomiting

This may be experienced immediately after starting the pills. Generally these should disappear after three months but if they continue, even after three months the doctor should be consulted.

B. Depression

Women who have high progesterone and low estrogen have this problem so it is better to have pills with low progestogen levels.

C. Migraine and severe headache

In case of migraine or severe headaches, the doctor should be consulted.

D. If there is an increase in the blood pressure

Heart attack, swelling in the body, disruption in blood circulation, breast cancer –there are chances that these may occur in women who use the contraceptives for a long time

Based on the given information one should decide on what contraception to use. One must remember that it is less harmful use contraceptive pills than undergoing frequent abortions.

New contraceptive pills:

This is available in India and it needs to be used only once a week. The brand name is 'Saheli' and was first introduced in Delhi and is now available in major cities. The side effects are supposedly less harmful but the information given for other oral contraceptives is applicable in the case of Saheli too.

A8 Condoms

The condoms used by men provide protection against conception and STIs. Condoms are made out of a very thin rubber called latex. It is available in various colours and sizes. Certain condoms are lubricated or may contain spermicide.

Everyone must have heard of "Nirodh". It is manufactured by the government. Apart from this there is Kamasutra, Musky, Pink, Kohinoor, Adam and Moods and many other brands of condoms available in India. These are available in medical shops, pan beedi stalls, cigarette stalls and provision stores at cheap rates. Government hospitals, health centers and certain voluntary organizations also supply condoms free of cost. VHNs and CHWs supply this in the villages during their field visits free of cost.

Condoms are desired by couples to postpone the first pregnancy and for spacing between children.

a condom not only prevents pregnancy but also protects from STIs, RTIs. the condom alone provides protection from sexual transmission of HIV infection from one person to another. This can be used to protect from STIs even after tubectomy, vasectomy and IUD insertion. If the condom is used properly each and every time the spread of STIs from one person to another can be avoided.

How it works

1. It protects the passing of men's sperm into the vagina of the women so that conception can be avoided.
2. The condom protects the spread of STI's from one person to another during sexual intercourse.

How to use it?

1. Remove carefully from the packet. Handle carefully to avoid scratches. The rolled condom should not be straitened before using.
2. Before wearing the condom remove the air from it. Leave some gap in the end to collect the sperm before wearing the condom.
3. Fix the condom during erection and cover the penis, slowly try to roll and avoid nails touching it as it may cause a hole in the condom.
4. After sexual intercourse before there is reduction in erection slowly remove the condom.

After using once throw it in the dustbin. Use a new condom every time.

Advantages:

- Condoms are very cheap and easily available
- They can be used without any medical advice or tests
- They are easy to use, have no side effects and do not cause any health problem
- They can be used continuously for many years
- It gives sexual satisfaction and protects from pregnancy and STIs

- One can stop using condoms at any point of time
- It is the best method if used properly and the user can stop using it at any point
- It helps in spacing and is a simple method that promotes the health of the mother and child

It prevents the spread of moniliasis, and reproductive tract infections, STIs , HIV. Absence of use even once may cause the infection. Although the HIV virus is minute it cannot permeate the rubber of the condom.

General doubts about condom usage and explanations

1. Many feel that they do not get sexual satisfaction by using a condom – it is a false opinion. The feeling of safety from STIs and avoiding pregnancy are sufficient to provide a sense of satisfaction.
2. Condom breaks easily

If it is not used properly condom generally breaks or tears

If used beyond the date of expiry, it may tear.

It may also tear due to absence of lubrication in women during sexual intercourse or in the case of forced sexual intercourse.

The condom may tear if other lubrication is used when using a condom. Sometimes the condom may tear due to careless use of finger nails while wearing it.

All over the world, couples use condoms and feel it the best method as compared to other contraceptive methods. It is the only method that protects from sexually transmitted infection.

A9 Female condoms

We are aware of male condoms likewise the female condom is a new entry in the market. It is available in big cities. Female condoms are made out of thin plastic called polyurethane. Like male condoms one side is closed and one side is open. There are two rings fixed on either side. Women use these rings to fix the condom in place. The female condom like the male condom is used to postpone pregnancy, for spacing and protection from STIs and HIV.

How does it work:

During sexual intercourse the penis o enters the vagina and the condom prevents the sperms from entering the vagina and they are collected in the condom.

How to fix the condom:

This should be fixed a while before sexual intercourse.

Remove the condom from the packet. Squat on the floor. Hold the rings on the sides of the condom using the thumb and index finger slowly start inserting the condom into the vagina using the index finger. Carefully insert it because the nails may damage the condom. After inserting the condom remove the ring in the closed part of the condom. The ring at the open end remains outside the vagina.

Advantages:

- Women can control use and at the same time be protected from STIs
- It protects from pregnancy and spread of STIs and RTIs as it covers the vagina fully
- This can be used without medical tests/advice
- There are no side effects and it is thicker than male condom
- Unlike male condoms this need not be removed immediately after sexual intercourse

Remember

- Female condom should be used only once
- Expired condom should not be used
- Should not be stored in any place where the temperature is high

Problems/disadvantages

There is difficulty in fixing the condom. As it is newly introduced the price is very high. It is available in big cities only. It costs thrice as much as the male condom.

(Source: RUWSEC pamphlets)

B1 Natural Family Planning methods

Coitus Interruptus (Withdrawal)

In coitus interruptus, the penis is withdrawn from the vagina prior to ejaculation. This method mainly depends on the exact time of withdrawal before ejaculation which may be difficult to achieve for some of the couples. Even if the couple succeeds on many occasions it may fail any single occasion. This method is difficult for very young men/teenagers to manage till they learn to recognize and control time of ejaculation. Many couples however use this method successfully.

Cervical Mucus Method This method also known as the ovulation or Billing method depends on the observation of changes in the consistency and the volume of cervical mucus in relation to the ovulation. On feeling the cervical mucus in the vagina by fingers the dry days and the wet days are recognized by the women. The wet days are the fertile days. When the mucus is like the white of an egg it is unsafe to have sexual intercourse if you want to avoid pregnancy. The number of wet days are about 10 days in 28 day cycle. Wet days start with sticky white mucus for 2-3 days following the 2-3 dry days after menses. Sticky white mucus days is followed by clear slippery profuse mucus for 3-5 days (this slippery mucus is capable of being stretched between two fingers) . The last day is called the peak day. Following peak day there is sticky mucus for 3 days. This the end of fertile period.

Rhythm Method or Calendar Method. This method is based on an observation that the ovulation in females takes place 2 weeks before menses. Now as we know that the menses cycles in women may not be on precise day every month, the calculation of the safe period is done on the basis of duration of 12 previous cycles. [use a calendar to explain] First note down the shortest and the longest cycles during the last 12 cycles. The first fertile day will be minus 18 days from shortest cycle.

The last fertile day would be minus 11 days from the longest cycle. For example : - if the short cycle is 25 days the first fertile day would be (25 minus18) = 7th day if the longest cycle is 32 days, the last fertile day would be (32 minus11) = 21st day. Thus there should be abstinence for 2 weeks from two days before 7th till 21st day

Basal Body Temperature Method. This method involves detecting the time of ovulation by observing temperature shift of 0.05 ° C at luteal phase following ovulation. The female has to observe abstinence during first half of menses cycle till 3 days of elevated temperature at 0.05 ° C. Interpreting and maintaining temperature chart may require lot of care and thus failure chance is very high.

C1 Narratives

1. Pushpa is 24 years old and has borne three children already, lost two and is pregnant fro the fourth time in five years of marriage. She has no time to rest and no sympathy from her mother-in-law, who virtually terrorizes her. Her husband is in and out and there is hardly a moment of privacy to talk to him about her problems, tell him that she does not want any more children, that she wants to terminate the pregnancy and go for sterilization. He responds to her gestures of affection but when he realizes that what she really wants is to get him to concede to her request for birth control, he feels cheat and that she is 'using' his feelings for her. The communication is broken off and he becomes distant.

2. Malar 21 years old and her husband, Sankar 26 years old had a love marriage and live in Selaiyur not very far from Chennai. They both work, Shankar at the Electricity Board office and Malar in a garment factory in the area. Malar and Shankar feel that they don't want to have children for some time because they have just begun working and want to be financially comfortable before they plan a family. There is a lot of pressure on both to have a child immediately. But they have been managing to stick to their decision. They have not been using any contraception since their marriage almost a year ago. Shankar is not comfortable about using a condom as he feels that it hinders sexual pleasure. Malar is nervous and does wants to explore contraceptive options so she decides to go to the health center [PHC] and speak to the nurse there

C2 Discussion points

Individual

Lack of information; myths about vasectomy; condoms; reluctance to use methods due to side effects

Household

Lack of decision making power (woman), lack of control over her sexuality/fertility; lack of access to resources (if has to buy it from private shop/clinic if not available in the public system)

Side effects leading to days away from work – which is unaffordable in poor homes, especially as the woman has to do a lot of physical labor in and out of the house; Contraception is seen as the woman's responsibility. (This point maybe true for the state and the community too)

Community

Lack of information /counseling for men and women regarding contraception; lack of range of contraceptives; irregular visits and irregular stock restricting regular supply of contraceptives. Non availability of contraceptives at most PHCs; Lack of follow up services. If there is a problem with a contraceptive, it is not easy to access treatment.

Gender insensitive: the system usually forces the woman to take responsibility for contraception and blames her for failure or non use of it. The system is not sensitive to the reasons for the woman not using contraceptives. For eg previous experience with IUD – and having to go from one health facility to another to get it removed.

Some of the methods are completely in the control of the doctor. They can be inserted/removed only by the doctor and the woman has no control over it. This in situations where the above is prevalent.

Unethical practices – contraception without the knowledge of the woman, clinical trials among poor women

State

Target oriented versus right to control fertility etc; vertical programmes like camps that do not provide any follow up services.

C3 **Characteristics of good quality family planning services:**

- A choice of three or more contraceptive methods are available
- Services are available also to single men and women
- Those visiting the health center for the first time are given information on all the contraceptives available including their effectiveness and potential side-effects.
- For each method, information includes: how it works; side effects; contraindications; what to do in case of a health problem related to its use; clarify which methods protect from STIs including HIV and which do not.
- Allowed to choose a method of their choice freely
- For those reporting problems with using a method, other options are available.
- Permanent irreversible methods are offered only to those who have no doubts or objections against them. There is no questions of ‘ talking people (women) into accepting’ these methods.
- Women can seek information and discuss contraception in private and not have to talk in the presence of others
- There are no incentives and disincentives to women and men for the practice/non practice of contraception
- Service providers are not pressured into finding acceptors by any means, overt or covert or through punishments and rewards
- Service providers have training in communication skills; have adequate information about various methods of contraception and skill to provide these. Guidelines and manuals for reference and pamphlets and mass communication material are readily available to service provides in the health facilities where they work.
- Service providers in sub centers have supervision and guidance in their work
- For any method provided, the necessary screening is done to rule out contraindications
- In case of women opting for Oral contraceptives,injectables, or implants pregnancy test is done to rule out pregnancy.
- IUDs and implants are inserted with due attention to asepsis
- Requests for removal of IUDs or implants by current users will be attended to and removal effected.
- Abortion services are available
- Follow up care is an integral part of service deliverywomen who have health problems related to contraceptive use are given appropriate treatment
- Women who are found to be suffering from reproductive health poblems in the course of screening are provided treatment. In case of other problems they are referred to apt health facilities Counsel about natural methods to those contraindicated for other methods, so that no one is denied control over their fertility owing to their health problems.

(ICPD preparatory meeting report: ICSA: 18-20 March: Sundari Ravindran)

Infertility

Reproductive health includes not only the ability to avoid pregnancy but also the bearing of children. Infertility affects both men and women of reproductive age. However the impact of infertility is especially felt by women in a society where she is valued most for her ability to bear children. 'A woman who had to wait eight years before she could get pregnant said that people were saying that even if the family had bought a buffalo, they would have done better. They would have had additional income. Feeding and taking care of her was in no way useful to the family: there were no children.' *(An analysis of the health care system from the perspective of third world women.)*

Women's entire existence seems worthless if they are unable to bear children, given the social ideology under which we live. Secondary infertility due to infections of the reproductive system is known in the culture; people know you can become infertile after having one child or two children. and so they prefer to have all the children they want in quick succession and perhaps after that they can start thinking about whether they want or do not want any more children.

The society is not accepting of childless women, and the value attached to child bearing is so deep rooted that women themselves have very low self esteem.

