COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION

TRAINER GUIDANCE AND INTRODUCTION

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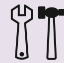
Training Guidance for the Community-Based Management of Acute Malnutrition (CMAM) Trainer's Guide and Participant Handouts

TRAINER'S GUIDE ICONS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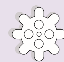
ACTIVITY

HANDOUT

POWERPOINT PRESENTATION

ANSWER KEY

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MODULE 1: OVERVIEW OF COMMUNITY BASED MANAGEMENT OF ACUTE MALNUTRITION (CMAM)

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Introduce Participants, Training Course, Modules and Course Objectives
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3. Discuss Medical Treatment and Nutrition Rehabilitation in Supplementary Feeding

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1. Review Admission, Treatment and Discharge Procedures for Supplementary Feeding
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3. Review the System for Recording RUTF Distribution and Stock Levels

ABBREVIATIONS AND ACRONYMS

ACF	Action Contre La Faim
ACT	artemisinin-based combination therapy
AED	Academy for Educational Development
ARI	acute respiratory infection
ART	antiretroviral therapy
ARV	antiretroviral
AWG	average daily weight gain
BCC	behavior change communication
CBO	community based organization
CCC	Community Care Coalition
CDC	Centers for Disease Control
CHC	child health card
CHP	community health promoter
CHPS	Community-Based Health Planning and Services Initiative
CHPS-TA	Community-Based Health Planning and Services Initiative – Technical Assistance
CHW	community health worker
CMAM	Community-Based Management of Acute Malnutrition
CMV	combined mineral and vitamin mix
CRS	Catholic Relief Services
CSAS	centric systematic area sampling
CSB	corn-soy blend
CTC	community-based therapeutic care
DHMT	district health management team
DHS	Demographic Health Survey
DSM	dry skim milk
EBF	exclusive breastfeeding
EDL	Essential Drug List
ENA	Essential Nutrition Actions
ENN	Emergency Nutrition Network
EPI	expanded programme of immunization
FANTA	Food and Nutrition Technical Assistance Project
FAO	Food and Agriculture Organization of the United Nations
FBF	fortified blended food
GAM	global acute malnutrition
GHS	Ghana Health Services

GI	gastrointestinal
GMP	growth monitoring and promotion
GSHP	Ghana Sustainable Health Project
HBC	home-based care
HEW	health extension worker
HFA	height-for-age
HIRD	High Impact and Rapid Delivery
HIV	human immunodeficiency virus
HMIS	health management information system
IEC	information, education and communication
IFE	Infant Feeding in Emergencies
IMCI	integrated management of childhood illness
INAAM	Integrated Nutrition Action Against Malnutrition
ITN	insecticide treated net
IU	international units
IYCF	infant and young children feeding
KCAL	kilocalories
LNS	lipid-based nutrient supplement
LOS	average length of stay
LRTI	lower respiratory tract infection
M&E	monitoring and evaluation
MAM	moderate acute malnutrition
MAMI	Management of Acute Malnutrition in Infants Project of the Institute of Child Health
MCH	maternal and child health
MCHN	maternal and child health and nutrition
MDG	Millennium Development Goal
MICS	Multiple Indicator Clause Survey
MOH	Ministry of Health
MSF	Médecins Sans Frontièrs
MUAC	mid-upper arm circumference
NCHS	National Centre for Health Statistics
NFDM	non-fat dry milk
NGO	nongovernmental organization
NRC	nutrition rehabilitation centre
NRU	nutrition rehabilitation unit
OI	opportunistic infection
OICI	Opportunities Industrialization Centers International
OPD	outpatient department
OTP	outpatient therapeutic programme

