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Community Level Interventions For Improving Maternal, Neonatal And Child Health: A Training Tool Kit

DESIGN, PLANNING AND IMPLEMENTATION OF THE SUKSHEMA PROJECT

Community Level Interventions for Improving Maternal, Neonatal and Child Health: Design, Planning and Implementation of the Sukshema Project is the first module of the tool kit in a series of seven on enhancing community engagement for improving outreach, shaping demand and strengthening accountability to improve maternal, neonatal and child health outcomes in Karnataka.

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DESIGN, PLANNING AND IMPLEMENTATION OF THE SUKSHEMA PROJECT

KHPT
Karnataka Health Promotion Trust

National Rural Health Mission
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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PREFACE

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Health Workers
Module 5: Improving Enumeration and Tracking
Module 6: Home Base Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 1: Design, Planning and Implementation of the Sukshema Project is aimed at Resource Persons (RPs) and other developmental professionals working in the area of Maternal Neonatal and Child Health (MNCH). It gives the background of the Sukshema project and its intervention theory and approach to MNCH in reducing the infant mortality rate (IMR) and the maternal mortality rate (MMR) in eight northern districts of Karnataka. It highlights the main strategies in the project aimed at enhancing the community's engagement in improving outreach, increasing demand for MNCH services and building accountability and transparency in the service delivery systems in the field. The module explains the participatory development of tools, approaches, and training of trainers (ToTs) processes. For facilitators it gives an overview of sessions included in the seven modules of the Tool Kit, including a suggested time frame. It also sets the stage for training with guidance on facilitation, including preparation, process management, resource management, and human relations. The section 'Getting Started: Doorway to Successful Training' should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. It contains a set plan of sessions that set the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

CONTENTS

ACRONYMS

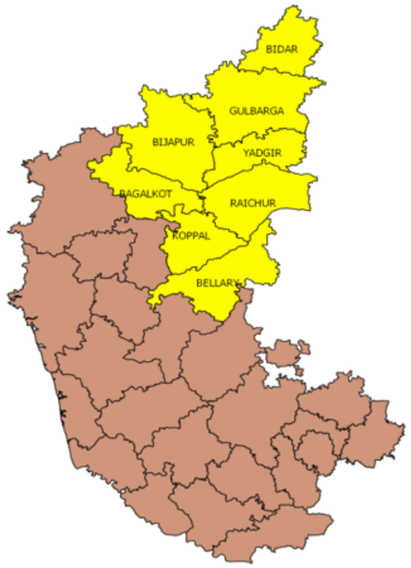
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARS	Arogya Raksha Samitis
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BPL	Below Poverty Line
CBO	Community Based Organization
CDL	Community Demand List (CDL1) Tool
DOH	Department of Health
EDD	Expected Date of Delivery
FLW	Frontline Health Worker
FP	Family Planning
FRU	First Referral Unit
GoK	Government of Karnataka
HBMNC	Home Based Maternal Newborn Care
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
JHA	Junior Female Health Assistant
JSY	Janani Suraksha Yojana
JHA	Junior Female Health Assistant
KHPT	Karnataka Health Promotion Trust
MDG	UN Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PNC	Post-natal Care
PRI	Panchayat Raj Institution
RP	Resource Person
SBA	Skilled Birth Attendant
SC	Sub Centre
SC/ ST	Scheduled Caste/ Scheduled Tribe
SCM	Supportive Community Monitoring
SHRC	State Health Resource Centre
SHS	State Health Society
SRS	Sample Registration System
TBA	Trained / Traditional Birth Attendant
TT	Tetanus Toxoid
VHW	Village Health Worker
VHSNC	Village Health and Sanitation Nutrition Committee

1. INTRODUCTION

1.1 BACKGROUND OF THE SUKSHEMA PROJECT

India launched its National Rural Health Mission (NRHM) in April 2005 to tackle the high burden of maternal, neonatal and child morbidity and mortality in India's rural populations. Key aspects of the NRHM are its enormous scale, its focus on extending services to the rural poor, and its inherent flexibility for introducing innovative approaches for improving health system responses to improve maternal, newborn and child health (MNCH) outcomes.

Congruent with the NRHM's objectives and approaches, the Bill & Melinda Gates Foundation's (the Foundation's) Maternal and Neonatal Health (MNH) Strategy seeks to improve MNCH outcomes in the world's poorest regions by catalysing health system responses to ensure that critical, proven interventions during pregnancy and in the neonatal period reach underserved populations. While the NRHM provides a broad canvas with processes and funding mechanisms to achieve health goals, the Foundation's strategy focuses on a critical technical intervention package to enhance the performance of health systems. The Foundation has awarded funds to the University of Manitoba and the Karnataka Health Promotion Trust (KHPT) to support the Government of Karnataka (GoK) to develop and implement strategies to improve MNCH in alignment with the NRHM's objectives and approaches.



Sukshema project districts

The Sukshema project was designed and planned to focus on improving the availability, accessibility, quality, utilization and coverage of critical MNCH interventions among the rural poor in eight priority districts in northern Karnataka: Bagalkot, Bellary, Bidar, Bijapur, Gulbarga, Koppal, Raichur and Yadgir.

The goal of the Sukshema project is to support the GoK to improve MNCH outcomes in rural populations through the development and adoption of effective operational and health system approaches within the NRHM. To achieve this goal, the project is designed to integrate and align key aspects of the Foundation's MNH strategy with the NRHM's health system infrastructure and mechanisms in the eight project districts, with the following four key objectives:

1. Enable expanded availability and accessibility of critical MNCH interventions for rural populations.
2. Enable improvement in the quality of MNCH services for rural populations.
3. Enable expanded utilization and population coverage of critical MNCH services for rural populations.
4. Facilitate identification and consistent adoption of best practices and innovations arising from the project at the state and national levels.

The project had two phases: planning and implementation. The 12 month planning phase was intended to: 1) carry out various assessments related to project objectives; 2) design implementation models for improving availability, quality and coverage of the interventions; and 3) develop health system responses necessary to implement the models. The 48 month implementation phase focuses on supporting the NRHM to implement and assess strategies for delivering the intervention package, and translating knowledge developed through the project for wider dissemination, as well as advocacy and adoption of key elements by the NRHM at state and national levels.

2. GAPS IN MNCH SERVICES

The assessments carried out under the project have indicated that critical gaps in the availability, accessibility, quality, utilization and coverage of MNCH services exist at three levels: health system, facility and community. level. The latest available data on maternal mortality rate (MMR) is for the period 2010-12. During this period, the MMR of India was 178 per 100,000 live births. The latest infant mortality rate (IMR) for the country as per the Sample Registration System (SRS) 2012 was 42 per 1000 live births, which had decreased from 47 in 2o10 and from 50 in 2009. The Maternal Mortality Estimation Inter-Agency Group - WHO,UNICEF,UNFPA, World Bank report titled "Trends in Maternal Mortality: 1990 to 2010" ranked India 126 out of 180 countries in ascending order of MMR. As per the report published by UNICEF in 2012 titled "Committing to Child Survival; A Promise Renewed" India ranked 45 out of 195 countries in the world in descending order of IMR. Although much effort has gone into health system strengthening, such as enhancing the functional abilities of staff nurses, providing job aids and checklists to simplify their work, improving the drug supply and strengthening referrals, there are a number of gaps that still exist.

2.1 GAPS IN AWARENESS AND GENDER

Currently, there is a lack of awareness in the community on healthy practices and available services for the mothers and newborns through the MNCH continuum of care. Often existing cultural practices and beliefs, and insufficiently informed decisions, become barriers to access of MNCH services. The findings from Sukshema's assessment of community facilitators and barriers for utilization of MNCH services have re-confirmed that the practices related to pregnancy, delivery, and post-natal care, as well as the decisions to seek care, are institutionalized within the family. The elders in the family, particularly the mothers-in-law and the mothers, as well as the husband, play an important role in decisions on seeking care, as well as in perpetuating unhealthy practices. Therefore, the Sukshema project plans to focus not only on the pregnant woman or new mother, but to also target family members and the wider community. Otherwise, its MNCH activities would only be partially successful.

The status of women in Indian society must also be taken into account when looking at the situation of maternal and child health. Before pinning all the blame on poor awareness levels among women, it is important to look at other factors that either directly or indirectly affect a woman's health during the MNCH continuum of care stages. In rural India the family members have a bearing on all aspects of an individual's life. Members of the family, especially the male and the elderly, generally make decisions for the rest of the family. These decisions are usually based on "family values" and what is considered socially "appropriate", rather than based on individual needs and facts.

For example, several cultural and traditional beliefs that exist in rural and even some pockets of urban India drive women and families to make decisions that are more often detrimental to the health of the women and the child. There are prevalent myths and misconceptions about pregnancy, delivery, new mothers and child care. The preference for sons leads to repeated abortions and poor birth spacing. The belief that hard work during pregnancy will help prevent caesarean deliveries. The belief that more blood loss after child birth means more body impurities are expunged, thus keeping the body slim after delivery. The belief that the first breast milk (actually very rich in colostrum), is impure because of its yellow colour, so the newborn should not be fed with it. All of these misconceptions have been culturally intertwined within families and are repeatedly reiterated by the elders in the family.

Studies have shown that the father, mother, husband, in-laws, grandfather and grandmother, living together in an extended family situation, exert a tremendous influence on the pregnant woman, leaving her with little option but to succumb to the pressure and submit to their decisions.

Addressing awareness about the larger gender realities is essential to build a holistic perspective of MNCH. Thus, the Sukshema project plans to offer an intensive training that brings front line health workers (FLWs) together and leads them through a process of critical thinking, reflection and evaluation of issues around MNCH and gender-social perspectives.

2.2 GAPS IN COVERAGE AND OUTREACH

In the MNCH continuum of care, existing data indicates that the coverage of target populations is poor and inequitable. More than half of all maternal and newborn deaths occur during childbirth and the first few days of a baby's life; this is also the period when health coverage is lowest. An effective MNCH continuum of care focuses on two dimensions in its provision:

- Time; recognizing the need to ensure essential services for mothers and children during pregnancy, childbirth, the postpartum period, infancy and early childhood.
- Place; or linking the delivery of essential services in a primary health care system that integrates home, community, outreach and facility based care. The impetus for this focus is the recognition that gaps in care are often most prevalent at the locations – the households and community – where care is most required.

Available data indicates that the coverage of target populations for MNCH services is poor and inequitable: there are unreached populations for many services, and those who are reached do not receive a complete package of services through the MNCH continuum of care from antenatal to child care. For instance, as per the District Level Household Survey (DLHS) for northern Karnataka, while 74% of pregnant women received tetanus toxoid (TT) injections, fewer than 27% received the full set of ANC visits. Similarly, only 52% of recently delivered women received a postnatal care visit within 48 hours of delivery. A large proportion of certain populations, particularly migrants, and those belonging to scheduled castes and tribes, seem to be left out of the registers maintained at the Sub Centres (SCs). While the proportion of institutional deliveries has risen in recent years, only a small proportion of mothers stay for 48 hours after delivery in facilities. As per the state Health Management Information Systems (HMIS), only 38% of women delivering in institutions during August 2010 -July 2011 stayed for at least 48 hours after delivery.

