OVERVIEW OF MTOTO MWEREVU STUNTING REDUCTION TOOLKIT

PURPOSE

The Mtoto Mwerevu Stunting Reduction Toolkit is a resource for government and organisations involved in addressing stunting and broader nutrition issues in Tanzania. Its goal is to provide government, donors, non-governmental organisations, and civil society organisations (CSOs) with programmeming recommendations and tools to help implement successful multi-sectoral social and behaviour change (SBC) interventions aimed at preventing and reducing stunting.

Working with the Government of Tanzania (GoT), the DFID-funded ASTUTE stunting reduction programme developed the toolkit. The ASTUTE programme, implemented by IMA World Health, began in 2016 and works in five Lake regions of Tanzania: Mwanza, Shinyanga, Geita, Kigoma, and Kagera. During the programme, IMA has worked closely with government and project partners to develop several new tools (including checklists, guidelines, job aids, etc.) to address stunting for use by community volunteers, CSOs, and government at all levels.

Through the toolkit, you will learn about tools and approaches ASTUTE used to improve nutrition in the Lake zone of Tanzania. It may also help other regions identify and scale-up successful SBC and multi-sectoral nutrition interventions. All pieces of the toolkit align with the GoT National Multisectoral Nutrition Action Plan.

CONTENTS

The toolkit has a mixture of new and existing materials generated by the project, including:

- **Programme learning and implementation suggestions** around how to strengthen capacity of communities and government in managing nutrition interventions (at community, district, regional level); monitoring and evaluating nutrition programmes; strengthening capacity of nutrition programme implementers, including in relation to Water, Sanitation, and Hygiene (WASH); early childhood development; gender equity and their implications for stunting reduction; and nutrition advocacy in a multi-sectoral environment.
- **Stunting reduction programme tools**, including training manuals, job aids, data collection forms and tools at district and community level, programme guidance, and checklists for implementers at various levels (national, regional, district, community).
- A collection of programme **stunting operations research** and recommendations for Tanzania nutrition SBC programme implementers.
- A collection of **radio and TV spots** with engaging and evidence-based messages that government and implementers may consider using or broadcasting.

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HOW TO COLLABORATE SUCCESSFULLY WITH THE GOVERNMENT OF TANZANIA TO IMPLEMENT MULTI-SECTORAL NUTRITION INTERVENTIONS

KEY APPROACHES USED AND LESSONS LEARNT FROM THE DFID ASTUTE PROJECT

INTRODUCTION

Before the ASTUTE programme, many nonprofit nutrition programmes were run parallel to government programmes rather than in unison. This is due to a combination of factors, including donor requirements, timelines, and external staffing patterns. As a result, the nutrition programmes and implementers often failed to communicate regularly and integrate their work plans with government efforts. That meant interventions often ended after the donor-funded programmeming did, as the government was not brought into continuing the interventions since they didn't align to district/ regional or national plans. To tackle this, DFID deliberately designed ASTUTE in consultation with the government and ensured it aligned and supported the Multi-Sectoral Nutrition Action Plan. Upon start-up, the ASTUTE team communicated with the government that the programme is there to support the nation's best interests and their country plans. By involving the government, the programme benefits, because implementers fully understand the feasibility of implementation given cultural practises, laws, or barriers that might otherwise keep the programme from succeeding. We wove this principle throughout ASTUTE and share our recommendations on government engagement below.

RECOMMENDATIONS

Engage Key Stakeholders

(Ministries, Government organisations, Development partners, Regions, LGAs and Nongovernment organisations):

At the beginning of the ASTUTE programme, IMA followed an orderly and robust process of government engagement to share the project's objectives and see how it could align with Government of Tanzania (GoT) nutrition efforts. Given the multi-sectoral nature of nutrition, there are many government nutrition stakeholders. IMA first engaged with the President's Office - Regional Administration and Local Governments (PO-RALG), the Ministry responsible for overseeing sectoral affairs (including nutrition) at the regional and local levels. IMA also reached out to other nutrition-related national ministries with a role in nutrition implementation, such as the Prime Minister's Office (PMO), the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC), and the Ministry of Agriculture (MOA). Other government organisations included the Tanzania Food and Nutrition Centre (TFNC), Regional Administrative Secretaries (RAS) and their Regional Medical Officers (RMOs), and Local Government Authorities (LGAs) such as District Executive Directors (DED) and District Medical Officers (DMOs).

Introducing the project to these key national stakeholders made it possible for IMA and its partners to work more effectively with regions, councils, wards, and villages in the target regions, as they were confident that the project was in line with government strategy and endorsed by their superiors. With these subnational stakeholders, we met with and shared the ASTUTE project objectives, intervention strategies, donor expectations, total funding, duration, and coverage of the programme. Additionally, it created an open conversation whereby IMA could convey the programme's expectations from the government, including required

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manpower, time commitments, social mobilization, financial commitment expectations, and office space (if applicable). The programme was planned in more detail and refined with government officials during the project inception period and moved forward only with their approval and the donor/funder support. Some activities and costs in ASTUTE were paid for by the Government of Tanzania and others were supported by other donors/funders.

Clarify programme roles and share progress regularly:

IMA developed and signed Memoranda of Understanding (MOU) with all five of the local RASs in the regions where it implemented the project before commencing activities. We also signed MOUs with the 36 DEDs as well at district level, outlining the scope, roles, and responsibility of those involved in the intervention. By defining roles up front, and consulting on how the project should work, it created a positive working relationship from the local level to the national level. The MOUs and conversations helped shape mutual expectations and understanding, as well as establish channels for information flow from PO-RALG to RASs.

We routinely shared the ASTUTE quarterly and annual reports containing progress in milestone achievements and challenges with the national government (PO-RALG, PMO, TFNC). Later on we were instructed by PO-RALG to incorporate our quarterly project progress into DnuOs' quarterly reports for submission to the Regional level and National level. Additionally, we regularly invited the PO-RALG representative (nutrition focal point) to visit ASTUTE regions as well as LGAs to conduct supportive supervision. In turn, ASTUTE then participated in the annual budgeting session with the government, and conducted budget advocacy sessions with leaders at the regional and council level. Overall, it was vital to have a strong monitoring and evaluation team to collect relevant data from the community level by community health workers (CHWs), CHWs supervisors, and district nutrition officers (DNuOs).

Transparency about project finances with the government:

One of the most effective methods for creating strong relationships with the government was through Fixed Obligation Grants (FOGs). FOGs were issued to both the national government and to certain subnational areas to support ASTUTE activities. ASTUTE is the first programme to implement FOGs in the government system for multi-sectoral nutrition activities. The FOGs provided concrete resources to supplement government investment in nutrition and helped increase government buy-in by showing that ASTUTE was committed in multiple measurable ways.

FOGs also strengthened the national and local capacity for future nutrition and development programmes by giving the government the opportunity to manage donor funds and align them with government nutrition strategies. IMA also encouraged the government to contribute financially to nutrition activities to strengthen their capacity to implement nutrition activities, both financially and logistically. ASTUTE provided supportive technical assistance in technical work plan and budget alignment in support of these efforts.

Engage multiple sectors of the government for success:

The Tanzania Multi-Sectoral Nutrition Strategy is vital because it engages other sectors in advancing nutrition. We tried to mirror this multi-sectoral engagement in ASTUTE, involving government managers and specialists from agriculture, business development, water and sanitation, regional nutrition, and medical officers. Their involvement in ASTUTE varies based on their sector of specialisation. IMA often includes these various groups and organisations in stakeholder meetings, especially including marginalised groups such as women group leaders who can identify malnourished children. By working with a wide variety of sectors, ASTUTE was able to establish community and government investment in the success of the programme.

ADVOCATING FOR NUTRITION AT THE DISTRICT LEVEL IN TANZANIA:

LESSONS LEARNT AND TIPS FOR TANZANIAN CIVIL SOCIETY ORGANISATIONS (CSOS)

Author: PANITA

WHY IS IT IMPORTANT TO ENGAGE CSOS TO ADVOCATE FOR NUTRITION AT THE DISTRICT LEVEL?

In Tanzania, district-level governance happens through Local Government Authorities (LGAs). These entities were created by the government to decentralise government power to the district level. When implemented properly, decentralisation involves more people at the local level in the planning and implementation of development programmes. Tanzania's National Multi-Sectoral Nutrition Action Plan (NMNAP; 2016-21) tasks districts to do the following:

- Strengthen district coordination of nutrition work across sectors through Multi-Sectoral Coordination Committees for Nutrition;
- Establish district-level Nutrition Units to provide technical support in the planning, implementation, and evaluation of multi-sectoral nutrition programmes;
- Identify nutrition challenges and solutions within each district;
- Integrate nutrition activities into Comprehensive Council Development Plans;
- Strengthen community-based activities to fight malnutrition;
- Support wards and villages (mtaa) to integrate nutrition into their own development plans and to implement, monitor, and evaluate nutrition activities in the context of the NMNAP.

Given the large role that districts play, it is important that CSOs engage district authorities and other key stakeholders to improve the nutritional status of women and children. The NMNAP also calls for non-governmental organisations (NGOs), community-based organisations (CBOs), and faith-based organisations (FBOs) to play a significant role in advocating for nutrition activities at the district level. Led by PANITA, the DFID ASTUTE project worked to strengthen CSOs' ability to conduct multi-sectoral nutrition advocacy at the district level, in line with NMNAP and government guidelines.

KEY APPROACHES USED

- ASTUTE was the first time that a large nutrition project engaged PANITA as a Civil Society platform to reach large numbers of individuals with nutrition interventions. PANITA built CSO capacity through training, mentoring, and monitoring of CSO staff in 1) project management and governance 2) how to engage government counterparts, and 3) how to deliver high impact Social and Behaviour Change nutrition activities (support groups);
- With respect to engaging government counterparts, PANITA helped CSOs work more effectively with DnuOs and other district officers responsible for nutrition. PANITA also helped CSOs integrate their own work with district plans that included interventions for nutrition;
- PANITA facilitated joint annual review meetings with CSOs and council officials such as Nutrition Officers, community development officers, and others to share updates on implementation of the ASTUTE project and to harmonise the NMNAP reporting requirement for CSOs at the district level.
- CSOs built strategic relationships with decision makers and other influential people in order to move the nutrition agenda forward;
- CSOs identified local champions for nutrition in their respective districts, which resulted in increased resources for nutrition activities;
- CSOs strengthened existing support groups through social behaviour change strategies;
- CSOs were proactive members in district and regional committees, including district steering committees, consultative districts, and other platforms that advance nutrition, per the NMNAP. Even when CSOs were not formal members of Multisectoral Nutrition Steering Committees, their participation added value.

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CHALLENGES AND SOLUTIONS TO CSO ENGAGEMENT

- Historically there has been a culture of mistrust between CSOs and government officials which has caused friction and has negatively affected the working relationship at the council level between CSOs and their counterparts. PANITA built working relationships between CSOs and districts by bringing them together at annual meetings to improve understanding of their respective roles in nutrition and increase communication between groups. At these meetings, DNuOs and community development officers were invited to participate and present their work. This process was instrumental in strengthening relationships.
- There are too many reporting requirements. LGAs sometimes issue multiple reporting requirements that CSOs must complete regularly. Creating a harmonised framework across sectors would reduce labour. PANITA helped CSOs and district officials develop one report for the district nutrition officer. This report replaced the two reports that were required previously.
- Some CSOs have a limited understanding of their roles and responsibilities within the revised Terms of Reference (TOR) for District Multi-Sectoral Nutrition Steering Committees, thus reducing their ability to be effective advocates for nutrition. To address this issue, PANITA helped CSOs understand how they can contribute to TORs through training and mentoring.

Despite progress made in improving CSO and district collaboration, these challenges remain and require ongoing support.

CSO NUTRITION TOOLS

There are several tools that Tanzanian CSOs can use to improve their nutrition advocacy work, both within and outside of the ASTUTE Toolkit:

- The NMNAP can be used to help CSOs review and align their efforts within the NMNAP. The NMNAP can be found here: http://scalingupnutrition.org/wp-content/uploads/2017/09/NMNAP_Tanzania.pdf
- The revised Multi-Sectoral Nutrition Steering Committee TOR provides guidance on how committees should operate. The TOR can be found here: https://www.panita.or.tz/wp-content/uploads/2014/04/panita_national_4.pdf
- A series of checklists to monitor nutrition activities and supervision for regions, districts, health facilities, and CBOs. These can be found here: https://www.panita.or.tz/wp-content/uploads/2014/04/panita_national_2.pdf
- Multi-sectoral nutrition scorecards and reports from districts, available via DMSNCs; bottleneck nutrition analysis, and Joint Multi-sectoral Nutrition Reviews.

STEPS TO CONDUCTING PERSONALISED SUPPORT GROUPS FOR ACTION

4 STEPS FOR CONDUCTING PERSONALISED SUPPORT GROUPS FOR ACTION

Steps	Things the volunteer should do:
1. Personalise (Mtazano)	• Show genuine interest in each group member. • Ask about health issues group members face.
2. Discuss and Brainstorm solutions (Jadili na chemsha bongo)	• Ask group members what small practices they can try so that they overcome the health issue they've identified. If group members struggle to identify practices they can try, refer to your menu of practices and, based on the health issues group members have already reported, choose 3-4 small, doable actions (SDAs). • Present 3-4 SDAs to the group. Explain what each SDA means.
3. Teach back and Commit (Unaweza nieleza ulivyo elewa na utayali)	• Ask group members to identify benefits of practising each of the SDAs. • Have group members teach back what they perceive each SDA to be so that you are sure they understand the 3-4 SDAs. • Have the appropriate group members to commit to practising 2-3 SDAs—either from what group members themselves identify as practices they can try or from your menu of practices. It is likely that group members will commit to different SDAs. This is perfectly fine. • Help group members identify any challenges with the 2-3 SDAs they've committed to try by asking: What makes it hard to practise these new behaviours? • Ask group members: Who can support you as you try these practices? The SDAs should be specific to relevant group members. For example, if babies' crying is a problem for parents of children less than 6 months old, ask parents of children less than 6 months old to commit to 2-3 SDAs related to crying. • Ask all other group members what they can do to support these parents as they try 2-3 SDAs. • Have all who are willing to raise their hand and/or say aloud what SDAs they're committing to. • Record each group member's new SDA in your counter book.
4. Tell others (wambiye na wengine)	Have everyone who is willing to do so commit to telling others what they have learnt today. Have everyone invite their neighbours to the next meeting.

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EXAMPLE: 4 STEPS FOR CONDUCTING PERSONALISED SUPPORT GROUPS FOR ACTION

Steps	Things the volunteer should do:
1. Personalise	"Karibu! We're very glad you have come to the support group. We're certain that you'll find today's meeting beneficial! Let's start by discussing some of the health challenges you or your children have had recently. What health issues are you facing?" [Group responds that their infants cry a lot.]
2. Discuss and Brainstorm solutions	"What are some of the things you can do to help calm your baby?" Group responds: breastfeed the baby, give gripe water, give traditional medicines. [Volunteer refers to his menu of practices and chooses 3-4 small, doable actions (SDAs) that are beneficial to the child.] "You are right that breastfeeding the baby can really calm her down. In addition to breastfeeding, you can: • Check to see if the baby is wet • Avoid giving traditional medicines, herbal treatments, or gripe water (it contains alcohol and damages the baby's brain) • Calm the baby by rocking her to sleep, holding her on your tummy or lap, and rubbing her back • Take the baby to the health facility worker if you think she might be sick."
3. Teach back and Commit	"What do you think the benefits are of: • Breastfeeding the crying baby? • Checking to see if the baby is wet? • Avoiding traditional medicines and treatments and gripe water? • Rocking or holding the baby? • Taking the baby to the health facility when sick?" "What does it mean to: • Breastfeed the crying baby? • Check to see if the baby is wet? • Avoid traditional medicines and treatments and gripe water? • Rock or hold the crying baby? (Can you demonstrate how this is done?) • Take the baby to the health facility when sick?" [Volunteer clarifies any misperceptions about the SDAs.] "Now that we've talked about the things you can do to comfort your crying baby, can those of you who have babies commit to trying 2 or 3 of these actions? Which ones will each of you commit to?" [Have group members individually commit to trying 2 or 3 small, doable actions. Let each individual pick the 2 or 3 actions that he or she thinks they can try.] "What do you think might make it hard to practise these new behaviours? Who can support you as you try these practices?" [Volunteer, help individuals resolve any challenges caregivers may face.] "For everyone else who doesn't have a young child, what can you do to support these parents as they try 2-3 SDAs?" [Have all who are willing raise their hand and/or say aloud what SDAs they're committing to.] [Record each group member's new SDA in your counter book.]
4. Tell others	"Can each of you tell your friends and family what you have learnt today? Can you invite their neighbours to the next meeting?"

5 STEPS FOR FOLLOWING UP ON PERSONALISED SUPPORT GROUPS FOR ACTION

Follow-up Support Groups	Things the volunteer should do:
1. Teach back and Follow up	• Have group members teach back what they know about the SDAs discussed in the last meeting. • Ask if support group members were able to try the SDAs.
2. Congratulate	Congratulate support group members as a whole for making an effort to try a new SDA. Avoid congratulating only those individuals who successfully practised SDAs.
3. Resolve barriers	Resolve barriers for group members who weren't able to adopt the new SDA
4. Share successes	• Have group members share their experience trying the new SDAs. • Help those who weren't able to adopt the new SDA resolve any challenges they face.
5. Repeat	Start with a ***new practice*** using the same participatory approach, including teach back.

EXAMPLE: 5 STEPS FOR FOLLOWING UP ON PERSONALISED SUPPORT GROUPS FOR ACTION

Follow-up Support Groups	Things the volunteer should do:
1. Teach back and Follow up	"Last week we talked about things parents can do to calm their babies. What does it mean to: • Breastfeed the crying baby? • Check to see if the baby is wet? • Avoid traditional medicines and treatments and gripe water? • Rock or hold the crying baby? (Can you demonstrate how this is done?) • Take the baby to the health facility when sick?" Were you able to try any of the new behaviours you committed to? Which behaviours?"
2. Congratulate	"I want to congratulate all of you for making an effort to try these new practices. It's not easy to do something new!"
3. Resolve barriers	"What were some of the challenges you faced since our last support group when you tried these new practices?" [Volunteer: help resolve barriers.]
4. Share successes	"Who can tell me about their experience trying a new behaviour? For those of you who weren't yet able to try the practices you said you'd try, what can we do to help?"
5. Repeat	"We've now worked on calming the crying baby and we made great progress! Today, let's talk about your children (those more than 6 months old) eating eggs, fish, and dagaa." [Volunteer uses the same participatory approach, including teach back].

SUPERVISORY SUPPORT AND CAPACITY BUILDING

CSO staff, do the following:

1. Prepare for support group

- Help volunteers secure buy-in from community.
- Plan for cooking or other hands-on demonstration.

2. Observe volunteers facilitating groups

- Use checklists.
- Help volunteers point out the benefits of new, small, do-able actions.

3. Coach volunteers

- Build volunteers' skills, especially to:
  1. personalise
  2. discuss and brainstorm, and
  3. teach back.

4. Conduct role plays & field practice

- Help volunteers reflect using job aids and checklists.

5. Continue to monitor; repeat process monthly

- Have volunteers and support group members observe household practices between support groups.
- When possible, have group members bring evidence of behaviour change to the next meeting (e.g., soap).

SMALL, DO-ABLE ACTIONS (SDAS) CSO VOLUNTEERS AND CHWS CAN RECOMMEND TO FAMILIES

Attend support groups!
Welcome CHWs to your house!
Speak with a CSO volunteer and CHW!

MATERNAL HEALTH

Serve antenatal care (ANC)

- Recognise signs and symptoms of pregnancy
- Decide to seek ANC early, before the end of the first trimester
- Plan transport, resources, and logistics
- Have husband accompany wife
- Attend all recommended ANC visits
- Obtain all required services from qualified provider at each visit
- Adhere to provider instructions during and following each visit

Maternal nutrition

- Take iron or IFA tablets or syrup before and during your pregnancy, according to health facility workers' direction
- Eat an extra meal or an extra amount at each meal
- Eat healthier foods
- Reduce your household workload by having your husband and in-laws help out with some of the chores
- Seek advice about maternal nutrition

CHILD HEALTH

- Take the sick child (diarrhoea, fever, cough, rapid breathing) to the health facility immediately
- Give a child with diarrhoea ORS (Oro), zinc, homemade solution, and more liquids and foods
- When you work outside the home or plan to be gone from the child for a while, make arrangements for childcare, preferably from an adult

NUTRITION

Early initiation of breastfeeding

- Have newborn placed on chest and breast immediately (within first hour after birth)
- Allow newborn to suckle, even if milk does not appear to be presenting
- Don't give prelacteal feeds (something other than breast milk in the first few days of life)
- Give colostrum

Exclusive breastfeeding

- Decide to breastfeed exclusively
- Plan with family members how to breastfeed exclusively if the mother is away from the baby
- Make sure baby attaches properly to the breast and positioning of the baby against the mother is good
- Feed only breast milk day and night when the baby is hungry or when it is time (8-12 times per 24 hour period)
- Do not give or allow others to give the child water, other liquids, foods, or things like gripe water, herbal medicines, and traditional medicines. Only give medicines when prescribed by a doctor or other health worker
- Allow time to feed; let the baby finish all the milk in one breast then offer the other breast
- Seek care for breast or breastfeeding problems
- Ask the father, mother-in-law, and other family members to help with one of the tasks you normally carry out
- Try calming the crying baby by rocking the baby to sleep or holding the baby on his or her tummy on your lap and rubbing the baby's back
- If you think the baby cries because he or she is sick, see a health worker
- Instead of selling chickens, other small livestock, and eggs give them to your family first

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Complementary feeding

- Obtain animal source foods (especially eggs, dagaa, and other fish) and nutrient rich fruits and vegetables
- Prepare and offer food of the right consistency, based on the age of the child
- Prepare and feed the required number of meals based on the age of the child
- Prepare and feed meals of adequate amounts based on age
- Prepare and feed meals hygienically
- Be patient when the child feeds and actively encourage the child to eat
- Replace sweet snacks and sugary drinks with healthy snacks

Measurement of child's growth

- Take vitamin A when asked to do so by a health facility worker
- Grow colourful crops in your home garden
- When you go to the health facility, make sure your child's height and weight are recorded and that the health facility worker gives you recommendations about how to make your child healthy

WASH

Handwashing with soap

- Construct or purchase a handwashing station (e.g., tippy tap)
- Obtain soap (or ash) and water
- Make sure soap and water are available at handwashing station at all times
- Place water and soap near the latrine
- Place water and soap near the place where food is prepared
- Wash hands before feeding the baby — whether the mother feeds the baby or anyone else
- Wash hands with soap and water after handling infant faeces at any point
- Wash hands with soap and water after handling animal faeces
- Wash the baby's hands frequently

Sanitation

- Keep animals caged
- Keep animals away from children
- Hold (or have someone else hold) the baby so that he or she is out of the dirt
- Find a secure way of keeping your animals outside of the house at night
- Decide to build or access a latrine
- Build or access an improved latrine
- Always use the latrine for human faeces, including faeces from babies
- Cover the latrine hole
- Maintain latrine and surroundings

Water

- Collect water from an improved source
- Transport water in a clean, covered container
- Treat water by boiling, solar water disinfection, chlorination, or filtration
- Store water in a clean, covered container out of the reach of children
- Retrieve water using a clean, long-handled implement (e.g., spoon or ladle)
- Provide water to children with a clean cup

EARLY CHILDHOOD DEVELOPMENT

- Fathers and mothers, speak to your infants and children as early as possible, even if you think they can't hear or respond
- Fathers and mothers, tell your children a story, even when they are very young
- Fathers and mothers, make simple toys from locally available materials for your children to play with
- Play with your children
- Name the objects around the young child so that the child learns them
- If available, take your child to a learning centre or early childhood learning centre, including kindergarten or community child care
- Sing to your child
- Draw with your child
- Count with your child

WOMEN'S WORKLOAD

- Fathers and grandparents, help your wife or daughter-in-law with chores such as carrying water, washing clothes, etc.
- Fathers, help feed your children

POSITIVE DEVIANCE/HEARTH (PDH) APPROACH FOR STUNTING REDUCTION

Positive Deviance/Hearth is a social and behaviour change (SBC) and community mobilization strategy adopted by the DFID ASTUTE project for rehabilitating malnourished children both in the community and in their own homes.[1] "Positive deviants" are parents or other caregivers who are as poverty-stricken as their neighbours, but who have well-nourished children. Positive deviants are able to raise well-nourished children because they practise uncommon but healthy behaviours related to feeding, hygiene, and health seeking. In Tanzania, trained community health workers (CHWs) share the uncommon behaviours positive deviants practise through 12 days of practical sessions for parents of malnourished children, referred to as **"hearth sessions."** During this time, locally accessible and affordable nutrient-dense food is prepared, cooked, and served by mothers being supervised by CHWs to malnourished children in the group. Additionally, parents try the other behaviours positive deviant parents practise, including practises related to hygiene, sanitation, and early child development (ECD).

Children qualify for the program based on low weight for age and wasting, with the initial assessment of nutritional status carried out at the local health facility using weight-for-age and mid-upper arm circumference measurements as screening indicators. The strategy targets children 6-36 months of age who are mildly, moderately, and severely underweight. During the PDH program, children are weighed on days 1 and 12, and following the program at 30th and 90th days and at 6 months and 12 months. Weighings are frequent to demonstrate children's progress toward becoming well-nourished. Caregivers' daily attendance is tracked during hearth sessions. Subsequently, CHWs follow up with each participating child and caregiver in their home and record how the child is doing and whether caregivers are practicing the behaviours promoted during hearth sessions. PDH has enabled hundreds of communities to reduce current levels of childhood malnutrition and has the potential to prevent malnutrition years after the program's completion.[2] In addition to helping young children gain adequate weight, children also become more active, joyful, and playful and demonstrate an increased appetite.

LESSONS LEARNT AND RECOMMENDATIONS FOR IMPLEMENTING PDH IN TANZANIA

1. TRAINING

ASTUTE first piloted PDH in four regional/local government areas with malnutrition >30%. PDH was then scaled up to all five lake zone regions where ASTUTE is operating. Figure 1 provides a schematic of how PDH works.

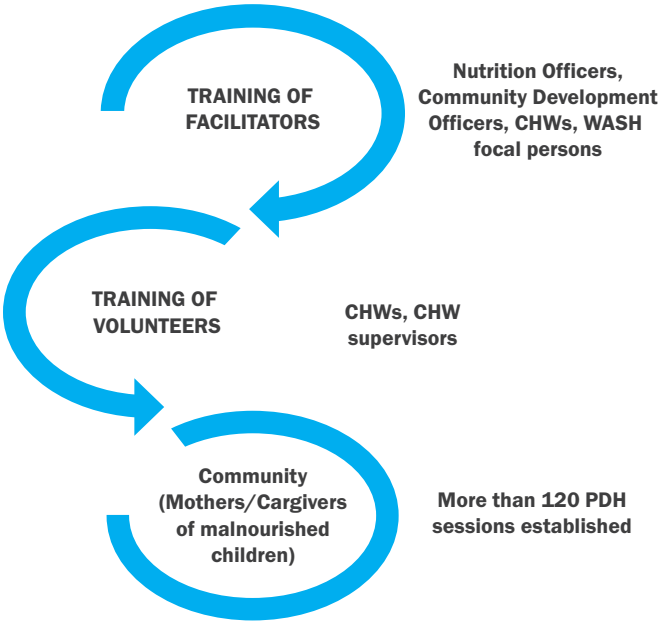

Figure 1. Cascading model from regional/district to community level

2. PLANNING AND COMMUNITY MOBILISATION

- Before launching PDH at the community level, first ensure that criteria for beginning the PDH program are met. These criteria are: 30% prevalence of moderate and severe malnutrition (or higher), homes are located a short distance from one another, community commitment, availability of nutritious foods (which caregivers contribute), and availability of health facilities.
- Fully involve ward development committees and village leaders to ensure they play a lead role in planning and overseeing all PDH activities.

1 https://www.k4health.org/toolkits/pc-nutrition/positive-deviance-hearth-nutrition-model
2 https://journals.sagepub.com/doi/pdf/10.1177/15648265020234S204

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3. NUTRITION ASSESSMENT AND SITUATIONAL ANALYSIS

- Liaise with health facilities within the ward to get a sense of which villages have the highest level of moderate and severe acute malnutrition, based on the health facilities' routine nutrition assessments during growth monitoring activities.
- Involve health facility workers in weighing children and recording their weights during home visits.
- Conduct focus group discussions, market survey, and seasonal calendar, transect walks, community mapping, and Positive Deviance Inquiry (PDIs).[3]
  - Use community members and staff in every community to conduct PDIs.
  - PDIs should be conducted in at least two villages which meet PDH criteria.
  - There should be 4-6 PDIs with positive deviants and two PDIs with negative deviants.

4. MENU PREPARATION AND HEARTH SESSIONS

- Design optimal hearth menus based on locally available and affordable foods. Affordability of foods is verified through the PDI.
- Hearth sessions should be limited to 10-15 children; more than this number makes it difficult to conduct effective hearth sessions.
- Record attendance and the percent of children who graduate.
- Child's weight must be classified as "healthy or mildly" underweight, regardless of weight gain. If the child does not meet other criteria, they must repeat the hearth for another 12 days.
- Ensure that caregivers bring a daily contribution of food and/or materials to the hearth sessions; this is a must!
- Make certain that caregivers are present for all 12 days of hearth and are actively involved in each session; also a must!
- Ensure caregivers "teach back" what they have learnt at each hearth session so that the CHW is certain each caregiver understands the behaviour he or she must practise at home.

5. FOLLOW-UP VISITS, MONITORING AND EVALUATION

- CHWs conduct follow-up visits at home every 2–3 days for two weeks after the Hearth session.
- Check the impact by measuring weight gain at 12 days, 30 days, three months, six months, and one year after participating in hearth.

6. COMMUNICATION

- Situational analyses, weighing, and Hearth session reports should be available to Ward Executive Officers and Village Executive Officers for their input and records.
- Communities should be informed of anthropometric and other health data, PDH attendance, increases in children's weights, and graduation rates for those attending PDH sessions.

Challenges encountered during Hearth sessions	Proposed solution
Unclear criteria for wealth ranking and subsequent misclassification of PDH households.	Community leaders (hamlet leaders) should help set criteria during wealth ranking sessions and identification of PDH households.
Most government health facilities use hanging scales which are subject to great error during weighing of children.	Use digital scales or, in the worst case, follow the recommended steps to use hanging scales to avoid errors.
Drop-outs and defaulters from the hearth sessions.	Involve local leaders in all steps of PDH implementation and engage individuals with influence on childcare and feeding, particularly grandmothers. Encourage those who stay in the group to informally share messages with those who have dropped out.
Inaccessibility of certain foods (e.g., protein sources, fruits, etc.).	Advocate for homestead gardens among community members.Ensure menus are diverse and according to seasonal availability of foods.
Few children are graduating from hearth sessions.	Prior to Hearth sessions, deworm all children, update immunisations, and provide needed micronutrients. Ensure criteria for starting PDH programs are met.

3 These techniques are used for the situation analysis of the community and are useful in identifying positive and negative behaviours that affect the health and nutrition status of children

Make Me a Change Agent

A Multisectoral SBC Resource for Community Workers and Field Staff

June 2015

These Make Me a Change Agent lessons were developed by the CORE Group Social & Behavior Change Working Group, and the Food Security and Nutrition Network Social & Behavioral Change Task Force, with significant contributions from Food for the Hungry.

USAID FROM THE AMERICAN PEOPLE

TOPS Promoting excellence in food security programming

FSNNetwork Food Security and Nutrition Network

coregroup Advancing community health worldwide.

FOOD FOR THE HUNGRY

Make Me a Change Agent:

A Multisectoral SBC Resource for Community Workers and Field Staff

The Technical and Operational Performance Support (TOPS) Program is the USAID/Food for Peace-funded learning mechanism that generates, captures, disseminates, and applies the highest quality information, knowledge, and promising practices in development food assistance programming, to ensure that more communities and households benefit from the U.S. Government's investment in fighting global hunger. Through technical capacity building, a small grants program to fund research, documentation and innovation, and an in-person and online community of practice (the Food Security and Nutrition [FSN] Network), The TOPS Program empowers food security implementers and the donor community to make a lasting impact for millions of the world's most vulnerable people.

Led by Save the Children, The TOPS Program is a consortium program drawing on the expertise of its partners: CORE Group (knowledge management), Food for the Hungry (social and behavioral change), Mercy Corps (agriculture and natural resource management), and TANGO International (monitoring and evaluation). Save the Children brings its experience and expertise in commodity management, gender, and nutrition and food technology, as well as the management of this 5-year (2010–2015) US$20 million award.

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Contents

Abbreviations and Acronyms

BCA	Behavior Change Agent
CHW	community health worker
EBF	exclusive breastfeeding
FSN	Food Security and Nutrition (as in The FSN Network)
HIV	human immunodeficiency virus
MC	Motivating Conversation
MI	Motivational Interviewing
MMCA	*Make Me a Change Agent* (this curriculum)
NGO	nongovernmental organization
NW	neighbor woman
ORS	oral rehydration solution
PTA	parent-teacher association
QIVC	quality improvement and verification checklist
SBC	social and behavioral change
TIPS	Trials of Improved Practices
TOPS	Technical and Operational Performance Support (as in The TOPS Program)
VHC	Village Health Committee

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Introduction

The Technical and Operational Performance Support (TOPS) Program, the Food Security and Nutrition (FSN) Network's Social and Behavioral Change (SBC) Task Force, and the CORE Group SBC Working Group are pleased to offer this set of field-friendly SBC lessons entitled *Make Me a Change Agent*, or MMCA. These lessons seek to build the skills of community-level workers, such as community development agents, community health workers, and agriculture extension agents, so that they can be more effective behavior change promoters in their communities. The lessons are not sector specific, but are tried and true generic skills, such as communication and storytelling, that can help a development worker in any sector become more effective as an agent of behavior change.

These lessons were developed by experienced SBC specialists from multiple nongovernmental organizations (NGOs), most of whom are active members of the CORE Group SBC Working Group and the FSN Network SBC Task Force. Together these people worked voluntarily to identify the necessary skills related to behavior change, establish a lesson plan format and preferred training methodology, design the lessons, develop the handouts and visual aids, and review and test the materials. The CORE Group SBC Working Group reviewed the lesson plans, which also have been field tested. Many of the lessons had already been used by individuals or organizations, were adapted for this curriculum, and are now being offered as part of this set of skill-building exercises.

Knowing that community-based development workers often are too busy to attend a lengthy course or might prefer to learn one skill at a time, the MMCA lessons were designed to be conducted individually or as a cohesive curriculum. Most lessons range in duration from a few hours to a half-day. They could be offered as a week-long training or as a continuing education course over a period of time. Supervisors and their teams could select specific skills that need to be built or reinforced and cover only those lessons, or the entire curriculum can be offered. The lessons are arranged in a suggested order because some build on the skills developed during previous lessons.

Lesson 1: Behavior Change through Effective Communication

Achievement-Based Objectives

By the end of this lesson, participants will have:

- Described why a Behavior Change Agent (BCA) needs good communication skills
- Defined good communication
- Practiced three types of listening, including reflective listening
- Given examples of open-ended and closed questions

Duration

4–5 hours

Materials

- Flip chart paper and markers, masking tape, blank paper (letter size), note cards or small pieces of paper, and pencils with erasers (1 for each participant)
- Lesson 1 Handout 1: Good Communication (1 copy per participant)
- Lesson 1 Handout 2: Respect Wheel (1 copy for each group of 4–5 participants)
- Lesson 1 Handout 3: Showing Respect (1 copy per participant)
- Lesson 1 Handout 4: Listening Role Plays (6 copies)
- Lesson 1 Handout 5: Listening Techniques (1 copy per participant)
- Lesson 1 Handout 6: Drawing a Bug to Practice Listening
  (1 large copy or drawing to show participants at the end of exercise)
- Lesson 1 Handout 7: Open-Ended and Closed Questions (1 copy per participant)

Why this Lesson?

Effective communication is one of the most important skills Behavior Change Agents (BCAs) need, but much of their training is on technical content and program messages. This lesson will help BCAs improve their communication skills so they can work more effectively with communities to promote behavior change.

Advanced Preparation

Throughout this manual, the term BCA is used to represent the wide variety of roles held by workers that promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, or peer educator).

For Task 4, review the three role plays in **Lesson 1 Handout 4: Listening Role Plays**. If appropriate, adapt the role plays to fit the topics or issues covered by the participants' program

area(s). Select 6 participants (2 for each role play) and give them copies of the role plays in advance so they can practice.

Read the two sets of questions in **Lesson 1 Handout 7: Open-Ended and Closed Questions**. Decide which option best meets the needs of your group, or write an example that is more relevant.

Tasks

1. Warm-Up Activity (15 minutes)

    1a. Divide the group of participants into pairs. Explain that the partners will interview each other about the following questions then use the information gathered to introduce their partners to the larger group. If needed, write the questions on the flipchart.

    - Who is someone you really like to talk with, and why?
    - Name a communication skill that YOU feel you do well?