OVC	orphans and vulnerable children
PD	Positive Deviance
PHC	primary health care
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmition of HIV
PRA	Participatory Rural Appraisal
QHP	Quality Health Partners
ReSoMal	Rehydration Solution for Malnutrition
RRA	Rapid Rural Appraisal
RUSF	ready-to-use supplementary food
RUTF	ready-to-use therapeutic food
SAM	severe acute malnutrition
SC	stabilization centre
SC-USA	Save the Children USA
SD	standard deviation
SFP	supplementary feeding programme
SMART	Standardized Monitoring and Assessment for Relief and Transition
SNNPR	Southern Nations, Nationalities, and People's Region
SQUEAC	semi-quantitative evaluation of access and coverage
SST	supplementary suckling technique
SWOT	strengths, weaknesses, opportunities and threats
TB	tuberculosis
TF	task force
TFC	therapeutic feeding centre
UN	United Nations
UNICEF	United Nations Children's Fund
UN/SCN	United Nations System Standing Committee on Nutrition
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WFA	weight-for-age
WFH	weight-for-height
WFP	World Food Programme
WHO	World Health Organization
WSB	wheat-soy-blend

OVERVIEW OF CMAM TRAINING

1. BACKGROUND ON CMAM AND CTC

RATIONALE FOR THE COMMUNITY-BASED APPROACH

Nearly 20 million children under 5 suffer from severe acute malnutrition (SAM), which contributes to an estimated 1 million deaths among children every year.[1] Most of these children live in South Asia and sub-Saharan Africa.

Until recently, the management of SAM has been restricted to facility-based approaches, greatly limiting coverage and impact. In response, the Community-Based Therapeutic Care (CTC) approach to the management of acute malnutrition was developed in 2001.[2] The approach aims to reach the maximum number of children with acute malnutrition and to ensure access and coverage by providing treatment at many decentralized sites instead of a few centrally located inpatient facilities.

Community-Based Management of Acute Malnutrition (CMAM) evolved from CTC and consists of four main components: community outreach, outpatient care for the management of SAM without medical complications, inpatient care for the management of SAM with medical complications, and the management of moderate acute malnutrition (MAM). As evidenced with CTC programmes, most children with SAM have no medical complications and can be treated in outpatient care without admittance to inpatient care at a health facility with 24-hour care. Central to outpatient care is the innovation of ready-to-use therapeutic food (RUTF), which was designed to match the nutrient profile of therapeutic milk (F100). RUTF is a generic term for dry solid foods that are soft or crushable and can be eaten by a child without the addition of water to the food. The most commonly used RUTF is a lipid-based nutrient-energy-dense paste, which, unlike liquid F100, can be used and stored at home with minimal risk of microbial contamination.

To date, experience in implementing the community-based approach has primarily been in the emergency context, with demonstrated results showing that it is appropriate and feasible to implement all four components at the same time. *Community-Based Therapeutic Care: A Field Manual* reflects this experience, providing standard protocols for the treatment of acute malnutrition in the community and primarily targeting nongovernmental organizations (NGOs) working with local and national Ministries of Health (MOH) to implement programmes in an emergency context.

However, given the high numbers of children with SAM in some non-emergency populations, the demand for accessible treatment for SAM in non-emergency contexts is increasing. Experience from emergency community-based programming suggests that community-based management of SAM in non-emergency contexts could be feasible and effective if integrated into existing health services. Adapting the community-based model to non-emergency contexts is context-specific. Compared with the emergency-based model, external NGO/support inputs in a non-emergency situation are different and focus more on building the MOH's capacity to provide treatment services within its health system.

Also, in non-emergency programmes, the supplementary feeding component for the management of MAM is dropped or adapted because MAM can be addressed through other prevention and treatment programmes. Several countries, including Ethiopia,

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[1] World Health Organization (WHO), World Food Programme (WFP), the United Nations Standing Committee on Nutrition (UN/SCN) and the United Nations Children's Fund (UNICEF). Joint Statement. Community-based management of severe acute malnutrition. June 2007.

[2] Collins, S. "Community-based therapeutic care: A new paradigm for selective feeding in nutritional crisis," Humanitarian Practice Network Paper 48, ODA 2004.

