Sangini
(Navvivahit Dampati Swasthya Pustika)
Training cum Reference manual for Young couple Peer leaders

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ABOUT THE MANUAL

Q. – Why has the training manual been developed?
The following manual addresses the important aspects related to the health of young married couples. It has been designed for peer leaders in a simple language with interactive activity based teaching and learning methods. It addresses nutrition, reproductive health, violence, mental health and preconception care. Prevention of diseases and promotion of health among couples is the basic aim of preparing this manual. Such a comprehensive module for young men and women does not exist; to the best of our knowledge. Hence it was need of the hour to contextualize the different aspects relate to the health of young couples into one manual for users.

Q. – Why is it important to focus on young couples?
Globally around 18 million women under the age of 20 give birth every year, representing up to one-fifth of all births, with almost 95% of them occurring in developing countries. Significant evidence show that closely spaced pregnancies (less than 18 months interval) and pregnancy before 20 years of age have strong correlation with poor maternal and neonatal health outcomes including higher rates of pregnancy related complications. The young married couples, in lower- and middle-income countries, face barriers in accessing quality reproductive and other health services because they are either missed by policies or are not reached by programs. Their age, lack of education, limited social agency, power imbalance and inadequate negotiation skills in their marital relationships and their economic dependence trap them in a cycle of poverty with rapid and repeated childbearing. While a substantial proportion of pregnancy, child bearing and parenthood occurs in women aged 15–24 years within the context of marriage or cohabitation, they are less knowledgeable about reproductive health, and are less likely to use contraceptives and other maternal health services in comparison to women aged 25–29 years. Further, young married women of many poor communities are less likely to obtain contraceptive services because they are expected to bear children soon after marriage, and being hindered in seeking antenatal and delivery care because of practical or social restrictions. The structural strains of parenthood and financial need and their interaction predict problematic and supportive spousal relationships and the difference in the levels of these two relationships. Problematic relationships with spouses have considerably stronger impacts than supportive relationships on mental illnesses. However, the difference between the amounts of supportive and problematic relationships with spouses has a greater impact on mental health than levels of either considered separately. Mostly, pregnancies among young married women are unplanned or poorly timed, contributing to a high rate of unsafe abortions. In 2008, an estimated 8.7 million unsafe abortions, representing 41% of all unsafe abortions in developing regions, took place among women aged 15–24 years. Thus, there is a need for evidence-based knowledge on effective ways of reaching out to young married women with the required health interventions.
FIGURE 1. Preconception care components and importance

FIGURE 2. Preconception care completes the coverage across the life course

Source: WHO report on preconception care-regional expert group consultation
Q. – What are the national and international strategies and policies for newly married couples?

A new WHO report shows that preconception care has a positive impact on maternal and child health outcomes. In February 2012, a World Health Organization (WHO) meeting brought together researchers, practitioners and programme managers with experience in preconception care, as well as United Nations agencies and partner organizations to achieve a global consensus on the place of preconception care as part of an overall strategy to prevent maternal and childhood mortality and morbidity. An agenda for action was agreed upon at the meeting, including actions to:

- Build regional and national capacity to plan, implement and monitor preconception care programmes and services.
- Stimulate and support country action.
- Carry out demonstration projects in selected countries.
- Document and disseminate good preconception care practices.

Government of India in the continuum of care model of RMNCH+A addresses segment of populations. The Government has come up with multiple schemes to promote gap between marriage and first pregnancy and also between pregnancies. Some of the schemes are mentioned below:

**FIGURE 3.** Preconception care components as suggested by WHO
Scheme: Prerna Strategy

In order to help push up the age of marriage of girls and space the birth of children in the interest of health of young mothers and infants, Jansankhya Sthirata Kosh (National Population Stabilization Fund), an autonomous body of the MoHFW, Govt. of India has launched PRERNA, a Responsible Parenthood Strategy in all districts of seven focus states namely Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand, Odisha, and Rajasthan.

The strategy recognizes and awards couples who have broken the stereotype of early marriage, early childbirth and repeated child birth and have helped change the mindsets of the community.

In order to become eligible for award under the scheme, the girl should have been married after 19 years of age and given birth to the first child after at least 2 years of marriage. The couple will get an award of ₹10,000/- if it is a Boy child or ₹12,000/- if it is a Girl child. If birth of the second child takes place after at least 3 years of the birth of first child and either parent voluntarily accept permanent method of family planning within one year of the birth of the second child, the couple will get an additional award of ₹5,000/- (Boy child) / ₹7,000/- (Girl child). The amount of award is given to the beneficiaries in their Adhar linked account through direct beneficiary transfer (DBT). The scheme is meant only for below poverty line (BPL) families.
Important Conditions:
1. Couple must belong to BPL family
2. Age of lady should not exceed 30 years
3. The girl should have been married after 19 years
4. First child birth after at least 2 years of marriage
5. Second child birth after at least 3 years of the first child birth
6. Either parent voluntarily accepts permanent method of family planning within one year of the second child birth.