    1b. Allow participants about 5 minutes to talk together, then ask each person to introduce their partner and present their responses to the group. On the flipchart, list the communication skills mentioned by the participants (the skills of the person they like to talk with, as well as the skills that they do well).

    1c. When everyone has been introduced, read the list of communication skills out loud. Note that this list shows that the participants are already very familiar with what "good communication" is and that they already have practice with many communication skills. Facilitate a brief discussion using the following questions.

    - For the skill that you do well, is this a skill that you've always had? If not, how did you improve? Can someone share an example of how you improved a communication skill?
    - Which of these skills do you think you could continue to improve?

    1d. Note that during this lesson, participants will have an opportunity to learn not just from the activities, but also from each other. Encourage participants to use their best communication skills during the training and to pay attention to what others do well and give those skills a try themselves.

2. Good Communication (10 minutes)

    2a. Ask participants to imagine that the list is a description of good communication. Ask them if anything is missing. Ask them to think about the type of communication skills needed by a BCA; what else should be added to the list?

2b. Distribute **Lesson 1 Handout 1: Good Communication**. Ask a volunteer to read the definition aloud. Ask participants if they would add to or change the definition in any way.

2c. Continue with a discussion based on the following questions.

- What differences can you see between the list of skills in this handout and the flip chart list? (Encourage participants to add items from the flip charts to their handout).
- Why is it important for Behavior Change Agents to learn and practice communication skills? (Listen to the group's response then add any of these points if they were not mentioned: Good communication builds trust; it makes people feel respected and heard and, as a result, more likely to listen to and learn from you; it helps ensure that people understand what you are saying; good communication, encouragement, and support build people's confidence to try new behaviors and skills.)

2d. Summarize by explaining to participants: When you communicate well by showing respect, listening, promoting dialogue, being supportive, learning about people's realities, and adapting what you say to people's situations, you will have a better chance of succeeding at helping people learn information, get services, and try new behaviors.

When you get to know families on a more personal level, you can better understand the difficulties they face in trying new behaviors and talk with them to help them find ways to remove or overcome those difficulties. This is much more effective and respectful than insisting on behaviors that may be unrealistic. It makes it more likely that they will be able to do the new behaviors and continue to do them over a long period of time.

3. Showing Respect (30 minutes)

3a. Explain to participants: To communicate well with people, you must be able to make them feel comfortable and respected. In this activity, we will discuss what makes people feel respected and how you can show respect to the families you will work with. The following activity provides a chance to explore what makes people feel respected and how we can show respect to the people and families with which we work.

3b. Tell participants: Quietly on your own, take a minute to think about a time when you felt respected. What was happening that caused you to feel respected?

3c. After a couple minutes, divide participants into small groups of four or five people. Give each group a copy of **Lesson 1 Handout 2: Respect Wheel** and a marker.

3d. Explain to participants: Now you will have 10 minutes for the next part of the activity. Share your thoughts with your small group members. Then, as a group, choose short phrases or words that complete the statement: "I know that I am being respected when…" Write these short phrases or words on the spokes of your group's respect wheel. You can add more spokes and phrases if needed.

3e. After 10 minutes, ask all groups to post their respect wheels on the wall and have participants circulate the room to view everyone's work. Ask participants to use a marker to draw a smiley face (or other symbol) on any of the wheels next to a way that they often show respect to others already and a star (or other symbol different from the first) next to a practice they would like to increase or improve.

3f. Ask participants to return to their seats. Then facilitate a discussion based on the following questions.

- How can we show respect for the people we serve and for the people we work with?
- Are there ways we can ask others to show respect for us?

3g. Distribute **Lesson 1 Handout 3: Showing Respect**. Ask participants to read the handout (or ask a volunteer to read the list out loud) and compare the items on the list to the items they wrote on the respect wheels. Ask participants to add things from their own lists to the handout to make a more complete list.

3h. Summarize by telling participants: Effective communication creates a feeling of security and respect. A Behavior Change Agent must create this feeling of security and respect with each family so that family members feel comfortable sharing their ideas without fear of rejection or disapproval. Respect for the ideas, customs, and rights of the family members should form the basis for all of your interactions. During this training let's practice showing respect for each other.

4. Listening Skills (30 minutes)

4a. Tell participants: As we have discussed, Behavior Change Agents must use good communication skills to help improve the welfare of families in their communities. Part of being a good communicator is listening well. In this activity we will focus on our listening skills.

4b. Ask the group the following questions and encourage a brief discussion that could include the answers given below each question.

- What is the difference between "hearing" and "listening?"

  - Hearing is involuntary; listening is voluntary.
  - We always hear things around us, but we don't always pay attention to what we're hearing.
  - Hearing something doesn't mean that you understand it.
  - Hearing doesn't require any effort.
  - Listening well takes some effort.
  - When we listen we try to understand; we listen for meaning, not just the words.

- What do you think you must do in order to listen well?
  - Pay attention to what the person is saying.
  - Avoid becoming distracted or thinking about other things while the person is talking.
  - Show that you are listening by looking at the person, responding to what the person is saying, or asking questions if appropriate.
  - Avoid thinking so much about your response that you don't truly hear and understand what the person is saying.

- If you are not paying attention or if you are thinking ahead to how you will respond while the other person is talking, how might this affect communication?
  - You may not understand the person's specific situation.
  - You might not fully understand what is being said.
  - You might interrupt or frustrate the person.
  - The person will stop sharing information and feel that he/she is not being listened to.

- Why is it important for Behavior Change Agents to listen well when they communicate with families or other community members?
  - BCAs must communicate to help people overcome obstacles that prevent them from learning, getting services, and trying new behaviors.
  - BCAs must listen well to be able to understand other people's problems from their perspective and learn about other people's realities.

4c. Explain to participants: Now you will watch three role plays that demonstrate different listening techniques, all of which are important to Behavior Change Agents.

4d. Post three blank pieces of flip chart paper on the wall. Invite the participants you selected to act out the role plays in **Lesson 1 Handout 4: Listening Role Plays** to come to the front of the room and perform. Limit each role play to a few minutes. Ask

participants to watch each listener carefully during the role plays to see what they are doing. Do not tell the group what technique each role play will be demonstrating.

4e. After the first role play ask participants the following question, and write responses briefly on the first blank flip chart sheet that you posted, leaving a blank space at the top of the sheet: What did the listener do during the role play? (For example, the listener used only non-verbal communication, such as eye contact and nodding her/his head, and brief responses, such as "yes," "I see," "uh huh," to show interest and to encourage the person to continue speaking)

4f. Repeat this process with the remaining two role plays on asking clarifying questions and listening and reformulating.

4g. After all three role plays are completed review each flip chart with answers to the question "What did the listener do during the role play?" After you review each sheet, write the name of the listening technique at the top of the sheet, either:

- Listen without Responding
- Ask Clarifying Questions
- Listen and Reformulate

4h. Ask the following questions and encourage a brief discussion. Potential answers follow in parentheses.

- When do you think it would be most effective to use the "listen without responding" technique? (When someone is very upset or emotional about something, when someone is staying on the topic and does not need much prompting or help to continue speaking, when you understand everything that is being said)

- When do you think it would be most effective to use the "ask clarifying questions" method? (When you are trying to learn something, when you are not sure you have understood everything that has been said, when you need more information, when you are trying to help a person brainstorm solutions to a problem)

- When do you think it would be most effective to use the "listen and reformulate" technique? (When you are trying to understand someone's perspective on an issue, when you want the person to know that you understood what he/she said, when you want to reinforce a key message)

4i. Direct participants to **Lesson 1 Handout 5: Listening Techniques** for more information about these techniques.

4j. Tell participants: While each of these listening techniques may work best at different times, good listeners often switch between all three within one conversation. All three

listening techniques are important, and a good Behavior Change Agent should learn and practice using all of them.

5. Practice Listening (45 minutes)

5a. Explain to participants: We are now going to practice our listening skills.

5b. Distribute a blank piece of letter-sized paper and a pencil with eraser to each participant.

5c. Explain the task to participants: Your task is to listen to my instructions and draw what I tell you on the blank piece of paper. You will only listen and draw. You may not ask questions or make comments. You may not look at anyone else's drawing.

5d. Verbally give participants instructions for drawing the image in **Lesson 1 Handout 6: Draw a Bug to Practice Listening**,[1] line by line (see below). Give detailed instructions so that participants will be able to reproduce the drawing as best they can (but don't show them the image). You may repeat each instruction once only. Do not let participants ask questions or make comments; they should draw in silence. Do not show the image to participants. Do not let participants look at each other's drawings.

Instructions to Give Participants on How to Draw the Bug

- The bug is round.
- The bug has 8 legs, grouped in pairs, with 4 legs on the left and 4 legs on the right. In the pairs, one leg is longer than the other.
- The bug has 2 eyes on top of the body.
- The bug has 2 squiggly antennas.
- The bug has 2 pea-pod shaped wings.
- The bug has a spot next to each wing.
- The bug has a triangular stinger on the bottom of its body.
- The bug has 2 feelers on each foot, one longer than the other and both coming from the same side of the leg.
- The bug has a round mouth, placed between the 2 eyes.
- The bug laid 5 square eggs to the left of the stinger.

[1] If you distribute the entire lesson to participants, consider changing the diagram and instructions so they will not have seen it already.

5e. After you have finished giving instructions for the drawing, DO NOT show participants the original drawing yet. Lead a brief discussion by asking:

- How close do you think your drawings are to the original drawing?
- How did you feel not being allowed to see the original drawing or ask any questions?

5f. Tell the participants: You can now ask me a few questions to clarify the drawing instructions and to make some changes to your drawing, if you think it's necessary. Spend about 5 minutes doing this.

5g. When participants have finished improving their drawings, show the large drawing you prepared. Ask participants to hold up their drawings so everyone can see them.

5h. Ask participants the following questions and encourage a brief discussion.

- Which of these drawings are most similar to the original drawing?
- For people whose drawings are the most similar to the original: How did you do this?
- For everyone: What helped you the most as you were drawing?
- What was frustrating or unhelpful as you were drawing?
- How did it help to be able to ask clarifying questions?
- What did you learn from this exercise?

5i. Tell participants: You have just practiced two of the listening techniques: "listening without responding" and "asking clarifying questions." Both listening techniques are useful. While listening without responding can be effective, asking questions for clarification often helps you better understand what someone is saying to you. Knowing when to pose questions and which questions to ask also are important skills.

5j. Tell participants: Now we will practice "listening and reformulating." This is the most challenging listening technique. Let's review what we mean by reformulating.

5k. Divide the group in half and ask the two smaller groups to sit in two circles so that all the group members are able to see and hear each other easily. Ask participants to listen carefully. Explain the exercise: Both small groups will discuss an assigned topic (select a mildly controversial topic that everyone should have an opinion about and consider asking some people to take a position opposite to their true opinion to assure a more lively discussion). Everyone should participate in the discussion, but there is no prescribed order. Both small group discussions will happen simultaneously. One group member will start the discussion by expressing an idea or opinion about the topic. Before a second person can respond or contribute his/her own idea, he/she first has to reformulate or summarize what the first person said. It's important when reformulating to avoid simply repeating what the first person has said; the idea should be expressed in different words. The first person has to be satisfied that his/her idea

has been reformulated accurately. Only then can the second person contribute his/her own ideas. A third person reformulates the second person's idea, then adds his/her own idea. Continue the discussion in this way. Everyone should participate in the discussion. You will continue the discussion until everyone has had a chance to speak, or until time is up.

5l. Tell participants: You have just practiced the third listening technique: "listening and reformulating." This kind of listening is also sometimes called "reflective listening." This has several purposes: it can help the listener be sure they understand correctly and it helps the speaker feel heard and understood. This can be especially helpful when dealing with difficult or controversial topics or when settling disputes and can help build trust and mutual respect.

6. Open-Ended and Closed Questions (1 hour)

6a. Explain to participants: In order to start a discussion with a mother or to understand the concerns of a farmer, you need to ask some questions. It is important to ask questions in a way that encourages people to talk with you and share more information. This helps you learn more in the time available. Two types of questions that we commonly use are open-ended and closed. Does anyone know the difference between these types of questions? (Answers: Closed questions can usually be answered by a "yes" or "no" answer or are limited to a short list of answers, and open-ended questions allow for the respondent to form a response on his/her own that is usually fuller and tells more about the respondent's opinions.)

6b. Add:

- Open-ended questions are usually the most helpful if you want to start a discussion. To answer them, a person must give you some information. Open-ended questions usually start with "How? What? When? Where?" For example, "How are you feeding your baby?" "What helps you decide when to sell your harvest?"
- Closed questions are usually less helpful to start a discussion. They usually lead to shorter, more limited answers, such as a "Yes" or "No." Closed questions usually start with words like "Are you…?" or "Did you…?" For example: "Did you breastfeed your last baby?" If a mother says "Yes" to this question, you still don't know if she only breastfed or if she also used other kinds of food.

6c. Tell participants: Now we are going to practice creating open-ended and closed questions.

6d. Pass out a note card or small piece of paper to each participant. Ask each participant to write one closed question on the card. Collect the cards and redistribute them. Then ask each participant to reformulate the closed question into an open-ended

question and write the open-ended question on the other side of the card. When everyone has finished, go around the room and ask each participant to read the closed question and the way he/she reformulated it. Check for understanding. Potential closed questions and their reformulated counterparts are listed below.

Potential Closed Questions	Reformulated Open-Ended Questions
Does your baby sleep with you?	Where does your baby sleep?
Have grain banks helped your community?	How have grain banks affected families in your community?
Does your baby eat porridge?	What kinds of foods does your baby like to eat?
Do you give fruit to your child often?	How often does your child eat fruits?
Does your family drink river water?	Where are some places you can get water for your family?
Is your baby vaccinated?	What vaccinations has your baby received?
Do you know how to prevent malaria?	What have you heard about preventing malaria?

6e. Distribute **Lesson 1 Handout 7: Open-Ended and Closed Questions**. Let participants know which option will be used (Option 1, Option 2, or another example that you prepared in advance). Ask volunteers to read the words of the community member in each demonstration while you read the part of the BCA. After each demonstration, comment on what the BCA learned.

- Discuss Demonstration A by asking:
  - What happened in the role play? (Answers include: the BCA got "yes" and "no" for answers and didn't learn much, it can be difficult to know what to say next.)
  - What kind of information did the BCA get from the person? How much information, and what type? (Answers include: the person answered "yes" or "no" only, the BCA got limited information.)
  - Why did this happen? (Answers include: the BCA did not ask questions that encouraged the person to give more information.)
  - How helpful was this conversation for the Behavior Change Agent and for the person? (Answers include: probably not that helpful, the BCA got limited information, the person did not learn anything.)
- Discuss Demonstration B by asking:
  - What happened in the role play? (Answers include: the BCA started a more open dialogue, more information was shared).

- What kind of information did the Behavior Change Agent get from the person? How much information and what type? (Answers include: the BCA asked open-ended questions, the person could not answer with only a "yes" or a "no," the person had to give some information, the BCA learned much more.)
- Why did this happen? (Answers include: the BCA asked questions that encouraged the person to give more information.)
- How helpful was this conversation for the Behavior Change Agent and for the person? (Answers include: probably more helpful, the BCA learned more about the person.)

7. Wrap Up (5 minutes)

   7a. Wrap up this activity by asking participants what they learned about good communication. Ask them which communication skills they plan to practice during the next week and how they think those skills might improve their work in the community.

Lesson 1 Handout 1: Good Communication

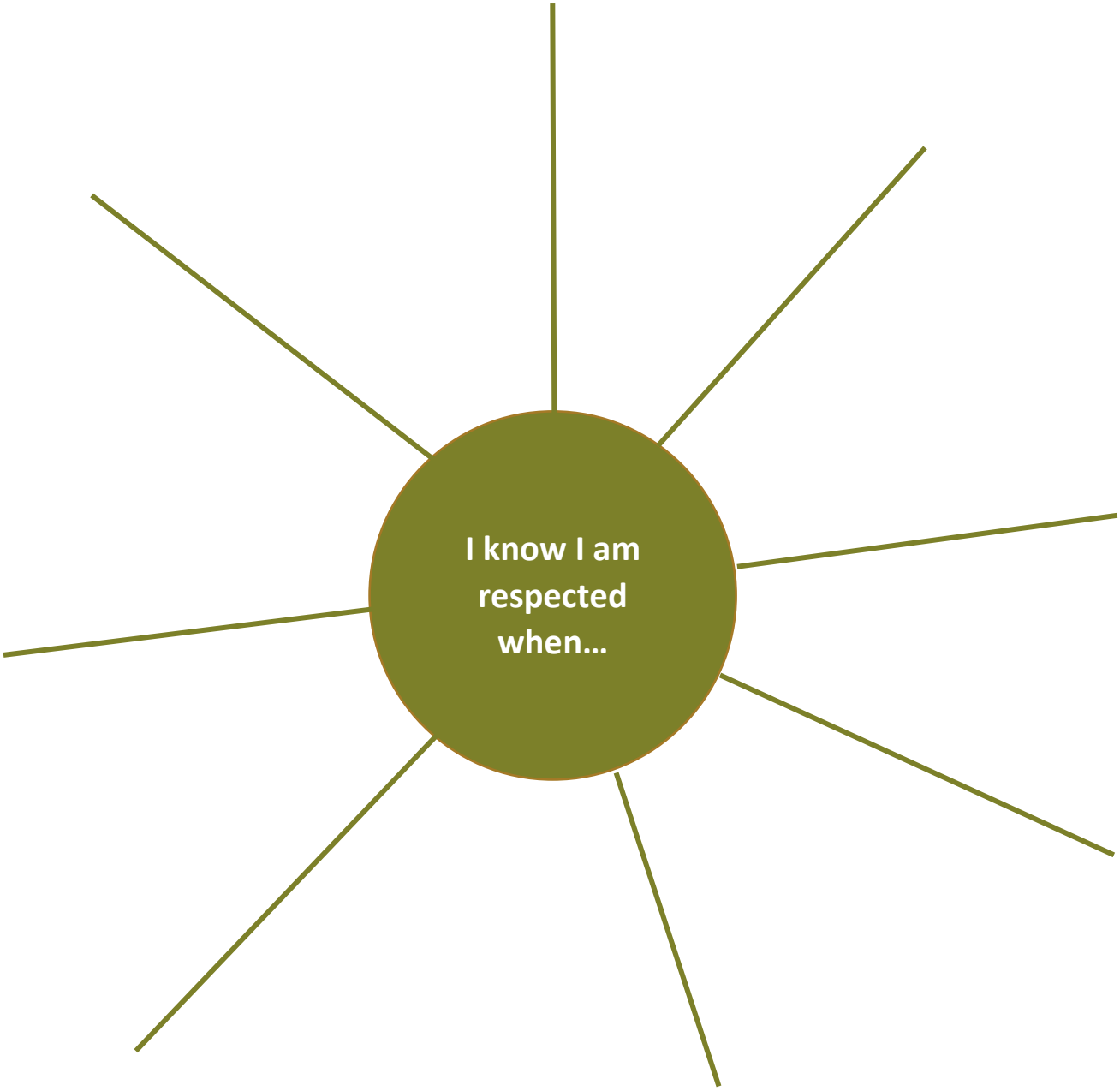
What is “good communication”?

Good communication occurs when a message is sent by one person and received and understood by another person(s), and both parties feel that they have been understood.

Which communication skills does a Behavior Change Agent need?

- Show respect for people.
- Explain things clearly.
- Ask questions to make sure people understand.
- Ask open-ended questions and promote dialogue.
- Learn about and acknowledge people’s ideas and realities.
- Ask about people’s experiences and opinions, and build on them.
- Listen carefully and actively to what people tell you, and show that you understand.
- Observe people’s expressions and body language to see how well you are communicating.
- Have accurate technical knowledge and be honest when you don’t know an answer.
- Shape what you are saying to the person’s situation and reality.
- Do not scold, lecture, or dictate to people.
- Act as a resource, not an authority.
- Be culturally sensitive.
- Be honest about what you can and cannot do.

Lesson 1 Handout 2: Respect Wheel



Lesson 1 Handout 3: Showing Respect

- Create ways to get to know individual family members and for them to get to know you. Learn the names of all family members and always call people by name.
- Learn about each family's life and show your understanding of their difficulties and challenges.
- If it is normal for this culture, look at people when you speak with them.
- Listen carefully and thoughtfully.
- Communicate with people one-on-one (not only in large groups).
- Encourage people to share their ideas and opinions.
- Listen to people's ideas, and give people a chance to discover their own answers and insights.
- Ask open-ended questions about what people already know about the topic you are communicating.
- Show you understand people's knowledge and the positive, healthy behaviors they already are using.
- Ask open-ended questions so that you can learn about and better understand each family's situation and life.
- Encourage people to ask questions and answer them to the best of your ability. If you don't know the answer to a question, say that you do not know but will find out.
- When sharing new information, find out what people already know about the topic and sensitively add information.

Lesson 1 Handout 4: Listening Role Plays

Role Play 1: Listen without Responding

Instructions: The two actors should sit facing each other. The role play should last 1–2 minutes.

Speaker: Tell the listener about someone you know who was sick and what happened to him/her.

Listener: While the speaker is talking, just listen. You will not respond or ask questions, but (if culturally appropriate) you will maintain eye contact with the speaker in a friendly way. Nod and say things like "uh-huh," "hmm," and "yes" (sounds of encouragement) from time to time, when appropriate.

Role Play 2: Ask Clarifying Questions

Instructions: The two actors should sit beside each other, not necessarily face to face, but close. The listener is a BCA who has just met a new contact in a new community. The role play should last 1–2 minutes.

Speaker (community member): We've had agriculture extension agents do demonstration plots here in the past.

Listener (BCA): Ok, who did they work with?

Speaker: Mostly with the school, I think.

Listener: How did it go?

Speaker: Ok. I think the children enjoyed it.

Listener: What did the community think of the project?

Speaker: They thought it was nice that someone wanted to work with the school.

Listener: Who could I talk with at the school if we wanted to do another demonstration, at the school, or with other people in the community?

Speaker: You could talk with the teacher on Monday, or come to the village council meeting next month.

Listener: Ok, great!

Role Play 3: Listen and Reformulate

Instructions: The two actors should sit beside each other, not necessarily face to face, but close. The speaker should explain his/her opinion about the services he/she received at the health center. The listener should respond by summarizing and restating the speaker's ideas. The actors should follow this script or create something similar.

Speaker: I can't believe what happened at the health center today! When I arrived at 8:30 there were already 10 women waiting for their prenatal consultations. I know we usually have to wait, but today it was ridiculous!

Listener: Hmm. Sounds like you had a rough day.

Speaker: Yes. And, after I arrived several other women arrived and we were about 20 altogether, and no one was attending us. We waited until about 11:00 and no one ever arrived, no staff at all! Finally, just as I was getting ready to go home, the cleaning lady came and told us that the nurse had to take a woman in labor to the hospital for an emergency. I wish I'd known that earlier in the day. What a waste of my time.

Listener: It sounds like you are really frustrated because you had to wait a long time. And, you didn't appreciate being made to wait. It sounds to me like you wish someone had left a note or somehow notified all the women coming for their prenatal visits so you would know not to wait, then it wouldn't have been such a waste of your time.

Speaker: That's right!

Lesson 1 Handout 5: Listening Techniques

1. Listen without Responding

The listener uses only non-verbal communication (eye contact, nodding the head, open posture) and brief responses ("uh huh," "yes," "umm") to show interest and to encourage the speaker to continue speaking.

The listener avoids gestures that communicate boredom, like checking his/her watch, drumming his/her fingers, or signs of impatience to get to the point.

This technique encourages the speaker to speak freely and express his/her ideas.

2. Ask Clarifying Questions

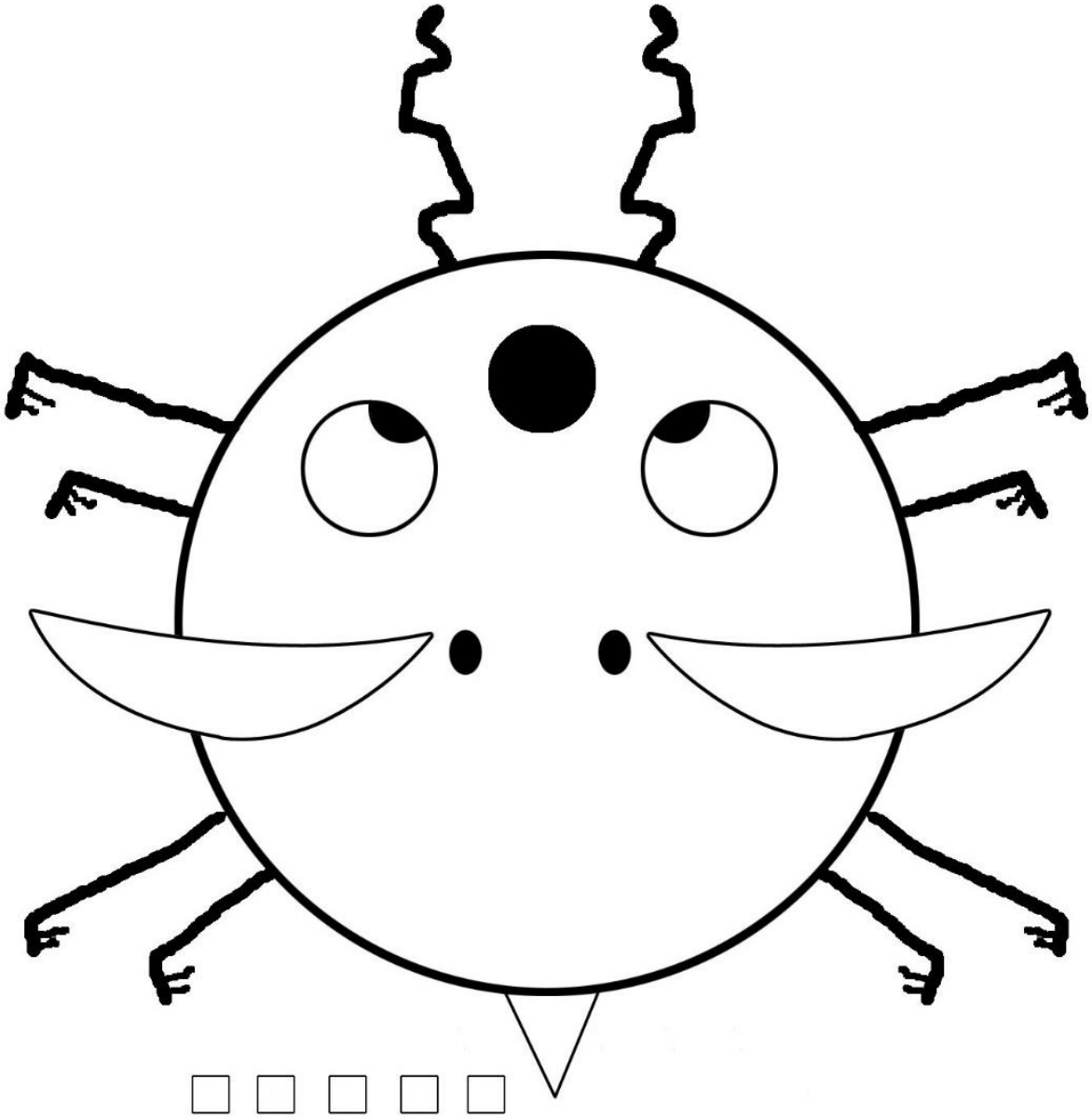
The listener asks specific questions of the speaker to clarify what the speaker is saying.

This technique helps the listener get more information about the situation in order to understand the speaker well. It helps the speaker to consider all aspects of the situation or topic by answering questions related to his/her ideas. This technique also can help the speaker and listener evaluate alternatives and possible solutions.

3. Listen and Reformulate

The listener restates in his/her own words what he/she understood the speaker to have said. The listener can use reframing statements to reformulate, such as "it's like you're saying," "what I hear you saying is," or "so if I understand you correctly." This technique helps the listener ensure that he/she understood what the speaker said. It also allows the speaker to clarify anything that the listener did not understand because he/she can hear ideas repeated back in summary form and the listener will allow the speaker to correct his/her understanding.

Lesson 1 Handout 6: Drawing to Practice Listening



Lesson 1 Handout 7: Open-Ended and Closed Questions

Option 1: Breastfeeding

Demonstration A: Closed Questions to which the Mother (Mary) can Answer "Yes" or "No"

BCA: Good morning, Mary. I am Martha, the Community Health Worker. Is Peter well?

Mary: Yes, thank you.

BCA: Are you breastfeeding him?

Mary: Yes.

BCA: Are you having any difficulties?

Mary: No.

BCA: Is he breastfeeding very often?

Mary: Yes.

Demonstration B: Open-Ended Questions

BCA: Good morning, Mary. I am Martha, the Community Health Worker. How is Peter doing?

Mary: He is well, and he is very hungry.

BCA: Tell me, how are you feeding him?

Mary: He is breastfeeding. I just have to give him one bottle in the evening.

BCA: What made you decide to do that?

Mary: He cries more at that time of day, so I thought my milk is not enough.

Option 2: Village Savings and Loans Association (VSLA)

Demonstration A: Closed Questions to which the Community Member (Mary) can Answer "Yes" or "No"

BCA: Good morning, Mary. I'm Martha, a member of the village savings and loans association. Have you heard about the association?

Mary: Yes, thank you.

BCA: Can you come to our meeting tomorrow?

Mary: No, I can't.

BCA: Do you think you'd like to come to one in the future?

Mary: Maybe.

BCA: Do you have any questions about the association?

Mary: Not right now, thank you.

Demonstration B: Open-Ended Questions

BCA: I'm Martha, a member of the village savings and loans association. What have you heard about the association?

Mary: That people can borrow money from you for projects.

BCA: That's right. How do you think being part of a VSLA might help you and your family?

Mary: I'm not sure. I don't know much about how it all works.

BCA: How would you feel about coming to our next meeting, just to meet some of the group members and see how it works for them?

Mary: That would be nice, but I'm very busy with chores and the children.

BCA: I understand. A lot of our members are very busy, too. We keep our meetings brief to respect everyone's time. What time of day works for you?

Mary: In the afternoon, usually.

Lesson 2: Empathy: Understanding the Perspective of Another

Achievement-Based Objectives

By the end of this lesson, participants will have:

- Explained the basic definition of empathy
- Shared experience of showing empathy/feeling empathy
- Shared an example of a work situation when empathy was/could have been useful
- Practiced naming emotion
- Discussed the importance of properly expressing emotion and accepting difference
- Reviewed reflective listening

Duration

2 hours 20 minutes

Materials

- Flip chart, index cards, and markers
- Lesson 2 Handout 1: The Definition of Empathy (1 copy per participant)
- Lesson 2 Handout 2: Four Skills for Improving Empathy (1 copy per participant)
- Lesson 2 Handout 3: Smiley-Face Feeling Guide (1 copy for each group of 4–5 people)

Why this Lesson?

Empathy has been found to be a facilitator of behavior change.[2] Developing empathy improves a Behavior Change Agent (BCA)'s relationship with community members and increases his/her ability to work with them to address barriers to behavior change.

Advanced Preparation

Throughout this manual, the term Behavior Change Agent (BCA) is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, or peer educator).

If you will use photographs instead of the **Lesson 2 Handout 3: Smiley-Face Feeling Guide**, choose some in advance so they are ready when it's time to present them.

[2] Clark, et al. 2013. Facilitators and barriers to initiating change in medical intensive care unit survivors with alcohol use disorders: A qualitative study. *Journal of Critical Care* 28(5): 849–856. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23876701

Tasks

1. Warm-Up Activity (15 minutes)

    1a. Conduct a beginning exercise that allows the participants to get to know each other a little better.

    1b. For example, "two similarities and one difference": Ask participants to form groups of three people who don't know each other well. They should talk together and find two interesting things they all have in common and one thing that is different or unique to each person in the group. Give them about 5 minutes to discover their similarities and differences, then ask each group to share with the larger group.

    1c. Thank the participants for sharing and facilitate a brief discussion based on the following questions.

    - What kinds of questions did you ask to find out your similarities and differences?
    - How does exploring these kinds of things improve our relationships with others?

2. Defining Empathy (15 minutes)

    2a. Explain to participants that today's session will focus on a relationship skill called "empathy." Start the discussion with the following: What does "empathy" mean to you? You can give your personal definition or tell us about other words that remind you of empathy or that are similar to empathy.

    2b. After several participants share their ideas, summarize and discuss the definitions. If the participants' input has not covered the following definition, share it with participants: the ability to see and understand from the perspective of another.

    2c. Refer participants to **Lesson 2 Handout 1: The Definition of Empathy**. Ask a volunteer to read the definition out loud, and ask the group for their comments or any additions.

    2d. Explain that people often confuse empathy with sympathy. Review the differences and discuss. Ask participants to find the local words for both empathy and sympathy and record them (or ask a participant to record them) on flip chart paper. Post these words (in the local languages or vocabulary) in a visible spot in the room.

3. Exploring Personal Experiences with Empathy (30 minutes)

    3a. Explain to participants: Now that we've defined the word "empathy," let's see how it applies to our own lives. Please think for a minute about a time in your own life when you showed empathy to someone else or when someone empathized with you.

    As facilitator, you may want to first share a personal example that is simple and clear (for example: "My sister was really nervous because she was going to give a

presentation to the village health committee, with her supervisor there at the meeting. I used to get very anxious when I had to speak in public, and I know it can be extra stressful when you want to do well in front of a supervisor. So I talked with her about it to try to understand how she was feeling and to let her know I care.")

3b. Put the participants in pairs and ask them to share their experience with their partner.

3c. After a few minutes and while the participants are still in pairs, say: Now think of a time when someone did NOT show you empathy.

3d. Ask participants to share their example with their partner. Encourage them to choose an example that is personal but that they feel comfortable sharing with the group. Note that the example does not need to be sensitive or private. For example: "Last week, I had a hard time keeping up at work because I was sick, and one of my coworkers didn't care that I wasn't feeling well, and was rude to me about not getting all my work done."

3e. Ask the group to come together and share any particularly interesting stories they heard. If needed, ask:

- What do you remember feeling when you were in the situation where someone did not show you empathy?
- How was that different from the feelings you had in the first situation, when you were shown empathy?
- How did you react? What did you do in your situation?

3f. Ask participants to think about their personal experiences with empathy. Then ask participants the following questions and write their answers on a flip chart.

- In what ways would showing empathy help a Behavior Change Agent be more effective? (Answers could include: when people feel they are being empathized with, they are more likely to listen to suggestions; when a BCA is empathetic, he/she is more likely to understand the barriers to behavior change and is better able to help the person to adopt a new behavior)

- If a Behavior Change Agent is not empathetic, how will that likely affect his/her work? (Answers could include: people may not like that BCA; people won't listen to, trust, or follow the BCA's suggestions; the BCA may feel frustration from not being able to understand situations from the perspectives of community members)

3g. Summarize the discussion by reading the following:

> **Why is empathy important?**
>
> Developing empathy improves a BCA's relationship with community members and increases his/her ability to understand and work through barriers to behavior change, while also learning more about why the person might want to change.

4. How to Build Empathy (15 minutes)

4a. Tell participants: Now that we've recognized the importance of empathy, we are going to learn how to build our skills in empathy. Just as people cannot become good at football without practice, it is difficult to see from another's perspective without practice. However, we all are capable of empathy!

4b. Pass out **Lesson 2 Handout 2: Four Skills for Improving Empathy**. Ask volunteers to read aloud each section of the handout. Explain that in the remainder of the lesson they will gain skills in each of these areas.

5. The Ability to Read Emotion (30 minutes)

5a. Tell participants that to communicate effectively they need to be able to understand how someone is feeling. Divide participants into groups of three or four people, and ask each group to draw a couple of faces from **Lesson 2 Handout 3: Smiley-Face Feeling Guide** on flip chart paper, or use a few photographs of people with easy to understand expressions. For each face, ask participants: How do you think this person is feeling? How did you know what the person is feeling?

5b. Tell participants: Name some signs of emotion that help us know what people are feeling. Signs of emotion can be spoken, including both the words someone uses and how he/she says them. We also can see emotion through facial expressions and body language. For example, someone with his/her arms crossed may be feeling defensive or uncomfortable. Are there any additional signs that we should look for? (Allow participants to provide some answers.)

5c. Explain that experienced facilitators often read participants' body language during a training session to see whether participants are bored, frustrated, interested, needing a break, and more. Having an idea of how the group is doing helps enhance the facilitator's efficacy.

5d. Ask a few volunteers (or all of the participants) to quickly strike a pose to demonstrate with body language an emotion that they have felt in a training session. Then you, the facilitator, must try to name as many emotions as you can. This activity should take one or two minutes and can bring a few laughs. If the group has trouble with this or

participants are shy, you can reverse the activity and, as facilitator, demonstrate several emotions (e.g., cross your arms and look defensive, rest your head in your hands and look tired, look eager and wave your hand as if you want to ask a question, scratch your head and look puzzled) while participants try to read your body language.

Tell the group: An effective Behavior Change Agent is alert to both body language and speech and will change his/her approach based on his/her interpretation of those signs; this is one way a Behavior Change Agent can demonstrate empathy.