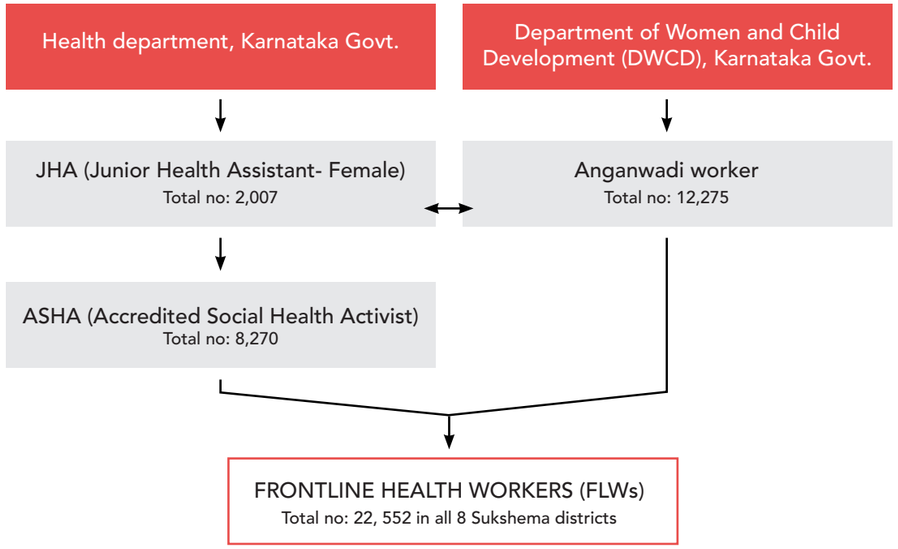
In order to ensure that services are rendered at the right time and place, there needs to be a plan to maintain and track the beneficiaries of maternal and new born services. Currently there is no standard format for planning services. A critical gap in outreach includes unreached target populations such as migrants, poor families, those belonging to the Scheduled Caste/ Scheduled Tribe (SC/ ST) community. Very often these marginalised groups are left out due to social and cultural factors along with the practical difficulties in reaching these groups. Even if they are targeted, not all services reach them due to lack of individual-centred assessments and lack of focus on prioritizing hard-to-reach populations. This renders the MNCH programme inequitable.

Another gap is those who are reached receive incomplete package of services that puts mothers and infants at risk of morbidity and mortality, increasing their vulnerability. This is because poor planning and monitoring, especially at the individual level, affects outreach for service delivery. Gaps caused by lack of tools and job aids for planning effective outreach, poor communication skills and absence of clear concise key messages affect the health seeking behaviour among the target populations, resulting in poor access of all services across the MNCH continuum of care. All of these challenges point to the need for building capacity to provide services.

Another important factor is the underlying role of the larger community to be aware of the issues and barriers to maternal and child health at the village level and exercise responsibility and accountability to reduce maternal and infant deaths. The process of ensuring increased coverage should provide ample space for the community to participate and develop ownership. Effective outreach therefore is a result of skilled and well trained FLWs equipped with the needed tools and job aids, and an aware community that supports and owns this effort.

2.3 GAPS IN ROLES AND RESPONSIBILITIES

Community outreach in providing MNCH care services is of utmost importance. Strong outreach means increased coverage for services and improvement in the demand and the accessibility of MNCH services. At the community level the FLWS, including the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW) all play a vital role in providing the health services related to pregnant women, nursing mothers and newborns.



In Karnataka State, the term Junior Female Health Assistant (JHA) has now replaced the role of the Auxiliary Nurse Midwife (ANM). The JHA plays a multitude of roles including:

- Informing women about the side effects of immunisation, importance of breast feeding, maternal and new born care at home, permanent and temporary family planning options
- Enrolling pregnant women and filling in "Thayi" card during the registration
- Explaining immunisation process to new mothers and giving TT injections
- Measuring the blood pressure of pregnant woman, checking the weight of the child after delivery and giving iron tablets 5 months after delivery
- Educating about nutritious food, hygiene and institutional delivery to the woman
- Providing information to the pregnant woman about the benefits of scanning
- Providing information about the government schemes available to 1st and 2nd delivery mothers
- Referring pregnant women with complications to higher care centres
- Conduct deliveries in case of emergencies in the sub centres
- Conducting home visits
- Educating the family about home based care needed for the new born baby, especially with low birth weight
- Providing information to nursing mothers about precautions to be taken to avoid infection
- Collecting blood samples if the pregnant woman or the nursing mother has a fever

The Accredited Social Health Activists (ASHAs), being members from the neighbourhood, are the community resources to facilitate a positive change in awareness and practices around maternal and child health through the continuum of care. They have been described as activists in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. Their tasks include outreach activities such as motivating women to give birth in hospitals, linking them to MNCH services provided by the government, mobilizing children to attend immunization clinics, encouraging family planning (e.g. surgical sterilization), treating basic illness and injuries with first aid, keeping demographic records and participating in activities to improve village sanitation. ASHAs also serve as an important communication channel between the healthcare system and rural communities.

Although the ASHAs undergo a fairly comprehensive initial training about their functions, in practice, their focus has been on referrals, or bringing people to services – particularly for institutional delivery. There has been very little emphasis and expectation from them as a change agent – in influencing awareness and practices related to critical MNCH services. There are no easy-to-use interpersonal communication materials and job-aids to facilitate ASHAs in performing the role of a change agent. There also is a need for focus on the critical MNCH issues around which the ASHAs need to work with the families to improve their awareness and practices.

The Anganwadi Workers (AWWs), delivering services through the Department of Women and Child Development, focus on health education promotion highlighting nutrition. They are tasked with:

- Mobilizing pregnant women for immunisation camps
- Encouraging and motivate people to seek institutional delivery and adopt family planning methods
- Registering newborns
- Conducting home visit to give nutritional advice to pregnant and nursing mothers of children 6 months to 3 years old
- Conducting mother's meeting and nutrition camps to provide health education and distribute nutritious food for pregnant women , nursing mothers and children 6 months to 3 years old
- Keeping track of the children's weight and refer malnutrition cases to higher care centres
- Enrolling malnourished children in the Bhagyalakshmi scheme (only for the BPL card holders)
- Identifying sick children and refer them to higher care center for treatment under the "Bala Sanjeevini" program
- Conducting Balavikasa Samithi meetings
- Identifying healthy children and showcasing them in baby shows

2.4 GAPS IN COORDINATION

Although all three FLW groups were supposed to be working towards the same goal - improving MNCH - one of the key gaps that was noted in the field was the lack of coordination between them. This gap affected their relationship with each other as well as that with the community. In the field these three groups had created barriers between themselves, making sure they did not mix either personally or through their work. Rather than having the community needs drive them, it was their own department guidelines and personal differences that guided them. For example, age difference, varying work experiences, caste differences and being employed by different Government Departments kept these workers from being united on the ground for a common cause.

Although each group does have designated roles, focusing on collaborating and coordinating their roles would allow them to get more satisfaction out of their work. If they worked together they could channel their energy and efforts towards finding effective strategies to challenges and sharing burdens. For any program to be successful it is crucial that the stakeholders involved are sensitive to and supportive of each other. Therefore, while each group of FLWs has to take care of their own responsibilities, they also need to understand the responsibilities of other groups and to build effective coordination on the ground. This could create an enabling work environment for all FLWs. Working together in a coordinated manner can also help them take a united stand when faced with hurdles like non-supportive community members and families.

2.5 GAPS IN COMMUNITY SUPPORT AND ENGAGEMENT

Engaging the community in planning and monitoring health service delivery is central to enhancing the availability, accessibility, quality and use of the public health system. The NRHM has positioned community ownership as central to its strategy, primarily through the Village Health, Sanitation and Nutrition Committee (VHSNC). The VHSNCs are village-level bodies comprised of key stakeholders who serve as a forum for village planning and monitoring. VHSNCs were formed to ensure that no section of the village community is excluded from services; to prepare a village health plan to suit local realities and necessities; to provide monitoring and oversight to all village health activities; and to ensure that untied funds are appropriately used for improving maternal and neonatal health in the village. Facilitative monitoring and support to FLWs through VHSNCs to better MNCH outcomes is a feature of strengthening community accountability. As well as the VHSNCs, in Karnataka, Arogya Raksha Samitis (ARS) have been established as sub-committees of the Public Health Planning and Monitoring Committees to provide community oversight at the facility level.

A review of the existing community based bodies, their current functions, and the existing gaps and challenges suggest poor knowledge about health systems and procedures among the members, poor understanding of their role in the community, especially with regard to MNCH, and an absence of tools to help VHSNC members to systematically support the monitoring processes. Additionally, there was a felt need to change the perception of monitoring among the VHSNC members of being authoritative, probing and supervisory, to being supportive, participatory and facilitating.

Under Sukshema, as part of the community interventions, the Supportive Community Monitoring (SCM) intervention was designed, piloted and implemented in order to address the above gaps. This intervention helps sensitize and strengthen the existing community structures as envisaged by NRHM, which would in turn strengthen community monitoring at the village levels. The SCM intervention contributes to this process by assisting the VHSNCs to systematically and periodically assess and reflect on the key MNCH and health related indicators and processes around service delivery in their areas. This in turn contributes to their planning and ownership of the health system delivery processes on the ground.

Another key expected outcome form this process is to bridge the widening gaps between the community structures and the health service delivery mechanisms at the village level. The Sukshema project believes that improved supportive community monitoring could lead to building mutual trust between the FLWs and the community representatives, and encourage them to take joint responsibility of improving MNCH outcomes. Every village has VHSNCs in place as per the mandate of the NRHM. To form an SCM a six-member group should be selected and approved that includes the VHSNC president, representatives of FLWs, representatives from women's and youth groups, and people from the SC/ST community. In Karnataka, the NRHM has also engaged non-government organisations (NGOs) in building the capacities of these community structures. KHPT is one of these NGOs, working in Bagalkot and Koppal to build VHSNC capacity through the Samartha project.

3. INTERVENTION THEORY AND APPROACH

In line with the Foundation's MNH strategy, the Sukshema project has prioritized technical interventions and solution levers. Through piloting and field testing of innovations and adaptations, and scale up at all levels, the Sukshema project aims to improve MNCH outcomes in northern Karnataka. The broad intervention approaches and strategies are represented in Figure 1.