Infertility as a consequence of STIs and infections following surgery –abortion or delivery is the cause in half of all infertile couples. However awareness about infertility is sadly lacking and the health system has not done much to remedy the situation. Treatment facilities and counseling for the couple and families, follow up services are limited in the public health system. This limits accessibility of such services by poor women and men (when they are willing) as they cannot afford to undergo treatment at a private facility.

This chapter provides an overview of infertility in men and women and the impact of infertility on the lives of women.

Session 1: Infertility — 3 hours 15 minutes

Session objectives: At the end of this session participants will be able to:

A. Explain what is infertility

B. Describe causes for infertility in men and women

C. Describe the impact of infertility on the lives of women

Training materials required for this session:

A Prepared chart on content

B Prepared chart on content, pictures

Methodology:

Present the session objectives

A. What is infertility — 10 minutes

Ask participants what they understand by infertility. Then explain using content in (A1).

B. Causes for infertility — 45 minutes

Ask participants if anyone can explain the biological factors that influence conception and pregnancy. Listen to the responses then explain that in order to understand infertility one must understand the biological factors and phases that influence conception and pregnancy. Explain using (B1) content.

Ask participants to think about what could be the reasons for infertility in women and in men. Draw two columns on the writing board and title it as given in (B2). Encourage the participants to provide the content and using the filled grid given (B2). Strike off inappropriate responses and add those that are missing.

Then explain that infertility in both men and women may be caused by congenital defects. Malnourishment and anemia may cause infertility and/or miscarriage. If a woman experiences several miscarriages or premature births, then she must have nutritious diet and iodine supplements. Should prevent anemia and based on the doctor's advice should have iron/folic tablets. Miscarriages in the early months of pregnancy needs checking for syphilis too. Repeated RTIs. STIs and PID can lead to infertility. Early detection and treatment can prevent the problem.

What to do when a couple is unable to conceive after trying for a year (5 minutes)

Ask participants what should a couple do when they are unable to conceive a baby after trying for about a year. Then explain that both partners should be encouraged to go for counseling.

- Men and women should be encouraged to go for testing and treatment at the earliest so that the problem can be treated.

- Follow up to ensure that the treatment is completed. Several partners do not complete the treatment as it can take a long time and they are unable to afford it especially if they are from poor households

C. Impact of infertility on the lives of women **45 minutes**

Ask participants to work in two groups:

Group 1 : Discuss the ways in which women are treated by the family and the society when she does not get pregnant and the effect it has on their emotional and physical health.

Group 2 : Discuss why men are reluctant to go for check up or counseling and treatment. Do the society and family members play a role in this?

Sum up the discussion with (C1).

What would you do? **45 minutes**

Divide participants into 2 groups. Give copies of the story (C2) to each group. Ask them to read the story and discuss and respond to the questions given. Discuss the responses in the large group. Thereafter if time permits as participants to enact the story or discuss so that Padma talks to her husband and the couple talk to their family about Kannan not wanting to remarry and agreeing to go for the test and treatment- to reflect the alternative or how it could /should be.

Clarify issues and sum up the learning from the presentations.

Activity ***45 minutes***

Divide participants into groups to:

Compose a song to educate community about infertility affecting both men and women, therefore the woman should not be harassed, and that both need to get tested and treated to solve the problem. The song should also stress upon the point that the value and status of women in the household and society should not depend on her producing children (especially sons).

Let participants present and choose the best or a combination of the good ones for duplication and distribution.

Materials used for training / handouts include:

A1 Infertility is the condition when pregnancy does not take place for a couple even after 2 years of trying. It affects men and women equally. Unfortunately in our societies men are reluctant to go for testing and the woman is blamed and suffers emotional trauma within the family because of this. Sometimes the man marries again in order to beget children.

'Infertility is usually defined with reference to the woman because the woman's inability to conceive can be identified even if it is because of male infertility.

Infertility maybe Primary or Secondary

Primary Infertility: the woman has not conceived despite cohabitation and exposure to pregnancy for a period of two years. Clinicians usually use one year of unsuccessful efforts to conceive as the criterion for initiating diagnostic procedures

Secondary Infertility: The woman has previously conceived but is subsequently unable to conceive, despite cohabitation and exposure to pregnancy for a period of two years. If the woman has previously breast-fed an infant, then exposure to pregnancy is calculated from the end of the period of lactational amenorrhea.'

B1 Conception and pregnancy are complicated processes involving many biological factors and phases: the man needs to produce healthy sperm and the woman healthy eggs; the cervical mucus needs to be healthy and abundant so that the sperm can travel up through the cervical canal to the uterus and fallopian tubes; the fallopian tubes need to be open and accessible so that the sperm can reach the egg; the sperm has to be able to fertilize the egg when they make contact; the fertilized egg (the embryo) has to be able to implant in the woman's uterus; and, finally, both the embryo and the woman's uterine environment need to be healthy and strong for the baby to come to term. If any one of the biological factors is impaired or damaged in any way, infertility can result. Infertility in women has been linked to aging, a history of pelvic inflammatory disease, and certain lifestyle behaviors.

B2

Reasons for infertility in women	Reasons for infertility among men
- Cysts in ovaries	- Lack of healthy sperm
- If the inside of the uterus is hard	- Not enough sperm
- If eggs are not formed in the ovaries	- Damage to the testes
- Absence of uterus from birth	- Drugs, cigarettes, toxins can reduce sperm count
- Change in the structure of the uterus, fallopian tube	- Repeated STIs or RTI
- Fallopian tubes are blocked or scarred due to PID	- Excessively over weight or under weight
- Because of repeated STIs, RTIs & PID	
- Excessive overweight or underweight	
- Smoking or eating disorders	
- Consequences of infections following abortion or delivery	

C1 Infertility has tremendous social and emotional consequences for the woman. The woman is usually blamed for infertility although the problem may lie with the man or the woman. Men are reluctant to go for testing and treatment if found to have a problem.

In poor households, women who are unable to conceive (it may or may not be the woman's problem) may be abandoned, or the man marries a second time.

Investing resources on a second marriage is perceived as more fruitful than going through a process of tests and treatment.

Women who are childless are considered inauspicious. They are not invited to ceremonies/social functions, they are not even allowed to hold other children.

Several myths surround infertility including treatment practices. This maybe because of ignorance, reluctance to invest in care and treatment for women.

The woman suffers emotional and mental health consequences of infertility which may cause loss of self esteem and other psychological problems

C2 **Padma's story**

Padma has been married for 5 years to Kannan. They have been trying to conceive but have failed so far. Kannan's family wants a son from him so they have been trying for two years to get him to agree to marry again. He is attracted to Padma but for the last one year has been seriously thinking that he needs to marry again to beget a child. His friends and others have been putting tremendous pressure on him and insulting him saying that 'he is unable to do it'.

Padma wants her husband to also go for medical checks but is afraid of him. She has regular periods. Kannan had some genital warts in the early months of their marriage and with some traditional medicine it disappeared.

When Padma goes to her parents village to help her younger sister with her delivery, Kannan's family arrange and get Kannan married again. Padma is not informed. She comes to know only when she returns that her husband has another wife. The shock is too much for Padma to bear but she is unable to do anything about it. Her parents cannot afford to have her back, she has two more younger sisters to get married. Her husband spends sometime with her to pacify her mainly because he still finds her attractive. She needs him but …….

Padma constantly suffers from headaches and cries a lot. She is very sad all the time and worries about her future. The second wife Radha too is not yet pregnant. Padma tells her husband in hurt and anger one day, "Well if it was my problem, then why is your second wife still not pregnant?" Kannan slaps her.

Discuss:

What should the couple have done?

What do you think is Padma's state of emotional and physical health?

Who is responsible for Padma's state in her marriage?

How could things have been different for Padma?

SPECIFIC SEXUAL AND REPRODUCTIVE HEALTH CONCERNS OF ADOLESCENTS AND YOUNG PEOPLE

Overall objective:

- Provide adolescents with the information and tools necessary to cope with the physical and emotional changes of adolescence;
- Help them evolve into mature and well-adjusted adults capable of confidently and responsibly making decisions concerning various aspects of their lives and
- Enable them to adopt values and behaviour patterns that subscribe to egalitarian and human gender relations and uphold social justice.

This module covers:

Chapter 1: Assertiveness 4 hours 15 minutes

Chapter 2: Developing meaningful relationships and evolving one's guiding principles for life 19 hours 10 minutes

Chapter 3: Special health concerns of adolescents 5 hours 15 minutes

Chapter one and two deal with helping adolescents become more expressive and assertive in relationships with their peers and with others, including and making and implementing decisions within these relationships.

Chapter three deals with specific Sexual and reproductive health (SRH) concerns of unwanted pregnancy, Sexually Transmitted Infections (STI) and also deals with prevalent problems of substance use and suicide. All three chapters facilitate acquisition of knowledge and skills to make informed and responsible decisions concerning sexuality, marriage, through adolescence and thereafter; create gender awareness to help change harmful behaviour patterns, promote egalitarian gender relations.

The module has been designed for trainings with adolescent participants. The sessions are also relevant to adult groups, with appropriate modifications. Sessions from other modules can be used for adolescent groups with appropriate modifications.

Assertiveness

Being assertive in sexual relationships would be difficult if one was not assertive in all relationships. Assertiveness is especially a challenge for women and girls who are socialized to subordinate their own feelings and opinions to that of their husbands and significant elders in the household. Assertiveness is an issue also for young men and adolescent boys in a traditional society such as ours where older people – especially men - are vested with the power to decide on the lives of the young people in their extended family or kin group. Young men are also subjected to a great deal of peer pressure and sometimes engage in behaviour they might not want to really engage in, in order to be accepted by their peer group. For example, doing drugs, drinking, smoking, sex and others.

This chapter one includes the following sessions:

Session 1: Assertiveness in all relationships 2 hours 15 minutes

Session 2: Assertiveness in intimate relationships 2 hours

Session 1: Assertiveness in all relationships

Session objectives: At the end of the session participants will be able to:

A. Describe situations demanding assertiveness and barriers to being assertive

B. Explain how to be assertive

Training materials required for the session:

A. Charts /board, pens / chalk, 3 situations for discussion

B. Charts with materials for discussion, paper, pens, chart / board, pens / chalk

Methodology:

Present the objectives of the session.

A. Situations demanding assertiveness and barriers to being assertive 1 hour

Ask participants to reflect on what assertiveness means and explain that when the facilitator counts to three, all participants have to freeze with an expression or a stance that would reflect assertiveness as perceived by them.

Assertiveness means to state something positively, forcefully in a bold and confident manner, in anticipation of denial or objection. (10 minutes)

Divide participants into 3 groups. Give each group one situation and ask them to discuss (15 minutes) and enact role plays (15 minutes). Encourage them to include other issues that they feel are relevant based on their experiences.

After each role play discuss (15 minutes) and note on a chart/board the major barriers to being assertive from the perspective of adolescents and young people. During the role play and discussions issues regarding 'fear of losing the friendship', 'fear of violence if refuse to do something, ' significance of peers and inability to go against popular opinion' , 'lack of confidence in saying no' etc may emerge and must be noted for discussion. Also make note of the ways in which the participants asserted themselves in the situation. How did they do it? What were they thinking about? Would it be possible in real life situations. If not, what are the reasons?

At the end of the activity sum up the various points/issues that are obstacles/barriers in being assertive (5 minutes)

- lack of awareness about assertive behaviour, we may not realize that it is an option
- anxiety, fear of expressing ourselves even when we know what we want to say
- low self esteem, we may not think that what we want is worth asking for
- not having the words to express our feelings and needs
- having learned behaviours that hinder assertive expression
- being in situations which make it difficult, sometimes impossible, to act assertively

B. How to be assertive 30 minutes

Present the steps to being assertive (A2) in situations in the future referring to examples from the role plays in previous activity. Thereafter discuss how to behave in a mature manner (A3) and share opinions with confidence (A4).

Activity ***45 minutes***

Divide participants into two groups and ask them to role play situations in which the various aspects discussed in the session are included. Each group then presents the role play with commentary to clarify and explain the steps to being assertive.

Sum up saying that perhaps the greatest barrier/obstacle to being assertive is not feeling good about ourselves. That is influenced by the messages we give ourselves as well as what the society, and people around us give. The first step therefore would be to build our self confidence.

Note: Building self confidence is a need that might arise in this session. A couple of activities are included in the 'Additional reference reading for facilitators'.

Any of these situations can be adapted for workshops with adults. An additional situation that can be used with adults is also included.

Materials used for training / handouts include:

A1 Situations

1. You are 5 close friends. You are a better student as compared to the others. In the previous annual exam you did not allow them to copy from you. Tomorrow is the mid year examination.

