SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION (SBCC) TRAINING

MODULE 3

FOR MID-LEVEL MANAGERS

Duration: Two Days

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सत्यमेव जयते

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FOREWORD

The Ministry of Health & Family Welfare is uniquely advantaged with an institutional structure that enables integration of social and behaviour change communication (SBCC) as a key component in health programming to achieve health outcomes. From an IEC Division at the level of the Central Ministry and parallel IEC bureaus at the State departments of health to a frontline functionary force of around 2 lakh ANMs and 9 lakh ASHAs at the community level, SBCC is recognized as critical to generating demand for health services. Diligence and dedication of this team ensures that health and nutrition counselling and communication reaches door to door in the country. Given the significant responsibility of these functionaries at various levels, understanding of SBCC and skills in interpersonal communication (IPC) is of paramount importance. As the ASHAs and ANMs interface with families, they need to have the necessary skills to negotiate correct health behaviours, and motivate families and communities to initiate, maintain and promote these behaviours.

In view of the primacy accorded to SBCC, the Ministry of Health & Family Welfare welcomes the '*Tarang*' SBCC training package developed by UNICEF in collaboration with the Ministry. The training package is not limited merely to the frontline functionaries but recognises the need for an effective pool of SBCC master trainers from within the health system to be available to build the capacity of these functionaries. It also recognises the need of frontline functionaries to have management and supportive supervision support from their senior and mid-level managers so that they can stay motivated and perform optimally. *Tarang* fulfils this need as it contains SBCC modules for master trainers, senior managers, and mid-level managers based at state, district and block levels.

A training package is ultimately as good as its utilisation. The Ministry has shared information regarding the SBCC training package with the health departments of all State governments. It is also being used currently under GAVI's health systems strengthening initiative. I look forward to the modules under *Tarang* being optimally utilised for skill upgradation for all health programs.

I heartily commend the team at UNICEF for putting together this training package.

(Dr. Rakesh Kumar)

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FOREWORD

Institutional strengthening through capacity development and skill enhancement is an important human resource strategy. It is especially relevant in light of the fact that while the Government has the required resources, appropriate policy framework, and large- scale public service and flagship programmes, what is equally important are capacities at individual, institutional and policy levels to ensure effective delivery, meet demand, and improve the reach and use of these services.

With this consideration, UNICEF in discussion with Ministry of Health & Family Welfare, has developed the '*Tarang*', social and behaviour change communication (SBCC) training package. The package comprises five modules for divergent SBCC stakeholders such as master trainers, senior managers, mid-level managers, and frontline functionaries. There is an exclusive module on social inclusion, appreciating that this is an important element in programming for change.

Since the modules are skill-based, they can easily be adapted to suit any program requirement with minor modification in examples and role plays. Thus, the package can be used for any flagship program such as the Integrated Child Development Services, *Swachh* Bharat Mission, Integrated Child Protection Services, and others. A strong communication component in these programs will enhance reach, ensure quality exchange between service providers, communities and families, and in the long run yield improved results.

UNICEF is fully committed to effectively support relevant Government Ministries and State Departments through a more efficient delivery system. I am confident that the SBCC training package will contribute in a fruitful manner towards strengthening the SBCC component of significant government flagship programmes that ensure the rights and wellbeing of all women and children in India.

Louis-Georges Arsenault
Representative

ACKNOWLEDGEMENTS

The TARANG Social and Behaviour Change Communication (SBCC) training package, designed to develop understanding of and capacities in integrating social and behavior change communication as a key component of public health programming, comprises five modules. It was conceptualized and guided by a core team from the UNICEF India Office, including Mario Mosquera, Chief, Communication for Development; Rachana Sharma, Communication for Development Specialist; and Geeta Sharma, Communication for Development Officer.

Training modules 1-4 have incorporated valuable recommendations made by the Immunization Division, Ministry of Health & Family Welfare and the Immunization Technical Support Unit (ITSU) following a close review.

The package was developed, pre-tested, and finalized by a team of consultants and the agency New Concept Information Systems.

Acknowledgements are also due to the UNICEF India C4D network, in particular Alka Malhotra, Bhawani Shankar Tripathy, Seema Kumar, Sanjay Singh and Bhai Shelly for their insights at various stages of development of this package.

CONTENTS

DAY I PROGRAMME SCHEDULE

Session No.	Topic	Time	Methodology
1	Inauguration and Introduction	10:00 to 10:30	Introduction and pairing of participants
2	Changing Paradigms in Development Communication	10:30 to 11:15	Presentation and discussion
11:15 to 11:30 Tea break (15 minutes)			
3	Introduction to the 'TARANG' Communication Module	11:30 to 12:15	Presentation and discussion
4	Introduction to Communication	12:15 to 13:00	Exercise (railway compartment) and discussion
13:00 to 14:00 Lunch break (60 minutes)			
5	The Behaviour Change Process	14:00 to 15:00	'*Shanta*'s Story' followed by discussion
6	Qualities of a Good Communicator	15:00 to 15:30	Plenary and discussion
15:30 to 15:45 Tea break (15 minutes)			
7	Introduction to Interpersonal Communication; The GATHER Concept	15:45 to 16:45	Film: ASHA, *Ek Nai Subah* and discussion
8	Review and Reflections of the day	16:45 to 17:15	Feedback from participants

LIST OF TRAINING MATERIALS

Session 1

Picture cards cut into two (draw different pictures on a card (4"x 3") and cut each into two pieces. The number of cards should be half the number of participants plus the two facilitators and each should get a piece when cut). The cards could also be of the letters in the alphabet.

Session 2

- Writing board and marker pens
- PowerPoint Presentation

Session 3

PowerPoint presentation on making of the new Social & Behaviour Change Communication Modules

Session 4

- Picture of a railway compartment
- Blackboard and chalk or chart paper and sketch pen
- Film *Rachanatmak Ravayya*
- VCD player and laptop with LCD projector

Session 5

Story cards, blackboard and chalk or chart paper and sketch pens

Session 6

- Chalk and blackboard or Chart paper and marker pen
- Chart: knowledge, communication skills and values

Session 7

- CD of the film ASHA, *Ek Nai Subah*,
- CD player and TV
- Writing board and marker pens
- Chart paper and sketch pens

Session 8

- Writing board and chalk or marker pens
- A paper ball

SESSION 1

INAUGURATION AND INTRODUCTION

10:00 to 10:30 (30 minutes)

SESSION OUTCOME

At the end of the session, participants would have:

- Introduced each other, creating a friendly environment.

MATERIALS REQUIRED

- Picture cards cut into two [draw different pictures on cards (each 4"x 3") and cut each into two pieces. The number of cards should be half the number of participants plus the two facilitators and each should get a piece when cut]. The cards could also have the letters of the alphabet.

METHODOLOGY

Pairing using picture cards.

PROCESS

1. One of the facilitators begins the session by saying, "On behalf of the Institute (Training Centre) and facilitators' team, I welcome each one of you to today's sessions on introducing the new SBCC module for field functionaries and community volunteers. With communication becoming central to development programming, we hope that this module will be a great help to all in reaching out to families and communities to bring about social and behaviour change. We will be discussing details of the module during the course of the sessions."

   "But before that, let's start by introducing ourselves. Some of you may be acquainted with each other and some of you may not. So let's try to get to know each other through a simple exercise."

2. Now put the cards cut into halves in a box the centre of the room and mix them up well. Ask each participant to come and pick a card. The two facilitators too should pick a card each. Once everyone has a card, tell the participants, "Each of us has a card with half a picture. We now have to find out who has the other half of the picture. Please move around and find out who has the other half of the picture. Once you find that person stay together as a pair. Start."

3. If the total of participants and facilitators is an odd number, ask the person left out to join any pair; or one of the facilitators should not pick a card and join one of the pairs making it a triad. Once all the participants are in pairs each person should: say his/her name; what he/she does; also briefly share one programme communication activity that he/she has seen in the course of work which he/she felt was either successful or not successful.

   After each of them has done this, which may take about 5 minutes, ask the participants to sit with their partners. Now ask each one to introduce his/her partner. The facilitators also join in.

CONCLUDING THE SESSION

Conclude the session by thanking them for actively participating in the exercise and also for sharing their experiences in programme communication. Tell the participants that we will build on the discussions in the subsequent sessions.

SESSION 2

CHANGING PARADIGMS IN DEVELOPMENT COMMUNICATION

10:30 to 11:15 (45 minutes)

SESSION OUTCOME

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

- Describe the changes that have taken place in development communication in order to bring about the desired behaviour changes.

METHODOLOGY

PowerPoint presentation and discussion

MATERIALS REQUIRED

Writing board and marker pens

PROCESS

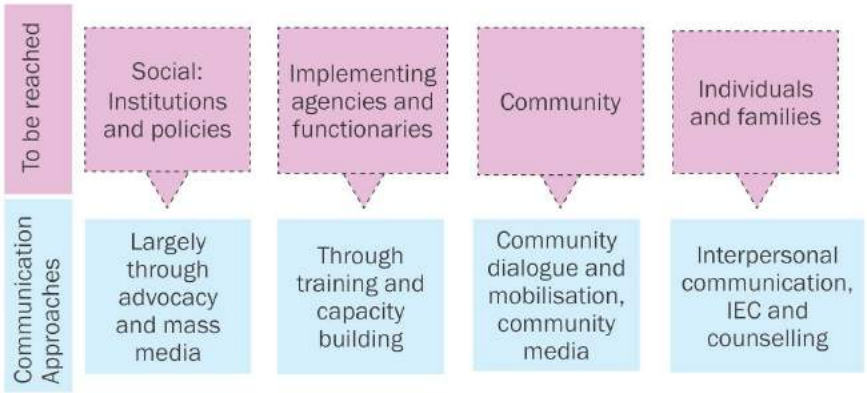
Start the session by saying, "Over the last few decades, there have been subtle shifts in the way development communicators have approached communication strategies in influencing behaviour change. It has been a process of evolution and today we have a much more comprehensive approach to handle social and behaviour change within development programming."

1. Ask the participants to tell how they/their department have perceived communication in the past.
2. Ask them to tell the difference between the 'family planning' campaigns of the 1970s and the 'polio campaign' of recent times. What communication tools were used then and now?
3. Once the participants have finished, sum up, covering the following points:
    - In the 1950s and 1960s when development was measured using the Gross National Product (GNP) as the indicator where capital-intensive approaches and centralised planning were the norm, it was believed that mass media would raise the aspirations of the people and bring about desired behaviour changes. A large number of radio stations and newspapers were used to disseminate messages targeting populations in the hope that this would help bring about changes. This was a one-way approach.
    - It was thought that mass media was important because only through them could the countries with limited resources hope to provide information to vast numbers by disseminating the messages at the rate required for development.
    - It was then felt that mass communication alone would not produce the desired results, but that there was need for the dissemination of messages through opinion leaders. This brought in the initial concepts in interpersonal communication strategies where individuals within communities were inducted to spread messages and influence individuals and families.
    - The 1970s and 1980s focused on bringing about individual behaviour change and the concept of Behaviour Change Communication (BCC) came into being. BCC is closely associated with Social Marketing Strategies which were seen as a means to promote a particular behaviour or social change through communication.

- Almost simultaneously the concept of Information, Education and Communication (IEC) was also evolving where the emphasis was on dissemination of messages through production and use of audio visuals and print materials.
- In all the above approaches the concept of stakeholder participation was totally missing. The idea that stakeholders should necessarily participate in the communication process was brought out as early as in the 1960s with the work that was being done in Latin America by Paulo Freire. This did not catch the attention of communication planners at that time.
- However, with human rights based programming gaining ground in the late 1990s and early 2000s where participation became a critical right of every individual, family or community, the concept of participatory approaches to communication gained prominence. The paradigm that every individual, family or community has the right to make 'informed choices' stressed the importance of empowering them with the right knowledge and skills to make such choices. Communication is no more seen as a top-down approach where families and communities are targets for behaviour change. Today, development communication is considered to be a multi-stakeholder and participatory process where the involvement of all stakeholders is important.
- Today 'development' is seen as creating an environment in which people can reach their full potential and lead productive, creative lives in accordance with their needs and interests. According to the UNDP Human Development Report 2012, people are the real wealth of nations and emphasis should be on the need for expansion of their choices so that they lead lives that they value.
- In today's development context it is important to understand that wide social acceptance about the need for specific change has become a pre-condition for individual behaviour change. Change is often influenced by other people's expectations, which is in turn shaped by the current social and cultural norms. Therefore it is important that communication strategies address social change, creating community norms. Social and Behaviour Change Communication (SBCC) addresses both social and individual behaviour change.

4. Sum up the discussions with the following:

We have seen that communication approaches have been evolving over time and today there is a much more comprehensive understanding of the process. Some of the areas that require our communication activities are given below:



CONCLUDING THE SESSION

Conclude the session with the following:

- Thus, we see that a communication plan should address various stakeholders at various levels and that the approaches at different levels could be different or a mix of different approaches, depending on the need.

- The SBCC modules that are being introduced are largely to address communication needs at the community, family and individual levels. The modules deal with IPC, Counselling, IEC and Community Dialogue tools.
- We will discuss these in detail in the next few sessions.

TEA BREAK
11:15 to 11:30 (15 minutes)

SESSION 3
INTRODUCTION TO THE '*TARANG*' COMMUNICATION MODULE
11:30 to 12:15 (45 minutes)

SESSION OUTCOMES
At the end of the session, participants will be able to:
- Describe the background against which the module has been developed, the principles used in developing the modules and the contents of the different items.
- List the items in the modules and their use at various levels.

MATERIALS REQUIRED
- Writing board with chalk/marker pens
- PowerPoint presentation, LCD projector and laptop or computer

METHODOLOGY
PowerPoint presentation and discussion

PROCESS
1. The facilitator begins the session by saying: "We will now have a brief introduction to the new Social & Behaviour Change Communication Module that has been developed. Much work had gone in to its making including review of existing modules and materials, field visits to states and interactions with various stakeholders at the state, district, block and field level. The faculty of various training centres were also met and their inputs taken. I will now take you through a PowerPoint presentation that summarises how the modules were made and what they contain."
2. Now start the PowerPoint presentation and go through the slides one by one.
3. Allow participants to raise questions during the presentation. Answer them based on the module.

CONCLUDING THE SESSION
Conclude by saying that in the following sessions we will have a detailed look at some of the important sessions from the 5-Day training Module.

SESSION 4

AN INTRODUCTION TO COMMUNICATION 12:15 to 13:00 (45 minutes)

SESSION OUTCOMES

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

- Describe the communication loop with the different steps therein.
- Explain the need for the communicator and the receiver to be on the same wavelength for effective communication to happen.
- Give examples of why one-way communication invariably leads to distorted messages.