Ghana, Malawi, Sri Lanka and Zambia have begun integrating the community-based management of SAM into existing health services, with decreased inputs from NGOs. Documentation of many of these experiences can be found in the workshop report for the International Workshop on the Integration of Community-Based Management of Acute Malnutrition (www.fantaproject.org).

A NOTE ON THE USE OF TERMS

Using different terms that mean much the same thing can be confusing. This training guide uses several key terms that differ from *Community-based Therapeutic Care: A Field Manual*:

Community-Based Management of Acute Malnutrition (CMAM) refers to the management of acute malnutrition through:

- Community outreach
- Outpatient care for children under 5 years old with SAM without medical complications
- Inpatient care for children under 5 years old with SAM with medical complications and infants under 6 months old with SAM (with or without medical complications)
- Supplementary feeding for the management of MAM (Note: In a non-emergency context, where the CMAM services are providing a safety net for SAM, the management of MAM may not be included.)

Community-Based Therapeutic Care (CTC) is a community-based approach for the management of acute malnutrition in emergency settings and comprises inpatient or stabilization care, outpatient therapeutic care, supplementary feeding and community outreach. CMAM evolved from CTC.

2. ABOUT THIS TRAINING GUIDE

This training guide focuses on the community-based management of SAM in children under 5 years old. It is designed to increase participants' knowledge of and build practical skills to implement CMAM. The guide complements *Community-Based Therapeutic Care (CTC): A Field Manual*, the World Health

Organization (WHO) protocols for the management of SAM and the WHO training modules for inpatient management of severely malnourished children.[3] The guide is intended to be adapted according to the context to ensure that national guidelines and protocols for the management of acute malnutrition and local models and materials are taken into account. Note that while national guidelines must be respected, the guide reflects evidence-based information or current best practices unless stated.

PARTICIPANTS

The training guide is designed for health care managers and health care providers who manage, supervise and implement services for the management of SAM. This includes health care providers who are involved in health outreach activities (e.g., health outreach coordinators, community mobilization coordinators, district supervisors for community health workers [CHWs]). It will also be useful for MOH officials at the national, regional and district levels; health and nutrition programme managers and technical staff of NGOs; and United Nations (UN) technical staff involved in the

[3] WHO, *Management of Severe Malnutrition: A Manual for Physicians and Other Senior Health Workers*, Geneva 1998.

WHO, *Management of the Child with Serious Infection or Severe Acute Malnutrition*, 2000.

WHO, *Training Course on the Management of Severe Acute Malnutrition*, Geneva 2002.

management of acute malnutrition in children. The guide is designed to be adapted for the target audience when necessary.

TRAINERS/FACILITATORS

At least two trainers/facilitators should lead the training per 15–25 participants. The trainers should be familiar with the community-based approach for managing acute malnutrition and experienced in the practical application of community-based outpatient care for SAM. This overview module contains guidance for trainers/facilitators on planning the course and describes the communication and training methods used in the guide.

TRAINING IN THE CLASSROOM AND THE FIELD

The training methods and activities used throughout the modules will be practical and participatory, building on participants' knowledge, skills and experience. In addition to the written materials and practical exercises in the classroom, some of the training modules include fieldwork in communities, health facilities, and outpatient and inpatient care sites. This fieldwork complements the theory learned in the classroom and gives participants an opportunity to develop the practical skills required to implement CMAM.

3. METHODS AND MATERIALS

The full course takes about 10½ days and places significant emphasis on developing practical skills. It requires about four days of classroom work and about 6½ days in the field.

MODULES

There are eight modules ordered sequentially. Trainers/facilitators may adapt the length of the modules, leave out a module or change the order of the modules according to the context and the target audience's needs. The modules are generic. Every context is different, and trainers/facilitators will need to modify the modules according to the context, guidelines and national protocols in a given country. Implementers are continuing to gain more experience with CMAM in non-emergency contexts. The training modules will be updated periodically to reflect new international guidance.