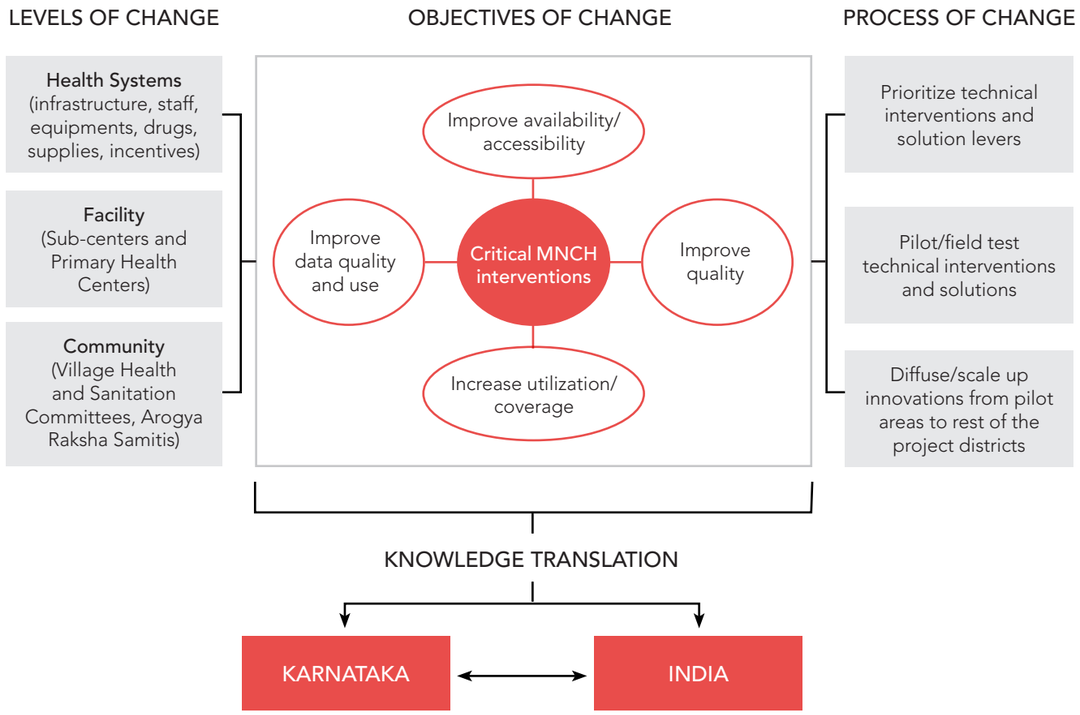


Figure 1: Sukshema intervention approach and strategy

4. SUKSHEMA'S FOCUS ON A MNCH CONTINUUM OF CARE

MNCH represents one of the greatest areas of global inequities in health, with disparities both across and within regions. Each year far too many women and infants die from causes that are both preventable and easily treatable. Yet effective interventions exist that can be delivered through well-functioning health systems, along the MNCH continuum of care. These interventions can significantly reduce maternal and neonatal morbidity and mortality.

These interventions can be broadly grouped into the following main categories: comprehensive family planning; skilled health care for women and newborns (antenatal care, quality delivery care with a skilled birth attendant, emergency obstetrics and neonatal care, postnatal care and essential newborn care); safe abortion services (where abortion is legal); and improved childhood nutrition. Sukshema's interventions and the location of the intervention (facility, community or both), are indicated in Figure 2.

The MNCH continuum of care extends from pre-pregnancy to the postnatal period and up to 12 months of age for the infant and up to 5 years for a child. However, extra focus has been given to interventions at the time of delivery and the period from 48 hours to 1 week after birth. This period represents a critical time where more than half of maternal and neonatal deaths occur. Additionally, the success of the Janani Suraksha Yojana (JSY) scheme in northern Karnataka has led to an increase in facility-based deliveries predominantly at primary health centres (PHCs), which has overburdened facilities and compromised quality of delivery and neonatal care. With over 80% of pregnant women now delivering in facilities, the project has also prioritized interventions that specifically target improved MNCH care at the facility level. The need to strengthen existing critical skilled birth and postnatal care services at PHC level is essential and very timely given the local context and shift towards facility based delivery; failure to do so will result in a critical lost opportunity to improve MNCH.

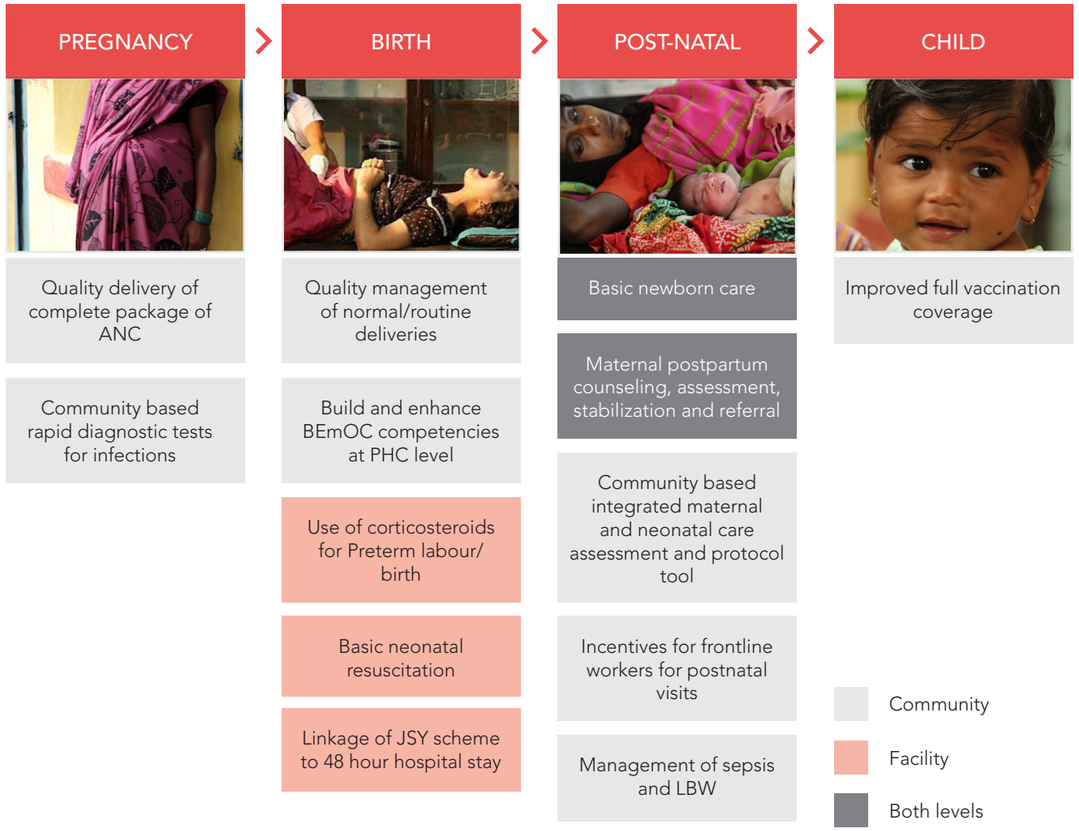


Figure 2: Interventions across continuum of care

5. SUKSHEMA'S TECHNICAL INTERVENTION PACKAGE

A key to the Sukshema project is the selection of a critical technical intervention package that is relevant to the local context and is based on strong evidence. This technical intervention package forms the basis for the improvements in MNCH that the project wishes to attain, and represents the "what" of the project. It consists of two types of interventions:

1. Primary – interventions that have been prioritized to be included in the Sukshema project due to: (a) strong evidence; (b) need for the intervention in project districts driven by current levels of utilization and coverage; and (c) fit with the Foundation's priorities; and
2. Innovations – interventions that are either new to Karnataka or need to be adapted to the local context.

After examination and discussion of the evidence from baseline surveys and secondary data, a list of possible technical interventions was prepared. The technical interventions were prioritized for inclusion if they met all of the following criteria:

- Strong evidence of effectiveness in improving MNCH outcomes (morbidity and mortality);
- Need (poor coverage) for the intervention;
- Intervention a priority for NRHM and the GoK;
- Intervention a priority for the Foundation;
- Minimal duplication of the intervention with other programmes; and
- Feasible and scalable implementation in the local context.

The technical interventions that make up the critical package were selected because they represent a group of proven and innovative interventions that collectively address the most pressing gaps in current MNCH services in northern Karnataka. Therefore, these interventions are likely to produce the greatest improvement in MNCH outcomes in the area. Table 2 shows the level of change expected, the objective of the change and the critical gaps that fit within the solution categories.

TABLE 2: CRITICAL GAPS/BARRIERS AND SOLUTION CATEGORIES

Levels of change	Objectives of change	Critical gaps/Barriers	Solution categories
Health systems	Enable expanded availability and accessibility of critical MNCH interventions for rural populations	• Inadequate distribution of facilities and staff across populations and geographies • Inadequate availability of supplies and equipment • Inadequate access for the rural poor to specialist services for delivery and newborn care	1. Influencing policy and planning 2. Improving capabilities of and tools for health providers 3. Engaging community in planning and monitoring 4. Shaping demand 5. Strengthening data management and use
Facility	Enable improvement in the quality of MNCH services for rural populations	• Weak clinical, managerial, and administrative competencies inhibit the ability to deliver critical health interventions and services	
Community	Enable expanded utilization and population coverage of critical MNCH services for rural populations	• Limited awareness of available services and incentives for maternal and newborn health • Cultural practices and beliefs that determine health seeking behaviour • Poor community engagement in exercising rights to quality services • Poor coverage of target populations for MNCH services– unreached target populations and reached by incomplete package of services	
Cross-cutting	Improve data quality and use	• Poor data quality and analytical skills weaken programme management delivery and improvement	

6. SOLUTION CATEGORIES AND LEVERS

6.1 PRIMARY AND INNOVATIONS SOLUTIONS

The solution levers represent the "how" of the package, i.e. these are the activities that need to be undertaken for effective implementation of the technical package. These solution levers address critical gaps and have impacts across several project objectives and technical foci. Two types of solution levers are envisaged:

1. Primary – solution levers that have been shown effective in India or elsewhere, that can be readily integrated into existing platforms and taken to scale quickly.
2. Innovations – solution levers that have less evidence to support their effectiveness, and that would need to be applied in a significantly novel way, or that involve a fundamentally different operating model. These solution levers would need targeted creation of infrastructure or new capabilities and would need to be pilot tested for feasibility of implementation and/or effectiveness.

Within each solution category, specific solution levers have been identified as key. The coloured areas in Table 3 represent community interventions, many of which are innovations.

TABLE 3: SPECIFIC SOLUTION LEVERS

1. Influencing policy and planning	2. Improving quality of care at birth and immediate postpartum care at facilities	3. Improving management and delivery of outreach services and shaping demand	4. Strengthening accountability	5. Strengthening data management and use
(1) Facilitation of policy changes that respond to critical issues related to infrastructure, staff, supplies and financial incentives (2) Improvement of public-private partnerships	(3) On-site mentoring for improved clinical care and service delivery	(4) Micro-planning tools and methods to ASHAs and ANMs to improve coverage (5) Integrated maternal and newborn management tools to improve identification and actions for postnatal danger signs (6) Family focussed communication tools and materials to use with families to influence awareness and practices	(7) Community monitoring tools for VHSNCs	(8) Development and implementation of data quality controls and audits (9) Development and implementation of protocols for data analysis and use for programme review, planning and problem solving

6.2 SUKSHEMA'S COMMUNITY INTERVENTION OBJECTIVES

Sukshema community interventions are designed and implemented with the following objectives:

1. To increase ***the frequency and quality of interactions*** between beneficiaries and FLWs.
2. To ensure that <u>all</u> pregnant and postpartum women, newborns and infants ***enter*** into the MNCH care continuum.
3. To ensure that <u>all</u> pregnant and postpartum women, newborns and infants ***continue*** in the MNCH care continuum.
4. Enhance participation of community-level structures in ***supporting and monitoring*** the utilization and coverage of MNCH services.

7. SUKSHEMA'S TOOLS TO IMPROVE MNCH SERVICES

A critical gap in monitoring and planning coverage for services through the MNCH continuum of care was that there were no tools and aids available for FLWs to map and track pregnant women and children. The existing tools available did not provide an integrated approach to the health of the mother and the baby and there was no focus on the FLWs to be change agents to encourage improved MNCH practices in the community. There were also no tools that could aid FLWs to screen for danger signs among mothers and newborns and to quickly link them to skilled care when needed.

To improve the coverage for routine maternal and newborn services, particularly for the SC/ST and poor families, the Sukshema project designed interventions and developed tools and aids in consultation with the FLWs to help make these interventions successful.