5e. Ask participants: What are some emotions that you might encounter while working in the community?

As the participants share their answers, write them on individual index cards. If a participant repeats a previously shared answer, you can still write it on an index card. Ask participants to share until you have at least one card for each participant.

5f. Give each participant a card with an emotion written on it. Ask participants to take turns acting out that emotion. As each participant acts out the emotion, the audience participants should guess what the emotion is.

5g. Explain that being able to "read" emotions requires BCAs to pay careful attention.

6. Appropriately Expressing Emotion (15 minutes)

6a. Tell participants: The beneficiaries are not the only people that feel a range of emotions. We are people too, just like the community members. To be effective BCAs, we must learn how to appropriately express our own emotions.

6b. Ask participants the following questions and record their answers on the flip chart.

- What are some emotions you often feel during your work? (Answers could include: happy, frustrated, sad, excited, tired.)
- What are some appropriate ways to express these emotions? (Answers may include: Use "I" statements; take a deep breath, which is helpful because it gives us extra time to relax ourselves and not respond right away when we are feeling angry or frustrated.)

  Note: After each new answer to this question, ask the participant to explain why the action is helpful.

6c. Ask participants: Now let's compare our list to the list in Handout 1. Is anything missing? If any of the items from the handout are missing from the new list, add them to the flip chart.

7. Listening and Reformulating (5 minutes)

    7a. Tell participants: In Lesson 1 you learned about different ways of listening. One of them is called “listening and reformulating.” Can anyone remind us what that is? (Answer: Reformulating is when you summarize or restate in your own words what a person has said to you. It is important not to simply repeat what the person has said, but to say the idea in your own words.)

    7b. Ask participants: Why do you think this is an important part of empathy? (A possible answer: You need to understand what someone is saying if you want to understand his/her perspective.) Great! Listening and reformulating skills are very important for developing and showing empathy.

8. Accepting Differences (5 minutes)

    8a. Ask participants: What might we do when you simply don’t agree with the other person’s perspective? (Take a few responses.)

    8b. Tell participants: This of course happens to all of us, but as Behavior Change Agents, we want to be able to respond professionally, without damaging the relationships we are building with community members. It is important to remember that we should focus on the behavior that we are trying to change, but not pass judgment on other individuals. Throughout your training, you will learn creative and effective ways to help people change their behavior even when your perspective may be different from theirs.

9. Wrap Up (10 minutes)

    9a. Tell participants that to wrap up this lesson on empathy, you’d like to hear from them ways they can use empathy in their work next week. Give them a few minutes to share answers with the group.

    9b. Tell participants: I encourage you to check in with each other next week to see how well you did with using empathy and if it was helpful.

Lesson 2 Handout 1: The Definition of Empathy

What is "empathy?"

Empathy is the ability to:

- See and understand the perspective of another person
- Put yourself in his/her shoes (or imagine what it would be like to be in his/her situation)
- Understand the emotions and thoughts of another person

What is the difference between "empathy" and "sympathy?"

- Empathy is a stronger emotional feeling, where the on-looker shares the emotional state (e.g., distress, sadness, glee) of the other person as if it was his/her own feeling.
- Sympathy is the recognition, perception, understanding of, and reaction to an emotional state or need of another person.

	Empathy	Sympathy
Definition	Understanding what others are feeling because you have experienced it yourself or can put yourself in their shoes	Acknowledging another person's emotional hardships and providing comfort and assurance
Example	I know it's not easy to lose weight because I have faced similar problems myself	When people try to make changes like this (such as, lose some weight) at first it seems difficult
Relationship	Personal	Friends, family, and community (the experience of others)
Healthcare context	Relating with your patient because you have been in a similar situation or experience	Comforting your patient or his/her family

Lesson 2 Handout 2: Four Skills for Improving Empathy

1. Ability to Read Emotion

- Pay close attention to:
  - Words spoken
  - Verbal tone
  - Facial expressions
  - Body language

2. Ability to Appropriately Express Emotion

- Use "I" statements, not "You" statements (e.g., I feel worried that you haven't been coming to the clinic," not "You didn't come to the clinic").
- Recognize negative emotions and use control methods.
  - Take a deep breath, breathe slowly.
  - When you know your advice will create difficulties for your clients, begin with an empathetic statement that shows you understand their feelings. Then explain why the change you are suggesting is important and the reason for it. (For example: I realize it's hard to walk two miles to the clinic. I can understand why you would rather just go to the corner store. But it's important that you only get the real medicine they give at the clinic because the store medicine won't work.)
  - Leave the situation if necessary (for example, if you are getting angry and feel you won't be able to express your emotions appropriately at that moment).

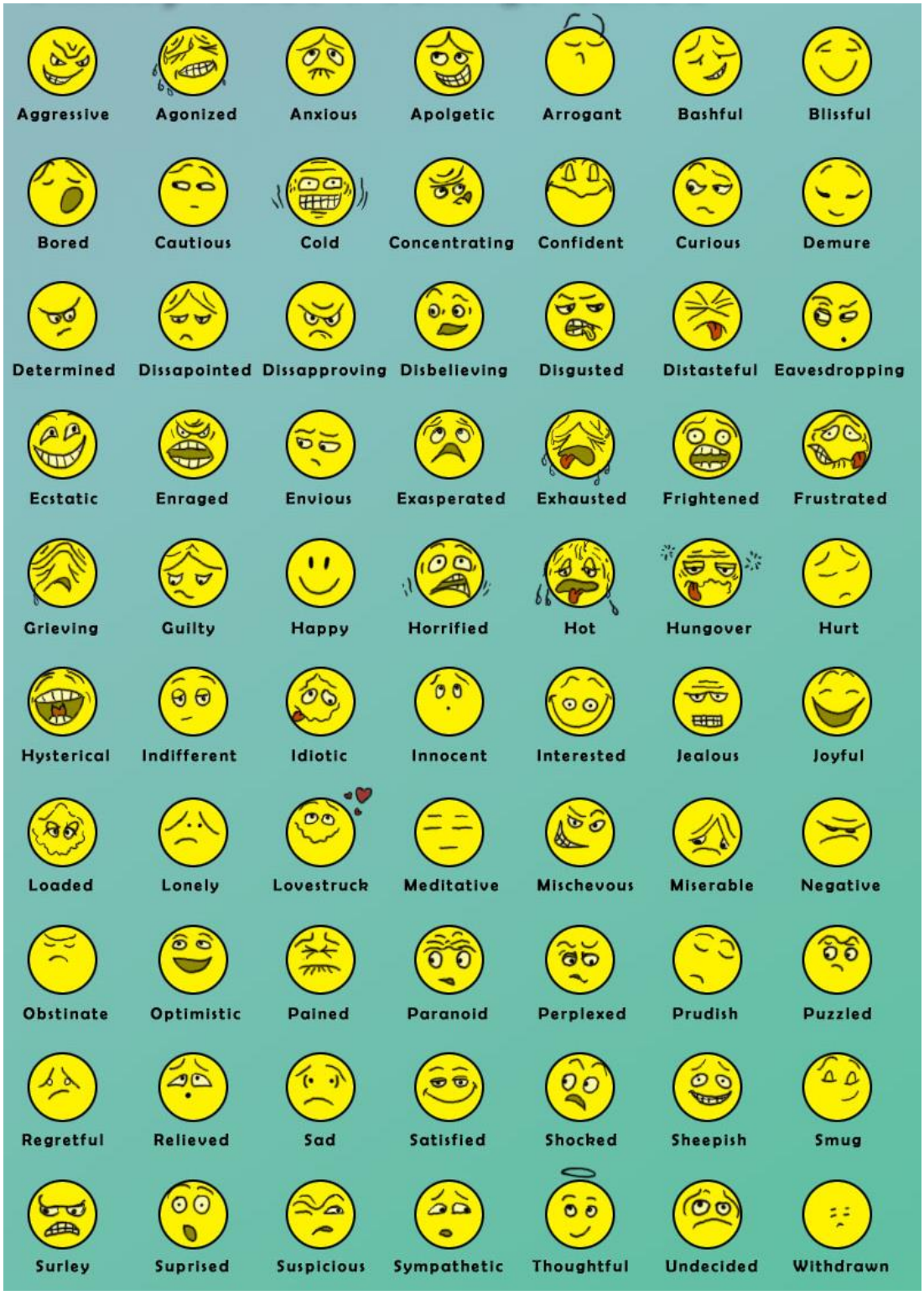
3. Ability to Listen Effectively

- Use listening and reformulating skills (i.e., restate or summarize in your own words what you've heard, for example "So, I want to make sure I understand: you are feeling frustrated about this because you don't have enough time," "What I hear you saying is that…").

4. Accept Differences

- Remember that you are trying to change the behavior, not the person.
- Explore how behavior change is possible while accepting differences of opinion or belief.
- Ask questions to understand the differences in approaches and what is or could be a motivator for them to change behavior.

Lesson 2 Handout 3: Smiley-Face Feelings Guide



Lesson 3: Negotiated Behavior Change[3]

Achievement-Based Objectives

By the end of this lesson, participants will have:

- Defined the word "negotiate"
- Explained why skills in Negotiated Behavior Change would be useful for a Behavior Change Agent (BCA)
- Identified the steps in Negotiated Behavior Change
- Practiced negotiating a behavior change with a familiar scenario about a relevant topic
- Critiqued their own skills in Negotiated Behavior Change
- Critiqued a fellow participant's skills in Negotiated Behavior Change

Duration

2.5 to 3.5 hours

Materials

- Flip chart paper, markers, and masking tape
- Pre-written flip chart paper with the list of ideal behaviors being promoted by participants
- Pre-written flip chart paper with the steps of the Negotiated Behavior Change process
- Lesson 3 Handout 1: Negotiated Behavior Change (1 copy per participant)
- Lesson 3 Handout 2: Role Play Dialogues: Negotiated Behavior Change (or adaptation; 2 copies)
- Lesson 3 Handout 3: Illustrations of the Steps in the Process of Negotiated Behavior Change (1 set for each group of 4–5 participants)
- Lesson 3 Handout 4: Steps in the Process of Negotiated Behavior Change (1 copy per participant)
- Lesson 3 Handout 5: Role Play Scenarios (1 copy, with scenarios cut apart)
- Lesson 3 Handout 6: Observation Checklist (1 copy per participant)

Why this Lesson?

In the process of adopting a new behavior people often encounter personal challenges (difficulties, barriers, or obstacles). Behavior Change Agents (BCAs) can learn to help their target audience overcome these obstacles by learning Negotiated Behavior Change skills.

[3] Note to Trainers: Participants in this lesson would benefit from already having been trained in good communication skills (listening, open-ended questions, respect, and empathy). Furthermore, trainers might like to choose between this lesson and Lesson 5: Home Visits/Individual Counseling, since they teach the same method for changing behavior.

Advanced Preparation

Throughout this manual, the term Behavior Change Agent (BCA) is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

If the BCAs promote a set of "ideal behaviors" or "Essential Actions" (such as Essential Nutrition Actions or Essential Hygiene Actions) as part of the project/program, list these behaviors on flip chart paper for use with the introduction to ideal behaviors in Step 2a.

Choose two volunteers to do a role play and ask them to practice ahead of time using one of the scripts in **Lesson 3 Handout 2: Role Play Dialogue: Negotiated Behavior Change**. Option A is a role play about exclusive breastfeeding. Option B focuses on incorporating fish from personal fishponds into the family diet. These role plays can be changed by the facilitator in advance to include information and behaviors that are more relevant to the local situation and the BCAs' work in the community. Make sure that each of the eight steps in the process of Negotiated Behavior Change, which are listed in the subheadings of the role play dialogue in Lesson 3 Handout 2, are clearly demonstrated in the role play.

On flip chart paper, prepare a list of the keywords from **Lesson 3 Handout 3: Steps in the Process of Negotiated Behavior Change** (Greet, Ask, Listen, Identify, Discuss, Recommend and Negotiate, Agree, Appointment).

Copy and cut out the large illustrations in **Lesson 3 Handout 4: Illustrations in the Steps in the Process of Negotiated Behavior Change**. There is one set of illustrations featuring women and another set featuring men. Facilitators should make additional copies as needed (one set of illustrations featuring either men or women is needed for each small group of four to five participants).

Read and select appropriate role play topics from **Lesson 3 Handout 5: Role Play Scenarios**. For some groups, the facilitator might need to write new scenarios that are more relevant to the BCAs' work.

Tasks

1. Warm-Up Activity (20 minutes)

    1a. Explain to participants: One of a Behavior Change Agent's most important tasks is to increase behaviors that we know will help community members be healthier. So, today we will learn about and practice a skill that we can use to help people work through personal obstacles to change.

1b. Explain that they will start the lesson with a quick activity to help "put themselves in the shoes" of community members. Conduct an exercise that allows participants to share some behavior changes that they are working on in their own lives.

For example, you can play "two truths and a lie," where participants think of two behaviors that they are currently trying to change and one that they are not currently working on. Then they share their three behaviors with the other participants, who try to guess which two are truths and which is a lie. (For example, "I am trying to eat a fruit and a vegetable with every meal" [truth]; "I'm taking acrobat lessons to get more exercise" [lie]; "I'm trying to not text on my phone when I'm with my family" [truth]). Encourage participants to have fun with the activity.

2. Ideal and Next Best Behaviors (20 minutes)

2a. Explain to participants that some of the behaviors they just shared could be described as "ideal behaviors," or actions that we consider the most beneficial for reaching a certain goal. Ask participants to share some of the ideal behaviors that they promote in their work as BCAs. (If the participants work with a program-specific set of "Essential Actions" or ideal behaviors, share the flip chart list that you prepared in advance.)

2b. Ask participants: Is it always possible or easy for community members to practice the ideal behavior? (They should answer "no." If they don't, remind them to think of their own potential barriers to practicing the behaviors they mentioned during the first exercise).

2c. Ask participants: What are some of the reasons that community members might not do the ideal behavior? (Answers could include: no way to get the materials they need, cultural taboos, fear of bad results, difficulty remembering how/when to do the behavior, religious views, fear of bad effects from doing the behavior, thinking the danger isn't likely to happen to them, thinking the danger isn't serious)

2d. Ask participants: When mothers or other community members have trouble changing their behavior, what is the role of the Behavior Change Agent? (They should answer: to help the person find ways to overcome the difficulties.)

Explain that one way to overcome difficulties is called Negotiated Behavior Change.

2e. Explain to participants: Before you can use the Negotiated Behavior Change approach, you need to know two things: What is the ideal behavior? What would be a next best behavior that the person could try out, or a behavior that is "on the way" to using the ideal behavior? Sometimes this can be a similar behavior, but done less often or using lower amounts, etc.

- Referring to the flip chart of ideal behaviors, ask participants to write down what they think would be next best behaviors for each of the ideal behaviors shown on the flip chart.

- Ask trainees to share their ideas and discuss. Come to an agreement about the next best behaviors.

3. Definition and Advantages of Negotiated Behavior Change (20 minutes)

   3a. Ask the group if they have ever heard of Negotiation for Behavior Change. Ask them to think about what this might mean.

   3b. Read out loud and discuss briefly the definition of the approach found in **Lesson 3 Handout 1: Negotiated Behavior Change**. Take questions.

   3c. Divide participants into small groups of four or five and ask them to discuss and make a list of what they think the advantages of Negotiated Behavior Change might be. Give them a few minutes to do this, then ask each group to share a few examples. Write these responses on flip chart paper.

   3d. Distribute a copy of **Lesson 3 Handout 1: Negotiated Behavior Change** to the participants and ask them to compare the advantages list they made to the list found in the handout. Ask them to add to the handout any ideas on their list that they think are important.

4. Naming the Steps in Negotiation (30 minutes)

   4a. Explain to participants: You are now going to watch a role play that shows the steps in Negotiated Behavior Change.

   4b. Ask the previously chosen volunteers to perform one of the role plays found in **Lesson 3 Handout 2: Role Play Dialogues: Negotiated Behavior Change** (or the adaptation that was prepared in advance). Make sure that each of the eight steps in the process of Negotiated Behavior Change, which are listed in the subheadings of the role play dialogue in Lesson 3 Handout 2, are clearly demonstrated in the role play.

   4c. After the role play is done, ask participants to tell you what they saw, including: What happened first? Then what happened? Show the flip chart list of steps that you prepared in advance (using **Lesson 3 Handout 4: Steps in the Process of Negotiated Behavior Change** as a guide). Ask participants if they saw all these steps in the role play.

   4d. Ask that participants return to their small groups. Provide each small group with a set of the illustrations from **Lesson 3 Handout 3: Illustrations of the Steps in the Negotiated Behavior Change Process**. Ask each group to arrange the pictures in order,

according to the list of steps on the flip chart (and without looking at Lesson 3 Handout 4).

4e. Once participants are done arranging the pictures in order, distribute a copy of **Lesson 3 Handout 4: Steps in the Process of Negotiated Behavior Change** to each participant and ask each group to compare their order with that in the handout.

Point out that some people find images useful as reminders of the steps in a process. Encourage participants to review the illustrations and/or written descriptions for each step as they continue with this lesson.

4f. Explain to and ask participants: In the negotiation process there needs to be at least one follow up visit. What do you think is the purpose of the follow-up visit? (Answers could include: to see if the mother/person has tried the behavior change and what the results were, to see if the obstacle has been overcome; to find other behaviors that the mother/person might need to adopt.) During the follow-up visit, the Behavior Change Agent should follow the same Negotiated Behavior Change process, only this time the Behavior Change Agent asks about the agreed-upon behavior first and goes on from there.

5. Practicing Our Negotiation Skills (1–2 hours)

5a. Explain to participants: We have discussed some of the theory behind the Negotiated Behavior Change process. Now it's time to put our knowledge into practice ourselves.

5b. Divide the group into small groups of two or three. Give each small group a different role play scenario from the list in **Lesson 3 Handout 5: Role Play Scenarios**. (Or, each group can decide to work on another situation that is relevant to their work.) Ask each small group to discuss the scenario and develop a role play of 2–3 minutes on how to negotiate the behavior change. One person will play the role of the BCA, and the other will play the role of the community member. The third person can play the role of an influencing person (like a husband or mother-in-law, if need be). Each small group will take a turn performing its role play in front of the large group.

5c. Before the first role play is performed, distribute **Lesson 3 Handout 6: Observation Checklist** to each participant and explain that two group members will complete it for each role play (the facilitator should randomly choose two participants to fill the checklist before each role play begins). Share the following instructions for using the checklist.

- Check off the steps of the process as they are completed during the role play.
- When the role play is complete, the participants completing the form will have a few minutes to provide feedback to the performers. They should ask the performers, "What do you think went well?"

- Then, the observers can provide additional constructive feedback if needed, using phrases such as, “What if…?” or “How about …?” (Those giving feedback should be kind and encouraging, and not too detailed – we are just learning! Those receiving feedback should just say “Thank you” and not argue or explain why they did things a certain way.)

- If time permits, other participants will be able to provide additional verbal feedback to the performers.

5d. After all the role plays are complete, facilitate a discussion based on the following questions:

- How did you feel as the community member? How did it go, from your point of view?
- How did you feel as the Behavior Change Agent? How did it go, from your point of view?
- What was difficult?
- What can you improve?

6. Wrap Up (10 minutes)

6a. Explain that the Negotiated Behavior Change approach can be used with any behavior in any sector. Point out that the process requires at least one follow-up visit to see how the recommendation is being followed and to name other behaviors that the person should adopt according to the situation.

6b. Ask participants how they might start incorporating Negotiated Behavior Change into their own work as BCAs.

Lesson 3 Handout 1: Negotiated Behavior Change

Description of the Approach

Negotiating for behavior change means that the Behavior Change Agent (BCA) works together with a community member to consider various options and decide what that person will do. The BCA will not **force** the person to do something. The BCA listens respectfully to what the other person is saying. In the end, both people will agree with the decision that the other person takes. Remember that this process is a negotiation.

Advantages of Negotiation

- Negotiation encourages continued change because it demonstrates how small steps can help people reach bigger goals.
- Negotiation forms a bridge between the needs and values of the community and scientific knowledge.
- Negotiation helps BCAs learn what community members think, feel, and do by using skills of listening, asking, and negotiating. This information can help the BCA support people as they identify and work around barriers to change.
- Negotiation promotes positive approaches in BCAs and encourages a willingness to learn from the community, empathy for community members' situations and difficulties, and a better understanding of opportunities for realistic change.
- Negotiation builds trust between the BCA and community members because they have had a chance to express themselves and have their situations taken into account.
- Negotiation with various families identifies the best practices possible within a given situation, even if those are not necessarily the optimal practice.

Lesson 3 Handout 2: Role Play Dialogues: Negotiated Behavior Change

Option A

Behavior: Exclusive breastfeeding

Scenario: Mother says baby (2 months old) needs to drink water

Actors: Behavior Change Agent (BCA), Mother, Mother-in-Law

Actor	Dialogue
1. Greet	
BCA	Good morning, Mary. I am glad to see you. I hope you are doing well. Congratulations on the birth of your son.
Mother	Welcome. I'm glad to see you. Thanks for coming to see me.
2. Ask **3. Listen**	
BCA	How old is Paul now? How is he doing?
Mother	Paul is 2 months old now, and he's doing just fine. I weighed him for the first time last week.
BCA	That's wonderful. What did they tell you about Paul's weight gain?
Mother	They said he gained the right amount of weight. Look how fat he is!
BCA	That's good news. Congratulations! Tell me, how is Paul feeding?
Mother	He's breastfeeding well, both day and night. He's very hungry all the time.
BCA	That's good news. Tell me, when you have to work outside the home, who takes care of Paul and how do you manage the feeding?
4. Identify	
Mother	Yes, that is a challenge. Sometimes I have to leave Paul at home and my mother-in-law takes care of him. Sometimes she gives him water to drink or juice since it's so hot these days. She says babies need more fluids during the hot season.
BCA	So your mother-in-law is giving Paul some water and maybe juice. How do you feel about that?
Mother	She has raised many children, so she has a lot of experience.
BCA	Yes, that is true. Is your mother-in-law at home now? Can she join us?
Mother	Yes, she's here. I'll call her (calls the mother-in-law to join them). This is my mother-in-law, Helen.

Actor	Dialogue
5. Discuss	
BCA	Hello. I am happy to meet you. Congratulations on such a beautiful grandson. I understand you are helping Mary take care of Paul when she is away from home. That is very helpful.
Mother-in-Law	It's nice to meet you. Yes, I enjoy taking care of Paul when Mary is away.
BCA	I understand that you are concerned that when it's hot like this, that Paul needs to drink more fluids.
Mother-in-Law	Yes, we have known this for a long time. I learned this from my own mother.
BCA	It's true that when it's hot everyone needs to drink more, but did you know that breast milk contains a lot of water? So each time Mary breastfeeds Paul, she is giving him water.
Mother-in-Law	I didn't know that. That's interesting. But when Mary is away from home, I need to give Paul some water.
6. Recommend	
BCA	I understand that you are worried that Paul needs water in this hot weather, but Paul's stomach won't be ready for other drinks and food until he's about 6 months old. Water and juice can upset Paul's stomach and cause diarrhea. Diarrhea in a young infant can be very serious. I would like to make a suggestion. When Mary needs to leave Paul with you, she should first give him a good feed and plan to be gone only a few hours. That way she'll be back in time to feed him again when he's hungry. Do you think you can do this until Paul is 6 months old and ready for other foods?
Mother	Oh my! Six months—that's another 4 months!
Mother-in-Law	That's a long time. Surely he will need food before then.
BCA	I see that another 4 months seems like a long time. How about trying to only give breast milk for the next month? Helen, you can remind Mary to give Paul a good long feed before she goes out. What do you think of that suggestion?
Mother	What do you think, Helen? Just another month? Then we can see.

Actor	Dialogue
7. Agree	
BCA	After a month, I can come back and we'll see if Paul is continuing to gain weight. That is the perfect way to know if he's healthy. What do you think, Helen?
Mother-in-Law	OK, we can try it for just a month.
BCA	So, do we agree that Paul will only be given breast milk during the coming month?
Mother and Mother-in-Law	Yes.
8. Appointment	
BCA	That's great! I will plan to come back in a few weeks to see how things are going. Is that OK with you? And, if anything comes up in the meantime, please just come see me.
Mother	OK, I will. Thanks for coming by.
BCA	Paul is a lucky baby to have such a loving mother and grandmother!

Option B

Behavior: Incorporating fish from personal fishponds (aquaculture) into children's diet

Scenario: Mother wants to include fish in children's diet but husband sells all the fish at market

Actors: Behavior Change Agent (BCA), Mother, Father

Actor	Dialogue
1. Greet	
BCA	Good morning, Angela. How are you doing? I hope your fish pond is prospering. Congratulations on the first harvest of fish!
Mother	Welcome. It's good to see you again. Thanks for coming to visit.
2. Ask **3. Listen**	
BCA	So I understand it's been about 6 months since you installed your fishpond. How is it going?
Mother	Things are going pretty well. We received some great training and have been trying to apply everything that the fishery outreach workers taught us.

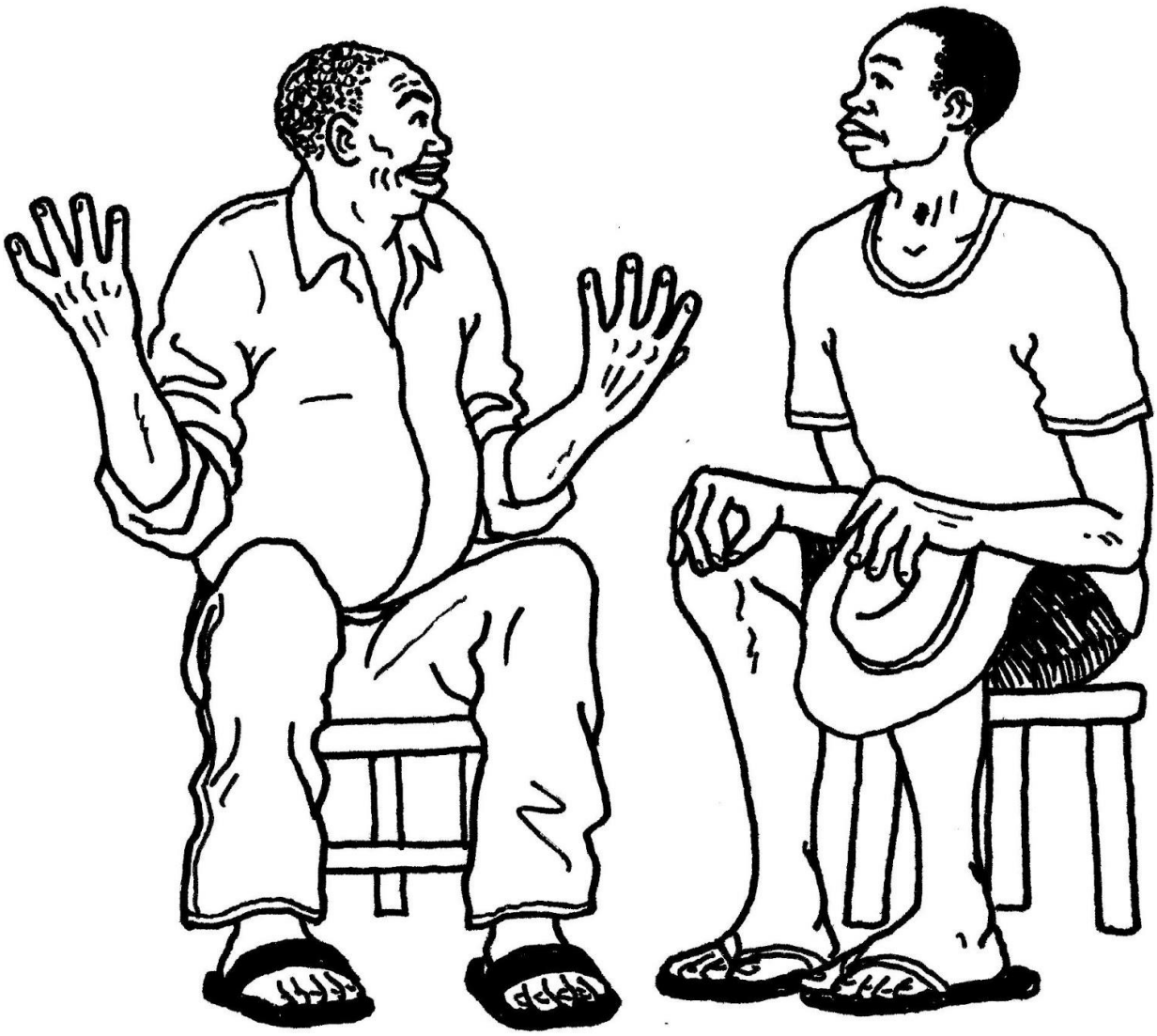
Actor	Dialogue
BCA	That's good to hear. Didn't you also have a visit from the local health care worker?
Mother	Oh, yes. She mentioned that many children are undernourished in our community, and that we need to try including other foods in their diet, like fish.
BCA	That's is true. Fish are an important source of protein! Tell me, how is it going?
Mother	Well, I have been trying, but there are some things that have made it quite difficult.
BCA	It can be hard to try to change your family's diet, and I'm very happy that you are trying. Can you tell me about some of the things that have made it hard for you?
4. Identify	
Mother	Yes, well, my husband doesn't want me to use the fish from our fishpond in our family meals. He wants to sell all the fish because he says we can make more money.
BCA	So your husband thinks that making money at market is more important for the family than incorporating new foods into your children's diet?
Mother	Yes, he feels that our kids look just like the rest of the kids in the village and they are all pretty healthy. I mean, they get sick sometimes, but he says that is just normal.
BCA	And what do you think?
Mother	Well, in the education sessions we learned that children should eat more foods and different foods to ensure that they grow up big and strong.
BCA	This is true. Have you tried to talk to your husband about this?
Mother	Yes, but it is hard and he doesn't always listen.
BCA	Maybe it would help if we talked with him together. Is your husband around? Can he join us?
Mother	Yes, he's just outside. I'll call him (calls the husband to join them). This is my husband, Cipriano.

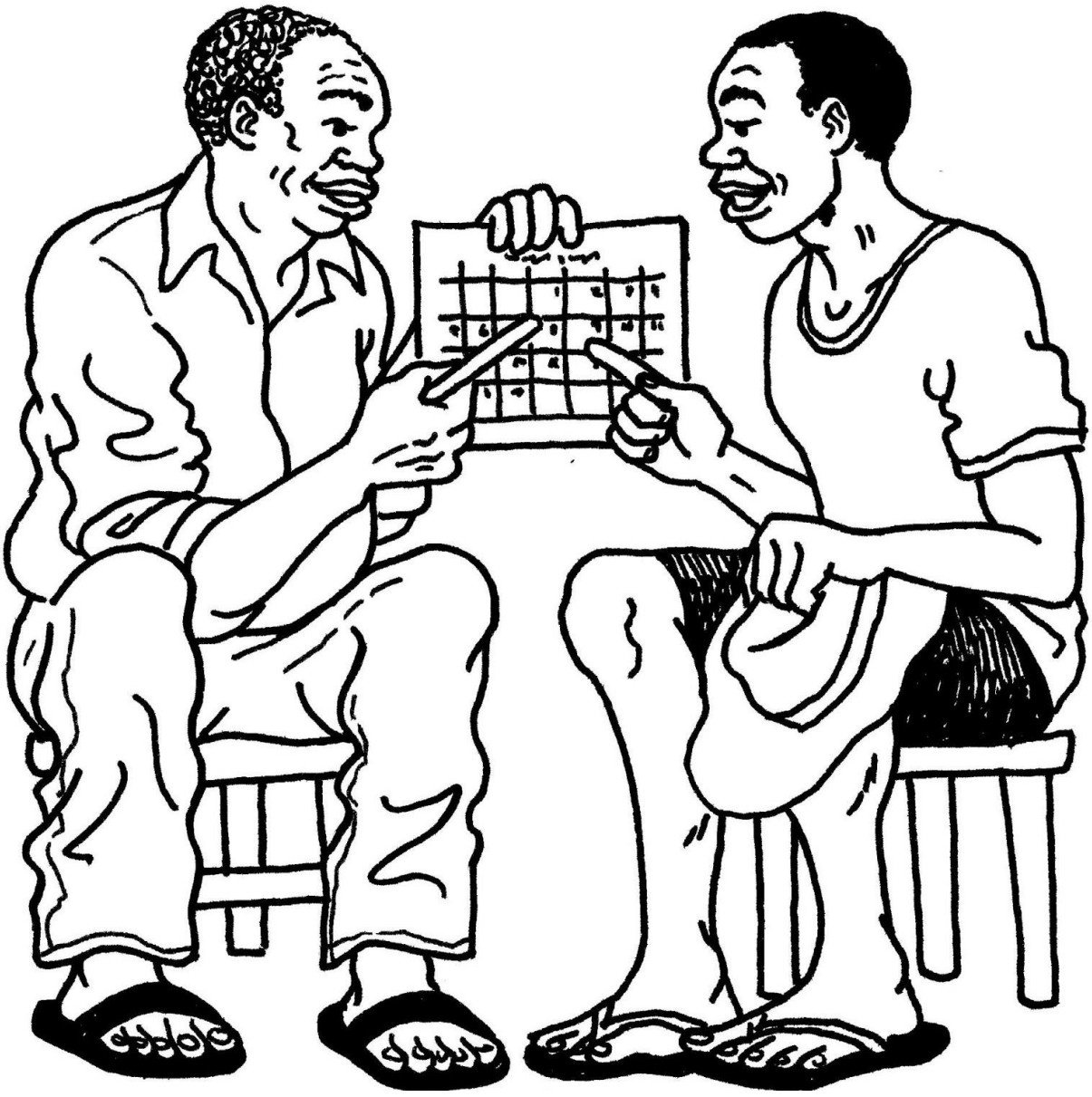
Actor	Dialogue
5. Discuss	
BCA	Hello. I am happy to meet you. Congratulations on your beautiful fishpond! I understand it was a lot of work, but that you have finally started harvesting the fish. That is great news.
Father	It's nice to meet you, too. Yes, I am very proud of our fish. It took a while for them to grow, but now it's all worth it.
BCA	I understand that you have been selling the fish you harvest at market to get more money.
Father	Yes, almost everyone in our community enjoys eating fish, and my neighbors are happy to buy from me.
BCA	It's good that people enjoy eating fish. They are a great source of protein, which is important for the body to grow and have energy. Do your kids like to eat fish?
Father	I don't know. We don't really feed them fish because they are so valuable I sell them all. I mean, I know my wife wants to feed them fish, but the kids are so small they don't need to eat that much anyways.
BCA	The kids are small at their young age, but they also have the most growing to do. They actually need even more food at this time in their lives, especially food from animals, so they can continue to grow into strong healthy adults.
Father	Hmm. I never thought of it that way. But, the money is important too.
6. Recommend	
BCA	I understand that you need to make money and that selling fish at market adds another source of income. But, it is also important to make sure your kids have enough quality food. The food you feed them now will determine how healthy they are later. I would like to make a suggestion. When Angela prepares food, why don't you help her to include some fish for each of the family members: you, her, and each of your children? You will still have a lot of fish to sell and your kids will be getting the nutrients they need. Do you think you can do this?
Mother	Wow! Adding fish to everyone's plate every day—that is going to be a lot of fish!
Father	Yeah, I don't think I can afford to keep all those fish for just our family.
BCA	I see that including fish in your household diet every day is a lot to ask. How about trying to add fish to your meals every other day? Angela can you

Actor	Dialogue
	remind Cipriano to save a few fish for you to make with dinner every other day? What do you think of that suggestion?
Mother	What do you think, Cipriano? Every other day would be okay. The kids do love to eat fish…
Father	Well, I guess we can try it out.
7. Agree	
BCA	Great! Why don't you keep track of how many fish you sell per week and how many fish your family eats. Also, we can measure the kids now and then check them again when I come back in a couple months to see how much they grow!
Father	Ok, I guess we can try it for a couple months.
BCA	So, do we agree that Angela will feed everyone in the family fish at least every other day?
Mother and Father	Yes.
8. Appointment	
BCA	That's great! I will plan to come back in 2 months to see how things are going. Is that OK with you? And, if anything comes up in the meantime, please just come see me.
Mother	OK, I will. Thanks for coming by.
BCA	No problem. I am glad the fish pond is working out and that your kids are going to benefit on top of the added income for the family.

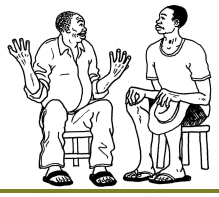
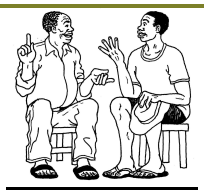
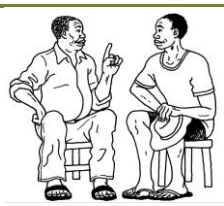
Lesson 3 Handout 3: Illustrations of the Steps in the Process of Negotiated Behavior Change

This handout includes two sets of illustrations: one depicting two women chatting and the other depicting two men chatting. Both sets are placed in order of the eight steps of Negotiated Behavior Change.