   You feel that copying is not right. In such a situation how will you assert your opinion/feelings.
2. Your friends love watching movies. You also bunked class and went along with them. The last time your father got to know, he beat you and warned you. This time once again your friends want to go for a movie and presume that you will go along too. You don't want to go. What will you do?
3. You go regularly to tuition class. Today for some reason there is a bus strike and it is getting dark. A man whom you have seen frequently but don't have a good feeling about him says that he is going to take an auto. He asks you to go along. You don't wish to go with him. How will you refuse his offer.

A2 Steps to being assertive

- State your feelings about the issue, rather than blame the person. Do not start with 'you always…', but with 'when you …., I feel ….'
- State clearly your preferred solution to the situation
- Wait patiently for the response
- If s/he sidetracks, bring the issue back on track and state your issue and the solution once again
- If the respondent turns recriminatory (threatens, shouts), don't back-track. State what you would do if the problem is not solved
- If the respondent gives a positive response, thank him/her and bring closure to the issue. In case an acceptable solution cannot be reached, express regret and leave

A3 To behave in a mature manner:

- Assert your rights without insulting / putting down others
- Have confidence to do what you think is right and in a way that others are not faced with a problem
- Take responsibility for your actions. Don't get pulled/pressured by others
- Find possible solutions to your problems without blaming it on destiny
- In case of a difference of opinion, allow it to be shared without losing your temper. Respect others opinions

A4 How to share your opinions with confidence *(non verbal):*

- Face the person and make eye contact while talking (women often speak with eyes averted or head bowed)
- Posture: stand and sit straight, be relaxed. Do not fidget with your hands or do anything else that reflects being unsure or uncomfortable
- Facial expressions: can support your verbal message. (Does your face express when you are angry, sad, scared)
- Talk clearly, without swallowing words. Voice (tone, pitch) should express an assertive attitude

Session 2: Assertiveness in intimate relationships

Session Objectives: At the end of the session participants will be able to:

A. Describe barriers to being assertive in sexual relationships and how these can be overcome

B. Learn to say 'No'

Training Materials required for the Session:

A. Vignettes on a card, paper, pens, charts, materials 'Saying No',

B. Situations for discussion

Methodology:

Present the objectives of the session.

A. Barriers to being assertive in sexual relationships and how these can be overcome 1 hour 15 minutes

The activity is a series of vignettes (A1) of commonly used strategies by young men to persuade their sweethearts who refuse to have sex. These are based mainly on Tamil movies and television soap operas, and popular novels. Following each vignette, ask participants to come up with ways in which they would respond to these words of persuasion.

Ask for 7 pairs of volunteers. If the group is smaller then more than one situation can be given to the same pair. Explain that they are in 'love' with each other. Give each pair a reaction from the box on a card. Ask them to enact the situation/s with various alternatives. Ask them to think through a variety of ways of saying no without breaking off the relationship or placing the relationship in jeopardy. However, in the case of the more aggressive threats – the last two situations –the challenge is to remove oneself from the situation of immediate threat, which may mean using one's wit and without getting into a confrontation. Ask participant –observers to add on. (20 minutes)

Discuss in large group the issues and consequences of the reactions. Ask the pairs who enacted the situations how they felt. Ask participants if they have experienced such situations and how they dealt with them. Ask if it was the same as being assertive in situations in the earlier activity. Explore reasons (20 minutes).

Women receive messages from various sources which is part of the way they are socialized. For example, women are supposed to be submissive and not get angry or express it, behave in a way that is different from the way men behave, which might make it difficult to assert themselves in these and other situations. Other issues that might come up in the discussion are about sexual norms. It is acceptable for men to have pre marital and extra marital relationships whereas women are not expected to indulge in such behaviour and maybe 'punished' for it by society through restrictions on mobility, social interactions etc. Women may also lack information about contraception and maybe fearful of getting pregnant or getting an infection etc.

Ask participants to go back to their original pairs that enacted the situations earlier and the participant observers to provide the suitable assertive response to each situation (A2). If the situation enacted earlier had already included some of these statements, or in case of shortage of time, the facilitator may go over them orally. (30 minutes)

B. Learn to say 'No' 40 minutes

Divide participants into two groups. Give each group a situation (B1) and ask them to discuss and complete the story reflecting upon all that has been covered in the session . (Discussion and completing the story:20 minutes+ presentation:10 minutes+ post presentation:10 minutes)

- Ask the participants for solutions to the situations, specifically about how the women/girls can be assertive in these and similar situations
- How can women/girls protect themselves from such situations. This can be discussed in the group

Explain that postponing or delaying sexual relationships is not easy to do in all situations, but there are some ways to delay sexual intercourse (B2).

Materials used for training / handouts include:

A1 **Vignettes for discussion** *(written on cards)*

- I am sorry that you do not trust me
- I know that you want this as much as I do. Don't be afraid, I'll make sure nothing goes wrong.
- I love you more than my life. I am willing to confront all obstacles in order to win your hand. It makes me sad that you are not willing to do even this for me.

- What is the point of living when you don't really love me. You will understand the depth of my love when word reaches you of my suicide.
- You look lovely even when you are angry, it makes me crazier about you
- Don't be a prick-tease. Do you really want to pretend that you did not have sex in mind when you came to meet me all alone in this lonely spot?
- Do you think you can say no to me and walk off? I'll make sure your reputation is ruined and no one will ever marry you. What I cannot have, no one ever will

A2 **Saying no** (written on a chart)

- Once is enough to get pregnant.
- This is not a game. I do not want to get sexually transmitted infections/ HIV or pregnant.
- May be I am not yet ready for a sexual relationship.
- I do not want a sexual relationship now.
- If you want, we can just hug each other.
- I know that not everyone gets involved in sexual relationships.
- I do not know about sex and without having indepth knowledge/information I do not want to take steps towards it.
- I do not like it when you compel/force me like this. I am leaving.
- I feel that I will be well only if I am not involved in sexual relationship.
- I also feel like /desire to have a sexual relationship but I do not want it now.
- Don't try to impress *(mayakardu)* me. I do not want a sexual relationship, that's all.
- I am confident, I feel that I do not want this relationship now.

B1 **Situations for discussion** (written on cards)

1. Vasanthi is a 14 year old school going girl. Her neighbor who is a college student helps her with her studies. He has known Vasanthi since she was a child. Her parents consider him as Vasanthi's brother. One day in the morning Vasanthi was alone at home, her parents had gone for a wedding. As usual the neighbor came over, knowing that nobody was at home he started to misbehave with Vasanthi. When Vasanthi asked him to stop misbehaving he replied that she invited him into the house and now was asking him to stop misbehaving? He tries to come closer to Vasanthi and forces her.
2. Anita's mother had decided to get Anita married to her uncle (mother's brother Sekar) when she was a child. Both the family members liked each other. But the age difference between them was ten years. Sekar had finished his education and was working in Chennai currently. Anita was in school. Sekar came to Anita's home for a holiday and they were alone at home. Sekar forced Anita to have a sexual relationship with him, saying that she should trust him as she was going to be his wife anyway. Anita was upset. H e said that he had been waiting for her for a long time and he had never looked at any other women. He got angry! Anita was puzzled and worried that he may begin to hate her and on the other hand she was scared!

B2 In delaying sexual relationships any three of the following could be helpful: (written on a card)

- How far do you want to go? (your limit vis-à-vis sex) Decide this in advance, before you find yourself in complicated situation.
- Avoid arguments /discussions about love that draw you in.
- Be clear about your limit- do not give mixed responses.
- Pay careful attention to your feelings. When the situation puts you in a difficult position with regard to your feelings then get out of the place.
- Get involved in activities that could be distracting.
- Do not talk for long with any person who forces you to have a sexual relationship.
- Make it absolutely clear at the beginning of the relationship that you do not desire to have a sexual relationship.
- Avoid going out with any person/s you do not trust.
- Avoid lonely / isolated places.
- Avoid being alone with the person in a room or vehicle (car).

Additional reference reading for facilitator:

The following are exercises (additional) that maybe used if necessary:

1. Building self confidence/self esteem (45 minutes)

Objective: To help participants clarify their self image and understand what they value most about themselves; to practice assertive communication

Materials Required:

Small cards +pens+ safety pins

Ask participants to close their eyes and think about the qualities that they like in themselves. Ask them to write five qualities that would best describe them on one side of the card. (10 minutes)

Ask them to pin the card with the safety pin and walk around in the group to see what the others have written on their cards. (10 minutes)

Divide participants into groups of 3-4 and ask them to communicate assertively their qualities.

2. Magic Mirror

Objective: To provide opportunities for participants to think about changes they would like to make in themselves

Tell participants that in the previous activity they reflected on their likable qualities. Everyone may have some qualities/ characteristics that we would like to change. This activity provides that opportunity.

Ask participants to stand in a circle. Play some music or clap your hands and ask participants to move around and find a partner. Ask each pair to stand facing each other. Explain that one of the pair is a magic mirror. And the other person has the opportunity of a lifetime today because the mirror can change things. Look into the mirror (your partner) and say ' I would like to change / stop being…..and become…..or get….'

Each participant can change a maximum of five qualities.

After the first partner is through, the second one follows the same with partner I becoming the mirror.

Discuss in large group some of the qualities that were 'changed', if the participants were planning to change them in real life and what steps they had/plan to take towards achieving that. (This activity can be adapted to any situation.)

3. Assertiveness: Situation for adults

You are Rani, you work in a community organisation. Your friend and co-worker Leela has been borrowing small amounts of money from you. She has not returned the amounts borrowed over the past month as yet. You have heard that she returned amounts owed to another colleague, and it made you feel like you were being taken for granted. Today, she has approached you for another loan. You would like to refuse. How would you do this assertively? (include steps responding assertively to this from the session)

One example: from an earlier workshop by RUWSEC. Can be used as dialogues and enacted:

Rani: 'When you keep borrowing money from me, but do not return it promptly, while you return money borrowed from others, I feel I am being used like a door-mat, and it makes me angry with myself.'

Leela: 'Come on, Rani. Don't be that way. I returned the money to Gita because she is not a close friend like you. I thought you would understand.'

Rani: 'I would have preferred if you had returned the money when you said you would. If there was a problem, it would have been better if you had given me an explanation. I don't think it is a good idea for us to continue in these roles of lender and borrower, this will damage our friendship.'

Leela: 'Rani, I thought you were my friend. Now I know that you value money more than friendship. Alright then, thanks for opening my eyes. I don't need the loan from you.'

Rani:'That still does not take care of the small problem of returning the money you still owe me. Could you please tell me a definite deadline by which I can expect to be repaid?' ..and so on.

Developing meaningful relationships and evolving one's guiding principles for life

This chapter covers:

Session1: Relationships with peers, parents and significant adults	2 hours
Session 2: Platonic relationships	2 hours 40 minutes
Session 3: Non platonic – sexual relationships: Love and Romance	7 hours 30 minutes
Session 4: Same sex relationships	3 hours
Session 5: Planning for the future: gender equal relationships	4 hours

Session1: Relationships with peers, parents and significant adults

Session Objectives: At the end of the session participants will be able to:

A. Give reasons for and deal better with conflicts in their relationships with peers parents, significant adults in their lives

Training Materials required for the Session:

A. Situations for discussion, papers, pens, charts/board, chalk

Methodology:

Present the objectives of the session.

A. Understand reasons for and deal better with conflicts in their relationships with peers parents, significant adults in their lives **2 hours**

Divide participants into three groups. Give each group a situation (A1) to discuss and present as a role play.

After presentations discuss the issues that emerge, followed by reenactment of the role play to portray a productive resolution. Follow the same process for all the three situations (45 minutes).

Discuss in large group all the three situations and the issues that emerged (10 minutes). List these issues and also list the solutions if they have already been discussed /enacted. Discuss what the consequences of such conflicts could be if not resolved. (10 minutes)

For example, reasons for conflict: Situation 1

Reasons why conflict arises: lack of communication between the father and son, high expectations, father not being aware of the issues in school. For example. parents react to their childrens' failure in school harshly without discerning the reasons for the poor performance. This may be particularly true in government run schools in the rural areas which are lacking in infrastructure and teachers etc. Others might perceive it as a loss of face. Also, in such a situation they maybe focused on their own pain and disappointment, especially if the family is poor and had to make many sacrifices towards education of the children. These and other reasons may result in a breakdown of communication between the adolescent and the parent.

