

# MODULE 19

## WORKING WITH COMMUNITIES IN EMERGENCIES

Part 1: Fact sheet

Part 2: Technical notes

Part 3: Trainer's guide

Part 4: Training resource list



**Harmonised Training Package (HTP):**  
Resource Material for Training on  
Nutrition in Emergencies. Version 2, 2011

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### Module 19: Working with communities in emergencies

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## The Harmonised Training Package (HTP): Resource Material for Training on Nutrition in Emergencies

### What is the HTP?

The Harmonised Training Package: Resource Material for Training on Nutrition in Emergencies (the HTP) is a comprehensive documentation of the latest technical aspects of Nutrition in Emergencies (NiE). The word **Harmonised** reflects the pulling together of the latest technical policy and guidance, the word **Training** refers to its main application and the word **Package** refers to the bringing together of the subject matter into one place. It is organised as a set of modules by subject, each containing technical information, training exercises and a resource list for use in training course development.

The HTP is an initiative of the IASC Global Nutrition Cluster (GNC) and has been endorsed by the GNC and its member's agencies. In 2007, the IASC GNC commissioned the UK based partnership, NutritionWorks, to develop a training resource to facilitate capacity development in the NiE sector. HTP Version 1 was launched in 2008. HTP Version 2 update in 2010/11 was funded under an USAID OFDA grant to the UK based charity, the Emergency Nutrition Network (ENN). The update was undertaken in an ENN/NutritionWorks collaboration, with NutritionWorks responsible for overall coordination and editorial management, and editorial oversight and module production supported by the ENN.

### What the HTP is not

The HTP is not a ready-to-use training course. It cannot be used as an 'off the shelf' package; rather, it should be used as a resource package during a process of course development by experienced trainers.

### Who is the HTP for?

The HTP is a primarily a **resource for trainers** in the NiE sector and it can be used by individuals to increase their technical knowledge of the sector. It is designed to provide trainers from any implementing agency or academic institution with information from which to design and implement a training course according to the specific needs of the target audience, the length of time available for training and according to the training objectives. It is written in clear English and will be available in other languages in the future.

### How is the HTP organised?

The HTP is organized into four sections containing a total of 21 modules which can be used as stand-alone modules or as combined modules depending on the training needs.

#### Section 1: Introduction and concepts

1. Introduction to nutrition in emergencies
2. The humanitarian system: Roles, responsibilities and coordination
3. Understanding malnutrition
4. Micronutrient malnutrition
5. Causes of malnutrition

#### Section 2: Nutrition needs assessment and analysis

6. Measuring malnutrition: Individual assessment
7. Measuring malnutrition: Population assessment
8. Health assessment and the link with nutrition
9. Food security assessment and the link with nutrition
10. Nutrition information and surveillance systems

### **Section 3: Interventions to prevent and treat malnutrition**

11. General food distribution
12. Management of moderate acute malnutrition
13. Management of severe acute malnutrition
14. Micronutrient interventions
15. Health interventions
16. Livelihoods interventions
17. Infant and young child feeding
18. HIV/AIDS and nutrition
19. Working with communities in emergencies

### **Section 4: Monitoring, evaluation and accountability**

20. Monitoring and evaluation
21. Standards and accountability in humanitarian response

Each module contains 4 parts which have a specific purpose as follows:

**Part 1:** The Fact Sheet – provides an overview of the module’s topic and is designed for non-technical people to obtain a quick overview of the subject area.

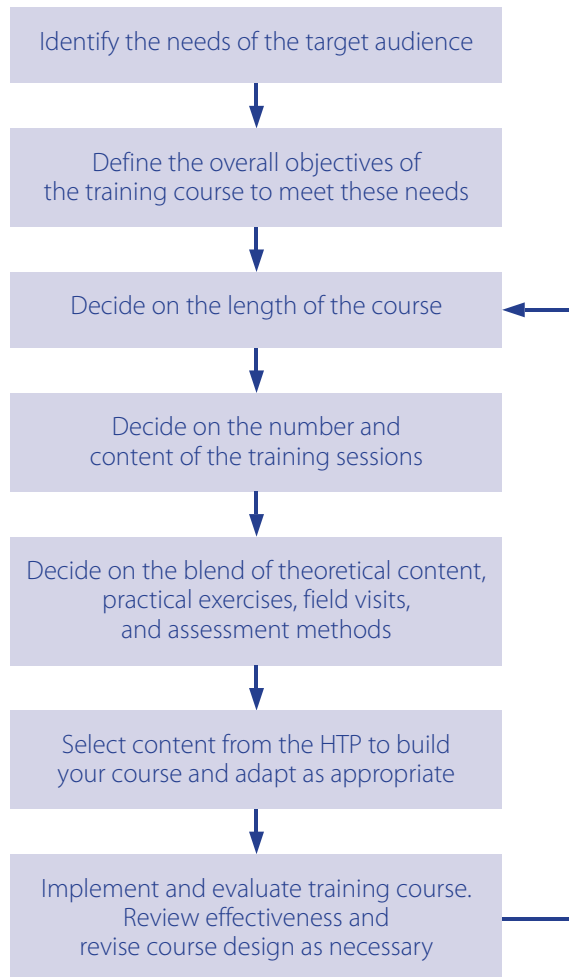
**Part 2:** The Technical Notes – for trainers and trainees, provides detailed technical guidance on current policies and practice.

**Part 3:** The Trainers’ Guide – aims to help trainers develop a training course and provides tips and tools which can be adapted to the specific training context.

**Part 4:** Resources – lists of relevant available resources (including training materials) for the specific technical area.

## How to use the HTP

The HTP should be used during a process of course development. The process of course development involves a number of steps and these are summarised in the diagram below.





## PART 1: FACT SHEET

The fact sheet is the first of four parts contained in this module. It provides an overview of working with communities and outlines key information regarding *behaviour change communication* (BCC) activities in emergency settings. Detailed technical information is covered in Part 2. Words in *italics* are defined in the glossary.

### Working with communities

All emergency related programming needs to work with the support of the community and this is enhanced by good relationships, effective communication and mutual trust & respect. Active community participation, particularly from women, is needed to support situation assessment and programme design.

Relationship building requires an understanding of the prevailing culture, of how things work and the importance of collaboration and mutual respect. Good communication with host populations is a two way process and it is necessary to:

- Listen to the priorities and needs of a range of community members.
- Outline the mandate, aims, and proposed activities of the agency as well as making clear what the agency cannot address.
- Negotiating the roles and responsibilities of the host community
- Explaining the time frame, exit strategy and limitations of the agency.

### Understanding the community

A community is not a homogenous group of people, but is made up of various different groups separated by gender, religion, economic status, ethnicity and many other factors. Different groupings have different levels of influence and powerful members, such as administrative or religious leaders, can be very helpful to an agency hoping to gain the trust and support of a community.

Established community groups and organisations, such as women's groups, village development committees and farming associations, can also be influential and may have similar interests or concerns to your agencies mandate.

It is important in an emergency to ensure that those affected are directly involved in all stages of the response. As stated in the Sphere Common Standard 1, people's capacity and strategies to survive are integral to the design and approach of the humanitarian response and agencies should act to progressively increase the disaster affected people's decision making power and ownership of programmes during the course of a response.

Typically the most marginalised and vulnerable groups have the most needs, but are often the least involved in programming, as they are occupied by day to day survival. It is important that their priorities and opinions are sought out and considered even though they can be hard to find.

**Community Participation** is the active involvement of the community in the planning, management, implementation, monitoring and evaluation of services and projects. Active community participation is essential for effective health and nutrition programming in emergencies to ensure relevance, acceptability and to enhance sustainability of project interventions. Community participation should be broad-based across the society and it is particularly important to seek involvement with women since in almost all communities they are the primary care givers for the children and family.

### The Humanitarian Charter

The importance of working with communities is core to the Sphere Minimum Standards in Disaster Response. Standard 1: **People-Centred Humanitarian Response.**

'People's capacity and strategies to survive with dignity are integral to the design and approach of humanitarian response' and

'Agencies should act to progressively increase the disaster affected people's decision making power and ownership of programmes during the course of a response.'

## Working with volunteers

Humanitarian agencies often recruit volunteers from the community as well as paid staff. The issue of motivating and retaining volunteer staff needs careful consideration and should be in line with local rates of pay.

## Behaviour change communication (BCC)

BCC is a programming approach that can be used with communities to improve their nutrition and health outcomes; it uses a considered communication strategy developed from evidence based theories and models of behaviour change. There are varied approaches to BCC undertaken by different agencies to support optimal behaviour and to communicate effectively with groups of people though these at times require a lengthy reiterative process, which may not be possible in all emergency contexts.

**Nutrition BCC** has recently started to be recognized as an important part of emergency nutrition programming, and well-designed BCC activities can increase the effectiveness of the emergency response and ensure that those affected are able to participate in the emergency response. Adequate knowledge, skills and motivation to ensure adequate nutrition is a needed for survival, especially during times of crisis.