Lesson 3 Handout 4:
Steps in the Process of Negotiated Behavior Change

		1. **Greet** the person and establish confidence.
		2. **Ask** the person about current behaviors/practices.
		3. **Listen** to/reflect on what the person says.
		4. **Identify** any difficulties/obstacles and possible causes; select one difficulty/obstacle to work on.
		5. **Discuss** with the person different possible ways to overcome the obstacle.
		6. **Recommend and negotiate doable actions**: Ask for solutions from the community member; offer additional options/suggestions and NEGOTIATE with the person to help him/her select one option/action that he/she can try.
		7. Person **agrees** to try one or more of the options, and the person **repeats** the agreed upon action.
		8. Make an **appointment** for the follow-up visit.

Lesson 3 Handout 5: Role Play Scenarios

- A BCA meets a woman who does not feel that she should give her child more food when he is sick.
- A BCA finds out that a herder has not had his animals dewormed by the veterinarian as recommended.
- A BCA finds out that a school director has taken over the supervision of the school improvement project that the parent teacher association (PTA) was supposed to oversee.
- A BCA finds out that some parents are keeping their daughter home from school to do chores. She arrives late to school 3–4 days each week.
- A BCA notices that herders in the community bring their sheep to the community well used for drinking water. The sheep are not only coming to drink, but they are spending a portion of the day resting in the area around the well. There is another well 5 km away.
- A BCA learns that a pregnant woman is sharing her food ration with the families of her two brothers, leaving very little food for herself and her two children, ages 2 and 4.
- A BCA meets a woman who has two children, a boy and a girl both under 5 years of age, and receives food rations for them both. She only gives the rations to her boy child, thinking his health is more important.
- A BCA working with technology support finds out that the records for the program in the subzone are only being kept in paper copy and are not entered in the data filing system.
- A BCA working as a finance manager supervises a field officer who always turns in expense reports without receipts after travel.
- A BCA meets a pregnant woman who thinks the mosquito net is too hot to sleep under.
- A BCA meets a pregnant woman who plans to give birth at home because the health center is too far away.
- A BCA is working with a pregnant woman who thinks having two clinic visits (or antenatal consultations) is plenty.

Lesson 3 Handout 6: Observation Checklist

Did the Behavior Change Agent (BCA) do the following?

- ❑ 1. **Greet** the person and establish confidence.
- ❑ 2. **Ask** the person about current practices.
- ❑ 3. **Listen** to the person.
- ❑ 4. **Identify** obstacles and a next best practice that the person can try.
- ❑ 5. **Discuss** with the person different possible ways to overcome the obstacle.
- ❑ 6. **Recommend** ways to overcome the obstacles and practice an intermediate behavior.
- ❑ 7. Gain **Agreement** of the person to try the recommendation.
- ❑ 8. Make an **Appointment** for the follow-up visit.

Ask the BCA to name one or more thing(s) he/she did well. Note your observations here:

Name one important thing you recommend the BCA work on to improve the next time:

Lesson 4: Home Visits/Individual Counseling[4]

Achievement-Based Objectives

By the end of this session, the participants will have:

- Discussed their program's expectations regarding home visits
- Defined the purpose of the home visit
- Listed the steps and qualities of an effective home visit
- Practiced conducting a home visit
- Critiqued a home visit

Duration

3–3.5 hours

Materials Needed

- Flip chart paper and markers
- Pre-written flip chart entitled "Purpose of a Home Visit"
- Scenarios for role plays (1 scenario per pair of participants)
- Lesson 4 Handout 1: Purpose of a Home Visit (1 copy per participant)
- Lesson 4 Handout 2: Role Play Dialogue: Showing Steps in a Home Visit using the Negotiated Behavior Change Process (2 copies; see "Advanced Preparation" for variations)
- Lesson 4 Handout 3: Steps in Conducting a Home Visit (1 copy per participant)
- Lesson 4 Handout 4: Quality Improvement and Verification Checklist: Home Visits/Negotiated Behavior Change (1 copy per participant)

Why this Lesson?

Frequently a Behavior Change Agent (BCA) is called to visit someone at home—to do a home visit—as part of the behavior change promotion process. BCAs will benefit from knowing the best way to conduct a home visit, the main purpose of which is to promote behavior change.

Advanced Preparation

Throughout this manual, the term Behavior Change Agent (BCA) is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

[4] This lesson is best done after Lesson 1: Behavior Change through Effective Communication. Also, this lesson can be helpful in reinforcing the concepts shared in Lesson 4: Negotiated Behavior Change. However, for some groups, Lesson 4 and Lesson 5 may seem too similar and the facilitator may choose to do one or the other, not both.

Before conducting this lesson, become informed about the participants' programs' policies about home visits. This should include the frequency, the designated audience to be visited, and the purpose of the home visit (if there is a particular one for the project).

Practice the role play in **Lesson 4 Handout 2: Role Play Dialogue: Showing Steps in a Home Visit using the Negotiated Behavior Change Process** with co-facilitators or, if there are no co-facilitators, share the handout with two randomly chosen participants so they may practice for the role play. Additional role play scripts are available in **Lesson 3 Handout 2: Role Play Dialogues: Negotiated Behavior Change**. If appropriate, the facilitator should adapt these scripts to suit the responsibilities of the participants.

Develop home visit scenarios (one for each pair of participants) that are based on the behaviors being promoted by the project for the exercise in Task 5: Practicing Home Visits. For scenario ideas, refer to **Lesson 3 Handout 5: Role Play Scenarios** (from the lesson on Negotiated Behavior Change). In some groups, participants might like to make up their own scenarios in order to practice on a case that is especially relevant to their own experience in the community.

Tasks

1. Warm-Up Activity (15 minutes)

    1a. Conduct a brief introductory exercise to help participants get comfortable with talking with each other and start thinking about home visits. For example, have participants talk with a partner (preferably someone they don't know well) about a type of food they like to prepare when someone is visiting their home or about a traditional food that they enjoy eating when they visit friends and families.

    1b. Allow about 5 minutes for discussion, then ask participants to share their findings with the larger group.

    1c. Facilitate a discussion based on the following questions.

    - Why do you choose to share that particular food with guests?
    - Or, why do you think your hosts choose that food to share with you?
    - What are some of the other ways that you make guests feel welcome in your home?

2. Structure of BCA Home Visits (15 minutes)

    2a. Explain to participants that one of the responsibilities of many BCAs is to visit people at home, also known as conducting a home visit. Note that meeting with someone in his/her own home is a powerful way to connect with that person, learn about his/her life, and provide support throughout the behavior change process.

2b. Ask participants to think for a moment about what might be the same and what might be different about making a visit to the home of a friend or relative compared to visiting the home of a community member in the role of BCA. (Similarities might include: it's important to show respect and warmth, ask about how the people in the home are doing. Differences might include: a BCA's visit to a community member has a particular purpose, the BCA will usually not discuss his/her own personal issues, there is less sharing of food/gifts. Here you may also want to briefly discuss the cultural and program concerns, expectations, or policies related to food during home visits. For example, in some programs, the BCA may accept tea during a home visit but is expected to politely refuse food that is offered.)

2c. After a brief discussion, note that today's lesson will review the structure and purpose of home visits conducted by a BCA. Note that participants will have an opportunity to practice the steps of a home visit and learn how to use their time with community members more effectively.

2d. Ask the participants to recall their project's proposed home visit schedule. As participants explain their project's protocol, write some notes about it on a flip chart.

3. Purpose of the Home Visit (10 minutes)

3a. Ask participants: What do you understand is the purpose of a Behavior Change Agent's home visit?

Remind them that a home visit usually takes place after the BCA has already conducted some educational activities.

3b. Write participants' ideas on a flip chart entitled "Purpose of a Home Visit." Brainstorm for about 5 minutes.

3c. Refer participants to the **Lesson 4 Handout 1: Purpose of a Home Visit**. Compare and contrast the participants' list with the handout.

4. How to Conduct a Home Visit (30 minutes)

4a. Ask participants the following questions and lead a discussion.

- Have any of you ever been visited at home by someone like a Behavior Change Agent, such as a church member or health worker?
- Thinking about that home visit you received, can you share how you felt about it?
- Was it a positive experience? If yes, what made it positive?
- How did the person doing the visit act?
- How did you feel?

If none of the participants has experienced a home visit, ask: What do you think are the qualities of a good home visit by a Behavior Change Agent?

4b. Divide participants into small groups and pass out flip chart paper and markers. Ask the participants to list on the flip chart paper the qualities of a good home visit. Ask them to think about specific communication skills they might use and actions they might do during the visit. Give them a few minutes to do this, then ask a few small groups to share their lists. (The lists might include: show respect by calling the person by name, ask if the time of the visit is convenient, ask about the welfare of family members, be culturally sensitive, provide context-specific information, show interest in understanding the person's particular situation, not be intrusive, be patient, and actively listen.)

4c. Explain to participants: Now let's look at the steps for conducting a home visit.

4d. Demonstrate the role play in **Lesson 4 Handout 2: Role Play Dialogue: Showing Steps in a Home Visit using the Negotiated Behavior Change Process**, which describes a simple home visit that includes the steps in Negotiated Behavior Change. Instruct the participants to try to name the different steps while they watch the role play.[5]

4e. After the role play, ask participants to name the steps they observed. List them in order on a flip chart.

4f. Ask participants: What surprised you in this home visit? What stood out for you? Was anything about it different from home visits that you have been doing or have seen? (Answers should include: the focus on promoting behavior change, specifically through negotiation)

4g. Distribute **Lesson 4 Handout 3: Steps in Conducting a Home Visit Using Negotiated Behavior Change**. Ask participants to review the steps and discuss the following.

- What difficulties might you have in conducting a home visit like this?
- What skills can you use to work around those difficulties?

4h. If any of the participants supervise BCAs, discuss the following: Part of your job is to help Behavior Change Agents conduct effective home visits, during which they support and assist people in adopting new behaviors. How might you evaluate and, if needed, help them to improve the quality of their home visits? (Answers can include: join them on a home visit, provide feedback, arrange for the BCA to accompany an experienced BCA on a home visit)

[5] Alternatively, the role play script can be read aloud by some participants so that everyone can note the steps as they follow along with the dialogue. Additional role play scripts are available in Lesson 3 Handout 2: Role Play Dialogues: Negotiated Behavior Change.

5. Practicing Home Visits (1.5–2 hours)

5a. Explain to participants: One of the best ways to work around difficulties and improve the effectiveness of home visits is to practice. The more we practice, the more comfortable we will feel with the steps of the process, and the more we will be able to act naturally with community members while in their homes. This will help us have an open dialogue and learn more about the community members. During this part of the lesson you will have a chance to use the skills and knowledge you have gained about home visits.

Note: If the participants have already completed Lesson 1: Behavior Change through Effective Communication and/or Lesson 4: Negotiated Behavior Change, encourage them to practice those skills as they continue with this lesson.

5b. Remind the group of the lists they made of the communication skills and actions they would use to make a good home visit. Inform them that they will now practice combining these skills with the steps in Negotiated Behavior Change.

5d. Divide the group into pairs. Assign a role play scenario to each pair (or ask each pair to think of a home visit scenario that is relevant to their project). Explain that each pair will now develop a role play lasting no more than 5 minutes, where one person is the BCA and the other is the person being visited.

5e. Distribute **Lesson 4 Handout 4: Quality Improvement and Verification Checklist: Home Visits/Negotiated Behavior Change** and explain that these are the basic steps/qualities we look for in the home visit. Tell participants that they should make sure to follow these steps when developing their home visit role plays. They should also use Lesson 4 Handout 3 as a guide. Allow 20 minutes for the pairs to prepare and practice their role plays.

5f. Ask for two volunteers per role play to complete Lesson 4 Handout 4 while watching the role play, then give these to the role play pair as written feedback. Explain that Advanced Lesson 1 provides more detail on how to use quality improvement and verification checklists (QIVCs). These checklists are meant to help workers know what is expected of them and to encourage them, to monitor their work, and to improve performance.

5g. Ask pairs to come forward and present their role play. Applaud and thank each pair. Ask presenters to share what they thought went well and what was difficult, if anything.

Note: The facilitator should time each role play and stop it (even if it's not done) after 5 minutes. If there is more than one facilitator and if time is short and/or there are

many participants, consider dividing the trainees into two groups and conducting the roles plays simultaneously, with one facilitator observing each group.

6. Wrap Up (10 minutes)

   6a. Wrap up with a discussion of the lessons learned through the home visit role plays, asking:

   - How do you now feel about your skills in doing an effective home visit?
   - To what extent do you think your home visits will be more effective in promoting behavior change?
   - How do you think the person being visited will feel about receiving such a home visit from you?

Lesson 4 Handout 1: Purpose of a Home Visit

1. Get to know community members better; allow time for direct dialogue.
2. Get to know the other members of the family and engage any influencing groups.
3. Build trust between you and community members.
4. Learn about and show respect for what community members are already doing well in their own homes.
5. Learn about the context in which the behaviors will be practiced and be better able to suggest way to overcome obstacles.
6. Check for practice of the behavior.
7. Negotiate with the community member about trying the new behavior.
8. Demonstrate to the community member that you care about him/her.

Lesson 4 Handout 2: Role Play Dialogue: Showing Steps in a Home Visit using the Negotiated Behavior Change Process

Scenario: Mary's baby Paul has diarrhea and she took him to the clinic for treatment, but waited longer than 24 hours to do so because her husband did not approve

Actors: Behavior Change Agent (BCA), Mother, Mother-in-Law

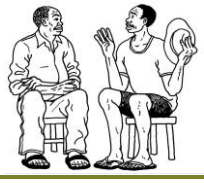
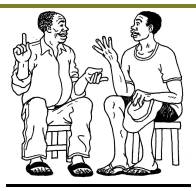
Actor	Dialogue
1. GREET the person being visited in a friendly manner and introduce yourself to/greet the head of the household (if present). Ask if other members of the family are present who might need to participate in the discussion (influencing groups).	
BCA	Good morning, Mary. How are you doing? Did you remember that I was going to visit you today?
Mother	Hi Rosemary, yes, I remembered. Welcome. Come in.
BCA	Thanks. How is your husband? Is he here now?
Mother	Oh he's fine. But, he's at work now.
BCA	Please tell him I said hello.
Mother	OK, I will. Thanks.
BCA	Is your mother-in-law at home now? I would like her to join us if she can.
Mother	Yes, she's here. Let me get her.
BCA	Hello, my name is Rosemary, and I'm here to talk with Mary about what she can do to keep the family healthy. We have been meeting with other mothers in the neighborhood these past few months to talk about this. I think your input will be important in this discussion.
Mother-in-Law	Hi, my name is Fancy. Yes, Mary has told me a bit about the meetings. I also think it's important to talk about ways to keep the family healthy.
2. ASK the person (people) how things are going, with a focus on issues relevant to the BCA's program. **3. LISTEN** and reflect on what is said.	
BCA	How are Paul and Timothy doing?
Mother	Both the kids are doing well now, thanks. But, last week Paul had a bout of diarrhea.
BCA	Hmm, I'm sorry to hear that. Tell me about what happened.

Actor	Dialogue
Mother	Well, it started on Monday. He had several loose stools for 2 days.
BCA	Hmm. That sounds serious. What did you do?
Mother	Well, the first day I didn't do anything, since all children get diarrhea from time to time. But then he got very weak, and I got scared.
BCA	What did you do then?
Mother	I talked with my husband, and we decided to wait another day to see what would happen.
BCA	I see. During this time, what were you giving Paul to eat and drink?
Mother	Well, I remembered the lesson, so I prepared the oral rehydration solution and gave that to him. I also encouraged him to eat. But, he refused.
BCA	That's very good, Mary. I am so pleased you prepared the ORS. It's also important that children with diarrhea continue to eat. Then what happened?
Mother	As I said, even though I gave him the ORS, because he wasn't eating and the diarrhea continued, he got very weak. On the third day we finally decided to take him to the clinic, where they gave him some medicine and he got better quickly.
BCA	I am glad you decided to take him to the clinic. How do you feel about that decision, Fancy?
Mother-in-Law	Well, I wish we had taken Paul to the clinic sooner. The clinic is fairly close. But, my son didn't approve.
4. IDENTIFY difficulties/obstacles. Optional step: If this is not the first home visit, review the key points of the last (prior) meeting, if relevant to the difficulties/obstacles.	
BCA	I see. So your son was not in favor of going to the clinic right away. Mary can you tell me what you remember about the lesson about seeking help at the clinic when a child has diarrhea?
Mother	Hmm. We talked about how dangerous diarrhea in children can be and that it's important to go to the clinic. And, that's what we did.
BCA	That's true. Do you remember what we said about WHEN you should take a sick child to the clinic—how quickly?

Actor	Dialogue
Mother-in-Law	I think Mary told me that it's important to go right away, like during the first day—24 hours.
BCA	That's right, Fancy. Good memory! If a child passes three loose stools in a day or has blood in the stool, it's very important to go to the clinic immediately. Waiting at home, even if you are giving ORS, can be dangerous. A young child can easily die if the diarrhea is bad enough. What prevented you from going to the clinic more quickly?
Mother	Well, my husband thought we should wait. He didn't think it was that serious.
BCA	*Reflecting on Mary's response.* Hmm, I see. So, having permission from your husband to take the child to the clinic is a critical step and if he doesn't agree…
Mother	Well, if he doesn't agree, then we can't go.
Mother-in-Law	Yes, he needs to give Mary the money to buy the medicines.
5. DISCUSS ways the person or people can overcome the difficulties.	
BCA	I see. So in the future it would be important to make sure your husband understands how serious diarrhea in children can be. How do you think we could help him understand this? What can you do?
Mother	Well, I can talk to him and tell him the things I learned in the meeting. I could arrange for you to talk to him.
BCA	Fancy, is there anything you can do?
Mother-in-Law	Well, I also could talk to him about the importance of seeking health care quickly, and if this happens again, I can remind him that we shouldn't wait. If he doesn't agree, then I will try to convince him.
6. RECOMMEND and negotiate doable actions and help select one option/action to try.	
BCA	Those are all great ideas! So you could talk with him together, or separately about how serious diarrhea can be and about getting health care within 24 hours of it starting. Which would work better for you?

Actor	Dialogue
7. The person **AGREES** to try one or more of the options, and REPEATS the agreed upon action.	
Mother	Ok, I think I would like for Fancy and me talk to him together about what we learned: about the importance of going to the clinic quickly when one of the kids has diarrhea and what can happen if we wait too long. Fancy, can you help me?
Mother-in-Law	Yes, I can help you, for sure.
8. Make an **APPOINTMENT** for the follow-up visit.	
BCA	That sounds like a fine plan. I also can lend you the flip charts from the lesson. When do you think you'll have time to talk with him?
Mother	That would be great. The pictures will help to convince him. I'll try to do it this week. OK?
BCA	Yes, that's fine. Then would it be OK if I passed by the week after next—say 2 weeks from today—to see how things went?
Mother	Yes, that would be fine.
Mother-in-Law	Yes, no problem.
BCA	Well, Mary, I want you to know that it was great that you remembered to give ORS to Paul when he had diarrhea. That really helped him a lot. Keep up the good work. And I'll see you 2 weeks from today.
Mother	Thanks for the visit, Rosemary.
Mother-in-Law	Yes, thanks for including me in the discussion. We look forward to seeing you again.

Lesson 4 Handout 3: Steps in Conducting a Home Visit Using Negotiated Behavior Change

		**1. <u>Greet</u>** the person in a friendly way and introduce yourself to the head of household (if present). Show interest in the situation of each family member. Ask if other members of the family are present that might need to participate in the discussion (influencing groups).
		**2. <u>Ask</u>** the person about how things are going with current and new behaviors, with a focus on issues relevant to the project.
		**3. <u>Listen</u>** to /reflect on what the person says.
		**4. <u>Identify</u>** any difficulties/obstacles and select one to work on. Optional step: If this is not the first home visit, review the key points of the last (prior) meeting, if relevant to the difficulties/obstacles. If there are urgent issues (such as a sick child) make these a priority.
		**5. <u>Discuss</u>** ways the community member(s) can overcome the difficulties.
		**6. <u>Recommend and negotiate doable actions</u>** and help select one option/action to try.
		**7.** Person **<u>agrees</u>** to try one or more of the options, and the person **repeats** the agreed upon action.
		**8.** Make an **<u>appointment</u>** for the follow-up visit. Congratulate the person on his/her good work. Thank him/her for making time to talk with you and remind him/her when you will be coming back for a follow-up visit.

Lesson 4 Handout 4: Quality Improvement and Verification Checklist: Home Visits/Negotiated Behavior Change

Name of the Supervisor/person completing the QIVC: _____

Name of the Behavior Change Agent (BCA) being observed: _____

Community: _____ Date: _____

	Yes	No
1. Did the BCA greet the person being visited and establish confidence?	❒	❒
2. Did the BCA introduce him/herself and greet the head of household (if present)?	❒	❒
3. Did the BCA ask if other members of the family are present that might need to participate in the discussion (influencing groups)?	❒	❒
4. Did the BCA talk with the person being visited about how things are going with current or new behaviors?	❒	❒
5. If there were urgent issues (such as a sick child), did the BCA prioritize them and make appropriate recommendations or referrals?	❒	❒
6. Did the BCA review the key points of the last (prior) meeting?	❒	❒
7. Did the BCA listen to/reflect on what the person being visited said?	❒	❒
8. Did the BCA identify difficulties/obstacles to behavior adoption?	❒	❒
9. Did the BCA discuss realistic options for overcoming the obstacles?	❒	❒
10. Did the BCA recommend/ask for doable actions?	❒	❒
11. Did the BCA ask the person/people to agree to try one or more of the solutions?	❒	❒
12. Did the BCA ask the person/people to repeat the agreed-upon action?	❒	❒
13. Did the BCA set a date for the follow-up visit?	❒	❒
14. Did the BCA congratulate the person/people on their good work?	❒	❒
15. Did the BCA thank the person/people for making time to meet?	❒	❒
16. Did the BCA remind the person/people of the date for the follow-up visit?	❒	❒

Score: _____ (Calculate the score by counting the number of yes answers and dividing by the total number of questions that were applicable to the situation. This number is usually kept as a percentage. See Advanced Lesson 1 for more information).

Comments:

_____

_____

_____

_____

Lesson 5: Behavior Change through Guided Testimonials

Achievement-Based Objectives

By the end of this session, participants will have:

- Defined "testimonial" and "guided testimonial"
- Generated a list of advantages of using testimonials
- Heard an explanation of some of the ways that testimonials help change behavior
- Listed the steps in using guided testimonials
- Practiced coaching/guiding someone to give a good testimonial
- Practiced/observed someone giving a good guided testimonial

Duration

4 hours

Materials Needed

- Pre-written flip chart with the definition of a testimonial
- Lesson 5 Handout 1: Why are Testimonials Effective? (1 copy per participant)
- Lesson 5 Handout 2: Steps in Organizing a Testimonial (1 copy per participant)
- Lesson 5 Handout 3: Example Testimonial (1 copy per participant)
- Lesson 5 Handout 4: Small Group Instructions for Preparing Testimonials (1 copy for each group of 4 participants)

Why this Lesson?

Guided testimonials can be an effective way for Behavior Change Agents (BCAs) to change the misperception that no one else is practicing a particular behavior (e.g., contraception, using new seeds) or using a product (e.g., oral rehydration solution [ORS] with zinc). Testimonials give people a chance to see someone "like them" talking about the advantages of a behavior or product. Learning how to plan a guided testimonial, as opposed to a spontaneous testimonial, is a useful tool for a BCA's work in the community.

Advanced Preparation

Throughout this manual, the term Behavior Change Agent (BCA) is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

On flip chart paper, write the "Definition of a Testimonial" as shown in the text box in Task 3.

Tasks

1. Warm-Up Activity (10 minutes)

    1a. Conduct a quick activity that gets the participants laughing and comfortable with interacting with each other.

    1b. For example, ask participants to form a large circle. Toss a soft ball (or ball of crumpled paper) to a participant, stating his/her name as you do so. Ask that person to then toss the ball to another person, while also stating their name loudly. Repeat until everyone has tossed the ball and the last person has thrown it back to you (the facilitator). Ask them to repeat the process again, a bit more quickly, throwing the ball to the same person each time and repeating the names loudly and clearly. About halfway through the cycle, toss in another ball. A moment or two later, add another. Try to keep the cycle going for another one or two rounds, with all three balls in play.

    1c. This exercise is usually fun and helps participants feel more relaxed (and have a chance to laugh a little) with each other. When they return to their seats, remind them that laughter can be helpful in their work as BCAs, Ask them to share some thoughts about the benefits of laughter in their work with communities. This game may also remind BCAs of all the different things they have to pay attention to in their work. Sometimes there is a lot going on at once!

2. Introduction to the Lesson (10 minutes)

    2a. Explain to participants that we will start today's lesson by reflecting for a moment on our own lives. Ask participants: How many of you have felt that you were doing something a bit unusual, that others around you didn't normally do? How did that make you feel? Thank them for sharing and note that those kinds of thoughts/feelings are very common – and they are also experienced by people in the communities in which we work.

    2b. Share the following with the participants: Research has revealed that people who live in communities where it's important to be seen as "one of the group" or "not outside the norm" are strongly motivated by the idea that everyone is doing or approves of a behavior. In societies like this, showing that other people approve of the behavior or that others are doing it already can be a very powerful force for behavior change. In this lesson, we will learn how to use the power of social norms—this desire to do what is approved of or to be "one of the group"—to promote behavior change through the use of guided testimonials.

3. What is a Testimonial? (15 minutes)

    3a. Start by asking participants: Has anyone heard of testimonials before? What are they?

Listen to their responses, then reveal the following definition, already written on a flip chart.

Definition of a Testimonial

A testimonial is a first-hand written or spoken report of one person's experience with a product or behavior. It is given to influence another person's opinion about the benefits or value of something and to show how barriers to behavior change were overcome.

3b. Some examples of testimonials are:

- A farmer explaining to a group why she terraced her land and the benefits that she saw from that in terms of soil conservation
- A mother explaining to other women in her church why she decided to have her child vaccinated and how she made that happen
- A youth explaining over the radio the benefits of volunteering in his community to help the elderly
- A mother explaining to a group why she decided to not give a laxative to her newborn baby

3c. Explain to participants: When a celebrity gives a testimonial for a product or behavior, we usually call it an "endorsement." We call it a testimonial when ordinary people promote a product or behavior.

3d. Ask participants: Have you ever heard endorsements or testimonials on the radio or television? For which products or services?

3e. Ask participants: Has anyone ever heard of a guided testimonial?

3f. Explain to participants: A guided testimonial is when a Behavior Change Agent coaches or assists a person who has experience doing the behavior in how to deliver a testimonial more effectively.

4. What Makes Testimonials Effective? (15 minutes)

4a. Ask participants: Why do you think people use testimonials? What are their advantages?

4b. Refer participants to **Lesson 5 Handout 1: Why are Testimonials Effective?** Ask participants to read individually (or in small groups) and identify the reason they think would be most likely to get them to change their own behavior.

5. The Steps Involved in a Guided Testimonial (30 minutes)

   5a. Ask participants if any of them have used testimonials to promote behavior change. Ask one or two participants to describe the process they used to organize the testimonial.

   5b. Distribute **Lesson 5 Handout 2: Steps in Organizing a Testimonial** and ask participants to compare the processes their fellow participants just described with what is written in the handout. If they don't mention it, note to participants that Lesson 5 Handout 2 describes a very deliberate process. Explain that for testimonials to have the optimal effect, it's not enough to ask someone to talk about his/her experience; the testimonial should be thought through and well prepared. It might be helpful for some groups to review the eight steps of organizing a testimonial by reading them out loud and having someone in each group write them on flip chart paper (for use as an additional guide during the role play preparation).

   5c. Distribute **Lesson 5 Handout 3: Example Testimonial**. Ask participants to read it and identify the eight different elements that a testimonial should include. Ask what else could be added to the testimonial to make it even more convincing.

6. Guided Testimonials Practice (90 minutes)

   6a. Divide the participants into small groups of about four people each. Ask each group to select a person to be their group leader (or you may wish to assign a person as small group leader when dividing up the group).

   6b. Give each small group leader the set of instructions in **Lesson 5 Handout 4: Small Group Instructions for Preparing Testimonials**. Ask the small groups to read and follow the instructions for planning a testimonial, including getting approval for the testimonial topic.

   6c. Tell the participants that they will now practice preparing someone to give a testimonial (remember it is not just one person who prepares the testimonial; the group helps the selected person by asking them questions about the new behavior). Once the testimonials have been prepared, move on to **Task 7**.

7. Practice Giving a Guided Testimonial (70 minutes)

   7a. Have the participants from each small group give their testimonials to the larger group. After each testimonial, ask the larger group to share:

   - What they liked about the testimonial
   - What they think could be done to further improve the testimonial

7b. You may wish to create a competition by having the participants vote on which testimonial was the most convincing.

8. Wrap Up (10 minutes)

8a. Ask participants to share ideas on the following questions.

- Why do you think testimonials are an effective behavior change strategy?
- What needs to be included in the testimonial to make it convincing?
- What kinds of questions should the Behavior Change Agent or facilitator ask after a testimonial to ensure that the key messages were received by the audience?

Lesson 5 Handout 1: Why are Testimonials Effective?

- Testimonials are **first-hand**, meaning that the presenter is presenting his/her own experience. Using the example of improved silos, if a leader in your community talks about how well it worked for him during the last harvest season, you will be more likely to believe him and try it yourself.

- Testimonials often **reach people on an emotional level**. The person not only presents the facts about the thing being promoted, but also promotes how he/she felt about it. If the mother promoting oral rehydration solution (ORS) is very excited about it, you, as a mother, will be more likely to get excited about it, too. **People get other people excited**. Reading something on a poster will rarely excite people.

- When a volunteer gives a testimonial, people usually think that he/she is **honest and objective** because he/she is not paid by anyone to give the testimonial. The people hearing the testimonial are more likely to think that the person is promoting the item or behavior **just because it works and he/she likes it**, not because someone paid him/her to promote it. The same is not always true of a nongovernmental organization (NGO) worker promoting the advantages of something; people may believe the worker has to promote it as part of their job.

- A group's **trust and respect** for the person giving the testimonial **makes it easier for others to believe and try out** what the person is presenting. They may say, "Just because Henry has recommended it, I will try it!"

- If a person has heard a testimonial and decides *not* to try the thing being promoted, he/she perceives that **it could affect his/her relationship** with the person giving the testimonial in a negative way. On the other hand, someone who *does* try out what is being promoted may have a better relationship with the person giving the testimonial. Sometimes people will try something that they really do not expect to work just because of the person who recommended it.

Lesson 5 Handout 2: Steps to Organizing a Testimonial

1. **Identify the behaviors that you are promoting that have low or less than desired adoption rates**, such as behaviors that require a person to use a service or do an action that is disapproved of by influential people in their lives. That means that you might start by promoting the new behavior with a small group of community members through an approach such as Trials of Improved Practices (TIPS), then begin using guided testimonials after some people have adopted the behavior.

2. Identify the people in the community that have experience practicing the behavior and that know the benefits of it. **Choose the person** to give the testimonial carefully, after talking with multiple people that practice the behavior. Make sure the person is **respected** in the community and is excited about the product or behavior that you want to promote.

3. **If the person is excited about the product or behavior, ask him/her questions** to help him/her to state what barriers he/she overcame to be able to practice the behavior and what the positive results of practicing the behavior are. Explain that many people have not even tried what is being promoted. **Ask if he/she would like to share his/her story** with others so that they will be more willing to try it out. Explain how important it is that more people begin doing what is being promoted.

4. **If he/she agrees to share his/her story, explain:**

   - When and where you will need him/her to speak
   - To which group of people he/she will be speaking
   - What should be included in the testimonial

     Things to Include in a Guided Testimonial

     1. Name the behavior being discussed.
     2. Explain how you learned about the product or practice (behavior).
     3. Share your initial reaction to the product or practice.
     4. State how and when you first tried the product or practice.
     5. Explain how you worked through any barriers.
     6. Explain the advantages you discovered.
     7. Share who supported your decision to use the product or practice (e.g., husband, mother).
     8. Explain why you decided to keep doing the practice or using the product.

   - How long the testimonial should last (probably 5–15 minutes)
   - The importance of telling the story with enough information and specific detail that people can understand and relate to why the person is excited about this product or practice in the testimonial
   - The importance of showing enthusiasm for what is being promoted

5. **Give the person some time** (e.g., a few days to a week) to prepare what to say and to practice it.

6. **Have the person practice telling you the testimonial at least twice** and, if you have the option, record it on tape or video. Coach the person to include all of the important parts of the testimonial (in the list above) and to leave out anything that is not useful or that would be discouraging to other people. When the person can give the testimonial with enough details without reading it from written notes and you think he/she is ready to address a group, invite him/her to a group meeting to give the testimonial.

7. **Have the person give the testimonial to a group** (e.g., mothers club, farmers' association) that you are regularly meeting with to promote behaviors. Do not interrupt the person while he/she is giving the testimonial. But, when the testimonial is finished, ask questions so that he/she can include any details that may have been left out of the testimonial. Discuss the product, technique, or behavior being promoted by referring back to what this opinion leader said in the testimonial.

8. **Get commitment from the group.** Ask the group, "How many of you would be willing to try out what Mr. [Name] tried out?"

9. **Tell the group that you want to hear someone else's testimonial the next time you meet** (if the product or behavior is something that can be tried out before the next meeting). Choose the person who will give the next testimonial by talking with people informally after the meeting. Assure that the person selected is someone who can give a positive testimonial. Subsequent testimonials after the first can be more natural and may not need as much coaching, but with less practice and coaching, you may have to ask future presenters more questions after they give their testimonials.

Some General Guidelines

- Include a problem solved (or objection that is overcome).
- Have the person include a lot of examples or specifics in the testimonial, which makes it more real and easier to understand and imagine.
- Target testimonials to the specific audience you have in mind, and have people give testimonials to a group of people "like them" (e.g., fathers giving testimonials to other fathers, youth giving testimonials to other youth).
- Use "live" (in-person) or video testimonials rather than written ones, where possible. Radio is another medium that can be used to share testimonials.

Lesson 5 Handout 3: Example Testimonial

Good morning everyone. I'd like to share with you today my story about why I decided to get a dog as a guardian. For the longest time a man from our neighborhood was our guardian. Joshua became a friend of the family, and he was with us for a very long time. Over that time he got older, of course, and it became harder and harder for him to stay awake during the entire night, which is when we really needed him. Also over those years, things changed in our neighborhood. The youth became bolder and things became more dangerous as thugs started roaming the streets and taking advantage of innocent people. There were many break-ins and many guards were injured while defending the property of their employers.

When Joshua became too old and frail, we decided to get a dog to be our guardian. We had heard from some friends that people in rural areas use dogs and they are very effective. At first I wasn't too keen on the idea because I have never been a "dog lover" and I thought it would cost a lot to maintain the dog. I thought the dog would be dirty and smelly. But someone offered me a guard dog and I decided to give it a try, since we felt very vulnerable, not being guarded by anyone, especially at night. In fact, before we finally got the dog, someone broke into our house at night and stole our new radio. That incident really motivated me.

So, I had to think through what it would require of me to own a guard dog. We had to build a shelter for the dog to keep it out of the sun and the rain. We just built a small lean-to, so that was easy. Then I had to figure out what to feed the dog. At first I thought dogs need to always eat meat and that I'd have to buy expensive food. But, my friends told me that dogs eat almost anything, so, as it turned out, he was fine to eat the scraps from our meals. I only have to feed him a decent meal about once a week. This costs less than what we paid Joshua. Then we had to train the dog to recognize and become friendly with the family members. Of course, he immediately liked me because I'm the one who feeds him. But, the rest of the family deliberately played with him, praised him, and called him by name, and after a week or so he knew everyone in our family and began to feel loyal toward us. I also soon learned that dogs kept in families aren't dirty or smelly.

What I didn't know would happen is that he'd make everyone feel happy! Even though this is a serious guard dog, he also is fun, and when you return home each day, he greets each person wagging his tail and he seems to be smiling. We also felt very secure when he was guarding the house at night.

Where I live people are typically afraid of strange dogs, so they naturally stay away, but our dog is very alert to strange sounds, especially at night, and when people walk too closely to our gate or the wall that surrounds our house, the dog jumps up and begins to investigate. If he feels there is a threat he begins to bark—not a friendly little bark, but a menacing scary bark that tells the potential intruder that he means business.

Everyone in the house, but especially my mother-in-law, is so happy with my decision to get a guard dog. We feel so much safer and we sleep soundly. In fact, ours is one of the few houses in our neighborhood that hasn't been robbed since we got the dog a year ago. So we plan to keep using a dog as our guardian.

Lesson 5 Handout 4: Small Group Instructions for Preparing Testimonials

1. Choose one person who will lead the small group work for this exercise (the "group leader" mentioned below).

2. The group leader should ask each member of their small group to name a practice (behavior) that he/she adopted in the past 5 years. This can be a development practice (e.g., taking their children for vaccines, using oral rehydration solution [ORS], building an improved silo, terracing land) or a personal behavior that they feel has benefited them and/or their family members. (It is possible to give a testimonial about a product, but for this lesson create a testimonial about a behavior.) Ask:

   - Who encouraged you to adopt the practice?
   - Why did you adopt this practice?
   - What are the benefits (advantages) of the practice that you adopted?
   - What sort of results did you see when you adopted the practice?

