

# PART 3: TRAINER'S GUIDE

The trainer's guide is the third of four parts contained in this module. It is NOT a training course. This guide provides guidance on how to design a training course by giving tips and examples of tools that the trainer can use and adapt to meet training needs. The trainer's guide should only be used by experienced trainers to help develop a training course that meets the needs of a specific audience. The trainer's guide is linked to the technical information found in Part 2 of the module.

Module 19 is about working with communities in emergencies and focuses on Behaviour Change Communication (BCC). It covers approaches to working with communities and implementing BCC activities and how these approaches can strengthen an emergency response. Nutrition BCC in emergencies may often be a low priority in the early stages of an emergency response and is an area that would greatly benefit from more guidelines to help formulate a coherent BCC strategy based on tried and tested BCC methods in emergency situations.

BCC activities can greatly increase the effectiveness of an emergency response as they aim to empower individuals or entire populations to maximize the use of the resources that can protect their nutritional status and support them in adapting to a difficult and changed environment. Practitioners working in emergency nutrition situations need to be aware of the importance of BCC and how to implement BCC activities.

### Navigating your way round these materials

The trainer's guide is divided into six sections:

1. **Tips for trainer** provide pointers on how to prepare for and organise a training course.
2. **Learning objectives** sets out examples of learning objectives for this module that can be adapted for a particular participant group.
3. **Testing knowledge** contains an example of a questionnaire that can be used to test participants' knowledge of food security either at the start or at the end of a training course.
4. **Classroom exercises** provide examples of practical exercises that can be carried out in a classroom context either by participants individually or in groups.
5. **Case studies** contain examples of case studies (one from Africa and one from a different continent) that can be used to get participants thinking through real-life scenarios.
6. **Field-based exercises** outline ideas for field visits that may be carried out during a longer training course.

# CONTENTS

## 1. Tips for trainers

## 2. Learning objectives

## 3. Testing knowledge

**Exercise 1:** What do you know about working with communities and BCC?

**Handout 1a:** What do you know about BCC?: Questionnaire

**Handout 1b:** What do you know about BCC?: Questionnaire answers

## 4. Classroom exercises

**Exercise 2:** Useful steps to designing an BCC activity

**Exercise 3:** Using BCC to address a particular nutrition problem

**Handout 3a:** Micronutrient deficiencies in Sudan

**Handout 3b:** Micronutrient deficiencies in Sudan: The real experience

**Exercise 4:** Understanding the main methods of communication

**Handout 4a:** Case study on the use of theatre in Burundi

**Exercise 5:** An analysis of issues surrounding community outreach work in North Darfur

**Handout 5a:** An analysis of issues surrounding community outreach work in North Darfur

**Handout 5b:** An analysis of issues surrounding community outreach work in North Darfur: model answers

## 5. Case studies

**Exercise 6:** Understanding the main areas of focus in BCC

**Handout 6a:** Facilitator's notes on different BCC approaches

**Handout 6a:** Case study I: Problems with compliance during a pellagra outbreak in Angola

**Handout 6b:** Case study II: Understanding community barriers to uptake of community-based therapeutic care programmes

**Handout 6c:** Case study III: Breast feeding practices following the earthquake in Pakistan

**Handout 6d:** Case study IV: Child feeding practices in Afghanistan among displaced populations

## 6. Field-based exercises

**Exercise 7:** Finding out about knowledge, attitudes, beliefs and practices (KABP) using focus group discussions

**Handout 7a:** Facilitator's notes on how to conduct focus group discussions

**Handout 7b:** How to conduct a focus group discussion

**Exercise 8:** Finding out about key informant interviews

**Handout 8a:** How to conduct a key informant interview

# 1. Tips for trainers

## Step 1: Do the reading!

- Read Parts 1 and 2 of this module.

## Step 2: Know your audience!

- Find out about your participants in advance of the training:
  - How many participants will there be?
  - Do any of the participants already have experience of BCC?
  - Could participants with BCC experience be involved in the sessions by preparing a case study or contribute through describing their practical experience?

## Step 3: Design the training!

- Decide how long the training will be and what activities can be covered within the available time. In general, the following guide can be used:
  - A **90-minute** classroom-based training can provide a basic overview of BCC.
  - A **half-day** classroom-based training can provide an overview of BCC and include some practical exercise.
  - A **one-day** classroom-based training can provide a more in-depth understanding of BCC and include a number of case studies.
  - A **one-day** classroom plus field-based training can provide theoretical and practical experience.
- Identify appropriate learning objectives. This will depend on your participants, their level of understanding and experience, how they want to use the training in their future work, and the aim and length of the training.
- Decide exactly which points to cover based on the learning objectives that you have identified.
- Divide the training into manageable sections. One session should generally not last longer than an hour.
- Ensure the training is a good combination of activities, e.g., mix PowerPoint presentations in plenary with more active participation through classroom-based exercises, mix individual work with group work. Also, don't underestimate how useful the 'old' method of flip charts can be, especially when they are colourful and well framed.

**Step 4: Get prepared!**

- Prepare PowerPoint presentations with notes (if they are going to be used) in advance and do a trial run. Time yourself!
- Prepare exercises and case studies. These can be based on the examples given in this trainer's guide but should be adapted to be suitable for the particular training context. You may choose to audio-record case studies instead of writing them out. Sphere and IRIN may also have useful video clips that could be used.
- Prepare a 'kit' of materials for each participant. These should be given out at the start of the training and should include:
  - Timetable showing break times (coffee and lunch) and individual sessions
  - Parts 1 and 2 of this module
  - Pens and paper

**REMEMBER**

People remember 20 per cent of what they are told, 40 per cent of what they are told and read, and 80 per cent of what they find out for themselves.

People learn differently. They learn from what they read, what they hear, what they see, what they discuss with others and what they explain to others. A good training is therefore one that offers a variety of learning methods which suit the variety of individuals in any group. Such variety will also help reinforce messages and ideas so that they are more likely to be learned.

## 2. Learning objectives

Below are examples of learning objectives for a session on working with communities and nutrition BCC. Trainers may wish to develop alternative learning objectives that are appropriate to their particular participant group. The number of learning objectives should be limited; up to five per day of training is appropriate. Each exercise should be related to at least one of the learning objectives.