First of all, family-focused communication (FFC) is an intervention to improve the engagement and communication with community members, be it pregnant women, families or children. It aims to build rapport and trust so that the knowledge shared by the FLWs can be translated into positive behaviour change among the community members. For this to happen, every FLW needs to be trained on personality development and communication skills including convincing, persuading and positive authority over her target audience to build enabling environments. FFC Tools and behaviour change communication (BCC) materials include a diary, calendar with story-line messages on birth planning and emergency preparedness, and reminder cards – a set of cards with key messages used during home visits. Module 4 gives more details about the FFC Tools.

Secondly, an intervention designed to improve the enumeration and tracking of pregnant women was developed to improve planning for outreach services and coverage. The Community Demand List (CDL) Tool is a visual aid that replaces multiple registers, reduces manual entry of columns and is easy to carry. Using this tool, the ASHA will be able to list all the target population (pregnant women, recently delivered women and the newborns) in her allotted geographic area in a particular month, and track the same during pregnancy, delivery, 42 days post-delivery and nine months of immunization of the newborn. It will identify gaps in reaching target populations to help her plan activities accordingly, while being able to prioritise services due to selected risk and vulnerability factors such as age, caste, poverty level, migration, gravida, complications in previous pregnancies, and previous place of delivery. Module 5 gives more details about the CDL Tool.

The third intervention and tool was designed to improve comprehensive home based care through identification of complications and knowledge about suitable remedial measures. The Home Based Maternal and Newborn Care (HBMNC) Tool can improve the quality of interactions between the ASHA and the pregnant/recently delivered woman and the newborn during the antenatal and postnatal periods. It helps ASHAs remember to seek certain information from the mother about herself or the newborn. The HBMNC Tool captures the health status of the pregnant/ nursing mother in the same format as the health centre, which helps the ASHA to track important care services. Module 6 gives more details about the HBMNC Tool.

Lastly, the supportive community monitoring (SCM) intervention and tool addresses the following gaps: lack of community platforms for planning and monitoring village health programs; the negative perception that monitoring is authoritative, probing and directive; the lack of ownership and accountability of the village health programs in general and MNCH issues in particular; and the widening gap between needy communities and the health service system. The Supportive Community Monitoring (SCM) Tool focuses on the VHSNC members and encourages discussion with ASHAs, AWWs, and community representatives. It also highlights the need for VHSNC members to reflect on the gaps in support they provide to FLWs focused on MNCH, availability of health staff, sub-populations that need support, and community practices and beliefs. Module 7 gives more details about the SCM Tool.

8. IMPLEMENTATION ACTIVITIES

8.1 IMPLEMENTATION STRATEGY

The Sukshema project's community intervention implementation strategy included field testing of the tools and methods in two of the projects districts, including Bagalkot and Koppal, and then scaling-up to the remaining six districts of Bellary, Bidar, Bijapur, Gulbarga, Raichur and Yadgir, based on the learning. This also included leveraging support from the GoK departments for rolling out these tools and methods.

The recruitment and training of Resource Persons (RPs) to support the FLWs was also piloted in Bagalkot and Koppal, before being rolled out throughout the Sukshema project area. The RPs included the technical leads and managers at the central office, district program specialists, and district monitoring and evaluation (M & E) specialists.

The three-day induction training covered the following topics: introduction to Sukshema's goals, objectives, technical interventions and solution levers; services to be provided throughout the MNCH continuum of care; service delivery mechanisms; and proposed interventions at the community level for the FLWs and community structures. The training method included lectures, group work and role plays.

There was a second 3-day training that took place during June 2012 for FLWs on all the components of FCC. The topics covered included: perspectives on community outreach; improving basic communication skills among FLWs; achieving coordination among all the FLWs at the village level; and skills to facilitate SC level meetings and coordination among functionaries.

8.2 DEVELOPMENT OF MATERIALS

The Sukshema project organized field testing of the developed tools and processes that would empower the FLWS to strengthen the MNCH activities in the target district. A three day tool development consultation workshop was organized that included a selected group of FLWs, ASHA mentors, VHSNC/Panchayat members, RPs, sub-district coordinators, district coordinators, the project technical leads and managers, district program specialists and district M&E specialists. The workshop participants reviewed the tools and then drafted the guidelines for use of these tools.

Selected members of FLWs were trained on how to use the tools and the initial reaction was encouraging. For example, after using the tools in the field for a few days, the ASHAs reported that the ETT tool was beginning to bring positive results with improved planning and outreach. One ASHA in Bagalkot reported that, "This is the simplest tool that we have ever used and it has drastically simplified our recording process and the burden of referring to innumerable registers has been reduced". Another ASHA from Koppal stated, *"One single woman can be tracked throughout her service cycle using this single tool. It helps us to plan our monthly home visits and also track migrant women, which had been a big challenge."*

After piloting the HBMNC Tool and the SCM Tool, the following voices reflected their usefulness. Another ASHA from Koppal said, "This training helped me to gain more clarity on the importance of prioritizing messages when we do home visits. Earlier, during each of my visits, I found myself giving the woman the same messages. This training has helped me to use it as a checklist to see if the right messages are reaching the women for the particular stage they are in." A VHSNC member from Bagalkot noted that, "Before the training we all had heard about monitoring, but we had no idea about what exactly we had to monitor to improve on MNCH in our village. The training gave us clarity on how and what to monitor."

8.3 DEVELOPING THE TOOL KIT

The aim of the Tool Kit was to develop a participatory resource that would increase the availability, accessibility, quality, utilization and coverage of critical MNCH continuum of care interventions focused on rural poor

pregnant women and their family members to improve services. Existing MNCH materials, developed through GoK programs and other development initiatives across the country, were critically reviewed by MNCH experts, KHPT staff and FLWs in the target communities. The materials adapted for inclusion in the modules of the Sukshema project's Tool Kit were then critically evaluated for relevance, applicability and usefulness to ensure that the information would be extremely relevant in the field. Then these materials were piloted.

8.4 TRAINING OF TRAINERS (TOT)

Qualified individuals who could act as Trainer of Trainers (ToTs) were identified. This group of facilitators was a mix of mid-level and senior staff who had a good understanding of the context of the field and the issues faced by FLWs. They also had experience in sharing information and transferring skills. They were trained on all six modules using the same participatory methods that they would then pass on to the FLW facilitators. FLWs who had good communication skills, a deep understanding of the context in the field, adequate knowledge of MNCH issues, and high confidence levels were chose to be facilitators.

8.5 ROLL OUT AND REACTION TO THE TRAINING

A plan to rollout the Sukshema project's Tool Kit was implemented and the results were equally as positive as with the individual tools. The FLWs were appreciative of the training opportunity, which brought all the FLWs together under one roof for the first time. The training served as an opportunity for them to understand each other's roles and challenges and encouraged mutual support for their work and their personal challenges. The training also dealt with socio-cultural issues around MNCH that helped build perspectives of the team. The following quotations highlight the positive reactions:

"In my 30 years of experience I have not attended a training of this kind. This is the first time that all three FLWs: ASHAs, JHAs and AWWs, were brought under the same roof for training. It was an excellent thing to do. We always worked in isolation and we carried our department wise differences into our work. This training helped us break that unhealthy practice" **– JHA, Bagalkot**.

"Previously, when I did home visits, my concentration was only on pregnant women and nursing mothers. At the end of this training I understood that family members also should be counselled closely as they have a great influence on women and their decisions during pregnancy and delivery" **– ASHA, Bagalkot**.

"We had very poor perception concerning MNCH issues. The training helped us see that we are working for women and not for any particular government department. We are now able to identify with the issues and struggles of women and give them support and advice" **– AWW, Koppal**.

9. TOOL KIT OUTLINE

9.1 PLANNING FOR THE TRAINING

The Tool Kit was specifically developed to strengthen the capacity of the FLWs in the eight priority districts of the Sukshema project in northern Karnataka. The project has envisaged a new workforce of local level workers designated as Resource Persons (RPs). The RPs are trained on all modules in the Tool Kit and function as ToTs for the FLWs. The RPs not only train, but support and mentor the FLWs. It is expected that the newly trained and motivated FLWs will in turn build the capacities of the ASHAs working under different PHCs to help them improve the quality of their performance in providing MNCH continuum of care services to pregnant women, their families, and their community.

The Tool Kit should be used after recruiting the RPs. Each RP is in charge of one PHC which comprises of about 16-20 villages. The training will be conducted at the PHC or the SC level with approximately 20 to 30 participants in each training session. Local training venues for both residential and non-residential trainings should be identified to ensure easy travel and provide a comfortable stay for the participants to maximize their utilization of time. Travel Allowance (TA)/ Daily Allowance (DA) for the participating FLWs can be mutually agreed upon after discussion with the concerned GoK departments.

All the modules have been field tested with a variety of participants with varying literacy levels. The ToTs have ensured that the facilitators know how to present the information in each session so that all participants can absorb it verbally, or through the use of participatory facilitation methods. The role of the facilitator will be to determine what level the participants are at, and what information, and in which form, to deliver in the training. It is envisaged that medical staff, for example Medical Officers, either in the project staff or within the GoK's health department, could be leveraged as resource people for technical sessions.

9.2 REGISTRATION PROCESS

Before the training starts for any of the seven modules, ensure that every participant registers himself or herself. Each participant must enter their name, designation, place of work, contact number and signature in a register provided at the entrance to the training hall. Once the participant finishes entering these details, the facilitator or an assistant will distribute the training kit with a note pad, pen, and handouts of the reading material to the participants and guide them inside the hall. The facilitators need to ensure that all the participants complete the registration process.

9.3 THE SEVEN MODULES

The Community Level Interventions for Improving Maternal, Neonatal and Child Health Tool Kit is a series of seven modules:

Module 1: Design, Planning and Implementation of the Sukshema Project
Module 2: Core Concepts of Maternal, Neonatal and Child Health
Module 3: Sukshema's Community Level Interventions
Module 4: Communication and Collaborative Skills for Front Line Health Workers
Module 5: Improving the Enumeration and Tracking Process
Module 6: Home Based Maternal and Newborn Care
Module 7: Supportive Community Monitoring

Module 1: Design, Planning and Implementation of the Sukshema Project is aimed at Resource Persons (RPs) and other developmental professionals working in the area of Maternal Neonatal and Child Health (MNCH). It gives the background of the Sukshema project and its intervention theory and approach to MNCH in reducing the infant mortality rate (IMR) and the maternal mortality rate (MMR) in eight northern districts of Karnataka. It highlights the main strategies in the project aimed at enhancing the community's engagement in improving outreach, increasing demand for MNCH services and building accountability and transparency in the service delivery systems in the field. The module explains the participatory development of tools, approaches, and training of trainers (ToTs) processes. For facilitators it gives an overview of sessions included in the seven modules of the Tool Kit, including a suggested time frame. It also sets the stage for training with guidance on facilitation, including preparation, process management, resource management, and human relations. The section 'Getting Started: Doorway to Successful Training' should always be used to start a training workshop: initially if covering all modules at one time, or as a refresher if modules are scheduled over a period of time. It contains a set plan of sessions that set the stage for the workshop activities and logistics, covering welcome, introductions, objectives, hopes and fears, and ground rules.