MATERIALS REQUIRED

- The picture of a railway compartment as shown in the lesson plan
- Blackboard and chalk or chart paper and sketch pen
- Film *Rachanatmak Ravayya*
- Video player and TV or laptop and LCD projector

METHODOLOGY

- The 'railway compartment' exercise.
- Follow-up discussions.
- Conclude with the film *Rachanatmak Ravayya.*

PROCESS

1. Ask for 10 Volunteers. One of the facilitators takes Volunteer #1 and leaves the training hall. He/she gives the volunteer the picture of the railway compartment and tells him/her to study it (2 minutes to study the picture).

2. The facilitator informs the Volunteer that his/her task will be to convey what is in the picture to volunteer #2.

3. Once the Volunteer is ready to describe the picture, ask him/her to come into the training room. Now the other nine Volunteers are taken out of the training hall by the second facilitator. Then Volunteer #2 from among them is called in. Ask Volunteer #1 to describe what was in the picture to Volunteer #2. Tell him/her that he/she can only listen to what Volunteer #1 is saying and cannot ask any questions for clarification. Once Volunteer #1 has completed describing the picture, ask him/her to sit among the participants and not to talk to anyone.

4. Now call Volunteer #3 into the training hall. Ask Volunteer #2 to describe what he/she heard from Volunteer #1 to Volunteer #3. As before, Volunteer #3 cannot ask any questions. Once Volunteer #2 has completed, ask him/her to sit next to Volunteer #1, but not to speak anything.

5. Repeat the process till Volunteer #6 is briefed by Volunteer #5. Now ask Volunteer #6 to tell all the participants what he/she understood about the picture. The description he/she gives will be very different from what is really in the picture.

6. Show the picture to all the participants so that they are able to see the distortions that have taken place.

7. Now tell the participants that the exercise is not yet over. Call in Volunteers 7 and 8. Give the picture to Volunteer #7 and ask him/her to study it so that he/she can describe it to Volunteer #8. Volunteer #8 should not see the picture. Once he/she is ready to describe the picture, take it away. Now ask Volunteer #7 to describe the picture to Volunteer #8. Tell Volunteer #8 that he/she can ask questions to get clarifications. Once Volunteer #7 completes describing the picture to the satisfaction of Volunteer #8, ask Volunteer #8 to describe the picture to all the participants. Once again show the picture to all participants so that they are able to make out the distortions.

8. Tell the participants that there is one more part to the exercise. Call in Volunteers #9 and 10 and give the picture to Volunteer #9. Ask him/her to study the picture so that he/she is able to convey what he/she sees to Volunteer #10. Once he/she is ready, ask him/her to describe the picture to Volunteer #10 and tell him/her there are no restrictions. He/she can even show the picture and describe it. Now tell Volunteer #10 to describe the picture to the participants. Stop the exercise here; ask all participants to go back to their original seats.

9. Ask the participants, "What did we see here? What were the differences in the three parts of the exercise? Which team/pair was able to give the best description of the picture?"Ask the following questions and note the answers:

   - How many women are there?
   - How many persons are there?
   - How many children are there?
   - Which language has been used by the railways on the compartment partitions, by passengers on their luggage? (Facilitator to note: Does someone point out that everything is written in mirror image?)

10. Why did that team/pair succeed? Allow sufficient time for the participants to reflect and share their views.

11. The points emerging from the discussions are noted on the board.

12. Ask the participants whether they have had any experience where messages got distorted. Have five to six participants share their experiences.

CONCLUDING THE SESSION

We saw three different communication styles here.

Case 1: The communication was one way where the listener could not ask any questions; he/she could only listen to the volunteer.

Case 2: The listener was free to ask questions and get clarifications. In this case the message was better delivered compared to the first case.

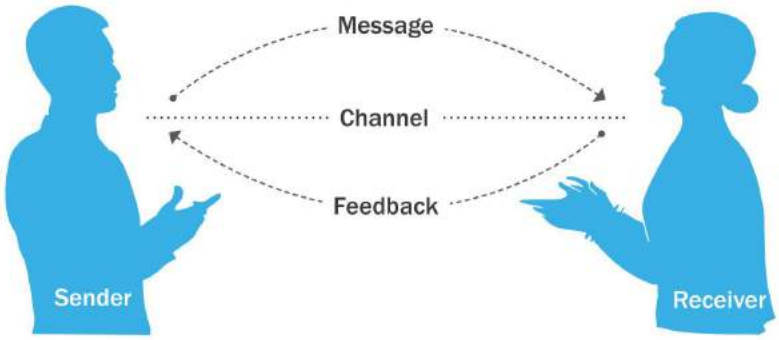
Case 3: The messenger and the listener were able to discuss the picture while looking at it. The listener fully participated in deciding what the picture depicted. She/he was not just a silent listener who could only ask questions but was actively involved in deciding what the picture depicted. The third communication style gave the best description.

When the message is not clear, it often gets distorted.

- Some new things get added and some information goes missing. Little things assume big proportions and big things are trivialised.
- Of the many facts, only a few are transmitted as they are passed from one person to another.
- Very often, unusual interpretations are given, and often these have much to do with a person's mind, temperament and prejudices.
- These can also end up as rumours or a story.

Therefore, for communication to be effective there has to be a dialogue where the communicator and listener are actively involved and interact with each other.

Draw the diagram as shown below on the board.



- When a message is conveyed by one person, the other should receive it without distortions. This can be ensured when the receiver gives a feedback to the sender and repeats the message so that clarifications can be provided if needed. So effective communication should have a loop which ensures that the sender and the receiver have the same understanding.
- So when we communicate with women, families and communities it is very important that we take feedback from them and listen to them very carefully to ensure that the message has been is understood clearly.
- Ask the participants what, in their opinion, are the do's and don'ts for good, effective communication. Listen to some responses, and then display the chart below.

Effective Communication

Do's

- Involve your receiver in the feedback process (remember Case 2 and 3 from the exercise).
- Try to develop a shared experience of communication as equal partners (remember Case 3 from the exercise).
- Act on the feedback and create opportunities for clarifications (remember Case 3 from the exercise).

Don'ts

- Avoid one-way communication (remember Case 1 from the exercise).
- Avoid lengthy communication. In order to be effective communication should be broken into short pieces (remember how lengthy communication was less effective in Case 1, and how small pieces of information coming one after another improved the communication in Case 3).

Part 2: VCD *Rachanatmak Ravayya*

1. Tell the participants that you will be showing them a short film tilled "*Rachanatmak Ravayya* and that they should watch the film carefully and contribute to the discussions that follow.
2. Tell them that they will be viewing the film in two parts and that after each part there will be a discussion.
3. Screen the film and stop at the point when, after talking to the mother, the ASHA worker takes the umbrella and walks into the village.
4. Ask the participants the following questions: What did you see here? How effectively did the ASHA worker communicate with the mother? What went wrong in the communication? Ask them to recall the communication loop and reflect on what they saw based on the principles of good communication. Ask "What could have been done to improve the communication?"
5. Generate a discussion; give participants time to reflect and share their views.
6. List the points that emerge on the white board or on the chart paper.
7. Now screen the rest of the film.
8. At the end of the film, ask the participants the following questions: What did you see in this part of the film? Why did the ASHA get a positive response? What are the positive factors ASHA's way of communications?
9. As the participants respond write the points on the board or chart paper.

CONCLUDING THE SESSION

Using the points listed on the board or chart paper and referring to the communication loop reiterate the reasons for communication failure as well as for effective communication.

LUNCH BREAK
13:00 to 14:00 (60 minutes)

SESSION 5
THE BEHAVIOUR CHANGE PROCESS
14:00 to 15:00 (60 minutes)

SESSION OUTCOMES

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

- List the different steps involved in the behaviour change process.
- Relate personal experiences to the different steps in the behaviour change process.
- Articulate the role of the communicator in each step of the behaviour change process.
- List the barriers that could occur in each stage of the behaviour change process.

MATERIALS REQUIRED

- Story cards
- Black board and chalk or chart paper and sketch pens

METHODOLOGY

The session is divided into three parts:

Part I: Telling a story using the story cards.

Part II: Presenting the first chart depicting the seven steps in behaviour change.

Part III: Conclusion.

PROCESS

Part I: Telling a story using the story cards

1. Using the story cards to narrate the following story

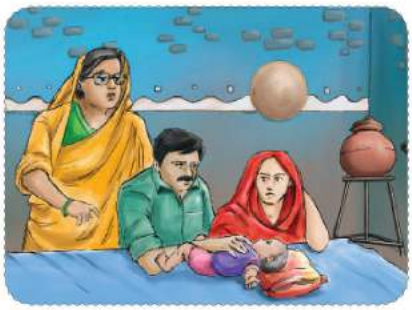
***Shanta's* Story**

Sumitra, the ASHA of village *Rampur*, was concerned that a few families in the village were not bringing their babies for immunisation. So, she decided to visit their homes and explain to them the importance of immunisation and the need to get their children immunised. One of the houses she visited was that of *Shanta*, a lady with a 6-month-old baby who had never been immunised. When *Sumitra* discussed the need to immunise her son, *Shanta* said that her family did not believe in immunisation and that her mother-in-law and husband, *Ramlal*, would never allow her to immunise the child. *Sumitra*, in a very friendly and caring manner, explained to *Shanta* why immunisation was important that and asked her to attend the VHND the following Wednesday along with her baby. *Shanta* promised to discuss this with her family.

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

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

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



Sumitra then decided that the only way to ensure that the child got immunised was to convince *Ramlal*. She spoke to the *Sarpanch* and also to two of *Ramlal*'s neighbours who were his friends. Together they had a long discussion with the family informing them that all the children in the village were being immunised and that there had been a marked reduction in diseases. They also told the family that it is the right of every child to get immunised and that parents should not be guilty of not taking care of the health of the child. Both - *Ramlal* and his mother were convinced and even accompanied *Shanta* to the PHC where the child received the second dose of vaccines. Since then the parents have been very careful and have ensured that the child receives all vaccinations, including against measles and Vitamin A prophylaxis. *Shanta* now actively advocates on the need to get babies immunised.

2. Once you complete narrating the story, ask the following questions:
   - What did you think of the story? Do you find families like *Shanta's* who are reluctant to follow your advice?
   - How did *Sumitra* handle the case? Did she try to find out the reasons for *Shanta's* husband's and mother-in-law's opposition to immunisation? Did *Shanta's* family accept her advice and get the child immunised as advised?
   - How did *Sumitra* finally convince the family and win *Shanta's* support in promoting health care?
   - What is it that *Sumitra* could have done better? (Like counselling the family at the time of first immunisation)
3. Allow sufficient time for the participants to reflect and share their views on each of the above questions: Keep asking questions to elicit the following:
4. During her first visit to *Shanta*'s house, *Sumitra* was able to create an *awareness* as well as a *desire* in *Shanta* to get the child immunised. But *Ramlal* and her mother-in-law influenced her and dissuaded her from immunising the child.

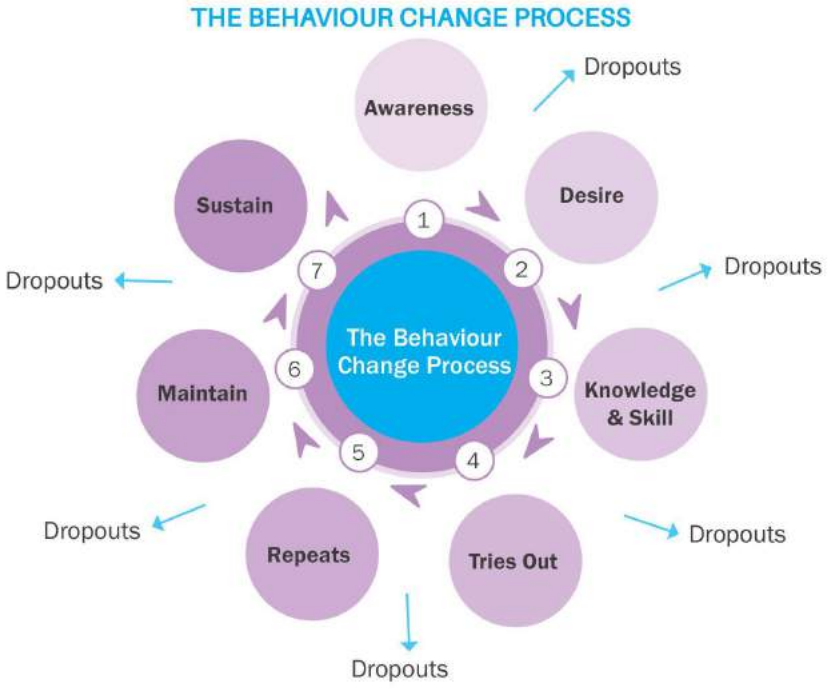
- On the second visit with the AWW, they were able to get *Ramlal*, his mother and *Shanta* to agree to test the *desired* behaviour change by getting the baby immunised with the first dose.
- But, again, the fact that the *baby had fever* and also that they were not fully convinced about the cause,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

Part II: Presenting the first chart depicting the seven steps in behaviour change

14:00 to 15:00 (60 minutes)

Leading from the discussions on *Shanta*'s story in Part I, initiate discussion on the behaviour change cycle.

Step 1 in the change process is to become *AWARE* of a change that needs to take place. Write *'Aware'* on the board and discuss how *Shanta* became aware that immunisation is good for the child. This awareness could come from a neighbour, a relative or a friend or through the ASHA or the AWW or the ANM or any other functionary. It could also be through the media – newspaper, radio or TV. Once the same message is heard several times (e.g., every child should be immunised, every child should be in school, institutional deliveries are safest for mother and child etc.), one develops a *DESIRE* to test the change. This is Step 2 of the change process. Write '*Desire*' on the board as shown in the chart and draw an arrow indicating that awareness leads to a desire for change. Now that one desires the change, one will look at ways to make the change and this could be acquiring a new *SKILL* (as in the case of the skill to breast-feed a baby the right way) or *KNOWLEDGE* (as in the case of finding out when and where one's child can be immunised).



An enabling environment consists of

- Supportive relatives and neighbours.
- Functionaries and volunteers and other opinion leaders through their sustained encouragement, through counselling and dialogue and provision of quality services.
- The communication media through supportive messaging.

Therefore, Step 3 is acquiring the necessary skill or knowledge to make the behaviour change. Write KNOWLEDGE (in *Shanta*'s case the knowledge was where to get the immunisation done for her baby as well as knowing the schedule of immunisation) or '*Skill*' (as in the case of being able to breast feed a child the right way) on the board as shown in the chart and draw an arrow to indicate that desire leads to acquiring the necessary knowledge and/or skill to make that change.

Now that one has acquired the knowledge and/or the skill, Step 4 will be to *TRY OUT* that change (e.g. taking the child for immunisation for the first time or starting to consume IFA tablets as advised by the ASHA). Write *TRY OUT* on the board as shown in the chart and discuss this as the fourth step in the change process.

