MODULE 19

Working with communities in emergencies

PART 2: TECHNICAL NOTES

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

Summary

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

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

Key messages

1. A good understanding of the community, its context and its concerns are key to the design of relevant, culturally acceptable and effective projects.

2. Working with communities is core to the Sphere Minimum Standards in Disaster Response. Standard 1 states that 'People's capacity and strategies to survive with dignity are integral to the design and approach of humanitarian response'.

3. The motivation & retention of staff, both paid and volunteer, needs careful consideration and should be in line with local rates of pay.

4. An understanding of local nutrition practices and the communication of appropriate information increases the effectiveness of an emergency response.

5. BCC activities should have evidence based content that is targeted, context specific and implemented via a range of locally understood communication channels. They can be widely used in nutrition programming
   a. To promote the use of good behaviours
   b. To familiarise communities with the use of new products or services
   c. For community sensitisation and investigating barriers to service uptake.

1. Working with communities

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

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

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

Understanding the community

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

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

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

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

Box 1: Community Participation

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

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

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

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

A United States Agency for International Development (USAID) programme review[1] on working with community health volunteers and concluded that;

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

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

• In times of food shortage the able bodied may migrate, either permanently or seasonally, in search of employment, aiming to send home remittances.

• In insecure environments the professional classes may take their entire families to safer environments leaving communities bereft of qualified health personnel.

• Refugee populations may travel as 'villages' and host a spectrum of skilled personnel including 'local' leaders and administrative structures. They may travel by car, bus, horse and cart or on foot; they may have all or none of their possessions.

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

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

The Humanitarian Charter and Sphere Project

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

Box 2: Sphere standards (2011)

Common standard 1: People centre humanitarian response

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

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

Key indicators

• Project strategies are explicitly linked to community-based capacities and initiatives

• Disaster-affected people conduct or actively participate in regular meetings on how to organise and implement the response (see guidance note 1 and 2)

• The number of self-help initiatives led by the affected community and local authorities increases during the response period (see guidance note 1).

• Agencies have investigated and, as appropriate, acted upon complaints received about the assistance provided

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Source: The Sphere Project *'Humanitarian Charter and Minimum Standards in Humanitarian Response'* 2011.

The Humanitarian Charter also states as a key action that agencies should act to "progressively increase the disaster affected people's decision making power and ownership of programmes during the course of a response". Diagram 1 (below) illustrates how the increased participation and ownership by the community may evolve.

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[1] **BASICS II** Community health worker incentives and disincentives. How they affect motivation, retention and sustainability. USAID.
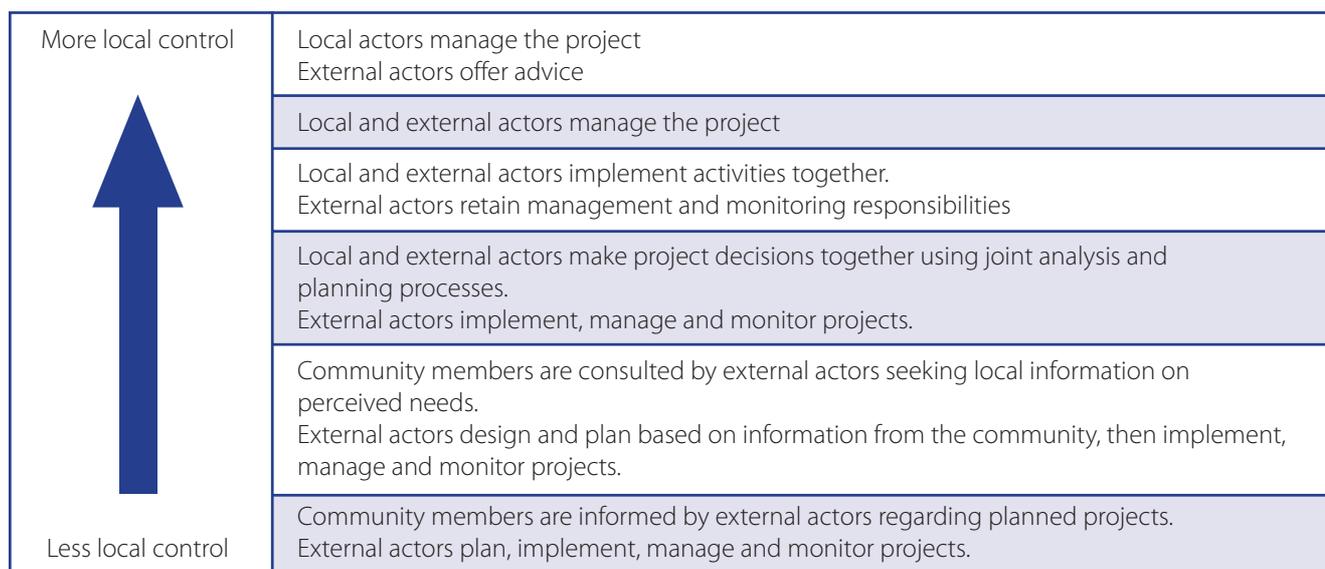
TECHNICAL NOTES