Module 2: Core Concepts of Maternal Neonatal and Child Health trains the resource persons (RPs) employed by the Sukshema project on technical information on the maternal neonatal and child health (MNCH) continuum of care. This continuum includes four stages: Antenatal care – care during pregnancy; Intra-natal care – care during the delivery and first two hours after the delivery; Post-natal care (mother and newborn) – care during the first 42 days; and Child care – care of the child up to year 5. The training sessions details critical issues in the MNCH continuum of care's four stages and lays the foundation and understanding of related concepts and medical terminologies among the front line health workers (FLWs), including the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW).

Module 3: Sukshema's Community Level Interventions is aimed at Resource Persons (RPs) to provide an overview of the community level interventions planned under the Sukshema project. Enhancing communication is highlighted in the family focused communication intervention and the enumeration and tracking intervention seeks to bridge the gaps that occur in the Maternal Neonatal and Child Health (MNCH) continuum of care. Two other tools are introduced: one to improve the quality of interaction during home based care, the Home Based Maternal Newborn Care (HBMNC) Tool; and the other to enhance planning, accountability and monitoring of health service delivery through the Supportive Community Monitoring (SCM) Tool. This module also gives participants the opportunity to clarity roles and responsibilities of a number of field level workers in the Sukshema project and in the Government of Karnataka (GoK) health service.

Module 4: Communication and Collaborative Skills for Front Line Health Workers focuses on the Junior Female Health Assistant (JHA), the Accredited Social Health Activist (ASHA), and the Anganwadi Worker (AWW), the three groups that are key front line health workers (FLWs) in the Sukshema's project. The module will lead them through sessions that will enhance their understanding about: gender and social issues related to the acceptability and access to Maternal Neonatal and Child Health (MNCH) continuum of care services; the importance of focussing on the family as a unit for bringing about desired changes related to MNCH practices; and addressing the gaps in coordination among FLWs in the field. Overall the module aims to improve communication skills during outreach and interactions with the pregnant woman, her family and the community through Family Focused Communication (FFC) Tools, which can help FLWs value themselves and their work, both when working independently or in a group.

Module 5: Improving the Enumeration and Tracking Process enhances the capacities of the Accredited Social Health Activist (ASHA) and the Junior Female Health Assistant (JHA) to identify, register and track all pregnant women in her area across the Maternal Neonatal and Child Health (MNCH) continuum of care. One of the key challenges identified in the field was the absence of effective enumeration and tracking tools. This led to gaps in the number of pregnant women accessing the full extent of services throughout the MNCH continuum of care service. The Community Demand List (CDL) Tool was developed specifically to identify which women in a specific area should be given what services and when the next service is due. The practical hands-on introduction to this tool should improve utilization of all MNCH services by all pregnant or recently delivered women and their newborns.

Module 6: Home Based Maternal and Newborn Care is a training module for Accredited Social Health Activists (ASHAs) developed to enhance their communication skills and quality of homes visits. Once the ASHAs complete the enumeration and tracking of their area, they have the responsibility to ensure that all services reach the beneficiaries. It is the ASHAs' prerogative to reach out to the mother and child through home visits to deliver information, create awareness, identify symptoms of risk early and make timely referrals. In this context the quality of home visits conducted by the ASHAs need to result in bridging the information gap to a greater extent and bring about the expected results mentioned above. This module aims to specifically improve the capacities and the skills of the ASHA to conduct effective home visits by using the Home Based Maternal Newborn Care (HBMNC) Tool.

Module 7: Supportive Community Monitoring (SCM) aims to develop the capacity of the members of the Village Health and Sanitation Nutrition Committee (VHSNC). These members are tasked with providing support to the front line health workers (FLWs) in their village, monitor service access and delivery, as well as participate and share responsibility to improve the Maternal Neonatal and Child Health (MNCH) outcomes and general health status of their village. The module is intended to help the VHSNC members understand the concept of supportive community monitoring as opposed to authoritative supervision. It aims to help VHSNC representatives engage the community in planning and monitoring health service delivery to enhance the availability, accessibility, quality and use of the public health system. Through the formation of a smaller group of active Supportive Community Monitoring (SCM) members who are trained to carry out specific roles and responsibilities, this can be achieved. These SCM members will be trained to use a SCM Tool that allows them to conduct a regular joint reflection process, leading to community monitoring and evaluation of health delivery systems on the ground.

9.4 TOOL KIT TRAINING SCHEDULE

The Tool Kit modules have been envisaged, designed and piloted in the field as an interrelated package of information. For effective results it is recommended that each module is presented as part of the entire Took Kit, and not in isolation. However, although a detailed outline of the Modules and the Sessions is presented below, there is scope for facilitators to adapt this training depending on the profile, background, literacy level of the participants and overall context of the training environment.

The proposed training schedule is as follows:

Module 1: Design, Planning and Implementation of the Sukshema Project
The training sessions of Module One starts at Chapter 11 (Getting Started).
The preliminary chapters 1-10 serve as introduction to the tool kit.

1. Introduction
   1.1 Background of the Sukshema Project

2. Gaps in MNCH services
   2.1 Gaps in awareness and gender
   2.2 Gaps in coverage and outreach
   2.3 Gaps in roles and responsibilities
   2.4 Gaps in coordination
   2.5 Gaps in community support and engagement

3. Intervention theory and approach

4. Sukshema's focus on a MNCH continuum of care

5. Sukshema's technical intervention package

6. Solution categories and levers
   6.1 Primary and innovations solutions
   6.2 Sukshema's community intervention objectives

7. Sukshema's Tools to improve MNCH services

8. Implementation activities
   8.1 Implementation strategy
   8.2 Development of materials
   8.3 Development of the Tool Kit
   8.4 Training of Trainers (ToT)
   8.5 Roll out and reaction to the training

9. Tool Kit Outline
   9.1 Planning for the training
   9.2 Registration process
   9.3 The seven modules
   9.4 Took Kit training schedule

10. Facilitation approach and process
    10.1 Qualities of a facilitator
    10.2 Roles and capacities of a facilitator
    10.3 Facilitation skills
    10.4 Preparing for the training
       10.4.1 Preparation
       10.4.2 Process management
       10.4.3 Resource management
       10.4.4 Human relations management
10.5 Energizers

10.6 Recap sessions and evaluation activities	
11. Getting started 11.1 Doorway to successful training Welcome participants Introductions of participants Objectives of the workshop Hopes and fears Ground rules for the workshop	3 hours

Module 2: Core Concepts of Maternal, Neonatal and Child Health	
Session 1: Understanding MNCH continuum of care	2 hours 30 minutes
Session 2: Antenatal care (ANC)	2 hours 30 minutes
Session 3: Delivery / intra-natal care	3 hours
Session 4: Post-natal care (PNC)	3 hours
Session 5: Child care	3 hours
Session 6: Critical issues in MNCH continuum of care	1 hour
Session 7: Post-test and training evaluation and feedback	30 minutes
Total time for Module 2	**15 hours 30 minutes**

Module 3: Sukshema's Community Level Interventions	
Session 1: Understanding Sukshema's community level interventions	1 hour
Session 2: Enhancing communication and coordination using family focused communication	2 hours
Session 3: The Arogya Mantap - providing space for collaboration and discussion	30 minutes
Session 4: Bridging gaps in MNCH continuum of care through enumeration and tracking	1.5 hours
Session 5: Improving the quality of interaction in providing home based maternal, neonatal and child care	1 hour
Session 6: Enhancing accountability through supportive community monitoring	2 hours
Session 7: Staff structure, roles and responsibilities and drawing-up an action plan	1 hour
Session 8: Training evaluation and feedback	30 minutes
Total time for Module 3	**9 hours 30** minutes

Module 4: Communication and Collaborative Skills for Front Line Health Workers	
Session 1: Underlying causes of mother and infant mortality	1 hour 30 minutes
Session 2: Understanding family focused communication (FFC)	1 hour 30 minutes
Session 3: Enhancing communication skills: five activities for FLWs	4 hours (for all 5 activities)
Session 4: Understanding women and their status in the society	1 hour 30 minutes
Session 5: Power walk	1 hour 30 minutes
Session 6: Developing different perspectives	45 minutes
Session 7: Maternal and child care: Then and now	1 hour
Session 8: Coordination and collaboration in the field	4 hours 30 minutes (for all 6 activities)
Session 9: Training evaluation and feedback	30 minutes
Total time for Module 4	**16 hours 45 minutes**

Module 5: Improving the Enumeration and Tracking Process	
Session 1: Community outreach for MNCH continuum of care	1 hour
Session 2: Critical role of job aids and Tools in outreach	1 hour
Session 3: Challenges in outreach	1 hour
Session 4: Introduction & practice of the Community Demand List (CDL1)Tool	2 hours
Session 5: Introduction and use of the Community Demand List (CDL2) Tool	1 hour 30 minutes
Session 6: Vulnerable groups: identification and problem solving	2 hours
Session 7: Training evaluation and feedback	30 minutes
Total time for Module 5	**9 hours**

Module 6: Home Based Maternal and Newborn Care	
Session 1: Maternal, infant and child mortality	30 mins
Session 2: Stages of service delivery	1 hour
Session 3: Front line health workers: providing MNCH continuum of care services	1 hour
Session 4: The HBMNC Tool:providing quality MNCH continuum of care services	1 hour
Session 5: Using the HBMNC Tool – Section 1 Identification	1 hour
Session 6: Providing ANC services	1 hour
Session 7: Using the HBMNC Tool – Section 2 ANC	1 hour
Session 8: Providing Intra-natal (Delivery) care services	1 hour
Session 9: Using the HBMNC Tool – Section 3 Delivery	1 hour
Session 10: Providing PNC services	1 hour
Session 11: Using the HBMNC Tool – Section 4 PNC	1 hour
Session 12: PNC home visits: Health education and counselling	1 hour
Session 13: Introducing IEC materials	30 minutes
Session 14: Practical use of the HBMNC Tool	2 hours
Session 15: Training evaluation and feedback	30 minutes
Total time for Module 6	**14 hours 30 minutes**

Module 7: Supportive Community Monitoring	
Session 1: Sharing knowledge and purpose	30 minutes
Session 2: Critical MNCH issues	1 hour
Session 3: Understanding the importance of the SCMT	1 hour
Session 4: Modalities, role and responsibilities of the SCMT	1 hour
Session 5: Understanding the SCM Tool	2 hours
Session 6: Selection of a SCMT convener	45 minutes
Session 7: Responsibilities of the SCMT members	30 minutes
Session 8: Drawing up a SCMT action plan	1 hour 15 minutes
Session 9: Quiz and training evaluation and feedback	30 minutes
Total time for Module 7	**8 hours 30 minutes**

10. FACILITATION APPROACH AND PROCESS

10.1 QUALITIES OF A FACILITATOR

Almost anyone can become a facilitator as long as they have the ability to acquire the right attitudes, behaviours, knowledge, and facilitation skills, and be able to apply these confidently in a workshop focused on MNCH.

Ideally, facilitators should:

- Speak the local language of the participants
- Understand the culture of the participants and the social context
- Be willing and interested in learning from the participants
- Have a basic knowledge of MNCH services and activities
- Be committed to improving the MNCH continuum of care services
- Have an open attitude to using participatory training activities/tools to fully involve and engage participants
- Be able to plan, monitor, and evaluate the training process, or be able to acquire these skills

10.2 ROLES AND CAPACITIES OF A FACILITATOR

Roles of a facilitator

A facilitator needs to perform several roles effectively and efficiently:

- **Planner:** Need to be familiar with the topic, session plans, materials and training process in advance to ensure that the objective of each training session is achieved.
- **Advocate for participation:** Need to encourage and elicit active participation of all participants to build their capacity in all areas of improving the MNCH continuum of care services.
- **Trust builder:** Need to build trust between participants and yourself, as well as between different participants and groups who may have different viewpoints and priorities, such as the FLWs.