Individuals analyse the experience of trying out the change behaviour and if the assessment is negative (as in *Shanta*'s case), the person drops out from the process; if it is positive the tendency is to try it out once again, in other words *REPEAT* the action. This is Step 5 of the cycle. Write REPEAT on the board as shown in the diagram and discuss the same with the participants.

If the experience of Step 5 was good, one will tend to repeat the action; in other words MAINTAIN (Step 6) the behaviour and soon it becomes a SUSTAINED (Step 7) behaviour change or a habit. Write MAINTAIN and SUSTAIN on the board as in the chart with the arrows linking them and discuss these steps with the participants. The behaviour change cycle is thus competed.

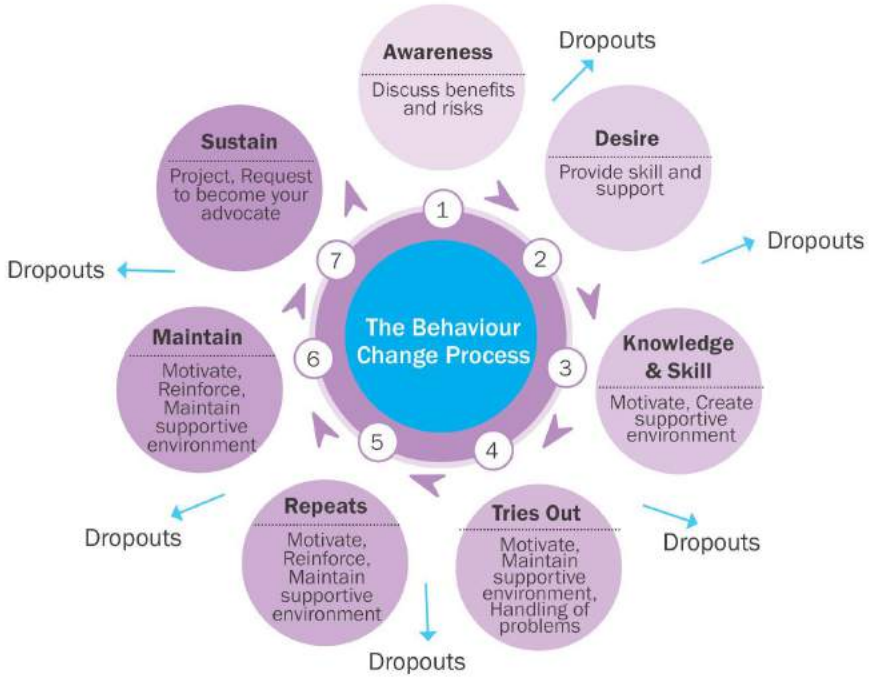
Mention, also, that there could be new awareness coming in and there could be a change cycle even on the same behaviour following the same cycle: for example, switching from a 'pinch of salt and a scoop of sugar' to the use of ORS packets.

Inform the participants that in the actual training the participants participate in a group discussion, sharing their experiences on the behaviour change process followed by group presentations. This part is being skipped due to shortage of time. The intention here is to give glimpses of a few sessions in the module.

CONCLUDING THE SESSION

Using the diagram that was drawn in Part II of the session and the discussions, complete the chart indicating that at any step of the cycle one could dropout from the behaviour change process unless there is someone motivating and 'facilitating' the person to make that change.

THE BEHAVIOUR CHANGE PROCESS AND THE FRONTLINE FUNCTIONARIES' ROLE



This is where the ASHA or the AWW or the ANM or any other worker should monitor and support the individual to carry on with the change process. We know of many cases where infants dropout after taking the first or second dose of immunisation. If we are to prevent such dropouts we need to follow up with each family 'at risk' and support them in understanding the need for the changed behaviour. Therefore it is critical that an ENABLING ENVIRONMENT is created and sustained to help individuals, families and communities make the desired change. An enabling environment would consist of the following:

- Supportive relatives and neighbours.
- Functionaries and volunteers and other opinion leaders through their sustained encouragement through counselling and dialoguing, provision of quality services.
- The media (press, radio, TV etc.) through supportive messaging.

In conclusion, ask the participants how they found the entire session. Ask them what the major learning outcomes were and whether they were able to relate to the behaviour change process. Tell them that we will be further building on the concept and working on behaviour change in the coming days as well.

SESSION 6

QUALITIES OF A GOOD COMMUNICATOR 15:00 to 15:30 (30 minutes)

SESSION OUTCOME

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

- List the knowledge skills and values/attitudes required of a good communicator.

MATERIALS REQUIRED

- Chalk and black board or chart paper and marker pen
- Chart: Knowledge, Communication Skills, Values

METHODOLOGY

Lecture and discussion

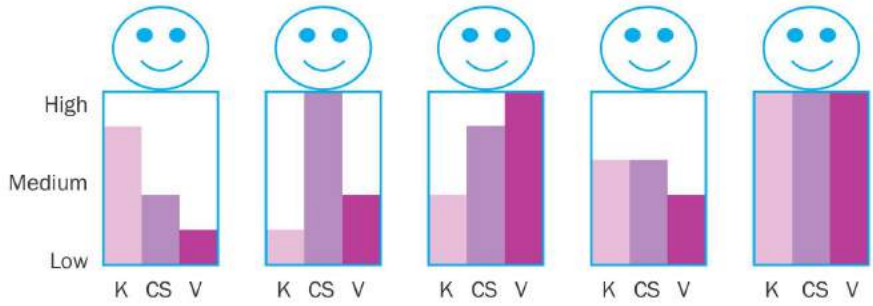
PROCESS

Ask the participants what competency means. Generate a discussion. Conclude by saying **that competency is the ability of a person to carry out an activity or a task effectively, producing the desired results.**

1. Then ask, "What are the essential ingredients that constitute competency?". Generate a discussion on this. Conclude by saying that competency consists of three key elements: Knowledge of the task, skills to perform the task and the right values and attitudes that make one perform the task well. In the case of a communicator, the skills required are good communication skills. There is a chart given at the end of the session which lists knowledge, skills, values, etc. It will be useful if this chart is displayed in the training hall and discussed.
2. Draw Figure 1 on the board or chart paper where the communicator has good knowledge, lower communication and much lower values and attitudes. Ask the participants what would be the performance of such a communicator. Generate a discussion on this.
3. Draw Figure 2 where the communicator's communication skills are good, but knowledge and values are poor. What would be the performance of such a communicator?
4. Next, draw Figure 3 where the person has high values but less knowledge and communication skills. Discuss how this person would perform.
5. Draw Figure 4 where the communicator has less knowledge, low communication skills and low values. How would such a person perform?
6. Finally, draw Figure 5 where the communicator has all three aspects – knowledge, communication skills and values in equal amounts. What would be the performance of such a person?

CONCLUDING THE SESSION

From the above discussions it can be seen that a good communicator should have the knowledge, skills and the right values and attitudes to be effective in the field. Lack of any one of the above qualities makes him/her ineffective. We need to be motivated and committed to bring about change within communities. Then we will find ways to acquire the knowledge and skills to perform our tasks better.



K = Knowledge, CS = Communication Skills, V = Values /Attitudes

Knowledge, skills and attitudes/values that a good communicator should have

Knowledge	Communication Skills	Values /Attitudes
• Knowledge of the topic and how it has to be handled • Knowledge about the target population being addressed – their beliefs, values, traditions, social norms etc. • Knowledge of the region where one is working • Knowledge of local leaders, opinion makers, functionaries etc.	• Ability to build rapport with individuals and groups • Ability to see oneself as part one of the community • Ability to speak effectively • Ability to listen attentively • Ability to negotiate and handle arguments etc. • Ability to analyse situations and different points of views • Ability to use positive body language for best impact • Ability to 'emphasise' • Ability to use different tools for effective communication – posters, flip charts, exercises, community dialogue tools etc.	• Being honest and transparent (ASHA in the film *Rachanatmak Ravayya* was thinking something about the mother but not saying it – result poor communication) • Respect for all, including the poor and marginalised (Again in the same film, was she respectful to the mother in Part I? What was the change in her behaviour in Part II? The result was good communication) • Treating all equally irrespective of religion, caste, gender, age, physical condition and socio-economic status (ASHA did not ask the mother to sit while she herself was sitting in Part I, in Part II she actually sat with the child and fed the child – difference resulted in good communication) • Commitment to one's work and mission (Remember this when you see the movie ASHA, *Ek Nai Subah*) • A sense of fairness and justice (In Part I of ASHA, *Ek Nai* ...you will see how the ASHA is being unfair to the mother) • A belief that every individual or family has the right to make his/her/its choices and that one's role is to provide them with the right knowledge and skills to make 'informed choices'. (In Part II of ASHA, *Ek Nai*...you will see how the ASHA helps the mother in making her choice)

TEA BREAK

15:30 to 15:45 (15 minutes)

SESSION 7

INTRODUCTION TO INTERPERSONAL COMMUNICATION; THE GATHER CONCEPT 15:45 to 16:45 (60 minutes)

SESSION OUTCOMES

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

- List what constitutes *"Muskurahat"* or "GATHER" and describe its relevance in interpersonal communication.
- Explain how effective interpersonal communication can be done.

MATERIALS REQUIRED

- The film ASHA, *Ek Nai Subah*
- CD player and TV
- Writing board, chart paper and marker pens

METHODOLOGY

Film viewing followed by discussion.

PROCESS

- Explain the concept behind the word *"Muskurahat"* (**मुस्कुराहट**) or "GATHER" and detail what each alphabet in the word stands for as given below:

मुस्कुराहट

मु – मुस्कुरा कर अभिवादन करेंगी।

अपने कार्यक्षेत्र में जब आप किसी से भी मिलती हैं तब निश्चय ही प्रसन्नता पूर्वक मुस्कुराते हुए मिलती हैं। साथ ही साथ, सामने वाले के पद और समयानुकूल अभिवादन भी करती हैं।

स – सवाल पूछ कर समुदाय से जानकारी लेंगी कि उनकी स्वास्थ्य संबंधी क्या समस्याएँ हैं और व्यवहार परिवर्तन में क्या-क्या बाधाएँ हैं?

सवाल पूछ कर समुदाय की स्वास्थ्य संबंधी समस्याओं और व्यवहार परिवर्तन की बाधाओं की जानकारी लेंगी। इससे समुदाय की ज़रूरतों की जानकारी मिल पाएगी ताकि उनको आवश्यकतानुसार सही परामर्श दिया जा सके।

कु – कुशल स्वास्थ्य व्यवहार के लिए उनकी आवश्यकतानुसार पर्याप्त जानकारी देंगी।

कुशल स्वास्थ्य व्यवहार पर चर्चा करेंगी और उनकी आवश्यकतानुसार (जोकि पिछले चरण द्वारा पता लग चुकी हैं) जानकारी देंगी, खासकर अगर आपके सामने नई माता हो, गर्भवती स्त्री हो या फिर कोई किशोरी। कुषल व्यवहार पर जानकारी देते समय ध्यान रखना होगा कि इन माता, किशोरी या स्त्री को कोई सवाल अथवा परेशानी तो नहीं है? साथ-साथ, यह भी पूछना होगा कि क्या पिछले बार दी गई सलाह को अपनाने में कोई परेशानी हुई? अगर हुई तो वह क्या थी? अगर कोई नया मसला है तो वह क्या है?

रा – राय बनाने में मदद करेंगी; एक ऐसी राय बनाने में, जिससे माता खुद फैसले करने में सक्षम बनें।

माता से बात कर राय बनाने में मदद करेंगी। अगर कोई समस्या नहीं हो तो जो बात अच्छी चल रही है उसको और सुदृढ़ करेंगी। यदि कोई प्रश्न या समस्या हो तो उसके विभिन्न पहलुओं पर विचार-विमर्श और प्रश्न करेंगी। समस्या से जुड़ी यदि कोई नई जानकारी आपके पास है तो उसके विषय में अवश्य चर्चा करें। इस जानकारी से होने वाले फायदे-नुकसान पर भी चर्चा करेंगी। इससे नई माता, गर्भवती महिला या किशोरी को समस्या का समाधान या प्रश्न का उत्तर ढूँढ़ने में सहायता मिलेगी। इस प्रकार महिला स्वयं फैसले लेने में सक्षम बनेगी।

ह – हाल सुधारने पर चर्चा करेंगी, खासकर अगर कोई परेशानी या सवाल हो तो।

हाल सुधारने पर चर्चा करेंगी, खासकर अगर कोई परेशानी या जटिल सवाल हों तो। इस प्रक्रिया में समस्या का निवारण आप-आशा दीदी नहीं करेंगी अपितु समस्या का समाधान ढूँढ़ने की क्षमता को बढ़ावा देते हुए मदद करेंगी। सलाह सिर्फ तब ही देंगी जब कोई नुस्खे या सुझाव पर व्यवहार करने में कोई परेशानी या अड़चन आ रही हो। हाल सुधरने की चर्चा को समाप्त करने के पहले कम से कम एक या दो बातों पर सहमति बनानी चाहिए। समस्या के समाधान के क्रियान्वयन के तरीके या रास्तों पर भी सहमति होनी चाहिए।

ट – टिकाऊ और सरल संबंध की आशा के साथ विदा लेंगी।

टिकाऊ और सरल संबंध की आशा और पुनः जल्दी मिलने के वादे के साथ विदा लेंगी। टिकाऊ संबंधों के लिए समय-समय पर दोबारा मिल कर वर्तमान स्थिति की भी जानकारी लेती रहेंगी ताकि समय रहते उपयुक्त सुझाव दिया जा सके।

OR

GATHER

G–GREET the caregivers (establish rapport): It is necessary to overcome biases to meet people as equals. Greeting people personally helps in building rapport to a great extent.

A–ASK caregivers (gather information): It is important to elicit the needs of the caregivers, prioritising information to make it more relevant. Asking should not be limited to mere medical history because other aspects of a person's life (life stage, lifestyle, personality, etc.) often impact an individual's post-counselling behaviour more than his/her medical history.

T–TELL (provide information): Avoid information overload such as reciting details on all the processes at one time because there is a limit to how much information people can retain. Instead, package the information in smaller module and check for understanding after delivery of each module. Specific information organised logically is retained longer and more completely, especially if the individuals are encouraged to ask questions.

H–HELP the individual: This is the decision-making or problem-solving moment. The provider is helping the individual sort through the information, lifestyle and life-stage issues to come up with various alternatives, and to consider the advantages and disadvantages of each alternative.

E –EXPLAIN to the individual: Once the individual has made a choice, the provider uses IEC material to help the individual remember key information. The provider also uses IEC material to remind them of important discussion points. IEC materials reinforce key information, advantages and disadvantages.

R –RETURN/REFER/REALITY CHECK: Return visits or referrals should be planned. If necessary, repeat the information given.