3. Given the participants' responses, the group leader will identify one person who would be able to provide the best testimonial for the behavior. This should be a person who can list multiple reasons for adopting a practice and who was happy about the results.

4. Once the behavior and the testifier have been selected, **get approval from the workshop facilitator to move ahead with that behavior**.

5. The small group leader should ask the volunteer testifier a few questions to help him/her recall details about the process of what was done and the results. See if the volunteer can recall enough of the details to provide a good testimonial. If he/she cannot, choose a different person to give the testimonial.

6. Once the volunteer testifier has been selected, ask the volunteer the following questions so he/she knows what to include in the testimonial. Have the volunteer make a few notes of his/her responses to remember what to say.

   - How did you learn about this practice? Who suggested that you do it?
   - What was your initial reaction when someone suggested that you do it?
   - When did you first try it out?
   - How did you try it out? What did you do, specifically? (Make sure the volunteer testifier gives details on this and does not just say "I gave my child ORS." The testifier should explain it in a way that you can see in your mind exactly what he/she did.)
   - Did you encounter any barriers when you tried it out? How did you work through those barriers?
   - What advantages did you discover when you tried the practice out?

- Who supported your decision to do it? What did they say to you about it (if anything)? (Prompt for specific people who may have supported them: What did your mother think about it? Your husband? The nurse? The field agent?)
- What are the main reasons you decided to continue doing the practice?

7. Remind the volunteer testifier that it is important to **include a lot of details** when sharing the testimonial and to **look interested** in what he/she is saying (e.g., smiling, maintaining eye contact, other culturally specific cues to show that he/she honestly is excited about what he/she saying in the testimonial).

8. Explain to the volunteer that he/she will now **practice** giving the testimonial to the small group without you asking a lot of questions. The volunteer should include the same information that he/she mentioned when you asked questions, but put it into a short speech about the practice he/she will promote with the testimonial.

9. As the volunteer is practicing the testimonial, he/she can refer to written notes to remember the key points to make.

10. Once the volunteer finishes practicing the testimonial, ask the other small group members what they liked about the testimonial and to give suggestions for ways to improve the content and/or the delivery.

11. If the volunteer needs more practice, have him/her give the testimonial again. Try to offer fewer prompts/less coaching this time.

12. Return to the larger group.

Lesson 6: Storytelling for Behavior Change

Achievement-Based Objectives

By the end of this session, participants will have:

- Articulated the importance of storytelling as a Behavior Change Agent (BCA) skill
- Identified the difference between an open-ended story and a closed-ended story and in what situations each type should be used
- Written an open-ended and a closed-ended story using the steps to writing a better story
- Practiced storytelling
- Critiqued their own and their co-participants' storytelling skills

Duration

3 hours

Materials

- Flip chart with Story Definitions
- Flip chart with the Adult Learning Cycle
- List of behavior changes promoted by the participants in their work
- Lesson 6 Handout 1: Closed-Ended Story: Blood Worms (1 copy per participant)
- Lesson 6 Handout 2: Open-Ended Stories (1 copy per participant)
- Lesson 6 Handout 3: Discussion Questions for Closed-Ended Stories (1 copy per participant)
- Lesson 6 Handout 4: Discussion Questions for Open-Ended Stories (1 copy per participant)
- Lesson 6 Handout 5: Guidelines for Developing Behavior Change Stories (1 copy per participant)
- Lesson 6 Handout 6: Elements of a Story (1 copy per participant)

Why this Lesson?

Behavior Change Agents (BCAs) can use stories to effectively connect with their intended audiences and move them to take action. Stories are entertaining and easy to remember, and they tend to provide emotional and cultural "hooks," allowing the audience to identify with the place and characters without making them feel bad about their current lack of knowledge or inaction. Stories can move us to action by:

- Inspiring or motivating us to do something
- Showing us how a problem can be solved

Advanced Preparation

Throughout this manual, the term Behavior Change Agent (BCA) is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

Prepare a flip chart with the Story Definitions (from Task 3). Prepare another flip chart with the Adult Learning Cycle shown in Task 5.

Change the names and other details of the stories in **Lesson 6 Handout 1: Closed-Ended Story: Blood Worms** and **Lesson 6 Handout 2: Open-Ended Story: Story of a Death** so that they are appropriate for your local audience. Practice reading the stories aloud.

Develop a list of behavior changes that are promoted by the BCAs in their work. In Task 7, these behaviors will be assigned to participants as the focus of the stories they will develop.

In Task 8, the facilitator demonstrates effective storytelling techniques. This can be done using a story from Handout 1 or Handout 2 or one of the stories created by the participants earlier in the session. Or, if appropriate, the facilitator can prepare a story in advance that matches the participants' project or program topics.

Tasks

1. Warm-Up Activity (5 minutes)

    1a. Tell participants that today's lesson will focus on storytelling, so they will start with an activity that will help them tap into their natural creativity. Explain that they will work as a group to make up a story, taking turns to complete the phrases "Unfortunately, …." then "But fortunately…"

    1b. For example, the first person starts the story with a sentence such as, "Unfortunately, my goat ran away last week." Then the next person adds, "Fortunately, it was found by my cousin in the next village over." The next person continues, "Unfortunately, my cousin couldn't bring my goat back because the goat had begun behaving very strangely…" and so on. The process continues, alternating between "fortunately" and "unfortunately" until all participants have had a chance to contribute to the story.

    1c. Remind participants that they do not have to be serious or realistic during this activity. Encourage them to have fun and get in touch with a childlike sense of creativity. The game works best if participants think quickly and don't worry about doing it perfectly. Continue until the story reaches a natural stopping point, it becomes so ridiculous everyone is laughing, or time is up.

2. Stories for Behavior Change (10 minutes)

   2a. Tell participants: In our jobs as Behavior Change Agents we are trying to solve problems such as ill health, malnutrition, or poor agricultural production. To do this we encourage people to adopt new behaviors. One of the ways we can encourage people to adopt new behaviors is by telling stories. How many of you have recently heard or told some stories? What kinds of stories can you think of? Where did you hear them, or to whom did you tell them?

   2b. Explain to participants: There are stories about talking animals and people with special powers, there are stories to help us remember how things were long ago, there are love stories and adventure stories with happy endings and with sad endings, and many more kinds of stories. Some stories are mostly for entertainment, others are intended as teaching stories, and often the stories we love the most are entertaining, emotional, and help us learn something about ourselves or something that relates to our own lives. Why do you think that stories are used so often with children?

   2c. Explain to participants: Despite the detailed information that is often found in a story, stories are one of the easier things for us to remember. Stories are also entertaining. They tend to hold the attention of both children and adults much better than a lot of other education methods.

   2d. Explain to participants: Teaching through stories also is helpful when you do not want to make someone feel bad about their lack of knowledge. It helps the person to think

about what needs to happen in a given situation. It also allows them to identify with the character in the story who finds a solution to the problem.

3. Definitions and Examples: Closed-Ended and Open-Ended Stories (25 minutes)

3a. Explain to participants: In this lesson we are going to talk about two types of teaching stories: closed-ended and open-ended. A "closed-ended story" is an account of an event, true or imaginary, that promotes the adoption of actions or attitudes. Specific behaviors are mentioned in the story that we want to promote in communities.

3b. Display the flip chart that you prepared in advance with the story definitions (below) and explain the definition of a closed-ended story.

Story Definitions

Closed-Ended Stories → promote a specific behavior to solve a particular problem

Open-Ended Stories → generate many possible solutions to a complex problem

3c. Distribute **Lesson 6 Handout 1: Closed-Ended Story: Blood Worms**. Read the story with participants. (**Note:** Practice ahead of time and be sure to watch your pace, be animated, and use different voices for different characters. Change the names of the characters to local names to make it feel more familiar to the listeners.) Then use the following questions to discuss.

- What was the main problem in the story? (Answer: Bloodworms, Schistosomiasis)
- What happened to the two brothers after bathing in the water? What symptoms did they have? (Answer: Belly pains, blood in urine)
- What did they think caused their illness? (Answer: The townspeople are poisoning us!)
- What did their neighbors and the chief tell them? (Answer: Each family had their own well, the history of the problem and how the community solved it)
- What was the solution to the problem? (Answer: Stopped urinating in river, dug wells for drinking, got treatment for disease, stopped bathing in contaminated or uncertain water)
- In terms of health, what are the things that we learned to do from this story? (Answer: Construct and use latrines, construct and use wells for drinking / washing water, treatment of disease)
- Have people in your community (or country) had problems that stemmed from using river water? Could they resolve the problems they have by doing similar things (latrines, wells)?

3d. Explain to participants: Now I am going to tell you a different type of story. This next one is an example of an **open-ended story**. Some people also call it a "problem story" since it tells about a problem but doesn't explain what to do about it; rather, the listeners are asked to propose their own solutions to the problem.

3e. Distribute **Lesson 6 Handout 2: Open-Ended Stories**. You can choose to work with **Option A: The Star Student** or **Option B: Story of a Death**. Read through the story with participants. (**Note:** Practice ahead of time and be sure to watch your pace, be animated, and use different voices for different characters. Change the names of the characters to local names to make it feel more familiar to the listeners.) Then discuss the story by posing the questions for each option, below.

- Option A: The Star Student
  - What were the main problems in the story? What went wrong? (Answers can include: Leila's mother doesn't have a lot of support, Leila is responsible for most of the household chores, she has a long walk to school, she isn't able to get enough sleep, she doesn't have time to study)
  - How could these problems have been prevented? (Answer: Identifying and addressing barriers to attending school)
  - Have people in your community ever had these kinds of problems?
  - How can we prevent this problem?
- Option B: Story of a Death
  - What were the main problems in the story? What went wrong? (Answers can include: Amina doesn't rest when needed, she doesn't know what danger signs to look for, she and her husband do not have a plan for emergencies)
  - How could these problems have been prevented? (Answer: Identifying and addressing barriers to receiving antenatal care)
  - Have people in your community ever had these kinds of problems?

    How can we prevent this problem?

4. Uses and Limitations of Both Types of Stories (5 minutes)

4a. Ask participants: In what situations do you think you would want to use a closed-ended story? (Answers are as follows.)

- You should use **closed-ended stories** when you want **to promote a specific behavior or set of behaviors** to resolve a problem. Closed-ended stories are appropriate for promoting specific behaviors, like exclusive breastfeeding, use of latrines, hand washing, and other key actions. They are *not* the best method to use

when you want to generate ideas concerning many alternative ways of dealing with a problem. For example, if there is a problem with violence against women in a community or people do not have a way to get crops to market and you want to involve people in deciding what things they would do to solve that problem, an open-ended story would be more appropriate.

- **Open-ended stories** are used when you want to generate discussion **to identify many possible solutions** to more complex problems. When you do not have an idea of a clear strategy to tackle a particular problem, think of using an open-ended story. With an open-ended story, you can generate a list of ideas for solutions that could be used in the community to combat a problem. Afterwards, you could use a closed-ended story to promote one or more of the behaviors (e.g., a story on how to convince younger girls not to marry older men). You should *not* use an open-ended story when people already have decided what action they will be taking to resolve a problem or when there is really only one good way to properly resolve a problem.

5. Developing Discussion Questions (20 minutes)

5a. Ask participants: What did we do after I told each story? (Answer: we discussed it) How does the discussion make the story more effective? (Answer: it helps people imagine the situation happening in their own community; it identifies new, locally appropriate solutions)

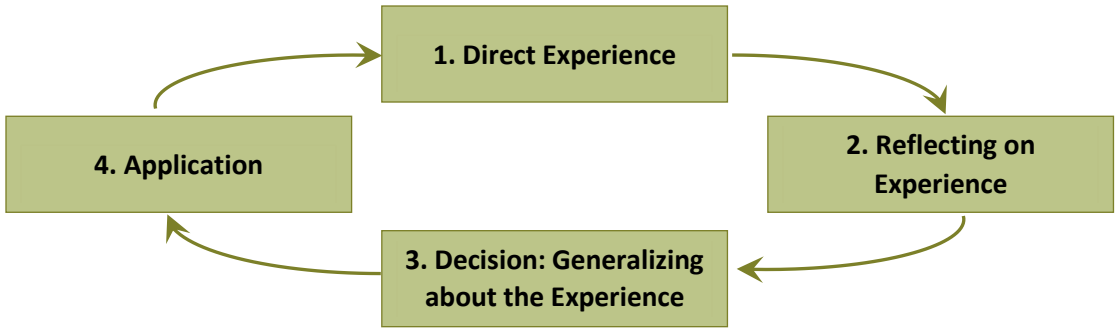
5b. Explain to participants: It's very important to always have a discussion after a story is told.

5c. Ask participants: What types of questions do you think would be useful to discuss after a closed-ended story is told?

5d. Explain to participants: After you have given community members the "direct experience" of a story, there are several questions you can ask to help them reflect, make a decision for themselves, and consider practicing the behavior themselves.

5e. Show the flip chart that you prepared in advance, with the Adult Learning Cycle (below), and review the steps of the cycle**.** Explain that the story itself is a kind of direct experience: when you listen to a story you imagine you are there.

Flip Chart: Adult Learning Cycle



5f. Distribute **Lesson 6 Handout 3: Discussion Questions for Closed-Ended Stories** and ask participants to review it individually (or ask a volunteer to read it out loud). Ask participants what other questions they might add to encourage the listeners to reflect, make a decision, and consider practicing the behavior. Ask for a few suggestions and encourage participants to write those on the handout.

5g. Ask participants: What type of discussion questions would be useful to ask after an open-ended story is told?

5h. Distribute **Lesson 6 Handout 4: Discussion Questions for Open-Ended Stories** and ask participants to read it individually (or ask a volunteer to read it out loud). Ask what other questions could be asked to help the discussion. Hear a few suggestions and encourage participants to write those on the handout.

5i. Tell participants: Remember…

- It is extremely important to let people discover the message for themselves, rather than telling them all the answers.
- The questions used after a story should point out the negative consequences of negative behaviors and the positive consequences of positive behaviors.

6. Guidelines for Writing Stories (15 minutes)

6a. Distribute **Lesson 6 Handout 5: Guidelines for Developing Behavior Change Stories** and ask participants to review the guidelines. Take questions about the guidelines.

6b. Distribute **Lesson 6 Handout 6: Elements of a Story**. Explain to participants: Brian McDonald, the author of *Invisible Ink: A Practical Guide to Building Stories that Resonate*, gives these steps as a guide to writing a better story. Though the guide is flexible and not all stories need to follow it exactly, he says that most stories have these steps.

6c. Divide the participants into pairs and ask each pair to review the stories in Lesson 6 Handout 1 and in Lesson 6 Handout 2. Ask each pair to try to fit each story into these seven steps. Select two to three pairs to share what they did. Did both stories have all the steps? Why or why not?

7. Writing Stories (20 minutes)

7a. Assign each pair a behavior from their project. Ask pairs to develop a short story that promotes the assigned behavior. Give them 15–20 minutes to work on their story.

8. Storytelling Technique (60 minutes)

8a. Explain to participants: Now that we have learned how to write stories, we are going to look at what it takes to be a good storyteller.

8b. Choose one story from the handouts or from among those just written, or bring another short example from your project to practice storytelling for the participants. You will read the same story twice. The first time, read the story in a boring way. The second time, tell the same story with changes in tone and volume and with enthusiasm.

8c. After telling the story, ask participants to identify the differences between the two "tellings." Explain that a story can be very well written, but if it is not delivered well, it will not capture and hold the attention of the listener.

8d. Combine the pairs that developed stories into small groups of four. Using the stories that the pairs wrote for this lesson, ask each person to practice telling their story to the others in their group using their best storytelling skills. The facilitators should circulate and observe the groups, giving a little feedback if appropriate (for example, share two positive observations, plus one thing to work on, using phrases such as, "What if… ?" as in, "What if you showed a little more excitement?" or, "What if you used more gestures?"

8e. After everyone has had a chance to tell their story, the small group should select one person from their group to present their story to the larger group. Listen to one story from each small group. Ask a few participants to tell the storytellers something they really liked about the story and how it was told. Thank the presenters, and give them a round of applause.

9. Wrap Up (10 minutes)

   9a. Ask the participants the following questions.

   - What opportunities exist in your project for using storytelling to promote behavior change?
   - How would you know when to use an open-ended or closed-ended story? Can someone share an example of how you might use one or the other?
   - How can you use storytelling in your work during the next few months?
   - What steps would you take to get ready to tell a story and help make sure the story will work well before using it with the community?

Lesson 6 Handout 1: Closed-Ended Story: Blood Worms

There were once two brothers named Fernando and Hernando. The two brothers decided to go visit some relatives who live in a distant village. During their visit, they would walk to the river each day to bathe, and they talked about how surprising it was that hardly anyone else frequented the river. They asked their neighbor, Mr. Tufo, about the situation, and he told them that each family had their own well. Fernando looked at Hernando and frowned, but said nothing. Later the two brothers talked about how unsociable this was for each family to have their own well instead of gathering at the river! After 3 months, both brothers began having belly pains and soon started noticing blood in their urine. Hernando grabbed his brother by the arm, looked him in the eyes in a panic, and said, “Brother, the townspeople are poisoning us! They do not like visitors here!” They went to the village chief to complain.

Upon explaining their troubles to the chief, the brothers were told that, years ago many of the people in the village had belly trouble and blood in their urine. One of the tribes in the community began to argue with the other tribe, and neighbors accused each other of putting curses on their households and making them bleed. The smaller tribe of people was planning on leaving and moving to another village when a health worker advised them that the disease came from tiny creatures living in pools and streams where people bathed. These baby worms went through the skin of the bathers and traveled through the blood to their bellies. The villagers also learned that the eggs of the worms were passed in people’s urine or feces and would be washed by rain into the pools.

Both tribes, upon the advice of the health worker, began to use shovels to bury their feces, built latrines, and stopped urinating in the river. They also dug wells to draw water for drinking and washing. Soon, no one in the village complained of belly pain and bloody urine. The two tribes began to get along with each other, as well.

The two brothers followed the example of the rest of the villagers and soon became healthy again. After that, whenever they had a problem, they were sure to first discuss it with their neighbors to see what they could learn from them.

Lesson 6 Handout 2: Open-Ended Stories

Option A: The Star Student

Leila enjoys school, and she especially enjoys learning about math and practicing her reading. Last year, she was one of the top students in the 4th grade! Unfortunately, she hasn't been able to go to class very often this year. She has a new baby sister and her father has traveled to another part of the country to look for work. She has two older brothers and two younger sisters, one of whom is her sweet new baby sister. Leila's mother needs her help to take care of them all. Leila loves her brothers and sisters and wants to help, though she also misses school, her teacher, and her friends.

There are many chores to do each day, and Leila does them very well. She goes to the river to get the water, washes clothes, and prepares the meals. She often helps with the weeding in the family's small field. She wakes up early and works hard all day. Sometimes she goes to the market to help her mother when they have some extra vegetables to sell. Even when she makes it to school, she is often too tired from her chores and the long walk to pay attention, and there is not much time for studying when she gets home.

This year, she missed so much school that she will not pass to the next grade. She feels very embarrassed and sad. She decides to focus on helping her mother and not worry about going to school.

Option B: Story of a Death

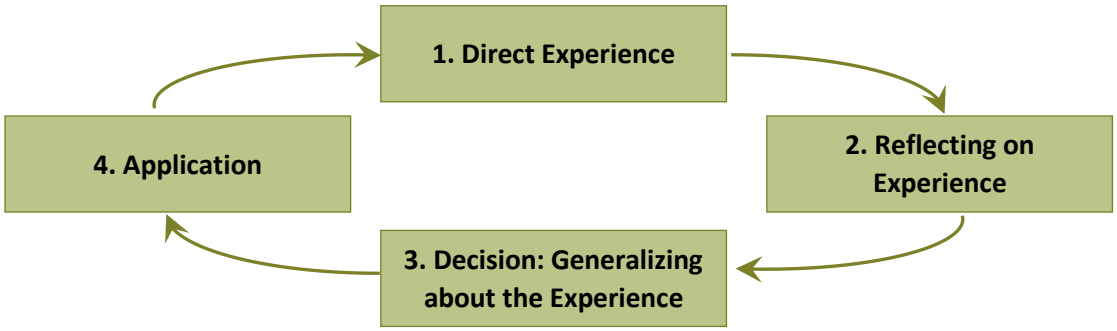
Amina is pregnant. She wakes up early and works hard all day. Sometimes she lifts heavy things. She doesn't have any help. She has no time to rest. In the afternoon, Amina sees her pregnant friends on their way to the health facility for their antenatal visits, but she doesn't join them. She continues to work. One day while working in the fields, Amina notices blood on her clothes. She doesn't tell anyone. Amina washes her clothes but she doesn't tell anyone about the blood because she doesn't know any of the danger signs to look for when she's pregnant.

The next morning Amina wakes up with a lot of blood on her mat. She calls to her husband to get help. Amina's husband runs around the village looking for transportation. He finds that most of the men are in the fields. It takes him a long time.

By the time he has found help and comes back to the house he sees that Amina has died.

Lesson 6 Handout 3: Discussion Questions for Closed-Ended Stories

Here are some example questions that correspond to each of the steps in the Adult Learning Cycle.



Reflection

- What were the main problems raised in the story?
- How did people try to resolve the problems? What happened? How did they finally resolve the problem?
- In terms of health (or agriculture or another sector, depending on the story), what were the most important practices that were mentioned in this story?

Generalization/Personalization

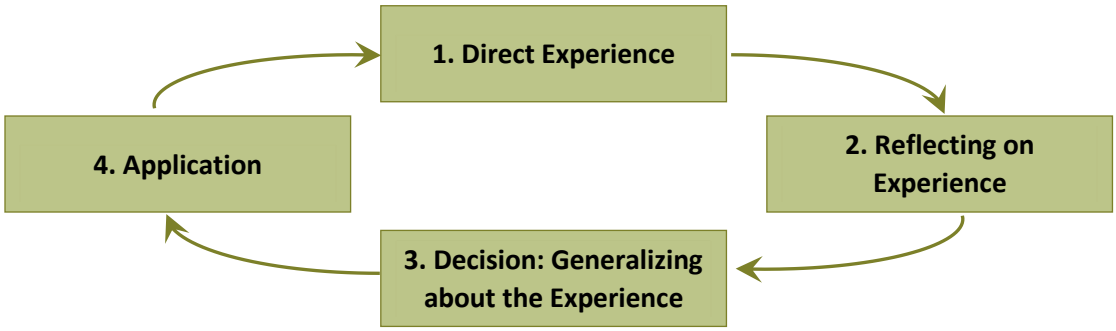
- Who do you identify with in this story? What would you do?
- What did you learn from this story?
- Have you seen that problem in your community?
- Do you know people who might identify with the different characters in the story?
- Would it be possible for people in your community to resolve problems in the same way as the people in the story? What might the challenges be? What would be easy to implement? Should we do that?

Application

- What do we need to do to encourage people in this community to adopt this behavior? How could we begin that work?

Lesson 6 Handout 4: Discussion Questions for Open-Ended Stories

Here are some example questions that correspond to each of the steps in the Adult Learning Cycle.



Reflection

- What were the main problems raised in the story?
- What else might cause difficulties related to these problems that was not talked about directly in this story?
- How could the people in the story solve the problem?
- How could the people in the story prevent the problem?
- How would you describe the reasons for the problem in this story to a friend?

Generalization/Personalization

- Who do you identify with in this story? What would you do?
- What did you learn from this story?
- Have you seen that problem in your community?
- Do you know people who might identify with the different characters in the story?

Application

- What are the ways that we could prevent that problem (or solve it) in this community?
- What do we need to do to encourage people in this community to adopt this behavior? How could we begin that work?

Lesson 6 Handout 5: Guidelines for Developing Behavior Change Stories

1. Remember that a **closed-ended** story should be used when you are trying to promote a **specific behavior**. Clearly identify the specific behavior that someone did in the story, and repeat the behavior throughout the story.

    - For example, it would be better to say "Martine persuaded her relatives to help her build a hand washing station at their home" than to say "Martine decided she wanted to have better cleanliness and hygiene at her home."

2. An **open-ended story** should be used when you want to **start a discussion about many possible solutions** to a problem.

3. **Give names** to the people and the setting in your story, or mention their profession (for example, the schoolteacher) instead of calling them "the man" or "the youth." That makes it easier to remember the story.

4. Use **place names** that sound familiar and believable, but don't use the name of a real place (to avoid stigma).

5. The situation in the story should look like something that could be true. In some cultures, a real situation can be acted out in the story by animals or other characters who represent certain personalities and meanings.

6. Make the story **simple and clear**.

7. The story should **focus on a specific behavior change**, not just on receiving information or learning about a new practice.

8. It should take no more than **5 minutes** to tell the story. (This does not include the questions that are discussed after the story.)

9. Include enough **detail** to make the story interesting, but not so much that the important messages get lost.

10. Be **descriptive and dramatic** about important parts of the story. Let the reader know what people's emotions were at different parts of the story. Help the reader visualize what is happening in the story, as if they were watching it happen.

    - For example, instead of saying, "The Promoter found that Felipe had a fever," you could say "Andrea, the Promoter, noticed that beads of sweat were forming on Felipe's forehead as he struggled to breathe. She quickly took his temperature, and both she and Felipe's mother gasped when they found that it was already 41 degrees!"

9. At times, you should use a little bit of humor in your stories, but the humor should not be the central focus of the story. It is good when stories are funny enough or unique enough that people want to tell the story to other people.

10. Stories should be constructed to include **traditional knowledge or beliefs** when relevant. Remember, many traditional practices can be positive, and some that are harmful or no longer helpful might be respectfully adapted to incorporate newer practices. When writing a story, **be careful** not to always make local or traditional practices or people look bad. If the weakness of a local custom is pointed out, you may want to mention that people have good reasons for what they did in the past, but sometimes circumstances change or we have new information and practices change over time.

11. You can **draw comparisons** in your stories.

    - For example, you can compare a family who took its sick baby to the health facility for treatment to a family who did not. Or you can write a story that starts with a description of someone's life before they practiced a certain behavior, then explains how they learned to do the new behavior, and later describes his/her life when applying the skills that they learned.

12. If your project has done **formative research** on the behavior and you know what the most important barriers to adopting the new behavior are, incorporate that information into the story showing a way to overcome the obstacle.

Lesson 6 Handout 6: Elements of a Story

1. There was a time when _____
2. And every day _____
3. Until one day _____
4. And because of this _____
5. And because of this _____
6. Until finally _____
7. And ever since that day _____

Lesson 7: Learning through Cross-Site Visits

Achievement-Based Objectives

By the end of this lesson, participants will have:

- Identified the qualities that make a cross-site visit a valuable learning experience
- Reviewed steps for planning a cross-site visit
- Created a cross-site visit itinerary to meet the needs of the learners
- Discussed how to use cross-site visits to promote behavior change in their communities

Duration

1.5 hours

Materials

- Paper, pencils, and markers
- Lesson 7 Handout 1: Story of a Cross-Site Visit (1 copy per participant)
- Lesson 7 Handout 2: Checklist for Planning a Cross-Site Visit (1 copy per participant)

Why this Lesson?

There are many ways that Behavior Change Agents (BCAs) can help community members to learn about a new behavior/practice. One way is to have members of one community visit members of another, nearby community to learn how they solved a problem. For a cross-site visit to be a good learning experience, planning is required. In this lesson we will learn how to plan and carry out a cross-site visit to promote behavior change.

Advanced Preparation

Throughout this manual, the term Behavior Change Agent (BCA) is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

Tasks

1. Warm-Up Activity (30 minutes)

    1a. Conduct an introductory exercise that gets participants talking to each other and thinking about sharing their knowledge and experience.

    1b. For example: Divide participants into four groups. Give each group a piece of paper and pens/pencils/markers. Ask them to imagine that they are going to live on a deserted island for 5 years. (Or, the facilitator can pick another isolated location, such

as the moon, on a boat, or on a mountaintop). Explain that they can only take five items with them to this place. They must decide as a group which five items they would like to take. Each group should sit far enough away from the other groups that they cannot hear or see what the others are discussing. They can write out their list or make drawings of the five items.

1c. After about 5–10 minutes, explain that each group will now have an opportunity to choose a representative who will visit another group, see which items they have selected, ask a few questions, then report back to their own group. Each group will then have a few minutes to make changes to their own list, based on any new ideas gained from other groups.

1d. Ask the representatives to switch between groups (for example, the representative from Group 1 visits Group 2, and vice versa; Group 3 visits Group 4, and vice versa). Allow about 2 minutes for the representatives to review the items and ask questions of the group members.

1e. Instruct the representatives to return to their original groups and allow 3–5 minutes for the groups to discuss and make changes to their lists, if desired.

1f. Allow each group to present its list. Then facilitate a discussion based on the following questions.

- How did you decide on the five items to bring along? What difficulties did you have in coming to an agreement? How did you work through this?
- How did your list change after learning about another group's list? If you made some changes, what inspired you to do so? If you didn't make changes, what made you decide to stick with your original plan?
- What did you think of sending a representative to visit another group? What would have been different if everyone could see the other lists for themselves? Would it be helpful to be able to visit multiple groups or to choose which group to visit? Why?
- After learning about each group's list, what other changes might you make to your own lists?

1g. Thank the participants for their creativity and share the following: As Behavior Change Agents, one of our responsibilities is to help community members figure out how to solve problems through new behaviors or practices. But neither a BCA nor a single community has all the answers to every problem. So one of the ways we can help is to bring together communities and help them learn from each other. That is the theme of this lesson: helping communities to learn from each other through cross-site visits.

2. Group Discussion about Cross-Site Visits (10 minutes)

   2a. Ask participants to reflect for a moment on a cross-site visit or field visit they participated in or organized. If participants have no prior experience with these, ask them to think of a time when they learned and were inspired by seeing how others were solving a problem or using a new/different technique, product, or practice.

   2b. Explain that both sides— the people visiting the new site and the people who are being visited—benefit during a cross-site visit. Facilitate a discussion based on the following questions.

   - For those of you that have visited another site, what worked well about the visit? How did seeing the technique or practice first-hand help you learn? (Responses might include: While some people learn best in a classroom, I like to see the solution in action and maybe have a chance to try it out myself; it's more believable and realistic to see other people doing the practice; I can learn how to do the same thing in my own community by talking with others and asking questions; it's nice to know that there are other people I can rely on for help/advice if I decide to try it)

   - For those of you who hosted visitors, how was that helpful for you? (Responses might include: I felt proud of how well our project was going; I felt motivated to continue after seeing how what we were doing could help others; I liked being able to share our mistakes and solutions so that others don't need to waste their own time/effort)

   - If few or none of the group members have participated in a cross-site visit, ask participants to imagine what would be helpful about visiting and hosting

3. Planning a Cross-Site Visit to Enhance Learning and Behavior Change (45 minutes)

   3a. Emphasize that, for all the reasons just shared, a cross-site visit can be a fun and very inspiring way to encourage behavior change in our communities.

   3b. Note that in order for community members to get the most benefit from the visit, the BCA should make sure it is well organized. Ask participants for some thoughts about how a poorly-organized visit might affect community members' experience. (Responses might include: They might focus on the frustration of waiting or wasting time, instead of the benefits of the new practice; their frustration could make them feel less motivated to try the new behavior; they might lose trust in the BCA and the other community)

   3c. Emphasize that these frustrations can be avoided by doing some planning and organization in advance. Explain that they will now work together to review the steps

for planning a site visit. By the end of the lesson, they will have practiced completing a checklist they can use to help their next site visit go smoothly.

3d. Read the example of a cross-site visit in **Lesson 7 Handout 1: Story of a Cross-Site Visit**. Adapt the terms and topic as needed to match the interests of your participants and the focus of their project area(s).

3e. Ask the participants how they think this visit would be helpful to both the visitors and the hosts. Ask them how they think the visit was able to go so smoothly.

3f. Distribute **Lesson 7 Handout 2: Checklist for Planning a Cross-Site Visit**. Explain that this is a tool that BCAs and community members can use to make sure that a cross-site visit is as effective and fun as possible. Ask them to imagine that they are the BCA who prepared the visit they just heard about. Read through the checklist as a group, verbally completing each section using the example that you just read out loud.

For example, for "What do we want to learn?" ask participants to imagine what topics/questions/concerns the BCA wrote down as part of the planning process. (Responses might include: steps of the process, costs, materials needed, problems and solutions, benefits for families)

3g. Now ask participants to think of a site that their community members (or BCAs) could visit sometime during the next few months. Encourage them to be realistic and to use this opportunity to practice preparing as if for an actual site visit. Ask them to work individually to complete as much of the checklist and schedule as possible. After 10 minutes, ask a few participants to share their plans with the larger group.

4. Wrap Up (10 minutes)

4a. Tell participants: There are many ways that Behavior Change Agents can help community members learn. The Behavior Change Agent doesn't always have to have the answers or the solutions to a community's problems. Some solutions can be found by learning from what other communities have done. This is why organizing cross-site visits can be so beneficial. However, for cross-site visits to be effective learning opportunities, they need to be well organized. If they are well organized and well implemented, cross-site visits can be very powerful learning experiences.

4b. Facilitate a brief discussion based on the following questions.

- How can you use cross-site visits in your work?
- How might your community benefit from hosting visitors? How could you make this happen?

Lesson 7 Handout 1: Story of a Cross-Site Visit

A group of 10 farmers from a village association wanted to learn more about aquaculture. They worked with their local Behavior Change Agent (BCA) to arrange a visit to a nearby community where people had been doing fish farming for several years. They took the bus and arrived at 9 am. The visitors were greeted by John, a community leader who had helped arrange the visit.

After a brief introduction, the visitors went to the pond of a farmer named Michael, who was just starting out. He showed them how he was digging the pond and some of the tools and materials he was using. The visitors asked questions about planning, costs, and the time involved.

Then they visited another farmer named Mary, who had been maintaining her ponds for some time. She demonstrated to the visitors the different ways of feeding and caring for the fish. The visitors had an opportunity to observe and practice catching, checking, and feeding the fish. They talked with Mary about problems she had experienced and how she dealt with them.

Finally, they met with Esther and Martin, who showed the visitors how they harvest, package, and store the fish. They talked about how they have added the fish to their meals and how they sell some of the fish.

The fish farmers and their families demonstrated how they cook the fish. The visitors had brought some vegetables and other foods to share. They all ate a meal together and talked more about their families, communities, and the projects they were working on for the next year.

Lesson 7 Handout 2: Checklist for Planning a Cross-Site Visit

Why and Where Should We Visit?

❑ What do we want to learn?

_____

_____

_____

❑ Who can teach us about this?

Community contact person: _____

Other community members we'd like to meet with *(who has been involved and can teach us the different steps?):* _____

_____

❑ What questions do we want to ask? What would we like to see? *Email or talk with the hosts about these questions and interests before the visit. Confirm arrangements to meet with people who can provide answers and demonstrate the practices/techniques/behaviors.*

Questions:_____

_____

_____

Things to see/observe/practice: _____

_____

_____

What Other Information Do We Need Before the Visit?

- ❑ How long will it take to get there? _____
- ❑ What mode of transportation will we take?: _____
- ❑ How do we get there? (directions to the site): _____
  _____
- ❑ What time should we arrive? _____
- ❑ How long will we stay? _____
- ❑ What will the schedule be? (use the form, below, as a guide)
- ❑ Does the community agree to the schedule? YES / NO

Things to Take

- ❑ Letter of introduction or invitation to show to authorities if the group is stopped on the road (if needed)
- ❑ Refreshments or box lunches/food to share with hosts (if needed)
- ❑ Cameras (if photos or video are wanted/needed)
- ❑ Notebooks and pencil/pens, for note taking; If the group would like to assign a recorder, who should it be? _____

After the Visit

- ❑ Discuss the visit and lessons learned. Sample discussion questions include:
  - What was your favorite part of the visit? What made that special for you?
  - What surprised you?
  - What would you like to try out for yourself? What are the first steps you'll take? What other resources or information do you need? How can we work together to do that?
  - What do you think you might do differently? What are the first steps you'll take to try it this way?
  - What projects or practices are done in this community that you might like to share with others?
- ❑ Prepare a cross-site visit report with the date, itinerary, participants' names, and contact information for the people at the other site, learning objectives, important lessons learned, and follow-up action steps.

Sample Schedule

Arrival Time: _____

- Meet with hosts/introduction activity.
- Discuss ground rules (e.g., show respect, allow time for demonstration then share questions/answers, give constructive feedback, no cell phone use)
- Review the schedule.

