MODULE THREE

Community Outreach

MODULE OVERVIEW

This module explains why community outreach is not only a component of community-based management of acute malnutrition (CMAM), but an indispensable complement to outpatient care programmes, as well as why it should be approached systematically and well in advance of actual CMAM startup.

Community outreach is not a new concept within the health sector. It is important to emphasise that all efforts should be made to assess the existing health outreach systems and actors and that community outreach for CMAM should build upon and further strengthen these existing systems.

The suggested activities and methods explain what community outreach is, address what the barriers are to accessing CMAM-type services, and what preparations are needed to effectively reach communities with severely malnourished children. The module reviews the elements in and components of mobilising community outreach with the goal of maximising CMAM services, minimising the number of defaulters, and ultimately reducing deaths due to severe acute malnutrition (SAM).

The module provides participants with information, tools and skills to plan their own CMAM community outreach activities and an opportunity to practice these skills in the field. During the field visit, participants will go through all the steps needed to develop a community outreach strategy and an action plan.

I. COMMUNITY OUTREACH: CLASSROOM

LEARNING OBJECTIVES	HANDOUTS AND EXERCISES
1. Explain the Importance of Community Outreach to CMAM Outcomes	Handout 3.1 Principles of Community Outreach in the Context of CMAM Exercise 3.1 Barriers to Access Role-Play Exercise 3.2 Overcoming Obstacles to Community Participation in CMAM
2. Identify Key Elements of a Community Assessment	Handout 3.2 Community Assessment Handout 3.3 Community Assessment Steps and Methods
3. Identify Key Steps in CMAM Outreach	Handout 3.4 Community Outreach: From Assessment to Strategy Handout 3.5 Community Outreach Strategy Handout 3.6 Example: Selection of Candidates for House-to-House Case-Finding Exercise 3.3 Comparison of Case-Finding Models Exercise 3.4 Worksheet: Selection of Candidates for Community Outreach
4. Discuss Considerations for Developing and Using CMAM Messages	Handout 3.7 Developing Simple and Standardised CMAM Messages Handout 3.8 Reference: Handbill Messages
5. Discuss Preparations for Community Mobilization and Training	Handout 3.9 Key Actions in Community Mobilisation and Training
Wrap-Up and Module Evaluation	Handout 3.10 Elements and Sequencing of CMAM Community Outreach

MATERIALS

- *Community-based Therapeutic Care (CTC): A Field Manual*
- Flip chart, markers
- Cards for **Exercise 3.2 Role-Play: Barriers to Access**

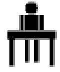
ADVANCE PREPARATION

- Room setup, materials noted above, flip charts, markers, masking tape
- The evening before the training or earlier, select six players to take part in a role-play and distribute role-play cards to the selected participants

MODULE DURATION: THREE HOURS IN CLASSROOM FOLLOWED BY ONE-DAY SITE VISIT

Note: Depending on the needs of their audience(s), trainers may choose to skip or spend more or less time on certain learning objectives and activities. The module duration is an estimate of the time it takes to complete all the learning objectives and activities.

LEARNING OBJECTIVE 1:
EXPLAIN THE IMPORTANCE OF COMMUNITY OUTREACH TO CMAM OUTCOMES



Become familiar with **Handout 3.1 Principles of Community Outreach in the Context of CMAM**, **Exercise 3.1 Barriers to Access Role-Play**, and **Exercise 3.2 Overcoming Obstacles to Community Participation in CMAM**.

BUZZ GROUPS AND PARTICIPATORY LECTURE: WHAT IS COMMUNITY OUTREACH IN THE CONTEXT OF CMAM? If participants took part in **Module One**, ask them to form groups of 2-3 and quickly describe what they know about community outreach in the context of CMAM. Ask a few volunteers to briefly respond and fill in the gaps in the discussion with **Handout 3.1 Principles of Community Outreach in the Context of CMAM, Sections 1-3**. Make particular note of the two key activities of community outreach in the context of CMAM: 1) active case-finding for early detection and referral, and 2) home visits for follow-up of problem cases. Explain that this training module looks at how to most effectively establish these two key characteristics through a four-step process.

Write the following four steps on a flip chart so that they can be referred back to throughout the module.

1. Community Assessment
2. Formulation of Community Outreach Strategy
3. Development of Messages and Materials
4. Community Mobilisation and Training

GROUP DISCUSSION: THE POWER OF COMMUNITY OUTREACH. Draw **Figure 3.1** (on the next page) on the flip chart and review the components of CMAM. Ask participants why community outreach surrounds the other components.

Fill in gaps in the discussion, noting that community outreach feeds into and is necessary for the other components to function well. Experience with CMAM has demonstrated repeatedly that provision of outpatient care without community outreach will rarely result in high service or programme service access and uptake (or service coverage). Therefore, case-finding and referral at the community level are necessary to ensure that coverage reaches acceptable levels and that SAM is identified and presented early, which lead to good clinical outcomes and decreased strain on inpatient facilities.

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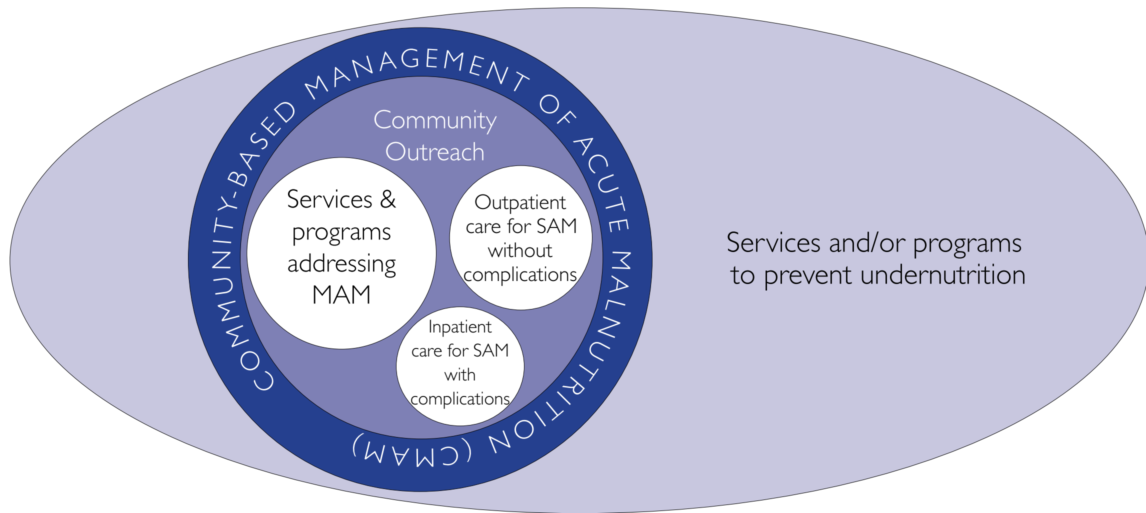
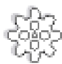
FIGURE 1. CORE COMPONENTS OF CMAM





BRAINSTORM AND GROUP DISCUSSION: OBSTACLES TO PARTICIPATION IN CMAM. Ask participants to think of obstacles faced in a community that might impede participation in CMAM. Write responses on the flip chart and fill in gaps:

- **Poor awareness** of the service within the community being served
- **Community mobilisation has been overly broad**, resulting in too many ineligible cases arriving and being rejected
- **Referral and admission criteria are not aligned** (e.g., mid-upper arm circumference [MUAC] is used for community screenings but final admission at site is based on weight-for-height [WFH]), leading to rejection of referred individuals at the site and damage to the programme's reputation
- People might be aware that there is a new nutrition service, but **local medico-cultural traditions do not connect advanced wasting or swelling with undernutrition** and awareness of traditional medicines might be stronger
- There might be **stigma in the community or the influence of peers or family members** might serve as disincentives
- Community mobilisation or site selection may have overlooked **important community gatekeepers or opinion-makers**
- **Other services at the primary health care (PHC) facility are poorly regarded** by the community (e.g., because medicines are not available, because hours are irregular, because staff are overworked, because access to treatment requires long waits) which projects a negative view on CMAM simply by association when it is established at the PHC facility
- The **location of outpatient care sites** might require an unreasonable amount of travel time for target communities or make the sites inaccessible due to barriers like seasonal flooding
- Participation may be **interrupted by seasonal labour patterns** beyond the control of the service, such as temporary relocation of families from homes to more remote farms during the weeding or harvesting seasons

EXERCISE 3.1 BARRIERS TO ACCESS ROLE-PLAY. Confirm that the players have read the role-play cards (copy below) distributed in advance (see **Advance Preparation**). Explain that the role-play should unfold as a series of scenes between the mother and the other players. Spend five minutes with all the players to answer questions they may have and suggest ways to make their performance more realistic.

The audience (those not acting out the role-play) should not be present when you explain the roles to the players. They may, however, be asked to participate in the final scene, where they may collectively act as a crowd of curious onlookers and care-seekers at the outpatient care site.

After the role-play, help the participants to list the obstacles and analyse the scenario:

- Which of these barriers are likely to be an issue in their own community?
- What other factors hinder participation?
- What measures would help eliminate these barriers?

Community Mother: You are a mother of five children, living in a community that is a two-hour walk from the nearest government health post. Your 2-year-old daughter has been sick since her younger sister's birth six months ago. You have tried many local remedies but nothing seems to make her better. She is now very thin and has almost no energy. You are very worried. You have heard that there are people going house to house to measure children's arms, but you are not sure why. You are sceptical of these volunteers because some of the same people were appointed as "health messengers" last year and have a reputation for harassing people about building latrines. There are even rumours that some families in a nearby community were fined for not building latrines, and your husband (who is out) forbade you from allowing the messengers into the family compound. When a messenger arrives and asks to see your children, you have mixed feelings: You want to obey your husband, but you do not wish to anger the community chairman by refusing his emissaries. When the messenger assures you that s/he is not here to look at your latrine, you reluctantly agree to admit him/her. At first, you are not planning to show him/her your sick child.