Nutrition BCC can be widely used and can help

- a. To promote good behaviour and to discourage poor practices
- b. To familiarise communities with the use of new products or services
- c. For community sensitisation and investigating barriers to service uptake

## Examples of nutrition BCC activities in emergencies

- Promotion of exclusive breastfeeding
- Communication on the dangers of bottle feeding.
- Supporting appropriate complementary food preparation
- Promotion of micronutrients: their importance, deficiency related diseases and compliance
- Training community volunteers to recognise and refer the clinically malnourished
- Introducing unfamiliar or new foods/commodities (e.g., micronutrient powders, CSB+)
- Supporting hand washing and hygiene
- Promoting health seeking behaviour

## What are the characteristics of a successful BCC approach?

BCC approaches must be participatory and grounded on existing local knowledge and behaviours or practices about nutrition in order to be successful. Participatory assessment tools can be used to engage with the community and these include semi-structured interviews with key informants, group interviews, mapping and ranking exercises.

BCC approaches should use specifically tailored activities, messages and recommendations that are targeted at promoting specific behavioural changes. Successful approaches often have the following characteristics:

- Recognize that people have strong and varied beliefs, that approaches should be based on observed behavioural practices and not on anecdotal evidence or preconceived notions.
- Be based on a clear assessment of the nutrition problem, analysis of its causes and a considered plan of action to address it.
- Clearly defining the behaviour problems that should be changed or improved.
- Assessing the most effective motivations and most significant barriers to new practices.
- Include a variety of communication channels with a consistent message between them. A two-way communication channel should be included.
- Take into account the motivations of particular population groups and work with communities and community leaders.
- Be targeted at a specific group(s) and communicate a clear message.
- Provide information to allow a reasoned choice.
- Updated based on continuous monitoring and evaluation

## Communication channels

There are several ways in which BCC activities can be carried out including training volunteers or health workers; using social and mass media such as TV, radio, mobile phones or using small media such as posters and leaflets.

In many successful BCC approaches, a combination of methods has been applied. The skills of staff from a range of sectors should be harnessed. Special training of local staff may be necessary. It is extremely important to make sure that the messages delivered through various channels are consistent and/or complementary and are not contradictory.



- **Face-to-face or interpersonal communication**

This is a two-way and effective approach not simply to impart knowledge but to promote behaviour change. The relatively small number of people who can be reached however will limit its impact. Practical demonstrations (e.g. demonstrations and practical cooking sessions of how to prepare *blended foods for complementary feeding*) are also used.

- **Group communication**

Group communication includes the use of existing social forums and can support new ones. These have been targeted by many nutrition programmes in emergencies to disseminate nutrition-related information. The best approach is to focus on short and positive messages. Examples of existing social forums include:

- Religious and political meetings
- Women's associations
- Farmers' associations
- Youth groups
- Local markets

- **Mass media communication**

This has the potential advantages of reaching large numbers of people rapidly. Well planned mass media communication has been used successfully for public information campaigns in emergency situations. It should use the most appropriate means of communication, target a single problem or behaviour, and communicate a single message clearly and in a positive way.

Common forms of mass media communication include radio and television messages that are listened to by a large number of people, printed messages in newspapers, magazines or posters, and messages relayed through popular media such as village singers, village announcers, traditional storytelling, participatory theatre, puppet theatre, song and dance.

There are also potential drawbacks to a mass media approach including the misinterpretation of messages, the inability of carers to ask questions about what they hear and thus dispel any confusion, and the risk of marginalizing those without access to mass media.

### Key messages

1. A good understanding of the community, its context and its concerns are key to the design of relevant, acceptable and effective projects.
2. Working with communities is at the heart of the Minimum Standards in Disaster Response. Common standard 1: Participation states that 'The disaster affected population actively participates in the assessment, design, implementation, monitoring & evaluation of the assistance programme'.
3. The motivation & retention of staff, both paid and volunteer, needs careful consideration and should be in line with local rates of pay.
4. An understanding of local nutrition practices and the communication of appropriate information increase the effectiveness of an emergency response.
5. BCC activities should have evidence based content that is targeted, context specific and implemented via a range of locally understood communication channels. They can be widely used in nutrition programming
  - To promote the use of good behaviours
  - To familiarise communities with the use of new products or services
  - For community sensitisation and investigating barriers to service uptake.



# PART 2: TECHNICAL NOTES

The technical notes are the second of four parts contained in this module. They provide information on how to work effectively with communities in emergencies and guidance on implementation of *behaviour change communication* (BCC) activities. These notes are intended for people involved in nutrition programme planning and implementation. The notes aim to cover the major technical details, highlighting challenging areas and provide information on accepted current practices. Words in *italics* are defined in the glossary.

#### Summary

All emergency programming needs to work with the support from the affected community and is enhanced by good relationships and effective communication based on mutual trust and respect. Active community participation, particularly from women, is needed to support situation assessment and nutrition programme design.

Section 1 provides guidance on understanding the community, working with volunteers and the role of good communication. Section 2 introduces BCC as a reiterative process between technical specialists and the local community. Various participatory assessment tools are discussed along with suitable channels of communication. BCC activities aim to support the community in adopting positive nutrition and health behaviours using a well-researched communication strategy.

#### Key messages

1. A good understanding of the community, its context and its concerns are key to the design of relevant, culturally acceptable and effective projects.
2. Working with communities is core to the Sphere Minimum Standards in Disaster Response. Standard 1 states that 'People's capacity and strategies to survive with dignity are integral to the design and approach of humanitarian response.'
3. The motivation & retention of staff, both paid and volunteer, needs careful consideration and should be in line with local rates of pay.
4. An understanding of local nutrition practices and the communication of appropriate information increases the effectiveness of an emergency response.
5. BCC activities should have evidence based content that is targeted, context specific and implemented via a range of locally understood communication channels. They can be widely used in nutrition programming
  - a. To promote the use of good behaviours
  - b. To familiarise communities with the use of new products or services
  - c. For community sensitisation and investigating barriers to service uptake.

## 1. Working with communities

All emergency programming needs to work with the support of the affected community and this relies on both good relationships and effective communication. An understanding of the prevailing culture, of how things get done and the importance of collaboration and mutual respect is required and humanitarian workers need to show respect to both community leaders and members from the outset. Ideally a relationship of trust and respect will develop over time between the community and agency.

In many cultures there are standard protocols that people follow to mark respect, for example, formal introductions to a hierarchy of stakeholders which may start nationally, move down regionally and on to village level. This may appear daunting or time consuming but could be viewed as an opportunity to show respect for the culture and also to meet, and thereby understand a little better, a range of indigenous actors and should be perceived as time well invested. It needs to be acknowledged that some agencies working in emergency environments do not always manage to follow local cultural norms and, at times, are not even expected to do so by a host community once they have become accustomed to their ways. However in most situations, humanitarian agencies should respect cultural norms and working outside of them is likely to affect their ability to be effective and does not meet professional standards of practice.

Humanitarian agencies that are dependent on short emergency funding cycles and or high staff turnover rates may face particular difficulty in integrating effectively with, and learning from, local people.

### Understanding the community

The host community in which you work is not a homogenous group of people, but is made up of various different groups separated by gender, religion, economic status, ethnicity and many other factors. These different groupings will have different levels of power and influence in the community and it should be taken into account that powerful members, such as administrative or religious leaders, can be very helpful to an agency hoping to gain the trust and support of a community.

Established community groups and organisations, such as women's groups, village development committees and farming associations, can also be influential and may have similar interests or concerns to your agencies mandate.

It is important in an emergency to ensure that those affected are directly involved in all stages of the response. As stated in the Sphere Common Standard 1, people's capacity and strategies to survive are integral to the design and approach of the humanitarian response and agencies should act to progressively increase the disaster affected people's decision making power and ownership of programmes during the course of a response.

Typically, however, the most marginalised and vulnerable groups not only tend to have the most needs but also the least involvement in programming and it is thus vitally important that their views and opinions are sought out and considered. They can be hard to find as the most vulnerable are often the most occupied in working to secure the immediate needs of their family whether it be for food, shelter or healthcare. These groups, who may be illiterate or not well educated, need to be identified and their participation actively encouraged by agency staff. Community participation, see Box 1, should be broad across the society. It is particularly important to seek involvement from women since in almost all communities they are the primary care givers for the children and family.

### Box 1: Community Participation

Community Participation is the active involvement of the community in the planning, management, implementation, monitoring & evaluation of services and projects.

Active community participation is essential for effective health and nutrition programming in emergencies to ensure relevance, acceptability and enhance sustainability of project interventions.

Humanitarian agencies should, whenever they can, aim to tap into the social capital of their host community and recruit paid staff locally. One of the positive aspects of this is a stimulus to the local economy and another is local knowledge.

However, agencies tend to employ the better educated, often more affluent individuals who quite possibly have little understanding of the problems and issues faced by the most vulnerable.

A United States Agency for International Development (USAID) programme review<sup>1</sup> on working with community health volunteers and concluded that;

‘Programmes that do not recognise the complexity of local communities or ensure that the marginalised are given a voice may find that their CHWs (community health workers) are pawns of the local elite.’

In emergency situations the demographic of the area can be severely distorted in many ways as people adopt various coping strategies. Some examples include:

- In times of food shortage the able bodied may migrate, either permanently or seasonally, in search of employment, aiming to send home remittances.
- In insecure environments the professional classes may take their entire families to safer environments leaving communities bereft of qualified health personnel.
- Refugee populations may travel as ‘villages’ and host a spectrum of skilled personnel including ‘local’ leaders and administrative structures. They may travel by car, bus, horse and cart or on foot; they may have all or none of their possessions.