For trainers: The complete trainer course materials include this trainer guidance and information, the eight modules and participant handouts. The eight modules are designed to be used by trainers/ facilitators as guidance and are not intended to be given to participants. An evaluation form, included as a handout at the end of this overview, can be used for each module.

Each module includes:

- An overview
- A table detailing learning objectives and related handouts for classroom work
- A list of materials required, including reference materials (if applicable)
- Advance preparation that the trainer will need to do
- Suggested activities and training methods based on each learning objective with instructions for the trainer/facilitator
- A wrap-up and evaluation session for the module
- A table detailing learning objectives and related handouts for the field visit (when applicable)
- Suggested activities and methods to be conducted during the field visit (when applicable)

For participants: Participants are given a packet that contains handouts for each module.

Additional reference materials:

- *Community-Based Therapeutic Care: A Field Manual*. (Valid International, 2006)
- WHO, WFP, UN/SCN and UNICEF 2007 joint statement on community-based management of severe acute malnutrition
- Video on Concern Worldwide's CTC programme in Ethiopia
- *Management of Severe Malnutrition: A Manual for Physicians* (WHO, 1999)
- *Guidelines for the inpatient treatment of severely malnourished children* (WHO, 2003; available at www.who.int/nut/publications)
- Report on the *2008 International Workshop on the Integration of Community-Based Management of Acute Malnutrition* (FANTA, 2008)
- National guidelines and protocols for SAM, outpatient care, inpatient care and supplementary feeding (where available)
- Local outpatient care treatment cards, inpatient care treatment cards, supplementary feeding treatment cards, RUTF ration cards and supplementary feeding ration cards

The trainers/facilitators will need to provide all other course materials, including videos, blank cards, calculators, pens and notebooks, as needed.

METHODS FOR INSTRUCTION

This course is designed to build upon the participants' knowledge and experience and to be relevant to their needs and the needs of their communities. It uses a variety of training methods including written exercises, practical exercises in small groups, discussions, role-plays, video demonstrations, practice, case studies and guest speakers. These methods give participants a thorough overview of concepts and protocols. The course structure is designed to challenge participants to come up with their own solutions to problems. The practical field component will reinforce theory learned in the classroom and give participants an opportunity to develop the practical skills required to implement services. Descriptions of methods and guidance for conducting trainings with adult learners appear at the end of this module.

Participants also serve as resources for one another. Respect for individual trainees is central to the training and sharing of experiences is encouraged throughout.

4. COURSE PLANNING

COURSE TIME FRAME

The approximate time it takes to cover each full module is noted in the table below as a guide for planning purposes. Course plans will vary according to the target audience and the context, and trainers/ facilitators should adapt the training modules to suit participants' needs. Trainers may choose to shorten or skip some modules and spend extra time on others depending on the participants' knowledge, skills and objectives, as well as the training time available. Note that if Module One is skipped for any reason, trainers should give participants the following Module One handouts that are referred to in other modules:

Handout 1.1 Abbreviations and Acronyms,

Handout 1.2 Terminology for CMAM and

Handout 1.3 References and Further Reading.

PLANNING THE AGENDA FOR A CMAM TRAINING

	MODULE	APPROXIMATE CLASSROOM TIME	APPROXIMATE SITE VISIT/ FIELD PRACTICE TIME
#	Introduction	One hour	
1	Overview of Community-Based Management of Acute Malnutrition (CMAM)	One hour	One-day site visit
2	Defining and Measuring Acute Malnutrition	Two hours	See Module Four
3	Community Outreach	Three hours	One-day field practice
4	Outpatient Care for the Management of SAM Without Medical Complications	Six hours	Three-day field practice, during which participants will also practice skills covered in Module Two
5	Inpatient Care for the Management of SAM With Medical Complications in the Context of CMAM	Two hours	Half-day site visit
6	Supplementary Feeding for the Management of Moderate Acute Malnutrition (MAM) in the Context of CMAM	Two hours	Half-day site visit
7	Planning CMAM Services at the District Level	Five hours	
8	Monitoring and Reporting on CMAM	Four hours	Half-day field practice
Total		**26 hours (about four days)**	**6½ days**