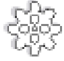
Nutrition Volunteer (male or female): You are trained to perform MUAC measurements on children by going house to house. Your work area covers four communities, including your own. You have limited formal schooling, but you are clever and are respected by people in your community who know you, even though you are young. While you are fairly confident of your ability to measure MUAC, you have not yet attended an outpatient care day because of the distance to the health post, so you are uncertain about what happens to the children you refer there. In this encounter, you are starting at a disadvantage: several months ago, you asked mothers/caregivers from your communities to gather their children in one spot for vaccination, but the vaccines did not arrive on time, leaving the mothers/caregivers waiting. You had to make a second appointment, and some mothers/caregivers are still resentful about having wasted their morning. This mother seems a little anxious, but you sense she might be persuaded to let you examine her children. After she finally allows you into her compound, you cannot answer all her questions. You therefore try to emphasise two important points to her and her husband (who has returned): 1) you are trying to save the lives of the sickest children, and 2) there is a new treatment for the most malnourished cases that can be given at home so that mothers/caregivers no longer have to spend weeks in the town hospital with their children.

First Neighbour (in community): You are spending the morning in the compound of your friend (community mother) when she is visited by the health messenger. You recognise him/her as the person who wasted your time on immunisation day and are openly antagonistic to him/her. Why should your friend waste her time with his/her new services? And aren't his colleagues causing people to be fined over latrines? When your friend finally shows her sick child to him/her, you recognise this as a problem created not by undernutrition but by "spoiled" breast milk. You counsel your friend to get roots from a community healer, boil them and bathe the child with the water. However, your friend eventually decides to accept referral to outpatient care, so you try to help by watching her other children for the day and cooking for her husband.

Husband: You come home to find your wife talking with the health messenger and are initially annoyed that she has let him/her into the compound. However, when it becomes clear he/she is not trying to make you build a latrine, you relax. You have to choose between the traditional remedy suggested by your neighbour and the messenger's advice to let your wife go to the health post where your child will receive a new treatment that can be brought home. You would not mind your wife's going to the health post, but in the past, you have seen that children in this condition have been moved from the health post to the district hospital with their mothers/caregivers where they spent weeks under care. You love your daughter and want her to recover, but you are also afraid of how this would affect your family. How would your family eat? Furthermore, it is the weeding season, and the time your wife spends at the health post—away from home—will reduce your harvest. You want assurances that she will be able to return from the health post promptly.

Second Neighbour (returning on the road): You are on your way back from the outpatient care site and are very annoyed. Yesterday you were called to attend a screening in your community. You waited all morning in the sun while children were measured. Your child was selected to attend outpatient care. But today, after walking over an hour to the health post, the outpatient care staff re-measured your child and refused to admit him. You and several other mothers/caregivers waited to speak to the head clinician because you thought the measurers were cheating you. After all, you were referred from the community with a note! However, the programme seemed to be taking all day, the staff were overworked and short-tempered, and the crowding was stressful. Therefore, you left without presenting your grievance. Why, you wonder, are people forced to waste their time like this during the harvest? As you walk home, you meet a woman from a neighbouring community (community mother) who says she was referred to the same programme. You tell her your story and bitterly advise her not to waste her time.

Outpatient Care Nurse: You have been busy all morning examining children as part of these new services. You are glad there is finally an effective treatment for very malnourished children, but things cannot go on as they are in the same disorganised fashion. People are everywhere in the clinic, asking for food and assistance. This is not a general store! You are a clinician, but increasingly you are being asked to manage a relief operation. The stress has been making you irritable, especially with mothers/caregivers who have been deliberately returning to the screening queue after being rejected just minutes earlier. Now here comes a mother (community mother) trying to get into the outpatient care line without even going to the screening queue first! The irritation is too much for you. You angrily tell her to go away. Now the crowd is getting involved. As you turn your attention back to the child in front of you, the last thing you see is the mother surrounded by people loudly offering contradictory advice.



WORKING GROUPS: OVERCOMING OBSTACLES THROUGH COMMUNITY OUTREACH. Divide participants into working groups and refer them to **Exercise 3.2 Overcoming Obstacles to Community Participation in CMAM**. Point out that it contains a summary of some of the obstacles just discussed. Ask the working groups to think about who should be involved in planning for community outreach to best overcome these obstacles and what other steps might be needed. Discuss.

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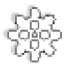
Direct participants to **Handout 3.1** for future reading and reference.

LEARNING OBJECTIVE 2:
IDENTIFY KEY ELEMENTS OF A COMMUNITY ASSESSMENT

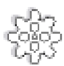
Become familiar with **Handout 3.2 Community Assessments** and **Handout 3.3 Community Assessment Steps and Methods**.

>> **Step One: Community Assessment**
Step Two: Formulation of Community Outreach Strategy
Step Three: Development of Messages and Materials
Step Four: Community Mobilisation and Training

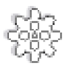


GROUP DISCUSSION: THE ROLE OF THE COMMUNITY ASSESSMENT. Note for participants that this is the first step in preparation for CMAM community outreach. In plenary, ask participants why a community assessment is important, what kind of information can be gathered, and how it can be used. Fill in gaps in the discussion as necessary, noting that:

- The assessment is an opportunity to consider community participation and service access and uptake in CMAM in a systematic way and in a specific implementation context.
- To best overcome barriers to participation, the community assessment can shed light on how the community is organised, how undernutrition is viewed, how the new service is likely to be received, and how the community can best support the outreach component.
- The community assessment should be used as an opportunity to identify and acknowledge the limits of staff knowledge of the local community.



PARTICIPATORY LECTURE: WHAT COMMUNITY ASSESSMENTS CONSIST OF. Review the content on **Handout 3.2 Community Assessments, Section B** making note of the two key questions that community assessments must answer: 1) what is likely to affect demand for CMAM locally, and 2) how can community outreach be organised (supply) to meet this demand most effectively?



WORKING GROUPS: METHODS OF COMMUNITY ASSESSMENT. Divide participants into working groups of four or five. Refer them to **Handout 3.2 Section B**. Ask them to think of their own communities and the most relevant factors affecting demand there. Reminding them that the assessment is an opportunity to identify and acknowledge the limits of staff knowledge of the local community, ask them who in the community they should approach to learn more about factors affecting demand. Have one group briefly report back in plenary.

Ask the same groups to think through the supply side and try to answer the questions in **Handout 3.2, Section C.** As with the demand side, ask them who in the community must be involved to help answer these questions. Have another group briefly report back in plenary.

Refer participants to **Handout 3.3 Community Assessment Steps and Methods**. Review in plenary and discuss any differences between their responses to the assessment steps and those involved on the handout.

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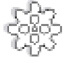
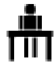


PARTICIPATORY LECTURE: METHODS OF COMMUNITY ASSESSMENT. Referring back to **Handout 3.3**, note for participants that:

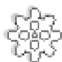
- Assessment methods vary but are qualitative and in the spirit of Rapid Rural Appraisal (RRA) or Participatory Rural Appraisal (PRA).
- Access to relevant secondary information should be assessed.
- The objective is to quickly generate usable information, not to produce a lengthy report.
- The steps and methods in **Handout 3.3** are a recommended minimum that can be built upon over time or if additional resources are available.

LEARNING OBJECTIVE 3:
IDENTIFY KEY STEPS IN DEVELOPING A CMAM OUTREACH STRATEGY



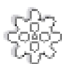
Become familiar with **Handout 3.4 Community Outreach: From Assessment to Strategy**, **Handout 3.5 Community Outreach Strategy**, **Handout 3.6 Example: Selecting Candidates for House-to-House Case-Finding**, **Exercise 3.3 Comparison of Case-Finding Models**, and **Exercise 3.4 Worksheet: Selecting Candidates for Community Outreach**.

Step One: Community Assessment
>> Step Two: Formulation of Community Outreach Strategy
Step Three: Development of Messages and Materials
Step Four: Community Mobilisation and Training



BRAINSTORM: INSIGHTS FROM COMMUNITY ASSESSMENTS. Note for participants that formulation of an outreach strategy is the second step in preparation for CMAM community outreach. Ask participants to summarize some of the insights obtained from a community assessment that could help to form the basis of a community outreach strategy. Answers may include:

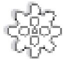
- The objectives and nature of the CMAM service: short term or long term; nongovernmental organisation (NGO)-assisted or Ministry of Health (MOH)-run; integrated or temporary/stand-alone
- Opportunities and barriers influencing participation (demand) in the community
- Resources and capacities influencing the availability of services (supply), particularly with regard to community outreach



WORKING GROUPS: FROM COMMUNITY ASSESSMENT TO STRATEGY. Divide participants into four working groups. Tell them you will explain four different key findings from a community assessment in Ethiopia and want each group to discuss one finding and how the community outreach strategy can address it.

1. Locally, a variety of causes are thought to underlie swelling and wasting, and not all are food-related. Presumed causes include breastfeeding while pregnant, exposure to bright sunlight, malevolent spirits, and the displeasure of ancestors.
2. Local churches are often the first resort families with sick children turn to; they borrow funds for treatment.
3. All parts of the community are uncertain about the relationship between proposed outpatient care of SAM and pre-existing anthropometric screening for the targeted general ration.
4. A cadre of unpaid community health workers (CHWs) are already conducting house-to-house health education regularly, but only literate workers receive regular training.

Ask each working group to report back on their findings and discuss together. Refer participants to **Handout 3.4 Community Outreach: From Assessment to Strategy** and compare the "implications for strategy" found in the second column with the working groups' responses. Discuss and fill in any gaps.