Solution: better communication (positive), understanding each others situations and planning to deal with the situation keeping these in mind. For example, The father tells the son that he is very disappointed, but would like to know why the son did badly. Did he have problems understanding what was taught ? Did he need extra tuitions? Would a change of school help? The son responds saying he was sorry that he had given up, and yes, extra tuitions from a private tutor would help. The father agrees to pay for extra tuitions, but wants an assurance from the son that he would put in the very best effort and make this worthwhile. They are not rich, and the money for extra tutoring had to come from cutting down on something else.

Ask participants to share some of the conflicts that they have had with adults and peers.

Draw a path that forks into two on the floor of the training area. Explain to the participants that after they share their experiences – they could walk down fork 1 to share how it was resolved and fork 2 to share how it could/can be resolved. For fork 2, other participants provide their inputs. (30 minutes)

Activity ***30 minutes***

Divide participants into groups.

Group 1: Develop a strategy to discuss and raise awareness and skills among parents, teachers and other significant adults towards improving their relationships with adolescent girls and boys.

Group 2: Develop skit (s) that can be used to discuss with adolescent groups on ways of dealing with conflicts with peers and adults in a productive way. Highlight the differences for girls and boys, if any.

Sum up that conflict among people is very often the result of an imbalance in the power within the relationship. For example, in a parent adolescent relationship, the parent is more powerful. However conflicts or open disagreement need not involve hostility or negative feelings and can be expressed verbally or nonverbally. Conflicts or disagreements may be about relatively unimportant things or may have long term consequences.

The attitude that a person has will impact how he/she deals with the conflict. Issues of self esteem and communication skills also play a significant role here. Adolescent girls are particularly vulnerable. They lack access to education usually beyond a certain point due to poverty and also because of prevailing social norms (refer situation 2). Her status at home is lower than a boy's and as in this situation girl's education is not priority and parents /adults believe " What is she going to do with all that education. Ultimately she has to get married and settle down and have children. If she is too educated then it would be difficult to find a groom". Faced with such situations, on the verge of discontinuation from school, is very common. In a poverty situation, parents may not be able to afford to educate all their children and may compromise on the girls. Distance to high schools and college may also be a deterrent.

Often the unacceptable behaviour of boys (refer situation 3) is due to lack of known alternative behaviours. They may have just wanted to talk to the girls but may not have known how to go about it. Further such behaviour is accepted and even promoted through popular media, songs etc

Materials used for training / handouts include:

A1 **Situations for discussion** (written on cards)

Situation 1: The father had high expectations of his son, and worked very hard to pay for the son's schooling. The son had been distracted and inattentive to school work for some months, and had failed in his final examinations. The son was aware of his father's expectations and found himself constantly failing to live up to it, making him feel anxious and distressed. At some time during the previous school year, faced with an unsympathetic class teacher who constantly berated him, he had decided that studying was not 'his thing'. He had joined up with a group of like-minded boys who couldn't care less about studies, and believed that this was 'cool' (trendy). Now that the results had come and he had failed, he was terrified of his father's reactions.

Situation 2: Shanti is very interested in her studies. She spends time every morning between 5 and 8 am with her lessons. Then she gets ready for school in a hurry and leaves. She returns at about 5 pm. Ten minutes after she gets back she begins her studies again. Once she starts her lessons she is oblivious to the passage of time. She dreams about getting the first rank in the school.

She stands first in class, brings home the certificates and prizes she wins and shows them to her mother and feels very happy. One day her mother got angry and tells her "Whats the use of all this? There is so much work at home. You are always with your books. Go and do some work". Shanti's mother is unhappy that Shanti does not help her with any household chores. So she tells Shanti to stop going to school and help around at home.

Situation 3: Two young men teasing teenage girls walking through the village's market area. The boys are trying to attract the attention of these girls, and only want to talk and interact with them. However the only way they know is the way it is shown in the movies and on TV. They begin making vulgar gestures, and commenting on the girls' physical features and the way they are dressed. The girls would not have minded simple human interaction, and are quite curious about getting to know young men in general. But the gestures by the boys are not socially acceptable. Further 'good' girls were supposed to ignore all male advances and walk away with their heads down.

Session 2: Platonic relationships

Session Objectives: At the end of the session participants will be able to:

A. Be familiar with existing beliefs about platonic relationships with the opposite sex

B. Reflect upon relationships with the opposite sex and develop one's own code of conduct for platonic relationships

Training Materials required for the session:

A. Points for discussion on a chart, blank charts, sketches, chart/board, pen/chalk

B. Board/chart, chalk/pens, paper, scissors, paint, sketches, old magazines, newspapers, pencils, erasers, glue, needle/thread or thread to tie papers together (for the activity).

Methodology:

Present the objectives of the session.

A. Existing beliefs about platonic relationships with the opposite sex **40 minutes**

Divide participants into smaller groups. Display the points for discussion in groups written on a chart (A1).

Introduce the activity. Ask participants to discuss and respond to the points displayed on the chart.

The discussion responses are recorded in the groups. Each group presents its responses in the larger group (30 minutes). Sum up (10 minutes):

a. Platonic relationship is a relationship is the absence of romance or sex. However such relationships are not acceptable between men and women (in the rural areas where RUWSEC works and in many other places). As a result the relationship with the opposite sex is either romantic and/or sexual or there is no relationship. Platonic relationship being unacceptable has negative consequences.

b. Some believe that an adolescent boy and a girl should not even talk with each other. Those who do are punished severely. This is particularly true for young women who may have to pay with her mobility and social interaction.

c. Others believe that life is love and marriage. Messages such as this reiterate and promote non-acceptability of platonic relationships. Men and women are brought up /socialized to believe that relationships with the opposite sex can only be sexual/romantic.

d. Even if a boy and a girl have a platonic relationship society views it negatively, always as a sexual relationship. Even peers and friends do the same and such perspectives act against such relationships and harms/breaks them.

B. Reflect upon relationships with the opposite sex and develop one's own code of conduct for platonic relationships **1 hour**

Ask participants for four volunteers. Brief one pair of the volunteers to role play an adolescent boy and girl in a platonic relationship and the other pair to enact a romantic relationship. The pairs role play followed by a discussion in the large group. Ask the pairs how they felt enacting the role plays.

Discuss: If a boy and girl have a platonic relationship how they will behave? If they have a non platonic relationship how will they behave?

How do we expect them to behave? What acts /behaviors will they/should they avoid?

What are the reasons and consequences of strict segregation (discouraging platonic relationships) between adolescent boys and girls?

List the 'guidelines' for platonic relationships that emerges in the group. Clarify that it may not be easy to always draw a clear line between platonic and non platonic relationship. This may differ according to existing norms and culture. For example, an adolescent boy and girl hugging may be perceived as 'normal' in some cultures but even holding hands maybe perceived as a sign of a non platonic relationship in others.

Activity ***1 hour***

Divide participants into 4 groups. Ask the groups to create a story about an adolescent boy and girls who have a platonic relationship using the materials provided. There need not be any text or text should be at the minimum. The participants may use about 10 sides of paper (not more) to develop the story. After completion the participants may stitch the pages together or tie them together to make a book.

A1 **Materials used for training / handouts included:**

Points for discussion to be displayed on a chart for the participants:

What have we learnt about relationship between an adolescent girl and boy? How should an adolescent boy-girl behave.

What are the messages/advice that we have received from the following/through the following?

1. Parents, teachers and elders
2. Movies – songs
3. Peers and friends

Session 3: Non platonic – sexual relationships: Love and Romance

Session Objectives: At the end of the session participants will be able to:

A. Describe non platonic relationships, (love and romance) better. (The session does not deal with same sex relationships)

B. Explain how decisions about love and sex are made

Training Materials required for the session:

A. Two A4 size cards with 'Agree', 'Disagree' written on them, sheet of paper with statements about love on a chart, paper, pens, charts, markers

B. Vasanthi and Murugan's story

Methodology:

Present the session objectives.

A. Understand non platonic relationships (love and romance) better 1 hours 30 minutes

Ask participants to think of love songs from the movies that they like, that they believe describes closely what they understand by 'love' and 'romance'. Ask each participant to sing a few lines from the song. (25 minutes)

Discuss and list some of the 'characteristics' of love /romance and sum up that love and romance may mean different things to different people and may also be expressed differently by people. (5 minutes).

Ask participants to move to the centre of the room and state that you will call out a statement about love (A1) they move to either side of the room – to the 'agree' or the 'disagree' corner, according to their opinion with regard to that statement. Mark the corners on opposite walls of the training area or on the floor. After each call note the number of participants who agree and the number who disagree. Allow participants to debate on each statement come to some consensus before moving to the next statement. (1 hour)

Activity

(20 minutes discussion+ 10 minutes each for presentation and 10 minutes post presentation)

Divide the participants into 3 groups and explain that each of them is going to make a film/movie about romance and love. Explain that for the purpose of this activity love between spouses, girl friend and boyfriend .

The film should reflect what the group decides are the essential qualities/characteristics of love. This may or may not be in keeping with what is acceptable in society. The groups can present it as a movie with songs and dialogues and narration.

Conclude the session with a brief disucussion of the process in the groups and the qualities or practices that are accepted as love but may not be healthy. For example, suicides, violence, control and suspicion / jealousy.

B. Be aware of how decisions about love and sex are made about 5 hours

Divide participants into two groups. Give each group one of the 'boy-meets girl' situations (B1) involving decision-making on the part of adolescent girls on matters related to love and sex. (1 hour 30 minutes).

In the large groups explore participants' perceptions about how such scenarios are likely to develop, discuss what they feel about these and how adolescents can make informed decisions.

Discuss the stories and the decisions that were taken.

What prompted Shiela and Sumathy to make these decisions.

What are / will be the consequences of these decisions?

Highlight the social norms that influence the decisions taken at each point. Explore if some of these norms are changing and how. For example, if Sumathy decides to meet Raju and tell him that they could meet but as friends as she was not interested in a romantic relationship with him.

Is this acceptable? What are the obstacles in the path of such a relationship?

Sum up the activity saying that decisions made are determined by the prevalent social norms. Challenging such norms are not easy but need to be done. For example, if Sumathy made the decision to meet Raju and express her willingness to be a 'friend'- that challenged existing norms on relationships between men and women.

Ask groups formed at the start of the session to interchange the names, ie Ramesh instead of Shiela and Raju in place of Sumathy and disucuss the situations. (15 minutes)

Discuss the process in the groups and what were the points/debates/arguments that came up. What did the groups feel about the situation and why?

How would Ramesh and Raju react? What would Sheila and Sumathy do? Are there differences between this and the previous situation? Reasons for differences?

The activity may bring forth norms regarding love/romance, sexuality and the difference in norms for men and women. (30 minutes)

Divide participants in four groups (45 minutes). Distribute the story of Murugan and Vasanthi (B2) to the groups.

Groups 1 and 3: Have to think through reasons why Murugan and Vasanthi may decide that it was not alright to have sex as yet.

Groups 2 and 4: Have to think of reasons which may lead Murugan and Vasanthi respectively to decide to start a sexual relationship.

Each group presents its views, and respond to the questions (B3). In the large group discuss if this exercise was useful in helping participants (young people) think through their own positions with respect to when and with whom to have sexual relations, and to take considered decisions.

Explain that this activity continues with the story of Murugan and Vasanthi and that the activity looks at how to prevent sexual harassment and abuse, to think through ways of tackling the issue in ways that respect the rights of the individuals affected and arrive at solutions.

Explain that Vasanthi says no to sex, but Murugan believes that she is shy, and that it will be okay if he forces her into intercourse. This is what he has heard from friends, and seen on movies and in television. Murugan has sex with Vasanthi against her will. Vasanthi is not in a position to scream and call for help. People would ask what she was doing there in the first place, how she came to be alone with Murugan. (10 minutes)

After completing the story, ask for participant-volunteers to play the roles of characters in the story. One person to be Vasanthi, and as the story moves forward in ways that Vasanthi thought it would, additional characters can be called upon to join in from among the participants. A skit should thus evolve, with each character developing her role as he/she goes along. The skit should be enacted at the centre of the room with the rest of the participants sitting in a circle around the room. (30 minutes)

Ask participants to provide inputs on what she should do and at every stage what her options could be. Explore all options during discussion.

At the end of the role play divide participants into smaller groups and ask them to discuss the questions (B4). The groups present their responses in the large group. Summarize the main issues that emerge in the discussion, highlighting how Vasanthi and others in her situation can be helped. (30 minutes)

Explain to the participants that Murugan and Vasanthi mutually decide to get into a sexual relationship. (45 minutes).

Brainstorm on what are the issues they must discuss before they do. Ask participants to reflect on sexual rights and responsibilities as perceived by them and list them on the chart..