### Examples of learning objectives

At the end of the training, participants will:

- Be aware of why it is essential to work with communities in communities
- Be aware of the Sphere Common Standards
- Be aware of the types of nutrition issues that can arise in emergencies that can be addressed through BCC approaches.
- Understand the importance of involving target communities in emergency nutrition response.
- Understand the importance of involving the affected community in identifying the problem to be addressed and the best approach to resolving the problem.
- Know about the range of BCC approaches that can be used in different situations.
- Know how to design a BCC activity.
- Be aware of the main methods of nutrition communication in an emergency.
- Know the main BCC delivery mechanisms

## 3. Testing knowledge

This section contains one exercise which is an example of a questionnaire that can be used to test participants' knowledge of why it is essential to work with communities in emergency response and the role of BCC either at the start or at the end of a training session. The questionnaire can be adapted by the trainer to include questions relevant to the specific participant group. It may also be helpful to consider using the questionnaire in advance of the training, in order to gather insights into the trainee group (see Step 2 above), and to give you time to fine-tune the training to their particular needs.

### Exercise 1: What do you know about working with communities in emergencies and nutrition BCC?

#### What is the learning objective?

- To test participants' knowledge about working with communities
- To test participants knowledge about BCC

#### When should this exercise be done?

- At the start or before a training session to establish knowledge level

#### How long should the exercise take?

- 20 minutes

#### What materials are needed?

- **Handout 1a:** What do you understand about working with communities in emergencies and BCC?: Questionnaire
- **Handout 1b:** What do you know about working with communities in emergencies and BCC?: Questionnaire answers

#### What does the trainer need to prepare?

- Familiarise yourself with the questionnaire questions and answers.
- Add your own questions and answers based on your knowledge of the participants and their knowledge base.

#### Instructions

**Step 1:** Start the session by going around the participants and asking them why it is important to work with communities in emergencies and why BCC may be important in emergencies.

**Step 2:** Note their responses on a blackboard or flip chart and return to this at the end of the training session and add to the points they have raised.

**Step 3:** Give each participant a copy of Handout 1a.

**Step 4:** Give participants 10 minutes to complete the questionnaire working alone.

**Step 5:** Give the correct answers as shown in Handout 1b and allow five minutes for discussion.

## Handout 1a: What do you know about working with communities in emergencies and about nutrition BCC? Questionnaire

**Time for completion:** 10 minutes

**Answer all the questions**

1. Does the Sphere common standard 1 support the involvement of the community in the design and implementation of emergency responses? *True or false*
2. Why is it important to engage with and try to understand the local community? *Write TRUE or FALSE after each sentence*
  - a) To show respect and basic courtesy
  - b) To learn about local cultural practices and means of communication
  - c) To adhere to the Sphere standards
  - d) To learn about appropriate local rates of pay
  - e) To discover and potentially utilise local expertise
  - f) To learn about gender roles, child and infant feeding practices
3. Which statement best describes Nutrition BCC? *Circle the correct answer*
  - a) Activities which aim to provide people with an informed base for making choices
  - b) A range of activities concerned primarily with nutrition education
  - c) A way of ensuring that emergency affected people participate in agency programmes
  - d) Activities that are implemented by health staff in clinics
4. Which of the following are BCC activities that can be implemented in an emergency? *Write TRUE or FALSE after each sentence*
  - a) Participatory drama
  - b) Television awareness raising programmes
  - c) Focus group discussions
  - d) Key-informant interviews
  - e) Peer education
  - f) Radio awareness raising programmes
  - g) Individual counselling
  - h) Puppet shows
  - i) Community based meetings
5. Are the following statements true or false? *Write TRUE or FALSE after each sentence*
  - a) BCC activities can only be implemented once an emergency is over
  - b) The co-operation of community leaders and other local people of influence is needed in many BCC activities
  - c) BCC activities are only needed when a new emergency resource is introduced
  - d) It is easy to design an BCC activity based on perceptions of nutrition problems
  - e) Women with young children should be the main focus of BCC activities
  - f) It is not possible to implement BCC activities in complex emergencies
6. Name 5 nutrition issues or problems that may arise in a nutrition emergency that can be addressed through BCC

## Handout 1b: What do you know about working with communities in emergencies and about nutrition related BCC? Questionnaire (Answers)

1. **TRUE**
2. **All are TRUE**
3. **a)**
4. **e) to i) are all TRUE**
5. **ii) are TRUE**
6. **Examples of issues/problems are:**
  - **Breast feeding**
  - **Micronutrient deficiency disorders**
  - **Recognising malnutrition**
  - **Treatment of malnutrition**
  - **Making the best use of rations (storage, processing, cooking etc.)**
  - **Complimentary food preparation**
  - **Nutritional well-being of the chronically sick (weight loss, loss of appetite, mouth ulcers, diarrhoea etc.)**
  - **Unfamiliar or new foods/commodities (e.g. blended foods)**
  - **Food hygiene**
  - **Rations including distribution points, content and quantities**
  - **Importance of health service uptake**
  - **Accessing fuel for cooking**



## 4. Classroom exercises

This section provides examples of practical exercises that can be carried out in a classroom context by participants individually or in groups. They are useful between plenary sessions, where the trainer has done most of the talking, as they provide an opportunity for participants to engage actively in the session. The choice of exercises will depend upon the learning objectives and the time available. Trainers should adapt the exercises presented in this section to make them appropriate to the particular participant group. Ideally, trainers should use case examples with which they are familiar.

### Exercise 2: Useful steps to designing a BCC activity

#### What is the learning objective?

- To know how to design a BCC activity

#### When should this exercise be done?

- Early on in the training session

#### How long should the exercise take?

- 30 minutes

#### Instructions

**Step 1:** Give the participants 10 minutes to brain storm in small groups and identify the key steps they would want to take before designing and implementing a BCC activity.

**Step 2:** Ask one member of each working group to feedback to the whole group their key steps and to write these up as headings on a flipchart or blackboard. Leave 10 minutes for feedback

**Step 3:** Spend 10 minutes running through the five key steps outlined in Part 2 Technical Notes and discussing these in the light of the steps identified by the groups.