Capacities of a facilitator

Knowledge and skills:

- Knowledge of MNCH and basic services. Facilitators should be able to provide basic and accurate information about the current situation for specific populations and how to improve outreach and increase demand for services in the field.
- Knowledge of a range of examples to illustrate the relevant social context and how to build accountability and transparency in the MNCH service delivery systems in the field to create a strengthened environment.

Attitudes and Behaviours:

- Perhaps the most important quality of a facilitator is that they acknowledge the importance and benefit of mobilizing the participants so that they want to develop the knowledge and skills necessary to carry out their job duties.
- A facilitator should also commit themselves to the principles of participation so each of the participants can fully explore their role in providing quality MNCH services.
- Facilitators should model attitudes and behaviours that are empowering rather than disempowering, enabling rather than dominating, participatory rather than excluding, flexible rather than rigid.
- There are many factors that encourage or inhibit a participant from fully taking part in workshop activities, such as language, experience speaking in public, and experience related to the topic.
  - Some FLWs have attended very few training programs. Even if they have attended a workshop/meeting, it probably would have been a traditional situation where there would have been minimum opportunity for participation in the process. The current training program is designed to be participatory in its approach.
  - Power relations related to people's social and economic position in the community can also have an effect and may affect a person's capacity to fully speak up and out during a workshop.
- To correct and balance such situations, a facilitator must create an environment that is conducive to open discussion, sharing of experiences, and asking and answering personal questions. He or she must create an atmosphere in which everyone feels respected, safe, and encouraged to share their true views, and to listen to, respect and interact with others who might have diverging views.
- To ensure learning:
  - Use the local language as much as possible. Introduce any medical terms in English, but explain them using the local terminologies.
  - Consolidate the learning at the end of each activity, session or day. Encourage participants to describe what happened, how they felt, or reacted to it; how does it relate to their work; and how they may apply it in future.

10.3 FACILITATION SKILLS

Active listening: This means more than just listening. It means helping people feel that they are being heard and understood. Active listening encourages participation and a more open communication of experiences, thoughts, and feelings. In active listening, the person listening:

- Uses body language to show interest and understanding. In most cultures this will include nodding the head and turning the body to face the person speaking.
- Uses facial expression to show interest and reflect on what is being said. It may include looking directly at the person speaking. In some cultures such direct eye contact may not be appropriate until some trust has been established.
- Listens to how things are said by paying attention to a speaker's body language and tone of voice.
- Asks questions to show a desire to understand.
- Summarizes and re-phrases the discussions to check on an understanding of what has been said and asks for feedback.

Effective questioning: This is essential in training or facilitating as effective questioning increases people's participation in group discussions and encourages their involvement in problem-solving. In effective questioning, the person asking questions:

- Asks open ended questions, for example using the six key "helper" questions: Why? What? When? Where? Who? and How?
- Asks probing questions by following up people's answers with further questions that look deeper into the issue. Continually asking "but why…?" is useful for doing this.
- Asks clarifying questions to ensure they have

understood. This can be done by re-wording a previous question.
- Asks questions about personal points of view by asking about how people feel and not just about what they know.

Facilitating group discussion: This increases the participation of all group members and ensures that a range of community perspectives and interests are included. Good facilitation skills help to improve the quality of group discussion and problem-solving. Facilitators can also help build consensus where necessary, and encourage participation and ownership of MNCH issues. When facilitating group discussions facilitators:

- Introduce themselves and the purpose and nature of the session to participants.
- Ask each person in the group to introduce themselves to each other.
- Ensure that everyone is comfortable and can see and hear each other.
- Agree with the participants on the aims of the session and how much time is available.
- Agree on 'ground rules' with participants, including the need to respect opinions and confidentiality.
- Agree with the participants on how the discussion will be recorded and what will happen to this record at the end of the session. Remember: this is 'their' process, not yours – allowing them to keep the drawings and diagrams from the session increases their sense of ownership in the process. However, taking notes and keeping copies may prove useful later.
- Help the participants to remain focused on the agreed aims of the session.
- Enable all group members to contribute to the discussion by paying attention to who is dominating discussions and who is not contributing (remember that people have different reasons for being quiet – they may be thinking deeply).
- Summarize the main points of the session and any action points that have been agreed upon.
- Thank the participants for their time and contributions and, if appropriate, agree on a time and place for a further meeting.

Parking lot: Introduce the concept of a 'parking lot'. Put a blank sheet or flip chart paper titled 'Parking Lot' at the front of the training room. Encourage participants to use the sheet to write/post issues and questions that arise during group discussion or in any module sessions. The parking lot list allows space for other participants to discuss any listed issue during tea breaks, or lunch. Alternatively, information can be sought from other external experts or project heads and shared with all during morning recap time or afternoon evaluation periods. Ensure that all questions raised in the parking lot are answered during the training programme.

Using participatory methods and tools: Avoid didactic teaching (teacher-centred, telling facts, and assuming right and wrong answers). Instead, become familiar with participatory forms of learning. Some suggestions for including participatory methods and tools are:

For introductory sessions, when participants are just becoming acquainted, they experience tension, doubts and suspicions. A new place, new environment and new faces could inhibit their participation. So be sure to create a supportive, fun and encouraging training environment. Although participants possibly come from the same background and geographical area, and may speak the same language, they may only have a nodding familiarity with one another, and may show reluctance to acknowledge individual relationships. Therefore, a positive beginning of the training is vital for both participants as well as facilitators. It aims to bring out the background of all the participants; their interests, hobbies and talents. Without reducing this session to mere formality for eliciting the names and contacts of the participants, the facilitator should find an innovative way to conduct self-introductions so that everyone feels like they know each other and has a better understanding of the other participants. In Session 5: Getting Started, there are a number of suggested activities to start off each module.

For awareness-generating sessions introduce the topic, then use role-plays, small group discussion, case studies, simulation, and learning games to provide an opportunity to experience the concept, share reactions and observations, reflect upon implications, and consequences, discuss patterns and dynamics, develop practical and conceptual understanding and apply it to real life situations.

- **Using a case study**
  - Note that a case study is used to offer an opportunity to participants to understand and appreciate different MNCH issues and to facilitate discussions that help them reflect and analyse real life actions, events, episodes and experiences based on their own experiences. A case study can be used to identify what went wrong in the complex situations and gain insights on how these types of incidences can be avoided in future. Multiple cases on similar situations are used to expose the participants to different dimensions of the situation/ problem and learn new concepts. However, most situations have complex backgrounds and it is not expected that participants will be able to assess all the factors that could have contributed to a particular situation. The purpose of a case study is to generate probing questions about what might have happened and to find an empowering solution.

For knowledge-based sessions start by introducing the topic, find out what the current level of knowledge is using the brainstorming technique, then use mini-lectures to present the information, backed up with audio-visual aids such as flip-charts or PowerPoint presentations. Follow-up with an exercise to practice the knowledge that was presented, then provide a handout to recap all information.

- **Using PowerPoint presentations**
  - Use PowerPoint slides for a better visual impact and as a reference point and as a base for creating a better understanding in the participants. But do not limit yourself to what is presented in the slides. Explain the medical terms that are used in the presentation thoroughly, and ensure that the participants understand the pie charts or any other statistics.
  - Add as much extra information as possible to help participants understand how that point is important for them to understand in the context of their responsibility to motivate the ASHAs and JHAs to provide better service and ensure that the maximum number of pregnant women access the complete package of MNCH care services.

For skills-based sessions explain and describe the skills first, followed by a demonstration, and then hands-on practice time, either in pairs or small groups, followed by group discussion of success/challenges with the process.

10.4 PREPARING FOR THE TRAINING

Before the training note that prior preparation is essential for effective facilitation. Note the four main aspects involved in conducting a training program: preparation, process management, resource management, and human relations management.

10.4.1 PREPARATION

Give yourself sufficient time to prepare for the workshop. Besides referring to the training materials, also take time to browse through relevant books, previous reports and articles to strengthen facilitation. Engage in research to keep you up to date with current issues linked to MNCH. A background study of a specific area where the Sukshema project operates in could lead to an awareness of existing gaps.

Be prepared for different skill levels of participants. Enlist the help of more proficient or literate participants to help those who are slower or who cannot write. If none of the participants can write, conduct the activity verbally and use pictorial representations or symbols to list their expectations.

10.4.2 PROCESS MANAGEMENT

Before the workshop the facilitator should read the entire module thoroughly to see how each session flows into the next and how all the activities are linked together to achieve the overall aim. If possible, conduct a small mock training program before the real workshop starts. Or, try to attend other training programs conducted by other facilitators. Make a note of how you would have facilitated the session in order to improve it and note the time keeping strategies and how to keep participants 'on track'.

In some sessions that use a 'mini-lecture' as a facilitation methodology, a facilitator 'script' is provided and the text is italicized and indented. Make sure you have read the background material on the topic so you will be prepared to answer any questions from the participants.

The facilitator should prepare materials and resources needed for each session well ahead of time. When you see that there is a PowerPoint Presentation (PPP) listed in the training materials, then a PPP can be prepared using the reading material in the annexures of the Tool Kit's Modules or the Information Guides in Module 6. Other materials to prepare might include flip charts, posters and handouts.

Each training session follows the same format and includes the following information:

- **Objectives:** What the facilitator hopes to achieve by the end of each session.
- **Methodology:** Teaching approaches and techniques used.
- **Duration:** Length of time for each session
- **Training materials:** Materials that the facilitator will use during the session
- **Tips for facilitators:** Gives extra information to help the facilitator have a successful teaching experience. These notes could include extra information on the session topic, reflection on how the session might proceed or what could be the potential questions/ concerns that are likely to be asked by a particular

audience and suggestions for replies
- **Process:** Step-by-step instructions on how to implement activities and run sessions.

To manage time, do not drag any session beyond the time allotted for it unless absolutely necessary. Frequently check to make sure the time schedule is being followed. If there is a lag in following the schedule, ask for participants support in getting back on track with the schedule and the topic. Use the "parking lot" to write and post issues that need to be considered later and not during the particular session.

10.4.3 RESOURCE MANAGEMENT

In good time before the workshop starts make sure all the logistical arrangements have been taken care of. Confirm an adequate training venue, accommodation, and food. Prior to the training make an observational visit to the venue to know more about the available facilities. If you find something lacking, you can bring it to the attention of the organizers. If you need any aides or assistants, make prior arrangements for their presence and also ensure task allocation well in advance. If any assistant facilitators or guest speakers are needed for any of the sessions, invite them early enough so they can plan and confirm their schedules.

10.4.4 HUMAN RELATIONS MANAGEMENT

Be aware that you will be the focus of attention during the training and be aware of your gestures and general conduct. During the training period, it is very important to get sufficient rest and sleep. Do not let problems or worries affect your peace of mind. Keep away from other work pressures and mentally fortify yourself to focus on the scheduled program. Begin the session with confidence and self-belief.