- Discuss each step in *Muskurahat* or GATHER in detail; clarify any doubts that participants may have.
- Once there is good understanding among participants on either of the two words, start showing the film ASHA, *Ek Nai Subah*.
- Stop the film at the point where the four questions are raised and ask the participants what the answers could be. Generate a discussion on the same and list all the shortcomings of the ASHA in her communication.
- Once this is done, resume showing the film. Stop the film once again when the next set of four questions appear. Get the participants to respond to the questions and note these points on the board or chart paper.

- Resume the film again. Stop the film when the next set of questions appear and get the participants to respond to the questions. Link them with either *Muskurahat* or with 'GATHER' and describe how the steps that were discussed in part I of the session actually helped the ASHA in getting positive outcomes including building strong relationships with the families and communities.
- Show the final part of the film and discuss the film once again.

CONCLUDING THE SESSION

- Once again discuss the six steps in "*Muskurahat*" or "GATHER" and relate them to what they saw in the film.
- Highlight the importance of rapport building to ensure that communication becomes effective.
- Recall the session on '**Qualities of a Good Communicator**' and once again highlight the importance of having the right values and attitude to be an effective communicator.

SESSION 8

REVIEW AND REFLECTIONS OF THE DAY 16:45 to 17:15 (30 minutes)

SESSION OUTCOME

At the end of the session:

- There will be a listing of the highlights of the day, the learnings and feedback on the sessions.

MATERIALS REQUIRED

- Writing board and chalk or marker pens
- A paper ball

METHODOLOGY

Getting feedback and comments from participants.

PROCESS

1. Tell the participants that this is the last session of the day where they can reflect on the major learnings of the day, give their feedback on the sessions and any other comments that they would like to make the day's sessions more effective. Tell them that you will throw the ball to any one participant and he/she will give his/her comments and then throw it to the next participant for his/her comments. The comment could be in the form of a learning, an expression of what one felt during the day or a suggestion to make the day's sessions more effective.
2. Make three columns on the board and give the headings LEARNING, FEELING and SUGGESTION. Throw the ball to any participant of your choice and start the above process. As the participants make their statements record them under the appropriate heading. Make sure that each participant contributes only one point. Once all the participants have contributed summarise what is written on the board.

DAY 2 PROGRAMME SCHEDULE

Session No.	Topic	Time	Methodology
1	Recall of Day I sessions	10:00 to 10:15	Discussion
2	Introduction to Social Inclusion	10:15 to 11:00	Simulation exercise and discussion
11:00 to 11:15 Tea break (15 minutes)			
3	Session on Social Inclusion (continued)	11:15 to 12:00	Film 'I Am a *Dalit*' and discussion
4	How to Conduct a Group Discussion	12:00 to 12:45	Use of sociogram and discussion
12:45 to 13:45 Lunch break (60 minutes)			
5	Use of a Community Dialogue Tool	13:45 to 14:45	Pulley exercise and discussion
6	Understanding Teamwork	14:45 to 15:30	Broken square exercise and discussion
15:30 to 15:45 Tea break (15 minutes)			
7	Planning and Organising a VHND	15.45 to 16.45	Film ASHA, *Ek Din Zindagi Ka* and discussion
8	Creating a Village Health Plan and Developing a Village SBCC Plan	16.45 to 17.45	PPT presentation and discussion
9	Valedictory Session	17.45 to 18.15	Feedback from participants

LIST OF TRAINING MATERIALS:

Session 1

No materials required

Session 2

- Six pieces of chart paper (30 cm x 15 cm)
- Marker pens (thick – preferably of different colours)

Session 3

- I am *Dalit* CD
- Laptop and LCD or TV
- DVD player
- White board and marker pens

Session 4

- Chart paper and marker pens

Session 5

- A pulley stand
- A doll
- String
- A plastic bag
- 12 thick VIPP cards
- Blackboard and chalk or chart paper and sketch pens

Session 6

- 12 pieces of the broken square.
- The key to the broken square
- Black board and chalk or chart paper and sketch pens

Session 7

- The film ASHA, *Ek Din Zindagi Ka* (VHND)
- VCD, a VCD player and TV
- Blackboard and chalk or chart paper and sketch pens

Session 8

- SBCC Plan framework (8-10) copies

SESSION 1

RECALL OF DAY I SESSIONS

10:00 to 10:15 (15 minutes)

- Welcome the participants to the second day of the orientation.
- Recall briefly sessions of day 1.
- Run through the schedule for the day.

SESSION 2

UNDERSTANDING SOCIAL INCLUSION AND ITS IMPORTANCE IN SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION

10:15 to 11:00 (45 minutes)

SESSION OUTCOMES

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

- Clearly describe what "exclusion" means and understand the humiliation, frustration, and sense of helplessness associated with it.
- Share their "feelings" after having experienced the imposed social restrictions and get fully sensitised to the need for focussing on inclusion in their communication plans.

MATERIALS REQUIRED

- Six pieces of chart paper (30 cm x 15 cm)
- Marker pens (thick – preferably of different colours)

METHODOLOGY

Simulation exercise and discussion

PROCESS

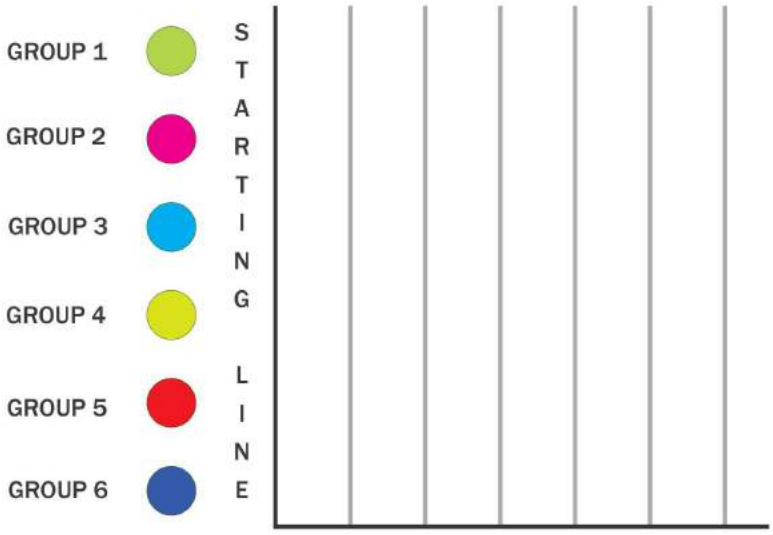
1. Divide the participants into six groups and give each group a piece of chart paper; Assign each group a role as given below:
    - Group 1 members are SC/STs.
    - Group 2 members are WOMEN (single mothers, widows & women heading households).
    - Group 3 members are DIFFERENTLY ABLED.
    - Group 4 members are RELIGIOUS MINORITY GROUPS.
    - Group 5 members are RICH/DOMINANT CASTE.
    - Group 6 members are HIV or LEPROSY AFFECTED PEOPLE.

    Tell the participants that during the exercise, the members of each group are required to feel, think and act as people belonging to the category assigned to them and their actions should reflect the reality in society.

2. Each group is given a piece of chart paper and a marker pen to make a placard. Ask them to write boldly and clearly the name of the category that is assigned to them.

3. Lines are drawn, on the floor of the training room and all the groups are made to stand at the starting point in the manner shown in the diagram below.

4. One of the facilitators reads out from a list of statements (given at the end of the session).



5. The participants are requested to listen carefully to each statement and then discuss among themselves and decide if they can follow the 'statements' as in **a real-life situation**.

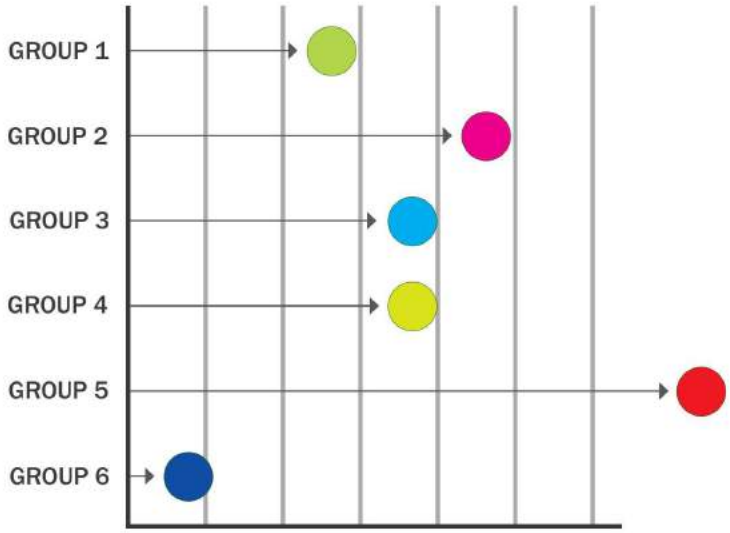
6. If any of the groups feel that they can perform the task in **a real-life situation** they ask a member of the group to hold their placard and step forward so as to stand on the line immediately in front of the starting point.

7. Conversely, if the groups feel that it is not possible to perform the task in a real life situation then they ask their representative (holding the placard) to remain wherever She/he is standing.

8. As the statements are read out, each group discusses the statement among themselves and then asks their representative to either remain where She/he is or take a step forward near the next line. This continues on until all the 10 or 12 statements are read out and acted upon.

9. The representative can keep stepping forward even after all six lines have been crossed.

10. At the end of the exercise you would have a situation where the groups are in different positions. The HIV/Leprosy affected people would have moved one or two steps forward, the *dalit*s three or four and so on. The rich /dominant caste will be way ahead.



11. Once the exercise is over ask the following questions:

- Which category advanced the most?
- Which category was last?
- What did we see here?
- How much did each category advance?
- Why are the categories where they are?
- What stops people from advancing; do the categories have equal status?
- If the answer is "no", ask why it is so.
- Which categories were happy and which were not?

Allow the members of different groups to share what they felt while doing the exercise. Did they feel a sense of injustice? Try and bring out the frustrations, and feelings of helplessness and sadness that some members would have felt.

Allow sufficient time for participants to reflect and share their feelings and thoughts about each of the questions. Remember we have to bring out the feelings of the participants so that they internalise what they are speaking and hearing.

Ask whether this situation exists within our communities. Are people being deprived of their entitlements just because of their social and economic status, gender or health status? Allow time for the participants to share their thoughts.

CONCLUDING THE SESSION

As wrap up to this part of the session convey the following:

- There are many inequities that still remain within our communities
- Large sections of our people remain discriminated against
- The problem is acute in the case of HIV and leprosy patients, widows, *dalits* and tribals; women in general are subjected to discrimination in almost all walks of life.

- The Indian Constitution gives every individual, irrespective of the religion, caste, gender or social status She/he belongs to, equal rights. The Universal Declaration of Human Rights, the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child accepted all over the world recognise that everyone is born equal and guarantee the fulfilment of human rights (short notes on various conventions are given at the end of session).
- The Government of India, over the past several years, has made human rights central to development programming – the right to food, the right to livelihood, the right to education and health care, and the right to information are all directed towards bringing about equity and social justice within our communities.
- It is extremely important that any SBCC initiative recognises this basic tenet and ensures that we target those who are discriminated against and are most vulnerable. Empowering them and bringing them into the mainstream will help us to achieve our targets.
- We need to focus on inclusion in all the activities that we undertake, including home visits (select houses of the poor and marginalised), group meetings (focus on the discriminated and ensure that they participate and share their views), service delivery (ensure that the poor and vulnerable are given priority and are covered) etc.

STATEMENTS TO BE READ OUT

How certain are you that...

- Your children will be treated equally in their school?
- You will receive rations due to you in the village ration shop?
- You will receive the best of attention when you go to your local PHC?
- The *Sarpanch*, ANM, doctor, AWW, *Gram Sevak* etc. will visit your house to discuss problems?
- You can buy a motorcycle for your son to attend college?
- You can attend and fearlessly participate in a meeting being held by the ANM and AWW and they will listen to you?
- Your daughters can pursue high school studies?
- You will get justice at the local Police Station?
- There will be no injustice against you at the place where you work?
- You can celebrate the next religious festival the way you want?
- You will earn equal wages for the same type of work done by men?
- You will be able to, if required, get an expensive operation for a member of your family?

NOTES FOR THE FACILITATOR

UNIVERSAL DECLARATION OF HUMAN RIGHTS (UN)

Provides equality, irrespective of caste, creed, religion and region. All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brother hood.

Everyone is entitled to all the rights and freedoms set forth in this declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW)

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination.

The Convention defines discrimination against women as "...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

NATIONAL COMMISSION FOR WOMEN

NCW is the apex national level organisation of India with the mandate of protecting and promoting the interests of women. Its major responsibilities include:

- Generation of legal awareness among women, thus equipping them with the knowledge of their legal rights and with a capacity to use these rights.
- Assisting women in redressal of their grievances through pre-litigation services.
- Facilitating speedy delivery of justice to women by organising *Parivarik Mahila Lok Adalats* in different parts of the country.

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD, 1989

Every child has rights without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

The rights include protection against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions or beliefs of the child's parents, legal guardians or family members. Every child must be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.

Other rights include: To diminish infant and child mortality; necessary medical assistance and health care to all children with emphasis on the development of primary health care; to combat disease and malnutrition; to ensure appropriate pre-natal and post-natal health care for mothers; to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents; and to develop preventive health care, guidance for parents and family planning education and services.

TEA BREAK

11:00 to 11:15 (15 minutes)

SESSION 3

SOCIAL INCLUSION (CONTINUED)

11:15 to 12:00 (45 minutes)

SESSION OUTCOMES

At the end of the session, participants will have:

- A deeper understanding of the problems of the *dalit* and other marginalised communities.
- A clearer understanding of the need to focus on excluded sections of society in the Social and Behaviour Change Communication initiatives.

MATERIALS REQUIRED

- The "I am a *Dalit*" CD, laptop and LCD or TV and DVD player
- Whiteboard and marker pens

METHODOLOGY

Screening of video and discussions

PROCESS

Tell the participants: "We have just seen exclusion of girls and women just because they belong to the female gender. We are now going to see a film that depicts the pitiable condition of *dalit*s and the 'oppressed' castes. After seeing the film we will discuss it so that we understand the problems better."

1. Screen the film
2. At the end of the film, ask the following questions:
   - What did you see in the film?
   - What were the key scenes?
   - What were your feelings as you were watching the film?
   - Have you had similar personal experiences?
   - Which are the other sections of society that suffer due to exclusion?