#### Discussion points for feedback in plenary

Emphasise that successful BCC approaches will have one or more of the characteristics:

- ➔ Take into account the motivations of particular population groups and work with communities and community leaders.
- ➔ Recognize that people have strong and varied beliefs and that approaches should not be based on assumptions about people's behaviour.
- ➔ Are based on a clear assessment of the nutrition problem, analysis of its causes and a carefully thought out plan of action to address the problem being addressed?
- ➔ Based on observed behavioural practices and not on anecdotal evidence or pre-conceived notions
- ➔ Are they targeted at a specific group and communicate a clear message?
- ➔ Provide information to allow a reasoned choice.
- ➔ BCC approaches that aim to persuade target groups to change their behaviour without their involvement or an understanding of the causes of their problems are rarely successful.

It is vital that participants realize that BCC activities are NOT being applied to a 'clean slate' on which new ideas can simply be written. Any BCC activities will need to take account of the complex nutrition related beliefs and behaviours that populations have.

**Exercise 3: Using BCC to address a particular nutrition problem****What is the learning objective?**

- To know how to design a BCC activity

**When should this exercise be done?**

- After Exercise 2

**How long should the exercise take?**

- 60 minutes

**What materials are needed?**

- **Handout 3a:** Micronutrient deficiencies in Sudan
- **Handout 3b:** Micronutrient deficiencies in Sudan: The real experience

**Instructions**

**Step 1:** Ask participants to read Handout 3a.

**Step 2:** Put them into small working groups (no more than five per group) and give them 30 minutes to design an BCC approach and address the questions.

**Step 3:** Each group feeds back. Provide 20 minutes.

**Step 4:** Use Handout 3b to describe what really happened and discuss for 10 minutes.

## Handout 3a: Micronutrient deficiencies in Sudan

Source: Field Exchange, Number 31 Sept 2007

In Darfur, Sudan, approximately 2 million displaced people depend on general rations to meet their energy and nutrient needs. Yet, micronutrient deficiency is considered a major problem in Darfur. As well as contributing to infant mortality, over 50 per cent of all children aged 6-59 months are estimated to suffer from anaemia while vitamin A deficiency is estimated at 36 per cent. The general rations contain micronutrients although the quantities are inadequate to meet the most vulnerable i.e. pregnant and lactating women and children under five years of age.

It was decided that in order to address the micronutrient problems in the camps, home-based fortification of the general ration should be undertaken using a micronutrient pre-mix called 'Sprinkles'. However, this pre-mix is completely alien to the IDP population. They do not know what it is for or how to use it. Furthermore, a micronutrient home-based pre-mix has never before been used in an emergency setting.

- 1. *What problem are you trying to address?***
- 2. *Who is the target group?***
- 3. *How will you find out how people view the problem identified?***
- 4. *What communication approach will you use to find out if the pre-mix is acceptable?***

### **Handout 3b: Micronutrient deficiencies in Sudan: The real experience**

In the real situation, prior to introducing the micronutrient pre-mix to correct the micronutrient deficiencies in these groups, a study was carried out in 2006 to test the acceptability of the pre-mix to the target population.

Over a four-month period, 250 families took part in the study. Focus group discussion explored their knowledge, attitudes and practices (KAP) on 'good nutrition' and 'eating habits' as well as the acceptability of the pre-mix. The overwhelming majority found the pre-mix easy to use and store, with 90 per cent accepting the new pre-mix as part of the general ration. Just 1 per cent of families did not continue using the premix. This was thought to be due to misunderstandings about its intended benefit.

**Exercise 4: Understanding the main methods of communication****What is the learning objective?**

- To be aware of the main methods of nutrition communication in an emergency

**When should this exercise be done?**

- Ideally, after Exercises 1 and 2

**How long should the exercise take?**

- 1 hours and 30 minutes

**What materials are needed?**

- **Handout 4a:** Case study on the use of theatre in Burundi
- **Handout 4b:** Trainer's notes on communication methods

**Instructions**

**Step 1:** Read Handout 4b and prepare a 25-minute presentation based on the notes and on your own experiences.

**Step 2:** Ask the participants to spend five minutes talking to the person next to them about a particular nutrition or health message they have heard, how and where they heard it and whether it was clearly understood.

**Step 3:** Ask each pair to feed back their experiences to the whole group and see if you can add to the list of how to make the approaches to BCC more effective. Allow 30 minutes.

**Step 4:** Following this, divide the participants into groups of five and ask them to read the section on communication methods in Part 2 of this module and Handout 4a.

**Step 5:** Ask each group to feedback to the wider group on their response to the case study questions. There are no right answers to this but the focus is on opening the minds of participants to the different methods for communicating with emergency-affected people. Allow 30 minutes.

## Handout 4a: Case study on the use of theatre in Burundi

Source: Zicherman, N., 'It is difficult to escape what is linked to survival': *Sexual exploitation and food distribution in Burundi*, Humanitarian Exchange, No. 35, November 2006.

**Time for completion:** 30 minutes

**Participants should be organized into groups of five and given 15 minutes to read the case study and a further 15 minutes to prepare answers. Groups should then answer the questions below and present back to plenary.**

### Background

CARE International has been a key partner of the World Food Programme (WFP) in Burundi since the outbreak of the civil war in 1993, distributing emergency food aid to refugees, returnees, internally displaced persons (IDPs) and others. As the security situation in the country has improved, the programme has moved from a generalized emergency feeding to semi-regular targeted distributions. Implementing partners and local government officials are supposed to identify households that meet pre-established vulnerability criteria, and are thus included in the beneficiary lists.

In light of various irregularities uncovered by field teams, CARE conducted a study between October 2004 and June 2005 to document whether sexual relations were being used as a means to access food aid, to identify the reasons and mechanisms behind such abuse if it was taking place, and to develop strategies to reduce the risk to beneficiaries.