For example, both of them have the right to information and knowledge about sexuality, sexual health, right to protect oneself from infection etc.

In case of community organizations think of strategies to prevent sexual coercion / rape. What role can they play?

Materials used for the training / handouts include:

A1 Statements about love for discussion on cards

1. Love at first sight is what you call true love.
2. When you love a person, you love everything about him/her.
3. Love can happen only once in a life time.
4. Even if a person has many undesirable qualities, your selfless love and dedication can make a new person of him.
5. Jealousy comes out of extreme love and passion.
6. To love is to take leave of reason, and let your heart dictate your decisions, not your head.
7. Love is a decision, a responsibility.
8. True love means to die together if it is not possible to live together. (There is a popular saying in Tamil to this effect).

9. Falling in love is a process that results from knowing and understanding a person.
10. Friendship, respect and trust are the basis of love that endures.

B1 **Situation and questions/ points for discussion** (written on separate charts)

1.Shiela is 15 years old. She lives in a village, but has recently started working in an urban factory. She commutes everyday to work. Shiela notices a young, good-looking man who appears to be waiting for her almost every day at the bus-stop where she alights. He then follows her to the gate of her factory. One day Sunita, a co-worker and close friend, brings her a letter from this young man, Ramesh. He would like her to meet him that evening outside the factory.

Decision point 1:

Will Shiela meet Ramesh that evening ? On subsequent evenings ?

If Shiela does not meet Ramesh, does she send a response through her friend ? Does she decide to tell Ramesh not to follow her or wait for her at the bus stop ?

If she does meet Ramesh and continues to do so over the next few days or weeks, we go to the next decision point.

Ramesh invites Shiela to stay back late one evening. He would like to take her out to dinner to celebrate his birthday. He suggests that Shiela tells her parents that she has to work over-time and will be late getting home.

Decision point 2:

Will Shiela agree to have dinner with Ramesh ?

If she does not agree, how does Ramesh react ? What is the next step in the relationship ?

If Shiela does go out for dinner with Ramesh, we go on to the next decision point.

It gets very late by the time dinner is over. Shiela has missed her last bus. She is terrified. Ramesh offers to take her to his room for the night, and to put her on the first bus the next morning. He reassures her that her parents need never know where she stayed the night, she could tell them that she missed the bus and stayed over in Sunita's house which was

close to the factory. Seeing no better option, Shiela agrees to go back with Ramesh to his room.

Decision point 3:

Will Ramesh make sexual advances to Shiela ?

Will he expect her to sleep with him, assuming that her agreement to come home with him implies her tacit willingness ?

Will Shiela agree, or will Ramesh force himself on her ?

Where do you think the relationship will go from here ?

2. Raju, his cousin Geeta and her friend Sumathy live in the same neighbourhood and study in the same high school. They take the same bus everyone from their village to the school which is located in a nearby town. Raju feels attracted to Sumathy. One day, he sends a letter through Geeta to Sumathy expressing his 'love' for her and asking her to meet him at the village temple that evening.

Decision point 1:

Will Sumathy go meet Raju ? If no, why ? What will she do next ? Will she ignore the letter, or send a reply?

If Sumathy does decide to meet Raju – what will she tell her mother?

***Decision point 2*:**

If the second option is taken. Sumathy meets Raju. What happens next ? Will Sumathy tell Raju that she too, loves him ? If not, what else will she do ?

Sumathy and Raju are seen talking together in a private corner by friends of Sumathy's mother. They make it a point to go straight back and tell Sumathy's mother that they saw Sumathy with Raju, and that she had better be careful about her daughter before the latter brings shame on the family.

What will Sumathy's mother do when she hears this ? Will she confront Sumathy ? Will she give Sumathy a chance to explain herself, or will she punish her ?

Will she tell Sumathy's father ? What will Sumathy's father do ?

B2 Murugan is 17 years old. He works in his uncle's shop. He is from a landless household and his parents are both wage workers in agriculture. Vasanthi is 15 years old, but looks older. She is conscious that she is attractive to

boys and men. Because her sister had a 'love' marriage against their parent wishes, Vasanthi is often warned by her parents not to 'stray' like her sister but restore her parents respect in the community by behaving like a 'decent' girl from a good family. Vasanthi and Murugan live in the same neighbourhood and are attracted to each other.

Murugan is shy by nature. Some of his friends have had sexual experience, and have often impressed upon him that he should 'try' it and not be a sissy.

One day Murugan and Vasanthi manage to find an opportunity to be alone, in the woods outside their village. Murugan tells Vasanthi that he loves her and makes physical advances. Vasanthi is in a fix. She feels inclined to go along, but is also afraid.

B3 **Questions for discussion** (on a chart)

- Why does Murugan think that Vasanthi was saying no because she was shy and that he should force her.
- What were the reasons that prevented Vasanthi from screaming?
- What does Vasanthi do? What should she do?
- How can she be helped?
- Who can help her? What about Murugan? What further role can he play in this whole situation?

B4 Questions for discussion: Why it was okay to have sexual intercourse from the perspective of the boy and also why the girl may say yes to the boy's advances. Why a boy would decline to have sex with a girl and also why a girl may say No to sex with the boy.

Session 4: Same sex relationships

Session Objectives: At the end of the session the participants will be able to:

A. Develop a better understanding about same sex relationships and be aware of issues/problems that gays and lesbians face especially during adolescence ' the coming out' period

B. Clarify our values regarding such relationships

Training Materials required for the session:

A. Three sets of six cards: Three cards with the picture/drawing of a woman/girl and three cards with those of a man /boy, chart/cloth, pins

B. Role play situations written on cards, paper, pens, charts

Methodology:

Present the objectives.

A. Develop a better understanding about same sex relationships and be aware of issues/problems that gays and lesbians face especially during adolescence ' the coming out' period 1 hour 30 minutes

Divide participants into three groups. Give one set of six cards to each group and ask them to discuss and pick those of the six persons who can and will be in an intimate relationship with each other. (10 minutes)

Discuss in the large group the process and reasons for the selection (10 minutes). Sum up that all the six persons can be in intimate relationships with each other. Pair up the cards so that there are three pairs of cards and pin it up on a chart/cloth.

- Heterosexual relationship (man and woman)
- Homosexual relationship (gay – man and man)
- Homosexual relationship (lesbian –woman and woman)

Discuss participants' reactions and feedback and clarify questions / doubts that may emerge. (20 minutes)

Clarify that Homosexuality (10 minutes) is the persistent sexual and emotional attraction to someone of the same sex. It is part of the range of sexual expression. Many gay and lesbian individuals first become aware of and experience their homosexual thoughts and feelings during childhood and adolescence. Homosexuality has existed throughout history and across cultures. Recent changes in society's attitude toward homosexuality have helped some gay and lesbian adolescents feel more comfortable with their sexual orientation. In other aspects of their development, they are similar to heterosexual youngsters. They experience the same kinds of stress, struggles, and tasks during adolescence.

Divide participants in four groups. Distribute the narratives (A1) to the two groups and ask them to discuss what issues and problems could confront homosexual adolescents. (45 minutes)

The groups present their responses and discuss the various issues that emerge in the large group. Sum up using chart about concerns among homosexual adolescents (A2).

Apart from issues related to sexual orientation, they experience similar problems during adolescence as heterosexuals. Highlight that society does not still accept homosexuality and therefore there are several young and old people who continue with their lives feeling guilty about their sexuality, or unable to be part of the mainstream and therefore suppress their sexuality or keep it under wraps. Homosexual adolescents have a special need for caring adults and peers who can help them establish a positive sexual identity and find social acceptance. This also requires changes in law as well as changes in the attitude of society, in social norms.

B. Clarify values regarding same sex relationships **1 hour**

Divide the participants into two groups. Handout the role play situations (B1) and ask the groups to discuss and enact them reflecting the points included in the handout. Discuss the role plays in the large group, clarify, plug gaps and sum up.

Homosexual adolescents have a special need for caring adults and peers who can help them establish a positive sexual identity and find social acceptance.

Parents and other significant adults , peers and organisations need to clearly understand that homosexual orientation is not a mental disorder. The cause(s) of homosexuality are not fully understood. However, a person's sexual orientation is not a matter of choice. In other words, individuals have no more choice about being homosexual than heterosexual. All adolescents do have a choice about their expression of sexual behaviors and lifestyle, regardless of their sexual orientation.

Parents and others need to be alert to these signs of distress because gay/lesbian youth account for a significant number of deaths by suicide in adolescence.

It is important for parents and peers to understand their teen's homosexual orientation and to provide emotional support. Parents often have difficulty accepting their teen's homosexuality for some of the same reasons that the youngster wants to keep it secret. Gay or lesbian adolescents should be allowed to decide when and to whom to disclose their homosexuality.

Counseling may be helpful for adolescents who are uncomfortable with their sexual orientation or uncertain about how to express it. They may benefit from support and the opportunity to clarify their feelings. Therapy may also help the teen adjust to personal, family, and school-related issues or conflicts that emerge. Therapy directed specifically at changing homosexual orientation is not recommended and may be harmful for an unwilling adolescents. It may create more confusion and anxiety by reinforcing the negative thoughts and emotions with which the youngster is already struggling.

Activity ***(30 minutes)***

Divide participants into two groups.

Group 1: To discuss and list strategies to support homosexual adolescents by youth groups/young people

Group 2: To discuss and evolve a campaign to raise awareness about homosexuality in the community.

In case this workshop is for NGO staffs or other adults: Discuss strategies to make support services like counseling available to the community; an exercise to gather referral information, may also be included

Discuss the strategies in the large group and share with the participants referral information about local support groups for gay and lesbians if available.

Materials used for training /handouts included:

A1 **Narratives for discussion** (written on cards)

1. Senthil is 17 years old. He stays with his parents and siblings in a village near Chengalpattu. He is presently doing a diploma in printing. Senthil has always felt he was different but could not understand it. While his friends were constantly discussing their relationships and attraction to women, he discovered that he was attracted to other boys/men. He initially thought it was a passing phase but it did not pass…..
2. Prema is 19 years old and works as a nurse in the government PHC. She had done her training near Chennai city. During the training she had stayed in the hostel. While she was there she felt that she was not like the other girls. She was not interested in men but attracted to women. She was afraid and became more religious and visited temples all the time.

Some concerns of homosexual adolescents

Adolescents who discover that they have a compelling interest in same sex partners often experience intense inner conflict. They get little approval for their sexual orientation and feel a profound sense of isolation and loneliness. In case they do 'come out' almost always their parents are very upset. Even very open minded parents respond with considerable pain because they know their youngster will encounter limited acceptance by the larger society. Homosexuality is still taboo and seen as a crime (even by law in our country).

They often have the following concerns:

- Feeling different from peers
- Feeling guilty about their sexual orientation
- Worrying about the response from their families and loved ones
- Being teased and ridiculed by their peers
- Worrying about AIDS, HIV infection, and other sexually transmitted diseases
- Fearing discrimination when joining clubs, sports, seeking admission to college, and finding employment
- Being rejected and harassed by others
- Gay and lesbian adolescents can become socially isolated, withdraw from activities and friends, have trouble concentrating, and develop low self-esteem. They may also develop depression

(www.pflag.org)

B1 **Role play situations**

1. Sankar is your close friend in the technical institute. One day when you both are having lunch together he tells you that he is attracted to other boys. He has known it for a long time but is very afraid and does not know what to do. He is concerned that you and other close friends may reject him.

   How would you react? Would this mean the end of friendship with Sankar? Why?

2. Sasikala and Chitra work in Chennai. Sasikala's parents live in the city, and Chitra's parents in a small town about 120 kilometres from the city. Sasikala tells her parents that she has fallen in love. Her parents are broadminded and happy for her. Then she tells them that she is in love with Chitra. She is a lesbian. Her parents are devastated. They are not very clear about homosexuality but cannot understand how their daughter could have this problem, what will others think/say. You are Sasikala's brother who also knows and is supportive.

   What would you say to your parents? How will you support your sister?

Session 5: Planning for the future

Session Objectives: At the end of the session participants will be able to:

A. Plan for the future: Understand and reflect on expectations from 'future' intimate partners (within marriage), gender equal relationships within marriage, planning the timing and number of children

B. Reflect on values in intimate relationships (including marriage)

Training Materials required for the session:

Copy of the game: Path of life on a sheet of paper. (Draw a path from the top left hand side that winds across the page till you reach the bottom right hand side. Draw some plants, homes, trees, stones mountains/hills on and around the path); old magazines, sketches, scissors, glue, paper, paints, colors (for photographs: If possible participants can be asked to bring a copy of their passport size photograph), Pictures (for choosing future partner)

Situations for discussion, charts, pens, chalk, cards (2 sets) with statements

Methodology:

Present the session objectives.