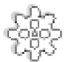


PARTICIPATORY LECTURE AND BRAINSTORM: METHODS OF CASE-FINDING. Explain to participants that the most important aspect of a community outreach strategy may be deciding how case-finding will be conducted.

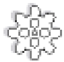
Define the three models found in **Handout 3.5 Community Outreach Strategy**:

- House-to-house case-finding
- Community case-finding
- Passive case-finding

Ask participants to describe some factors that would suggest which model (or sequence or combination) to use. Possible answers include: the degree of SAM in the community; community awareness of the signs of SAM; accessibility of homes and degree to which they are clustered; existing networks of CHWs and their workloads; time and resources available for training and outreach; whether or not case-finding is envisioned as a permanent need or temporary measure.

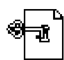


PRACTICE: DETERMINING METHODS OF CASE-FINDING. With participants still in working groups, refer participants to **Exercise 3.3 Comparison of Case-Finding Models.** Taking the three models for case-finding in sequence, ask groups to discuss the categories and fill in the matrix. Remind them of some of the factors discussed above, and if necessary get them started by asking which of the models are appropriate for start-up and which for post-start-up. In discussing the responses, note that there are no 'right answers' for every situation. The most important lesson from this exercise is that many decisions are trade-offs that balance convenience for community members against convenience for the service providers.



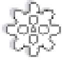
PARTICIPATORY LECTURE: SELECTION OF CANDIDATES FOR HOUSE-TO-HOUSE CASE-FINDING. Explain to participants that once a decision has been made concerning the type of case-finding to employ, the team will need to see who can most easily undertake this work. In some settings, the options may be very limited and the choice obvious. Where there are several options available, it can be a useful process to consider systematically the strengths and weaknesses of each in order to arrive at the best compromise.

Ask participants to look at **Handout 3.7 Example: Selection of Candidates for House-to-House Case-Finding**. The example is from the Southern Nations, Nationalities, and People's Region (SNNPR) in Ethiopia. The matrix ranks the candidates for house-to-house case-finding with a simple three-point scale across each of the key attributes: X is the low (poor) end of the scale and XXX is the high (good) end. The conclusion drawn in this case was that although all three types of CHWs had attributes in their favour, only the community health promoter (CHP) could both perform the house-to-house visits and accept the additional workload.



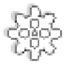
EXERCISE 3.3 COMPARISON OF CASE-FINDING MODELS (WITH ANSWERS)

MODEL	SUITABLE FOR	STRENGTHS	WEAKNESSES
House-to-House Case-Finding	**Both startup and post-startup** Situations where going house-to-house is the most appropriate way to announce the new service Situations where house-to-house outreach workers (e.g., CHWs, volunteers) are readily available Situations where social fragmentation or other factors prevent households from gathering together for community case-finding	Can more easily find "hidden" cases kept at home due to stigma, misdiagnosis or other factors	Requires a much larger number of trained volunteers Can be difficult to sustain over the long term Volunteers' MUAC measurements might not be accurate without high quality-training If visits are too frequent, house-to-house case-finding can become an intrusion to the families
Community Case-Finding	**Both startup and post-startup** Situations where families are already bringing children to centralised location for other services (e.g., immunisation, supplementary feeding services or programmes, screenings) Communities where distance between households makes it difficult to conduct house-to-house visits Situations where house-to-house volunteers cannot easily be recruited Situations where there is little likelihood of stigma or shame in publicly presenting a very malnourished child	Less effort for outreach workers than house-to-house case-finding Fewer screeners are needed than for house-to-house, allowing emphasis during training on securing reliable MUAC measurement from a smaller number of trainees	Gathering too many households in one location can create confusion and waste families' time Could reproduce existing patterns of access, catering to families who already are well served, while the marginalised stay home Screeners cannot come unannounced; people must be told when screening team will arrive, which requires advance planning and sticking to the plan
Passive Case-Finding	**Post-startup**, especially in settings where the prevalence of SAM is low Can be used in combination with periodic community screening Not yet extensively used in CMAM	Resources are targeted toward those most likely to encounter malnourished children, while the rest of the community is spared a campaign-style mobilisation that might waste their time	Use any candidate keeping in mind that some obvious candidates for a passive screener role might not have good working relations with MOH facilities, making referral to CMAM unreliable; possibilities: e.g., any outreach worker, any health care provider, traditional healers and religious leaders, private clinic staff



PRACTICE: SELECTING CANDIDATES FOR CASE-FINDING. Break participants into groups according to their districts and ask each group to fill in its own matrix using **Exercise 3.4 Worksheet: Selection of Candidates for Community Outreach**, based on local extension workers and volunteers. Ask them to list and consider the merits of at least three categories of candidates:

1. Health extension workers (HEWs) and volunteers (e.g., CHWs, community-based family planning distributors/educators, home-based care [HBC] volunteers, Vitamin A distributors)
2. Other extension workers and volunteers (e.g., agricultural extension workers, social welfare officers, NGO project workers)
3. Important community figures (e.g. teacher, priest or catechist, secondary school leavers, elected leaders, cultural leaders, traditional healers)



PARTICIPATORY LECTURE: ADDRESSING FOLLOW-UP ON PROBLEM CASES. Note to participants that because follow-up home visits are required only for problem cases—not the majority of outpatient care cases—non-problem cases can easily be neglected. However, it is important to make adequate provision for them.

As with arrangements for case-finding, plans for follow-up home visits should be made before the first outpatient care patients are received. Since the range of personnel available for follow-up home visits can vary from one outpatient care site to another, it might be impossible to make a "one-size-fits-all" arrangement. Instead, responsibilities might need to be worked out separately for each site.

LEARNING OBJECTIVE 4:
DISCUSS CONSIDERATIONS FOR DEVELOPING AND USING CMAM MESSAGES

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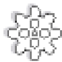
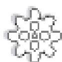
Refer back to **Exercise 3.1 Barriers to Access Role Play** and become familiar with **Handout 3.7 Developing Simple and Standardised CMAM Messages** and **Handout 3.8 Reference: Handbill Messages**.

Step One: Community Assessment
Step Two: Formulation of Community Outreach Strategy
>> Step Three: Development of Messages and Materials
Step Four: Community Mobilisation and Training

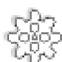


GROUP DISCUSSION: THE NEED FOR STANDARD CMAM MESSAGES. Remind participants that the development of messages and materials is the third step in preparation for CMAM community outreach. In plenary, explain that the most important messages are simple, standardised messages describing the program itself. Ask participants to describe why this is important. Remind them of what they witnessed in **Exercise 3.1 Barriers to Access Role Play**. Possible answers include:

- To clarify how the service is offered and to whom
- To ensure that the community is relying on accurate information and not rumours which can hurt community participation and service access and uptake
- To facilitate the spread of information through word of mouth



BRAINSTORM: DEVELOPING STANDARD CMAM MESSAGES. Ask participants to think through the key information (what? how? who? where? when?) that would need to be conveyed to make sure the community's understanding of the CMAM services is both accurate and complete. Write answers on a flip chart, filling in gaps with the typical content found in **Handout 3.7 Developing Simple and Standardised CMAM Messages, Section A.** Note for participants the importance of using the key messages as an opportunity to address concerns raised in the community assessment.

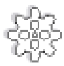


WORKING GROUPS: DEVELOPING AND USING HANDBILLS. Describe the process of creating a handbill from the standard CMAM messages (i.e. simplifying messages, translation into local language, back-translation, photocopying, disseminating, and tracking misconceptions once disseminated, reworking as necessary). Ask participants to form working groups of three or four and to think of different venues and audiences where the handbills could be used to spread accurate and complete information throughout the community. Also ask them to think of their own local circumstances and to try to think of how the handbill could be used to communicate through radio, public address systems, etc. Discuss and refer participants to **Handout 3.7 Section B** and **Handout 3.8 Reference: Handbill Messages**. Compare responses.

LEARNING OBJECTIVE 5:
DISCUSS PREPARATIONS FOR COMMUNITY MOBILISATION AND TRAINING

Become familiar with **Handout 3.9 Key Actions in Community Mobilisation and Training.**

Step One: Community Assessment
Step Two: Formulation of Community Outreach Strategy
Step Three: Development of Messages and Materials
>> Step Four: Community Mobilisation and Training



PARTICIPATORY LECTURE: PREPARING FOR COMMUNITY MOBILISATION AND TRAINING. Refer participants to **Handout 3.9 Key Actions in Community Mobilisation and Training**, reminding participants that this is the fourth step in preparation for CMAM community outreach. Outline the four key actions in preparing for community mobilisation and training:

- Establish reliable communications between service providers and community
- Assist communities with selection of outreach workers where necessary
- Train outreach workers (e.g., CHWs, volunteers) to perform case-finding
- Engage civil society partners

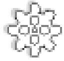
For each of the key actions, ask participants why the action is important using the content in column two ("Why?") of **Handout 3.9** as a guide for the discussion. Then describe the pointers in column three ("How?'). Answer any questions.

WORKING GROUPS: USING MOBILISATION AND TRAINING TO INCORPORATE BEHAVIOUR CHANGE COMMUNICATIONS (BCCS) IN CMAM SERVICES. Explain to participants that through exploring the causal factors behind SAM prevalence rates, CMAM staff may be able to find ways to introduce or reinforce preventive messages into CMAM routines. Ask participants to form working groups of three or four and to discuss how efforts in community mobilisation and training can be expanded upon to: identify relevant behaviour change messages; access information, education and communication (IEC) and BCC materials; and create a mechanism for their dissemination.