Partnering with a local theatre group called Tubiyage ('Let's talk about it'), which has extensive experience in facilitating community discussions on ethnic conflict, sexual violence, HIV/AIDS and other sensitive subjects, the research team used interactive theatre techniques to introduce the subject in focus groups and public fora and to elicit testimonials from community members. In the focus group discussions and semi-structured interviews, both victims and perpetrators confirmed that sexual harassment and exploitation were present in the food aid process. Exploitation took place in secret and was never discussed openly, certainly not during the public validation of beneficiary lists when irregularities are supposed to be identified.

Widows and other single women, either without husbands or without adult sons, were found to be particularly vulnerable, as they had no adult males in the household to protect their reputation, and no money to bribe the village heads to include them on the lists. Fear that they would be excluded from the lists was the main factor that led women to submit to requests for sexual favours. Perpetrators were generally those who established the beneficiary lists.

The participants in the theatre presentations and focus groups also unanimously confirmed the presence of bribes and other forms of corruption. Participants in the study suggested procedures to reduce the incidence of sexual harassment and exploitation of food aid beneficiaries. These included:

- Always having an employee of WFP or CARE present during the creation of lists to ensure transparency
- Electing mixed committees of beneficiaries, including women, to monitor list creation and food aid distribution
- Ending the involvement of the local administration in the creation of lists
- Ensuring that list validation is done publicly in every village with the active participation of women and young people

The study has proved to be a powerful tool for advocacy with WFP. Since sharing its findings, CARE has been allowed to devote more human resources to monitoring the development and public validation of lists, and the agency has been experimenting with new approaches. These include separate validations with men and women, and involving local partners, such as the Burundian Red Cross and the Catholic Church Diocese Committees, who are helping CARE agents to monitor targeting and list development at the village level.

### Answer the questions.

1. Was the use of drama an appropriate method for understanding the problems identified?
2. What are the main advantages of using this method?
3. What other methods could have been used?

## Handout 4b: Trainer's notes on communication methods

There are a number of methods for communicating nutrition messages: face-to-face communication, group communication through the use of existing social forums (e.g., markets, weddings, women's association), mass media communication and small media communication. In many successful BCC approaches, a combination of methods has been applied.

A key point to get across is that the participants need to understand that it is essential to investigate what the most popular means of communication actually are in a given emergency-affected population and to develop a communication strategy based on the findings of this enquiry. This enquiry must include an analysis of the degree of literacy as it may be that non-literate forms of communication are the most important among rural populations with women with low levels of literacy. Assumptions must not be made about levels of literacy or access to media among the affected population.

Remember that information alone, for example, only using BCC visual materials, may result in increased awareness about a nutrition-related subject but may have only limited impact on peoples practices or behaviours. It is very important where possible to stimulate shared learning through dialogue, participation and discussions with the emergency-affected communities. Involving affected families and communities allows them to determine among themselves what needs to be done, and by whom in the long run, thus establishing a sense of ownership of the processes in the different phases of their recovery from an emergency.

**Exercise 5: An analysis of issues surrounding community outreach work in North Darfur****What are the learning objectives?**

- To increase understanding of how to work effectively with communities
- To consider the issues that local staff face in their professional lives
- To consider ways in which the situation can be improved

**When should this exercise be done?**

- As part of a one- or two-day training course

**How long should the exercise take?**

- 2 hours

**What materials are needed?**

- **Handout 5a:** An analysis of issues surrounding community outreach work in North Darfur
- **Handout 5b:** An analysis of issues surrounding community outreach work in North Darfur: Model answer
- **Flip chart for plenary**

**Instructions**

**Step 1:** Divide the participants into groups of (maximum) five people.

**Step 2:** Give the groups 60 minutes to answer the questions and prepare a presentation of their answers.

**Step 3:** Give each group ten minutes for feedback in plenary.

**Step 4:** Give each participant a copy of Handout 5b.



## Handout 5a: An analysis of issues surrounding community outreach work in North Darfur

*Time for completion: 60 minutes*

*Participants should be organized into groups of five and given 15 minutes to read the case study and a further 45 minutes to prepare answers. Groups should then answer the questions below and present back to plenary.*

### Background

A review of the community outreach work associated with community based management of acute malnutrition (CMAM) programmes was conducted in North Darfur in August 2009\*. Three sites were included Abushok IDP camp, Zam Zam IDP camp and the Shahid health centre; each with a different context. Abushok was initially set up by an international NGO but handed over and now managed by State Ministry of Health and the host population, Zam Zam camp was run by an international NGO and Shahid health centre was managed by the Sudanese Ministry of Health.

It is common in the area for traditional healers to 'treat' undernutrition. In some areas it is believed that oedema is air under the skin and this burning is used to release the air. Other practices include applying herbs and the use of Quranic verses. The use of traditional practice delays referral to the health facilities and often after complications had set in necessitating admission to the stabilisation centre.

### Findings

CMAM outreach services at three sites were reviewed using qualitative methods using discussions and interviews with a range of key personnel and beneficiaries and this was supported by direct observation of the sites.

**Abushok camp:** The CMAM services were set up some years ago by Action Contre la Faim (ACF) but are now run by the SMOH. The community outreach worker (COW) and the COW supervisor are employed on a full-time basis and are highly educated and well trained. Staff are demotivated and unhappy with changes to their employment conditions since the takeover by the SMOH.

**Zam Zam camp:** This camp has two parts Old Zam Zam has had CMAM services since 2006 while in New Zam Zam CMAM was set up in 2009. They provide very good model and are both managed by Relief International. The community outreach worker (COW) and the COW supervisor are employed on a full-time basis. The community leaders are active and knowledgeable regarding undernutrition.

**Shahid Health Centre:** This government facility is managed by the SMOH and has offered CMAM services since 2008. It is well staffed and outreach is conducted once a week by a trained team but coverage is low. Resources for community outreach are limited with no nutrition or health educational materials, limited stationery and poor record keeping. Though they report 25% of admissions are from outside their catchment area.