- Alternatively refugee populations can be fairly homogenous, with disproportionately high numbers of one sex. This may be because some family members stay behind to protect assets or leave to seek employment elsewhere.

It is imperative that humanitarian agencies have a clear understanding of who, and what makes up the population that they are trying to serve so that needs can be assessed properly. It is also helpful to understand how the community functioned before the emergency.

### The Humanitarian Charter and Sphere Project

The importance of working with a community is reflected in the Humanitarian Charter and the Minimum Standards in Disaster Response produced by the Sphere project. This handbook is internationally established and has clearly laid out the minimum standards of practice expected of the humanitarian community. Sphere has incorporated ‘working with communities’ as one of the pillars that humanitarian work is based upon and forms a common standard that all sectors, including nutrition, should follow. See Box 2.

### Box 2: Sphere standards (2011)

#### Common standard 1: People centre humanitarian response

People’s capacity and strategies to survive with dignity are integral to the design and approach of the humanitarian response.

Agencies should act to “progressively increase the disaster affected people’s decision making power and ownership of programmes during the course of a response.”

#### Key indicators

- Project strategies are explicitly linked to community-based capacities and initiatives
- Disaster-affected people conduct or actively participate in regular meetings on how to organise and implement the response (see guidance note 1 and 2)
- The number of self-help initiatives led by the affected community and local authorities increases during the response period (see guidance note 1).
- Agencies have investigated and, as appropriate, acted upon complaints received about the assistance provided

Source: The Sphere Project ‘Humanitarian Charter and Minimum Standards in Humanitarian Response’ 2011.

The Humanitarian Charter also states as a key action that agencies should act to “progressively increase the disaster affected people’s decision making power and ownership of

programmes during the course of a response”. Diagram 1 (below) illustrates how the increased participation and ownership by the community may evolve.

<sup>1</sup> **BASICS II** Community health worker incentives and disincentives. How they affect motivation, retention and sustainability. USAID.

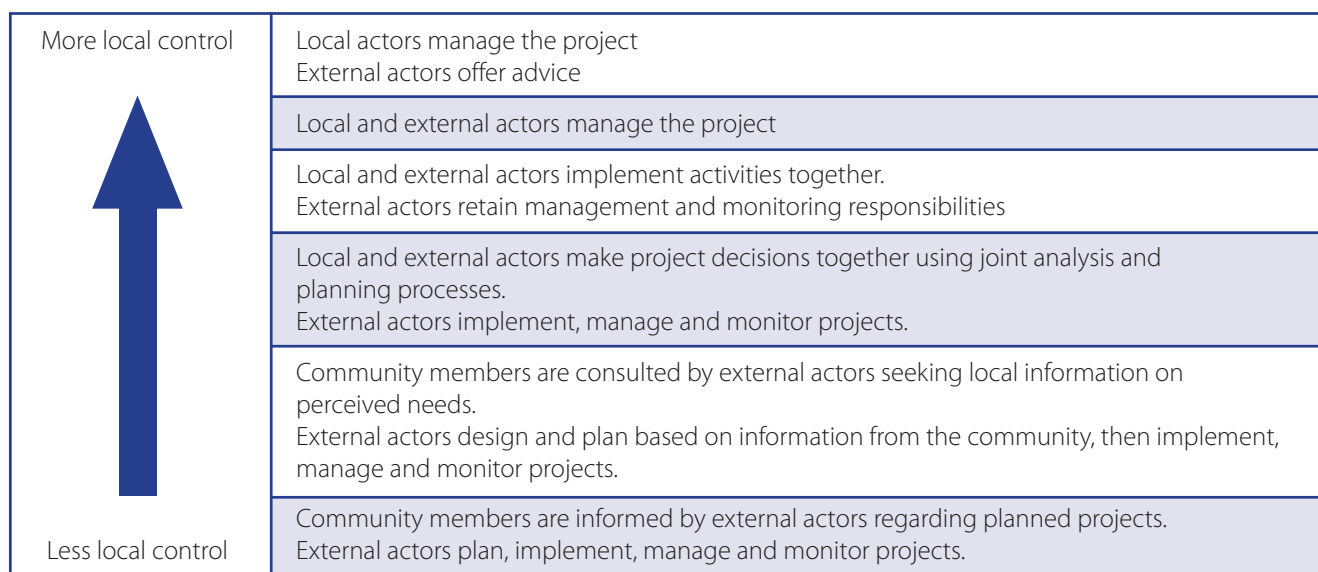
**Promoting Community Participation**

Community participation is promoted by establishing clear lines of communication, having a good understanding of the community and by working together to identify priority needs and activities. It is important to ensure that the breadth of the community is involved and that this includes women, children (who may be carers of younger children) and other relevant vulnerable and marginalised groups. Clear and transparent procedures for working with the community are also required – where project staff and the population can discuss current

and planned activities and the population can provide feedback and input into project decisions.

Where they exist, it is preferable to work through established community organisations, such as women’s groups, village development committees and farming associations, as the setting up of new groups has proved to be less sustainable. Working with established groups can avoid or minimise to an extent some of the power struggles that inevitably arise when people seek to establish their position in a new group.

**Diagram 1: Progressive increase in community participation and ownership of projects.**



Source: Interagency field manual on reproductive health in humanitarian settings. 2010

Good communication with host populations is necessary for smooth programme functioning and this requires a two way process of listening to the community as well as the giving of information. Methods of communication are considered in section 2.6 of this module.

For example, limited or poor collaboration over food aid or non-food items distribution dates may cause confusion, hardship and poor monitoring statistics through low turnout if they are scheduled on market, religious or holidays, as well as reflecting badly on the distributing agency.

Communication with the community should include:

- Listening to the priorities and needs of a range of community stakeholders including women and men.
- Outlining the mandate, aims, and proposed activities of the agency as well as making clear what the agency cannot address.
- Explaining the time frame, exit strategy and limitations of the agency.
- Negotiating the roles and responsibilities of the host community.
- Provision of information for important programming events such as food distributions, surveys and meetings.

The drawing up of food aid or non-food items distribution lists can be a very sensitive process requiring high levels of transparency. Inclusion on the list usually means access to free resources and can be sought after by some community members. Socially excluded families and the highly vulnerable may not be the most able to be get on the lists in some societies and, this may be in part due to different types of accountability. Humanitarian agencies are accountable to their donors who often wish the ‘most vulnerable’ to be targeted whereas local authorities are accountable to their own constituents/employers/leaders. Local authorities may view the ‘most vulnerable’ as being too hard to reach and not worth pursuing or alternatively as the ‘undeserving poor’. The constituents with the most influence are rarely the most vulnerable.

Humanitarian agencies and the community leaders are not always in agreement and how these differences are dealt with is important. Good communication, honesty and transparency can go a long way to smooth over issues, or even resolve them, though again it must be acknowledged that at times agreement will be impossible. At times, in emergency situations, the focus should be on maintaining the relationship for the future. In hostile and insecure environments full consideration must be given to the implications and nature of the relationship with community leaders.

**Working with Volunteers**

Humanitarian agencies also often depend on the work on a significant numbers of volunteers who may have a broad range of job titles – community health workers, nutrition educators, community educators etc. However, a community’s resources – time, money and people -can be scarce and its willingness and ability to provide volunteers can be limited. Working closely with an agency, perceived as having only a short term

presence, may not be viewed as their best use of limited resources. The issue of how to motivate volunteers is one that is often tackled in emergency programming and it continues to be an on-going issue. It is summarised in Box 3 below.

Community based management of acute malnutrition (CMAM) programmes require high coverage rates to maintain their effectiveness and this high coverage rate cannot be achieved without high levels of community mobilisation. This involves volunteers’ actively case finding and referring the undernourished to the programme (discussed in detail in Module13).

Volunteers need to be actively supported to maintain their motivation, ensure they have a good understanding of their duties and, that they are able to fulfil their duties with relative ease. A good network of volunteers from the community is more sustainable as it allows the work load to be shared, implemented well, and doesn’t over rely on a few individuals who may become overburdened and exhausted.

**Box 3: A comparison of cash versus non-monetary work incentives**

<b>Cash incentives</b>	<p><b>Positive effects</b>                  Enable people to work longer hours                  Allows a higher level of supervision                  Risk of losing the job/income encourages good performance                  Lowers the staff turnover                  Acts as a symbol of respect, acknowledgement and approval</p> <p><b>Negative effects</b>                  Unequal salaries between staff and agencies can be divisive.                  Can lead to demands for pay rises or other perks                  Can undermine volunteers relationship with the community as their accountability may move from community to their employer                  Can lead to heightened expectations from the community                  Are rarely sustainable</p>
<b>Payments in kind</b>	<p>Can be a compromise between cash and non-monetary incentives                  Food, education, agricultural inputs or preferential access to services have all been used.</p>
<b>Non-monetary incentives</b>	<p><b>Supervision or recognition</b>                  Acknowledges the role of the volunteer in the community</p> <p><b>Providing ID and transport.</b>                  This includes name badges, ID cards and t-shirts. These all facilitate access to a household.                  Access to bicycles or motor bikes.</p> <p><b>Providing equipment</b>                  These can support the volunteer to do their job and includes storage cabinets for record keeping, health education material, notebooks etc</p> <p><b>Personnel growth and development</b>                  The witnessing of positive change, for example recovery of severely malnourished/sick children, can be a strong motivator.</p> <p><b>Regular vocational training</b>                  Training needs to be appropriate, vocational rather than academic, and suited to the needs of the local community.</p> <p><b>Peer support and networking opportunities</b>                  These can be important for isolated or otherwise poorly supported volunteers.</p>

Adapted from *Community health worker incentives and disincentives. How they affect motivation, retention and sustainability.* USAID (2001).