   Generate a good discussion. Allow sufficient time for participants to reflect and share their thoughts, experiences and feelings.
3. Once the discussions are over, ask the following questions:
   - As development workers, what messages do the film and the bottle exercise give us?
   - What can we do to reach out to the excluded so that they become part of all our activities and benefit from our services?
   - List the points emerging from the discussions.
4. Now ask the following questions:
   - What are the ways in which we can make our SBCC strategies and initiatives more inclusive, so that we reach out to the poorest, excluded and most vulnerable?
   - What changes should we bring about in our work to ensure that the excluded get included and are mainstreamed?
   - List the points that emerge from the discussion and use these points to **conclude the session**.

FOR THE FACILITATOR

NOTES ON SOCIAL EXCLUSION

Social exclusion describes a process by which certain groups are systematically disadvantaged because they are discriminated against on the basis of their ethnicity, race, religion, sexual orientation, caste, descent, gender, age, disability, HIV status, migrant status or where they live. Discrimination occurs in public institutions, such as the legal system or education and health services, as well as social institutions like the household.

Socially excluded groups suffer from some or all of these denials.

As social exclusion is not only about attitudes but is built into the social structure, changing attitudes will not necessarily change social exclusion. The social structure of a society contributes to the formation of its attitude, and the attitude in turn contributes to the maintenance of the social structure. There is no easy way out of this horribly vicious cycle.

> Since social exclusion is about domination, discrimination and deprivation, those who benefit from it do not want to introduce any change, while those who are discriminated against, who are supposed to be 'inferior', 'incapable', 'less meritorious' and 'lower', are not in a position to mobilise and organise to alter the existing social system. They do not want to remain in the dehumanising social order but fear that they may be subjected to repression if they resist exclusion and discrimination.

During discussions in workshops on reconstruction of the *dalit* identity in six northern states by the Bihar Social Institute, it was found that the negative and derogatory perception of the dominant castes about *dalits* is that they are dirty and filthy, thieves and robbers, lazy, gluttonous (*pethu, khau*), dishonest and ungrateful. This negates the reality. For instance, empirical data does not support the perception that *dalits* are gluttons. The reality is that *dalits*, like anyone else, eat to survive.

Dalits perceptions about themselves is that they are capable but get no opportunities; that they are hardworking but do not get the fruits of their labour; that they are often put in a situation where they are forced to rob or lie; that they are culturally talented and are not immoral, on the contrary they are sensitive and emotional. Some would argue that this perception is unrealistic, even aspirational. However, Dr. Louis argues that a community that is at the receiving end also has scope for looking at the reality of their lives in a positive light.

Tribals face a peculiar dilemma. They have been organising to ensure their rights, and protect their culture and natural resources. But whereas formerly they were totally isolated, now they are the victims of discrimination. Non-tribals see tribals in a derogatory manner, particularly their food habits and ways of living, which are very different. The strong emerging tribal identity, however, sees them as the first inhabitants of this country who have contributed much to the culture, history and heritage of India, though little respect is today shown to their culture, social systems, political structures and economy.

Women are the most excluded and discriminated segment of the Indian population. Patriarchy is at the core of the structural element discriminating against women. Control of women's reproductive abilities and sexuality is in men's hands. Patriarchy limits women's ownership and control of property and other economic resources, including the products of their own labour.

Women's mobility is constrained and their access to education and information hindered. Over the years, it has been recognised that the experiences of a majority of women are grounded in both poverty and patriarchy. Both these feed into each other and subject women to exclusion and exploitation.

The Muslim community is another excluded group in India. There are more Muslims who live below the poverty line than any other group. They also earn much less (on average, Rs. 22,807 per year as against Rs. 25,653 for all others). Only 21 per cent of Muslims use the public distribution system, which provides subsidised food grain, as compared to 33.2 percent of the general population. Enrolment of Muslim children in schools is low (61.6 percent, while it is 71.4 percent for the general population), and the dropout rate is higher. Neither at the policy level nor in programme interventions do Muslims get their due share as citizens of this country.

In this environment, Dr. Louis points out, social exclusion is multiple and cumulative. For instance, a *dalit* or tribal girl suffers multiple exclusions by being excluded due to caste and ethnic reasons, and further excluded by location if she lives in a rural area where she cannot avail of facilities available to those in urban areas. If she is a differently-abled person, she suffers further discrimination by being deprived of life-enhancing mechanisms.

Source: Extracted from a paper titled "Social exclusion: Challenges for civil society organisations" (DFID)

SESSION 4

HOW TO CONDUCT A GROUP DISCUSSION 12:00 to 12:45 (45 minutes)

SESSION OUTCOME

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

- List the do's and don'ts of conducting a group discussion and define their role as facilitators of group discussions.

MATERIALS REQUIRED

- Chart paper and marker pens
- Annexure: How to conduct a Group Discussion

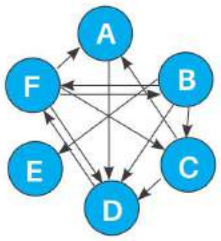
METHODOLOGY

Group discussions and plotting discussion on a sociogram

PROCESS

1. Call six participants – two who are very active and tend to dominate, two who are moderately active and two who are the silent– and ask them to form a group in the centre of the training room. Call three other participants who are active and have the other facilitator take them out of the classroom.
2. The facilitator who takes the three participants out of the classroom briefs them on their role as 'observers'. Tell them that they have to observe the group carefully and that each of them has to create a 'sociogram' that would depict how each of the group members participated in the discussion.

3. Give them clear instructions on how to create the sociogram.
   Follow the directions listed below:



   - Ask them to open a fresh page in their notebooks and mark six dots that create a circle with a diameter of about 3 inches. Each dot represents one of the members who will be participating in a group discussion in the training room. The listing of the names should be in the sequence in which the group members are sitting. Now put the name of a member against each of the dots.
   - When the group discussion starts, observe each member of the group. When one starts speaking observe who he/she is speaking, to and draw a straight line between the dots representing the two of them. For example, if D starts the discussion and looks at F while speaking, draw a line with an arrow from D to F as in the chart; then if F speaks looking at B draw a line with an arrow linking F and B. If C speaks next, looking at B link them both with an arrow. Keep recording the discussions by drawing an arrow as each member speaks till at the end there is a web depicting the way the discussions went. In case a member speaks without focussing on any one and is speaking to the group draw an arrow from him/her to each of the others, indicating that he/she is speaking to the group. Tell the participants **not to forget to mark the side chats that happen between members.**
   - Ask them once again if they have understood their roles clearly. If there are any doubts clarify them.

4. While one facilitator is briefing the three observers, the other gives instructions to the six members who will be involved in the group discussion as follows:
   - Tell the six participants that they will have to carry on a group discussion on 'Why is Social and Behaviour Change Communication the most important part of our work?'Ask them to select a leader from among them to lead the discussions. Tell them that they will be given 10 minutes for the group discussion and that they can decide how to conduct the discussion.
   - Tell the other participants to be attentive and to assess how good the discussion was.
   - Bring the three observers in and tell the group to start their discussion.
   - The two facilitators too should observe the participants carefully and create their own sociograms of the group discussion.
   - At the end of 8 minutes, tell the group that they have 2 minutes left and at the end of 10 minutes ask them to stop their discussion.
   - Ask the six group members how they found the group discussion, whether all members participated effectively, whether the leader helped in facilitating the discussion, whether anyone dominated etc. Ask each group member to share what they felt and how well or effectively they contributed to the discussion.
   - Give sufficient time for the group members to reflect and share their experiences.
   - Then ask the rest of the participants to comment on the way the group conducted the discussion and how effectively each member contributed. Give about 7 to 10 minutes for them to give their feedback.
   - Next, ask the three observers to share their observations with the help of the sociogram. Ask the first observer to explain what the sociogram is and what it depicts. In case there are gaps in his/her description, the facilitators join in and explain the sociogram in detail. The observer then explains how the discussion went using the diagram.
   - Now ask the other two observers to give their observations.

5. Next the facilitators make their own comments drawing conclusions from the sociograms presented. Focus particularly on the following points:
   - The role of the leader in facilitating the discussion.
   - The participation of individual members of the group.
   - Did anyone dominate the discussion and even prevent others from sharing their views?
   - Was there anyone who was silent and did not speak or spoke very little?
   - Was the group able to bring out relevant points on the topic given?
6. Finally the facilitators give their own views on the quality of the group discussion and narrate the story of the King and the *Kheer*.

The Story of the King and the *Kheer*

There was once a very benevolent king who always worked for the welfare of his people. The people loved and worshipped him. One day, the king was reflecting on his life and his kingdom. He was happy that he had been a much loved king, always putting the welfare of his people above everything else. But he also realised that most of his subjects had become lazy and were getting more and more demanding. They had started to expect everything from the king and this saddened him. So he decided to test his people and teach them that they too need to work to earn a living and should not be always dependent on him.

Accordingly, he made a plan, and the royal announcers, with their drums, informed the people that the King wished to eat *kheer* with his subjects. They announced that the King insisted upon one condition–each family would have to provide the milk for the *kheer* while the King would provide the rice, sugar and spices.

On the appointed day, the subjects lined up from early morning with milk cans to give milk to the King for his *kheer*. A huge vessel had been placed in an open area. Each person would walk up to the vessel, climb up the ladder, pour the milk into the vessel and then climb down another ladder. This went on until the last subject had poured his milk into the vessel. The cooking of the *kheer* started and as promised the other ingredients came from the King. After a long wait, the *kheer* was ready! Everyone including the King sat down to eat it. When the attendants started serving the delicacy and the people started eating there was complete silence, but not for long. Soon there was a murmur which grew into a loud noise that rose from every corner, "This is not ***kheer*** – this is ***meetha bhaat***!"

What really happened?

7. Distribute the hand out on "How to Conduct a Group Discussion" attached herewith.

CONCLUDING THE SESSION

"Our session here will be like the ***kheer***. The discussions become richer and more meaningful only when everyone contributes and shares ideas and views. It is important that all of us participate so that others get to know about our thoughts and feelings."

Similarly a group discussion in the field gets enriched by everyone's participation. If only few people dominate the discussion and some people keep quiet, those who are not encouraged to speak may not be able to clear their doubts and/or will not express their concerns about a behaviour change. This will result into incomplete and ineffective communication.

LUNCH BREAK
12:45 to 13:45 (60 minutes)

SESSION 5

USE OF A COMMUNITY DIALOGUE TOOL

13:45 to 14:45 (60 minutes)

SESSION OUTCOMES

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

- Use the outcomes of the Problem Analysis Process in an SBCC session using a community dialogue tool.
- Understand the importance of having the participation of community members, especially women, in bringing about behaviour change within families and communities.

MATERIALS REQUIRED

- A pulley stand
- A doll
- String
- A plastic bag
- 12 thick VIPP cards
- Black board and chalk or chart paper and sketch pens.

METHODOLOGY

- Pulley and doll exercise
- Demonstration and discussions

PROCESS

1. Invite the participants to spend a few minutes discussing the low immunisation status of children in our society.
2. Write at the centre of the board LOW IMMUNISATION STATUS OF CHILDREN and ask the participants to think of some of the main causes contributing this situation. Ask them to share their thoughts one by one, and as they share list the points below the heading. List 10 to 12 main causes.
3. Once this is done, ask the participants the following questions: How can these problems be addressed? How could the mothers be supported to ensure full RI coverage of their children? How linkages with better earnings (like MNREGA) support full immunisation? What support can come from local governance like village health and sanitation committee for complete RI? What are the factors that would help them? Ask them to reflect and share their thoughts one by one. As they speak, list the points above 'low immunisation status of children' as shown in the diagram.
4. What we see here is an interplay of forces acting in-favour of Immunisation and against it. This interplay of opposite forces is called Force Field Analysis. In order to move the equilibrium upwards or downwards we need to alter the forces. The following exercise will show us how the forces can be altered.

   (The diagram should be clearly visible to all).

These factors can help raise immunisation levels

- ANM sensitised for social intrusion.
- Discuss benefits and risks.
- Help the parents visualise child's future.
- Motivate and counsel.
- Highlight importance and urgency.
- Clear misconception.
- Handle objections.
- Explain in terms of changing health conditions and food habits.

Low immunisation status of children

These factors lower immunisation levels

- ANM does not "touch" our children.
- No immediate threat.
- Inability to "see" future of the child.
- Lack of concern.
- Lack of time.
- Misconceptions.
- Hearsay on after effects.

5. Tell the participants that they will do an exercise using the factors listed in the diagram and a community dialogue tool that will highlight these factors and facilitate dialogue with communities, especially women.

6. Ask the participants to stand in a circle. Place the pulley stand in the centre of the circle. Put the string through the pulleys and hang a bag on one end and a doll in a girl's attire on the other end. The doll should be lying on the floor.

7. Tie a string (preferably red in colour) horizontally one foot above the doll, parallel to the ground. (You can also ask two participants to hold the string parallel to the ground in a straight line.)

8. Now ask the participants, "What do you see here? What does the doll represent? A girl? Why is she on the floor? What does the string parallel to the ground represent?"Generate a good discussion.

9. Conclude by saying that the doll (girl) is on the floor because she is poor, helpless, has poor health etc. (Recall the negative points from the analysis done above.) The string parallel to the ground represents the BPL line; the girl is below the health line (normal body weight, no disease, complete immunisation). What we see now represents the poor children within our communities who lead a difficult life.

10. Let's now see how we can help this girl get out of this condition.

11. Spread the 12 thick VIPP cards on the floor near the doll. Ask any one participant to come forward and pick up one card. Ask him/her to write one or two words clearly on the card taken from point #1 of the positive factors from the analysis done in the earlier part of the session. For example if point #1 is 'ANM is sensitive towards social inclusion', he/she should write 'No social exclusion' on the card.

12. Now ask him/her to explain how 'No social exclusion' could help improve the immunisation status for children in a minute or two. He/she then puts the card into the plastic bag hung on the string.

13. Call a second volunteer and ask him/her to pick a card and write point #2 on the card and explain how this factor will improve the immunisation status of the poor girl.

14. Call 10 more volunteers from among the participants one by one and repeat the process till all the cards on the floor are used and put into the plastic bag.

15. As the cards are put into the bag, the girl will gradually start rising and by the time the seventh or eighth card is in; she will be standing and moving above the health line. Stop the process here and ask, "What do we see here?" Allow time for the participants to reflect and give their answers. Then continue the process.

16. By the time the 12th card is put in, the girl will be well above the health line.

17. Stop the exercise.

18. Now move to the second part of the exercise and discuss what happened in the first part.

19. Ask the participants:
    - What did you observe?
    - Where was the doll/girl at the beginning of the exercise and why?
    - What happened to the doll/girl as the cards were being put in?
    - What position is the doll/girl in now? How did the girl come above the health line?

20. Give sufficient time for the participants to reflect and share their thoughts. Bring out the following points:
    - The government is providing a wide variety of services at the community level; it is important that families and communities are fully aware of their entitlements and understand the benefit of these services so that they and their children benefit from these schemes and services.

- These schemes and services are primarily meant to improve the quality of life, especially that of the poor.
- There are many things that communities and families could do on their own that could also improve the situation of children and women.