---

\* FANTA II. *Community outreach for Community Based Management of Acute Malnutrition in Sudan; A Review of Experiences and the Development of a Strategy.* 2010

Table 1: Outline of the community outreach work in the three sites

	Abushok camp	Zam Zam camp	Shahid Health Centre
Number of COWs and scope of work	12 and 1 supervisor, FT Conducting outreach from 6 sites across the camp. It takes 45 days to cover their area. Whole population not covered by the 6 sites.	16 and 1 supervisor, FT COWs work in pairs to visit each house in their area once (maybe twice) each month.	6 including 1 male, PT 1 nutrition educator, FT 3 midwives, FT 1 medical assistant, FT Teams work together to cover their operational area every 7 months. They do outreach one day a week
Services provided	Previously: home visits with health & nutrition education and follow up of defaulters and non-responders. Also helped in clinic. Currently: screening of children attending health clinics in MUAC or weight for height.	Home visits: screening and referral for CMAM, medical care and vaccinations, health and nutrition education, follow up of defaulters and non-responders, weekly visits for all in CMAM. Occasional community talks.	Home visits: screening and referral for CMAM, medical care and vaccinations, health and nutrition education, follow up of defaulters and non-responders.
Referral process	Printed referral	Printed referral	Hand written referral, discarded at health centre
Data usage	Data available but no analysis.	Data available but no analysis.	Data available but no analysis.
Records	Numbers referred each week kept, but no feedback from supervisor	Numbers referred each week kept, supervisor feeds back.	No data available. Staff report 25% beneficiaries come from outside catchment area.
Community leader role	Active in early stages for awareness raising and sensitisation. No current involvement.	Active in early stages for awareness raising and still involved in sensitisation. Currently monthly meetings and named on referral form so leader may be contacted if child defaults	Active in early stages for awareness raising and sensitisation. No current involvement

Adapted from FANTA II. *Community outreach for Community Based Management of Acute Malnutrition in Sudan; A Review of Experiences and the Development of a Strategy*. 2010

**Consider what are the strengths and weaknesses of each of the sites.**

**Discuss why, you think, things are working the way they do.**

**How can you mitigate against the weaknesses, what resources do you have in the locality?**

## **Handout 5b: An analysis of issues surrounding community outreach work in North Darfur: Suggested answer**

For further details see Community outreach assessment of CMAM in Sudan. FANTA II, 2010. Below are some suggested areas for improvement but you may well have come up with additional ideas.

The established procedures in Old Zam Zam camp are good and can be used as a template to aim for at the other sites.

It is important to sensitively gain an understanding on the terms and conditions that the staff work under in the different situations/camps. It is quite common in emergency setting for quite low grade international NGO staff to receive much higher salaries than high ranking government employees. Low level government staff may have very low salaries, and be erratically paid. It is not realistic to expect people to work full time if they are not in receipt of a living wage. Conversely, high standards should be demanded from the well paid.

### **Supervision of outreach work**

Supervision seems weak in all sites. Supervisors should be encouraged to observe the COWs at work, provide feedback on their referrals to them and to hold regular staff meetings which can be used to disseminate information regarding the programme functioning.

### **Community leaders.**

Encourage the sustained and active engagement of the community leaders in supporting CMAM services. Liaison with community leaders, and facilitation of their active involvement, is the responsibility of the Supervisor. This can include sensitisation, facilitating referrals of new cases, supporting active case/defaulters finding, awareness raising of new or expanded activities. Try to utilise the skills of the leaders in Old Zam Zam, maybe they have some lessons to share.

### **Record keeping and reporting**

Shahid staff should keep records of outreach and other activities and ways to achieve this need to be explored. Staff of all sites could come together to discuss how the information can help them in their work and be used to improve the service.

### **Training of outreach staff**

All CMAM staff should receive training in line with their responsibilities, including outreach staff. Where possible use the skills, knowledge and experience of the best staff. Utilise the skills of the most knowledgeable staff to conduct refresher training to the COW teams. It is important to understand clearly the skill levels of the COWs to ensure that appropriate messages are disseminated.

### **Screening and referrals**

Shahid camp has very low screening coverage and Abushok does screening at the health facility. Consider if screening could possibly be done at the community level with volunteers to reach more children in a more timely fashion. This could lead to a larger programme so the capacity of the current services would need to be considered. Abushok could have routine community screening either by periodical gathering them at a central point or at household level.

**Follow up home visits**

It is necessary to develop appropriate guidelines for Health Visitors in each community context. If adequate staff are available in camp situation it may be appropriate to do weekly home visits for all children but this may not be viable where numbers of children or workload of outreach staff are high. A suitable compromise could be to do home visits once AND for default/non responders. It is important that each area has an appropriate, realistic and clear protocol for outreach work in their situation.

It may be useful to explore the reasons why this service stopped in Aboshok and see if there is a way to re-establish them.

**Traditional practices to treat malnutrition.**

The community leaders will know the traditional healers under their administration and this provides a basis for information sharing and negotiation. It may be possible to enable traditional healers to refer severely acutely malnourished children to the CMAM programme and to raise the standard of their knowledge. To do this it is essential that a good working relationship, based on trust, is developed between the traditional healers and the community leaders/health workers. This requires time, good negotiation skills and a solid understanding of CMAM.

**Health and nutrition education**

Source appropriate education materials and make available to outreach staff.

Senior managers – need to actively support outreach activities and commit to ensuring adequate management support of outreach work – which is central to quality CMAM programming.

**Exercise 6: Understanding different areas of focus in BCC****What is the learning objective?**

- To consider a range of BCC approaches that can be used in different situations

**When should this exercise be done?**

- After Exercise 5 and as part of a one- or two-day training course

**How long should the exercise take?**

- 3 hours

**What materials are needed?**

- **Module 19** Technical notes, section 2 Introduction to BCC
- **Handout 6a:** Case study I: Problems with compliance during a pellagra outbreak in Angola
- **Handout 6b:** Case study II: Understanding community barriers to uptake of community-based therapeutic care programmes
- **Handout 6c:** Case study III: Breast feeding practices following the earthquake in Pakistan
- **Handout 6d:** Case study IV: Child feeding practices in Afghanistan among displaced populations

**Instructions**

**Step 1:** Prepare and give a 10-minute presentation using module 19.

**Step 2:** Divide the participants into groups of (maximum) five people.

**Step 3:** Give hand outs to each group covering the main areas.

**Step 4:** Give the groups 30 minutes to read the case study and answer the questions and prepare a presentation of their answers.