Examples include:

- Once CMAM is under way, CMAM health care providers should talk with outpatient care providers and outreach workers to learn what the major causal factors appear to be based on SAM admissions to date.
- The district health management team, implementing agencies operating in the area, and local health facilities are likely to have access to a range of BCC and IEC materials on various topics about factors contributing to SAM (e.g., weaning foods, exclusive breastfeeding [EBF], dietary variety).
- Outreach workers conducting community-level or house-to-house MUAC screenings might benefit from simple training in the management of diarrhoea in children so they can answer questions about this during their rounds. Or, outpatient care staff or volunteers could share information about family planning options to the mothers/caregivers gathered for CMAM.

WRAP-UP AND MODULE EVALUATION



SUGGESTED METHOD: REVIEW OF LEARNING OBJECTIVES AND COMPLETION OF EVALUATION FORM

- Review the learning objectives of the module. This module covered:

    1. The importance of community outreach to CMAM outcomes
    2. The obstacles that can impede community participation in CMAM
    3. The areas of investigation that make up the community assessment
    4. The steps involved in moving from assessment to strategy
    5. Why it is important to simplify and standardise CMAM messages
    6. The main steps required to initiate active CMAM outreach

- Ask for any questions and feedback on the module.

- Refer participants to **Handout 3.10 Elements and Sequencing of CMAM Community Outreach**.

- Let participants know that they will have an opportunity to meet with community leaders, HEWs, volunteers, and community mothers/caregivers during the community outreach field visit.

- Ask participants to fill out the module evaluation form.

COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION

FIELD VISIT FOR COMMUNITY OUTREACH

The field visit is designed to allow participants to practice the steps needed to develop a community outreach strategy and an action plan. During the field visit, participants will interview one of the following four groups: community leaders; existing extension workers, CHWs and volunteers; younger community mothers/caregivers; older community mothers/caregivers including grandmothers. Participants then will consolidate findings from the interviews, create a handbill (messages to communicate) and begin devising a community outreach strategy and an action plan.

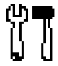
It can be difficult to practice realistic community outreach activities in an area that already has CMAM services. The visit should be done at a location that is not serviced by CMAM.

Preparations include meeting with community leaders to arrange for the group interviews, selecting community members for the group interviews, lining up translators, arranging transportation, and developing simple interview guides (lists of questions). Trainers might need to work through contacts in the community to make some of the arrangements.

The period allotted for this field visit is a fraction of the time needed to cover all aspects of community outreach. This particular site visit plan emphasises the community assessment, strategy and materials components.

These notes are a map of activities to be conducted during the visit. They are not meant to substitute for technical aids to qualitative research, such as focus group manuals, or for the trainer's knowledge and abilities. The trainer must use his/her judgment of the local setting to adapt the module content for best effect. The trainer must ensure that participants are aware of any cultural or community norms so they can adapt to them as necessary (e.g., if certain attire is expected).

FIELD VISIT ACTIVITIES	HANDOUTS TO TAKE TO FIELD VISIT
1. Practice Conducting Community Interviews 2. Consolidate Findings from Interviews 3. Practice Developing a Handbill 4. Practice Developing a Community Outreach Strategy and an Action Plan	Interview guide developed and provided by trainer Handout 3.4 Community Outreach: From Assessment to Strategy Handout 3.8 Reference: Handbill Messages Handout 3.11 Team Checklist for Community Outreach Field Visit



MATERIALS

- Spiral-bound notebooks

ADVANCE PREPARATIONS

- One week in advance, make arrangements with leaders of two communities to hold eight two-hour meetings in the communities. Four meetings will be held simultaneously in each community. Ideally, two communities that are very different from each other (e.g., environment, ethnicity, accessibility) should be selected, but the degree of local heterogeneity and availability of resources—especially transportation—will determine whether this is possible.

- Pointers:

  - Explain to the community leaders that the purpose of the meetings is to train health care managers and providers to consult with the community and that they will be asking community members about nutrition practices.
  - Select seven people for each community group.
  - If possible, have the mother/caregiver groups include women who are from different parts of the community but are likely to be comfortable talking together. The groups should not end up being dominated by one individual.
  - The interviews should be conducted where they are unlikely to be disturbed by curious onlookers. This need not necessarily be inside. It is best to avoid any spot connected with a powerful force such as the community council or the church/mosque.
  - The interview sites in each community should be separate enough so as not to disturb each other but close enough for the facilitator to circulate between them.

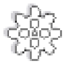
- While making arrangements for the locations, secure translators for each of the interview groups, assuming that the participants are not native speakers of the local language(s). This can be difficult, since good translation is a matter of temperament as well as of language competence. It should be sufficient for translators to be competent in spoken English; it is not necessary to use professional translators or individuals who have advanced knowledge of written English.

- One to two days in advance, the facilitators should re-familiarise themselves with the content of Module 3, especially the sections on conducting community assessment, formulating an outreach strategy, and developing messages and materials.

- One to two days in advance, the facilitators should develop three simple interview guides (lists of questions) covering questions for community leaders; extension workers, CHWs and volunteers; and the two community mothers/caregiver groups. Facilitators will need to tailor the questions to local contexts.

- The evening before the practicum, assign each participant to one of the eight groups. Ask the participants to designate two moderators/interviewers and one recorder for each group. Distribute the interview guides and ask the participants to review them and become comfortable with the content before the interviews. Have the moderators/interviewers decide which questions each will ask. Make sure designated recorders have spiral-bound notebooks for recording the discussion.

- The day before, ensure that transportation is available and, if appropriate, send a message to the communities confirming the team's arrival time. If possible, travel to the communities to confirm that arrangements for the group interviews are in place and to answer any questions the community members might have.



FIELDVISITACTIVITY 1:PRACTICE CONDUCTING COMMUNITY INTERVIEWS

SMALL WORKING GROUPS: Conduct interviews with community leaders; existing extension workers, CHWs and volunteers; younger community mothers/caregivers; and older community mothers/caregivers including grandmothers using simple interview guides developed by trainers.

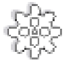
Form small working groups, with two participants serving at moderator/interviewers and one serving as recorder

- Transport participants to the two communities.
- Thank community leaders for allowing this learning opportunity, then have participants join their assigned groups.
- In each community, at least one facilitator circulates between the interview groups, noting progress and helping correct any problems or misunderstandings.
- In each group, have the two designated moderator/interviewers take turns asking questions and managing the interview.
- After the interview, the recorder should seek clarification for any uncertain points. After the interview subjects leave, the recorder completes the group's notes with the help of the other participants.
- Refer to **Handout 3.11 Team Checklist for Community Outreach Field Visit**.

FIELD VISIT ACTIVITY 2: CONSOLIDATE FINDINGS FROM INTERVIEWS

WORKING GROUP PRESENTATIONS, FEEDBACK/DISCUSSION: Consolidate and Present Findings

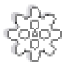
- Have participant groups consolidate findings from each community group they interviewed according to questions from the interview guides and this module's community assessment session.
- Ask each group to present its findings and write them on the flip chart. Help to tease out insights from the group presentations. Information is triangulated.
- Ask participants to discuss their experiences with the interviews. Offer an assessment based on observation of the interviews.
- Lead participants through a process of revision of the interview guides, stressing that the discipline of daily reflection and revision based on emerging insights is an important part of the assessment.
- Emphasise to participants that insights based on initial interviews must remain tentative. The normal practice is to conduct at least one such investigation for each outpatient care site.
- Develop a short list of emerging insights to guide discussion of strategy.
- Refer to **Handout 3.11 Team Checklist for Community Outreach Field Visit**.



FIELD VISIT ACTIVITY 3: DEVELOP A HANDBILL

WORKING GROUPS: Develop a Handbill

- Form five working groups.
- Using **Handout 3.8 Reference: Handbill Messages** as an example, have each group develop a handbill, working through several stages, including: discussing and agreeing on the main messages; summarising these in bullet points; writing the text out in full sentences and agreeing on the wording; and refining text to the simplest language possible for a "final" draft.
- If time allows, trainers can arrange for translators (ideally two per group) to translate the handbill into the language of local CMAM users. The two translators should do this independently, compare their versions and discuss differences with the participants to select the most accurate rendering.
- Ask groups to share their handbills.
- Discuss in plenary.



FIELD VISIT ACTIVITY 4: PRACTICE DEVELOPING A COMMUNITY OUTREACH STRATEGY AND AN ACTION PLAN

GROUP DISCUSSION: Community Outreach Strategy and Action Plan

- Using **Handout 3.4 Community Outreach: From Assessment to Strategy** as a model, help participants review insights from the interviews to draw conclusions about strategy. Emphasize that the conclusions must be practical and actionable.
- Structure the discussion by asking participants to consider at least the following: the appropriate duration of outreach, whether or how long to rely on active case-finding and which model to use, the pros and cons of using existing networks of volunteers or extension workers, and the involvement of civil society and other partners outside the official health sector. If time allows, trainers may wish to address these strategic questions in smaller groups and compare the groups' conclusions.
- Summarise the emerging strategy as bullet points on the flip chart, taking care to review the assessment insights that led to the conclusions.
- Ask participants to structure action plans around building a continuous relationship with the community, assisting the community with selecting outreach workers, training volunteers to perform case-finding, and engaging civil society partners.
- With the insights into the community that have been accumulated and shared, ask participants how they would allocate time for different mobilisation activities.

COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION

MODULE THREE

Community Outreach

LEARNING OBJECTIVES	HANDOUTS AND EXERCISES
1. Explain the Importance of Community Outreach to CMAM Outcomes	Handout 3.1 Principles of Community Outreach in the Context of CMAM Exercise 3.1 Barriers to Access Role-Play Exercise 3.2 Overcoming Obstacles to Community Participation in CMAM
2. Identify Key Elements of a Community Assessment	Handout 3.2 Community Assessment Handout 3.3 Community Assessment Steps and Methods
3. Identify Key Steps in CMAM Outreach	Handout 3.4 Community Outreach: From Assessment to Strategy Handout 3.5 Community Outreach Strategy Handout 3.6 Example: Selection of Candidates for House-to-House Case-Finding Exercise 3.3 Comparison of Case-Finding Models Exercise 3.4 Worksheet: Selection of Candidates for Community Outreach
4. Discuss Considerations for Developing and Using CMAM Messages	Handout 3.7 Developing Simple and Standardised CMAM Messages Handout 3.8 Reference: Handbill Messages
5. Discuss Preparations for Community Mobilization and Training	Handout 3.9 Key Actions in Community Mobilisation and Training
Wrap-Up and Module Evaluation	Handout 3.10 Elements and Sequencing of CMAM Community Outreach

FIELD VISIT ACTIVITIES	HANDOUTS TO TAKE TO FIELD VISIT
1. Practice Conducting Community Interviews	Interview guide developed and provided by trainer Handout 3.4 Community Outreach: From Assessment to Strategy Handout 3.8 Reference: Handbill Messages Handout 3.11 Team Checklist for Community Outreach Field Visit
2. Consolidate Findings from Interviews	
3. Practice Developing a Handbill	
4. Practice Developing a Community Outreach Strategy and an Action Plan	

HANDOUT 3.1
PRINCIPLES OF COMMUNITY OUTREACH IN THE CONTEXT OF CMAM

Community outreach is an essential component of CMAM (together with inpatient care for children with severe acute malnutrition (SAM) with medical complications, outpatient care for children with SAM without medical complications and, in some contexts, services to address moderate acute malnutrition (MAM). It helps to ensure that children with SAM are detected early—before the onset of medical complications—and referred for treatment, leading to better clinical outcomes and decreased strain on inpatient services. Community outreach is vital to CMAM in any context, whether it is implemented by nongovernmental organisations (NGOs) or the Ministry of Health (MOH) and whether the context is a nutrition emergency or a stable development setting.

Once CMAM has begun, community outreach is characterised by:

Active case-finding for early detection and referral: For CMAM to function effectively and for coverage to reach acceptable levels, severely malnourished children should be identified early, usually through active case-finding.

Case follow-up in the home: In a minority of cases, outpatient care protocols will trigger a follow-up home visit to:

- Check on a child who is not thriving or responding well to the treatment
- Learn why a child was absent from an outpatient care follow-on session
- Learn why a child defaulted (defined as missing three outpatient care follow-on sessions in a row)

The following steps are required to establish the two components of community outreach effectively:

Community Assessment
Formulation of Community Outreach Strategy
Development of Messages and Materials
Community Mobilisation and Training

These steps allow CMAM health care providers to understand and anticipate challenges and constraints to community participation and service access and uptake, without which CMAM is ineffective. They also help involve and empower communities. With proper preparation, community outreach can generate a cycle of positive feedback in the community so that mothers/caregivers refer each other to the services, increasing coverage. Without these steps, service or programme miscalculations can generate negative feedback and reduce participation. Without good service access and uptake, even the best-run outpatient care sites will have only limited impact.

THE NEED FOR BALANCE

- In both development and emergency settings, a key objective is to identify how to find children with SAM with the least inconvenience to the population. People might be more willing to put up with inconveniences to receive assistance during nutrition emergencies, but here too there are hazards. An overly broad mobilisation—one in which many people are screened but few end up being admitted—can backfire by alienating the community and diminishing further participation.

- The overall challenge is to **regulate access** to CMAM in the most effective way. There is always a **compromise or balance** to be struck: as CMAM is initiated, ineligible children should be discouraged from coming while as many eligible ones as possible must be encouraged to come. If this balance can be found, a cycle of positive feedback is generated as mothers/caregivers return home from the outpatient care site with positive news.

- By getting this balance wrong or ignoring it, CMAM can quickly get off on the wrong foot and, especially in emergency settings, overwhelm health care providers with large crowds, giving CMAM a reputation of being a waste of precious time.

INVOLVING THE RIGHT ACTORS

- It is easier to strike this balance when CMAM is being implemented by people with some familiarity with the region, e.g., the local MOH or an NGO with existing health or development programmes in the area. This is the case in both development settings and emergencies.

- Community outreach is not new to the health sector. All efforts should be made to assess the existing health outreach systems and actors, and community outreach for CMAM should build on and further strengthen these systems.

- Appointing a dedicated staff member to run the community outreach activities will enhance the success of all CMAM services.

- Preparation for CMAM will usually begin with discussion among members of the MOH district health management team (DHMT) and its local partners.

- Staff with experience with local health-seeking practices are likely to know the community gatekeepers who can help or hinder acceptance of the CMAM services. They usually have some means of sharing and receiving information from the community.

- People who usually are involved in the first exploratory discussions include:
  - District medical officer
  - District maternal and child health (MCH) coordinator
  - Supervisor of community health workers (CHWs, if other than MCH coordinator)
  - Staff of community-based organisations (CBOs) and/or NGOs with strong community links
  - Civil society or religious leaders with good knowledge of local health-seeking practices

HANDOUT 3.2
COMMUNITY ASSESSMENTS

A community assessment is the first step in preparation for CMAM community outreach.

A. WHY DO A COMMUNITY ASSESSMENT?

Community assessments are the learning part of community outreach preparation.

The role-play and preceding group discussion on the role of the community assessment showed that there are obstacles to service access and uptake and community participation in CMAM. The community assessment is an opportunity to consider these in a systematic way in a specific implementation context.

Well before CMAM is established, potential barriers to service access and uptake must be identified. To do this, planners must have a sense of how the community is organised, how undernutrition is viewed there, how the new service is likely to be received, and how the community can best support the outreach component.

The answers to many of these questions might seem apparent if CMAM is being delivered by the Ministry of Health (MOH) or a nongovernmental organisation (NGO) with longstanding experience in the community. However, even MOH staff could be outsiders and might not be fully conversant in the local language.

It is important that the community assessment be used as an opportunity to identify and acknowledge the limits of staff knowledge of the local community.

B. WHAT DO COMMUNITY ASSESSMENTS CONSIST OF?

One way to think of the assessment is in terms of supply and demand. Two major questions must be answered:

- What factors are likely to create and affect demand for CMAM locally?
- How can community outreach be organised to meet this demand most effectively (supply)?

Understanding demand involves spending time at the community level and interviewing community members about local perceptions and practices to develop a sense of where the demand-inhibitors might lie. **Areas of investigation** might include:

- **Local disease classification** for severe forms of acute malnutrition; health problems might be treated as something other than a nutritional problem, requiring special communication
- **Attitudes toward formal health services,** which involves identifying what other services are offered through the existing government health services and how they are perceived by the population; a perception of poor service could affect uptake of CMAM
- **Other paths to treatment, (**e.g., pharmacies, traditional healers) might have a role equal to or greater than MOH health services
- **Community homogeneity/heterogeneity:** various identity designators (e.g., language, ethnicity, religion, politics) can divide communities, making it necessary to provide information and services in an even-handed manner or to make special efforts to reach excluded or marginalised groups

- **Other barriers** to access, including:
  - **Poor awareness** of the service within the community being served
  - **Community mobilisation has been overly broad,** resulting in too many ineligible cases arriving and being rejected
  - **Referral and admission criteria are not aligned** (e.g., mid-upper arm circumference [MUAC] is used for community screenings but final admission at site is based on weight-for-height [WFH]), leading to rejection of referred individuals at the site and hurting the programme's reputation
  - People might be aware that there is a new nutrition service, but **local medico-cultural traditions do not connect advanced wasting or swelling with undernutrition**, as awareness of traditional medicines might be stronger
  - There might be **stigma in the community or the influence of peers or family members** might serve as a disincentive
  - Community mobilisation or site selection might have overlooked **important community gatekeepers or opinion-makers**
  - Other services at the **primary health care (PHC) facility are poorly regarded** by the community (e.g., because medicines are not available, because hours are irregular, because staff are overworked, because treatment requires long waits), and as a result, when CMAM is established at the PHC facility it is viewed negatively by association
  - The **location of outpatient care sites** might require an unreasonable amount of travel time for target communities or make the sites inaccessible due to barriers like seasonal flooding
  - Participation is **interrupted by seasonal labour patterns** beyond the control of the service, such as temporary relocation of families from homes to more remote farms during the weeding or harvesting seasons

Understanding supply also involves some community-level discussion (usually done at the same time as investigation of demand) but requires the assessors to also consider institutional and organisational factors at the facility and district level. Questions to be answered typically include:

- **Who are the likely candidates for case-finding?** Can these be identified from existing networks of outreach workers (e.g., community health workers [CHWs], health extension workers [HEWs], health educators, contraceptive distributors, home-based care [HBC] providers)? Are there other extension workers (e.g., agricultural, social welfare) or local community-based organisations (CBOs) who could also take on this role? Which of these seem to be most valued and respected by the community?

- **Where is the supervision of case-finding best situated**? How and to whom do existing outreach workers currently report? How reliable is this contact? Is there active monitoring from the District Maternal and Child Health (MCH) nurse or other members of a management team?

- **If volunteers will be used, what are the local limits to voluntarism?** Are there other forms of incentive besides payment that could help motivate them?

- **How strong/reliable are the links between health facilities and the community?** How can these be utilised or improved to establish a sense of community ownership of CMAM activities?

- **What leaders/gatekeepers must be involved to gain full access to the community** (i.e. for selection of volunteers, for house-to-house case-finding, for communicating the purpose of CMAM)?