## 2. Introduction to Behaviour Change Communication (BCC)

BCC is a programming approach that works with communities at field level to improve their health and nutrition outcomes using a considered communication strategy based on evidence based theories and models of behaviour change. In development contexts, it typically involves careful research and study of a population before a communication strategy is devised. However, in emergency affected populations the time available for study can be very constrained.

Communication with the local community is, nonetheless, an essential part of any nutrition emergency response to ensure that affected individuals or populations are involved in the emergency response, inform the emergency response and are given clear information to help them cope with unfamiliar situations or resources in order to protect and promote their nutritional status. BCC is a method to help achieve this. It is not a "luxury in an emergency. It is a necessary component of efforts to ensure the survival, health, development, protection and psychological recovery of an affected population".<sup>2</sup>

There are many approaches to BCC undertaken by different agencies to support good behaviours and to communicate effectively with people; however the ultimate aim of changing people's behaviour requires a lengthy reiterative process. This process uses a variety of techniques to repeat, familiarise and reinforce the message. For example, health worker messages

on the importance of exclusive breastfeeding can be supported by examples of mothers discussing the issue in popular soap opera TV/radio broadcasts and also with visual messages in posters.

**Nutrition BCC** has recently started to be recognized as an important part of emergency nutrition programming, and well-designed BCC activities can increase the effectiveness of the emergency response and ensure that those affected are able to participate in the emergency response. Adequate knowledge, skills and motivation to ensure adequate nutrition is a needed for survival, for example with exclusive breast feeding and this is especially important in emergencies.

Nutrition BCC can be widely used and can helpful

- a. To promote good behaviour and to discourage poor practices
- b. To familiarise communities with the use of new products or services
- c. For community sensitisation and investigating barriers to service uptake

Specific activities are listed in Box 4 and although many of the themes relate to traditional women's roles, men should be involved to increase overall nutrition knowledge and to win their enthusiasm and support for improved practices at the household level.

### Box 4: Examples of nutrition related BCC activities

- Promotion of exclusive breastfeeding
- Communication of the dangers of bottle feeding.
- Supporting appropriate complementary food preparation
- Promotion of micronutrients: their importance, deficiency related diseases and compliance
- Training community volunteers to recognise and refer the acutely malnourished
- Communicating information and understanding on ration content, quantities and rights
- Enhancing the utilisation of food aid rations (storage, processing, cooking, etc.)
- Introducing unfamiliar or new foods/commodities (e.g., *micronutrient powders*, CSB+)
- Supporting hand washing and hygiene
- Enhancing good health seeking behaviour
- Training in home gardening

In the past, *information, education and communication* (IEC) was often used in relation to nutrition education. However, the sector has evolved significantly over the past decade and IEC has largely been replaced by BCC and SBCC (social

behaviour change communication). Nowadays IEC refers to the tools commonly used whilst working with communities on BCC.

<sup>2</sup> United Nations Children's Fund, *Behaviour Change Communication in emergencies: A Toolkit*, UNICEF, New York, 2005.



The Academy of Educational Development (AED), the Manoff Group and UNICEF have produced a number of useful tools and resources (see part 4) to support their work in BCC. These resources can be used directly or adapted for use in emergency contexts.

UNICEF has produced a handbook on BCC specifically for use in emergencies. It outlines the general principles for BCC and provides detailed specific guidance for topics e.g. promotion of breast feeding. However, it is by working with and through communities appropriately that makes messages effective and more likely to be acted upon. Telling people what to do is not an effective strategy. BCC was devised to overcome this and is based on community engagement, allowing them to highlight their issues and to deduce the benefits of the proposed changes themselves. In short BCC aims to give ownership to the people.

AED define BCC as; “The strategic use of communication to promote positive health outcomes, based on proven theories and models of behaviour change. BCC employs a systematic process beginning with formative research and behaviour analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioural objectives.”

AED have established the “BEHAVE” framework as a clear and simple tool designed to aid BCC. It is based on the principle that asking the right questions leads to the right answers. The BEHAVE questions are designed to define:

- The target audience, by asking ‘who are you trying to reach?’
- The desired action, by asking ‘what do you want the target audience to do?’
- The determinants or what supports/prevents the action, by asking ‘what are the factors that influence or could influence the behaviour?’
- The interventions, by asking ‘which actions will be most effective in addressing the factors?’

These questions can be considered through a variety of different participatory assessment methods which are outlined in section 5.

It is accepted that knowledge and information are only part of the battle and often people have other barriers preventing them adopting behaviour. For example, in emergencies mothers can face extreme time constraints due to the time it takes to obtain and produce food for the family in changed circumstances. **Case example 1** illustrates an approach to facilitating women’s access to BCC activities in Ethiopia.

### Case example 1: Protecting infant feeding in Ethiopia 2006

Ethiopia is a poor country with high levels of malnutrition. Research found that absence of breastfeeding was the most important determinant of chronic malnutrition in babies less than six months of age. Babies not being exclusively breastfed were five times more likely to be malnourished than those who were.

It was also found that exclusive breastfeeding did not only depend on a mother’s knowledge but on her ability to **spend time** with her child to provide sufficient breast milk and that the poorest mothers faced the most constraints in being able to practice exclusive breastfeeding.

As a result, an approach was piloted whereby wealth-creation was promoted through loans, and lactating women were paid cash to attend nutrition BCC sessions rather than participate in employment-generating schemes such as food-for-work. The cash aimed to enable mothers to remain at home for longer periods of time and, together with the BCC, promoted breastfeeding.

Source: Yimer, T., Save the Children United Kingdom, 2006, unpublished report.

There are many other opportunities for linking BCC to emergency nutrition activities, for example, in on-site feeding programmes, supplementary and general ration distributions, community-based therapeutic care programmes, growth monitoring and promotion, training in home gardening, etc.

### What are the characteristics of a successful BCC approach?

Attempts at working with communities that are too direct and that do not involve the people early on are generally not successful. BCC approaches must be participatory, show clear benefits and be grounded on existing local knowledge and practices about nutrition in order to be successful. Successful BCC approaches often have one or more of the characteristics outlined in **Box 5**.

**Box 5: Characteristics of successful approaches to nutrition BCC**

- Recognize that people have strong and varied beliefs and that approaches should not be based on assumptions about people's behaviour.
- Based on observed behavioural practices, not on anecdotal stories or preconceived ideas.
- Base it on a clear assessment of the nutrition problem, analysis of its causes and a carefully thought out plan of action to address it.
- Include two-way processes so that those affected by disasters have opportunities to express their views, priorities and concerns.
- Take into account the motivations of particular population groups and work with communities and community leaders.
- Target a specific group and communicate a clear message.
- Provide information to allow a reasoned choice.

It is worth remembering that approaches to persuade target groups to change their behaviour without their participation or an understanding of the causes of their problems are rarely successful.

### 3. Developing a BCC approach in emergency programming.

The following the six steps summarised in **Box 6** aim to guide the development of a BCC strategy.

#### Box 6: Steps to guide a BCC strategy

##### Step 1

- Assess both the context and your agencies place within it. This includes the role of government/authorities, the national/local procedures and formalities, cultural norms and the relationship that your agency has with the community. It is important to start consultation with key members of the community who can influence their community at the outset.

##### Step 2

- Define the nature of the nutritional problem. This can be in terms of who is affected, what is the nature of the problem, how many and why they are affected. Participatory assessment methods can be helpful. Is it the entire population or a sub-group such as women with young children, fathers or influential leaders?

##### Step 3

- Identify the target group, define objectives and set indicators for monitoring. A consultation process throughout planning will help in the development of a common approach with the community and will reduce misunderstandings or conflicts with stakeholders.

##### Step 4

- Understand how the individual or population group views the problem and explore barriers to change. This step considers 'why' people are affected and seeks a deeper level of understanding. Participatory methods are used with the community to develop understanding of why people behave the way they do. The focus should be on a problem that the agency and community have identified together.

##### Step 5

- Develop and test the behaviour change strategy and/or message. The message should be context specific, culturally sensitive and tailored so that it minimizes negative feedback or stigma. Testing the strategy provides important information that can be used to refine approaches.

##### Step 6

- Choosing the right channels for communication. This step is based on the objective of the BCC activity as well as considering costs, availability of skilled human resources and accessibility of the beneficiaries to the proposed medium.

#### 3.1 Assess both the context and your agencies place within it.

In order to implement effectively, your agency needs to understand the prevailing context and its place within it as much as is possible. All agencies need to communicate and work with their communities but an honest assessment of an agency's strengths and weaknesses will help guide the scope of their work in BCC.

The context assessment includes the political situation, the role of government/authorities including their willingness and capabilities, the national/local procedures and formalities, cultural norms and importantly the relationship over time that your agency has had with both officials and the community.

Emergency nutrition programmes have been running for long periods, decades in some cases, in many parts of the world. Where this is the case, communities will already have perceptions and beliefs about the agencies long term intent and effectiveness. There also may be elements of resentment or mistrust over past interventions that need to be minimised.