21. Now move on to the next part of the exercise. Remove the cards from the bag; the doll will once again drop down to the floor. Remove the string from the pulleys and put it on the side of the wheel. Now add cards into the plastic bag; the doll will not rise as before. Even putting all the cards will not lift the doll above the health line. Put the string back on the pulleys and the doll gets lifted again.

22. Once this is demonstrated ask the following questions:
    - Did the doll get lifted up when the string was off the pulleys?
    - Why not?

    Give sufficient time for the participants to reflect and share their feelings and thoughts.

23. Now say, "We see that the pulleys play a very important role in lifting the girl above the poverty line". Then ask the following questions: What does the pulley represent? Does it represent government schemes, the *Panchayat*? Does it represent functionaries like the ASHAs, AWWs, ANMs, *Gram Sevaks* etc., who bring communities and services together? Generate a good discussion and highlight the critical role that the functionaries play in creating awareness among individuals, families and communities and motivate them to avail of the services that are being provided.

CONCLUDING THE SESSION

- Ask the participants how they found the session. Did they find the link between the Force Field Analysis and the pulley exercise?
- How did they find the use of the pulley, doll and cards as a community dialogue tool? Was it effective?
- Emphasise that it is only through participation and sharing their feelings and thoughts that people internalise messages and get motivated to change.
- A sustained dialogue is essential to bring about behaviour change.

TIPS FOR THE FACILITATORS

- The length of the rope should be such that one end is 2-3 feet above the ground.
- The doll should be lying on the ground to start with.
- The weight of six cards should be equal to the weight of the doll so that when six cards are placed in the plastic bag, the doll and the bag are on the same level.
- Do a thorough rehearsal before the actual exercise.
- Initiate discussion when each card is being read and put in the bag.
- Emphasise the community dialogue tool when wrapping up the session.

SESSION 6
UNDERSTANDING TEAMWORK

14:45 to 15:30 (45 minutes)

SESSION OUTCOMES

At the end of the session, participants will get a good understanding of:

- How teams should work.
- What the role of each member of the team is.
- What type of leadership that would bring about the best results.

MATERIALS REQUIRED

- 12 pieces of the broken square
- The key (guide) to the broken square
- Black board and chalk or chart paper and sketch pens

METHODOLOGY

The broken square exercise followed by discussion.

PROCESS

1. Tell the participants, "Our session now will be on team work, what a team means, its characteristics and the role that the members and the leader play."

   Ask them whether they belong to any team/s. If some of the answer "yes", ask them which team they are members of and who the other members of the team are. Ask them whether they have worked as members of a team and if "yes", ask two or three participants to share their experience very briefly.

2. Tell there are two types of teams. One within your own department you are a part of a team which comprises of your colleagues – peer level, juniors, and seniors. The other team is outside your department at the field level where you come in contact with people from other departments and share a common goal – like ANM, ASHA and AWW share a common goal of child health and development.

3. In Part A of this session, we will discuss the cross-functional teams. In Part B of this session we will discuss supportive supervision which helps in improving the intra-departmental teams' performance.

PART A

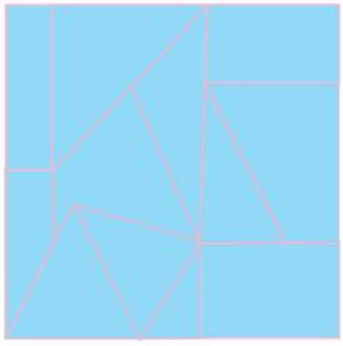
1. Now ask for five volunteers and send them out of the training room. Ask for five more volunteers and send them also out of the training room.

2. Tell the other participants that the first team that went out is the 'Planning Team' and the second team the 'Implementing Team'. Show them the square (key) as shown in the diagram. Also show them the 12 pieces that when put together will make the square.

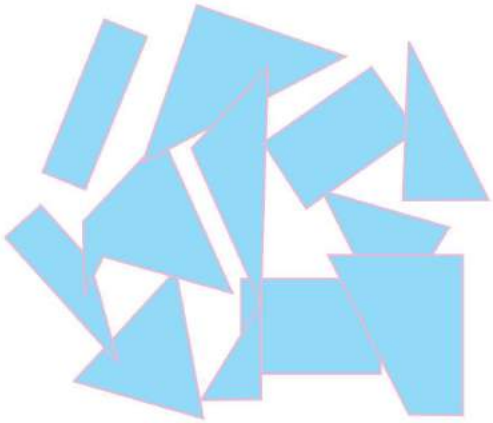
3. Now leave the 12 pieces and the Guide on the table. The 12 pieces will be all mixed up and separate.

4. Address the participants inside the training room:

   "You are the observers. Your task will be to observe how an individual behaves in both the planning as well as the implementing teams; also note the dynamics among the members as well as between the two teams. You will also observe different leadership styles as well as leadership transferring from one person to the other. Keep a note on each member and her/his behaviour.



Guide to making the Square



The 12 pieces that make the Square

At the end of the exercise you will have to share your observations with all the participants.

Keep your eyes and ears open; you will have a lot of fun".

5. Call in Team #1 and tell them the following:

   "You are the Planning Team and you have an Implementing Team that will carry out the task of making a square under your instructions. Your task is to direct your implementing team to make a square by putting together the 12 pieces kept on the table. You will be given 5 minutes to look at the separate pieces of the square and plan how they can be put together to make a perfect square. The Guide on how the square could be made is also on the table to help you. After five minutes, the Guide will be removed.

   Kindly note that you are not allowed to touch the pieces; you can only look at them and plan as a team how the square can be made.

   After 5 minutes, your Implementing Team will be called in and you will be given another 5 minutes to instruct and advise them how they can make the square. Again, you are not allowed to touch the pieces while instructing your implementing team. Your job is complete at the end of 5 minutes.

   Your success is when your implementing team completes the square.

6. Now give the Planning Team 5 minutes to plan making the square. After 5 minutes tell them to stop and call in the Implementing Team.

7. Address the Implementing Team members:

   "A square has been broken into pieces. You have to put these pieces together to complete the square. You have a Planning Team that knows how this can be done and they have been given 5 minutes to give you instructions to complete the task. During these 5 minutes you are not allowed to touch the pieces. Once the Planning Team completes the instructions you will be given 10 minutes to make the square. You will not be allowed to consult any members of the Planning Team while you are making the square.

   Your success in completing the square will also be the success of your planning team.

8. Ask the Planning Team to start briefing the Implementing Team on how to make the square using the 12 pieces. Remember to put away the guide. Also remind them that they are not allowed to touch the pieces. Give them 5 minutes to do this.

9. At the end of 5 minutes tell the Planning Team members that their job is over and that they should move out leaving the Implementing Team members to make the square.

10. Give the Implementing Team 10 minutes to make the square. After 10 minutes ask them to stop work. In most cases they would not have been able to complete the task.

11. Ask all the participants to go back to their respective seats.

12. Ask the Planning Team members the following questions:
    - Did your Implementing Team succeed in making the square?
    - Are you happy with the outcome?
    - Why did they fail? What was the problem?
    - Were you able to instruct the Implementing Team how to make the square?
    - Did you plan well?

Give the team members sufficient time to reflect and respond.

Now ask the Implementing Team members the following questions:

- Did you succeed in accomplishing your task?
- Why did you fail?
- What was the problem?
- Did your Planning Team give you the right instructions?
- How was the co-ordination among your team members?

Give the team members sufficient time to reflect and respond.

13. Now ask the other participants the following questions:
    - Why did the Implementation Team fail in its task?
    - Did the Planning Team do its job well?
    - What do you think went wrong?
    - What were the dynamics among the members of both the teams and between the teams?
    - Who were the leaders in the two teams? What was their style of leadership?
    - Were there members who were dominating? Were there members who were passive?

14. Generate a good discussion around these questions and give sufficient time for the participants to respond.

15. Then ask whether the members worked as a team? What are the important characteristics of a team?

16. Bring out the following characteristics of a good team:

    Every good team will have
    - Clear goals that all members share and aspire to achieve.
    - A detailed plan where tasks and responsibilities are clearly spelt out.
    - A maximum of about 15 members to be effective.
    - Strong bonding between members with mutual respect and appreciation.
    - A code of conduct with some rules and regulations that all members abide by.
    - A leader who is democratic and sensitive and respected by members.

CONCLUSION PART A

Conclude the discussion by saying, "We are all members of teams – the ASHA, the AWW and helper and the ANM are a team. The team could be expanded by including SHG leaders, *Panchayat* members, *Gram Sevaks* etc., depending on the tasks to be accomplished. Only when all members work as a team will we achieve results. Everyone should have the same goals and share the same vision and values. Each one should play his/her role well since these roles are inter-dependent. If one member does not perform well, the team does not perform well. This is something that all of us should remember always.

We have many challenges in the field, the greatest being creating awareness among families and communities and motivating them to make the right choices/ decisions. Only as a team can we succeed. **It is important that we strive to create a strong team at the village level consisting of the ASHA, the AWW, the helper, women and youth representatives as well as the *Sarpanch* and other elected representatives. Each member should have a clear understanding of the goal that needs to be achieved and the work should be delegated so that the team becomes effective and result oriented. We will see how such a team can work effectively in the next session where we will discuss the planning and organisation of the Village Health and Nutrition Day (VHND).**

PART B

Ask these question to the participants:

How do you want your supervisor to behave? List five good things and five things that you don't like in your supervisor. Generate a good discussion.

Ask the question: What do you think your subordinates would say about you? Do you think they will repeat some of what you have said? Generate a discussion.

Then display the following chart and explain the points linking it with their observations.

Supportive supervision is a collaborative effort between the supervisor and the health functionary to help the health functionary improve his/her performance and confidence.

- The Supervisor observes the health functionary's communication work with mothers/caregivers, and provides constructive feedback.
- The Supervisor should listen to staff and community.
- She/he should be able to empathise with others.
- She/he should provide continuous feedback to the staff.
- She/he should help each one achieve her/his targets.
- She/he should review staff performances periodically and offer support for mid-course correction.

CONCLUSION PART B

Supportive Supervision is different from traditional supervision. Traditional supervision involves more aspects of inspection and control, with a focus on ensuring adherence to policies and procedures. Supportive Supervision involves joint problem-solving to identify areas of strength and addresses any difficulties the health functionary experiences. It improves the motivation level of the health functionary.

TEA BREAK

15:30 to 15:45 (15 minutes)

SESSION 7

PLANNING AND ORGANISING A VILLAGE HEALTH AND NUTRITION DAY

15:45 to 16:45 (45 minutes)

SESSION OUTCOMES

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

- Plan a Village Health and Nutrition Day (VHND), the different activities that need to be carried out and the responsibilities of different functionaries.
- Understand the need to have the Village Health and Nutrition Committee meetings to review and plan activities for the coming months.

MATERIALS REQUIRED

- The film ASHA, *Ek Din Zindagi Ki* (VHND)
- Laptop or TV and LCD projector
- Blackboard and chalk or chart paper and sketch pens

METHODOLOGY

Viewing of the film and discussions.

PROCESS

1. Tell the participants that they will see how a good VHND can be organised. Ask them to watch the film carefully.
2. Familiarise yourself with the questions that are raised during the film at fixed intervals so that you can generate lively and useful discussions.
3. Now start showing the film and stop after the first set of questions appear. Generate a discussion on the questions. Allow participants to share their thoughts. Keep the discussions to the point.
4. Once the discussions are over, restart the film. Pause again when the next set of questions appears. Generate a discussion as before.
5. Continue the process till the end of the film.
6. Once the discussion on the film is over ask, "How is VHND conducted in your villages? Do you follow what was seen in the film? What problems do you encounter? How important is having a SBCC session on VHND? How do you plan for it?"
7. Allow sufficient time for the participants to reflect and respond.

CONCLUDING THE SESSION

- Conclude by saying the VHND is probably the most important day for any village and it is important that we conduct it in the best way possible; the Village Health, Nutrition, Water and Sanitation Committee should be roped in to support the day. Frontline functionaries like the ASHA, AWW, helper, ANM etc. should work as a team and clearly define the roles as shown in the film.
- Getting all families and the community to understand that VHND is crucial for the health of children and women is a challenge. Every child and woman should take advantage of VHND.
- It is also an important day to conduct an SBCC session in a planned way using a good community dialogue tool. These sessions should be planned well in advance and women should be aware of the sessions. It could be jointly conducted by the ASHA, AWW and the ANM.

SESSION 8

CREATING A VILLAGE HEALTH PLAN AND DEVELOPING A VILLAGE SBCC PLAN 16:45 to 17:45 (60 minutes)

SESSION OUTCOME

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

- Understand the process of developing a village SBCC Plan.

MATERIALS REQUIRED

SBCC Plan templates (8-10) copies

METHODOLOGY

PowerPoint presentation and discussion.

PROCESS

1. Tell the participants that they will look at the process of creating a village SBCC Plan through group work. What they will be doing is just an overview of the process. Also inform them that the ASHAs, AWWs, ANMs and other functionaries who will be undergoing the 5-day Module will actually do each step of the exercise.
2. Form six groups and give one copy of SBCC Plan template to each of them.
3. **Important: Make sure that you have read through this part of the 5-Day Module and prepare yourself for this presentation.**
4. Now explain each column of the template.
5. Request the participants to make an ideal SBCC plan for their group. Give the 30 minutes to prepare this.

CONCLUDING THE SESSION

Conclude by saying that:

- A communication plan cannot be an event but a process, well planned over the year.
- One challenge is to create a supportive and enabling environment where behaviour change is induced through social norms and the other challenge is to bring about the desired change in individuals and families.
- Community dialogue tools and group discussions are effective for creating an enabling environment while IPC and counselling are good at the individual and family level. Various aids can be used to help in communication.
- Social, print and electronic media can effectively transmit information and create awareness; these also reinforce what is being discussed at the community and family levels.
- A plan should look at a good media mix, clearly define audience groups and list the behaviour change that it wishes to bring about.

SESSION 9

VALEDICTORY SESSION

17:45 to 18:15 (30 minutes)

PROCESS

- Inform the participants that day's sessions have come to an end and that each one of them is welcome to give his/her feedback and comments on the sessions as well as the SBCC module.
- List the points that emerge on the board or on a chart paper.
- Conclude by saying that their support and understanding would be critical in rolling out such a module.

Thank all the participants for being present despite their busy schedules.

"TELL ME, AND I WILL FORGET.
SHOW ME, AND I MAY REMEMBER.
INVOLVE ME, AND I WILL UNDERSTAND."

Chinese Proverb

ANNEXURES

ANNEXURE I : Day 1, Session 2 – PowerPoint on Development Paradigm and SBC Theories (in the CD).

ANNEXURE II : Day 1, Session 3 – PowerPoint on *TARANG* SBC Communication Modules (in the CD).