Trainers/facilitators should develop a course plan that best suits the needs of their participants and their resources. Here are some considerations when planning the training agenda:

- Health care providers (practitioners) will usually complete all classroom modules, one to two days of site visits and 4½ days of practice in the field.
- Health care managers will usually complete all classroom modules and one to two days of site visits.

- Conduct a site visit as soon as possible so participants can see the relevance of the classroom sessions.
- To facilitate the hands-on nature of the field visits, it is ideal to have no more than five to seven participants at the same site at the same time. It might be necessary to schedule visits at multiple sites or times to accommodate all the participants.
- Provide sufficient time for transportation to and from field sites.
- Schedule time for debriefing and discussion of field visits.
- Be aware of the schedules of the sites you are visiting. For example, if outpatient care is available only in the morning, those field visits should be conducted in the morning.
- Schedule time on the first and last days for formal opening and closing of the overall training, as necessary and appropriate.

TRAINING TASKS AND RESPONSIBILITIES: KEY POINTS FOR PREPARATION AND PLANNING BEFORE TRAINING

It is necessary to plan for optimal outcomes well before the training. The following checklist outlines some essential tasks and responsibilities. The list should be adapted for the specific needs of a given training. Trainers/facilitators and key stakeholders in the participants' organizations should decide who is responsible for each task.

1. **Setting the Objectives and Expectations of the Training**

- Identify and collaborate with appropriate organizations and partners.
- Trainers/facilitators and organizations together identify the desired **goals and objectives**.
- Commit resources.
- Develop a training strategy to achieve the results, including refresher trainings and follow-up.
- Establish and commit to a system of supervision/mentoring.

2. **Participant Selection**

- Establish participant selection criteria.
- Know the audience (number and type of participants, e.g., MOH, NGO, doctors, nurses, auxiliaries, CHWs, health care managers, health care providers).
- Inform participants of the purpose of the training and clarify their roles and responsibilities after training (i.e., clear job expectations).
- Ask participants to bring relevant materials to share:
    - Nutrition surveys according to district/region

- Information on health, nutrition and undernutrition preventive and curative services in their communities and countries
- Information on the context of their health system: How it works, whether it is centralized or de-centralized, who operates in key areas (e.g., NGO, MOH)

3. **Understanding the Participants' Context: Mini-Situation Analysis** ▪ Identify the problem in participants' settings:
   - Emergency/development - Urban/rural
   - Seasonal challenges

- Identify national guidelines for the management of SAM.
- Research nutrition surveys according to district/region.
- Investigate health, nutrition and undernutrition preventive and curative services in participants' communities and countries.
- Describe the context of participants' health systems: how they work, whether they are centralized or de-centralized, who operates in key areas (e.g., NGO or MOH).

4. **Training Content**

- Adapt course content to the context; limit the content to what participants need to perform their professional responsibilities well.
- Ensure that course materials are consistent with national guidelines on indicator cutoffs for admission and discharge, the use of weight-for-height (WFH) or mid-upper arm circumference (MUAC) and the use of the National Centre for Health Statistics (NCHS) child growth references or WHO child growth standards.
- Prepare the training agenda and identify persons responsible for each element. ▪ Establish evaluation criteria.

5. **Logistics**

- Identify training days and times.
- Determine the training location (establish criteria for adequate workspace, supplies, equipment, job aids).
- Identify guest speakers, if applicable, ensure their availability and determine possible logistical needs (e.g., specific timing, transportation) ▪ Identify locations for the field visits.
- Plan the field visits with the sites' supervisors and staff:
  - Review the schedule of visits.