It is therefore important to assess your agencies ability to implement an activity and ask if your agency has the right culture and appropriate staffing in terms of numbers, the balance between local and international staff and their sector of expertise. It is important to keep in mind that in general terms, people communicate best with others of their own age, social class and from the same geographical area.

### 3.2 Define the nature of the nutritional problem

This can be in terms of who is affected, where they are, what the nature of the problem is and how many are affected. It should be possible to obtain some useful information from existing sources such as country-level demographic health surveys, multi-indicator cluster surveys as well as nutrition surveys. All potentially yield useful information from which the likely effects of the emergency on existing behaviours and practices can be anticipated. Information on cultural beliefs and practices is harder to find but should be sought out, enquiring within the community as necessary.

Enquiries can be supported by the use of participatory assessment tools. Examples of which include:

- Group discussion/interview
- Home visits (for assessing child feeding behaviours and nutrition counselling)
- Observation
- Mapping
- Seasonal calendars to assess food availability
- Problem ranking/sorting

An understanding of the pre-emergency nutrition situation is an important aspect of the emergency assessment process. From the BCC perspective, it is important to understand the typical nutrition-related behaviours and practices of the affected population. Beliefs such as those relating to *breast-feeding and complementary feeding* practices, traditional food consumption practices, food taboos and uptake of health services to name a few.

In Yemen for example, almost all babies are breast fed from birth to 6 months but 50% receive other liquids regularly before 3 months of age and sometimes, in advance of receiving breast milk<sup>3</sup>. The reasons for this are less well investigated but may include the absence of the mother and her lack of time. Therefore a simple message promoting breastfeeding may not be effective as it does not address the problem of women's workload. Furthermore, in Darfur strong beliefs mean family members may seek out traditional medicine to treat under-nutrition and only visit health facilities when a child's health continues to deteriorate. Aiming to change beliefs is unrealistic but perhaps encouraging the use health facility treatments might have more success.

It is vital to remember that BCC activities must be designed for a particular community or target group and based on known nutrition related beliefs and behaviours of that community. Behaviour change recommendations should also be tested with the target group to assess the feasibility of suggested behavioural solutions.

<sup>3</sup> IFPRI 2010 p57,

### 3.3 Identify the target group, define objectives and set indicators for monitoring.

A consultation process with the community throughout the programme planning stages will help in the development of a common approach and will reduce misunderstandings or conflicts with stakeholders.

The common target groups for nutrition BCC activities in emergencies will be

- Pregnant & lactating women and mothers of children under 2 years of age
- The acutely malnourished, including those with micronutrient deficiencies
- Those at risk of undernutrition
- Community workers, volunteers and mobilisers
- Individuals or groups exposed to a new food, technology or service.

Activities may also need to be targeted at those not directly affected by undernutrition. It may be necessary to win the support of key decision makers in the household including husbands or mothers-in-law. It may also be useful to raise the general level of nutrition understanding in a community. Other groups that may need to be considered include the elderly, those affected by HIV and AIDS and entire populations who are displaced from their normal environment.

Once the target group/s is known, it is essential to define the objectives of the BCC activity, e.g., the results that need to be achieved (these results may vary for the different phases of an emergency response). All programme objectives should be SMART and BCC is no exception though it can be more challenging as anticipated results are sometimes intangible:

- Specific BCC actions are clearly defined and understood by all
- Measurable changes/effects of the action are measured quantitatively or qualitatively
- Achievable BCC objectives are feasible in the local context
- Relevant BCC activities will contribute to an improved situation
- Time-bound in a set time frame

**Box 7: An example of a SMART objective and indicator****Objective**

Within six weeks of the start of an emergency, the number of community nutrition promoters who provide friendly and accurate answers to questions at every nutrition education session in the community would have increased from 30 to 60.

**Indicators**

The number of community nutrition promoters in the community

The number of nutrition education sessions

The number of reports of good/bad service from recipients of nutrition education. This could come from community meetings, supervisor reports, discussion with health workers and or other participatory assessment tools.

Once objectives have been defined indicators need to be set to so that you can monitor the activities progress. It is also worthwhile at this stage to consider where the information required can be found and if extra resources will be needed to gather it.

### 3.4 Understanding how the individual or population group views a problem and barriers to change

This is the stage when a deeper understanding of the issue is sought. Participatory investigation tools are used for this and these are outlined in section 5. These tools can be used to understand how emergency affected groups understand their nutrition-related problems, understand why they behave as they do and, provide an opportunity for communities to highlight ideas on how to address their problems. The focus should be on a problem that the agency and community have identified together.

Unless we know what people actually do, it is very difficult to define what change is required, and without an understanding of why or how people behave that way, it is very difficult to design efficacious BCC activities. It is essential to clearly understand why people are or are not doing certain things and to eliminate or reduce the barriers to the desired behaviour in order to enable change. Barrier analysis is a way of identifying why someone does not adopt a behaviour and helps us to understand the situation.

It should be remembered that a large proportion of carers seldom disclose their child caring habits for fear of being ridiculed by health staff in clinics and hospitals. There is frequently a cycle whereby the carer is told off for a particular practice and then hides the practices for fear of being ridiculed again and so the problem continues. Alternatively, if the problem, for example night blindness, a symptom of vitamin A deficiency, is not viewed as a problem by the community

they will have little motivation to modify their behaviour. This may be the case if a connection between eating particular foods, night blindness and the health of the child has not been made. Food taboos may also be important. Cultures have many different food beliefs and taboos and it is easy to ignore them if the belief does not fit with your own view. However if culture dictates that feeding eggs to children makes them steal then, in the short term at least, you should not advise this but come up with an alternative instead.

### 3.5 Develop and test the behaviour change strategy and/or message

This involves developing the message, testing its communication with a control group of subjects, obtaining their feedback and redeveloping to take account of their views and concerns.

Pre-testing of BCC activities is a key way of determining acceptability and feasibility within the prevailing context. It is also important to ensure that the correct message has been understood by different groups of people and that the different activities are consistent with one another. Again participatory methods can be used to test, and receive feedback about, the message including key informant interviews, for example, at clinics and group meetings in the community with small groups of the target audience (the Manoff Group and AED have worked on a method, Trials for Improved Practice, to test and improve activities in development contexts).

Monitoring and evaluation of BCC activities is important to allow on-going modification and fine tuning of the programme. Evaluation can be challenging as behaviour change can be a long term aim, however that is not a justification for inactivity. This is not always the case and many activities can have an effect within a short time frame such as those associated with promoting breast feeding which have an immediate effect on the wellbeing of babies and infants.

### 3.6 Choosing the right channels for communication

Successful approaches to BCC often involve more than one communication channel to help reinforce the information. Communication research studies have documented that individuals are particularly influenced to adopt new or improved practices through interpersonal communication with their peers or with opinion leaders. The studies have shown that using varied communication materials tend to reinforce the effectiveness of interpersonal communication. It is important to ensure that the different methods of communication used give consistent and complementary messages.

It is essential to investigate what the most popular, and still functioning, 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.

To choose the right mix of channels in the different phases of an emergency response, it is important to consider the following questions:

- How do affected families and communities seek information?
- How do affected families and communities share information?

- Who are trusted and respected spokespeople in the community or relief camp?
- Which groups have access to generators, mobile phones, megaphones, public address systems, radio or television?
- Which groups among the affected population do not have access to any media?
- What traditional, telecommunications and mass communication channels are available?
- Which groups can you reach via community-based groups such as social or religious functions?
- What are the levels of literacy among the target group?
- Will the chosen methods reach those with low levels of literacy?

In general, people communicate best with others of their own age and social class and from the same geographical area. This highlights the importance of having good local staff whenever possible as international staff will have many more barriers to effective communication to overcome. Gender is also an important consideration. All too often young male health workers are recruited, because they speak the agencies main language, and they may do some jobs admirably. However they are clearly not a good choice to support women breast feeding in communities. Extension workers (agriculture, community and health), health staff, teachers, youth leaders and other interested and influential individuals from the local community can be trained to pass on appropriate knowledge and skills.

## 4. Practical applications of BCC in nutritional emergencies

BCC can be useful in many areas of emergency nutrition situations and in practice; these areas may overlap with one another. Some examples follow

- Promotion of good behaviours such as exclusive breastfeeding and avoidance of risky ones such as bottle feeding.
- Familiarisation with the use of new products or services
- Community sensitisation and investigating barriers to service uptake

### 4.1 Promotion of good, and avoidance of undesirable, behaviours.

Promotion may focus on a particular behaviour to promote nutritional well-being such as exclusive breast feeding or

appropriate complementary feeding. It can also be used to highlight the risks associated with bottle feeding and the use of breast milk substitutes which is particularly problematic in emergency settings.

Positive practices within a community need to be protected and supported in times of disaster to avoid them being eroded. The most pressing example of this is the need to protect *infant and young child feeding* (IYCF). There is a common misconception that in emergencies mothers can no longer breast feed adequately due to stress or inadequate nutrition. Infant formula and other milk products are provided without proper assessment of needs or acknowledgement of the associated risks to infant health. The protection of IYCF is now a major focus of emergency nutrition programmes (see Module 17 on IYCF). The case example below from Pakistan describes how emergency situations can undermine breastfeeding and gives some ideas to improve the situation.