Jansankhya Sthirata Kosh has initiated the first of its kind of National Helpline in India on Reproductive, Sexual Health, Family Planning and Infant and Child Health etc. in 2008. The toll-free number 1800-116-555 can be accessed from anywhere in India. The National Helpline /call centre is expected to fill a huge gap in information that exists in communication with adolescent, about-to-be-married and newly married couple as well as people of all ages seeking reassurance before they visit a doctor. People are initially shy about visiting medical facilities and need guidance to address concern like contraception, safe abortion, emergency contraception, sexually transmitted diseases and reproductive tract infections. The aim of National Helpline is to provide reliable information various reproductive and child health (RCH) topics.

SANTUSHTI SCHEME
Santushti is a scheme of Jansankhya Sthirata Kosh (JSK) for high populated states of India viz Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh & Odisha. Under this scheme, Jansankhya Sthirata Kosh, invites private sector gynecologists and vasectomy surgeons (who are already working under NRHM scheme of GoI) to conduct operations in Public Private Partnership mode.

According to this Scheme, an accredited private Nursing Home/ Hospital (Quality assurance manual for Sterilization services), working under NHM can sign a MOU with JSK. Upon signing the MOU Pvt. Hospitals/NH shall be entitled for incentive, whenever it conducts 10 or more Tubectomy/Vasectomy cases in a month.

Q. – How was the training manual designed?
The manual was designed by taking inputs from experts in the field. Preventive, promotive and curative aspects were added to make it comprehensive for participants. Focus group discussion (FDGs) and in depth interviews were done with the peer leaders and young couples before developing the modules in the manual. The modules were designed accordingly. The manual aims to empower couples by enhancing knowledge, improving attitude and help them to develop necessary skills. The trainers for peer leaders have to build their technical knowledge as well as facilitation skills. This is a training-cum-reference manual which means training manual for staff to train peer leaders and the reference manual for peer leaders to plan, design, monitor and conduct sessions. Two different session plans have been given in the manual (the first session plan is for trainers of peer leaders to use while conducting 4 day workshop and second plan in annexure is for peer leaders to refer for conducting BCC sessions). Eight modules in the manual will be covered in 12 sessions by peer leaders. “Know more” sections have been added keeping in mind if someone wants to read more about certain topics, he/she can refer the content which are more technical.

Q. – How to use the manual?
The Manual includes eight modules, divided over four-day training workshop, with exercises ranging in duration from 15 minutes to 30 minutes each. Each session is accompanied by life skill based activities to practice the knowledge and skills learnt, which is followed by evaluation to strengthen the confidence level.

Each session includes:
• Learning objectives
• Case studies
• A list of materials needed (including training aids, hand-outs and audiovisual content)
• Time allotted
• Practice session and key messages
Step by step instructions for conducting the training are presented along with the reference handouts and annexures. The Manual will majorly focus on facilitation skills in view of executing the workshop involving group activities like role plays, group discussions etc. Care has been taken to keep the content simple and focused; the Manual will be supported with interactive discussions and practice sessions.

**Training Method**
The training methodology is based on adult learning principles. The methods used in this manual are: Brainstorming, Lecture, Group Discussion, Role Plays, Case Studies, Structured Exercises, etc.

**Training Materials Required**
- Manual and related handouts
- Stationary
- Board (optional)
- Colored chits
- Flipcharts (50 pages) and flipchart stands
- Glossy paper and chart papers
- Chalk and sketch pens
- Participants’ registration forms (1 per day)
- Game cards
- Flash cards
- Props like food items, bowls, etc. for live demonstration sessions.

**Evaluation of training: the training follows a 3 step evaluation process**

1. Facilitation skills evaluation, where in the practice sessions on facilitation skills by the participants will be evaluated by the trainer at the end of each session. This will help in enhancing the facilitation skills of the participants for conducting future sessions.

2. Pre and post training knowledge evaluation will evaluate the 4 days master training of peer leaders. This will be conducted using a small objective type questionnaire before and at the end of 4 days training. This will measure the degree of improvement in knowledge on the issues. It is done to make the training sessions more effective and acceptable for sustained and enhanced retention.

3. Participants’ feedback will be entertained at the end of the workshop by filling up a feedback form. This will help in assessing the quality and gaps in training workshop for future improvement.

