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 emphasize 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 mobilizing community outreach with the goal of maximizing CMAM services, minimizing 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 Standardized CMAM Messages Handout 3.8 Reference: Handbill Messages
5. Discuss Preparations for Community Mobilization and Training	Handout 3.9 Key Actions in Community Mobilization 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.

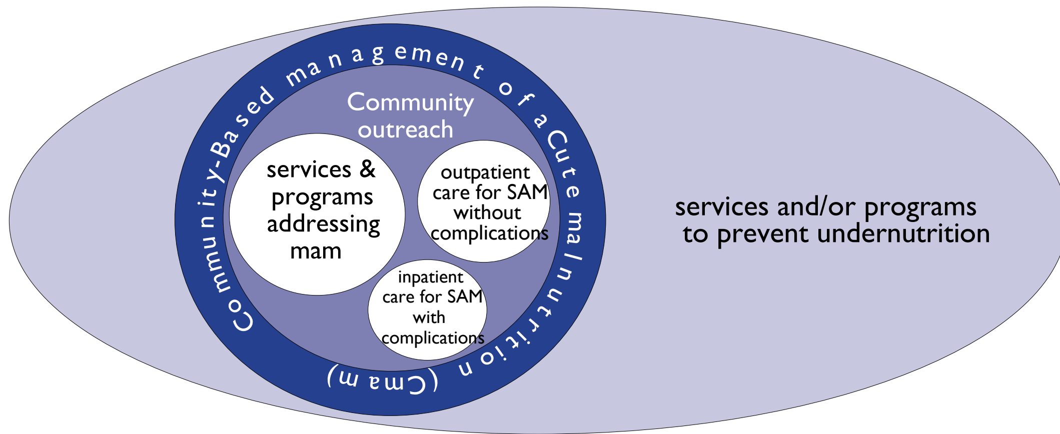
Write the following four steps on a flip chart so that they can be referred back to throughout the module.

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

FIGURE 1. CORE COMPONENTS OF CMAM



LO.1

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 mobilization 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 program'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 mobilization 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 labor 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.

LO.1

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 analyses 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 skeptical 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 rumors 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 emphasize 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 Neighbor (in community): You are spending the morning in the compound of your friend (community mother) when she is visited by the health messenger. You recognize him/her as the person who wasted your time on immunization 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 recognize 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 neighbor 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 Neighbor (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 neighboring 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 disorganized 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.

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 Mobilization 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 organized, 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 organized (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.

PARTICIPATORY LECTURE: METHODS OF COMMUNITY ASSESSMENT. REFERRING BACK TO **HANDOUT 3.3**, NOTE FOR PARTICIPANTS THAT:

LO.2

- 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 Mobilization 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 organization (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 favor, 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 centralized location for other services (e.g., immunization, supplementary feeding services or programme, 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 marginalized 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 mobilization 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)

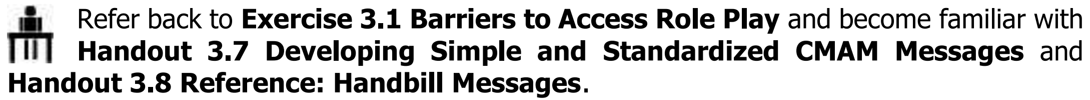
PARTICIPATORY LECTURE: ADDRESSING FOLLOW-UP ON PROBLEM CASES. Note to participants that because follow-up home visits are required only for problem cases—not the majority of outpatient care cases—non-problem cases can easily be neglected. However, it is important to make adequate provision for them.

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.

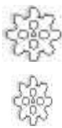
LEARNING OBJECTIVE 4:

DISCUSS CONSIDERATIONS FOR DEVELOPING AND USING CMAM MESSAGES

Refer back to **Exercise 3.1 Barriers to Access Role Play** and become familiar with **Handout 3.7 Developing Simple and Standardized 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 Mobilization 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, standardized 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 rumors 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 Standardized 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 Mobilization and Training.**

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

PARTICIPATORY LECTURE: PREPARING FOR COMMUNITY MOBILISATION AND TRAINING. Refer participants to **Handout 3.9 Key Actions in Community Mobilization 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 mobilization 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 mobilization and training can be expanded upon to: identify relevant behavior 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 diarrhea 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 standardize 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 emphasizes 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	Interview guide developed and provided by trainer
2. Consolidate Findings from Interviews	Handout 3.4 Community Outreach: From Assessment to Strategy
3. Practice Developing a Handbill	Handout 3.8 Reference: Handbill Messages
4. Practice Developing a Community Outreach Strategy and an Action Plan	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-familiarize 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.

FIELDV ISIT ACTIVITY 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.
- Emphasize 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; summarizing 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.
- Summarize 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 mobilization activities.