A. Plan for the future: Understand and reflect on expectations from 'future' intimate partners (within marriage), gender equal relationships within marriage, planning the timing and number of children
2 hours 25 minutes

Display the copy of the 'Path of Life' and ask participants to create their paths. The participants will use the Path of Life game (30 minutes) to examine their own past- to think about the ups and downs in life and how he/she was able to or if unable to resolve the problems and overcome the downs.

Ask participants to draw on the blank sheet of paper given to them based on the drawing done by the facilitator. Ask participants to draw their past. Encourage them to be creative. Ask participants to go through the path and reflect on how their decisions or lack of power to make decisions affected their life thus far. In the large group ask

participants to share how they felt about doing this exercise and if any of the participants would like to share their 'paths'.

Thereafter ask the participants to plan their future: to reflect on their dreams for the future -of what they will be or what they want to achieve by the time they are thirty five years old. This will include college /school, training, job, marriage, children etc. (10 minutes)

Place/stick pictures (A1) on the wall or on the floor. Ensure that the pictures are placed far apart so that participants can move around. Ask participants to stand next to the picture they like. Explain to the participants that these are the pictures of men or women they might marry. They have to choose one. Explain that each of the pictures shows the relationship between intimate partners in different ways. After all the participants have selected their 'partners', ask the participants how they interpreted the pictures and the reasons for selection of particular pictures/situations. Note the points on charts/board. (30 minutes)

Ask participants to create a family photograph taken when he/she is 35 years old. The photograph must reflect and/or the presentation must include career they want to pursue (for example: if participant wants to be a doctor can be reflected in his/her photo of himself/herself), if and when they plan to marry, whom they plan to marry (refer earlier exercise), where they would like to live, work, live in a joint or nuclear family number of children, gaps between children. (30 minutes)

Ask participants to now go around the group and pick a partner. Explain that the pair should pretend that they are going to be married or have married recently. (If all male or all female groups, the pair has to decide who will be the man and woman and play the role accordingly.) Ask the pair to share their photos. Ask them to discuss their future based on their individual expectations and dreams to come to a consensus. (10 minutes)

Guide each participant or those who want to share in the group, starting with the exercise of choosing their partner –husband/wife, reasons for the selection. List on board /chart.

Thereafter the participant shares the process of the photograph and then the pairs share about their discussion –

Did they have differences of opinion and how they went about the process of planning the future? Was what they planned as a couple different to their individual plans for their future? How did they feel about planning their future together?

Discuss who normally makes the decisions in a marriage. For example, about children, when and how many etc. Is the woman involved?

Highlight the differences in social norms for men and women (refer to the choosing the partner exercise) and differences in power to decide between men and women.

What would happen if things don't go as planned - for example, if the couple plan to have one child but are unable to have any. Who is blamed? Why? Explore gender roles and relationships. (30 minutes)

Ask participants for their feedback about the exercise and any 'lessons' that they would like to follow in their own lives. (10 minutes).

B. Reflect on values in intimate relationships (including marriage) 1 hour 30 minutes

Mark three corners of the training area as 'A' 'B' and 'C'. Explain that participants choose a card (B1) with the facilitator, read the situation and read the three solutions aloud. (These situations are a sample and made primarily for women participants and need to be modified based on the context.) thereafter the participant has to choose option A, B or C and move to the respective corner.

Participants who chose the option 'A' move to one corner of the room, those to chose option B group themselves in another corner, and so do those who chose option C move to another corner.

Each group then discusses its position with the other, arguing back and forth about which option represented a more egalitarian relationship.

The groups discuss their views and why they chose the course of action that they did in the situations presented.

Sum up saying that there can be different options and choices made by women and men related to each other in an intimate relationship , ie our expectations from partners may vary widely, which are also largely determined by social norms for men and women and relationships between them. The exercise was a means of reflecting on expectations and choices vis-à-vis intimate relationships (45 minutes).

Ask participants to sit in a circle around the room. Draw a straight line in the centre of this circle, and mark one end 'totally acceptable', and the other end, 'totally un acceptable'. Mark the centre 'and could go either way'(meaning, depends on the specific situation). Keep two sets of cards (B2) with statements written on them, near the line. Participant go to the centre of the room, pick a card , read it aloud, and then place it at a point along the line according to her/his position on that statement. Thus, if they find the statement totally unacceptable, they

should keep it at that end of the line. If they find it not quite acceptable, but not totally, they should place it between the 'unacceptable' and the midpoint, and so on. After the cards have been thus laid out, ask the participants to give reasons to support their opinions.

Discuss in the large group the differences for men and women and the reasons and consequences for these differences.

Sum up stating that everyone has a right to their own opinions and values but this is the time that one can reflect and clarify those values and how those values will shape our future. (45 minutes)

Materials used for training / handouts included:

A1 The following pictures should be prepared in advance, preferably on charts so that they can be reused for future trainings. Ensure that the pictures are not too small so that it can be seen by the participants from at least three feet distance.

Picture 1: A woman is doing all the household work and as being respectful to the elders in the house and the man is lying down reading a book

Picture 2: The man is speaking and the wife is standing with a lock on her mouth signifying that when a man speaks his wife must listen

Picture 3: The woman is speaking and the man has a lock on his mouth

Picture 4: There are three stools/chairs. The man is sitting on one and the wife is sitting on the floor showing respect for her husband

Picture 5: There are three stools/chairs. The man is sitting on one and the wife is sitting on another

Picture 6: The man is cooking while the wife is resting (lying down)

Picture 7: The woman is cooking and the man is resting (lying down)

Picture 8: The man is cooking while the wife is watering the plants

Picture 9: The woman is holding the man's hand and pointing to the bed, indicating she would like to have sex

Picture 10: The man and the woman are having sex but the wife is not looking very happy and the man is smiling (happy)

B1 Situations in a typical marital relationship in the rural Indian setting and three different options to be written on cards. (A, B and C) for preferred behaviour in that situation. Situations may be altered based on context. This was originally compiled for women participants and has been modified here.

1. You and your partner have a rare day to be together without anyone else present. You would prefer to

A. Spend the day together at home, talking and being together

B. Go shopping, go to the movies and eat out

C Visit your parents' home together

2. When (s)he was leaving for work this morning, she/he had promised to go out to the movies after (s)he returned from work this evening. But (s)he has returned late. You would

A. Not speak to him/her when (s)he returns home, but express your anger by banging the door / vessels in the kitchen

B. Give her/him a piece of your mind as soon as (s)he comes back

C. Find out from her /him why (s)he is late, before reacting

3. The worst thing you can learn about your wife/husband is that

A. (S)he cannot have a child, and knew this even before marriage to you but did not reveal this to you

B. (S)he is having an affair

C. (S)he has a sexually transmitted infection

4. Your partner sees a beautiful man/woman and remarks how attractive he/she looks. You will

A. Be hurt but not discuss it

B. Have a fight about how (s)he would dare to have a roving eye when you were there

C. Treat it like any other comment and agree or disagree according to what you really think

5. You are very sick at that time your husband forces you for sex (Use with women participants)

A. No option so I will agree

B. I will avoid and fight with him

C. I will patiently explain my condition to him and make him understand

6. When you discuss about birth of children you opt for 2 children and he opts for 3 children, you disagree (with women participants)

A. Only men have the right in decision making.

B. Will explain my point and make him understand

C. Will disagree and fight with him

B2 **Situations to be written on cards (2 sets).** This is only a sample, to be modified as per the context.

- To fall in love with another person after you are married
- To do something that you do not believe in and consider unethical, because it makes the person you love happy
- To have a sexual relationship with someone you do not love
- To have a sexual relationship with someone you love, before you are married
- To watch pornographic films
- To not tell the person you are married to about an affair you had before marriage
- (As a woman) To break off with your girl friend because your husband does not like you to be friends with her
- The person you love making fun of you in public in a way that is humiliating
- To keep some things secret from the person you love because you know s/he will not approve of it
- To continue in an intimate relationship with a person who does not respect you
- (As a married woman) To admire the good looks of a man who you find physically attractive

Special health concerns of adolescents

Adolescents need information and services to understand their sexuality, protect themselves from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. Early marriage, early motherhood curtails opportunities- education and employment and has long term adverse impact on quality of life. Typically adolescents are poorly informed about how to protect themselves.

Programmes should also include support mechanisms for the education and counseling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Health services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs and ensure that attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need including on sexually transmitted diseases and sexual abuse.

Most importantly adolescents must be involved in the planning, implementation and evaluation of such information and services.

This chapter includes the following sessions:

Session 1: Risks of sexual relationships with regard to unwanted pregnancy and getting an STI including HIV — 5 hours 15 minutes

Session 2: Substance Use and other addictions — 4 hours 35 minutes

Session 3: Suicide — 2 hours 10 minutes

Session 1: Risks of sexual relationships with regard to unwanted pregnancy and getting an STI including HIV

Session Objectives: At the end of the session participants will be able to:

A. Understand the risks of sexual relationships with regard to unwanted pregnancy and getting an STI including HIV

B. Explore how these can be prevented - understand barriers to SRH services and how these can be addressed

Training Materials required for the session:

A. Gita-Murugan story, condoms, bananas (or models of penis), chart with pros and cons of contraceptives, charts, pens

B. Charts, pens, grid (saying no), Chart 'Saying No'

Methodology:

Present the objectives of the session.

A. Understand the risks of sexual relationships with regard to unwanted pregnancy and getting an STI including HIV — 2 hours 15 minutes

It would be useful to cover Conception, male and female sexual anatomy and reproductive system prior to the present one. If these topics have not been covered before explain briefly the concept of conception and contraception.

Divide participants into two groups. Distribute copies of the narrative (A1) to each group. (1hour 30 minutes)

Ask the groups to discuss the narrative and respond to:

Group 1: You are Gita's close friend and she has come to you for advice.

Group 2: You are Murugan's close friend and he has come to you for advice.

Clarify that the activity's focus is to prevent unwanted pregnancy. The groups present their responses/advice in the large group as a role play. List the issues that emerge in the presentation and the discussion. Clarify the myths about pregnancy in the narrative and any other that come up during the discussion.

Explain how Gita and Murugan can prevent pregnancy, the pros and cons of contraceptive methods (A2) and specifically why some methods are not suitable for adolescents.

Conclude the activity with an exercise to use the condom. Each participant or pairs of participants may be given a banana and a condom. Guide participants step by step to use the condom.

(For details about HIV/AIDS and STIs/RTIs refer Module 4-Chapter 2. If the topic has not been covered, then briefly introduce the topic to the participants.

Ask participants what they know about protecting themselves from STI infections Listen to their responses and using the content from the session on RTIs/STIs and HIV explain the many ways that transmission can take place. if not covered already.

Younger women are more susceptible because the cervix is still immature and they have lesser production of vaginal mucus, which offers a less effective barrier to infective agents. State there is no really safe sexual practice except for being in a monogamous relationship where both partners are uninfected. The only way a person can prevent sexual transmission of STI or HIV is to use the condom every time one has sex.

B. Preventing unwanted pregnancy and Sexually transmitted infections (STIs), including HIV

2 hours 30 minutes

Brainstorm on what are the barriers to avoiding pregnancy and STIs. List and discuss how these barriers maybe overcome. (15 minutes)

Explain the next exercise helps adolescents, mainly adolescent girls to learn to be assertive in different situations towards preventing STIs, pregnancy etc. Highlight the fact that adolescent girls may not always be asked consent for sex; their 'no' may not be taken seriously. (Refer to previous sessions)

Explain to the participants that when reason/s for 'not wanting to have sexual relationship' are given, some people find different ways of trying to change our mind and make us say 'Yes'. (10 minutes)

The next activity tries to share various ways of tackling the situation, providing the appropriate response.

Divide participants in two groups. Give each group the grid (B1) on a chart. Display the 'Saying NO' options on a chart. (B2). Ask participants to carefully read the statements given that try to compel to agree or say 'yes'

Based on the statement that force to say 'yes', use the list of statements displayed on the chart 'Saying No' and select appropriate statements. Write this response in the spaces provided.

The two groups present the responses and discuss them filling any gaps if necessary. Sum up that asserting oneself or saying 'no' to sexual intercourse if one does not desire it may also prevent pregnancy and STIs.

Explain that the purpose of the activity is to understand the barriers in accessing health services for adolescents (1 hour 20 minutes). Divide participants in two groups. Ask participants to reflect upon the GITa and Murugan story. Explain that instead of the situation in the previous activity, Gita and/or Murugan are unable to get advice from their friends because they don't know have the knowledge/information.