Promoting Community Participation

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

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

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

More local control	Local actors manage the project External actors offer advice
↑	Local and external actors manage the project
	Local and external actors implement activities together. External actors retain management and monitoring responsibilities
	Local and external actors make project decisions together using joint analysis and planning processes. External actors implement, manage and monitor projects.
	Community members are consulted by external actors seeking local information on perceived needs. External actors design and plan based on information from the community, then implement, manage and monitor projects.
Less local control	Community members are informed by external actors regarding planned projects. External actors plan, implement, manage and monitor projects.

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

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

Communication with the community should include:

• Listening to the priorities and needs of a range of community stakeholders including women and men.

• Outlining the mandate, aims, and proposed activities of the agency as well as making clear what the agency cannot address.

• Explaining the time frame, exit strategy and limitations of the agency.

• Negotiating the roles and responsibilities of the host community.

• Provision of information for important programming events such as food distributions, surveys and meetings.

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

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

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

Working with Volunteers

Humanitarian agencies also often depend on the work on a significant numbers of volunteers who may have a broad range of job titles – community health workers, nutrition educators, community educators etc. However, a community's resources – time, money and people -can be scarce and its willingness and ability to provide volunteers can be limited. Working closely with an agency, perceived as having only a short term presence, may not be viewed as their best use of limited resources. The issue of how to motivate volunteers is one that is often tackled in emergency programming and it continues to be an on-going issue. It is summarised in Box 3 below.

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

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

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

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

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

2. Introduction to Behaviour Change Communication (BCC)

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

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

There are many approaches to BCC undertaken by different agencies to support good behaviours and to communicate effectively with people; however the ultimate aim of changing people's behaviour requires a lengthy reiterative process. This process uses a variety of techniques to repeat, familiarise and reinforce the message. For example, health worker messages on the importance of exclusive breastfeeding can be supported by examples of mothers discussing the issue in popular soap opera TV/radio broadcasts and also with visual messages in posters.

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

Nutrition BCC can be widely used and can helpful

a. To promote good behaviour and to discourage poor practices

b. To familiarise communities with the use of new products or services

c. For community sensitisation and investigating barriers to service uptake

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

Box 4: Examples of nutrition related BCC activities

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

In the past, *information, education and communication* (IEC) was often used in relation to nutrition education. However, the sector has evolved significantly over the past decade and IEC has largely been replaced by BCC and SBCC (social behaviour change communication). Nowadays IEC refers to the tools commonly used whilst working with communities on BCC.

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[2]   United Nations Children's Fund, *Behaviour Change Communication in emergencies: A Toolkit*, UNICEF, New York, 2005.

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

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

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

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

- The target audience, by asking 'who are you trying to reach?'

- The desired action, by asking 'what do you want the target audience to do?'

- The determinants or what supports/prevents the action, by asking 'what are the factors that influence or could influence the behaviour?'

- The interventions, by asking 'which actions will be most effective in addressing the factors?'

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

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

Case example 1: Protecting infant feeding in Ethiopia 2006

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

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

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

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

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

What are the characteristics of a successful BCC approach?

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

Box 5: Characteristics of successful approaches to nutrition BCC

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

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

3. Developing a BCC approach in emergency programming.

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

Box 6: Steps to guide a BCC strategy

Step 1

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

Step 2

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

Step 3

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

Step 4

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

Step 5

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

Step 6

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

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

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

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

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

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

3.2 Define the nature of the nutritional problem

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

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

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

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

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

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

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

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

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

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

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

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

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

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[3] IFPRI 2010 p57,

Box 7: An example of a SMART objective and indicator

Objective

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

Indicators

The number of community nutrition promoters in the community

The number of nutrition education sessions

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

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

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

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

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

It should be remembered that a large proportion of carers seldom disclose their child caring habits for fear of being ridiculed by health staff in clinics and hospitals. There is frequently a cycle whereby the carer is told off for a particular practice and then hides the practices for fear of being ridiculed again and so the problem continues. Alternatively, if the problem, for example night blindness, a symptom of vitamin A deficiency, is not viewed as a problem by the community they will have little motivation to modify their behaviour. This may be the case if a connection between eating particular foods, night blindness and the health of the child has not been made. Food taboos may also be important. Cultures have many different food beliefs and taboos and it is easy to ignore them if the belief does not fit with your own view. However if culture dictates that feeding eggs to children makes them steal then, in the short term at least, you should not advise this but come up with an alternative instead.