- **What channels exist for spreading information about CMAM, and what risks and advantages are associated with each?** For example, while local health educators might be an effective way to pass information to households, they might not be the best channel to use if they have a reputation for simply repeating un-actionable messages (e.g., urging families to boil water when wood for fuel is scarce, urging families to wash clothes when soap is unaffordable). In this case, other influential people (e.g., traditional healers, clan leaders, religious figures) might be an important additional channel.

HANDOUT 3.3
COMMUNITY ASSESSMENT STEPS AND METHODS

Step	Method	Area of investigation/Questions to be answered	Time Required
1: Defining the parameters of the CMAM programme	Briefing to confirm CMAM objectives	▪ Is this a short-term intervention to address a nutrition emergency or will it be a permanent part of PHC services? ▪ Will this be NGO-assisted or run independently by the MOH? If NGOs are to be involved, what will their role be? ▪ To what degree will the program be integrated into the existing health system? ▪ Is community case-finding needed only at startup, or will it be conducted indefinitely?	1-3 hours
2: District-level-review to understand the local context	District-based discussions with NGO/MOH/civil society key informants at the district level	▪ Local health-seeking practices ▪ Community coherence/difference ▪ Broad patterns of undernutrition (e.g., seasonal, spatial) ▪ Available networks of extension staff and volunteers ▪ Potential allies (e.g., civil society, political leadership, private health sector)	1-2 days but might require additional time to contact and make arrangements with resource persons
3: Community-level review to complete information gathered at district-level	Community-level discussions to fill gaps that could not be answered at district-level	▪ Further information on above topics is gathered in community meetings with separate groups of: – Community leaders – Community extension workers and volunteers ▪ Special attention is given to finding information on issues related to excluded groups and cultural barriers, (e.g., cases where women are not allowed to travel without a male relative)	Varies greatly, depending on size and homogeneity of project area; plan for at least 1 day in the catchment of each outpatient care site but also factor in time required to plan and make appointments for meetings.
4: Beneficiary-level discussions to determine perspectives, knowledge, vocabulary of SAM	Interviews with mothers/ caregivers to fill gaps	• Visual aids depicting SAM are used in individual or group interviews with community mothers/ caregivers to gather more detailed information on: – Disease names and presumed causes – Clues as to who might see (and therefore refer) these children – Attitudes toward existing extension networks	2-4 days depending on cultural homogeneity and ease of access; it is possible to have discussions with mothers/caregivers at local MCH clinic, but better information often is obtained when discussion takes place in the community, away from the clinic

HANDOUT 3.4
COMMUNITY OUTREACH: FROM ASSESSMENT TO STRATEGY

EXAMPLE FROM ETHIOPIA

	Key Findings	Implications for Strategy
1.	Locally, a variety of causes are thought to underlie swelling and wasting, and not all are food-related. Presumed causes include breastfeeding while pregnant, exposure to bright sunlight, malevolent spirits, and displeasure of ancestors.	Include a communications component that uses local disease terms for acute malnutrition, particularly for swelling and wasting. Explore a range of local treatments and try to involve healers in referral to CMAM.
2.	Local churches are often the first recourse for families with sick children, as they borrow funds for treatment.	Churches and mosques should be the first stop in a campaign to inform civil society partners about CMAM. Ultimately, they might refer potential clients in need.
3.	All parts of the community are uncertain about the relationship between proposed CMAM and pre-existing anthropometric screening for the targeted general ration.	Immediately take steps to prevent the outpatient care services or programmes from receiving large numbers of ineligible self-referrals.
4.	A cadre of unpaid community health workers (CHWs) are already conducting house-to-house health education regularly, but only literate workers receive regular training.	Use these CHWs for house-to-house case finding, but put priority on re-energising the group of illiterate volunteers with mid-upper arm circumference (MUAC) training.

HANDOUT 3.5
COMMUNITY OUTREACH STRATEGY

Formulating an outreach strategy is the second step in preparation for CMAM community outreach.

A. LIST AND DISCUSS KEY INSIGHTS FROM THE COMMUNITY ASSESSMENT

A community outreach strategy is determined by the outcomes of the community assessment. The assessment will have clarified the overarching questions about the objectives and nature of the CMAM service as well as both barriers and opportunities affecting participation in the community.

Other questions will remain, such as determining who should be involved and how efforts should be prioritized to achieve maximum service access and uptake. To answer these questions, insights from the assessment should be reviewed and their implications for the outreach strategy should be considered.

The product of this strategy discussion should be **a list of key insights and their implications** for the CMAM service. This list does not need to be elaborate or complicated. It can usually be done point by point on a single piece of paper.

B. DETERMINE THE MOST APPROPRIATE METHOD OF CASE-FINDING

An essential aspect of outreach strategy involves deciding how case-finding will be conducted. Considerations include: 1) whether or not a campaign-style mass screening is needed at start-up, either to gauge levels of severe acute malnutrition (SAM) or to establish awareness of CMAM; 2) how and when to transfer active case-finding from such campaign-style efforts to routine systems of primary health care (PHC) outreach; 3) where active case-finding can most likely be sustained with a minimum of external inputs.

Case-finding methods normally fall into one of three models:

- **House-to-house case-finding.** In this approach, roaming outreach workers (e.g., community health workers [CHWs], volunteers) periodically perform the bilateral pitting oedema and mid-upper arm circumference (MUAC) checks in the home. This approach is sometimes necessary at startup to ensure that pockets of the community are not overlooked and that all families are aware of CMAM. However, if admission numbers are high enough to demonstrate the benefits of CMAM, families will usually begin to self-refer, allowing for a shift to less-active forms of case-finding.
- **Community case-finding.** In this approach, the bilateral pitting oedema and MUAC checks are performed in the community or neighbourhood, bringing children from different households together. This can be done either by CHWs performing regular scheduled outreach (e.g., maternal and child health [MCH] visits, growth monitoring and promotion [GMP] sessions) or by specially recruited volunteers. Unscheduled community case-finding can also be performed at formal and informal community activities and gatherings, market days, and other settings where children are present. This approach is used in many nutrition emergencies.
- **Passive case-finding.** In this approach, the initiative rests with families, who must seek referral to CMAM from trained individuals in the community. This can only be done once knowledge of CMAM is well established. These individuals are usually resident CHWs or volunteer members of health extension services. They also could be teachers, home-based care (HBC) group members, local healers, or others who are in contact with children in the CMAM age group.

The appropriate model to use (or sequence or combination to use) in a given setting depends on a variety of factors including:

- The level of SAM in the community
- Community awareness of the signs of SAM
- Accessibility of homes and whether they are clustered together or widely dispersed
- Existing networks of outreach workers and whether the workloads will allow for taking on active case-finding duties
- Time and resources available for training outreach workers involved in case-finding
- Whether active case-finding is envisioned as permanent or temporary

HANDOUT 3.6
EXAMPLE: SELECTING CANDIDATES FOR HOUSE-TO-HOUSE CASE-FINDING

EXAMPLE FROM THE SOUTHERN NATIONS, NATIONALITIES, AND PEOPLE'S REGION (SNNPR), ETHIOPIA

Type of Outreach Worker	Job Description (including supervision)	Proximity to Cases	Breadth of Coverage	Accessible/ Amenable to Training	Can Accept Additional Work	Capable of Use of MUAC	Accepted in all Parts of the Community
Health Extension Worker (HEW)	Community health worker (CHW) supervised by health centre staff	XX	X	XX	X	XXX	X
Community Health Promoter (CHP)	Volunteer mobiliser supervised by HEW	XXX	XXX	XXX	XXX	XXX	XXX
Community Care Coalition (CCC) Members	HIV/AIDS home-based care (HBC) volunteers (not established in all parts of district)	XX	XX	XXX	XX	XX	XXX

XXX = high
XX = medium
X = low

HANDOUT 3.7
DEVELOPING SIMPLE AND STANDARDISED CMAM MESSAGES

Development of messages and materials is the third step in preparation for CMAM community outreach.

A. STANDARDISE CMAM MESSAGES

The start of any new service is a time of great interest and speculation for community members, and unless the information vacuum surrounding CMAM is filled with accurate information, it will be filled with rumours which can hurt community participation and service access and uptake.

Health facilities in low-literacy environments typically rely on word-of-mouth communication with the surrounding community, and messages to health committees and community leaders might be passed through many people before they reach their intended recipients.

Key messages, expressed simply and explaining admission and practical aspects of inpatient and outpatient care must be developed, standardised and disseminated rapidly to avoid confusion and service access and uptake problems.

It is important to note that the purpose of the key messages is not to change underlying behaviours or practices but to clarify how CMAM is offered and to whom.

Standard CMAM messages should:

- Describe the target children using the local disease terms for wasting and swelling collected during assessment
- Explain the benefits of CMAM, noting that children with severe acute malnutrition (SAM) without medical complications can be treated in outpatient care once a week in the community and fed RUTF at home, meaning that mothers/caregivers no longer need to leave the family; that only few children with SAM with medical complications and infants under 6 months of age with SAM will need to be treated in inpatient care
- State the time and date of outpatient care sessions at the closest outpatient care site
- Explain the referral process, noting that the child is measured near home
- Explain (if appropriate) that families can also self-refer children with SAM by going to the nearest outpatient care site or health facility with CMAM services
- Explain that a child can be re-assessed (re-measured) at different intervals to monitor his/her nutritional status and be admitted if s/he has deteriorated
- Introduce ready-to-use therapeutic food (RUTF) not as a food but as a medicine or as a "medicinal food"
- Reflect the findings of the assessment and address concerns directly

B. CREATE A HANDBILL USING SIMPLE, NON-TECHNICAL LANGUAGE

Once standard CMAM messages have been developed in simple, non-technical terms, it is important to print them in the local language(s) so that every reader is receiving the exact same information regardless of possible language barriers.