#### Case example 2: Protecting breastfeeding following an earthquake in Pakistan: 2005

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 being breastfed, 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 breast milk.

The rapid assessment showed how the emergency situation had created a number of challenges for breastfeeding. There were many misunderstandings about breastfeeding, such as "once breastfeeding is stopped, it cannot be re-established", and "tired, traumatized 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 an 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.

To remedy the situation, posters and leaflets about the importance of breastfeeding were distributed and 'mother's corners' were established in camps where people were displaced. These were separate tents where women were given privacy to meet, breastfeed, exchange information and receive support and information from a female health worker who had training in breastfeeding BCC.

Source: Arts, M., 'Infant feeding in the South Asia earthquake aftermath', *Field Exchange*, 27, March 2006.

Achieving optimal IYCF practices in emergencies also need to include activities that address the non-behavioural determinants, such as mother's time constraints due to the additional demands on her during an emergency to obtain food for her family.

The adoption of bottle feeding following an emergency should be avoided whenever possible. The very real hazards of bottle feeding are significantly increased in most emergencies and

associated with increased morbidity and mortality. Breast feeding is known to be an effective survival strategy in developing countries and it is even more important in an emergency setting.

It may also be appropriate to promote the consumption of locally grown foodstuffs and/or wild foods as appropriate to combat micronutrient deficiencies.

## 4.2 Familiarisation with the use of new products or services

In many emergency settings, new resources are introduced such as a new type of food or health intervention. The acceptability of a new resource in an emergency setting depends on several factors including its quality, status and similarity to known resources. Information about new resources is as important as the resource itself as without appropriate and well-communicated information, it may be misused or it may not be utilised at all.

Case example 3 contains a description of how blended foods were introduced into a selective feeding programme for children in Iraq where conditions are highly volatile and insecurity restricts the movement of many staff. This shows that the introduction of new resources can incorporate BCC even in a very complex and challenging emergency affected environment. This case example highlights the use of a variety of communication channels including cooking demonstrations, publications and advertising on broadcast media.

### Case example 3: Introduction of a new resource in Iraq: 2004

In Iraq, various under five supplementary feeding projects were developed.

In 2004, in Basra Governorate, a supplementary feeding programme was established to improve the nutritional status of 60,000 malnourished children. It was decided that fortified corn and wheat soy blend (CSB/WSB) would be the ideal supplement. As the Iraqi people were not familiar with the product, an education and tasting campaign was launched at which sessions were held with the local population at nutrition growth monitoring centres to demonstrate the range of recipes that could be prepared using CSB/WSB. These were recipes based on traditional cooking preferences. The recipes were re-produced in a booklet that was translated into Arabic and over 2000 copies of the booklets were distributed.

In addition, radio and television broadcast a series of advertisements to inform recipients and request them to participate in the project. Doctors were interviewed about the importance of CSB/WSB and to highlight the education and tasting campaign. At the end of the promotional campaign, it was reported that an 80 per cent acceptability rate had been achieved.

Source: World Food Programme Kuwait/Basra offices, *Ad Hoc Supplementary Feeding Project: Basra Iraq*, WFP, July 2004.

## 4.3 Community sensitisation and investigating barriers to service uptake

Nutrition BCC can be used to enhance the effectiveness of a programme by increasing programme uptake and promoting the appropriate use of goods and services. For example, to enhance the nutritional benefit of cash distribution, a campaign may include key messages on the cultivation of fresh

fruit and vegetables, the consumption of micronutrient-fortified foods or the purchase of micronutrient-rich foods from local markets.

**Case example 4** describes the importance of understanding people's perceptions of a programme and how can enhance programme coverage.



## Case example 4: Understanding community barriers to uptake of CTC/CMAM programmes

Community-based therapeutic care (CTC) programmes or community based management of acute malnutrition (CMAM) programmes treat severe acute malnutrition through the provision of *ready-to-use therapeutic foods* (RUTF). A key element of this type programme is a high coverage rate and coverage surveys should be part of the monitoring and evaluation procedures. Surveys can also gather information on the primary reasons for non-attendance or barriers to service uptake.

Analysis of survey data from 2007 revealed that the prior rejection of a child from a CTC programme to be the most significant factor for future non-attendance. Mothers with undernourished children had refused to participate in the CTC programme if they had been rejected by programme staff at an earlier date. Rejection is closely linked to how communities find out about the programme as word of mouth is one of the three main forms of communication used in CTC programmes:

- Community sensitisation;
- Active case finding and
- Word of mouth.

Each channel has advantages and disadvantages:

**Community sensitisation** that provides clear messages can increase the number of eligible children presenting at the CTC sites. However, mass sensitization which inappropriately aims to attract all children for screening leads to high levels of rejection.

**Active case finding** can reduce the number of non-eligible children turning up at CTC sites but causes confusion if mid-upper arm circumference (MUAC) is used as the community referral criteria while weight-for-height is used as the site admission criteria as results may be different. This can lead to children referred by the community being turned away at the admission stage. The potential for this 'negative feedback' can be minimised if MUAC is used as admission criteria.

**Word of mouth** is a double-edged sword – a 'good' programme will have positive 'word of mouth', while a 'bad' programme will have negative 'word of mouth'.

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

- Explain admission and rejection to carers. Staff need to dedicate time to the crucial task of explaining the reasons for rejection.
- Monitor community perceptions. At a community level, mobilization workers need to constantly monitor community attitudes towards the programme, and to identify negative feedback early on. When discontent and fear of rejection arise, staff must devote time to explaining the reasons for rejection and the risks associated with non-compliance.

Further research on barriers to CTC programme uptake based on 12 programmes across five African countries revealed that 75% of non-attendance was due to the following three factors

1. Distance to the site
2. Community awareness of the programme
3. The way rejections are handled at the sites.

Source: Guerrero, S., 'Impact of non-admission on CTC coverage', *Field Exchange*, 31, September 2007.

Guerrero, S. 'Determinants of coverage in CTC programmes: towards a joint quantitative and qualitative analysis'. *Disasters*, vol 34, p571-585, 2010.

## 5. Participatory assessment tools

Participatory assessment is a method of situational assessment that engages with the community. They can be used to determine what needs to be done from the communities' perspective and what is feasible considering the prevailing constraints. A range of tools will usually be used and a range of people consulted – women, men, local authorities, health workers etc. Information collected should be cross-referenced to minimise bias.

The specific tools chosen will depend on context, cultural preferences and on how people normally receive/obtain information as well as on availability of resources and time and the nature of the problem being investigated.

### In-depth interview

An interview using a flexible guide of mainly open-ended questions (questions that cannot be answered with a 'yes' or 'no' or any other single word or number). The aim is to collect detailed information on the individual's beliefs and attitudes related to a particular topic so each topic can take up to one hour.

### Key informant

A 'key informant' is someone who has experience and knowledge on a topic of interest. Often they are community or organization leaders. The interviewer must develop a relationship of confidence with the individual so that his or her experience and insights will be shared.

### Semi structured interviews (SSIs)

A semi-structured interview is supported by a checklist of topics or questions to guide the process. It is normally conducted on a range of informants individually. The check list ensures a degree of commonality between interviews whilst also allowing informants to speak relatively freely and/or at length on a topic. Not all questions need to be asked of all interviewees.

### Group interview

One must be aware that in a group setting people tend to stick to consensus views and that certain groups may not feel able to speak freely. Group interviews are best combined with SSI and/or individual in depth interviews to cross reference information.

There are several different types of group interviews such as:

- **Structured** group interviews – participants are asked the same questions as individuals,
- **Focus group discussions** (FGDs) – a facilitator guides a maximum of 10 to 15 participants through a series of issues, with the group interacting with each other rather than just with the facilitator,
- **Community meetings** – formal discussions organized by the local group or agency to ask questions and/or make observations,
- **Spontaneous group discussions** -everyday meetings, e.g., a sports event, at which groups of people gather around to chat and a facilitator participates.

### Direct observation

This is an important and often overlooked tool. An observer records what he/she sees either using a checklist or by taking descriptive notes. The observation can include information on: the setting (the actors, context, and surroundings); the actions and behaviour of the actors; and what people say – including direct quotations.

### Mapping

This can help establish connections and local insights into what is 'useful' and 'significant' in order to understand community perceptions of the local environment, problems and the resources for dealing with them. There are several different types of mapping including: spatial maps; social maps (depicting social relationships); temporal maps (showing changes over time); aerial maps (aerial photographs or standard geographic maps) and organizational maps.

### Seasonal calendars

Ways of illustrating seasonal changes in subjects of interest e.g. harvests, labour availability, fever, seasonal changes in levels of malnutrition, women's workload, etc. Months, religious events, seasons and other local climatic events, for example, are used to illustrate time periods. Issues of interest are then discussed (sometimes using stones, sticks, or marks on paper in relation to these periods). Discussions usually highlight periods of maximum stress, constraints (no time or resources available), or the best time when new initiatives could be undertaken.

### Problem ranking/sorting

Cards with words or pictures are sorted into piles or ranked according to local criteria in order to understand how participants rank problems (e.g. obstacles to household level food security) in terms of frequency, severity, and so on. Ranking provides a systematic analysis of local terms, perceptions or evaluations of local issues.

## 6. Main methods of communication

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 associations); mass media communication including internet and social networking; and small media communication.