ANNEXURE III : Day 1, Session 4 – The picture of railway compartment.

ANNEXURE IV : Day 1, Session 5 – PowerPoint of *Shanta*'s story (in the CD).

ANNEXURE V : Day 1, Session 5 – PowerPoint of Behaviour Change Process and Roles (in the CD).

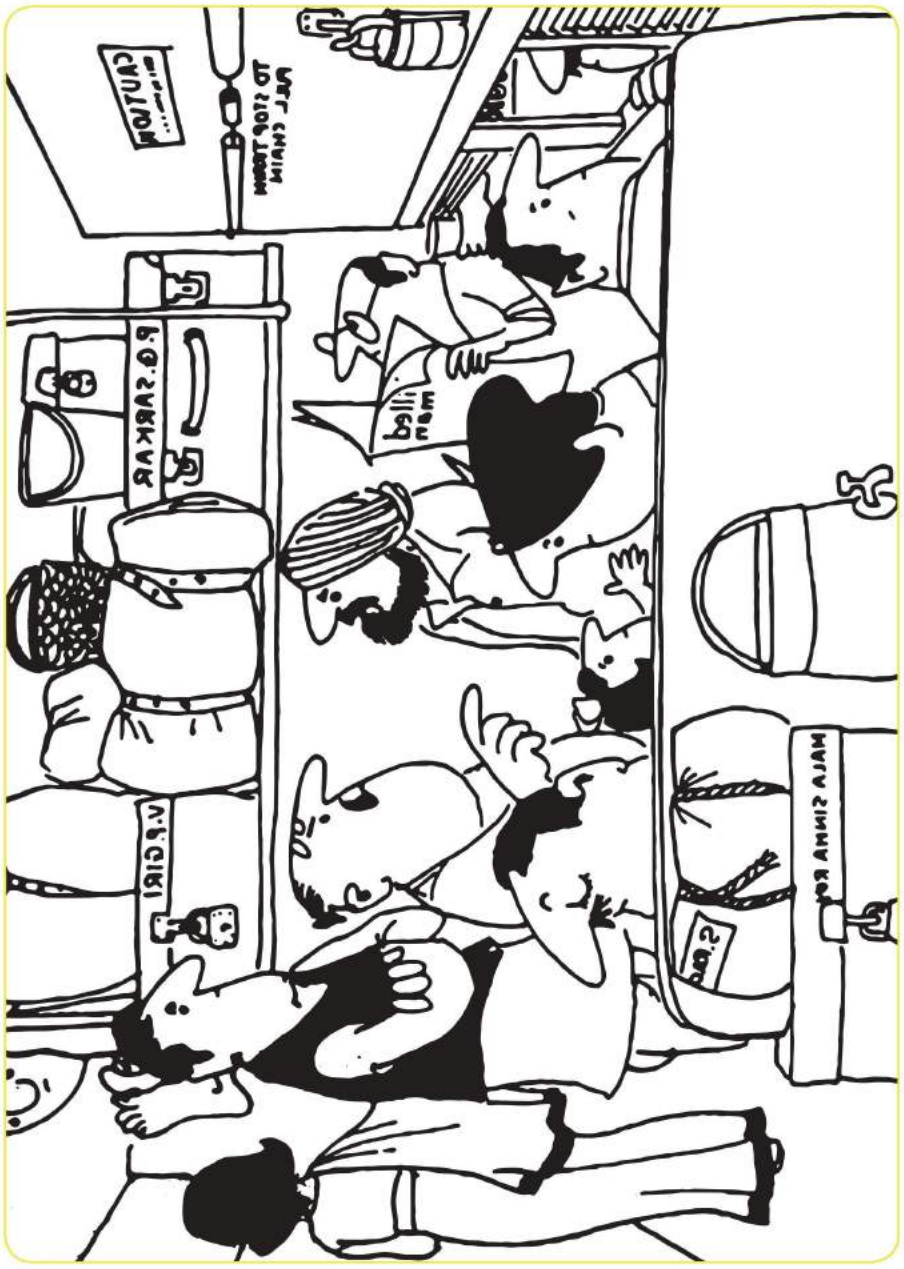
ANNEXURE VI : Day 2, Session 5 – Specifications for Pulley Stand.

ANNEXURE VII : Day 2, Session 8 – SBCC Plan templates.

ANNEXURE VIII : Pre-Post Format – SBCC Training for Mid-level Managers

ANNEXURE III Day 1 (Session 4)

THE PICTURE OF A RAILWAY COMPARTMENT



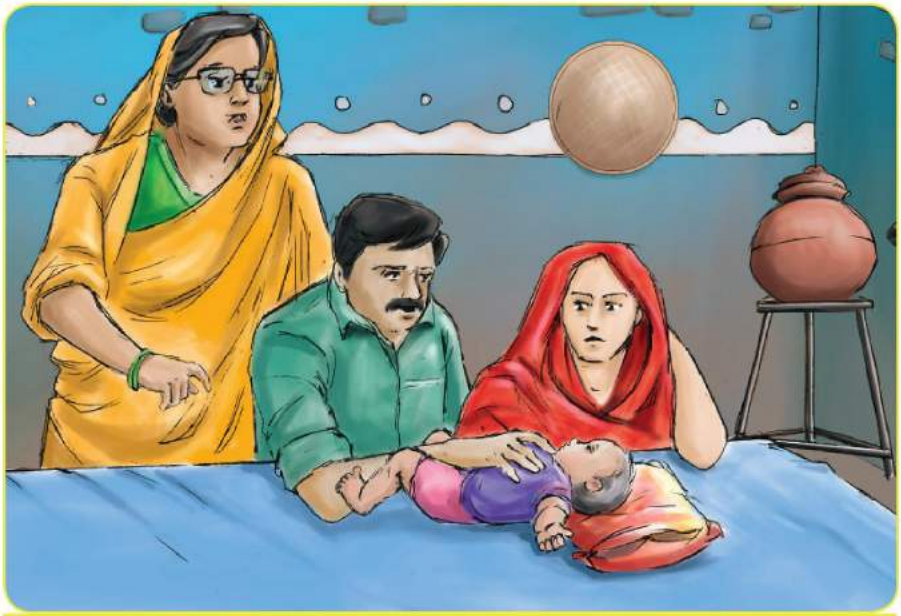
SHANTA'S STORY

Sumitra, the ASHA of village Rampur, was concerned that a few families in the village were not bringing their babies for immunisation. So she decided to visit them in their homes and explain the importance of immunisation to them and the need to get their children immunised.

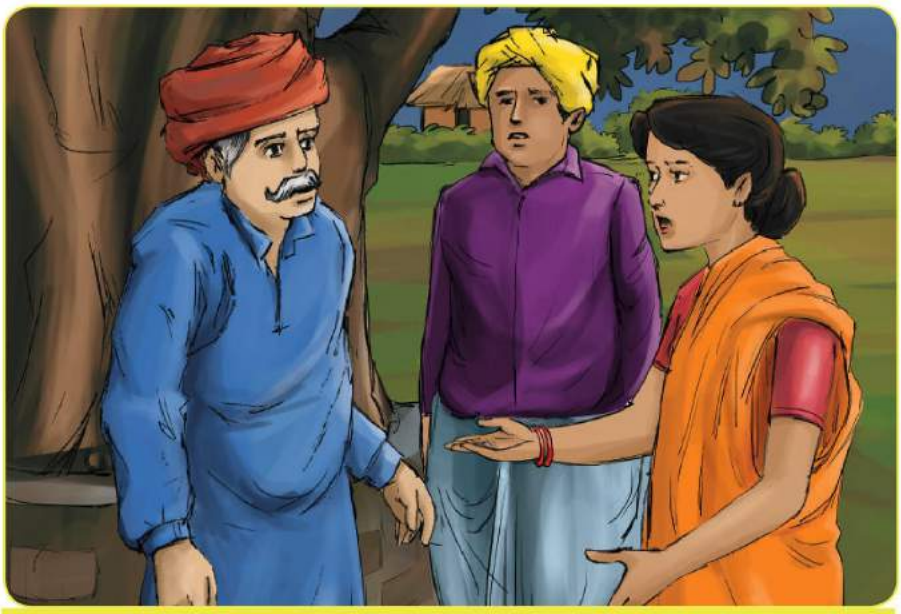
One of the houses she visited was that of Shanta, a lady with a 6-month-old baby who had never been immunised. When Sumitra discussed the need to immunise her son, Shanta said that her family did not believe in immunisation and that her mother-in-law and husband, Ramlal, would never allow her to immunise the child. Sumitra, in a very friendly and caring manner, explained to Shanta why immunisation was important and asked her to attend the VHND the following Wednesday along with her baby. Shanta promised to discuss this with her family.

On VHND, Sumitra noted that Shanta had not brought her baby for immunisation and so, after the session, she took the AWW to Shanta's house and was fortunate to meet both Ramlal and his mother. She explained to them too the need for immunisation. After much persuasion, they agreed to immunise the child.

As the ANM was still in the village they were able to administer the first doses of polio and DPT as well as BCG. Sumitra was very happy. She told Shanta and her family that they should bring the baby for the second dose of vaccines the next VHND in the following month.



A week later, Sumitra visited Shanta's house to find out how the baby was and also to remind them to bring the baby for the second dose. Shanta's mother-in-law complained that the child was restless after immunisation and had fever all through the night. Sumitra explained that it was normal for some babies to get fever after immunisation and that there was no cause for concern. On the next VHND, Shanta did not come to the PHC.



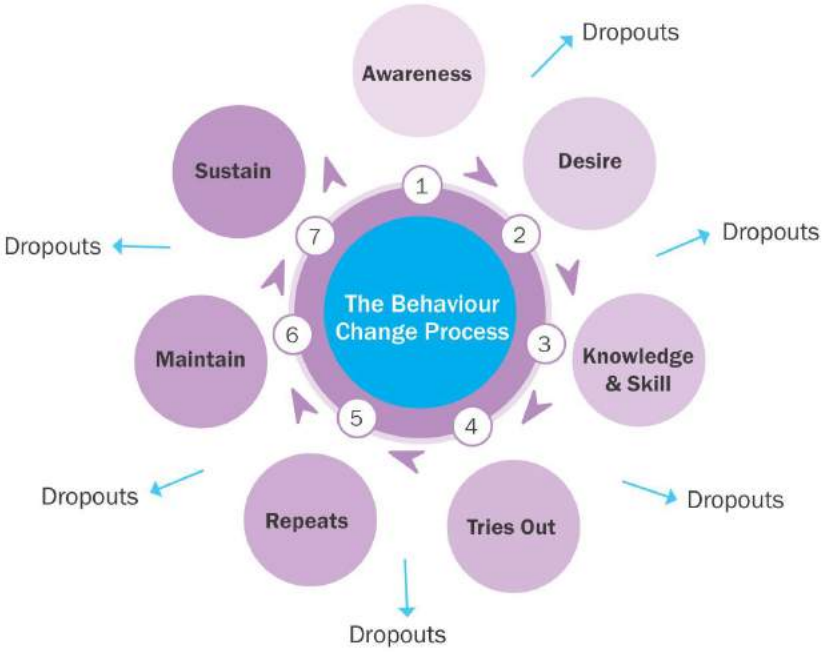
Sumitra sent the AWW helper to Shanta's house again, but she refused to come since her family was against any further immunisation since the child had fever the previous time and they had also heard that it could cripple the child. The child, thus, missed the second dose. Sumitra then decided that the only way to ensure that the child got immunised was to convince Ramlal. She spoke to the *Sarpanch* and also to two of Ramlal's neighbours who were his friends.

Together they had a long discussion with the family informing them that all the children in the village were being immunised and that there had been a marked reduction in diseases. They also told the family that it is the right of every child to get immunised and that parents should not be guilty of not taking care of the health of the child.

Both Ramlal and his mother were convinced and even accompanied Shanta to the PHC where the child received the second dose of vaccines. Since then the parents have been very careful and have ensured that the child receives all vaccinations, including against measles, and Vitamin A prophylaxis. Shanta now actively advocates on the need to get babies immunised.

ANNEXURE V Day 1 (Session 5)

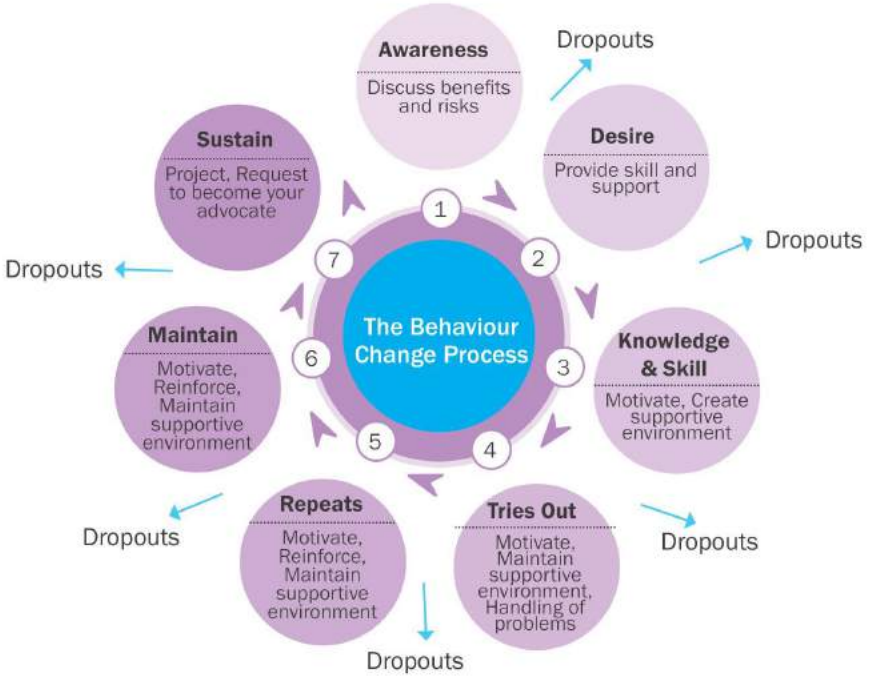
THE BEHAVIOUR CHANGE PROCESS



An enabling environment consists of

- Supportive relatives and neighbours.
- Functionaries and volunteers and other opinion leaders through their sustained encouragement, through counselling and dialogue and provision of quality services.
- The media through supportive messaging.

THE BEHAVIOUR CHANGE PROCESS AND THE FRONTLINE FUNCTIONARIES' ROLE



SPECIFICATIONS OF PULLEY

Dimensions:

18 inch/1.5 feet height (to be placed on the table) and 14" width wheel-to-wheel

Material:

Wooden (will be polished)

SBCC PLAN TEMPLATES

VILLAGE SBCC PLAN

Steps

- Begins with analysing the Village Health Map to assess the situation.
- Reference column 2 of Village Health & Nutrition Plan template.
- Develop Village Health and Nutrition Plan.
- Develop Village SBCC Plan.