**Step 5:** Give each group five minutes for feedback in plenary.

## Handout 6a: Case study I: Problems with compliance during a pellagra outbreak in Angola.

Source: *Field Exchange*, 10 July 2000.

**Time for completion:** 30 minutes

**Working in groups, read the following case example, address the questions below and prepare a brief presentation of your discussion.**

### Background

There have been a number of alarming instances where refugee and displaced populations have been affected by outbreaks of micronutrient deficiencies (e.g., beriberi, scurvy, pellagra) requiring urgent treatment. In such cases, the level of compliance among the affected population, e.g., the adherence to the drug regime, will determine whether the intervention is successful.

This case example given below describes a situation where a low level of compliance due to a lack of understanding about the benefits and required dosages among those affected undermined the treatment of pellagra, a micronutrient deficiency.

### What is pellagra?

Niacin deficiency results in pellagra, which affects the skin, gastrointestinal tract and nervous systems. For this reason, it is sometimes called the disease of the 3Ds – dermatitis, diarrhoea and dementia:

- Dermatitis develops as redness and itching on areas of the skin exposed to sunlight.
- The redness develops into a distinctive 'crazy pavement' pattern and is symmetrical and bilateral.
- Where dermatitis affects the neck, it is sometimes termed 'Casal's necklace'.
- A distinctive 'butterfly sign' around the nose and eyes is sometimes seen.
- Complaints of the digestive system include diarrhoea, nausea and sometimes constipation.
- Disturbances of the nervous system include insomnia, anxiety weakness, tremor, depression and irritability.
- Dementia or delirium is sometimes seen.

Pellagra may be fatal if not treated, the fourth D being death.

Maize-eating populations, who do not treat the maize to release niacin, are at risk of developing pellagra. Where niacin-rich foods, such as peanuts, have not been provided in emergency rations pellagra has arisen. Adults are at higher risk than children and women more than men.

### Pellagra outbreak in Angola

A pellagra outbreak hit war-affected Kuito town, the capital of Bie province in Angola in the second half of 1999 and a 'vitamin B complex' distribution to all women over the age of 15 years was initiated. The response was seen as an emergency measure as other sources of niacin, e.g., ground nuts, CSB and dry fish, were not available in the emergency general ration.

A nutrition survey conducted after the distribution assessed compliance with the vitamin distribution by counting the number of tablets left in the distributed tablet bags. A total of 950 women were assessed.

It was found that just 40 per cent were compliant, a percentage that was judged to be poor. Several explanations were offered for this:

- There was confusion between vitamins and contraceptive tablets which were only to be taken once monthly.
- The vitamin tablet appeared to increase feelings of hunger.
- There was a lack of understanding of the concept of prevention of micro-nutrient deficiency among beneficiaries.
- 20 per cent of women had fewer tablets than expected as they shared tablets with other family members or because they took more tablets than recommended.

***Answer the questions.***

- 1. Faced with a similar situation, discuss how you would increase the level of compliance among those affected.***
- 2. Design a promotional BCC activity stating the objective, target group, how you obtain information on the population's understanding of the problem and the mode of communication you would use and why.***

## Handout 6b: Case study II: Understanding community barriers to uptake of community based management of acute malnutrition (CMAM) programmes.

Source: *Field Exchange*, 30 April 2007.

**Time for completion:** 30 minutes

**Working in groups, read the following case example, address the questions below and prepare a brief presentation of your discussion.**

### Background

Increasingly, community based management of acute malnutrition (CMAM) interventions are including coverage surveys as part of the monitoring and evaluation procedure. Surveys include a questionnaire for carers of severely malnourished children **not enrolled** in the programme.

Analysis of the survey data revealed that the previous rejection of a child from the CMAM programme is the most significant factor for non-attendance. In other words, the 'carers' first experience with the programme directly determines their subsequent willingness to participate.

One in every three mothers with malnourished children not enrolled in CMAM programmes had refused to participate following a negative experience of rejection by programme staff at an earlier date. **This means that the issue of rejection is responsible for a decrease of over 35 per cent of programme coverage in the sample programmes surveyed.**

Rejection is closely linked to how communities find out about the programme. Three channels of communication exist in CMAM programmes: community sensitization; active case finding and word of mouth. Each channel has advantages and disadvantages.

Limiting or reducing the effects on programme performance is possible and the steps to achieve this include:

1. **Explain admission and rejection to carers.** Programme staff need to dedicate time to the crucial task of explaining the reasons for rejection. Furthermore, the ability of carers to return to sites for further screening (e.g., if the child's condition deteriorates) must also be part of this process.
2. **Monitor community perceptions.** At a community level, mobilization workers need to constantly monitor community attitudes towards the programme in order to identify negative feedback at an early stage. When discontent and fear of rejection arise, community workers must devote time to explaining the reasons for rejection and the risks associated with non-compliance. The role of community leaders in restoring trust in the programme is also proven to be critical.

### Answer the questions.

1. **Faced with a similar situation, discuss how you would overcome the problems identified.**
2. **Design an BCC activity that would enhance the CMAM programme's coverage stating the objective, target group, how you obtain information on the populations understanding of the problem and the mode of communication you would use and why.**



## Handout 6c: Case study III: Breastfeeding practices following the earthquake in Pakistan.

Source: *Field Exchange*, 27 March 2006.

**Time for completion:** 30 minutes

**Working in groups, read the following case example, address the questions below and prepare a brief presentation of your discussion.**

### Background

On 8 October 2005, Pakistan's North West Frontier Province and Pakistan Administered Kashmir were struck by an earthquake measuring 7.6 on the Richter scale. More than 70,000 people were killed, a similar number injured, and about 3 million people were left homeless. A rapid assessment of the food and nutrition situation found that 20 per cent of children under two years of age were no longer breastfeeding, 2 per cent because their mothers had passed away and 18 per cent because their mothers had stopped breastfeeding. The reasons given for ceasing breastfeeding were sickness of the mother and insufficient breastmilk production.