**Responsibilities of participants after receiving the training**
After completing the training, the peer leaders should be able to conduct the training by using the activities/steps of the session and be able to use the training materials (handouts, etc.) related to the issues. The facilitator (project staff) should play the role of a good trainer and motivator. The facilitator should be responsible for managing the training with support from other staff members of MAMTA.

**Peer leader- role in pregnant and lactating women**
Peer leaders are selected from the community from where females belong. Since they are of similar age group, they understand the problems and can help them to solve their problems in an effective and feasible way. Females can also discuss their queries easily since they might know them already. It is important because females may find it difficult to open up to any outsider to discuss their problems.

**Qualities of a good peer leader**

1. **A sense of purpose:** The aims and objectives must be clear, target members should be told about them and they should exemplify and uphold them in their own actions.

2. **Temperance:** A peer leader must strive to maintain a proper balance of emotions; this does not mean that leaders should be dispassionate. Quite the contrary- but there are times for passionate advocacy and times for quiet reflection and reconsideration. Balance is the key.
3. **Respect**: The dignity of each individual is the concern of any peer leader, and this is preserved by treating all with respect and ensuring they treat one-another similarly, regardless of differences.

4. **Empowerment**: The more skilled peer leaders are, the more they feel confident in their abilities and competent to make decisions, raise questions, see new possibilities, and disagree respectfully with others.

5. **Courage**: Peer leaders set direction, not wait for direction to emerge. They have to be willing to follow their convictions.

6. **Deep commitment**: Peer leaders should have deep commitment to their work and the wellbeing of everyone. It is this deep commitment that makes leadership so challenging, because it requires a commitment.

**Coordination with other health care workers**

Since peer leaders are from community itself, they can coordinate well with other workers like ASHA and ANM who are also responsible for health promotion and disease prevention among women. Peer leaders should learn to work as a team and sound communication and coordination should be made between other functionaries like health workers like ANM or medical officer.

Q. – Why peer leaders are trained?

The overall aim of training peer leaders is to influence and train mothers with the help of peer leaders who are the individuals who identify themselves as a leader and have gained respect of the fellows. Peer leaders are ones who are positive role models for others. Peer leaders can influence the attitudes and behaviour of others. They can motivate the others to bring a positive change. Skill development occurs best when it is made in form of an activity and is done with peers.

Q. – As a peer leader what am I supposed to do?

1. Line listing of pregnant, lactating women (15-49 years) and reaching them irrespective of religion, caste, with the focus on beneficiaries from most marginalised communities in your area with the help of project staff.

2. Make a group of 20-25 women and build rapport with them. This will help you in conducting sessions in a friendly environment.

3. Schedule the dates for your session after discussing microplans with project staff. Inform the group members about the days well in advance. Kindly share contact details, in case any help is needed they might contact you.

4. Conduct sessions as per the module. Help dispelling any myths and misconceptions with regard to health and protection issues during sessions. Ensure privacy and confidentiality about every member.

**Guidance and support for peer leaders**

Peer leaders will be supported by out reach workers and supervisors of the project who have been oriented on your role as a peer leader. They will be your mentors. Peer leaders can contact them any time and project staff can be invited also for introductory session with the group. They will help leaders in reaching out to beneficiaries, in provision of safe space in community to conduct sessions, help resolve any problem in carrying out work and ensure correctness of messages. They can help women clarify myths and misconceptions and answer queries. They can also help in providing referrals brought by leaders. Moreover they can contact health workers like ASHA/ANMs or AWWs for technical support or referral.

Q. – How to conduct a session in community with peers?

Peer leader to carry out session as formal group session, informal small group interactions and also one to one interactions. Peer leader has to conduct group sessions as given in manual spread over 12 sessions in 3 months duration (one every week). The format of session reporting and the checklist to keep track of topics covered with each peer group has been provided as annexure I and II respectively. The checklist forms have to be filled after conducting session verified by staff. Peer leaders will conduct 2 hour interactive session using the flip books and use this manual as reference in case of doubts or queries or to strengthen the technical knowledge. The session can be conducted at a suitable place in village.
4 Es for peer leaders to remember during sessions:
1. Encourage equal participation and dialogues within groups and resolve conflicts
2. Empathy and patience while conducting session
3. Exercises and energizers based interactive sessions for better learning and remembrance by members
4. Ensure recording of important notes, observations and suggestions from group.

Key Facilitation skills that will be ensured through training to prevent FAILure:
Face the audience while speaking
Focused and to the point
Approach participants to get their attention and solicit response
Ask open ended questions to encourage participation
Issue time to think and assimilate the information
Insight and non-judgmental attitude
Listen to what participants say
Look into their eyes