Discuss: Whom can they go to? Can they approach the local health centre (PHC)? What would happen, how would the situation unfold?

Groups present their responses, followed by discussion on barriers to care at all levels – household, community, state/national policies, programmes etc. Encourage participants to share personal experiences as well as experiences of friends, siblings, neighbors.

Ask participants in their groups to do a role play to reflect ' Good quality health services for adolescent girls and boys'.

Activity ***30 minutes***

Divide participants into 2 groups and ask them to either write a short skit that tells their peers how to avoid getting pregnant and how to avoid getting an STI or HIV OR to write a song on how to avoid getting pregnant and how to avoid getting an STI or HIV. Discuss and plug gaps.

If participants are members of the community/NGO, ask them to write a skit to increase awareness about how to avoid getting pregnancy and prevent STIs. Evolve strategies to lobby with the health system to provide health services to adolescents.

Materials used for training / handouts included:

A1 Narrative for discussion and role play:

Gita is 18 years old and lives in the dalit hamlet in Navalur village. Murugan is 20 years old and from the same village. They work in the same pharmaceutical company nearby. They plan to marry sometime in the future.

Murugan has been keen on a sexual relationship, as they are 'planning to marry anyway and love each other'. Gita is not very sure. He assures her that she cannot get pregnant if they have sex once.

A2 Some of the contraceptives are not suitable for unmarried women and especially adolescents girls to use.s

Sex	Suitable methods of contraception	Unsuitable methods of contraception
Adolescent Males	Condom, abstinence	Sterilization, Withdrawal method
Adolescent females	Pills, abstinence, condoms, Spermicides along with calendar method or cervical mucus method (calendar method alone or cervical mucus method alone can be risky for adolescents)	IUD, Injectables, calendar method or cervical mucus method alone, sterilization, implants

Give reasons for why the withdrawal method is risky for young men and adolescents especially those trying it the first few times that they have sexual intercourse. Explain that the IUD if inserted in women who have never conceived may cause problems later as there is a risk of ascending infection which may cause problems later in life.

B1 **Grid to be given to group** (reproduce on a chart)

1. Fear of pregnancy	2. Fear of STI's	3. Expectations from the family	4. Fear of violence
First time no chances of pregnancy	I know you are interested but you are saying no due to fear	Are You a young child to get scared Like this?!	I know that you also desire this. But you are saying no because you are scared.
5. Friendship	**6. You/your partner are drinking**	**7. You are not with the right person**	**8. Wait till marriage**
We are not just friends. Its more than that - I love you	Oh come on. Have a small peg. It will create the right mood for you.	You will not get a chance like this. Lets go.	Everyone says that.

B2 (Written on a chart and displayed)

Saying no

- Once is enough to get pregnant
- This is not a game. I do not want to get sexually transmitted infections/ HIV or pregnant.
- May be I am not yet ready for a sexual relationship
- I do not want a sexual relationship now.
- If you want, we can just hug each other.
- I know that not everyone gets involved in sexual relationships
- I do not know about sex and without having indepth knowledge/information I do not want to take steps towards it.
- I do not like it when you compel/force me like this. I am leaving.
- I feel that I will be well only if I am not involved in sexual relationship
- I also feel like /desire to have a sexual relationship but I do not want it now.
- Don't try to impress / flatter me. I do not want a sexual relationship, that's all.
- I am confident, I feel that I do not want this relationship now.

Session 2: Substance Use and other addictions

Session Objectives: At the end of the session participants will be able to:

A. Give reasons for addictions and physical and psychological health consequences of smoking and drinking

B. Describe ways to say no to substance use and exploring ways of providing support to persons with addictions

Training Materials required for the session:

A. Chart with statements for discussion, board, chalk, materials on consequences of smoking and alcohol

B. Charts, pen, paper, old magazines, colours/paints, glue, scissors.

Methodology:

Present the session objectives.

A. Understand reasons for addictions and physical and psychological health consequences of smoking and drinking **2 hours 50 minutes**

Explain that statements (A1) would be read out and participants have to 'agree' or 'disagree'. If a participant agrees, he /she stands and if he or she disagree they keep sitting.

Discuss each point. Those who agree and those who don't share the reasons for their responses, followed by the facilitators' explanation. Explain that all the statements should be disagreed with.

Say that any person can be given treatment if s/he wishes to give up the habit. Explain:

1. The consequences of smoking briefly
2. If you keep drinking for a long time it will lead to addiction. Without proper treatment it is very difficult to stop this habit. It will not do any good if you advise person who is an alcoholic instead you can give physical and psychological support to give up alcohol.
3. There are many ways to spend time, have fun. Certain examples can be given to the participants, like playing games. If necessary a workshop can introduce them to sports/games
4. There is no reason for drinking but people give many reasons for starting to drink. Some say they drink for peace of mind –instead they can do yoga and focus on doing some physical work, or something creative. Students say that they drink when they have some problem but advise them not to drink when they have problems and explain the consequences of drinking. They can be asked to think about positive role models who do not drink when they have problems.
5. We can help anyone who is addicted:
   a. We should accept that he/she is addicted

   Do not think that they will come out of it on their own. Do not get angry with them. Try to find some ways to make them give up the habits. Do not try to cover their mistakes

   b. Try to take them for treatment even if you fail many times don't give up. Thousands of people have benefited because of the treatment

   c. Don't keep on giving advice. Provide emotional support at the same time do not allow them to continuE the habit. Help them to complete treatment (45 minutes)

Ask participants if they know any song about drinking or smoking. Ask them to share if they do otherwise ask participants to mime reasons why adolescents smoke /drink. Each volunteer mimes one reasons and the group has to guess.

List the common reasons given for these habits especially among adolescents. Explain that a later exercise will clarify some of these points/reasons (30 minutes).

Divide participants in two groups. (40 minutes: discussion: 20 minutes+ presentation:20 minutes)

Group 1: Creates a skit about a person who is addicted to cigarettes. The skit must include the consequences of smoking for him/her and also for his friends, family etc.

Group 2 : Creates a skit about a person who is addicted to alcohol. The skit must include the consequences of drinking for him/her and also for his friends, family etc.

Discuss the skits in the large group. Distribute the materials on consequences of smoking (A2) and drinking (A3) to the groups. Read them in the large group and clarify doubts (20 minutes).

Activity ***30 minutes***

Divide participants into two groups. Ask:

Group 1 : To create an advertisement (print) to ask people to quit smoking

Group 2 : To create an advertisement to ask people addicted to alcohol to seek help and get treated

Groups present in the large group and ask participants to summarize the main issues from the session.

B. Describe ways to say no to substance use and exploring ways of providing support to persons with addictions **1 hour 45 minutes**

Narrate the situation (B1) to the participants. Ask 4 - 5 volunteers to present the situation as a skit and the group-observers provide options on refusing to drink and being assertive.

Sum up the activity referring to the role play and using the chart (B2) with the points 'How to be assertive and say no'. (45 minutes)

Activity ***I hour***

Divide into two groups.

Group 1 : Writes a song about the health consequences of smoking and alcoholism

Group 2 : Creates a skit (street play) about these problems than can be done in the community

In case participants are members of NGOs or community groups, to evolve strategies to raise awareness about the consequences of alcoholism and smoking; exploding the myths related to these habits- 'smoking is manly'. Explore possibilities for community based treatment and follow up, referral networks etc. Groups present, followed by discussion and summing up (30 minutes).

Materials used for training / handouts included:

Exercise: statements to initiate discussion (written on a chart)

A1

1. Limited smoking will not cause harm to the body – agree/disagree.
2. Inspite of advice and suggestions a person cannot stop smoking means he is a coward. Agree/disagree.
3. When friends spend time together it is bad and it affects the happiness of others if one does not drink or smoke – agree/disagree.
4. Some drink to forget their worries, without dealing with the worry one cannot change the drinking habit – agree/disagree.
5. One who is addicted to alcohol and other substances cannot be treated, even if we advice they will not listen to us, we cannot do anything – agree/disagree.

Consequences of smoking

Smoking causes serious health problems

A2

Cancer: Generally people who smoke have more chances of getting lungs and throat cancer. This conclusion is based on various research studies. People who smoke half a packet of cigarette daily have 7 times more chances of getting lung cancer when compared to non-smokers. People who smoke have more chances of getting affected with oral cancer.

Problems that affect lungs: In developing countries like India 75% of lung problems are due to smoking. Smokers often suffer from breathlessness, cannot perform hard manual labour and experience problems in breathing. Infection in lungs also causes heart attacks and leads to death.

Heart and other problems: There is an increased risk of death due to heart attack (26% -90%) for those who smoke. They also suffer from problems like ulcers in stomach, problems in gums and teeth, nerve problems in the brain which may lead to paralytic attack.

Carbon monoxide: Every cigarette produces 80 cubic centimeters of carbon monoxide which affects the nervous system. Inhaling this may cause headache, giddiness and nausea.

When carbon monoxide mixes with hemoglobin in the blood, it reduces the amount of oxygen in the body. Smoking two packets of cigarettes leads to 8% of carbon monoxide in blood and reduces 20% of oxygen in the body.

Why it is very difficult to stop smoking?

- Like a game youngsters start smoking and it is very difficult to leave it when they want it. So it is clever idea to avoid this habit.
- Nicotine in cigarette causes addiction and smoking becomes an addiction very easily.
- Once nicotine gets mixed with blood it makes the body crave for the same amount of nicotine always and causes addiction.
- Adolescents and young people are drawn by their cinema heroes and advertisements and start smoking.

- Some countries have been carrying out anti smoking public campaigns for several years and have banned smoking in offices and public places. [Has been done in India too].

Question: What steps should we taken to prevent smoking among adolescents

A3 Alcoholism – a treatable disease

Alcohol – some facts

- All alcohol beverages (whisky/brandy/arrack/gin/beer/toddy etc) contain the same mood changing drug, ethyl alcohol. Only the percentage varies.
- Alcohol contains no nutrients. It cannot help build one's physique or improve the health condition
- Soon after drinking, alcohol quickly reaches the brain and slows down its activity. Alcohol is not a stimulant. It only interferes with the way the brain works.
- Drinking does not help to handle negative feelings like anxiety, worry or frustration. It only magnifies the intensity of these feelings.
- Alcohol interferes with the normal sleep pattern. The sedation induced by alcohol prevents one from enjoying a deep restful sleep.
- Alcohol does not make one, more intelligent, witty or sophisticated or add to one's personality in any way. It only gets one drunk.

Alcohol-the damage it can cause

Brain

- Interferes with the coordinatiom and clear thinking
- Triggers off psychiatric problems ranging from depression to hallucinations and delusions
- Permanent damage to brain cells

Stomach

- Interferes with digestion
- Irritates the lining causing gastritis and ulcer
- Increases the incidence of cancer

Liver

- It takes an hour to break down one drink of alcohol
- Excessive drinking is a strain on the liver and can cause
- Enlargement due to fat deposits –fatty liver
- Inflammation of the cells-hepatitis
- Permanent damage – cirrhosis

Heart

- Rhythym and functioning are affected
- Heart muscles become weak reducing the pumping efficiency

Other problems

Neuritis – Damage to the nerve endings causing tingling, numbness or tremors

Pancreatitis – Inflammation and damage of the pancreas Skin problems, sexual problems, malnutrition and degeneration of muscles are also caused by excessive use of alcohol

Alcoholism- a disease

- Around 20% of all people who drink develop alcoholism
- Anybody can become an alcoholic. Age, education, intelligence – nothing matters.
- An alcoholic is one who continues to drink in spite of repeated problems in one or more areas of his life.
- Alcoholism is a progressive disease and the situation goes from bad to worse in he continues to drink
- Once alcoholism sets in, it is not possible to drink in a controlled manner. No matter how hard he tries, he is unable to reduce the quantity and frequency of drinking.

- Advising, threatening, finding a job, changing the residence, paying back his debts or settling his other problems do not really help. He needs to give up alcohol totally as the first step towards resolving his problems.
- He needs to give up drinking totally and live that way for the rest of his life. Whenever he tries to drink a little, he will revert back to excessive drinking. Total abstinence is the only solution.
- With treatment, the alcoholic will be able to stop drinking and lead a normal life just like anybody else.

B1 **Situation for discussion**

Ganesh went to Mahabalipuram with his friends. They planned to have a jolly good time and for sight seeing. When they were sitting on the beach, one friend took out a beer bottle and drank it and passed on to others. Ganesh said no to it. The friends scolded him and called him a coward and asked him why he had come along and so on. To stop the argument Ganesh asked a friend to sing and the rest clapped hands and stopped the argument.