The rapid assessment showed how the emergency situation had created a number of challenges for breastfeeding. There were many misunderstandings about breastfeeding, like "once breastfeeding is stopped, it cannot be re-established", and "tired and malnourished mothers cannot breastfeed", and the perception that some women do not produce enough milk and that nothing can be done to improve the situation.

There was also a widespread assumption that all mothers breastfeed and that breastfeeding did not require effort to be maintained. This was also apparent from the fact that few interventions to protect, promote and support breastfeeding were undertaken in the initial period after the earthquake.

**Answer the questions.**

- 1. Faced with a similar situation, discuss how you would overcome the problems identified.**
- 2. Design a BCC activity that would protect breastfeeding stating the objective, target group, how you obtain information on the population's understanding of the problem and the mode of communication you would use and why.**

## Handout 6d: Case study IV: Child feeding practices in Afghanistan among displaced populations.

Source: *Field Exchange*, 2 August 1997.

**Time for completion:** 30 minutes

**Working in groups, read the following case example, address the questions below and prepare a brief presentation of your discussion.**

### Background

As the emergency came under control in Afghanistan in the mid-1990s, a small-scale dry supplementary feeding programme was established in some IDP camps. The food ration included per two-week period for each child or pregnant/lactating woman: BP5 biscuits (37 bars), wheat flour (200g), lentils (50g) and oil (50g).

An evaluation of the use of BP5 biscuits was carried out at the same time as a nutrition survey. The overall acute malnutrition rate in the camp was acceptable with 4 per cent global acute malnutrition and 0.6 per cent severe acute malnutrition. It was found that 65 per cent of the children attending the feeding centre were in fact well-nourished but clear criteria were not being applied for admissions and discharges.

The nutrition surveys looked into infant and child feeding practices and it found that BP5 was believed to be the 'best food on earth for children' and that other complementary foods were being disregarded at home. Many people were also buying BP5s at high prices. A particularly worrying aspect was the finding that BP5 was being increasingly used as a complimentary food rather than traditional foods available at home.

The evaluation concluded that the introduction of BP5 was changing traditional food practices to a food source that was more expensive, no better for weaning purposes than local foods and the supply of which was not sustainable.

### Answer the questions.

- 1. Faced with a similar situation, discuss how you would overcome the problems identified.**
- 2. Design an BCC activity that would encourage the population to avoid this practice stating the objective, target group, how you obtain information on the population's understanding of the problem and the mode of communication you would use and why.**

## 6. Field based exercises

The section outlines ideas for exercises that can be carried out as part of a field visit. Field visits require a lot of preparation. An organization that is actively involved in programming or nutrition surveillance has to be identified to 'host' the visit. This could be a government agency, an international NGO or a United Nations agency. The agency needs to identify an area that can be easily and safely visited by participants. Permission has to be sought from all the relevant authorities & communities and care taken not to disrupt or take time away from programming activities. Despite these caveats, field based learning is probably the best way of providing information and new skills that participants will remember.

### Exercise 7: Finding out a bout knowledge, attitudes, behaviour and practice (KABP) using focus group discussions

#### What is the learning objective?

- To provide practical experience of how to conduct focus group discussions

#### When should this exercise be done?

- As part of an in-depth course

#### How long should the exercise take?

- 0.5 day (excluding travel)

#### What materials are needed?

- Pens, paper, clip board
- **Handout 7a:** Trainer's notes on how to conduct focus group discussions
- **Handout 7b:** How to conduct a focus group discussion

#### What does the trainer need to prepare?

- Organize the field work for groups of two people doing one focus group discussion. This can be done at a maternal and child health clinic or in a refugee/IDP camp or in a community.
- Work with the participants the day before the field work to develop key questions and practice their communication skills.
- Read Handout 7a and prepare a short presentation.

#### Instructions

**Step 1:** Give each participant a copy of Handout 7b.

**Step 2:** Divide participants into groups of two to carry out the field work.

**Step 3:** Spend no more than 1 hour carrying out the focus group discussion.

**Step 4:** Allow the participants 1 to 1.5 hours to analyse their findings. Participants should give each other feedback on their conduct during the group discussion (Peer review).

**Step 5:** Bring all the participants together for 1- to 2-hour plenary feedback using notes in Handout 7b.

## Handout 7a: Facilitator's notes on how to conduct focus group discussions

A Focus Group Discussion (FGD) is a group discussion of approximately 6 to 12 persons guided by a facilitator, during which group members talk freely and spontaneously about a certain topic.

A FGD is a qualitative method. Its purpose is to obtain in-depth information on concepts, perceptions and ideas of a group. A FGD aims to be more than a question-answer interaction. The idea is that group members discuss the topic among themselves, with guidance from the facilitator. The interaction between the group members is closely observed to understand how the group collectively discusses the topic and creates meaning or definitions.

FGD can be used to **develop appropriate messages for nutrition BCC**. For example, in an IDP camp it is decided by an agency that there is a need to focus on complimentary feeding problems most often encountered by mothers who are newly displaced and what to do about them. The focus group discussion could be used for **exploring relevant local concepts** about complimentary feeding as well as for **testing the messages**.

FGDs can be a powerful research tool providing valuable spontaneous information in a short period of time and at relatively low cost.

FGD should *not* be used for quantitative purposes, such as generalization of findings for larger areas, as this would require more elaborate surveys.

FGDs can complement nutrition surveys to find out more about a particular issue or problem.

It is important to be aware that in group discussions, people tend to centre their opinions on the most common ones, on 'social norms' whereas in reality, opinions and behaviour may be more diverse. Therefore it is advisable to combine FGDs with at least some key informant and in-depth interviews.

Before carrying out a FGD, you need to consider the following:

- Define the objective of the FGD.
- Define the target group based on sound knowledge of the local area.
- Try to ensure that participants in the FGD are from similar backgrounds.
- Ensure participants in the FGD feel that what they have to say is said in confidence.
- Give the FGD participants advance warning of the FGD.

Develop a discussion guide or series of open ended questions.

## Handout 7b: How to conduct a focus group discussion

*Time for completion: half day*

### Step 1

The aim of the focus group discussion is to find about current KABP around breastfeeding.