The knowledge and skills of local staff or influential community members who can be involved will be an important factor in determining the method and the success of the intervention. Skilled staff from a range of sectors (e.g. health, agriculture and community development) can be given special training, for example, on breastfeeding counselling, whereas influential community leaders can be involved by fulfilling a peer education role in promoting certain nutrition or health related behaviours to reach their community members.

To get a message across effectively, different channels of communication may need to be used for different target groups or for different circumstances. For example to promote and protect breast feeding it may be necessary to target health workers, mothers and influential family members. Careful consideration needs to be paid to the best methods of influencing each group and to ensure that the messages are consistent and or complementary to each other.

Remember that information alone, for example, only using IEC visual materials, may result in increased awareness about a nutrition-related subject but may have only limited impact on people's practices or behaviours. It is very important where possible to stimulate shared learning through dialogue, participation and discussions with the affected communities in emergencies. 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 the emergency<sup>4</sup>.

### 6.1 Face-to-face or interpersonal communication

This is an interactive and effective approach to share knowledge and to promote behaviour change. The relatively small number of people that can be reached, however, will limit its impact. It is often more costly than a mass media approach and is usually adopted in the following settings:

- Targeting individuals with specific nutrition related information (e.g. parents of malnourished children attending health centres or therapeutic feeding centres).

- Targeting specific sub-groups (e.g., schoolchildren who are receiving school meals or HIV positive mothers with new-borns to reduce HIV transmission).
- Obtaining specific insights into a problem, for example, with uptake of a particular resource or technology or it may also take the form of small focus group discussions.

Face-to-face communication can be made more effective through:

- Using printed materials (e.g. wall charts, flip charts and brochures) though these require a certain level of literacy among the target group (It is possible to produce picture only materials accompanied by careful explanations).
- Practical demonstrations that do not require a literate audience (e.g., demonstrations of how to prepare blended foods for complementary feeding, how to process and cook a new food commodity, or demonstrations of re-lactation methods for nursing mothers).

Face-to-face communication works well during home visits or at health centres when problems of a sensitive nature such as voluntary counselling and testing for HIV and AIDS and infant feeding can be discussed confidentially and help and advice offered.

### 6.2 Group communication

Group communication includes the use of existing social groups that meet on a regular basis. These have been targeted by many nutrition programmes in emergencies to disseminate nutrition-related information. The best approach is to focus on short and positive messages.

Non-formal education programmes (e.g., literacy classes, youth and women's groups) are also potential channels. However, both adults and children can easily lose interest, so communication methods should be as visual, interactive and participatory as possible.

Mothers, carers, grandparents and older siblings can be actively involved in BCC sessions tackling health, hygiene, food preparation and complementary feeding. This is also an opportunity for them to contribute their own knowledge and skills. They should have a chance to practice their new knowledge and skills, and exchange experiences so that they are motivated to learn and continue to practice what they have learned.

<sup>4</sup> Adapted from *United Nations Children's Fund, Behaviour Change and Communication in Emergencies: A Toolkit*, UNICEF, New York, 2005.

## TECHNICAL NOTES

In addition, in refugee or internally displaced persons (IDP) camps there may be opportunities at onsite feeding sessions or central locations, such as food distribution sites or water collection areas for group communication. With more dispersed populations, social or religious spaces and events may be more appropriate for opportunities and BCC activities. Weddings and local market gatherings may also offer BCC group communication opportunities.

Other examples of existing social forums include:

- Religious and political meetings.
- Women's associations
- Farmer's associations
- Youth groups

### 6.3 Mass media communication

This can include print, radio, internet/social networking, text messaging, television and cinema. It has the potential advan-

tage of reaching large numbers of people in a short time. The mass media are most effective when coupled with other communication approaches through which the affected community can talk about the new information with someone whom they trust, such as community leaders.

Well planned mass media communication has been used successfully for public information campaigns in emergency situations. Common forms of mass media communication include:

- Radio and television messages are listened to by a large number of people. The audience needs frequent exposure to the message, which should be specific, simple and positive. Radio messages can be imparted through spot announcements, slogans and jingles, discussions, interviews, mini-dramas and music.
- Printed messages in newspapers, magazines or posters ensure longer-term exposure to messages when widely displayed.

#### Case example 5: Infant feeding in emergency response, Haiti earthquake, January 2010

In Haiti an earthquake of magnitude 7.0 struck on 12th January 2010. It resulted in extensive and widespread devastation. The Haitian Government estimated that those affected by the quake included;

- 230,000 people dead,
- 300,000 injured and
- 1,000,000 made homeless.

They also estimated that 250,000 houses and 30,000 commercial buildings had collapsed or were severely damaged including the National Assembly and the main UN offices.

On the 20th January a joint statement on infant and young child feeding (IYCF) was released by UNICEF, WHO and WFP calling for support to IYCF and outlying their harmonised message. This included acknowledging the risks of bottle feeding and requested NO donations to be made of breast milk substitutes, bottles or milks.

The majority of infants less than six months of age were at least partially breast fed and this provided a basis to be built upon. A series of 10 key messages, appropriate to the Haitian context, were drawn up (translated into Creole and French) and printed in small media and disseminated via humanitarian agencies.

Radio broadcasting was decided upon as the most suitable channel for mass media communication. The same 10 key messages were used as public broadcasts in the following days and weeks.

This was supported by a dedicated telephone line that the public and agencies could call for clarification or advice on any aspect of IYCF.

Source: Joint statement on IYCF, UNICEF/WHO/WFP. January 2010.

Personnel communication Ali Maclaine.

There are potential drawbacks to a mass media approach to be aware of are:

- Misinterpretation of messages by some or all if not carefully considered
- Messages tailored for general consumption, not taking into account the unique needs of the affected community
- Often not interactive and thus people are unable to ask questions and dispel any confusion
- Risk of marginalizing those without access to mass media or from different language or socio-cultural groups, e.g., the affected population may lack access to radio or television

## 2.4 Small media

Small-scale community media can be the most practical, useful and effective way to reach affected people during an emergency. These media include community radio (generator or battery-powered FM transmitters), community bulletins or flyers and loudspeakers or megaphones. With community

coordination and support, it is possible to plan, produce and disseminate messages with affected community members.

Messages can also be relayed through village singers, village announcers, traditional storytelling, puppet theatre, song and dance, etc. These forms of communication combine entertainment with education.

### Case example 6: The use of small media in the Philippines, post typhoon Ketsana, 2009.

In the Philippines, typhoon Ketsana/Ondoy hit in September 2009 and caused a month's rainfall to fall in a single day washing away homes and causing extensive flooding. An estimated 460 people were killed and flood waters were up to 46 cm deep in some areas.

IYCF programming was set up in the evacuation centres. Small media were developed, tested and designed for use by community workers. This involved

1. A printed flip chart being produced. This could be read in breast feeding corners, used for group sessions or for one to one counselling sessions. The first page had 6 key messages and then the following pages were based on each of these messages. Each section page was colour coded to ease navigation.
2. The flip chart took several weeks to develop as it had to be tested with mothers, and other groups. Testing revealed that the use of appropriate photos was important in this culture and that women responded better to photos of clean, modern, rich mothers, as this is what they aspired to, whereas typical 'emergency photos' were less engaging.
3. Canvas posters were developed in addition to paper ones. This was initially done so that the posters didn't add to the rubbish. However the canvas ones proved popular as they could be reused and continued to be used after the emergency had passed.
4. Innovative forms of media can be considered and in the Philippines fans were produced. They were printed with the six key IYCF messages on them and were proved to be very popular as people used them for fans, to cool off, get rid of flies, etc.

Source: Personal communication, Ali MacLaine, Independent consultant on IYCF

## 2.5 Participatory drama

This approach has been used in emergencies and allows the affected community to be directly involved in the drama itself which gives individuals greater control and helps them to explore issues and possible solutions. Participatory drama can encourage participation in the decision-making, implementation, monitoring and evaluation phases of emergency projects. Key points to consider when using participatory drama in an emergency are:

- It stimulates critical thinking, stresses process rather than outcomes.
- A community can prioritize their needs.
- It develops a sense of community ownership.
- It offers a creative approach to deal with distress and trauma and thus supports healing among affected community members.

Case example 7 shows how participatory drama was used in Burundi to explore a particularly sensitive issue and to help identify local solutions to the problem.

**Case example 7: The use of participatory drama in Burundi: 2006**

CARE International has been a key partner of the WFP in Burundi since the outbreak of the civil war in 1993, distributing emergency food aid to refugees, returnees, IDPs and others. As the security situation in the country has improved, the programme has moved from generalized emergency feeding to regular targeted distributions. Implementing partners and local government officials are supposed to identify households that meet pre-established vulnerability criteria and are therefore included in the recipient lists. Irregularities were uncovered by field teams and a CARE study was undertaken to document whether sexual relations were being used as a means to access food aid and to identify the reasons for such abuse.

Partnering with a local theatre group called Tubiyage ('Let's talk about it'), which has extensive experience in facilitating community discussions on sensitive subjects, the research team used participatory drama to introduce the subject in focus groups and public fora, and to elicit testimonials from community members. The participants unanimously confirmed the presence of bribes and other forms of corruption.

The participants in the participatory drama suggested ways to tackle the problem including always having an agency employee present during the creation of the food distribution lists and involving local people in monitoring and involvement of the local administration in the creation of lists.