Village SBCC Plan									
Areas of intervention	**Social & behaviour change listed**	**What are the barriers or triggers to behaviour change?**	**Who is to be addressed?**	**What approach should I use?**	**What tools or materials should I use?**	**When should I develop the plan?**	**Who will help me?**	**How should I follow up?**	**How should I monitor the change?**
Location of government service centre	Women safety should become a social responsibility at the village level.	Local norms on women safety	Village boys, young men and women and village elders	Group discussions - mixed groups with adolescents, men, women, elders	Open discussions and story telling (pick a story from the newspaper)	Organise a special session	*Gram pradhan*, local religious leaders	Have a meeting once in 15 days for next two months	Walk around the PHC once in 15 days to verify the surveillance groups; ask women if they feel safer
Health care seeking behaviour	Pregnant women should be asking for and availing ANC check-ups.	Inaccessible area, delays, Low literacy, old tradition, customs, discourteous behaviour of frontline functionaries	Mothers, husbands, mother in law	*Saas bahu sammelans; pati-patni sammelans;* joint home visit with VHSC member	Organise a group meeting with the women of that community to know the reasons for not coming for ANC.	Immediately after finding that there are pregnant women in the community who have not come for ANC	A woman from same group who has completed all ANCs and can be projected as a role model	Every quarter	Obtain data for ANCs; Home visits
Status of:									
Pregnant women & lactating mothers	Mother-in-law and other family members support healthy care practices for pregnant and lactating mothers and newborns	Lack of awareness on danger signs, Social Norms related to early bathing & cleansing of baby & pre-lacteal feeds	Families and mother in law	Frequent home visits	Flip books, posters, films	Quarterly, also cover all pregnant women from their registration onwards till ANCs	AWW/ANM	At the time of each ANC	Home visits
Adolescent girls	Women in family and frontline functionaries explain and discuss menstrual hygiene behaviour with young girls	Lack of awareness, social taboo resulting in inhibitions to discuss with /educate girls	Adolescent girls, mothers	Counselling sessions at school, and *Anganwadi* centre	Group meeting with mothers using doll-pulley	Monthly meetings	*Gram pradhan* (if a woman) or *Pradhan's* wife	Monthly	Increased use of clean cloth/ sanitary napkins observed through home visits
Children under 6 years	RI is recognised as a preventive measure; community recognises the importance of preventive behaviour over curative medicine	Lack of awareness, Traditional negative values, Inaccessible area, negative attitude of service providers, low priority toward health.	Mothers, husbands, mother in law	Social dialogue; use of religious leaders	Group meeting with mothers using doll-pulley	Monthly plans	Local religious leaders, school teacher, mothers of children with full immunisation coverage	Fortnightly, Ongoing verification of 'due-lists'	Actual number of immunisations done; verification with due list

Village SBCC Plan									
Areas of intervention	**Social & behaviour change listed**	**What are the barriers or triggers to behaviour change?**	**Who is to be addressed?**	**What approach should I use?**	**What tools or materials should I use?**	**When should I develop the plan?**	**Who will help me?**	**How should I follow up?**	**How should I monitor the change?**
VHND	Create demand for and participation in VHND.	VHND is organised as a festival like event	Families and caregivers	Convergence of all departments - especially Health and ICDS	Wall paintings, children '*prabhat pheris*'	Two weeks before every VHND/RI day	MO I/C, ICDS Supervisors, PRI & VHSC Members, local RMPs, Religious leaders	Ongoing activity, weekly follow up with due list	Number of persons visiting on VHND, increase in the number of counselling sessions on a VHND
Water & sanitation	Village water and sanitation committee (VWSC) should be empowered; community interest in water and safety of water sources is increased	Water is not seen as a limited resource; Price of water is not acknowledged as people get it free; awareness on water cleanliness is poor - what looks clean is perceived as clean	All community members - mainly parents; VWSC members	Group discussions on sources of water contamination, proper storage of water, and recycling of kitchen water into kitchen garden	Community dialogue tool doll-pulley	Quarterly	School children; women	During home visits; at the village handpump /well	Home visits
Environmental sanitation & hygiene	Community takes the responsibility of making the village ODF	Old practices of OD; Health - specially children health and women safety can be triggers	Men, Women, specially young women; VWSC members	Group discussions; village walks through OD sites in group	Wall paintings, group meetings	Quarterly in consultation with *Panchayat*	*Gram Pradhan*	Quarterly	Home visits
Any other issue that the group comes up with									

Analysing the village health map

Issue	What needs to be analysed
Layout of the village	• Location of the households, where the very poor, the scheduled castes, minorities live. How far the poor are from the AWC, the school, VHND site, the *Panchayat Bhavan* etc
Location of government service centres	• Are they centrally located? • Does everyone have easy access? • Who benefits most from the location? • Who are at a disadvantage?
Health care seeking behaviour	• Which are the families that don't come for ante-natal check up and immunisation of babies, don't consume IFA tabs, avoid government services? • Where do they live in the village? Do they belong to the poorer and discriminated sections? • Whom do they go to for health care?
VHND	• How well is the VHND organised? • Does the community cooperate and support the organisation of the session? • Do families come voluntarily or have they to be called? Do the families know when this session is to be held? • Do they know what services are offered? • How dote ANM and ASHA and the families/mothers of newborns interact?
Water & Sanitation	• What are the water sources? • What is the quality of water? • Are the sources chlorinated at regular intervals? • How is water stored in houses? And how is it handled? • How many houses have toilets? How many defecate in the open? • Do people wash their hands with soap after defecation and cleaning? • Where do children defecate? • Do mothers wash their hands with soap after washing children? • Are there a large number of diarrhoea cases?
Environmental Sanitation & Hygiene	• Are the surroundings of the tubewells and other water sources clean? • Do schools and the AWC have water and toilet facilities? • Are there spaces used for open defecation? • How harmful is that for health? • Do they have a drainage system or soak pits to handle waste water? • Are cattle tied very close to houses or within houses?
Any other issue that the group comes up with	• Ambulance service, emergency care etc.

Village Health & Nutrition Plan

Areas of intervention	Problems identified in order of priority	Actions required	Social change that should happen within communities	"Behaviour change that should happen within families (What should be the desired behaviour change that should happen at the individual, family and community level so that expected outcomes are achieved?)
Location of government health service centre	PHC is located on a lonely patch making it difficult for the women	Since PHC can not be shifted, the surroundings should be made safer through supportive environment	Women safety should become a social responsibility at the village level.	Village boys/young men/women volunteer to form surveillance groups around the PHC
Health care seeking behaviour	Women from a particular community are not coming for ANC	Explore the causes	Women should be willing to talk about their reservations. Organise a group meeting with the women of that community to know the reasons for not coming for ANC.	They start coming for ANCs and take 100 IFA tablets
VHND	People need repeated reminders to come for the VHND	VHND should be perceived as a major health event	Involve multiple stakeholders - PRI members, local school teachers, ICDS/Health, NGOs to publicise the event.	Families come for the VHND and discuss their issues with ANM/AWW
Status of:				
Pregnant women & lactating mothers	Women do not recognise danger signs just after delivery and it prevents seeking medical care in time	Improved HBPNC	Mother-in-law and other family members get involved with child's health	Mother-in-law and other family members recognise danger signs

Areas of intervention	Problems identified in order of priority	Actions required	Social change that should happen within communities	"Behaviour change that should happen within families (What should be the desired behaviour change that should happen at the individual, family and community level so that expected outcomes are achieved?)
Adolescent girls	Menstrual health is not a priority	Menstrual health related issues are discussed and explained to the girls	Village elderly women discuss the issue with young girls	Girls use a clean sun-dried cloth/ sanitary napkin
Children under 6 years	Not all children complete RI and children drop-out in between a RI schedule	Identify barriers and facilitators for complete RI for all children	RI is recognised as a preventive measure; community recognises the importance of preventive medicine over curative medicine	Parents give priority to RI
Water & Sanitation	Water is not stored safely and is wasted	Water storage to improve and it should be chlorinated	Village Water and Sanitation Committee should be empowered; community interest in water and safety of water sources is increased	Sources of water are safe and water is used judiciously
Environmental Sanitation & Hygiene	Open defecation exists	Construct toilets at home and make existing toilets functional	Community takes the responsibility of making the village ODF	Families use toilet at home; child faeces are disposed safely and properly
Any other issue that the group comes up with				

Village SBCC Plan

Column	What to fill up
Social & behaviour change needed as listed in the previous session	This is taken from the group work done in the previous session. List it under each area of intervention.
What are the barriers to behaviour change?	List the barriers to bringing about the change (attitudes, customs, lack of awareness etc.) Remember the Problem Analysis exercise.
Who are the stakeholders?	Define at what level – individual, family or community – you wish to bring about the change. In some cases it could be at all three levels, in some it could be at two levels and in some, just one. It could even be a few individuals or a few families.
What approaches should I use?	Should it be IPC/counselling through home visits, or group sessions? Should it be at the level of community leaders or should it be at the community level using media? In some cases, you might decide to use multiple approaches.
What tools or materials should I use?	Should I use counselling, discussions using flip charts, films or other AV material including the community dialogue tools? Again, it could again be a mix of some of the above.
When should I develop the communication plan?	Should I do it when the problem occurs? Should I do it at the change of season? Should I do it at the VHND or should I organise special sessions? How many times should I do it, what frequency should I follow?
Who will help me ?	Should I take the help of other colleagues (ASHA, AWW, ANM etc.), PRI members, SHG leaders, youth volunteers etc.? If you need them then you have to plan the session with them and each of your team members should have clear roles.
How do I follow up?	How frequently should I follow up? Should I do another session using another tool? When should I conduct the follow-up home visits etc.?
How do I monitor the change?	Should it be through families accessing services, communities bringing about changes at the village level through various activities, or by tracking individuals and families?

Village SBCC Plan Template

Areas of intervention	Social & behaviour change listed	What are the barriers to behaviour change?	What are the triggers to behaviour change?	Who is to be addressed?	What approach should I use?	What tools or materials should I use?	When should I develop the plan?	Who will help me?	How should I follow up?	How should I monitor the change?
Location of government health service centre										
Health care seeking behaviour										
VHND										
Status of: • Pregnant women & lactating mothers • Adolescent girls • Children under 6 years										
Water & Sanitation										
Environmental Sanitation & Hygiene										
Any other issue that the group comes up with										

ANNEXURE VIII

PRE-POST FORMAT – SBCC TRAINING FOR MID-LEVEL MANAGERS

Pre-Test ☐ Post-Test ☐

Participant's Name: ..... Date: .....

A. Describe your role in field-level SBCC interventions in 3-4 sentences.

.....

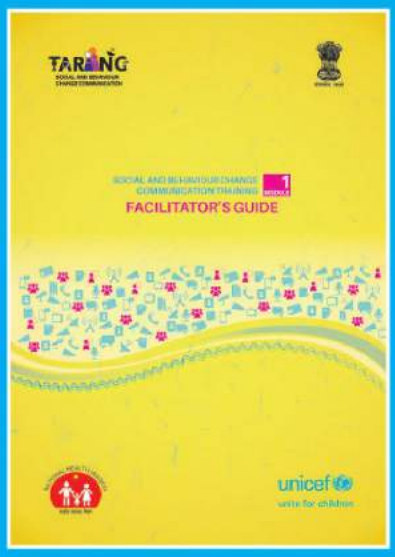
.....

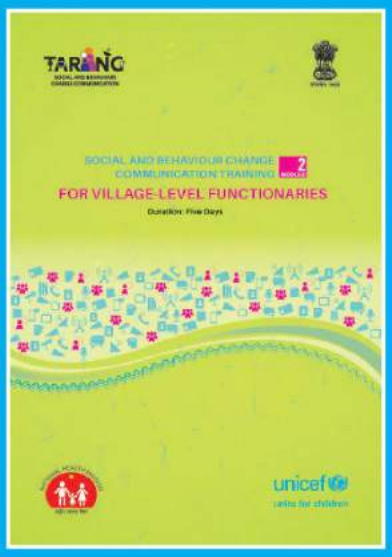
.....

.....

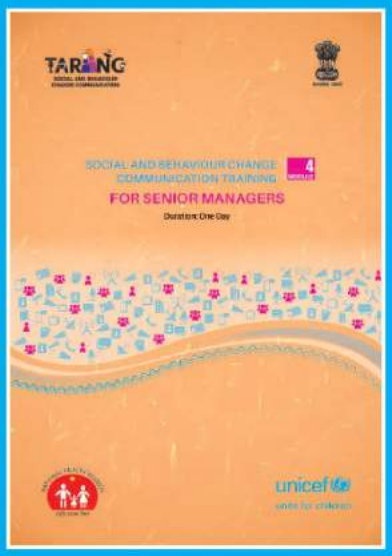
B. If you agree with the statements given below, please mark Y, else N

1	There is not much difference between IEC and BCC	Y	N
2	It is not possible to change the behaviour of a person	Y	N
3	Generally all families in the village are at the same level of understanding.	Y	N
4	All people have equal rights, therefore there is no need to provide special provisions for a group or community	Y	N
5	Process of communication becomes easier with the participation of all stakeholders	Y	N
6	There are seven steps in the behaviour change process	Y	N
7	Village Health & Sanitation Committees can play an important role in creating a supportive environment for behaviour change	Y	N
8	BCC approaches like counselling and IPC constitute a complete and comprehensive medium for effective communication at the village level	Y	N
9	Asking questions can be counter-productive in '*Muskurahat*/GATHER' - IPC	Y	N
10	Nature has divided the tasks and roles between men and women.	Y	N
11	Convergence of various services would create confusion at a VHND	Y	N
12	If a person interprets a message in a wrong way, it is that person's mistake	Y	N
13	There is a need to run special programmes for the disadvantaged sections of the society	Y	N
14	Radio and TV are media through which we can reach all people and we can change their behaviour	Y	N
15	Only a person with good command on language can be a good communicator	Y	N


TARANG
SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION TRAINING
MODULE 1
FACILITATOR'S GUIDE
unicef
unite for children


TARANG
SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION TRAINING
MODULE 2
FOR VILLAGE-LEVEL FUNCTIONARIES
Duration: Five Days
unicef
unite for children


TARANG
SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION TRAINING
MODULE 3
FOR MID-LEVEL MANAGERS
Duration: Two Days
unicef
unite for children


TARANG
SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION TRAINING
MODULE 4
FOR SENIOR MANAGERS
Duration: One Day
unicef
unite for children


TARANG
unicef
unite for children
SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION TRAINING
MODULE 5
SOCIAL INCLUSION AND COMMUNICATION FOR SOCIAL & BEHAVIOUR CHANGE
Duration: One Day