Creating a handbill is not costly; it normally just takes the use of a photocopier and paper. However, it does require a dedicated effort to think through the concerns and issues that emerged from the assessment and to address them directly with a set of core CMAM messages. It might take several attempts to boil these issues down to their simplest form, but it is worthwhile. It should take about a day to refine the messages and then arrange for them to be translated into the language(s) used in the homes of mothers/caregivers. The translated versions should then be back-translated to ensure accuracy by someone who did not translate the original into the local language(s). After dissemination, a record of any misconceptions arising from the handbill should be kept so that it can be revised periodically.

C. HOW TO MAKE THE BEST USE OF THE HANDBILL

- Use the handbill in information meetings with district and community leaders. Ask them to make announcements through their networks. Give them sufficient copies so that the handbill can be read aloud in the community. This should be done before active case-finding is initiated.
- Take the handbill to meetings with civil society partners (e.g., community-based organisations [CBOs], churches, mosques) and ask them to disseminate it.
- Create a separate handbill for significant minority language groups in the area.
- Tailor the handbill to address special concerns as they arise (e.g., confusion over whether referral constitutes admission).
- Where appropriate, pair with photographs of kwashiorkor and marasmus to help identify target children.
- Give copies to literate outreach workers so they can share the information accurately. They can use the handbill to make announcements at formal or informal gatherings (e.g., funerals, marketplace, water points, community government or committee meetings).
- Consider using radio, which has been a useful means of disseminating CMAM messages (e.g., Concern Worldwide's programme in the Democratic Republic of Congo).

HANDOUT 3.8
REFERENCE: HANDBILL MESSAGES

1. EXAMPLE FROM LUSAKA, ZAMBIA

HELP IS NOW AVAILABLE FOR FAMILIES WITH VERY THIN OR SWOLLEN CHILDREN

The New Treatment

A new treatment is now available at the health facility for children under 5 years old who are severely malnourished. Children who are very thin or whose feet have begun to swell but have no medical complications no longer need to spend a long time in the hospital. A new medicinal food is being offered for these children. Families can use it to rehabilitate their children at home.

How to Know Whether Your Child Needs this Treatment

To find out whether a child is eligible for this treatment, the child's arm is measured and his/her feet are checked. The arm measurement is taken with a tape similar to the cloth tape that tailors use in the marketplace. It is a fast, painless check that does not involve taking blood or injecting the child. Different people are being trained in this community in how to use the tape, so that in some cases the measurement may be taken by a person the child or family knows.

If you know a child who is very thin or whose feet have started to swell, tell his/her parents or guardians about this new treatment. They can ask in their neighbourhood for the name of a person trained to take the arm measurement, or they can go direct to the health centre.

Important Points to Remember

- The treatment will be offered every __________ morning at __________ clinic.
- Even *very* sick children can be helped with this treatment. Since the child remains at home, the parents/guardians can care for him/her at the same time as other children. However, the medicinal food is *only* for the very thin child and should not be shared.
- The treatment consists of medicines and a medicinal food made from groundnuts that comes in the form of a paste, so children normally have no trouble eating it. The results are usually very rapid.
- *(Note: The following paragraph should be adapted to the context.)*

  In different communities, the diseases of thin and swollen children go by different names. It is common nowadays to speak of njala, but in some places, a child might be said to have njisi (anyonkela), matufya, kalyondeyonde, midulo, kulowewa, or kulozedwa. Or the child might be said to be *osila* or *dayonda*. Families who suspect these diseases should also ask for their children's arms and feet to be checked, since the new treatment might also help these children.

2. EXAMPLES FROM GHANA

A. Sensitisation Letter to Civil Society Groups/Leaders in Agona District (includes key messages)

Date:
Postal Address/Name of Institution:

Dear Sir/Madam,

RE: NEW TREATMENT FOR CHILDREN WITH SEVERE ACUTE MALNUTRITION (VERY THIN OR SWOLLEN)

A new treatment is now available at Swedru hospital, Kwanyako, Abodom, Duakwa and Nsaba health centres under Agona District Health Directorate for children who are very thin or swollen (showing signs of severe acute malnutrition, or SAM). These children need a specific medical treatment and nutrition rehabilitation and must be referred to the health centre. If a child with SAM has good appetite and no medical complication, the child does not have to go to the hospital; s/he can be treated at home and followed up through weekly health centre visits. If a child with SAM has no appetite or has a medical complication, then s/he will be admitted to the hospital for a short time until the complication is resolved and then will receive further treatment at the health centre and at home. Children under 6 months who are very thin or have swelling will need specialised care in the hospital.

To determine whether a child is eligible for this treatment, his/her arm is measured in the community to see if s/he is too thin and both feet are checked for swelling. If the child is referred to the health centre, s/he is measured again at the centre and receives a medical check. If the child is too thin or has swelling but has good appetite and no medical complications, s/he receives a medical treatment and a weekly supply of the medicinal food free of charge. All small children with SAM and older children with SAM with medical complications will be referred to Swedru hospital for inpatient care. The arm measurement is taken with a tape similar to the cloth tape tailors use in the marketplace and can be taken by many types of persons. Community health workers or volunteers are being trained in communities around the above-mentioned health facilities to take the measurement, so that it may be taken by a person the child or his/her family knows.

If you know a child who is very thin or whose feet are swollen, tell the parents or guardians about this new treatment. They can ask around their neighbourhood for a community health worker or volunteer or someone else trained to take the arm measurement, or they can go directly to these health facilities.

We are confident that this new treatment will significantly improve the District's ability to support the recovery of malnourished children, and we look forward to your cooperation. Please do not hesitate to contact me for more information or clarification.

Yours faithfully,

DISTRICT DIRECTOR OF HEALTH

B. Sensitisation Letter to Private Clinics in Agona District (includes key messages)

Date:
Postal Address:

Dear Sir/Madam,

Re: Community-Based Management of Acute Malnutrition (CMAM)
As part of its mandate to improve the quality and accessibility of health services in Agona District, the Ghana Health Services (GHS) has introduced a new treatment for children under 5 years with a severe form of acute malnutrition (bilateral pitting oedema or severe wasting). The service is called Community-Based Management of Acute Malnutrition (CMAM). It brings the treatment of children with severe acute malnutrition (SAM) much closer to the family, making it possible for children and their mothers/caregivers to avoid the long stays at the Paediatric Ward or the Nutrition Rehabilitation Centre, which customarily have been necessary for treating undernutrition.

Children with SAM need a specific programme containing both medical treatment and nutrition rehabilitation, and must be referred to the health centre. If a child with SAM has good appetite and no medical complications, s/he can be treated at home and followed up through weekly health centre visits. If a child with SAM has no appetite or has a medical complication, then s/he will be admitted to inpatient care at Swedru Hospital for a short time until the medical complication is resolved and then receive further treatment at the health centre and at home. Children under 6 months who are very thin or have swelling will need specialised care in inpatient care at the hospital.

The treatment, which is free of charge, provides antibiotic, antihelminth and malaria drug treatment, vitamin A supplementation and a ready-to-use therapeutic food (RUTF) called **Plumpy'nut®** at the health centre level, which the families of eligible children can take home. Early detection of cases and referral for treatment is essential to avoid medical complications.

Children in the communities and the health facilities are checked for bilateral pitting oedema and screened for severe wasting based on a mid-upper arm circumference (MUAC) measurement with a specially marked tape (MUAC tape) for referral and admission to the CMAM service at the health centre.

We would like to involve a variety of health practitioners and service providers, including private clinics, to help us identify children with SAM so that they can be treated at an early stage. Currently the services are provided in five sites (Swedru Hospital and Kwanyako, Abodom, Duakwa and Nsaba Health Centres) under Agona District Health Directorate, but it is hoped that the services will be extended to other health centres in Agona District. We are writing therefore to kindly request that your facility brief all staff members, especially those in the Out-Patient Department (OPD), and have them refer children with bilateral pitting oedema and severe wasting to any of the above-mentioned health centres for treatment. The GHS SAM team would be pleased to provide your clinic with these tapes and train your staff in identifying children with bilateral pitting oedema and severe wasting.

We are confident that the CMAM services will significantly improve the District's ability to support the recovery of malnourished children, and we look forward to your cooperation. Please do not hesitate to contact us for more information or clarification.

Yours faithfully,

DISTRICT DIRECTOR OF HEALTH

3. Sensitisation Basic Messages - Public Address or Peer System Version in Agona District

Message to All Mothers/Caregivers with Children between 6 Months and 5 Years of Age from Ghana Health Services

A new treatment is now available for children under 5 years with severe acute malnutrition (SAM, very thin or swollen). These children need a specific programme containing both medical treatment and nutrition rehabilitation, and must be referred to the health centre. If a child with SAM has good appetite and no medical complications, s/he can be treated at home and followed up through weekly health centre visits. These children do not have to go to the hospital but can be rehabilitated while staying at home with their families. If the child with SAM has no appetite or has developed a medical complication, then s/he will be admitted to hospital for a short time until the complication is resolved and then receive further treatment at the health centre and at home. Children under 6 months who are very thin or have swelling will need specialised care in inpatient care in Swedru Hospital.

How to know whether your child needs this treatment
Some people within your communities have been trained to take an arm measurement of children with a small tape and check if both feet are swollen.

The treatment
All children found to be thin or swollen are referred to the health centre, where the arm measurement and swelling are checked again. If the children have appetite and are clinically well, they are given a medical treatment and a weekly supply of the medicinal food called **Plumpy'nut®.** Children who are very small or very ill will need referral to inpatient care.