- a) **Develop a set of questions/key areas that need to be covered during the discussion, such as:**
  - What levels of knowledge do the mothers have about the benefits of breastfeeding (high, medium or low)?
  - Is breastfeeding traditionally carried out?
  - Where do mothers get their information about breastfeeding from?
  - Do mothers believe that breastfeeding is a good thing or not?
  - Do they use alternatives to breastfeeding?
  - What prevents these mothers from practising breastfeeding?
  - Do mothers practice exclusive breastfeeding and for how long?
  - What effect has the emergency had on their practices?
  - What help do mothers need to breastfeed?
  - What are the complimentary feeding practices?
  - Are there factors that will make a mother stop breastfeeding?
- b) **Develop a recording sheet which allows participants to record points from the group discussion in a logical way.**
- c) **Decide how your group will organize the focus group discussion. For example: one person asks questions while the other takes notes. Make sure these roles are swapped to allow each participant to experience both aspects.**

### Step 2

The focus group discussion should last a maximum of one hour and involve no more than 6 to 12 breastfeeding mothers per group.

- Ensure that the mothers are sitting comfortably (and are with their babies).
- Ensure you inform them of the subject you wish to cover.
- Introduce yourselves and ask them to introduce themselves.
- One person leads the focus group discussion using the set of questions.
- One person records the answers on the recording sheet.
- A useful ending might be to say that you have covered the questions you had but was there anything else any of the group members wanted to say that would help you in your work.

### Step 3

Analyse your recording sheet and decide from the answers whether you would need to carry out any BCC related activities. If yes, answer the following questions:

- What would be the main objective of the BCC activity?
- Who would be the primary target group?
- What other group might you target?
- What method/s of communication would you use?
- Who would you work with to carry out the activities?
- When would you carry it out?

Also consider the way the focus group discussion went as follows:

- Was it easy to get people to talk?
- Did a few individuals dominate the discussion?
- Were you able to cover all the areas you needed to in the available time?
- Were there any sensitive areas which you were unable to cover?
- Was the focus group discussion useful?
- Will the findings help you to develop an BCC activity to overcome a particular problem?

### Step 4

- Present your observations of the process in plenary.
- Present your BCC plan of implementation.

**Exercise 8: Finding out about key informant interviews****What is the learning objective?**

- To provide practical experience of how to conduct a key informant interview

**When should this exercise be done?**

- As part of an in-depth course

**How long should the exercise take?**

- 0.5 days (excluding travel)

**What materials are needed?**

- **Handout 8a:** How to conduct a key informant interview
- Pens, paper, clip board

**What does the trainer need to prepare?**

- Organize the field work for groups of two people doing one key informant interview. This can be done at a maternal and child health clinic or in a refugee/IDP camp or in a community.
- Work with the participants the day before the field work to develop key questions and to practise their communication skills.
- Read the Notes for Trainers below and prepare a short presentation.

**Instructions**

**Step 1:** Give each participant a copy of Handout 8a.

**Step 2:** Divide participants into groups of two to carry out the field work.

**Step 3:** Get the groups to work out their main questions (examples provided in the hand-out).

**Step 4:** Spend no more than 1 hour carrying out each key informant interview.

**Step 5:** Allow the participants 1 to 1.5 hours to analyse their findings. This step could also include time for each member of a pair to give each other feedback on their conduct during the key informant interview (e.g., a form of peer review).

**Step 6:** Bring all the participants together for 1- to 2-hour plenary feedback.

**Notes for trainers**

The key informant interview is a standard anthropological method that is widely used in health related and other social development inquiry. This is one method used in rapid assessment for gathering information from individuals in an emergency affected community. The term 'key informant' refers to anyone who can provide detailed information and opinions based on his or her knowledge of a particular issue. Key informant interviews seek qualitative information that can be narrated and cross-checked with quantitative data, a method called 'triangulation'.

A key informant interview differs from a focus group discussion in that it tries to obtain more in-depth information from individuals.

Before carrying out the interviews consider the following:

- Define the objective of the key informant interview.
- Define the target group based on sound knowledge of the local area.
- Ensure participants in the interview feel that what they have to say is said in confidence.
- Give the participants advance warning of the interview.

## Handout 8a: How to conduct a key informant interview

### Step 1: Choose the interviewer.

The interviewer has to remain neutral and must refrain from asking biased or leading questions during the interview. An effective interviewer understands the topic and does not impose judgments.

Ideally, the interviewer should:

- Listens carefully.
- Be friendly and can easily establish rapport.
- Know and understand the local customs, behaviours and beliefs.

### Step 2: Identify suitable key informants.

Choose suitable key informants according to the purpose of the interview. A key informant can be any person who has a good understanding of the issue you want to explore. The informant can be a community member, teacher, religious or secular leader, indigenous healer, traditional birth attendant, local service provider, children and young people or others from the affected community. Interviews can take place formally or informally, preferably in a setting familiar to the informant.

### Step 3: Conduct the interview.

The aim of the key informant interview is to find out from local influential leaders about the reasons for very low uptake of clinic based vitamin A distribution among children and mothers. Examples of questions are:

- What has the leader heard about vitamin A?
- Does the leader know why the vitamin is important in child and maternal nutrition and health?
- Who did the leader hear the information from and was it well explained?
- What does the leader think members of his or her community understand about the supplement?
- What does the leader think is the main reason for carers not going to the clinic?
- What does the leader feel can be done to improve the uptake?
- Hold the interview in a place that can put the respondent at ease
- Establish contact first by introducing yourself.
- Thank the participant for making his or her time available.
- Describe the objectives of the interview.
- Review the interview guide questions together with your notes.
- If time allows tape recorder use, be sure to ask permission tape the interview.
- After each interview, transcribe the results of your discussion, using the guide questions in recording the responses.



Do not forget to:

- Assure the respondent of confidentiality.
- Avoid judgmental tones so as not to influence responses.
- Show empathy with the respondent and interest in understanding his or her views.
- Let the respondent do most of the talking.
- Be an active, attentive listener.
- Pace yourself according to the time you have allotted for the interview.

#### **Step 4: Present findings and key issues.**

- Present your observations of the process in plenary.
- Present key issues that have emerged that BCC could address.