  - Ensure that staffing and supplies are sufficient.
  - Ensure that site-based resource persons can participate.
  - Consider doing a field visit as early as possible in the training.
- Organize transportation for the field visits.
- Plan for any language barriers (between trainer and participants or between participants and locals). When available, pair participants with translators or community members who speak their language and the local language. Arrange for the translators (e.g., transportation if needed, compensation if applicable).
- Invite participants.

ANNEX

1. PRINCIPLES OF ADULT LEARNING

1. **Dialogue**: Adult learning is best achieved through dialogue. The majority of adults have adequate life experience to dialogue with any teacher about any subject and will learn new attitudes or skills best in relation to that life experience. Dialogue must be encouraged and used in formal training, informal talks, one-on-one counselling sessions or any situation where adults learn.

2. **Safety in environment and process**: Make people feel comfortable about the possibility of making mistakes. Adults are more receptive to learning when they are both **physically and psychologically comfortable**.
    - Physical surroundings (e.g., temperature, ventilation, overcrowding, light) can affect learning.
    - Learning is best done when there are no distractions.

3. **Respect**: Appreciate learners' contributions and life experience. Adults learn best when their experience is acknowledged and when new information builds on their past knowledge and experience (see "Relevance to previous experience" below).

4. **Affirmation**: Learners need to receive praise for even small attempts. They need to be sure they are correctly recalling or using information they have learned.

5. **Sequence and reinforcement**: Start with the easiest ideas or skills and build on them. Introduce the most important ones first. Reinforce key ideas and skills repeatedly. People learn faster when information or skills are presented in a structured way.

6. **Practice**: Allow learners to practice first in a safe place and then in a real setting.

7. **Ideas, feelings and actions**: Learning takes place through thinking, feeling and doing and is most effective when it involves all three.

8. **20/40/80 rule**: We remember 20 percent of what we hear, 40 percent of what we hear and see, and 80 percent of what we hear, see and do. Learners remember more when visuals are used to support the verbal presentation, and they remember best when they practice the new skill.

9. **Relevance to previous experience:** People learn faster when new information or skills are related to what they already know or can do.

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- **Immediate relevance**: People learn best when they can apply to the new topic things that they have learned in life or on the job.
- **Future relevance**: People generally learn faster when they recognize that what they are learning will be useful in the future.

10. **Teamwork**: Encourage people to learn from one another and solve problems together. This makes learning easier to apply to real life.

11. **Engagement**: Involve learners' emotions and intellect. Adults prefer to be **active participants** in learning rather than passive recipients of knowledge. People learn faster when they actively process information, solve problems or practice skills.
12. **Accountability**: Ensure that learners understand and know how to put what they have learned into practice.

13. **Motivation**: People learn faster and more thoroughly when they want to learn. The trainer's challenge is to create conditions in which people want to learn.

    - Learning is natural, as basic a function of human beings as eating or sleeping.
    - Some people are more eager to learn than others, and even within an individual, there are different levels of motivation.
    - The principles outlined here will help the learner become motivated.

14. **Clarity**

    - Messages should be clear.
    - Words and sentence structures should be familiar.
    - Trainers should explain technical words and make sure the learners understand the terms.
    - Messages should be VISUAL.

15. **Feedback**: Feedback informs the learner about her/his strengths or weaknesses.

Adapted from J. Vella. 1994. *Learning to Listen, Learning to Teach*.