First Presentation/Demonstration

- Name: _____
- Topic: _____
- Start time: _____
- End time: _____

Second Presentation/Demonstration (optional)

- Name: _____
- Topic: _____
- Start time: _____
- End time: _____

Add Additional Presentations/Demonstrations, as needed…

Discussion/Final Questions and Answers

- Time: _____
- Questions to ask: _____
  _____
  _____
  _____
  _____

Thank You/Conclusion: Time: _____

Departure Time:_____

Lesson 8: Behavior Change through Effective Facilitation

Achievement-Based Objectives

By the end of this lesson, participants will have:

- Described why a Behavior Change Agent (BCA) needs good facilitation skills
- Created a list of the most effective facilitation skills
- Ranked facilitation skills by importance
- Identified facilitation skills they need to improve
- Practiced effective facilitation skills
- Received and given constructive feedback on a facilitation exercise

Duration

2.5 to 4 hours

Materials

- Flip chart paper, markers, masking tape, and index cards
- List of topics for facilitation practice session (1 topic for each pair of participants)
- Lesson 8 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Behavior Change Agents' Facilitation Skills (2 copies per participant)
- Lesson 8 Handout 2: Facilitation Skills: Suggestions from an Experienced Facilitator (1 copy per participant)

Why this Lesson?

Effective facilitation skills, which are used to conduct education sessions and meetings, are one of the most important skills needed by a BCA. The typical BCA spends much of his/her time promoting behavior change by facilitating education sessions (e.g., trainings, meetings, and demonstrations). Unfortunately, most BCA's skill development focuses on technical content for his/her project area, not on *how to facilitate the learning process*. This lesson will improve BCA's ability to facilitate in a way that more effectively contributes to behavior change.

Advanced Preparation

Throughout this manual, the term BCA is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

Prepare a warm-up activity for Task 1 in case none of the participants volunteer to conduct an activity of their own.

In Task 5, participants will work in pairs to practice leading a 10-minute session on a topic related to their program area. Prepare a list of potential lesson topics that might be relevant to the participants and their programs.

Tasks

1. Warm-Up Activity (10–20 minutes)

    1a. Explain to participants that this lesson is about gaining and improving facilitation skills. Note that many facilitators start a lesson with a quick game or activity. Ask participants why they think so many facilitators begin a session in this way. (Answers may include: to energize people and get them thinking, help people feel comfortable with speaking around each other, help them learn more about and trust each other, introduce the topic in a fun and memorable way)

    1b. Ask participants if they have a favorite activity that they like to do when they facilitate, or if there's an activity that they enjoyed doing when they participated in a previous workshop or training. Request that a volunteer conduct his/her preferred activity with the group. (The facilitator should have an example warm-up activity ready, in case no one is comfortable facilitating their own on short notice.)

1c. Thank the volunteer and note that being able to facilitate an activity or lesson on short notice is a skill that takes experience and practice. Tell them that today's lesson will provide an opportunity to do this sort of lesson practice and get constructive feedback, so that they can work toward feeling more comfortable and natural as facilitators.

2. Reflecting on Our Own Experience (30 minutes)

2a. Ask participants the following questions.

- Why is it so important for Behavior Change Agents to practice and maintain effective facilitation skills?
- What parts of your jobs require you to use facilitation skills?

2b. Explain that effective facilitation skills are central to the BCA's job. For a person to change their behavior, they often need to gain new skills, acquire new information, or change their attitude. A BCA uses facilitation skills to enable these.

2c. Ask participants to remember an exceptionally good training they attended or a better-than-average education session or demonstration they participated in—any time when someone else was facilitating a learning opportunity in an effective way. Working individually, ask participants to list all the things the facilitator/trainer did well, i.e., things that made it easy and enjoyable for them to learn.

2d. Divide the group into smaller groups of 3–4 participants. Ask them to share their lists with their small group members, combine them to make one large list of facilitation skills, and write these on flip chart paper. Give participants 10 minutes to do this, then ask them to post their flip charts on the wall.

2e. Have the participants do a gallery walk around the room and read the other groups' lists. Have them take note of things other facilitators/trainers did well that they had not previously thought of.

2f. Ask the small groups to select one person from their group to make one large list of facilitation skills compiled from all the skills mentioned on all of the lists developed by the small groups so that each group has a master list of facilitation skills. Each group will need this full list for the next activity. (Later, you or a co-facilitator should type this master list up, print it, and distribute it to the participants.)

2g. Point out to participants that being an effective facilitator requires good planning, as well as effective management of the learning process.

3. Ranking Facilitation Skills (30 minutes)

   3a. Using the master list of facilitation skills prepared in the last activity, ask each small group to work together to rank the facilitation skills by relative importance.

   Note: There are a couple ways of doing this. You can instruct participants to write a number next to the skills on the list to rank them. Or you can ask them to write each skill on an individual index card and arrange them by importance.

   3b. Have one of the small groups report out the top five facilitation skills on their list. As they read each skill, write it on a flip chart and have the participants in the other groups raise their hands if they also have that skill in their top five. When the first group is finished, ask the second group to share any skills in their top five that have not been mentioned yet. Continue in this way until all the groups have shared. When they have finished, label the flip chart "Top Facilitation Skills."

   3c. Distribute **Lesson 8 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Behavior Change Agents' Facilitation Skills** and explain that this checklist is used to help monitor the quality of facilitation. Ask participants to compare the items on the QIVC with those on their master lists of facilitation skills. Ask them to note how many are on the QIVC and which are missing. Explain that this QIVC is only one example, and their organization(s) may develop new QIVCS or adapt existing QIVCs for their program(s) to include other skills the organization considers important.[6]

4. Facilitation Skills Self-Assessment (10 minutes)

   4a. Distribute an index card to each participant. Referring to the master list of facilitation skills, ask participants to identify the skills that they would like to improve (or add other skills that have not been mentioned yet) and to write these on the index card.

   4d. Invite a few participants to volunteer to share one item they wrote on their index cards. Ask all the participants to keep their cards for later use.

5. Practicing Facilitation Skills (1–2 hours)

   5a. Distribute **Lesson 8 Handout 2: Facilitation Skills: Suggestions from an Experienced Facilitator**. Discuss each point and take questions, then ask participants if they learned anything new from the suggestions or if any of the suggestions would be hard to do.

[6] Additional information and instruction on using the QIVC is available in Advanced Lesson 1: Quality Improvement and Verification Checklists (QIVCs) and Giving Feedback. Adaptable copies of QIVCs and related training slides and videos are available at http://www.fsnnetwork.org/quality-improvement-verification-checklists-online-training-module-training-files-slides-qivcs-etc.

5b. Note that there is blank space on the back of the handout. Ask a few participants to share some additional suggestions, and encourage everyone to write down any ideas that they think would be helpful in their own work.

5c. Explain to participants that *knowing* about good facilitation skills is a good start, but it takes practice to become a good facilitator.

5d. Divide the participants into pairs. Assign each pair a topic relevant to their program area (from the list that was prepared in advanced). Tell participants that they will create a lesson on their topic, lasting no more than 10 minutes.

5e. Ask each pair to prepare to present their lesson to the rest of the participants. Encourage them to create a written outline of the lesson to ensure that they are able to effectively present their topic within 10 minutes. Their lessons should include the facilitation skills that they want to improve. They can either make visual aids or use pretend visual aids. Give participants 25 minutes to prepare their lessons.

5f. Depending on the number of participants and the time available, choose one of the following procedures.

- Stay in the large group and have each pair present their lesson for the rest of the group.

  Or

- Divide the large group in half or into three small groups and situate the small groups in different corners/areas of the space. Assign one person to moderate the small group work. Each pair in the small groups will then present their lesson to the rest of the small group so that all of the groups can work simultaneously.

5g. Explain that before each pair starts their facilitation exercise, they should share with the group the aspects of facilitation that they want to improve (previously written on the index cards).

5h. Before the presentations begin, distribute another copy of the QIVC in Lesson 8 Handout 1 to each participant. Before each facilitation exercise, ask one person to complete a QIVC for the lesson and return it to the facilitator afterward. If the participants are working in smaller groups, ask the moderator of each group to choose the person to complete the QIVC. Give each participant 10 minutes to present; the facilitator/moderator should stop the exercise after 10 minutes, even if it's not finished.

5i. After each facilitation exercise, ask two observers to share one thing that they liked/thought went well, then ask two other observers to make one recommendation each about how to improve the facilitation. Remind participants that constructive feedback consists of concrete suggestions on what to do better and how (e.g., "I

suggest that…"). Also, since this is not a discussion, the only response from the participant receiving the feedback should be "thank you."

6. Wrap Up (10 minutes)

   6a. Ask participants to write down all the positive facilitation skills they observed during this lesson.

   6b. Ask participants to share things that they learned about their own facilitation skills and what they hope to continue to improve on.

Lesson 8 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Behavior Change Agents' Facilitation Skills

Name of Behavior Change Agent (BCA): _____

Evaluator:_____

Community: _____ **Date:** _____

METHODS	Yes	No
Set Up		
1. Did the BCA seat people so that all could see each other's faces?	❒	❒
2. Did the BCA wear appropriate clothing?	❒	❒
3. Did the BCA sit at the same level as the other participants?	❒	❒
4. *If using a lesson plan:* Did the BCA follow the lesson plan in the curriculum?	❒	❒
Overall Communication		
5. Did the BCA speak loud enough so that everyone could hear?	❒	❒
6. Did the BCA use proper eye contact with everyone?	❒	❒
7. Did the BCA use changes in voice intonation (not monotone)?	❒	❒
8. Did the BCA speak slowly and clearly?	❒	❒
9. Did the BCA move around the room/area without distracting the group?	❒	❒
10. Did the BCA always use examples/terminology that were culturally appropriate?	❒	❒
11. Did the BCA encourage comments by nodding, smiling, or other actions that show he/she was listening?	❒	❒
12. Did the BCA ALWAYS reply to participants in a courteous and diplomatic way?	❒	❒
13. Did the BCA prevent domination of the discussion by 1 or 2 people?	❒	❒
14. Did the BCA encourage timid participants to speak/participate?	❒	❒
15. Did the BCA use a participatory method? (game, skit, song, story, other: SPECIFY:_____)	❒	❒
16. Did the BCA ask the participants lots of (non-rhetorical) questions?	❒	❒
17. Did the BCA give participants adequate time to answer questions?	❒	❒
18. Did the BCA encourage discussion amongst participants?	❒	❒
Beginning		
19. Did the BCA clarify what behavior(s) would be discussed during the session?	❒	❒
20. Did the BCA clarify who should practice the behavior being discussed?	❒	❒
21. Did the BCA ask questions to relate the topic to the participants' experiences?	❒	❒
22. Did the BCA ask about the current practices of the participants?	❒	❒

METHODS	Yes	No
Middle		
23. Did the BCA use any props or tell a story to promote discussion?	❒	❒
24. *If pictures with key messages were used:* Did the BCA explain the meaning of each picture?	❒	❒
25. Did the BCA pass the pictures around so participants could see them up close?	❒	❒
26. Did the BCA demonstrate any skills that he/she was promoting?	❒	❒
27. Did the BCA ask participants what barriers to the promoted practices they might encounter?	❒	❒
28. Did the BCA elicit from the participants strategies to overcome barriers?	❒	❒
29. Did the BCA suggest other strategies to overcome barriers?	❒	❒
30. Did the BCA encourage comments by paraphrasing what people said (repeating statements in his/her own words)?	❒	❒
31. Did the BCA ask participants if they agree with other participants' responses?	❒	❒
32. Did the participants make lots of comments?	❒	❒
33. Did the BCA summarize the participants' discussion?	❒	❒
34. Did the BCA reinforce statements by sharing relevant personal experience or by asking others to share personal experience?	❒	❒
End		
35. Did the BCA verify that people understood the main points, using open-ended questions?	❒	❒
36. Did the BCA summarize the essential points of the lesson?	❒	❒
37. Did the BCA ask the participants to commit to try the new behavior?	❒	❒
38. Did the BCA finish the session within the allotted time?	❒	❒
Content		
39. Was the content of the educational messages CORRECT?	❒	❒
1 2 3 4 5 6 7 8 9 10 Poor Excellent		
40. Was the content of the educational messages RELEVANT to the participants?	❒	❒
1 2 3 4 5 6 7 8 9 10 Poor Excellent		
41. Was the content of the educational messages COMPLETE?	❒	❒
1 2 3 4 5 6 7 8 9 10 Poor Excellent		
42. OVERALL EVALUATION OF THE BCA's PERFORMANCE: 1 2 3 4 5 6 7 8 9 10 Poor Excellent		

Scoring: Yes = ____ Used (Yes + No) = _____ Score= _____%

Recommendations/Suggestions for Action/Comments: _____

_____

_____

_____

Lesson 8 Handout 2: Facilitation Skills: Suggestions from an Experienced Facilitator

1. Select just one or two behaviors/practices to focus on during a lesson so that you can discuss them in more detail.

2. Start the lesson off by introducing the topic, then asking the audience what they already know about the behavior/practice. Ask specific questions that will get people thinking realistically about the topic. For example, instead of asking “What do you know about this?” start the discussion with a question like “What do women do when they get pregnant to make sure they are healthy?”

3. Have laminated pictures that emphasize important aspects of the lesson. These should be about the size of copy paper or a bit smaller so they can be seen by many people, but also passed around so each person can get a closer look.

4. Lessons that tell a story, where people have names and get “introduced” to the group, are best. Stories that present a problem, share information, and require a decision are especially helpful (See Lesson 3). For example: “This is Fatimata. Fatimata just realized that she is pregnant. This will be her first baby and she’s not exactly sure what to do. What advice would you give to her?”

5. During the lesson, the facilitator should ask questions almost as often as he/she provides information. These questions should not just be about getting a list of facts (for example, "How many prenatal consultations should a pregnant woman have?”). Instead, they should encourage the audience to reflect (“Why do you think it’s important to have your first prenatal care visit during the first trimester?”). Many people in the group will already know some good reasons for the behavior and the facilitator just draws out that information and adds to it as needed. The lesson should be a real back and forth conversation, not a lecture.

6. A great facilitator creates an opportunity for the learners to *discover for themselves* and share knowledge with others.

7. When talking about behavior change, there always should be a discussion of barriers and solutions. Ask, “What will make it difficult for you to practice this behavior?” and then brainstorm as a group about how to overcome the barriers. The facilitator should not feel that he/she has to give the solution all the time.

8. Commitment is important. At the end of the lesson, it can be very powerful for people to say individually and out loud if they are willing to try the new behavior. The facilitator can also help people identify someone who will help them if they encounter problems while trying out the behavior (e.g., “Who would be willing to help Maria talk to her mother-in-law about the importance of exclusive breastfeeding?”).

Advanced Lesson 1: Quality Improvement and Verification Checklists (QIVCs) and Giving Feedback

Achievement-Based Objectives

By the end of this lesson, participants will have:

- Reviewed two quality improvement and verification checklists (QIVCs)
- Observed a simulated use of the QIVC
- Completed and scored two QIVCs
- Reviewed the steps for giving positive feedback

Duration

2 hours

Materials Needed

- Flip chart paper, markers, and pencils
- 20 small balls (or crumpled pieces of paper), a plastic bag, and a shoebox or similarly sized container or box
- Pre-labeled flip charts: Purpose of the QIVC and How to Score the QIVC
- Advanced Lesson 1 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Education Session Facilitation (2 copies per participant)
- Advanced Lesson 1 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback (2 copies per participant)
- Advanced Lesson 1 Handout 3: Role Play Part 1: Education Session (2 copies)
- Advanced Lesson 1 Handout 4: Role Play Part 2: Giving Feedback (2 copies)
- Advanced Lesson 1 Handout 5: Steps for Giving Feedback to Workers (1 copy per participant)

Why this Lesson?

As Behavior Change Agents (BCAs) participate in trainings and gain experience and practice in their communities, they also can benefit from effective supervision of the quality of their ongoing work. The QIVC, developed by Food for the Hungry, is a tool that has been found to help improve the performance of workers involved in behavior change programming. This lesson is designed to be used by BCAs at all levels and their supervisors in order to obtain the sort of feedback that helps workers become more effective agents of change in their communities.

Advanced Preparation

Throughout this manual, the term BCA is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

For the activity in Task 1, locate a shoebox or similarly sized container or box, 20 small balls or pieces of paper crumpled into a ball shape, and a bag in which to place the balls.

Prepare a flip chart with the three main purposes of the QIVC for Education Session Facilitation, as listed in Task 3b. Also prepare a flip chart with the information in the box **How to Score the QIVC** in Task 5e.

For Task 5, prepare to present a short role play of a BCA demonstrating a behavior/practice. **Advanced Lesson 1 Handout 3: Role Play Part 1: Education Session** describes a demonstration of how to make oral rehydration solution (ORS). If appropriate, this example can be replaced with a demonstration that is more relevant to participants' program area(s). If the example is modified, the outline in **Advanced Lesson 1 Handout 4: Role Play Part 2: Giving Feedback** also should be updated.

If there are two facilitators at the training, it would be best if they did the role play in Task 5 together, with one facilitator playing the role of the BCA and the other playing the role of the supervisor. If there is only one facilitator, choose a very competent participant to play the role of the BCA. Either way, practice the role play ahead of time. You also will need to ask a few participants to play the role of the people who are attending the education session.

With your co-facilitator or experienced participant, review **Advanced Lesson 1 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Education Session Facilitation**, **Advanced Lesson 1 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback**, Advanced Lesson 1 Handout 3, Advanced Lesson 1 Handout 4, and the instructions in Task 5. These materials will help the person playing the BCA know what good things to do. Work together to choose two or three things for the BCA to deliberately do wrong. This way the person playing the supervisor will be prepared to give appropriate feedback.

It is very important that the person playing the BCA not try to entertain the audience by acting silly during the skit, or making too many errors. This learning activity should provide realistic examples of effective and ineffective techniques and how the supervisor works with the BCA to improve. Also, make sure you have practiced giving appropriate feedback before training others.

In many cultures, supervisors are more prone to mark "no" for very tiny faults instead of marking "yes" if the facilitator in general completed the given task. Be sure to model how the

QIVC is a tool to compassionately encourage and improve the ability of workers. It is not a tool used to discourage a worker or to try to shame them into change.

Tasks

1. Warm-Up Activity (20 minutes)

    1a. Explain to participants that the lesson will start with a quick activity to get them thinking about today's topic: giving feedback. Request that a volunteer come to the front of the room and face the rest of the participants. Instruct him/her to remain facing forward. Then, quietly place a box or container somewhere behind the volunteer (in a way that he/she does not see or sense its location).

    1b. Give the volunteer the bag of 20 small balls or crumbled pieces of paper. Explain that the volunteer will try to get ten balls into the box by tossing them over his/her shoulder—without looking! The volunteer will need to rely on the input and feedback of the rest of the participants.

    1c. After each throw, the facilitator should choose one participant to give information to the volunteer (for example, "a little to the right" or "further back"). At first, the volunteer will not be able to ask any questions or respond to the feedback.

    1d. About halfway through (after about 10 tosses), ask the volunteer to pause. Check in with him/her to see if the feedback and input has been helpful. Allow him/her to ask clarifying questions from that point on. If needed, remind participants of the importance of being supportive when giving feedback.

    1e. When the volunteer has tossed ten balls into the box or runs out of balls (whichever comes first), thank everyone for helping with the activity. Facilitate a brief discussion based on the following questions.

        - What was challenging about this exercise? What went well?
        - How did it change the outcome to be able to have a dialogue about what was needed? How did using positive comments help the conversation?
        - How did practicing and gaining experience with this exercise change the outcome?
        - Has anyone ever felt like this in your work, like you're trying to reach a goal, but you aren't sure whether you're on the right track? What examples can you share?

2. The Importance of Monitoring and Evaluation (10 minutes)

    2a. Explain to participants: It takes a lot of practice and support to become an effective Behavior Change Agent, but continually trying to improve is worth the effort! Even if a certain behavior change strategy has been proven to be very effective, it might not

work if it isn't presented or shared well. That's why programs do monitoring and evaluation, so we can see how things are going.

2b. Point out that we look at both quantity and quality when we track a program's progress. Ask participants: What countable things do you usually monitor in your program? (Answers could include: how many trainings were conducted, how many demonstration plots were established, how many people attended education sessions)

2c. Tell participants: The amount of work done is important, but it's equally if not more important to know how well an education session was facilitated and how engaged the community members were in the program. To focus our attention on how well tasks and activities are done, Food for the Hungry developed a tool called the quality improvement and verification checklist, or QIVC.

3. The Quality Improvement and Verification Checklist Tool and How It Is Used (10 minutes)

3a. Refer participants to **Advanced Lesson 1 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Education Session Facilitation** and **Advanced Lesson 1 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback**. Explain that while we will be using these two QIVCs during this session, there are many other QIVCs that focus on other tasks. Other QIVCs created by Food for the Hungry can be found at http://www.caregroupinfo.org/docs/QIVC_Files.zip.

3b. Explain that the QIVC for Education Session Facilitation has three main purposes. Show the list that you prepared on the flip chart:

- To encourage a facilitator
- To monitor a facilitator
- To improve a facilitator's performance

3c. Ask participants: Who are the facilitators in your program? The QIVC can be used to encourage, monitor, and improve the work of each one of the team members in your program that are responsible for facilitating a learning experience.

3d. Explain to participants: The QIVC rapidly increases performance. Small improvements in performance can cause large changes in impact. However, QIVCs are useful only for tasks that can be observed and have multiple steps.

3e. Ask participants: What are some activities in our program that you can observe? Which of these activities is a process with multiple steps?

4. Review the Quality Improvement and Verification Checklist (15 minutes)

   4a. Go through each point on Handout 1 with participants. Make sure that they understand what each question means.

   4b. Explain to participants that most questions on the QIVC have a yes or no answer. After reading the question, they should decide if the answer is "yes" or "no" and mark the corresponding box.

   4c. If the question is not relevant for a particular training, then ~~draw a line through the YES or NO boxes~~. For example:

   - In question 11, if the topic was exclusive breastfeeding (EBF), the facilitator would have a difficult time demonstrating this activity. It is possible for the facilitator to demonstrate proper breastfeeding attachment, but EBF is not something that needs to be demonstrated during the lesson. You would mark a line through the ~~yes or no.~~

   - In question 16, if participants do not mention any barriers, ~~cross out this line~~ when monitoring the worker.

   4d. Tell participants: QIVCs should be adapted to fit the culture and design of different programs. After using the QIVC for 3 or 4 months, ask staff and volunteers to meet together to discuss the checklist. If specific questions are not appropriate or applicable to your situation, adapt or revise them as needed. However, be cautious. The QIVC was designed to ensure participatory teaching methods are used in each lesson. Make sure your final version continues to reinforce the key principles of participatory learning. For more information on key practices of adult learning, see Freedom from Hunger's Adult Education Materials at http://www.ffhtechnical.org/resources/education-modules.

5. Quality Improvement and Verification Checklist in Action (40 minutes)

   5a. Explain to participants: Now we're going to learn how the QIVC would be used. You are going to watch a role play of the Behavior Change Agent facilitating an education session and how the supervisor, who has come to watch, provides feedback to the Behavior Change Agent. During the role play, keep an eye on your copy of the QIVC and see for yourself how well the Behavior Change Agent conducts the education session. Then, when the supervisor gives feedback, use the other QIVC to see how well he/she does.

   5b. Explain to participants that the QIVC is only completed after the event, not during. This is done so the person filling out the QIVC can pay attention during the event being evaluated and not be distracted by filling out the QIVC.

5c. Explain that the role play will be done in two parts. In the first part, a BCA facilitates a meeting. In the second part, the Supervisor gives feedback to the BCA. Instruct participants to fill out the right QIVC after each role play. Answer any questions.

5d. Distribute an extra copy of each QIVC to participants. First carry out the role plays found in **Advanced Lesson 1 Handout 3: Role Play Part 1: Education Session** and make sure that the BCA teaches the audience how to do something, such as prepare ORS.

5e. After completing the role play, ask each participant to fill out and score their copies of the QIVC for Education Session Facilitation. Show the instructions in **How to Score the QIVC**, below, which you previously prepared on a flip chart. Ask some participants to share the scores they gave.

How to Score the QIVC

1. Count the number of "yes" responses.
2. Divide the number of "yes" responses by the total number of answered questions (questions answered with either a "yes" or "no" response).
3. Do not count the questions that are not applicable (those that are ~~crossed out~~).

5f. Repeat this process using **Advanced Lesson 1 Handout 4: Role Play Part 2: Giving Feedback** and Advanced Lesson 1 Handout 2.

5g. Ask participants the following questions. They should answer the questions based on what they saw in the skit.

- What should you say to the Behavior Change Agent when you visit her/him and plan to use a QIVC?

  Answers should include:
  - Don't worry!
  - This is not a test, but a tool to help you improve.
  - Teach as you normally do.

- What comments did the supervisor make during the educational lesson?

  Answers should include:
  - None! The supervisor should observe only and not interrupt or make comments to the facilitator.
  - After the session, the supervisor can address the participants as appropriate.

- Where did the supervisor talk about each of the points in the QIVC with the Behavior Change Agent?

  Answers should include:
  - In private, not in front of other people.

- Why did the supervisor explain the checklist to the Behavior Change Agent?

  Answers should include:
  - Because it is also a method for improving and encouraging the worker's performance.
  - The actions we consider to be perfect performance should not be kept secret from the worker.
  - All workers should know exactly what is expected of them.

- How should the supervisor speak to the Behavior Change Agent?

  Answers should include:
  - The supervisor needs to be gentle so the BCA does not feel shame.
  - Even if the BCA did very poorly on the checklist, the supervisor should emphasize areas where he/she has shown some improvement.
  - Ask the BCA which areas she wants to work on.
  - Focus on asking, not on telling.

6. More on Giving Feedback (15 minutes)

   6a. Read the following information to participants.

The Importance of Giving Positive Feedback

(From "Positive Image, Positive Action: The Affirmative Basis of Organizing" by David Cooperrider)

Many people believe that pointing out mistakes will eliminate failures and improve performance. However, studies have shown that the opposite is true especially when it comes to learning new tasks. In one experiment, for example, Kirschenbaum (1984) compared three sets of bowlers.

Group A did not receive any lessons, but tried to learn how to bowl on their own.

Group B was videotaped. All of the good things they did while bowling were compiled, and the mistakes were deleted from the tapes. These positive tapes were reviewed with each bowler pointing out the things they had done well to help them improve.

Group C also was videotaped. All of the bowling mistakes they made were compiled, and the good things they did were deleted off the tapes. The mistake tapes were reviewed with this group, pointing out areas they needed to improve.

Group B improved significantly more than all the others, and the unskilled bowlers in Group B (average of 125 pins) improved substantially (more than 100%) more than all other groups.

Since then, these results have been replicated with other athletic activities, giving the same results. Pointing out the things people do well helps them learn new skills and improves their performance in mastering new tasks.

6b. Facilitate a discussion based on the following questions:

- We have talked a lot about positive feedback. What's wrong with negative feedback?
- Wouldn't the worker improve faster if we told him/her everything that was done wrong? What is your opinion?

6c. Refer participants to **Advanced Lesson 1 Handout 5: Steps for Giving Feedback to Workers**. Tell participants that they will now review exactly how feedback should be given after an observation.

6d. Working in pairs, have participants review the handout and compare the points to what they observed in the role play. Ask some participants to share their observations.

6e. Ask participants the following questions and discuss responses.

- How is this way of giving feedback different from the way it is usually done?
- Which way do you think will result in improved performance?
- Which approach would help workers stay more motivated? Why?

7. Wrap Up (10 minutes)

7a. Facilitate a brief discussion based on the following questions.

- How do you think you can use these tools in your work? Can someone provide a specific example of how they plan to incorporate the QIVC?
- How might this help improve your program's outcomes?

Advanced Lesson 1 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Education Session Facilitation

Name of facilitator: _____ **Date:** _____

Evaluator: _____ **Community:** _____

METHODS	Yes	No
1. Did the facilitator seat people so that all could see each other's faces?	❒	❒
2. Did the facilitator sit at the same level as the other participants?	❒	❒
3. Did the facilitator introduce the topic well (who he/she is, topic, time)?	❒	❒
4. Did the facilitator speak loud enough so that everyone could hear?	❒	❒
5. Did the facilitator use proper eye contact with everyone?	❒	❒
6. Did the facilitator change his/her voice intonation (not monotone)?	❒	❒
7. Did the facilitator speak slowly and clearly?	❒	❒
8. Did the facilitator ask about the current practices of the participants?	❒	❒
9. Did the facilitator read each caption aloud to the participants?	❒	❒
10. Did the facilitator explain the meaning of each picture?	❒	❒
11. Did the facilitator demonstrate any skills that he/she was promoting?	❒	❒
12. Did the facilitator verify that people understood the main points using open-ended questions?	❒	❒

DISCUSSION	Yes	No
13. Did the facilitator ask the participants lots of non-rhetorical questions?	❒	❒
14. Did the facilitator give participants adequate time to answer questions?	❒	❒
15. Did the facilitator ask participants if there were barriers that might prevent them from trying the new practices?	❒	❒
16. Did the facilitator encourage discussion among participants to work around the barriers mentioned?	❒	❒
17. Did the facilitator encourage comments by paraphrasing what people said (repeating statements in his/her own words)?	❒	❒
18. Did the facilitator ask participants if they agree with other participants' responses?	❒	❒
19. Did the facilitator encourage comments by nodding, smiling or other actions to show he/she was listening?	❒	❒
20. Did the facilitator always reply to participants in a courteous and diplomatic way?	❒	❒
21. Did the participants make lots of comments?	❒	❒
22. Did the facilitator prevent domination of the discussion by one or two people?	❒	❒

DISCUSSION (continued)	Yes	No
23. Did the facilitator encourage timid participants to speak/participate?	❒	❒
24. Did the facilitator summarize the discussion?	❒	❒
25. Did the facilitator reinforce statements by sharing relevant personal experience or by asking others to share personal experience?	❒	❒
26. Did the facilitator ask each person to make a commitment?	❒	❒
27. Did the facilitator ask each person about previous commitments?	❒	❒

CONTENT	Yes	No
28. Was the content of the educational messages correct?	❒	❒
29. Was the content of the educational messages relevant?	❒	❒
30. Was the content of the educational messages complete?	❒	❒

31. Overall evaluation of the facilitator's performance:

Score: _____

Comments:

_____

_____

_____

_____

_____

Advanced Lesson 1 Handout 2: Quality Improvement and Verification Checklist (QIVC) to Evaluate Positive Feedback

Name of the person using this list: _____

Name of the person evaluated: _____

Community: _____ **Date:** _____

Number of yeses: _____ **Number of lines:** _____

Present grade: _____% **Previous grade:** _____%

CONTENT	Yes	No
1. Did the evaluator explain the purpose of the QIVC (to improve and measure work quality)?	❒	❒
2. Did the evaluator tell the person evaluated not to be afraid, that this is not a test, but rather something to help him/her improve?	❒	❒
3. Did the evaluator advise the person being evaluated not to say anything to the evaluator while being observed?	❒	❒
DURING THE OBSERVATION	**Yes**	**No**
4. Did the evaluator avoid making comments to the person evaluated during the health lesson?	❒	❒
5. Did the evaluator mark all the questions (yes or no) during or right after the observation?	❒	❒
FEEDBACK	**Yes**	**No**
6. Did the evaluator give the feedback in a private place?	❒	❒
7. Did the evaluator ask the person evaluated to take notes on his/her comments?	❒	❒
8. Did the evaluator discuss each positive point on the form?	❒	❒
9. Did the evaluator encourage the person evaluated about the things he/she did correctly?	❒	❒
10. Did the evaluator use positive body language when providing positive feedback to the person?	❒	❒
11. Did the evaluator use many encouraging words (e.g., excellent, very good) when providing positive feedback to the person?	❒	❒
12. Did the evaluator avoid the use of too many mixed comments (e.g., “This was excellent, but you have to …”) when providing feedback?	❒	❒
13. Did the evaluator always respond to the comments from the person evaluated in a courteous and diplomatic manner?	❒	❒

FEEDBACK	Yes	No
14. Did the evaluator mention the area(s) where the performance of the person evaluated was better than the majority of other people?	❒	❒
15. Did the evaluator discuss each negative point on the form?	❒	❒
16. Did the evaluator often ask the person evaluated to discuss the negative points in his/her performance self-evaluation before providing an opinion?	❒	❒
17. Did the evaluator use several examples to explain the correct manner of performing the parts of the process that were done incorrectly?	❒	❒
18. Did the evaluator maintain control of the evaluation process in an appropriate manner?	❒	❒
19. Did the evaluator help the person evaluated find solutions to the problems he/she has (e.g., in the community), where possible?	❒	❒
20. Did the evaluator keep the attention of the person evaluated?	❒	❒
21. Were the evaluator's suggestions correct?	❒	❒
22. Were the evaluator's suggestions appropriate for the context of the person being evaluated?	❒	❒
23. Were the evaluator's suggestions complete?	❒	❒
24. Were the evaluator's suggestions very specific?	❒	❒
AT THE END OF THE EVALUATION	**Yes**	**No**
25. Did the evaluator ask the person evaluated to give a summary of the things that should be improved?	❒	❒
26. Did the evaluator complete this list if the person evaluated could not remember all the things that needed improvement?	❒	❒
27. Did the evaluator ask the person evaluated to indicate his/her commitment to improve these things?	❒	❒
28. Did the evaluator ask the person to give a summary of the positive things that he/she did?	❒	❒
29. Did the evaluator complete this list if the person evaluated could not remember all the things he/she did that were positive?	❒	❒

Score: _____

Comments: _____

_____

_____

_____

Advanced Lesson 1 Handout 3: Role Play Part 1: Education Session

Introduction

Read the following introduction aloud to participants.

> The Behavior Change Agent is in the middle of an education session with a neighbor women's group about children and diarrhea. She has already taken attendance, told a story, and reviewed a flip chart with information. Now, during the break, she is preparing to demonstrate how to make oral rehydration solution for children with diarrhea. She is arranging the sugar, salt, container of drinking water, and container to mix the solution in (a 1 liter bottle). She has prepared a space for the NW to sit in front of her in a semi-circle so all the women can see each other. As the BCA is getting ready, her supervisor arrives and they have the following discussion.

Role Play

> **Supervisor:** Good morning Maria. How are you doing?
>
> **BCA:** Welcome! I'm fine. It's good to see you.
>
> **Supervisor:** I've come to pay you a visit and to observe your meeting. During this visit I will be completing the Quality Improvement and Verification Checklist for Education Session Facilitation. Remember the QIVC will help improve your work as a facilitator. It's not a test, so there's no need to be nervous. [She shows the QIVC to the BCA.] This is the same form that we have used before.
>
> **BCA:** Yes, I remember. I was just getting ready to show the women how to prepare ORS. The women will be joining me here. Since you are here, if I have any questions or problems, I'll be sure to ask for your help.
>
> **Supervisor:** Actually, Maria, I will just be watching you and not participating at all. Just carry on as if I wasn't here. Afterward we will talk about how the meeting went.

The BCA sits down and calls the NW to join her. The Supervisor sits to the side holding her QIVC. Once all the NW are sitting, one last woman arrives and sits behind everyone else, a little outside the group. The BCA conducts a 5–10 minute instruction of how to prepare ORS, reminding the NW about what they learned from the story and the flip chart that were covered prior to the demonstration. She makes sure everyone but the mother sitting a little outside the group has a chance to participate. The BCA does almost everything well but she does not ask the NW if they have any experience making ORS, and she does not make sure at the end that they all understood. The demonstration ends, and the BCA thanks the NW for coming.

Advanced Lesson 1 Handout 4: Role Play Part 2: Giving Feedback

The Behavior Change Agent (BCA) and the supervisor privately discuss the education session. The supervisor uses the following outline to discuss the BCA's performance.

- Ask, "How do you think you did?"
- Agree with positive points and mistakes the BCA mentions, as appropriate. Probe as needed: "What things did you do well? What things would you have done differently?"
- Review the positive things on the quality improvement and verification checklist (QIVC) (everything marked yes).
- If not mentioned earlier, ask the BCA about areas that you marked "no." For example, "Tell me about the woman who came in last, I thought she seemed left out of the group." Or "How did you think you did in reviewing the mothers' prior experience in making oral rehydration solution?"
- Reinforce things that the BCA says that could help her improve in these areas. Do not concentrate too much on what the BCA did wrong, but rather what she did well. Help her come up with ways to strengthen areas that need improvement.
- Ask the BCA to summarize the things that you discussed today (positive things and areas to improve).
- Give the BCA her score, and summarize anything that was missed.
- Ask her to commit to changing these things.
- Thank the BCA.

Advanced Lesson 1 Handout 5: Steps for Giving Feedback to Workers

1. Give feedback in private.
2. Ask the person being evaluated to take notes.
3. Discuss each positive point.
4. Encourage the worker on the things he/she did well.
5. Use positive body language.
6. Respond to the worker in a courteous and diplomatic manner.
7. Mention things the worker does especially well.
8. Discuss each negative point on the form, but remember to give three positive comments for every one comment about an area to improve.
9. Do not use make confusing, mixed comments that are partly positive and partly negative, such as “you spoke clearly, but I couldn’t hear you.”
10. Ask the worker to discuss his/her performance before giving your opinion.
11. Offer several examples to explain the correct manner of performing the tasks where the worker received a “no” on the quality improvement and verification checklist (QIVC).
12. Maintain control of the evaluation.
13. Help the worker find solutions to problems when possible.
14. Keep the worker’s attention.
15. Focus on what is correct, appropriate, and complete.
16. At the end of the evaluation, ask the worker to summarize the things he/she will improve.
17. If he/she forgot any areas, remind him/her of them.
18. Ask the worker to make a commitment to improve these issues.
19. Ask the worker to give a summary of the things he/she did well.
20. Add to this list if the worker forgot any positive areas.