Starting the training program on a relaxed and positive note is an important first step. Many of the participants will have little or no previous experience of having attended any training program or workshop. Therefore it is only natural that they might be anxious or unsettled. Training programs are usually arranged in a secluded place to keep the participants from getting distracted. This means that the participants have to travel to get to the training site. The journey and the unfamiliar surroundings of the venue will probably add to their uneasiness. Therefore, it is essential that the participants must be in a proper frame of mind to be able to participate actively in the training sessions. They should be given time to refresh themselves physically and to prepare themselves mentally. The facilitators should strive to create a warm, cordial and relaxed environment so that the participants can feel at ease with their surroundings and with each other. This is just as important as the actual training that will follow. Interacting and building rapport with co-facilitators, Sukshema project staff and the participants as much as possible will prove very useful during the workshop.

Focus on building rapport with the participants by:

- Respecting participants' local knowledge and encouraging them to participate actively in small groups and make presentations.
- Acknowledging the value of the contribution by each participant.
- Listening carefully to what participants say and responding to questions, observations and remarks in a positive tone.
- Accepting even incomplete ideas and trying to develop the ideas further, or asking for clarification.
- Not pretending to know the answer of a particular question if you do not. Be frank and tell participants that you will get back to them with more information.
- Being alert to the possibilities of problems arising in the groups and being prepared to deal with them. Do not allow one participant to dominate the discussion, or interrupt it. Address this clearly, but without hurting the dominating participant. You might say: "Let's give an opportunity to someone who has not spoken yet".
- Not becoming defensive, or ignoring the participant who interrupts. Instead, acknowledge the value of their input, but request them to keep their interruptions to the minimum, in the interest of the group. Suggest that the issues they raise could be discussed at length during lunch, or tea break, or once the session has ended.
- Avoiding a judgmental attitude.
- Establishing fresh rapport with the participants before starting a new session if each session is handled by different facilitators.

10.5 ENERGIZERS

The following activities and games can be used as energizers during the workshop to change the tempo of the day, keep people alert, help all participants mix with each other and make friends, revive interest levels and to help keep participants in a relaxed frame of mind. The facilitator should always ask everyone to participate, but stop the game or activity while the mood is still jovial, and make sure there is no negative competition among the participants. None of the energizers below require any materials.

S. No	Energizer/game	When to be used	Number of participants	Time required
1.	Rhythmic Claps	This can be used to prepare the participants for the sessions, or it can be used for calling the participants attention after a break, or to bring silence whenever the proceedings become too noisy.	The entire group	5 minutes
2.	Dancing Index Finger	This can be used to break the monotony between sessions, or soon after lunch to enthuse the group.	30-35	10 minutes
3.	Who is Your Favorite?	This can be used to mix the group and to break the monotony between sessions, or soon after lunch to enthuse the group.	30-35	10 minutes
4.	Rani's Choice	This can be used after a demanding session to rejuvenate the group.	30-35	15 minutes
5.	Idli-vada-chutney-sambar	This is most appropriate as an introductory game to help participants get comfortable. This can be used to mix the group and to break the monotony between sessions, or soon after lunch to enthuse the group. It also helps in the formation of small groups.	30-35	10 minutes
6.	Imitation Game	This can be used to form small groups, or to mix the larger group and also to break the monotony.	30-35	10 minutes
7.	Game of Rules	This can be used to mix the group and to break the monotony between sessions, or soon after lunch to enthuse the group.	30-35	15 minutes
8.	Gandhi Thatha Game	This can be used to induce laughter among the participants and lighten the atmosphere.	30-35	5 minutes
9.	Basket on My Head	This can be used to make the participants alert and think up ideas and names.	30-35	5 minutes
10.	Follow the Leader	This can be used to break the monotony and helps the quieter participants to come out.	30-35	5 minutes
11.	In the River, On the Bank	This can be used in between post lunch sessions to energize the group.	30-35	5 minutes
12.	Number Acting	This can be used in between post lunch sessions to energize the group.	30-35	5 minutes
13.	Catch the Color	This can be used to help the participants to get familiar the surroundings.	30-35	5 minutes
14.	Chicken and Chimp	This can be used to get the participants physically active and to break the monotony between sessions.	30-35	10 minutes
15.	Blind Mice	This can be used in between post lunch sessions to energize the group and break the monotony.	30-35	5 minutes
16.	Chain Running	This can be used in between post lunch sessions to energize the group and break the monotony.	30-35	5 minutes
17.	Dance to the Beat	This can be used to help the participants open up and break the ice.	30-35	5 minutes
18.	What-ho, How-much?	This can be used to form small groups, or to mix the larger group and also to break the monotony.	30-35	5 minutes
19.	Chitty Chitty Bang Bang	This can be used to make the participants alert and break the monotony.	30-35	5 minutes

Rhythmic Claps

As a relaxation exercise, this can be used to prepare the participants for the sessions, or it can be used for calling the participants attention after a break, or to bring silence whenever the proceedings become too noisy. Begin clapping after saying, "OK one, two, three clap". The group will begin by clapping their hands twice followed by three continuous claps and repeat the latter three times. Conclude with two short claps: (Tuk tuk- tuk tuk tuk; Tuk tuk- tuk tuk tuk; Tuk tuk- tuk tuk tuk; Tuk tuk!)

Dancing Index Finger

Ask participants to stand in a circle. The facilitator will tell the group to do as she does and say what she says. She will then lift up the right hand and draw attention to the index finger by folding the remaining fingers. Now twist and turn the index finger and tell the group that the finger is dancing. The entire group will follow suit to the accompaniment of the thakadimi-thakajanu tune and others will provide the chorus.

Next she will unfold the thumb and tell the group that the thumb is also dancing with the index fingers. This should be imitated by the group, again accompanied by singing of the thakadimi-thakajanu tune. Follow on with the left hand, first with the index finger and then the thumb joining in. After the group follows suit, the thumbs and index fingers of both hands should be dancing. Gradually let the body dance to the rhythm of the thakadimi-thakajanu tune.

Who is Your Favourite?

The participants will stand in a circle and each of them will draw a smaller circle around themselves. One participant must volunteer to stand in the middle of the large circle while the facilitator takes her place in the outer circle. The facilitator must now ask the participant in the middle the question, "Who is your favourite?" The participant must choose her favourite by indicating something worn by other participants. For example, she can say, "Those wearing watches are my favourite.", and all those participants wearing watches must change their place and go into someone else's place. Other favourites could include red saris and glass bangles. Each time, one participant will be left without a vacant spot and will assume the role of the facilitator in the middle to continue the game. Encourage participants to be quick in thinking and responding. If chairs are available they may be used for participants to play the game while seated instead of standing.

Rani's Choice

Invite one of the participants to come forward and declare her for the role of the Rani or Queen. The facilitator will act as the Minister to the Rani. Draw a fairly large circle around the Rani and say that nobody is allowed to come inside that circle. The remaining participants will form 4 groups. They have to please the Rani by bringing simple objects desired by her and hand it over to the Minister. Each time the Rani desires something, the group bringing the desired object at the earliest will get a point. After playing the game for a while, analyse why a certain group got more marks while others got less. Explain the need for creativity combined with intelligence. Note: Before starting the game, the facilitator can brief the participant playing the Queen to start the game asking for simple things inside the room or hall. For example, one pink chart paper, four black hair clips, a pair of brown slippers and so on. Some of the commonly desired objects may be brought from outside the hall as well.

Idli-vada-chutney-sambar

Divide the participants into four groups and name the groups as Idli, vada, chutney and sambar, which are all types of south-Indian food. Ask the members of each group to hold hands and then form a circle. Now the facilitator narrates a story in which the names idli, vada, chutney and sambar are repeated randomly. Each time this happens, the particular group while continuing to hold hands, should also sit down and immediately get up. This should be repeated every time the name of the group figures in the narration of the story. This exercise is continued till the ice is broken and everyone is smiling. Note: This doesn't have to be a full-fledged story, but can also be a spur of the moment spiel. For example, "My wife, children and I went to a hotel and asked the waiter for the menu. He told us that they had idli, vada, chutney and sambar. My wife ordered idli, vada, chutney and sambar. My son ordered for two idlis, one vada and chutney, and my daughter ordered three vadas, but refused the idlis and asked only for the sambar, but not the chutney, while I ordered two idlis and chutney."

Imitation Game

The participants will form a circle and the facilitator will count off each participant from 1 – 6 giving each a name of an animal or a bird. Tell all the participants to start moving around the room and to imitate the cries and movements of the animals or birds they have been named after. For example, if it is fish, the participants must imitate swimming; in case of frogs, the participants will jump and so on. Now the participants will be asked find a partner belonging to the same group of animals or birds. For example, the facilitator will announce that all frogs must form themselves into pairs and participants with that name will jump like frogs towards other frogs and become pairs. Similarly the facilitator can ask different kinds of birds to form pairs and so on.

Ensure that participants imitate the appropriate cries and movements throughout the period of exercise till pairs and subsequent groups are formed.

Game of Rules

Form two groups with equal number of members. Call two people from each group and ask them to stand on the spots already decided by the facilitator. Draw two lines a short distance away from the two spots and ask all other members of each group to stand behind these lines. Now ask the members on the two spots to stand facing each other and to then hold each other's hands and lift them up to form an arc wide enough to allow the other participants to run through it. When the facilitator announces "start", one participant from each group must run through the arc. Each participant in the group must complete their run, running back to their group to give a pass to the next member, who in turn must follow the same procedure. Continue till the last participant has completed the run. All participants are required to follow the following rules in this game:

1. They must run the course in front of their respective groups.
2. They should not touch anyone while running.
3. They must give a pass to the next group member in line.
4. All participants must stand behind their marked starting line.

Gandhi Thatha Game

The group is asked to form a standing circle and the facilitator should join the circle. It would be interesting if the facilitator could share a few thoughts on Mahatma Gandhi before starting the game. The rules are that the group must follow the cue provided by the facilitator. For example:
"Gandhi tata asks all of us to sit down."
"Gandhi tata asks all of us to remain standing."
"Gandhi tata asks all of us to do a slow jog."

Basket on My Head

All the participants must stand in circle. The facilitator should carry a basket on her head like a vegetable vendor and approach one of the participants and loudly announce her list of vegetables. The participant must instantly respond by naming the vegetables. If a participant fumbles while telling the names she has to carry the basket and continue the game. Now, she must go to another participant and announce that she is selling fruits and that participant will have to instantly come up with the right answers.

Follow the Leader

Select a leader from among the participants. She will start the game with an action or sound or both. Ask the remaining participants to imitate their leader. When the facilitator calls out "change", someone from the group will assume leadership and continue the game. Actions commonly include: dance steps, hunting gestures, or applying makeup. Stop the game after a couple of rounds. Encourage those who come forward when the change is announced. Continue the game until a sufficient number of participants get a chance to play the leader.

In the River, On the Bank

The participants will stand in two parallel lines, facing each other. Explain that all are standing on the riverbank and one step forward is the river. Participants will have to respond instantly to commands of "River" and "Bank". Start the game slowly and then increase speed as you vary the commands. Those who take a false step in response to the command will be out of the game.

Number Acting

Start the game by asking participants to speak aloud the numbers from 1 to 10. Next, the numbers will be written in the air by moving fingers, followed by arms, heads, and then the entire body, while both hands are placed on their waists!

Catch the Colour

The participants have to stand in a circle. The facilitator must loudly announce different colours one at a time. For each colour, the participants must rush towards their immediate surroundings and get something matching that colour. Those who fail to bring anything will be out of the game.