Source: Zicherman, N., *"It is difficult to escape what is linked to survival": Sexual exploitation and food distribution in Burundi*, *Humanitarian Exchange*, 35, 2006.

## 7. How to design print materials

Adapted from: United Nations Children's Fund, *Behaviour Change and Communication in Emergencies: A Toolkit*, UNICEF, New York, 2005.

When designing print materials, the number one principle is community engagement. Involve affected community members in all phases of material development. Before developing any print materials, review the objectives of your BCC activity and consider the main groups you want to reach (e.g., affected caregivers, children, health workers, teachers and others); establish whether they can read, and if so, whether they like to read. This would be best done before an emergency strikes because it would allow for significant pre-testing, translation to local dialects, and the input of various groups within the affected community. Working on print materials pre-emergency also allows you to design materials with greater assurance that the messages and graphics are culturally, religiously and gender-appropriate.

Choose a simple, logical design and layout as follows:

- Present only one message per illustration.
- Make materials interactive and creative.
- Limit the number of concepts and pages of materials.
- Messages should be in the sequence that is most logical to the group.
- Use illustrations to help explain the text.
- Leave plenty of white space to make it easier to see the illustrations and text.

Use illustrations and images

- Use simple illustrations or images.
- Use appropriate styles: photographs without unnecessary detail, complete drawings of figures when possible and line drawings.
- Use familiar images that represent objects and situations to which the affected community can relate.
- Use realistic illustrations.
- Illustrate objects in scale and in context whenever possible.

- Don't use symbols unless they are pre-tested with members of the affected community
- Use appropriate colours.
- Use a positive approach, negative approaches are very limited in impact, tend to turn off the affected community, and will not sustain an impact over time.
- Use the same language and vocabulary as your affected community; limit the number of languages in the same material.
- Repeat the basic message at least twice in each page of messages.
- Select a type style and size that are easy to read. Italic and sans serif typefaces are more difficult to read. Use a 14-point font for text, 18-point for subtitles, and 24-point for titles.
- Use upper and lower case letters.

### Special Note:

Combine print materials with small community media and other participatory communication strategies. Printed BCC materials are most effective when combined with other forms of communication. In the initial response, print media can be used to quickly dispense life-saving messages to large numbers of affected people.

## Conclusion

It is hugely important in an emergency to ensure that those affected are directly involved in all stages of the emergency response. As stated in the Sphere Common Standard 1, people's capacity and strategies to survive with dignity are integral to the design and approach of the humanitarian response and agencies should act to progressively increase the disaster affected people's decision making power and ownership of programmes during the course of a response. Nutrition BCC has only recently started to be recognized as an important part of emergency nutrition programming, and well-designed BCC activities can increase the effectiveness of the emergency response and ensure that those affected, are able to fully participate in an emergency response.





# 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.

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**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.

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\* 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.



# PART 4: TRAINING RESOURCE LIST

The training resource list is the fourth of four parts contained in this module. It provides a comprehensive list of reference material relevant to this module including guidelines, training courses and reference manuals. Part 4 provides background documents for trainers who are preparing training material. Currently, material on working with communities is limited.

### What can you expect to find here?

1. An inventory of existing **guidelines** and **manuals** listed alphabetically by agency name with details about their availability
2. A list of known **training resources** listed by agency name with details about:
  - Overall content
  - Intended use
  - Target audience
  - Length of time the course session has been designed for

### Guidelines and manuals

1. **BASICS II (2001). *Community health worker Incentives and Disincentives. How they affect motivation, retention and sustainability.* USAID**  
This publication reviews the advantages and disadvantages of incentivising volunteer staff with cash or in-kind payments. Essential reading for those working with volunteers.
2. **FANTA 2 (2010). *Community Outreach Assessment of Community based Management of Acute Malnutrition in Sudan.* Washington: FANTA 2.**  
This is a review of the services provided in Sudan that provides some key insights and recommendations on working with communities.
3. **Galasso (2009). *Improving nutritional status through behavioural change: lessons from Madagascar.* 3ie. *Journal of Development Effectiveness* Vol. 1, no 1, March 2009. 3ie.**  
This impact evaluation describes the positive effect of BCC on chronic undernutrition.
4. **Linkages (2004). *Behaviour change communication and improved infant feeding.***  
This course is designed to train community health workers in behaviour change communication skills to improve infant feeding, and to train the trainers of these community health workers. The training takes a practical approach to problem solving related to infant feeding.  
Availability: Downloadable as a pdf file on AED website  
Contact: [www.globalhealthcommunication.org](http://www.globalhealthcommunication.org)

## TRAINING RESOURCE LIST

5. **Mercy Corps & Health Alliance International ASSETS: Assessment of Emergency and Transition Situations**  
This manual provides an introduction to ASSETS, a tool that has been designed to assist in conducting assessments. It was originally developed for complex emergency situations.  
  
The guide has three sections: section 1 is an introduction to ASSETS and the tools, section 2 gives an overview of the General Assessment Tool (GAT) and how to use it and section 3 gives in-depth assessment of different sectors. It does not specifically cover nutrition sector but it does cover many of the qualitative methods.  
Availability: Downloadable as pdf file  
Contact: [www.mercycorps.org](http://www.mercycorps.org)
6. **UNICEF (2005) Behaviour Change Communication in emergencies: A Toolkit. New York: UNICEF**  
This toolkit is a useful resource that provides both a theoretical model for BCC and practical help in producing multi-media communications. It is designed to help programme managers to prepare, plan, implement and monitor behaviour change communication initiatives supporting health (and nutrition), hygiene and child protection efforts in emergencies.  
Availability: Downloadable as pdf file  
Contact: [www.unicef.org](http://www.unicef.org), [www.enonline.net](http://www.enonline.net)
7. **Valid International (2006) Community Mobilisation in Community-Based Therapeutic Care CTC: A Field Manual**  
This manual reflects the experience gained over five years of implementing and developing Community-based Therapeutic Care (CTC). It is a practical guide that aims to help health and nutrition managers to design, implement and evaluate CTC programmes. It includes a chapter on community mobilisation which discusses why mobilisation is important to CTC, describes the elements of a successful mobilisation effort and explains how to formulate and implement a mobilization plan.  
Availability: Downloadable as pdf file  
Contact: [www.validinternational.org](http://www.validinternational.org)
8. **AED (2004) The BEHAVE framework: A workshop on strategic planning for behaviour change. Washington: Academy for Educational Development**  
This is a workshop manual for the BEHAVE framework, a strategic planning tool for managers of behaviour change programmes. The manual is designed to assist program managers in accurately defining target audiences, required behaviours to solve health problems, determinants of behaviours that should be reduced, and the best behaviour change strategies.  
Availability: Downloadable as pdf file.  
Contact: [www.globalhealthcommunication.org/tools/54/](http://www.globalhealthcommunication.org/tools/54/)
9. **AED (2006) The Champion Community Initiative: Origins, Principles, and Potential Washington: Academy for Educational Development**  
This report provides a clear overview of the main principles of community mobilisation in development contexts. It does not focus on emergencies per se but does contain useful case examples of approaches used in various countries.  
Availability: Downloadable as pdf file  
Contact: [www.globalhealthcommunication.org](http://www.globalhealthcommunication.org)
10. **AED (2010). The C-Change project**  
C-Change has created this series of six modules for workshops on social and behaviour change communication (SBCC). Each module has an accompanying facilitator guide.  
Contact: [www.c-changeprogram.org/our-approach/capacity-strengthening/sbcc-modules](http://www.c-changeprogram.org/our-approach/capacity-strengthening/sbcc-modules)
11. **Bakewell O, Adams J and Pratt (2003). Sharpening the Development Process: A practical guide to the developmental process. INTRAC**  
This book is designed to help improve communication between different stakeholders by exposing them to each other's perceptions of interventions. The main focus is on the design of monitoring and evaluation systems but it has a useful section on tools and methodologies to use with communities.  
Availability: To purchase.  
Contact: [www.intrac.org](http://www.intrac.org)

12. **Davis, T. P. (2004) *Barrier Analysis Facilitator's Guide: A Tool for Improving Behaviour Change Communication in Child Survival and Community Development Programs* Washington: Food for the Hungry**  
Barrier Analysis is a rapid assessment tool used in community health projects to identify determinants associated with a particular behaviour. Once identified more effective behaviour change communication messages, strategies and supporting activities (e.g., creating support groups) can be developed. This guides trainers through a step-by-step process for analysis as well as some basic information on behaviour change theory. It contains power point presentations for teaching purposes.  
Availability: Downloadable as pdf file  
Contact: [www.barrieranalysis.fhi.net](http://www.barrieranalysis.fhi.net)
13. **The Manoff Group (2005). *Trials of Improved Practices (TIPS). Giving participants a voice in program design.***  
TIPS is a valuable tool in programme design that provides a methodology for pre-testing BCC activities although TIPS has not been used in emergency settings.  
Availability: Downloadable as a pdf file on Manoff Group website  
Contact: [www.manoffgroup.com/resources/summarytips.pdf](http://www.manoffgroup.com/resources/summarytips.pdf)
14. **McCoy et al. 3ie (2009). *Behaviour change interventions to prevent HIV among women living in low and middle income countries. International Initiative for Impact Evaluation.***  
This synthetic review outlines some of the limited success achieved in the field of HIV and BCC.  
Contact: [www.3ieimpact.org](http://www.3ieimpact.org)

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