If you know a child who appears to be very thin or whose feet are swollen, tell his/her parents or guardians about this new treatment. They can ask around their neighbourhood for a community health worker, volunteer, or someone else trained to take the arm measurement. Or, they can go directly to the following health centres to have their child measured any day. Follow-up service days are:

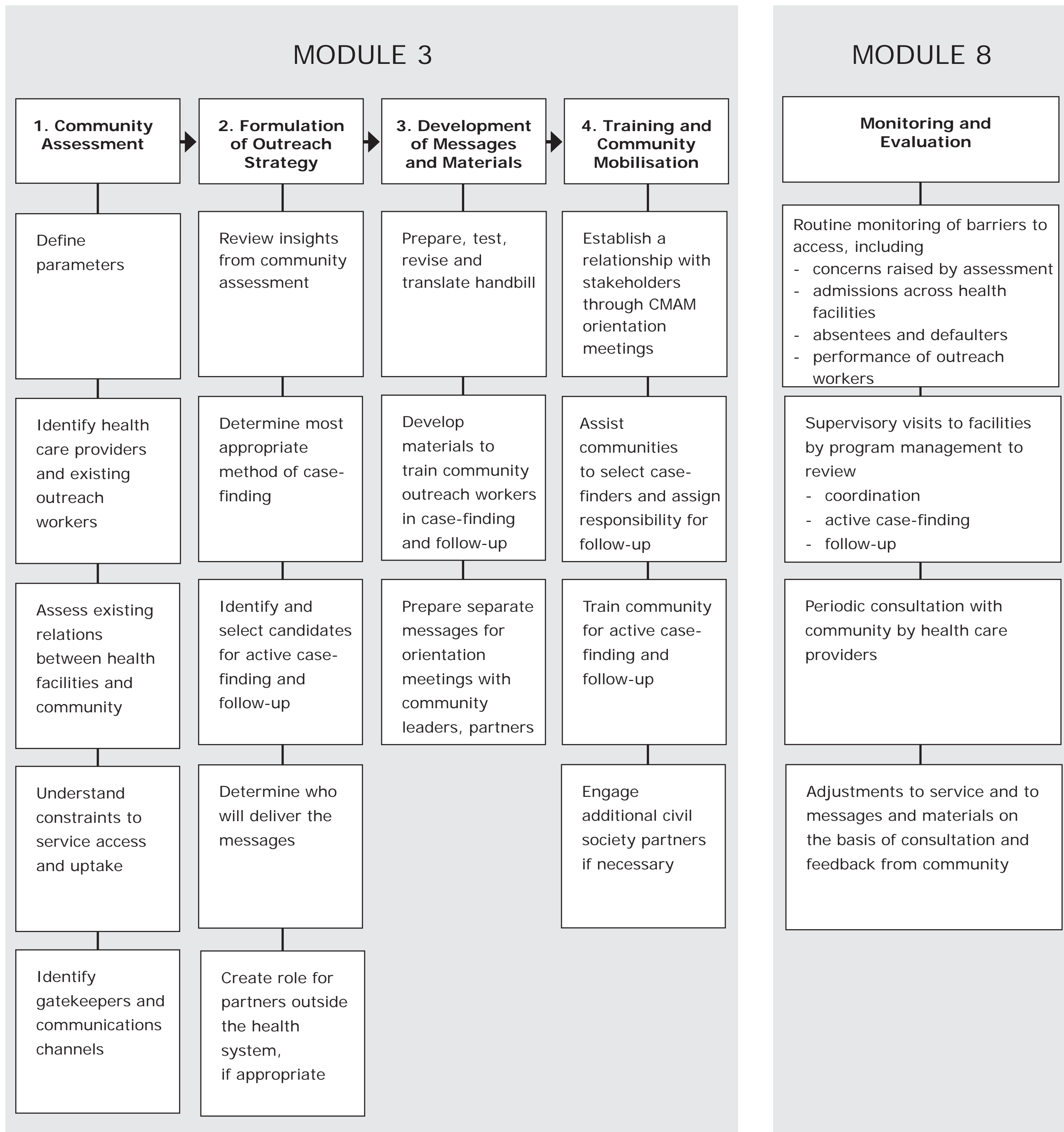
- Swedru Hospital on Monday
- Kwanyako Health Centre on Wednesday
- Abodom Health Centre on Wednesday
- Nsaba Health Centre on Friday
- Duakwa Health Centre on Friday

HANDOUT 3.9
KEY ACTIONS IN COMMUNITY MOBILISATION AND TRAINING

WHAT?	WHY?	HOW?
Establish reliable communication between health care providers and the community	CMAM implementation relies on good relations between service providers and the community, both at the start, when CMAM is explained, and later on. At the start, agreements must be made with the community concerning joint responsibilities (e.g., outpatient care day activities, volunteer case-finding, case follow-up). Issues and challenges that arise later (e.g., defaulting) will require the community's advice on correctives and assistance with implementing solutions.	▪ Conduct orientation meetings before startup that explain the purpose of CMAM. ▪ Seek the advice and involvement of standard health sector partners but also other gatekeepers, (e.g., administrative officials, political officials, religious officials). ▪ Look for ways to disseminate messages rapidly and without cost, such as at regular gatherings of political or traditional leaders. ▪ Make full use of the handbill, and adjust content as necessary. ▪ Take advantage of existing mechanisms for engaging community leaders on local health issues.
Help communities select outreach workers when necessary	If volunteers will be used for active case-finding, it helps to be part of the selection process, not to control who is selected but to ensure that volunteers understand what they are volunteering for. If extension workers will be used, it helps to be involved so that community leadership has a good sense of what is needed.	▪ Spell out the level of effort expected of outreach workers. ▪ Explain that the need for house-to-house case-finding will diminish after startup. ▪ Try to recruit outreach workers who: - Are accepted in the homes of all community members - Feel secure walking within and between communities - Are trusted to deal with all families fairly - Are prepared to assist at the outpatient care site if needed - Have the confidence to learn, if not literate

WHAT?	WHY?	HOW?
Train outreach workers (e.g., CHWs, volunteers) to perform active case-finding	Accurate assessment of bilateral pitting oedema and use of mid-upper arm circumference (MUAC) tape requires basic training. Giving good quality training to large numbers of outreach workers can be challenging, since considerable individual practice with MUAC is required. These trainings are often also the first real opportunity outreach workers have to learn about their new responsibilities.	• Conduct training at or near a maternal and child health (MCH) clinic or other location where many children under 5 are available for practicing. Make arrangements beforehand with mothers/caregivers and offer a bar of soap or other token as thanks. • Try to ensure that referral criteria used by outreach workers are identical to admission criteria at outpatient care sites to minimise the number of referrals rejected. • Be sure to allocate sufficient time for both the bilateral pitting oedema and MUAC practise and discussion. The topics should include: - Explanation of outpatient care and CMAM - Proposed role of outreach workers - Probable workload - MUAC measurement - Identification of bilateral pitting oedema - Referral procedure - Questions to confirm understanding of training
Engage civil society partners	Reaching out beyond the health sector can help identify and address gaps in community participation or service access and uptake.	• Brief the leadership of churches, mosques and community-based organisations (CBOs) about CMAM objectives and procedures. • Look for opportunities in their activities to identify children with severe acute malnutrition (SAM). Train outreach workers from their organisations. • Leave handbills so they can use a consistent message when passing information through their hierarchies.

HANDOUT 3.10
ELEMENTS AND SEQUENCING OF CMAM COMMUNITY OUTREACH



HANDOUT 3.11
TEAM CHECKLIST FOR COMMUNITY OUTREACH FIELD VISIT

COMMUNITY INTERVIEWS	
	Courteous treatment of community members
	Clarity of instruction/explanation to informants
	Efficient use of community time and maximum use of opportunities
	Ability to employ variety of tactics to prompt discussion
	Good written record of the discussion
INTERVIEW QUESTIONS – Based on interview guide developed by trainers	
POST-INTERVIEW DISCUSSION, PLANNING	
	Content gaps are recognised by team
	Team is able to distil useful insights from raw material of interview
	Team can identify changes and improvements needed to interview guides and process
	Team can draw practical operational conclusions from interview insights
	Team can determine priority messages and package them in the simplest, most appropriate form
	Team can demonstrate a grasp of the necessary next steps by devising an action plan for the mobilisation phase

EXERCISE 3.2
OVERCOMING OBSTACLES TO COMMUNITY PARTICIPATION IN CMAM

OBSTACLES	WHO NEEDS TO BE INVOLVED
Poor awareness of acute malnutrition	
Poor awareness of CMAM	
Community mobilisation has been overly broad	
Referral and admission criteria are not aligned	
Local medico-cultural traditions do not connect advanced wasting or swelling with undernutrition	
Stigma of acute malnutrition in the community or the influence of peers or family members	
Important community gatekeepers or opinion-makers to CMAM	
Primary health care (PHC) facilities are poorly regarded	
Location of outpatient care sites	
Interruption of seasonal labour patterns	

EXERCISE 3.3
COMPARISON OF CASE-FINDING MODELS

MODEL	SUITABLE FOR	STRENGTHS	WEAKNESSES
House-to-House Case-Finding			
Community Case-Finding			
Passive Case-Finding			

EXERCISE 3.4

WORKSHEET: SELECTION OF CANDIDATES FOR COMMUNITY OUTREACH

Job Description (including supervised by)	**Proximity to Cases** (sees children < 2 yrs)	**Breadth of Coverage** (exist in every community or catchment area)	**Accessible/ Amenable to Training**	**Can Accept Additional Work**	**Can Learn Mid-Upper Arm Circumference (MUAC)**	**Requires Little/No Extra Payment**	**Accepted in All Parts of the Community** (for house-to-house)
1. OUTREACH WORKERS (E.G., COMMUNITY HEALTH WORKERS [CHWS], HEALTH EXTENSION WORKERS [HEWS], VOLUNTEERS)							
2. OTHER EXTENSION WORKERS AND VOLUNTEERS							
3. IMPORTANT COMMUNITY FIGURES							