ANNEX

2. TRAINING METHODS AND HOW TO USE THEM

Training Method	How to Use
Group discussion: A group of no more than seven participants discuss and summaries a given subject or theme. The group selects a chairperson, a recorder and/or someone to report to plenary.	▪ Outline the discussion's purpose and write questions and tasks clearly to provide focus and structure. ▪ Allow enough time for all groups to finish the task and give feedback. ▪ Announce remaining time at regular intervals. ▪ Ensure that participants share or rotate roles.
Buzz group: Two to three participants discuss their immediate reactions to information presented and share examples and experiences.	• Clearly state the topic or question to be discussed along with the objectives.
Brainstorm: A spontaneous process through which group members' ideas and opinions on a subject are voiced and written for selection, discussion and agreement. All opinions and ideas are valid.	▪ State clearly the brainstorming rule that there is no wrong or bad idea. ▪ Ask for a volunteer to record the ideas.
Plenary: The entire group comes together to share ideas.	▪ Appoint a timekeeper. ▪ Pose a few questions for group discussion.
Role-play: Participants act out a specific situation based on the details about the "person" they are asked to play.	▪ Structure the role-play well, keeping it brief and clear in focus. ▪ Give clear and concise instructions to participants.
Case study: Pairs or small groups are told or read about a specific situation, event or incident and asked to analyses and solve it.	• Make the situation, event or incident real and focused on the topic.
Demonstration: A resource person performs a specific task, showing others how to do it. The participants then practice the same task.	▪ Demonstrate the appropriate and inappropriate ways to perform a task and discuss the differences. ▪ Have participants perform the task and give them feedback.

ANNEX

Training Method	How to Use
Field visit: Participants and trainers/ facilitators visit a health facility or community setting to observe a task or procedure and then practice.	▪ Before the visit, coordinate with the site, give participants clear directions before arrival and divide them into small groups accompanied by a facilitator. ▪ Meet with the site supervisor, staff or other representative on arrival. ▪ Provide opportunity to share experiences and give and receive feedback.
Action plan preparation: Participants synthesize knowledge, skills, attitudes and beliefs into a doable plan. This bridges classroom activities with practical application at work site.	Share action plans.
Talk/presentation: A speaker shares information, sometimes using audio or visual aids.	▪ Start with a **story or visual** that captures the audience's attention. ▪ Present an **initial case problem** around which the talk/ presentation will be structured. ▪ Ask participants **test questions** even if they have little prior knowledge to motivate them to listen to the talk/ presentation for the answer. ▪ Set a **time limit.** ▪ **Allow time for feedback**, comments and questions. ▪ **Pose a question** for participants to solve based on the talk/presentation.

ANNEX

3. SUGGESTED REVIEW ENERGISERS (GROUP AND TEAM BUILDING)

1. The participants and trainers form a circle. One trainer throws a ball to a participant and asks the participant a question. When the participant answers correctly to the group's satisfaction, she/he throws the ball to another participant and asks another question. The process is repeated until all participants answer a question satisfactorily.
2. The participants form two rows facing each other, each row representing a team. A participant from one team/row asks a question of the participant opposite him/her in the facing team/row. The participant answering the question can ask for him/her team's help with the question. When the question is answered correctly, the responding team earns a point and then asks a question of the other team. If the question is not answered correctly, the team that asked the question responds and earns the point. The team with the most points wins.
3. The participants form two teams. Each person receives a written answer to a question that the facilitator will ask. When a question is asked, the participant who believes she/he has the correct answer reads the answer. If correct, the person scores a point for his/her team. The team with the most points wins.
4. A participant picks a question from a basket and answers it; other participants give feedback. The process is repeated for the other participants.

ANNEX

4. HANDOUT – EVALUATION FORM FOR MODULE

1. Did the information presented meet the module's objectives?

2. What information would you like to see more in-depth?

3. What information was not particularly useful/helpful?

4. Were the materials presented in the module useful overall?

5. What materials were particularly useful? Please describe.

6. What materials were not useful? Please describe.

7. Do you feel you mastered the skill(s) needed for a given exercise/field practice?

8. How could the exercises/field practice be improved?

9. Which exercises or field practice sessions do you think worked best?

10. How could this module be improved to meet the objectives?

11. Do you have any suggestions on the training mechanics (e.g., training space, site visits, visual presentations, length of the course)?

Please feel free to use the other side to continue responses. Thank you!