Advanced Lesson 2: Motivating Conversations: Conversations for Change[7]

Achievement-Based Objectives

By the end of this session, participants will have:

- Understood how a Motivating Conversations (MC) approach can help Behavior Change Agents (BCAs) and community members work together to change behaviors
- Reviewed key MC principles and communication skills
- Practiced using the MC approach in difficult behavior change scenarios

Duration

2.25 hours

Materials

- Flip chart paper, markers, index cards or paper, and pencils/pens
- Soft ball or object that can be thrown by participants
- Pre-written flip chart paper with the Definition and Guiding Principles of MC
- Advanced Lesson 2 Handout 1: Role Play Response Prompt Cards (enough copies that each pair of participants will have 3 cards)
- Advanced Lesson 2 Handout 2: Background Information and Resources about Motivational Interviewing (1 copy per participant)

Why this Lesson?

Advanced Lesson 2 introduces a communication style called Motivating Conversations (MC), which is based on key concepts of Motivational Interviewing (MI). For more information about MI, refer to **Advanced Lesson 2 Handout 2: Background Information and Resources about Motivational Interviewing**. This kind of communication allows BCAs to help community members find their own solutions to their problems and get in touch with their own motivations for change.

This lesson is designed to build on BCAs' existing interpersonal and communication skills and to show how they can talk with community members in a way that promotes change. It should be done with groups of BCAs that have already completed Lesson 1: Behavior Change through Effective Communication.

[7] If you are doing several of the MMCA lessons, it may work better to do this one after Lessons 1 and 2.

Advanced Preparation

Throughout this manual, the term BCA is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

This lesson provides agriculture-related examples of MC responses/techniques. Please read the examples in advance and, if needed, adapt them to meet the needs of your BCAs.

Before the meeting, prepare a flipchart with the definition and guiding principles of MC found in Task 3a. In addition, make copies of and cut apart the cards in **Advanced Lesson 3 Handout 1: Role Play Response Prompt Cards** for use in the role-play at the end of the lesson. Make enough copies that pairs of participants will each have three prompt cards.

Tasks

1. Warm-Up Activity (10 minutes)

    1a. Introduce this lesson by telling participants: One of a Behavior Change Agent's responsibilities is to support individuals through the process of changing their behaviors to improve the health of families and entire communities.

    1b. Ask participants to form a large circle. Explain that they will do a quick activity to review some of the changes they would like to see in their communities. Toss a ball to one participant and ask him/her to share a behavior that he/she would like to see more of (for example, planting green manures). Ask that participant to toss the ball to someone else, who will then share an action or behavior that he/she would like to see less of (for example, burning of fields). Ask that person to toss the ball to another, who will share another "more" behavior. Continue in this way, alternating between "less" and "more," until all participants have shared.

2. Our Experiences as Change Agents (10 minutes)

    2a. Explain to participants that helping people to do more of some behaviors and less of others can be very rewarding, but it can also be very hard and frustrating. Ask the participants to raise their hands if they ever have been frustrated or disappointed by people not using a new or healthier behavior. Explain that this lesson will provide a chance to learn about a way of communicating to help BCAs be more successful in changing behavior in tough situations and to help reduce their feelings of frustration.

    2b. Ask each participant to think of a time when an individual or a group of people did not practice a new behavior or did not continue a behavior that was used at first. Now ask participants to think of how they felt about the people who did not change. For example:

Behavior Change Experience: A young man who had received education about HIV insists, "I'm not going to use condoms anyway."

My reaction: Why are you being so irresponsible?!

Or

Behavior Change Experience: A farmer who has learned about a new method agrees that it is helpful, but after several months still has not used it.

My reaction: You are so stubborn!

2c. Request that a few participants share their Behavior Change Experience and Reaction. Alternatively, participants can write their responses on note cards and the facilitator can redistribute them to other participants to be read out loud.

2d. Ask participants for their thoughts on why they sometimes feel frustrated when people don't change. (Answers might include: we believe that the behavior change can improve health and well-being, we worry that not changing the behavior can cause harm, we want to meet our program goals and we feel stressed when people won't change)

- Note that a person's behaviors and decisions may be confusing or frustrating when we have our own ideas about the "right" choice. Sometimes it seems that people don't think through their actions logically, their actions don't match their values or goals, they don't take information or facts seriously, or they say one thing but then do another.

- Emphasize to participants: Frustration, anger, and disappointment are common reactions when someone you are trying to help seems to be making unhealthy or unhelpful choices. It is normal to feel this way when you believe in the benefits of the behavior change and/or feel pressure to meet program goals. When we share knowledge or teach a new method and the community member does not use it, we might feel disappointed in that person and in ourselves!

2e. Offer this different way of thinking about these tough situations: Let's assume that each person has very good reasons for acting as they do and we can learn a lot from an honest discussion with the person about those reasons. For example, let's believe that the farmer has excellent reasons for not using a new farming method. Let's consider that he has been farming for decades and is an expert in his own life and which methods work best for him.

2f. Explain to participants that today they will practice skills that will help them talk with people in a way that focuses on partnership, acceptance, and the other person's existing strengths.

- Encourage participants to try to see themselves not as experts who share information or give advice, but rather as helpers who promote behavior change among people who already have a lifetime of personal experience and knowledge.
- Share that the skills in this lesson can help BCAs have conversations with community members that identify their personal reasons for wanting to change.
- Note that they are probably already practicing many of these skills every day!

3. Introduction to Motivating Conversations (10 minutes)

3a. Display a flip chart with the definition and guiding principles of MC written on it and ask a volunteer to read the definition out loud. Explain that we will be learning how to talk with people in a way that helps change behavior.

Definition of Motivating Conversations

Motivating Conversations is a method for increasing people's reasons for changing by helping them to understand their mixed feelings about a new behavior.

Guiding Principles of Motivating Conversations

- Working Together
- Building on Existing Strengths
- Emphasizing Free Choice
- Connecting Behavior with Values/Goals

3b. Ask participants for their thoughts about "mixed feelings" about a behavior change. Remind them of the example of the farmer who agrees that a new method is helpful, but still doesn't use it. Participants might mention that some people believe in the education provided by a BCA, but do not practice the recommended behaviors, or that some people value health and education, but their behavior choices don't always match their values.

3c. Explain that the guiding principles of MC help us think about how to talk with people in a way that encourages them to find their own good reasons to change. Describe the following principles:

- Working Together: We honor the person's experience and perspective and assume that we can learn from each other.
- Building on Existing Strengths: The person already has the resources and motivation to change and we will work together to find them. We help people learn from their own experiences.

- Emphasizing Free Choice: We respect the person's right to decide what to do. No one can make another person change.

- Connecting Behavior with Values/Goals: We can help people identify their personal values and goals, and to see how their present behavior might not match those values and goals. In this way, we motivate them to make changes that fit their life plans and hopes.

4. Creating a Good Relationship (10 minutes)

   4a. Explain to participants that they will now learn more about *how* to have the kinds of conversations that can motivate people in the community to make changes in their own lives. Emphasize again that they are probably already using a lot of these skills in their work and daily lives.

   4b. Remind participants that in order to talk with someone about changing a behavior, they must first build a good relationship with that person. Ask them how they usually create a good relationship with people in their community. List their suggestions on flip chart paper. (Answers could include: get to know a person by asking about their family, work, or interests; ask why the person is interested in your program/service and listen to the response; make positive comments; be friendly and welcoming; avoid giving advice or focusing on problems)

   4c. Note that the ability to connect with people comes naturally to some BCAs; for others, it may be a new skill that can be improved with practice.

   4d. Point out that early conversations with community members do not have to focus on behavior change or on giving information/advice about a BCA's program area. In order to show that they care about a person and their family, a BCA might not talk about any behavior changes at all until some trust has been created!

   4e. Discuss the following questions.

   - In the communities in which you work, how do you know when you've established trust with community members?
   - What do you do when you're not able to create a good relationship with some people?

5. How to Talk in a Way that Motivates Change (45 minutes)

   5a. Explain that now they will review and practice some ways of talking with people that can help them build strong relationships in the community and motivate behavior change, even with people that are sometimes hard to connect with. (Prepare to list the skills on flip-chart paper as you review each one. The list will include: "open-ended

questions," "provide information only after asking," "take a break," "personal control," "positive comments," "reflections," and "the power of silence.")

5b. Write "**open-ended questions**" on a piece of flip-chart paper. Ask someone to explain what an open-ended question is. (The answer should be: a question that cannot be answered with just a "yes" or "no" or another short response, which is typical of closed questions). If needed, add that open-ended questions encourage dialogue and show respect. They also show that you are interested in the other person and want more details. They can lead to a deeper conversation, especially with people who may be shy or not very talkative.

- For example: "Do you think organic pesticides are a good idea?" (closed) versus "What do you think are the benefits of organic pesticides?" (open-ended)

- Divide the group into pairs. Ask each pair to develop two open-ended questions that they could use to get to know a community member and two open-ended questions that they could use to find out how much a community member already knows about a behavior change being promoted by their program. Give the pairs about 10 minutes to write or discuss their questions, then ask a few volunteers to share their questions with the larger group.

- For more about open-ended questions, refer to Lesson 1: Behavior Change through Effective Communication.

5c. Note that since many BCAs are excited about their project and are under pressure to meet program goals, it can be easy to start teaching, giving advice, or sharing personal stories soon after meeting a community member. But, if we want to talk with people in a way that really encourages behavior change, we first need to listen to them and understand what they already know and think.

- Ask the group how they think someone feels when they are shown respect for their personal experience, instead of being given information or advice. For example, "How do you think people would feel if you first asked what they already do to improve their families' health, instead of starting a discussion with a list of the benefits of your recommended behavior change? (Responses could include: valued, capable, proud, understood, appreciated)

- Write "**provide information only after asking if it's wanted/needed**" on the flip chart. Explain that we want to listen to the community member, not just tell them what we know. Information and education are important, but in order to change behavior we want to focus on personal motivations, which usually are not directly linked to facts or information.

- For example, a BCA working with hand washing could find out how much the person already knows by asking, "What have you learned about how hand washing helps people stay healthy?" Find out if he/she would like additional information by asking, "Would you like to hear more about how hand washing can prevent illness?"

5d. Ask participants how they would respond if a community member said that he/she did not want to learn any more about their program or if the conversation became tense or got "stuck?" Add "**take a break**" to the list on the flip chart and remind participants that no one can *make* somebody else change or force someone to participate in a program.

- Ask participants what they might say to shift the conversation away from behavior change if the community member becomes uncomfortable, upset, or disinterested. (Examples could include: "It's ok if we don't talk about this now," "No changes need to be made today," "That's fine, thank you for letting me share a little about our program," "How about you tell me some more about what is working well for you now?"

- Emphasize that the purpose of taking a break is to pause the conversation, not end it completely. By respecting the community member's opinion at that moment, the BCA can improve the relationship in a way that might allow the conversation to continue in a more positive way during future visits.

5e. Add "**personal control**" to the list on the flip chart and reinforce that BCAs cannot force people to change their behaviors. Ask participants for examples of how they would let a community member know that he/she is in control. (Examples can include: "I'm very interested in listening to your decision about this change," "It's your choice," "No one can make you do it," "It's totally up to you.")

- Note that in many communities, some people may feel that they are *not* in control of their decisions due to family and social pressure or other circumstances. Emphasize that with MC, the BCA is careful to not place additional pressure on the person. Rather, the BCA uses effective communication skills to help the person feel supported and to draw out the strength that he/she already has to make realistic changes, even in tough situations.

- Explain that participants will have an opportunity in a few minutes to practice using MC by creating a role play. Encourage them to use this opportunity to see how MC can help them support community members who often feel powerless and unable to make changes in their lives.

- Ask participants how they think emphasizing free choice also can help the BCA. Remind them of the frustrating scenarios from the beginning of the lesson. Note

that not even the most experienced BCA can force people to change, so placing control of the behavior change decision back in the hands of community members can reduce BCAs feelings of personal frustration, disappointment, and failure. It also helps BCAs see the change process as a collaboration between two people who respect each other.

5f. Write "**positive comments**" on the flip chart. Explain that focusing on a person's successes or strengths shows respect for what they already have done.

- Request that participants write down or think about two positive comments they have received recently: one related to their work as a BCA and one related to their lives outside their BCA work.
- Discuss the following questions with the participants.
  - How did those positive comments affect your feelings about yourself and your abilities?
  - How do you think making positive comments might affect your relationship with community members?
  - What are some examples of positive comments that you can make related to your program area? (Examples can include: "I can tell that the health of your family is really important to you," "I've seen that you do a great job teaching your children what they need to know," "Good job, I know that you worked really hard on your crop last season," "I've seen you do a great job sharing your knowledge with other farmers.")

5g. Add "**reflections**" to the list on the flip chart. Explain that, during a conversation, BCAs can restate what they hear as short statements about the speaker's thoughts or feelings. This can be especially helpful when the person's behavior choices do not seem to match their values. Sometimes you might guess wrong—that's OK! Allow the other person to correct you. The explanation might turn into an honest talk about what would be needed for change to be possible for that person.

- For example: A farmer says, "I understand the benefits of organic pesticides for health and the environment, but I already work so hard and just don't have the time for it." The BCA responds, "Health is important to you, but right now doesn't seem like a good time to make those big changes that could improve your health and help the environment."
- Reflections also can be longer summaries of what someone has said. Summarizing shows respect by demonstrating that you paid attention and want to understand the other person.

- Remind participants that a key goal of MC is to find the motivations for change that already exist inside the other person. As BCAs, we need to listen carefully and understand the person's values and help them practice behaviors that match those positive values and personal goals.

5h. Ask participants: Who do you think should do more talking during a conversation with a community member: the BCA or the community member? What are the benefits of the community member talking more than the BCA?

- Write "**the power of silence**" on the flip chart. Explain that today we are practicing a communication style that encourages the community member to share their thoughts, existing knowledge, doubts, concerns, hopes, and motivations. We want to give them a chance to talk openly.

- Discuss the timing and possible difficulties of being silent and allowing the other person to talk. Note that the meaning of silence might vary based on culture, age, etc.; discuss these differences.

6. Practicing Motivating Conversations Communication Skills (45 minutes)

6a. Explain that now participants are going to practice the MC style of talking by doing role plays of the difficult situations they shared at the beginning of this lesson. If some participants brought up a different situation during the "personal control" discussion, they can focus on that instead.

6b. Divide participants into pairs. Distribute to each pair three cards from **Advanced Lesson 2 Handout 1: Role Play Response Prompt Cards**, which you made copies of in preparation for this lesson.

6c. Ask participants to review with their partners the difficult situations they shared at the beginning of the lesson. They should discuss the behaviors and communication styles in each situation and decide together which behavior/situation to work on.

6d. Ask each pair to develop a 2–3 minute role play that uses the types of responses found on their three response prompt cards as a way of drawing out a conversation about change from the community member (one participant will play the community member, the other will be the BCA). Explain that each pair will have an opportunity to present to the group.

6e. Allow 10–15 minutes for the groups to prepare their role plays. Visit each pair and provide additional information about the MC skills as needed. Encourage the participants to focus on learning about the community member's personal goals and motivations and how they're related to the behavior change.

6f. Ask several pairs to present their role plays. Request that the other participants try to identify the MC skills that were used by the BCA during the role play.

6g. After each presentation, ask the participants how the BCA spoke in a way that improved the relationship with the community member and/or helped him/her find a personal motivation for change.

7. Wrap Up (5 minutes)

7a. Close the session by asking participants to think about MC as a "conversation about change," a communication style about personal strengths, values, and interests. We can use this respectful approach to increase behavior change among community members, in our own families, and even for ourselves. We cannot *make* anyone change, but we can help create a way of talking that helps people get in touch with their own personal motivations and develop realistic plans that can lead to long-term change.

7b. If participants would like additional information about Motivational Interviewing, distribute **Advanced Lesson 2 Handout 2: Background Information and Resources about Motivational Interviewing**.

Advanced Lesson 2 Handout 1: Role Play Response Prompt Cards

Open-ended questions
Silence
Offering information only after asking if it's wanted/needed
Positive comments
Reflections
Emphasizing personal control
Taking a break

Advanced Lesson 2 Handout 2: Background Information and Resources about Motivational Interviewing

The activities in the lesson titled "Motivating Conversations" are based on a counseling approach called Motivational Interviewing (MI). MI was developed by the psychologists W.R. Miller and S. Rollnick and has been described as "a conversation about change" (Miller & Rollnick, 2013, p. 12).

This lesson is intended to help participants apply the "spirit" of MI to the change work they conduct every day as Behavior Change Agents (BCAs). Whether they are teaching new farming techniques, promoting microfinance projects, or counseling to reduce sexual risk, BCAs are focused on facilitating positive change in their community. As they talk with people, BCAs serve as partners in the change process.

This session should not be considered a training on MI. Indeed, Miller and Rollnick have noted that MI is not a "technique" or "gimmick" and that the "difference between *doing* MI and *being* MI" is "about 10 years" (2013, p. 35). Therefore, this session applies an MI perspective to help BCAs draw on and improve the positive conversation and counseling skills they already possess in order to work more effectively with community members. While the activities provide information and practice on the language style and conversational skills that can contribute to behavior change, the main emphasis is on developing and demonstrating an attitude of compassion and respect for others—a conversational style that naturally creates the space in which people can "talk themselves into change, based on their own values and interests" (Miller & Rollnick, 2013, p. 4). This session does not teach many of the terms and phrases associated with MI, such as "rolling with resistance;" rather, it includes activities that draw out the participants' natural conversation skills and promote the development of the "spirit of MI," as described by Miller and Rollnick in the third edition of *Motivational Interviewing* (see Chapter 2).

Resources

- Miller, W.R., & Rollnick, S. (2013). *Motivational Interviewing: Helping People Change* (3rd ed.). New York: Guilford Press.

  Note: Many of the key concepts in these sessions draw inspiration from the most recent edition of Motivational Interviewing. However, these sessions are not intended to be a formal, comprehensive training on MI.

- Wagner, C.C., & Ingersoll, K.S. (2012). *Motivational Interviewing in Groups (Applications of Motivational Interviewing)*. New York: Guildford Press.

  Note: Many BCAs work with small groups and may be interested in incorporating MI into group settings. Miller and Rollnick (2013) note that group MI can be challenging because each group member has less time to develop and voice their own change talk, and the group dynamic can alter outcomes for individual members. However, Wagner & Ingersoll (2012) provide information about how MI is applied in group psychotherapy.

For more resources, including books, articles, training exercises, video links, and more, see: http://www.motivationalinterviewing.org/motivational-interviewing-resources.

Advanced Lesson 3: Story Editing

Lesson Overview

According to Timothy D. Wilson, "we all have personal stories about who we are and what the world is like. These stories aren't necessarily conscious, but they are the narratives by which we live our lives" (Cook, 2011). While many people develop optimistic personal stories that help them live healthy, happy lives, others carry around negative stories about themselves and the world around them. These pessimistic, and sometimes deeply fatalistic - and often false - views create cycles of negative thoughts and assumptions that can lead to poor coping skills and self-destructive life choices.

The "story editing" approach helps people change these pessimistic stories in ways that can contribute to lasting, positive behavior change. The techniques involved in story editing are related to cognitive behavioral therapy and have been tested and proven to be effective in changing behaviors and wellbeing.

This lesson is divided into three parts:

- Part 1: Best Possible Selves (45 minutes)
- Part 2: Story Prompting (1 hour)
- Part 3: Personal Values Exercise (45 minutes)

The activities in these sessions help people develop new interpretations of themselves, past experiences, and their situation in life. Use of these exercises has resulted in increased optimism, overall life satisfaction, and improved health (Peters, 2013).

These activities can be used with Behavior Change Agents (BCAs), then adapted by BCAs as appropriate for their work with community members. The three parts can be done together as one session (approximately 3 hours long) or as individual activities.

Additional Resources

- Cook, G. (2011, September 13). "How to Improve Your Life with 'Story Editing'." *Scientific American*. Available at: http://www.scientificamerican.com/article/how-to-improve-your-life-with-story-editing/
- Wilson, T.D. (2011). *Redirect: The Surprising New Science of Psychological Change*. New York: Little, Brown and Company.
- Peters, et al. (2013). Specificity of the Best Possible Self intervention for increasing optimism: Comparison with a gratitude intervention. *Terapia psicológica Sociedad Chilena de Psicología Clínica* 31(1): 93–100. Available at: http://www.scielo.cl/pdf/terpsicol/v31n1/art09.pdf

Part 1: Best Possible Selves[8]

Achievement-Based Objectives

By the end of this session, participants will have:

- Recognized that everyone experiences periods of stress and discouragement and that various strategies can help us make positive decisions even during challenging times
- Practiced the Best Possible Selves activity
- Discussed how to adapt the activity to their work and communities

Duration

45 minutes

Materials Needed

- Paper and pencils/pens

Why this Lesson?

Everyone, including Behavior Change Agents (BCAs) and the community members they serve, goes through times of stress and discouragement. While some people are able to keep a positive view of life, others get caught in negative cycles of thinking. These negative patterns can affect the choices we make about our behaviors and the future.

However, these patterns of thinking can be changed. The Best Possible Selves exercise helps people imagine how well things can turn out in the future, with a focus on the steps they can take to reach those goals (since research shows that people who focus on the *process* of reaching a goal are more likely to reach and maintain it than those who only focus on the goal itself).

Advanced Preparation

Throughout this manual, the term BCA is used to represent the wide variety of roles held by workers who promote change. When facilitating this lesson and others, replace "BCA" with a title that is appropriate for your audience (such as agriculture extension agent, community health worker, peer educator).

Tasks

1. Introduce the activity by telling participants: As Behavior Change Agents, we talk a lot about how hard it can be to start and keep doing new behaviors. It's not always easy! Change is especially hard when the stress of daily life makes us feel distracted or discouraged. Today

[8] Adapted from Wilson, 2011, p. 73.

we're going to do an activity that can help us work towards our goals even during tough times.

2. Ask participants to think back over the past week or so and remember a time when they felt discouraged or frustrated at work, home, school, on a sports team, or in another activity or relationship. Ask them to raise their hands when they've thought of an example (but note that they don't have to share with the group). Once everyone is ready, request that they reflect silently for a moment on the types of thoughts and feelings that went through their minds during that time.

3. Note that negative thoughts can distract us and keep us from working on the steps that can get us to where we want to be. So, we will be doing an activity today that can help us get back in touch with the big goals and dreams that we have for ourselves, both personally and professionally. The exercise can be helpful for not only getting through tough times, but also for taking advantage of opportunities for change in our daily lives.

4. Read the following instructions to the group: "Think about your life in the future. Imagine that everything has gone as well as it possibly could. You have worked hard and reached all your life goals. You are living your life dream." Pause for a moment to allow the group to reflect.

5. Continue with the instructions: "Now you will have about 10 minutes to focus on this dream and the steps you took to make it happen." Explain that participants can choose to write, draw, or talk about their "best possible self" and the details about how they got there (e.g., going to school, getting a particular job, changing a behavior).

    5a. Ask participants to raise their hands if they would like to work on their own and write or draw. Give those participants paper and pencil.

    5b. Divide the remaining participants into pairs and inform them that they will talk with their partner for 5 minutes each about their "best possible self" and the steps required to get there. Note that while one person is sharing their partner should use active listening skills without providing their own opinion or feedback.

    5c. Before the participants begin, explain that they will continue this activity during three more short sessions, so they don't need to rush. Remind them to include details about the steps they would take to become this future self. Emphasize that this activity is intended to prompt personal reflection and that there are no right or wrong answers.

6. Allow participants to spread out and find quiet spaces as needed. Let all participants know when 5 minutes have passed; for the participants who chose to talk in pairs, instruct the partners to switch. Bring the group back together after 10 minutes.

    6a. During these 10 minutes, remain available and reread the initial instructions to participants as needed: "Think about your life in the future. Imagine that everything

has gone as well as it possibly could. You have worked hard and reached all your life goals. You are living your life dream. Now draw/write/talk about this dream and the steps you took to get there."

7. After 10 minutes, call the participants back to the larger group. Ask them to repeat this exercise for 10 minutes tonight and the following two evenings.

   7a. Those who are writing or drawing can add or remove steps and details and even rewrite/redraw their future life.

   7b. Those who spoke with a partner can meet up with that person or continue the discussion with someone they trust and with whom they feel comfortable sharing their honest thoughts. They may even want to invite the new partner to take a turn as well, sharing their dreams of a future self.

   7c. Remind the group that that this exercise is very flexible and can be personalized to fit what works for them. As they continue to think about their "best possible self" over the next few days, they may come up with new goals and ideas about what their future life looks like. They also can try out the different versions of the activity as desired (writing, drawing, or talking).

8. Invite participants to discuss with the larger group what it was like for them to start this activity and what they are thinking and feeling as a result.

9. Explain that participants can use this activity for themselves or with community members that may be frustrated or discouraged. The BCA might play the role of the friend and listen to the community member talk about their future life for 10 minutes a day without offering feedback or criticism. The BCA and community member also can work together to draw a picture depicting details of the community member's "best possible self" and the steps taken to get there to help prompt further thought.

10. Facilitate a discussion about other possible adaptations for local use.

    10a. For example, the BCA can give people in a farmers' group the following task:

    "Think about your farm in the future. Imagine that everything has gone as well as it possibly could. You have succeeded at having the best farm possible. Now, write/draw/talk about what you imagined. What did you do, specifically, to make that happen?"

    10b. A parents' group could be asked to do this task:

    "Think about your child in the future. Imagine that everything has gone as well as it possibly could in terms of your child's growth and health. You have worked hard and everything has turned out well for your child. Now, write/draw/talk about what you imagined. What did you do, specifically, to make that happen?"

10c. A youth group could be asked to do this task:

"Think about your life's work in the future. Imagine that everything has gone as well as it possibly could in terms of your education and job training. Everything has turned out well for you. Now, write/draw/talk about what you imagined. What did you do, specifically, to make that happen?

11. Wrap up: Ask participants to share what they will take away from this activity and how they might use some of what they have learned in their work.

Part 2: Story Prompting

Achievement-Based Objectives

By the end of this session, participants will have:

- Recognized how personal interpretations of events and behaviors can be incorrect and can create negative cycles of belief and action
- Learned how story prompting can help people to "reframe" events and shift negative thought cycles into more positive thought cycles, thus promoting positive behavior change
- Developed story prompts that they can use in their own work and to help members of their communities

Duration

1 hour

Materials Needed

- Flip chart paper, markers, paper, and pencils/pens

Why this Lesson?

We each have unique, personal versions of our life events and our own ideas about how the world works. These ideas about our personal story help us make sense of why things happen and often determine how we will respond. This activity helps participants see how their thoughts about themselves and their place in the world are connected to their behaviors and life choices. It demonstrates how "story prompts" can help people think differently about tough situations and take more positive and helpful actions.

Advanced Preparation

Depending on the audience, the facilitator may need to develop a more relevant example for Task 2. Suggestions include: a farmer who had a crop failure after trying a new method, an unmarried teenager who had unprotected sex after receiving prevention education, a woman who has been trying to make healthier decisions to control her diabetes.

Tasks

1. Introduce the activity by telling participants: As Behavior Change Agents, we think a lot about the choices that community members make and why they make those choices. Sometimes it's hard to understand why people decide to do things that might not seem "right" to us. Remember, sometimes our own decisions might not make sense to other people! One reason for this is that people can view the same situation very differently, based on their personal experiences. Each person then makes decisions based on their version, or story, about what is happening. Today we're going to look at how we can help people see tough situations in a more positive way and make more helpful decisions for themselves and their families in the future.

2. Read the following example: A new agriculture extension agent is almost finished with her third quarter of work. She is reviewing her first and second quarterly reports and looking at the information she'll need for her annual report. She is nervous because she has not had many participants in her program, even though she worked very hard and believes that the program could help farmers. As she works on the third quarter report, she sees that she is probably not going to meet the goals that she was given for the year. Her brain immediately starts to explain why she did not reach the program goals.

    2a. Ask the participants for ideas about what might be going through her mind.

    2b. Explain that this agriculture extension agent's thoughts can have a big impact on what she decides to do next. For example:

    - She might decide that she is simply not good at extension work and starts to think about quitting. She might think, "I guess I'm just not good enough at this and people don't want to work with me, so I shouldn't waste my time on extension work." The more she thinks about quitting, the less she wants to spend time meeting with other agents, attending program meetings, or visiting the farmers in her area. This creates a negative cycle, where she spends less time with her fellow volunteers, avoids her supervisor, and weakens relationships with the farmers.

      Ask participants if they can imagine what might happen next with her work. Discuss how those results would affect the way she thinks about her work in the future. (Example: She will have even lower participation and feel even more certain that she should quit)

    - Or she might see things differently: Another option is to consider is that she is new in this job and hasn't spent enough time building strong relationships with the farmers. She decides that she will need to spend even more time in the field for her program to do well. She starts spending more time with the farmers and less in the office and asks for help from her supervisor. She meets with an experienced

agent who has been successful in recent years and asks for help with getting more farmers involved.

Ask participants if they can imagine what might happen next and how those results would affect the way she thinks about her work in the future. (Example: More farmers participate in her programs and she feels motivated to continue to improve as an extension volunteer)

2c. Emphasize that this is an example of how one situation can be viewed in very different ways and how the person's thoughts influenced the behaviors that led to very different results. Those results are then connected to future thoughts and attitudes about the behavior, leading to a repeating cycle.

3. Ask participants to think (silently) for a moment about which type of thoughts they usually have when they're having a hard time: the more negative type in the first example or the more positive type in the second. Note that both types of thoughts are common and that it's normal to feel pessimistic in some situations and more optimistic in others. Ask them to think about how we can help ourselves and other people in our lives or work make a switch from a negative cycle of thinking to a more positive cycle.

4. After several minutes of discussion, thank the participants for their suggestions, and explain that an additional method for changing our thoughts is called Story Prompting, which helps people change the stories they usually use to explain why things happen. This is also sometimes called "reframing," like putting a new "frame" around the same picture so that you see it differently.

5. Here's an example of how Story Prompting works:[9] Some students have a really hard time when they start out at a new school. However, they do better when they are told that lots of other students also struggle and worry at first, then slowly improve. They learn that their struggle is a common, normal one and that they are not less skilled or less intelligent than everyone else. They also learn that even if their situation seems very difficult right now, other people feel the same way and there is hope that their situation can improve in the future, just as it did for many others. They alter their story to think, "This is normal, lots of people go through this, and I will also get through it and do better eventually."

6. How can we use this sort of story prompt to help other community members? Ask for some examples.

7. If needed and appropriate, share the following story about a woman named Maria who is struggling with exclusive breastfeeding: Maria is only giving her newborn baby her breastmilk, nothing else. At first things seem to be going ok, but when her baby, Joel, is 3

[9] From Wilson, 2011.

weeks old, he starts crying a lot. By the next week, he is crying even more. Every week, for 3 weeks, there is more and more crying. What is happening here?

7a. Ask the group for possible explanations and write them down on the flip chart. Ask them to include explanations that might be heard from members of the community (for example: baby has colic, mother's milk is too weak, mother is not making enough milk, evil eye, food disagrees with baby, need to give tea, the husband is being unfaithful to the mother).

7b. Now give more information: The baby is growing well and the Behavior Change Agent says the baby looks very healthy. Ask for more possible explanations of the crying and write them on the flip chart.

7c. Next, give participants information about normal newborn crying. For example: people who study infant behavior have found that most babies start crying more around 2 or 3 weeks, and the amount of time they spend crying increases until around 6 weeks of age. This is very normal. Then crying slowly decreases over time. This is true for babies who are breastfed *or* formula fed.[10]

7d. Explain to the group that many mothers give up breastfeeding in the early weeks because the baby is crying a lot. Ask for a volunteer to describe the possible negative cycle of thought that a mother might have about this situation. If a prompt is needed, ask the group to imagine a mother who thinks, "My baby is crying because I'm a bad mother," "maybe this is a just a bad baby," "my baby doesn't like me," or "it's because my milk is bad." How does this mother feel? What does she do?

7e. Ask the participants: Would it help a mother think differently if she knew that many mothers worry about this same thing and that it is normal for new babies to cry a lot? What if she also learned that there are some ways to help them cry less that don't involve giving up exclusive breastfeeding?

7f. Ask group members for ideas on how we could help the mother change her story. If needed, share the following example of an alternate explanation that you could give to the mother when you visit to help her change the story

- "Most babies cry a lot. It's normal for babies to cry more and more until they are about 6 weeks of age, then the crying starts to decrease. Your baby is healthy and the growth chart shows that she is growing well. Let's see if we can find a way to help your baby calm herself down. Just gently hold her hands together across her chest like this… Look, she calmed herself down! What a smart baby you have! And, how patient you are!"

[10] For more information, refer to http://www.allbabiescry.com/assets/docs/ABC_Booklet_English.pdf

- Tell participants: Babies are trying to tell us what they need when they are crying. Parents can learn to read and respond to their signals and this may reduce crying and help parents become more confident and enjoy their babies more.[11]

- Discuss with participants: How would this mother feel now? What might she do differently if she accepts this story (narrative) about her baby and herself?

7g. Reinforce the idea that by changing her personal narrative—the way she "frames" what is happening with her baby—the mother creates a more positive cycle of thought and behavior that can be beneficial for her and her baby.

8. Note that these changes in thinking can be helpful for all sorts of people and in many different situations. Ask participants to share comments or negative thought cycles they often hear in their communities. One key to identifying these negative thought cycles is to think about things that people tell themselves when confronting common challenges that make them "give up" long before they should. For example:

   - "We don't want to build latrines because we tried that years ago and it didn't work, so it is a waste of time to introduce them now."
   - "People argued too much when we tried to set up that community group, so there's no use in trying to set up other ones."
   - "I've tried adding more nutritious foods to my family's diet, but it's too much work and nobody likes the new foods."
   - "I learned about a new farming technique, but my neighbors made fun of me, so I gave it up."

9. Acknowledge that sometimes it is ok to let go of something if it is not working. Also emphasize that positive narratives need to be based on the truth. Ask for examples of situations where it may be misleading or unhelpful to insist that things will get better.

   9a. Note that story editing is useful in situations where people might give up before giving a strategy time to work. Remind participants that many people find it comforting and helpful to learn that other people have struggled with a similar issue, but were eventually able to overcome it and achieve their goal.

10. Ask participants to work with partner to describe a positive and a negative thought cycle about one of the situations listed in Step 8 (or another situation that they encounter in their communities or families). They can discuss the thought cycles with their partner, write them

[11] For more information on calming a baby, see the H.U.G. Your Baby website (http://hugyourbaby.org/), the H.U.G. Your Baby YouTube video *Being more confident as a new parent!* (https://www.youtube.com/watch?v=wvvL4GBodNE), and the *Reading and Responding to Your Baby Lesson Plan* (http://www.fsnnetwork.org/reading-and-responding-your-baby-lesson-plan).

down, or draw them. Request that one or two pairs show their examples to the larger group.

11. Ask the group if they would like an additional example, and, if needed, share the following: A community leader may think, "We installed tube wells and soon after, they were broken and no one used them. People are so careless. And I must not be a very good leader or I could have convinced them to take better care of them. I guess they were a waste of time and we shouldn't bother to fix them." A more positive story prompt ("frame") could be: "It's normal that a tube well will often get broken or damaged when it is first introduced in a community, as some of our tube wells did. Not all of them broke. This is something that many community leaders encounter. We just need to form a group of volunteers to repair and maintain the tube wells and to teach other community members about their maintenance."

12. Discuss as a large group how they can first identify negative narratives in their communities and then work with community members to change this thought cycle. Explain that one method is to create or share positive stories or testimonials with community members that are starting a new initiative or trying to make a difficult change. Examples might include skits, videotaped interviews, recorded testimonials, or written interviews that can be shared as part of the training or during follow-up sessions and site visits.[12]

    12a. Ask participants to work again with their partner to develop a testimonial or mock interview about the challenging situation they just discussed. The testimonial should focus on how they changed their personal story about it and include the story prompt features mentioned earlier (for example: many people have a hard time when they start something new, hard work and repeatedly practicing new skills can help us do better, focusing on finding solutions gets better results than blaming ourselves and others).

    12b. Request that one or two of the partners present their example.

13. Wrap up: Ask group members how they plan to use what they have learned in this lesson in their work as a BCA.

[12] For more on testimonials, see Lesson 6: Behavior Change through Testimonials.

Part 3: Personal Values Exercise[13]

Achievement-Based Objectives

By the end of this session, participants will have:

- Understood how negative thought cycles can impact behaviors and performance
- Learned how focusing on personal values can help people get through difficult situations
- Adapted the values exercise to the needs of the Behavior Change Agent (BCA) or his/her community

Duration

45 minutes

Materials Needed

- Paper and pencils/pens

Why this Lesson?