Chicken and Chimp

Divide the participants into two groups called Chicken and Chimp. Members of the two groups should form two parallel lines, standing about 5 feet apart. When the facilitator calls out "Chimp", the members from that group must run after the Chicken and catch them while they try to evade being caught. To make the game more interesting, the facilitator must keep suspense alive by starting with Chi.Chi.Chi…before saying either Chicken or Chimp! This not only creates confusion, but also makes participants more alert as they eagerly wait their turn either to catch or to run.

Blind Mice

Ask all the participants to close their eyes and slowly walk around like blind mice. They should not bang into each other. The facilitator must then ask the group to speed up their walking and finally ask them to run. Note: While playing this game, ensure that there are no obstacles on which participants can fall or hurt themselves.

Chain Running

Let all the participants stand apart and ask one to volunteer to start the game by running and touching another member. Now the other members must avoid being touched. Those who have been touched will hold hands and try to touch others. The chain will keep getting longer until the last person has been touched. Once a complete chain of the participants is formed, get them to sing a song while holding hands and moving around in a circle.

Dance to the Beat

Ask the participants if they would like to sing a song. Tell them that you will first start singing these words very softly: *daguchuku daguchuku daguchuku daguna dam dam dara dara dara dara dara dara dara*. Then ask the participants to raise their voice while singing these words. Then repeat the tune while holding their hands to be followed by head shakes. The activity should end with each member taking vigorous steps to the tune. All will join in the dancing and jumping with enthusiasm.

What-ho, How-much?

The participants will first stand in a circle and then jog clockwise. While they are moving, the facilitator in the middle should repeatedly ask them "What-ho, How-much?" while they respond with "As-much-as-you-say" while continuing to jog in the circle. Suddenly, the facilitator should say a number, for example 3. Instantly the participants have to break the circle and form a group with three members. Anyone who fails to do so will be out of the game before it starts again with a new number. Note: Try variations by saying "two and half" so that three members come together with two standing and one sitting.

Chitty Chitty Bang Bang

The participants stand in a circle and start saying numbers starting from 1. When it is the turn of the fifth participant, instead of saying 5, she has to say "Chitty Chitty Bang Bang", accompanied by a clap. This should be followed by every fifth participant (i.e., 5th, 10th, 15th, 20th and so on). If anyone just says "5", or "Chitty Chitty Bang Bang" without a clap, they have to leave the game. In that case, the next person is considered as the 5th person and is expected to follow the rules of the game.

10.6 RECAP SESSIONS AND EVALUATION ACTIVITIES

To ensure that the learning is lasting, at the start of each training day, recapture the previous day's learning. You can use a quiz format or any other interesting and innovative method for the recap. Then after each day of training, conduct an exercise that can give the facilitator an idea about the extent of participants' understanding as a result of the day's information. One suggestion is to have a brainstorming session at the end of each day to gather insights from the participants regarding learning and to get their opinions on and reactions to what has been presented by the facilitator. The facilitator should try to analyse this feedback as soon as possible so that the participants' likes and dislikes can be taken into consideration for future sessions.

Longer-term evaluation activities enable participants to assess both the positive and negative effects of training, focused on modules or the entire workshop. Each of the modules can be evaluated through a process designed to assess the overall influence the sessions' messages had on the participants attitudes, knowledge and practice levels. A facilitator can ask participants to reflect on a number of items including: the relevance of the topics covered; facilitation style; facilitators' use of language; space to freely express one's opinions; methodologies used; scope/level of participation; handouts and materials; adequate breaks; food; and accommodation. Evaluation is also important in collecting suggestions for future training sessions.

In this Tool Kit, each module ends with a training evaluation and feedback session using a feedback form that gathers information on a number of the identified factors above.

11. GETTING STARTED

11.1 DOORWAY TO SUCCESSFUL TRAINING

Welcome Participants

Objective

To welcome participants to the training and allow the facilitator to introduce themself and briefly explain the relevance of the training, including the importance of the participants' roles.

Methodology

Mini-lecture

Duration

30 minutes

Training Materials

Welcome signs or banners

Tips for facilitators

The training facilitator makes an introduction and shares the relevance of the workshop so that the participants have a clear view of its importance.

Process

- Display a welcome sign, a banner, or a PowerPoint slide that reads 'Welcome to the Community Level Interventions for Improving Maternal, Neonatal and Child Health Training' at the front of the training room as participants enter.
- Welcome the participants and any other guests who might be present to formally inaugurate the training workshop.
- Deliver a short lecture that gives information about the purpose in organizing the workshop.
- Encourage participants to ask questions for clarification.

Introduction of participants

Objective

To allow the facilitator to learn the names of participants and for the participants to become acquainted with each other in an enjoyable and relaxed atmosphere that builds trust and interest in each of the participants.

Methodology

Individual reflection and large group sharing

Duration

Approximately 45 minutes

Training Materials

As required depending on activity chosen

Tips for facilitators

It is important that everyone understands and respects each other as individual person with unique characteristics, so the introductions should not stop with only a name, but should be more intimate.

Process

- Start off by telling the participants that you would like to learn everyone's names, since you are going to be working together for several days.
- Initiate any one of the following activities:
  - **Activity 1:** The facilitator will ask the participants to pair up with someone seated close to them and introduce themselves to

each other. Give each pair 15 minutes to share names, where the live, information about their family and any issues concerning their work or their community that is important to them. Ask each pair to prepare a very short skit, song or poem (2 or 3 minutes) on one of these topics. Then ask the pairs to introduce each other to the group and give their presentation. The facilitator should not make any comments on the skits, songs or poems as this is for entertainment, not judgement. However, if their presentation is too long, ask the pair to cut it short.

- **Activity 2:** Each participant should be given a white postcard-sized piece of paper or card and a pen. Tell each participant to imagine that the card is a mirror. Ask them to draw an image of their face and hair on the card making it as life-like as possible, adding any distinguishing and individual features, such as moles, beards or eye glasses. Tell the participants that these cards will be collected and shuffled and then re-distributed to the group. The person getting the card then needs to find that person in the larger group. Once the two persons have found each other using the portrait cards give them 10 minutes to introduce themselves and get to know each other by asking and telling about their home town, profession, family, or friends. Have each pair introduce themselves to the larger group and tell how they managed to recognize that person from the drawing.

- **Activity 3:** Participants are asked to introduce themselves by stating their name along with an adjective that describes them. The exercise can be modified by asking participants to choose an adjective that starts with the same letter as their name. (For example, I am Simple Sarita). All subsequent participants are required to repeat the names and adjectives of previous participants before stating their name and adjective. (For example, She is Simple Sarita and I am Macho Mohan). Continue until all participants have introduced themselves in this way.

- **Activity 4:** Participants stand, or sit in a circle. Ask them to think about who they would like to be and why. They can be asked to choose from categories of famous people from history, sports, music, movies or characters who are known in the local community. Likewise they can be asked to choose their favourite fruits, colours, cartoon characters, etc. For example, if the selected category is movie actors, 'I would like to be Amitabh Bachchan because he is versatile'. If the selected category is flowers, 'I would like to be a Jasmine blossom because it smells wonderful '.

- **Activity 5:** Ask a volunteer to stand at the front of the training room with their back to the other participants. Stick one of the participant's names on the back of the volunteer. Then tell the volunteer that he/she will need guess the name of the participant that has been pasted on his/her back by asking questions to the rest of the group to guess the name. The questions can only be answered with 'yes' or 'no' (for example, 'Is this person female?' or 'Is this person working in my area?'). The volunteer may guess at any time. If he/she is correct, then the person who answered the last question will have a new name stuck on their back, and the activity continues as before. If they are wrong, they have to continue to ask more questions. Before starting the activity, agree on either a time limit or the number of questions before you change participants.

- **Activity 6:** Ask participants to run in a circle. Play music as they run. Ask them to stop when the music stops. Announce a number – for example 3, 4, 5. Participants should form groups of 3, 4 or 5, accordingly. Each time they meet in a group, they should share information about themselves. Encourage participants to form groups with new participants each time. The questions they ask of each other could include: name, designation, organization; favourite sweets; the person who motivates them the most; favourite colour and why, etc.

- **Activity 8:** Read different statements. Those who agree with these statements should come forward, form a group and introduce themselves. These statements could be: I like to watch movies; I am always late to office; I have two children; I am a slow eater; I like formal clothes, etc.

- **Activity 9:** Form two large circles with all participants - one inside the other. The participants in the inner circle should face the participants in the outer circle. Participants in the inside circle should walk in one direction and those in the outside circle should walk in the opposite direction. This way, each participant gets to face and meet a new person as the circle continues to move very slowly. When you meet a new person introduce yourself and share your area of interest.

Objectives of the workshop

Objective

To clarify the objectives of the workshop so that everyone has an understanding of the purpose and scope of the training.

Methodology

Large group discussion

Duration

30 minutes

Training Materials

Objectives listed on chart paper

Tips for facilitators

The particular module of the 'Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit' will determine which objectives the current workshop should be focusing on. For the relevant module, review each of the relevant session's aims that you intend to present in the current workshop and make a list of those objectives on flip chart paper.

Process

- Clarify that this workshop will cover material developed in the 'Community Level Interventions for Improving Maternal, Neonatal and Child Health Training Tool Kit' There are seven modules in the Tool Kit, all with a different focus.
- Display the objectives of this training on chart paper.
- Ask if there are any questions about any of the objectives.
- Display the objectives in the training room.

Hopes and Fears

Objective

To allow participants to voice their expectations and fears about participating in workshop.

Methodology

Reflection and large group discussion

Duration

45 minutes

Training Materials

Chart paper with two columns labelled 'Hopes' and 'Fears' and marking pens

Tips for facilitators

The participants may come up with a wide range of expectations, some of which may fall outside the scope of the training program. The facilitator will be responsible to clarify the scope and limitations of the workshop so that participants have a realistic view of the workshop's activities and outcomes.

Process

- Display the chart with two columns labelled 'Hopes' and 'Fears' at the front of the training room.
- Ask the group to brainstorm about what issues they want to put in each column.
- Notes their response on a flip chart.
- When the chart is filled up, go back and discuss each entry.
- Highlight any of the objectives that were discussed in the previous session and posted on the training room wall.
- Clarify any hopes that do not match with the objectives.

Ground rules for the workshop

Objective

To agree on a set of rules for the group during the training workshop.

Methodology

Large group discussion

Duration

30 minutes

Training Materials

Chart paper and marker pens

Tips for facilitators

- A core list of ground rules could include:
- Need to be punctual
- Confidentiality
- Good listening practices with only one person talking at a time
- Avoiding interrupting others
- No mobile phones in training room, or at least kept on 'silent mode'
- Respect for what others are saying…not to judge or ridicule anyone
- All trying to take part actively in discussion
- Not doing things that hurt or harm others
- Accepting that each of us has a right to change our minds
- Realising that all questions are worth asking
- Regular attendance at all sessions

Process

- Tell participants that they should agree on some ground rules, or ways of preventing any group tensions or conflicts during the workshop.
- Ask for a volunteer to write down topics while participants brainstorm ideas that they would like to include.
- Once all the rules proposed by the group are on chart paper, review them again together for clarity. Read out the rules and quiz the group on how each rule will help prevent tension or conflict during the workshop.
- Ask for a show of hands that all ground rules are unanimously agreed upon.
- Ask two participants to volunteer during the workshop to help remind the group of ground rules throughout the training workshop.
- Ask them to also: help in maintaining group co-operation and discipline; act as time keepers; and to liaise with the training team in case of problems.

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