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

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

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

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

3.6 Choosing the right channels for communication

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

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

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

- How do affected families and communities seek information?

- How do affected families and communities share information?

- Who are trusted and respected spokespeople in the community or relief camp?

- Which groups have access to generators, mobile phones, megaphones, public address systems, radio or television?

- Which groups among the affected population do not have access to any media?

- What traditional, telecommunications and mass communication channels are available?

- Which groups can you reach via community-based groups such as social or religious functions?

- What are the levels of literacy among the target group?

- Will the chosen methods reach those with low levels of literacy?

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

4. Practical applications of BCC in nutritional emergencies

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

- Promotion of good behaviours such as exclusive breastfeeding and avoidance of risky ones such as bottle feeding.

- Familiarisation with the use of new products or services

- Community sensitisation and investigating barriers to service uptake

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

Promotion may focus on a particular behaviour to promote nutritional well-being such as exclusive breast feeding or appropriate complementary feeding. It can also be used to highlight the risks associated with bottle feeding and the use of breast milk substitutes which is particularly problematic in emergency settings.

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

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

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

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

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

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

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

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

The adoption of bottle feeding following an emergency should be avoided whenever possible. The very real hazards of bottle feeding are significantly increased in most emergencies and associated with increased morbidity and mortality. Breast feeding is known to be an effective survival strategy in developing countries and it is even more important in an emergency setting.

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

4.2 Familiarisation with the use of new products or services

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

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

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

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

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

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

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

4.3 Community sensitisation and investigating barriers to service uptake

Nutrition BCC can be used to enhance the effectiveness of a programme by increasing programme uptake and promoting the appropriate use of goods and services. For example, to enhance the nutritional benefit of cash distribution, a campaign may include key messages on the cultivation of fresh fruit and vegetables, the consumption of micronutrient-fortified foods or the purchase of micronutrient-rich foods from local markets.

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

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

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

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

• Community sensitisation;

• Active case finding and

• Word of mouth.

Each channel has advantages and disadvantages:

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

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

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

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

• Explain admission and rejection to carers. Staff need to dedicate time to the crucial task of explaining the reasons for rejection.

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

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

1. Distance to the site

2. Community awareness of the programme

3. The way rejections are handled at the sites.

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

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

5. Participatory assessment tools

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

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

In-depth interview

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

Key informant

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

Semi structured interviews (SSIs)

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

Group interview

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

There are several different types of group interviews such as:

- **Structured** group interviews – participants are asked the same questions as individuals,

- **Focus group discussions** (FGDs) – a facilitator guides a maximum of 10 to 15 participants through a series of issues, with the group interacting with each other rather than just with the facilitator,

- **Community meetings** – formal discussions organized by the local group or agency to ask questions and/or make observations,

- **Spontaneous group discussions** -everyday meetings, e.g., a sports event, at which groups of people gather around to chat and a facilitator participates.

Direct observation

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

Mapping

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

Seasonal calendars

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

Problem ranking/sorting

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

6. Main methods of communication

There are a number of methods for communicating nutrition messages: face-to-face communication; group communication through the use of existing social forums (e.g., markets, weddings, women's associations); mass media communication including internet and social networking; and small media communication.

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

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

Remember that information alone, for example, only using IEC visual materials, may result in increased awareness about a nutrition-related subject but may have only limited impact on people's practices or behaviours. It is very important where possible to stimulate shared learning through dialogue, participation and discussions with the affected communities in emergencies. Involving affected families and communities allows them to determine among themselves what needs to be done, and by whom in the long run, thus establishing a sense of ownership of the processes in the different phases of the emergency[4].

6.1 Face-to-face or interpersonal communication

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

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

- Targeting specific sub-groups (e.g., schoolchildren who are receiving school meals or HIV positive mothers with new-borns to reduce HIV transmission).