B2 **How to be assertive and say no**

1. Put forth your viewpoint/problem clearly?
   When I don't feel like it and you force/compel me, I don't like it.
2. When they try to change your mind
   Look how seriously he is talking –and similar teasing
3. Do not get tempted and come back to your point
   Allow me to make my point./Allow me to complete what I was saying
4. Once again put forward your request. Do not lose your temper.
   No means no, let me be – okay.
5. They will force/compel you again
   We do not know why 'bores' like you come along
6. You refuse again
   Or
   Temporarily refuse / delay
   Or
   Give them an alternative suggestion like *'Lets sing and dance. Why continue with this irritating argument'*
   Or
   I do not want to have any this time. Maybe the next time.

Session 3: Suicide

Session Objectives: At the end of the session participants will be able to:

A. Describe myths about suicides

B. Explain warning signs, reasons and possible strategies of preventing them

Training Materials required for the session:

A. Copy of myths about suicide

B. Situations for discussion on cards, chart with observable warning signs, chart with reasons for suicide, pens, papers, charts, pens

Methodology:

Present the objectives of the session.

A. Understand myths about suicide **30 minutes**

Explain that there are many commonly-held misconceptions about suicide. These myths of suicide often stand in the way of providing assistance for those who are at-risk. By dispelling the myths, we will be in a better position to identify those who are at-risk and to provide the help that is needed.

Read the 'myth' (A1) and ask participants if it's a myth or a fact and ask them to give their inputs and clarify. (In case of time constraints choose those that are most important in your context) (30 minutes)

B Understand the warning signs, reasons for suicides and strategies to prevent them **1 hour 40 minutes**

Divide participants into two groups. Give one situation (A2) to each group and ask the participants to enact them. In the large group discuss the possible warning signs in each situation. List these on a chart / board.

Ask participants to give inputs based on their experiences and interactions with others. (30 minutes)

Sum up the activity with 'Observable signs of suicide risk /warning signs' (A3). (10 minutes)

Ask participants to refer to the situations of Kamala and Vinod and share what according to them were the reasons for them to be suicidal. Thereafter present the reason (A4). (15 minutes)

Activity ***45 minutes***

Divide into three groups. Ask the participants what the three most common reasons for suicide in their areas. List on the board and ask them to keep those in mind while planning strategies to prevent suicide and to provide support at the community level.

Discuss the various strategies and sum up (A5).

A1 **Materials used for training /handouts included:**

MYTHS about SUICIDE

There are many commonly-held misconceptions about suicide. These myths of suicide often stand in the way of providing assistance for those who are at-risk. By dispelling the myths, those responsible for the care and education of young people will be in a better position to identify those who are at-risk and to provide the help that is needed.

MYTH: Young people who talk bout suicide never attempt or complete suicide.

*FACT***:** Talking about suicide can be a plea for help and can be a late sign in the progression toward a suicide attempt. Those who are most at risk will show other signs apart from talking about suicide. If you have concerns about a young person who talks about suicide:

- Encourage them to talk further and help them to find appropriate counseling assistance
- Ask if they are thinking about making a suicide attempt.
- Ask if they have a plan.
- Think about the completeness of the plan and how dangerous it is. Do not trivialize plans that seem less complete or less dangerous. ALL suicidal intentions are serious and must be acknowledged as such.
- Encourage the young person to develop a personal safety plan. This can include time spent with others, check-in points with significant adults, plans for the future.

MYTH: A promise to keep a note unopened and unread should always be kept.

FACT: Where the potential for harm, or actual harm, is disclosed- then confidentiality cannot be maintained. A Sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note is a late sign in the progression towards suicide.

MYTH: Attempted or completed suicides happen without warning.

*FACT***:** The survivors of a suicide often say that the intention was hidden, however it is more likely that the intention was not recognized. These warning signs include:

- The recent suicide, or death by other means, of a friend or relative.
- Previous suicide attempts.
- Preoccupation with themes of death or expressing suicidal thoughts.
- Depression, conduct disorder or problems with adjustment such as substance abuse (particularly when two or more of these are present).
- Giving away of prized possessions, making a will or other final arrangements.
- Major changes in sleep patterns- too much or too little.
- Sudden and extreme changes in eating habits, losing or gaining weight.
- Withdrawal from friends/family or other major behavioral changes.
- Dropping out of group activities.
- Personality changes such as nervousness, outbursts of anger, impulsive or reckless behavior, or apathy about

appearance or health.

- Frequent irritability or unexplained crying.
- Lingering expressions of unworthiness or failure.
- Lack of interest in the future.

** A sudden lifting of spirits, when there have been other indicators, may point to a decision to end the pain of life through suicide.*

MYTH: If a person attempts suicide and survives, they will never make a further attempt.

*FACT***:** A suicide attempt is regarded as an indicator of further attempts. It is likely that the level of danger will increase with each further suicide attempt.

MYTH: Once a person is intent on suicide, there is no way of stopping them.

*FACT***:** Suicides CAN be prevented. people CAN be helped. Suicidal crisis can be relatively short-lived. Suicide is a permanent solution to what is usually a temporary problem. Immediate practical help such as staying with the person, encouraging them to talk and helping them build plans for the future, can avert the intention to attempt or complete suicide. Such immediate help is valuable at a time of crisis, but appropriate counseling will then be required.

MYTH: Suicidal young people cannot help themselves.

FACT: While contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain full self-direction and self-management of their lives.

MYTH: The only effective intervention for suicide comes from professional psychotherapists with extensive experience in this area.

*FACT***:** All people who interact with suicidal adolescents can help them by way of emotional support and encouragement. Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.

MYTH: Most suicidal young people never seek or ask for help with their problems.

FACT: Evidence shows that they often tell their school peers of their thoughts and plans. Most suicidal adults visit a medical doctor during the three months prior to killing themselves. Adolescents are more likely to 'ask' for help through non-verbal gestures than to express their situation verbally to others.

MYTH: Suicidal young people are always angry when someone intervenes and they will resent that person afterwards.

FACT: While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help. for most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.

MYTH: Suicidal young people are insane or mentally ill.

FACT: Although suicidal adolescents are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most are not legally insane. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need Psychiatric help.

MYTH: Some people are always suicidal.

FACT: Nobody is suicidal at all times. the risk of suicide for any individual varies across time, as circumstances change. This is why it is important for regular assessments of the level of risk in individuals who are 'at-risk'.

MYTH: Every death is preventable.

FACT: No matter how well intentioned, alert and diligent people's efforts may be, there is no way of preventing all suicides from occurring

MYTH: People who threaten suicide are just seeking attention.

FACT: All suicide attempts must be treated as though the person has the intent to die. Do not dismiss a suicide attempt as simply being an attention-gaining device. It is likely that the young person has tried to gain attention and, therefore, this attention is needed. The attention that they get may well save their lives.

MYTH: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

FACT: Talking about suicide provides the opportunity for communication. Fears that are shared are more likely to diminish. The first step in encouraging a suicidal person to live comes from talking about feelings. That first step can be the simple inquiry about whether or not the person in intending to end their life. However, talking about suicide should be carefully managed.

MYTH: Only certain types of people become suicidal.

*FACT***:** Everyone has the potential for suicide. The evidence is that predisposing conditions may lead to either attempted or completed suicides. it is unlikely that those who do not have the predisposing condition (for example, expression, conduct disorder, substance abuse, feeling of rejection, rage, emotional pain and anger), will complete suicide.

MYTH: Depression and self-destructive behavior are rare in young people.

*FACT***:** Both forms of behavior are common in adolescents. Depression may manifest itself in ways which are different from its manifestation in adults. Self-destructive behavior is most likely to be shown for the first time in adolescence and its incidence is on the rise.

MYTH: Suicide is painless

FACT: Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of the pain.

A2 **Situations for discussion and role play (written on cards)**

1. Kamala lived with her stepmother and father. She was 14 years old. Her step mother ill treated her- made her do all the household chores, shouted at her all the time, insulted her saying she was good for nothing. She made Kamala's father also believe that the girl was 'useless' etc. The situation had been worsening gradually. Kamala was even asked to stop going to school. Kamala got more and more dejected every day. She cried all the time. She often told her best friend and neighbor, Lakshmi, that she did not feel like living and there was no alternative but to die.
2. Vinod was 17 years old. He had two younger sisters. The family was very poor. His father died when he was younger and his mother worked as an agricultural labourer. He studied in the government school in the twelfth class. He studied hard for the final exams but failed two subjects. He was extremely disappointed and had not gone out of the house since the results. He told his mother that he felt tired all the time. He slept all the time and barely ate. He told his sisters that his life was over and there was nothing to look forward to. He gave his pencils, and other little things to his sisters saying they wont be of much use to him anymore and the sisters should use them.

A3 **Some observable signs of suicide risk** (Facilitator these are merely guidelines and may be different for some persons and in certain contexts)

Classroom behaviour

- Marked decline in school performance and levels achieved .
- Skipping classes and opting out of school activities generally.
- Poor concentration, sleepiness, inattentiveness
- Unusually disruptive or rebellious behavior.
- Death or suicide themes dominate written, artistic or creative work.
- Loss of interest in previously pleasurable activities.
- Inability to tolerate praise or rewards.

Interpersonal behavior

- Giving away prized possessions.
- Sudden changes in relationships, for example, exhibiting disruptive behavior.
- Withdrawing from friends and social involvements.
- Not wanting to be touched by others.

Other behavioral signs

- Apathy about dress and appearance.
- Sudden change in weight.
- Running away from home.

- Risk-taking and careless behavior
- 'Accident proneness'.
- Sudden and striking personality changes and changes in mood.
- Overt signs of mental illness (for example, hallucinations).
- Loss of sense of humor or sudden compulsive joking.
- Sleeping pattern changes.
- Self-mutilation behaviors.
- Noticeable increase in compulsive behavior.
- Development of extreme dependency.
- Sudden happiness after a prolonged period of depression.
- Impulsive tendencies.
- Depressive tendencies.
- Unrealistic expectations held of self

Verbal expression of suicidal intent or depression

- Direct statements, for example/ 'I wish I were dead', 'I'm going to end it all'.
- Indirect statements, such as, 'No one cares if I live or die', 'Does it hurt to die?'

A4 **Reasons for suicide** (on a chart) Modify as per context.

School and society

- In trouble with school authorities or police.
- Loss or disappointment in school.
- Change of school and/or address.
- Strong demands from adults for show of strength, competence and effectiveness.

Interpersonal and physical problems

- Loss of an important person through death or divorce.
- Recent suicide of friend or relative.
- Breaking (up with boyfriend or girlfriend.
- Exposure to violence, incest, rape.
- Abusing drugs or alcohol.
- Feared pregnancy.
- Refusal by significant other to provide anticipated help, support or love.
- Major disappointment or humiliation
- Major family dysfunction.

Home life

- Chronic depression or mental illness in parent(s).
- Incest or child abuse.
- Severe parental conflict.
- Family involvement with drug or alcohol abuse.
- Poor communication with parents.
- Pressures for high achievement to gain parental approval or acceptance.
- Exposure to suicide, suicidal behavior or violent death of family member or friend.

Interpersonal relations

- Involvement in physical violence.
- Inability to relate well to peers.
- Sexual promiscuity

- Inability to enjoy or appreciate friendships or to express affection openly.
- Mood swings and occasional outbursts.
- Feelings of worthlessness, being a burden or having let parents or others down.
- Feelings of guilt, failure. having no control over their lives.

B1 **Strategies (on chart).** This is only a sample.

Steps parents / teachers and significant adults can take

- Get help (medical or mental health professional)
- Support your adolescent son /daughter (listen, avoid undue criticism, remain connected)
- Become informed (library, local support group, organizations (NGOs) Internet)

Steps adolecents can take

- Take your friend's actions seriously
- Encourage friend to seek professional help, accompany if necessary
- Talk to an adult you trust. Don't be alone in helping your friend

In case of NGOs:

- Provide services –counseling and referral
- Training for community based health workers / school teachers, youth groups etc
- Coordinate community based awareness campaigns and simple workshops to provide information/awareness

(Reference: Mental Health Library,Royal Park Hospital, Parkville, Victoria 3052 August 1996]

Before women can take their destinies
into their own hands, they must understand the
objective condition of women and the many forms that
oppression takes in the lives of women.

What we need is a genuine give and take- you know
a little and I know a little. You may know something I need to know
and vice versa-if we get together, we win….
This is what we women need to do ….

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