- Obtaining specific insights into a problem, for example, with uptake of a particular resource or technology or it may also take the form of small focus group discussions.

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

- Using printed materials (e.g. wall charts, flip charts and brochures) though these require a certain level of literacy among the target group (It is possible to produce picture only materials accompanied by careful explanations).

- Practical demonstrations that do not require a literate audience (e.g., demonstrations of how to prepare blended foods for complementary feeding, how to process and cook a new food commodity, or demonstrations of re-lactation methods for nursing mothers).

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

6.2 Group communication

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

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

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

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

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

Other examples of existing social forums include:

• Religious and political meetings.

• Women's associations

• Farmer's associations

• Youth groups

6.3 Mass media communication

This can include print, radio, internet/social networking, text messaging, television and cinema. It has the potential advan-tage of reaching large numbers of people in a short time. The mass media are most effective when coupled with other communication approaches through which the affected community can talk about the new information with someone whom they trust, such as community leaders.

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

• Radio and television messages are listened to by a large number of people. The audience needs frequent exposure to the message, which should be specific, simple and positive. Radio messages can be imparted through spot announcements, slogans and jingles, discussions, interviews, mini-dramas and music.

• Printed messages in newspapers, magazines or posters ensure longer-term exposure to messages when widely displayed.

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

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

• 230,000 people dead,

• 300,000 injured and

• 1,000,000 made homeless.

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

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

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

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

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

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

Personnel communication Ali Maclaine.

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

• Misinterpretation of messages by some or all if not carefully considered

• Messages tailored for general consumption, not taking into account the unique needs of the affected community

• Often not interactive and thus people are unable to ask questions and dispel any confusion

• Risk of marginalizing those without access to mass media or from different language or socio-cultural groups, e.g., the affected population may lack access to radio or television

2.4 Small media

Small-scale community media can be the most practical, useful and effective way to reach affected people during an emergency. These media include community radio (generator or battery-powered FM transmitters), community bulletins or flyers and loudspeakers or megaphones. With community coordination and support, it is possible to plan, produce and disseminate messages with affected community members.

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

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

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

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

1. A printed flip chart being produced. This could be read in breast feeding corners, used for group sessions or for one to one counselling sessions. The first page had 6 key messages and then the following pages were based on each of these messages. Each section page was colour coded to ease navigation.

2. The flip chart took several weeks to develop as it had to be tested with mothers, and other groups. Testing revealed that the use of appropriate photos was important in this culture and that women responded better to photo's of clean, modern, rich mothers, as this is what they aspired to, whereas typical 'emergency photos' were less engaging.

3. Canvas posters were developed in addition to paper ones. This was initially done so that the posters didn't add to the rubbish. However the canvas ones proved popular as they could be reused and continued to be used after the emergency had passed.

4. Innovative forms of media can be considered and in the Philippines fans were produced. They were printed with the six key IYCF messages on them and were proved to be very popular as people used them for fires, to cool off, get rid of flies, etc.

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

2.5 Participatory drama

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

- It stimulates critical thinking, stresses process rather than outcomes.

- A community can prioritize their needs.

- It develops a sense of community ownership.

- It offers a creative approach to deal with distress and trauma and thus supports healing among affected community members.

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

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

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

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

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

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

7. How to design print materials

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

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

Choose a simple, logical design and layout as follows:

- Present only one message per illustration.

- Make materials interactive and creative.

- Limit the number of concepts and pages of materials.

- Messages should be in the sequence that is most logical to the group.

- Use illustrations to help explain the text.

- Leave plenty of white space to make it easier to see the illustrations and text.

Use illustrations and images

- Use simple illustrations or images.

- Use appropriate styles: photographs without unnecessary detail, complete drawings of figures when possible and line drawings.

- Use familiar images that represent objects and situations to which the affected community can relate.

- Use realistic illustrations.

- Illustrate objects in scale and in context whenever possible.

- Don't use symbols unless they are pre-tested with members of the affected community

- Use appropriate colours.

- Use a positive approach, negative approaches are very limited in impact, tend to turn off the affected community, and will not sustain an impact over time.

- Use the same language and vocabulary as your affected community; limit the number of languages in the same material.

- Repeat the basic message at least twice in each page of messages.

- Select a type style and size that are easy to read. Italic and sans serif typefaces are more difficult to read. Use a 14-point font for text, 18-point for subtitles, and 24-point for titles.

- Use upper and lower case letters.

Special Note:

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

Conclusion

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