As BCAs we help people in our communities make healthier decisions for themselves and their families. An important factor in being able to make and keep changes in our behaviors is a strong sense of self-worth. However, we all experience times in our lives when we feel "less than" other people or other groups of people. There may be beliefs that a particular group to which you belong (based on age, gender, social class, sexual orientation, race, educational level, tribe, ethnic group, or other characteristic) is somehow not as good as others. Sometimes the differences are real because of lower access to resources or opportunities, and sometimes what seems like a difference is actually an incorrect belief.

These feelings of being "less than" can create a negative cycle of ideas about ourselves and our ability to change and reach our goals. But, this cycle can be corrected by focusing on the good aspects of the group (or groups) to which we belong.

This lesson presents a simple exercise that has been found to help people focus on their most important values to increase the positive thoughts that can lead to beneficial behavior change.

Facilitator's Notes

For more on the research about the "value exercise," refer to Wilson, 2011, pages 225–234.

[13] Based on the "values exercise" use to overcome "stereotype threat" (Wilson, 2011, p. 225–234).

Tasks

1. Tell participants: As Behavior Change Agents, we help people in our communities make healthier decisions for themselves and their families.

    1a. Ask participants how they think community members need to feel about themselves in order to make changes in their own lives. (Answers can include: good self-esteem, that they have control over their lives, that they are good people)

2. Ask participants for examples of a group of people seen as "less than" or "not as good as" others in the community. These can be examples that they personally have experienced or that are experienced by some of the community members with whom they work. (Examples: men are not good at taking care of children, girls are not good at sports or math, boys can't cook, women can't drive as well as men, teenagers aren't hardworking)

3. Explain that you are going to share an example of how negative ideas about a group can affect the people in that group. Read the following.[14]

    In the United States, there is an old belief that people of color are less intelligent than whites. Even though science has shown that there is no inborn difference in intelligence between racial groups, this old belief still affects people. For example, in one study, when black students were given a test and told that it was a test of intelligence, they did not do as well on the test as white students. If they were not told that the test measured intelligence, they did just as well as whites on the very same test.

    3a. Ask the participants what they think might have made the students get lower scores when they thought the test measured their intelligence.

    3b. Explain that when people feel that they belong to a group that is believed to be "less than" other groups, they worry that they will prove everyone right, that they really aren't as good as others. This worry and anxiety makes it harder to concentrate, and they often do not do as well.

4. Explain that people do better when they see themselves as good, competent, and respected by others. When people feel that they are part of a group that is not as good as others, personal setbacks (such as a poor harvest or having a child who is malnourished) can be even more hurtful.

    4a. Share this example: It's been found that mothers are less likely to go to the clinic when a child is malnourished than when the child is sick.[15] Ask the group what they think

[14] Adapted from example about stereotype threat in Wilson 2011.

[15] Concern Worldwide did a study in Kenya in 2013 to look at barriers influencing care-seeking for malnutrition services and found that stigma and feeling ashamed were important factors in why fewer mothers accessed malnutrition services compared to mothers seeking care for sick-child services. (Bliss, J. R., M. Njenga, R.J.

might be going through the mind of the mother of the child who needs malnutrition services compared to the mother of the child who is sick (examples can include stigma and shame).

4b. If appropriate, the group also can discuss a situation that is more relevant to their work, such as a farmer who has had a poor harvest but doesn't want to work with an agriculture extension agent.

5. Share the following with the participants: When someone you know is a member of a group that is seen as "less than" others, you can remind him/her of the things that he/she does well and of the strengths in his/her culture or group. Research has shown that focusing on the strengths and values that are important to a person's group improves how they see themselves. They also do better when faced with tests or hard situations, especially when the test might prove or disprove those negative beliefs about their group.

6. A simple exercise can help people focus on these positive values and break that negative cycle of thinking.

   6a. Divide participants into small groups and hand out sheets of paper and pencils/pens.

   6b. Ask participants to pick a group about which their community sometimes holds negative beliefs. Ask them to list important positive values for that group or for people that they know who belong to that group (examples can include: strong family relationships, loyal friendships, hard work, religious participation, musical traditions, artistic expression, or political involvement). Allow a few minutes for the groups to create their lists.

   6c. Then ask participants to take a moment, individually, to imagine that they are a member of that group. Ask them to pick the value from the list that would be most important to them and write about why. Alternately, participants can prepare a short speech, about 1–2 minutes long, explaining why the value is important. Note that they do not have to share their responses with the group if they don't want to.

   6d. Ask for a couple of volunteers to share the value they wrote about or the short speech they prepared.

7. Now, ask the participants to think about a time when they felt "not good enough" or "less than" because they belong to a certain group. Ask them to repeat the value writing or speech exercise for themselves (make a list of important values, then focus on the most

Stoltzfus, & D.L. Pelletier. 2015. Stigma as a barrier to treatment for child acute malnutrition in Marsabit County, Kenya. *Maternal & Child Nutrition*. doi: 10.1111/mcn.12198. Available at: http://onlinelibrary.wiley.com/doi/10.1111/mcn.12198/abstract?campaign=wolearlyview)

important value). Note that they do not have to share their responses with the group if they don't want to. Ask a few volunteers to share their thoughts.

8. Thank the volunteers for sharing, and reinforce that this simple values exercise can interrupt a negative thought (and behavior) cycle when used during times of upcoming stress or struggle.

    8a. Acknowledge that a values exercise cannot take the place of larger social and structural changes to increase fairness and decrease poverty and discrimination. It also cannot directly change the negative beliefs held by others against certain groups. However, members of those groups can help themselves interrupt the self-destructive thought patterns that might keep them from working through such difficulties.

9. Wrap up: Ask the group how they might incorporate this values activity into their work with community members. (Examples include: Prior to asking women to take on leadership positions, have them do an exercise where they talk or write about things that they value or that are important to them; frequently invite group members to mention a value during group meetings and give them the opportunity to share positive stories about how their values helped them believe in themselves during stressful times)

IN-SERVICE TRAINING FOR CSO STAFF AND VOLUNTEERS: HOW TO CONDUCT PERSONALISED SUPPORT GROUPS FOR ACTION

Note: CSO staff and volunteers will be trained simultaneously

OBJECTIVES

This training will be conducted for CSO staff and volunteers during their monthly supervisory meetings. By the end of this lesson, participants will:

- Understand and use the 4 steps to conducting personalised support groups for action;
- Understand and use the 5 steps to conducting follow-up personalised support groups for action;
- Understand and use the list of small, do-able actions (SDAs);

Duration: ~4 hours

MATERIALS

1. CSO supervisors' guide to monthly meetings (English only)
2. Support group checklist for CSO supervisors for all topics (English only)
3. Support group job aid for CSO volunteers for all topics (English and Kiswahili)
4. Small, do-able actions CSO volunteers and CHWs can recommend to families (English and Kiswahili)
5. Word strips with steps to conducting personalised support groups for action (English and Kiswahili)
6. Word strips for steps to conducting support groups
7. Word strips with tasks within each step for conducting personalised support groups for action (English and Kiswahili)
8. A4 paper or flipchart paper and markers (if possible)

PREPARATION

- Ahead of time, CSO staff should already be familiar with materials 1-3, above.
- To the extent possible, have CSO staff read the steps to conducting personalised support groups for action ahead of the monthly meeting.
- Develop an acronym for the 4 and 5 steps of conducting improved support groups.

In attendance: all CSO staff and all volunteers from the CSO

INTRODUCTION [5 minutes]

Explain that:

- CSOs have been conducting support groups to improve community members' behaviours and improve the nutrition and health of women and children.
- We thank you for the way you have conducted support groups and changed the communities where you work.
- *Mtoto Mwerevu* has developed additional guidance about how support groups can become even more effective in changing people's behaviours.
- Today we are going to present, discuss, and practise **Personalised Support Groups for Action**.

EXPLAIN SOME OF THE CHALLENGES VOLUNTEERS HAVE HAD WITH SUPPORT GROUPS GLOBALLY [5 minutes]

Mention some of the bullets below (bolded text is particularly important for today's training:)

For parents:

- Lack of time, long distances to arrive at support groups
- Parents feel scolded
- Support groups might not be interesting or fun
- Support groups might not be relevant to the people in attendance
- **Support groups don't build on people's personal experiences.**

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For volunteers:

- Low attendance
- Target group doesn't attend
- Few mothers (or fathers) return for second support group meeting
- Parents seem to lack motivation
- Volunteers aren't appreciated for their hard work
- **Volunteers don't witness behaviour changes: resulting in kids remaining unhealthy**
- **Support groups often only provide information (and frequently, too much of it: support groups can be unfocused)**

REVIEW CSO STAFF AND VOLUNTEERS' EXPERIENCES WITH SUPPORT GROUPS [5 minutes; Assigned Person]

Ask:

- What is going well?
- What can be improved upon?
- What has been particularly successful about support groups?
- What has been challenging?

EXPLAIN THE PURPOSE OF TODAY'S TRAINING

[10 minutes; Assigned Person]

Pilot an improved approach to facilitating support groups. Get feedback from you:

- Will this new approach work?
- What did you like about the training?
- Was anything confusing or difficult?
- How might you change (improve upon) this training when we work with other CSOs?

This is the first time we've tried this approach. We need your input — now and after you've worked with this approach for a few months.

DEMONSTRATION OF A PERSONALISED SUPPORT GROUP FOR ACTION

[30 minutes; Assign two people to lead this portion and take alternating turns leading]

- Assigned person and assigned person demonstrate:
- Personalise: Assigned person
- Discuss and brainstorm solutions: Assigned person (for the first round with a good CSO), Assigned person (for the second round with a struggling CSO
- Teach back and commit: Assigned person
- Tell others: Assigned person

Discussion in plenary of what's different in the demonstrated support group generally, compared to support groups you're familiar with (use paper and markers if available).

Share handout (in Kiswahili) with steps and description of each step. Review each step one-by-one and have group ask questions and teach back what they understand.

As a review, show word strips for Personalise, Discuss and Brainstorm Solutions, Teach Back and Commit; and Tell Others. Have CSO staff arrange the word strips in the order they think is best.

REVIEW OF STEPS AND TASKS AND PRACTISE

[30 minutes review; 30 minutes practise]

Two organisation leaders and two CSO staff members help with the following tasks.

Break into four groups (each group is assigned a step) and have them do the following:

1. Read the tasks and clarify meaning with the two organisation leaders, and two CSO staff members.
2. Organise the tasks under each of their steps in order, using their handout.
3. Take away one of the papers with a task written on it. Group members repeat the step that is missing. At this point, it's no fair consulting the handout!
4. Repeat for every task until every slip with a task written on it has been taken away and group members can recite each step.
5. Identify a rationale for their step overall (e.g., the reason we need to personalise the support group is because…)
6. Pick one member of the group to demonstrate their step in plenary.

In plenary, the following will occur:

1. Describe at least one rationale for their step overall.
2. Demonstrate their step to the rest of the group.

Thus, each group demonstrates in plenary and in order (Personalise, Discuss and Brainstorm, etc.) the step corresponding to their group. *Only after all four steps have been demonstrated*, everyone gives feedback, starting with the first step (Personalise).

Observers (those not facilitating a support group during a given step) use checklists for support groups to make sure other elements of support groups are also present.

Once the entire support group has been demonstrated and everyone has had a chance to give feedback, have everyone review the handout with the steps and name any that were missed. Also review support group checklists to comment on what went well and what needs to be improved.

Emphasise that the support group should be a natural conversation and not something that requires rigidly following each step.

PRESENT AND REVIEW SDAS

[15 minutes; Assigned person]

1. Purpose
2. When used
3. How used
4. Questions?

PRACTISE IN THE FIELD [60 minutes; Assigned person and CSO staff oversee this part of the training]

RETURN TO THE CSO OFFICE TO DISCUSS WHAT WENT WELL AND WHAT CAN BE IMPROVED

[15 minutes; Assigned person]

Should be based on handout on personalised support group for action and checklists for support groups.

DISCUSS FOLLOW-UP SUPPORT GROUP

[10 minutes; Assigned person]

Ask what happens in the next support group session. Hand out 5 steps for following up on personalised support groups for action. Briefly review the handout.

FEEDBACK

Get feedback from you:

- Will this new approach work?
- What did you like about the training?
- Was anything confusing or difficult?
- How might you change (improve upon) this training when we work with other CSOs?

DEVELOP A PLAN [15 minutes; all]

Come to an agreement (CSO staff and volunteers) about a plan for conducting personalised support groups for action (implementation, monitoring, improvement).

USING PERSONALISED SUPPORT GROUPS FOR ACTION TO IMPROVE UPTAKE OF HEALTHY BEHAVIOURS

Support groups and other forms of counselling have the potential to affect a variety of maternal and child health behaviours and outcomes. A meta-analysis of nutrition education and counselling (NEC) interventions suggests that mothers' overall mean gestational weight gain was significantly higher amongst individuals participating in NEC, relative to control groups. Similarly, NEC substantially and significantly reduced risk of anaemia in the third trimester. These meta-analyses also indicate that there were significant gains in birthweight when NEC was provided along with nutritional support but not when provided alone. There is also evidence of a positive impact of NEC on intake of proteins and iron-rich foods amongst women but not consumption of energy-dense foods (Webb Girard and Olude, 2012).

While a number of implementing partners, including the Government of Tanzania, international NGOs, and CSOs use support groups regularly, they are often simply vehicles for sharing messages. Specifically, in Tanzania, support groups frequently fail to respond to the needs of the community (for example, CHWs often fix the topic of discussion ahead of time), are not tailored to group members, tell group members what they have to do, and don't commit support group members to changing their practices. These challenges are even more acute amongst CSOs that have limited capacity in behaviour change and programme outreach.

As part of the ASTUTE project, PANITA worked with 50 CSOs to strengthen their capacity in the management of support groups. This included hands-on training by the government and ASTUTE staff members, office-based and on-site mentoring, and the provision of checklists to ensure the quality of support groups (included as part of this toolkit). Additionally, in Geita region and elsewhere, PANITA piloted the use of Personalised Support Groups for Action.

Personalised Support Groups for Action differ from a more traditional support group in a number of ways. Steps to conducting such groups include the following steps:

1. **Personalise the group:**
   a. Show genuine interest in each group member.
   b. Ask about health issues group members face.
2. **Discuss and brainstorm solutions:**
   a. Ask group members what small practices they can try so that they overcome the health issue they've identified.
   b. If group members struggle to identify practices they can try, refer to your menu of practices and, based on the health issues group members have already reported, choose 3-4 small, doable actions (SDAs).
   c. Present 3-4 SDAs to the group. Explain what each SDA means.
3. **Teach back and commit:**
   a. Ask group members to identify benefits of practising each of the SDAs.
   b. Have group members teach back what they perceive each SDA to be so that you are sure they understand the 3-4 SDAs.
   c. Have the appropriate group members to commit to practising 2-3 SDAs—either from what group members themselves identify as practices they can try or from your menu of practices. It is likely that group members will commit to different SDAs. This is perfectly fine.
   d. Help group members identify any challenges with the 2-3 SDAs they've committed to try by asking: What makes it hard to practise these new behaviours?
   e. Ask group members: Who can support you as you try these practices?

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The SDAs should be specific to relevant group members. For example, if babies' crying is a problem for parents of children less than 6 months old, ask parents of children less than 6 months old to commit to 2-3 SDAs related to crying.

f. Ask all other group members what they can do to support these parents as they try 2-3 SDAs.

g. Have all who are willing to raise their hand and\or say aloud what SDAs they're committing to.

h. Record each group member's new SDA in your counter book.

4. **Tell others: Have everyone who is willing to do so commit to telling others what they have learnt today. Have everyone invite their neighbours to the next meeting.**

During the following (subsequent) support group, the group facilitator (in ASTUTE's case, the CSO staff member) follows these 5 steps:

1. **Teach back and follow up:**

   a. Have group members teach back what they know about the SDAs discussed in the last meeting.

   b. Ask if support group members were able to try the SDAs.

2. **Congratulate: Congratulate support group members as a whole for making an effort to try a new SDA. Avoid congratulating only those individuals who successfully practised SDAs.**

3. **Resolve barriers: Resolve barriers for group members who weren't able to adopt the new SDA.**

4. **Share successes:**

   a. Have group members share their experience trying the new SDAs.

   b. Help those who weren't able to adopt the new SDA resolve any challenges they face.

5. **Repeat: Start with a new practice using the same participatory approach, including teach back.**

Critical to the success of Personalised Support Groups for Action and support groups more broadly is:

1. Coordination of support groups with councils and wards through CSO participation in District Multisectoral Nutrition Steering Committees and coordination with local (ward and village) leadership.

2. Coordination of support groups with CHWs and their supervisors to ensure that support groups and home visits reinforce each other and are used effectively.

3. Repetition of key messages on MIYCAN, ECD, WASH, and women's workload that are broadcast via radio or shared using other media. For example, CSO support group facilitators might indicate: "Did you hear the message on the radio this week about how to reduce women's workload during pregnancy and breastfeeding? What do you think of the message? What can you do to reduce your workload?"

4. Use of evidence-based messages, broken down into small, do-able actions (for example, "buy soap in the coming week' rather than "wash hands with soap and water at all five critical moments for handwashing" which is almost certainly too complex to try)

Lessons Learnt and Actions Other Implementing Partners Can Use to Improve Support Groups

- ASTUTE found that community members responded much better to Personalised Support Groups than to traditional support groups that do not respond to the community's priorities. Likewise, community members were motivated to change behaviours when they saw their neighbours publically committed to doing so.
- Some CSOs had limited capacity to carry out support groups in general and Personalised Support Groups for Action specifically.
- Programme reach was limited.
- Personalised Support Groups for Action are a new way of managing a support group. They require time and assistance from PANITA and other umbrella organisations to help CSOs and support group facilitators make changes to how they usually manage support groups.
- Checklists are not used as much as they could be. Consequently, the quality of support groups is not always high nor consistent.

- Help implementing partners use the steps above to make support groups more personal. Mentor implementing partners repeatedly (including through observation of CSO support groups) to ensure that staff are able to respond to the priorities the community sets and commit support group members to trying one or two actions prior to next month's meeting.
- PANITA provided additional one-on-one mentoring and monitoring. PANITA can be consulted regarding how to support CSOs and other implementing partners in the use of group-based behaviour change strategies.
- This is a perennial challenge with small CSOs and not easily addressed without additional funding.
- Pilot test the use of Personalised Support Groups for Action in just a few wards. Provide extra support, as needed. Reflect on successes and challenges. Adjust training and mentoring and repeat the process in other locations.
- PANITA emphasises the use of checklists when they meet monthly with CSO staff. They also train CSOs in the use of checklists. The support group checklist is available as part of this toolkit. It should be piloted and adapted to address the needs of a particular implementing partner.

Support groups provide the opportunity to reach more beneficiaries than household visits but their limitations should be acknowledged. In order to improve upon support groups, CSOs and other implementing partners will need to manage support groups more effectively (for example, by using the lessons learnt, above) and modify existing behaviour change strategies to make support groups more responsive to community needs and more action oriented.

Reference: Webb Girard A, Olude O (2012). Paediatric and Perinatal Epidemiology. Nutrition education and counselling provided during pregnancy: effects on maternal, neonatal and child health outcomes.

UNITED REPUBLIC OF TANZANIA

How evidence transformed the design of SBCC strategies to improve nutrition in Tanzania

April 18, 2018; Nusa Dua, Indonesia

K Dearden, G Mulokozi, G Mbaruku, J Mugyabuso, M Linehan,
S Torres, P Remes, V Atugonza, D Kezakubi

The Challenge

When we aren't systematic about data collection and use, we build programmes on limited evidence …

… which means we run the risk of misusing resources designed to improve public health.


Objective: How to use evidence to design large-scale SBCC programmes

ASTUTE Programme

Objective: reduce stunting in children <5 years of age by:

1. Improving the government's response to nutrition at national and sub-national levels [Health; Agriculture; WASH; Early Childhood Development (ECD)];
2. Building capacity to support optimal care practices for maternal and infant and young child nutrition, WASH, and ECD; and
3. Increasing the knowledge of pregnant women, caregivers of children <2 years old, and household and community decision makers on:
   - Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN); WASH; and ECD.

ASTUTE is implemented by IMA World Health, PANITA, DMI, Cornell University, and the Government of Tanzania with funding from DFID.

Duration: 4.5 years (2016- 2020).

Coverage

5 Lake Zone regions:
Mwanza, Shinyanga, Geita, Kagera, Kigoma.

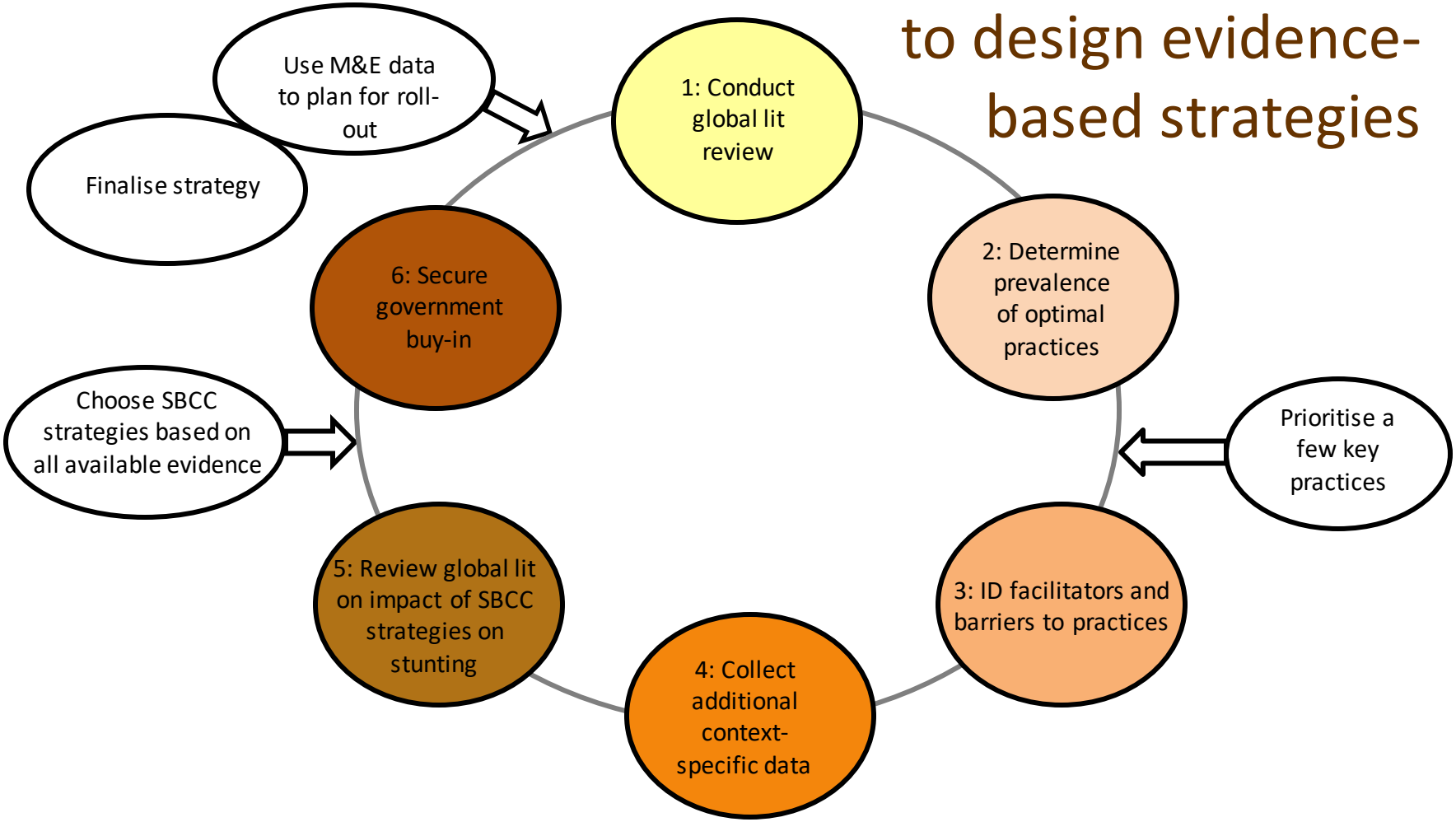
Targeted Population:

10.2 million total;

Over 3 million mothers and children.

Aim: >50,000 children will not be stunted.

Steps ASTUTE used to design evidence-based strategies



Case Study

Giving children >6 months animal source foods

Step 1: Conduct Global Literature Review

Does the peer-reviewed literature suggest an impact on stunting?

Yes!

Evidence comes from a variety of sources.

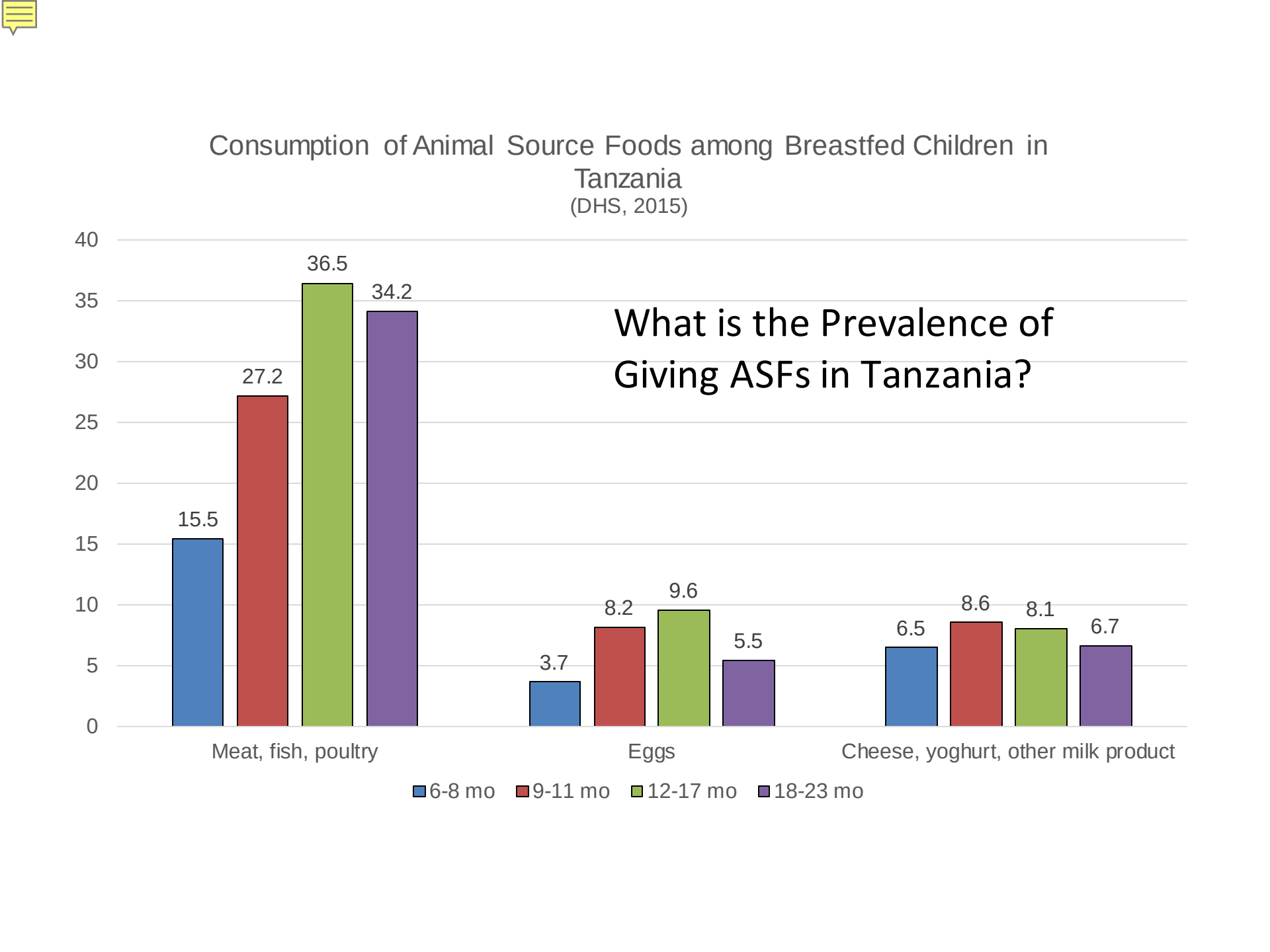
Bhutta ZA et al (2008). What works? Interventions for maternal and child undernutrition and survival. Lancet 371:417-40.

Bhutta ZA et al (2013). Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Lancet 382:452-77.

African Development Bank (2017). Synthesis of evidence of multi-sectoral approaches for improved nutrition. Author: Tunis, Tunisia.

…and many other studies.

Step 2: Determine Prevalence of Optimal Practices


Consumption of Animal Source Foods among Breastfed Children in Tanzania
(DHS, 2015)
What is the Prevalence of Giving ASFs in Tanzania?
40
35
30
25
20
15
10
5
0
15.5
27.2
36.5
34.2
3.7
8.2
9.6
5.5
6.5
8.6
8.1
6.7
Meat, fish, poultry
Eggs
Cheese, yoghurt, other milk product
6-8 mo
9-11 mo
12-17 mo
18-23 mo

Step 3: Identify Facilitators and Barriers to Optimal Practices

Per ASTUTE's literature review and formative research:

Barriers:

- Nutritious foods are expensive;
- Incomplete and incorrect advice on complementary feeding from health workers;
- Poverty, belief that children shouldn't be given preference for ASFs; and
- Chicken and eggs are for emergency cash and are not to be used as a nutritious food.

Facilitators:

- ASFs are available (e.g., small fish in 4 regions);
- Few food taboos;
- Men and women are open to trying new behaviours, including giving ASFs.

Step 4: Collect Additional, Context-Specific Data

What practices are people willing to try? Per ASTUTE's Trials of Improved Practices and recipe trials:

- **Recommendation:** use milk instead of water to prepare porridge.
  - Not well received in recipe trials.
- **Message:** children don't need teeth to eat foods such as eggs, meat, and vegetables if you mash them.
  - Fears of choking need to be addressed.
- **Recommendation:** add egg, *dagaa*, or vegetables to porridge.
  - It takes 8-10 times before a child is used to a new food. Keep trying!

Step 5: Review of the Literature on the Impact of SBCC Strategies on Stunting

The global literature suggests that:

The impact of health facility worker training on consumption of ASFs is mixed. In Tanzania, health facility workers (HFWs) rarely counsel on nutrition.

- ASTUTE provided 1-day orientation to HFWs rather than extensive training they might not use.

Support groups have mixed impact on ASF consumption but home visits have consistent positive effects.

- ASTUTE conducts support groups but prioritises home visits using negotiation to assist CHWs as they help families try new practices.

There is limited but positive impact of mass media on ASF consumption.

- ASTUTE broadcasts radio messages, including spots on men's roles (e.g., one radio drama between fathers who are fishing emphasises the importance of adding fish to children's porridge).

Positive deviance/hearth has an impact on animal source food consumption:

- ASTUTE pilots and carefully monitors programmes to determine nutritional impact.


Step 6: Secure
Government Buy-In

ASTUTE works with government at all levels to secure buy-in. Examples:

- Government and ASTUTE staff co-designed training;
  - Training was made more specific based on TIPs;
- Government reviewed ASTUTE's approach to radio and its SBCC strategy.

Challenges Using Evidence

- There may not be enough data about the:
  - Efficacy of interventions;
  - Prevalence of optimal practices in programme areas;
  - Facilitators and barriers; and
  - Impact of SBCC programme approaches.
- Weak studies or old data compromise decisions about programme design;
- Synthesising evidence takes time and capacity to use information;
- Findings from some project studies may not be available in time to influence programme design.

Conclusion

- We believe that when data are used systematically to design strategies, the impact of our programmes is maximised.

Thank you

Handout: Crocodile radio spot

Voices and a rowboat on the lake.

KASIMU: Maganga, we got more fish now than in the first round. The net is heavy.

MAGANGA: Kasimu, stop pulling. Stop! It's a crocodile!

KASIMU: Crocodile?

MAGANGA: Yes, thankfully we got some fish the first round. At least I got my child's meal.

KASIMU: We work in a dangerous environment and you feed a one-year-old child fish?

MAGANGA: I want my child to be strong and smart.

KASIMU: My child takes maize and cassava porridge only.

MAGANGA: Kasimu, in order for a child to grow well, he needs different nutritious foods, like fish, vegetables, lentils, and fruits while continuing with breastfeeding.

KASIMU: Why should I give him all that food? What's wrong with porridge?

MAGANGA: A child must be given additional nutritious food for him to grow well. We mix cassava porridge with groundnuts. Other days we mix with an egg, as we have been advised at the dispensary.

KASIMU: Really?

MAGANGA: Or we smash sweet potatoes and mix with fish fillet.

KASIMU: If I give those foods will my child be like yours? Your child is so healthy.

Parents and caregivers, continue to breastfeed a baby but once it's six months (old), feed it additional nutritious foods so that it has good physical and mental development.

HOW ASTUTE USES INNOVATIVE BEHAVIOUR CHANGE APPROACHES TO IMPROVE COMMUNITY NUTRITION PRACTICES IN TANZANIA

OVERVIEW

Social and Behaviour Change (SBC) programmes are most successful when they marry a thorough understanding of local context with a knowledge of state-of-the-art programmes that have improved nutrition outside of Tanzania. However, often, Tanzanian development professionals have not been exposed to the many successful nutrition programmes that are being implemented elsewhere. This brief outlines ASTUTE's efforts to bring together a solid understanding of both the local context and global experience in reducing stunting.

ASTUTE Programme Background

The ASTUTE programme has used a number of strategies to mobilise Tanzanian communities for behaviour change around stunting reduction, including:

Close collaboration with the Government of Tanzania (GoT) at all levels, such as support for the government's National Multi-sectoral Nutrition Action Plan (NMNAP). ASTUTE worked with the GoT to co-train 6000 community health workers (CHWs) and 1200 health facility workers (HFWs) on evidence-based SBC as part of the project.

Active engagement of government staff from agriculture, education, community development, and other sectors to improve the nutrition of women and children.

Capacity building in behaviour change of civil society organisation (CSO) staff, including how to make support groups both more personal and action-oriented.

Reminders to community members during home visits and support groups about ASTUTE's radio messages they are hearing each week.

Follow-up with families to see if they are able to practise recommended behaviours and to address challenges families face practicing those behaviours.

Positive deviance/Hearth—a government-implemented, assets-based strategy that helps communities identify the uncommon but beneficial practices that enable some families to keep their children well-nourished and to spread such practices to other community members.

KEY APPROACHES USED AND LESSONS LEARNED

Our recommendations—based on ASTUTE programme experience—appear below.

Use evidence to select a few behaviour change strategies that reduce stunting:

Prior to identifying how to best reduce stunting, ASTUTE staff 1) reviewed the government's nutrition-specific and nutrition-sensitive programmes and policies that were already in place, 2) identified especially poor practices among target populations, 3) conducted research to understand why individuals fail to practise behaviours known to reduce stunting, 4) apply health behaviour theory, and 5) thoroughly review the global literature about which programme interventions are most likely to reduce stunting.

We consulted the 2015-16 Tanzania Demographic and Health Survey (TDHS), conducted our own baseline survey and qualitative research (including Trials of Improved Practices), and reviewed health behaviour theories and the global programme literature on nutrition and stunting.

As examples of using the evidence base, per the 2011 TDHS (the most recent data at the time ASTUTE was designed), about one in three Tanzanian children 6-23 months of age consumed meat, fish, or poultry and only one in ten ate eggs in the previous 24 hours. Hence, we prioritised consumption of animal source foods during radio spots, home visits, and support groups. The scientific literature backs up the importance of animal source foods: starting at six months, children who eat meat, fish, and eggs; green, leafy vegetables; and orange-fleshed foods are less likely to be stunted. [1]

1 Arimond M, Ruel MT. Dietary diversity is associated with child nutritional status: evidence from 11 demographic and health surveys. Journal of Nutrition. 2004;134:2579–85. Dewey KG, Adu-Afarwah S. Systematic review of the efficacy and effectiveness of complementary feeding interventions in developing countries. Maternal and Child Nutrition. 2010;4:24–85. Dror DK, Allen LH. The importance of milk and other animal-source foods for children in low-income countries. Food and Nutrition Bulletin. 2011;32:227–43.

UKaid from the British people

IMA World Health

Health behaviour theory and research point to certain interventions that are particularly effective. For example, home visits are especially good at addressing the individual challenges mothers and fathers face as they try new practices such as hand washing. Support groups and radio are effective in increasing knowledge and improving social norms. We also found that certain programme strategies have a demonstrable impact on nutrition-related behaviours. For example, based on a comprehensive review of the literature,[2] 18 of 23 studies showed that community-based counselling and group education had a positive impact on breastfeeding practices. 10 of 13 studies showed associations between support groups and complementary feeding behaviours. In 28 of 32 studies, home visits had a positive impact on breastfeeding practices and in 6 of 13 studies, home visits were associated with improvements in complementary feeding.

To bring about behaviour change, establish and maintain one-on-one contact with caregivers: The government and implementing partners In Tanzania rarely use home visits to bring about behaviour change. Rather, most of their interventions are group-based, such as community-based support groups. ASTUTE believes it is very difficult to improve the way parents care for their children without understanding *why* parents are unable to try such practices as early childhood stimulation, hand washing, or feeding the child more frequently. Home visits allow CHWs to tailor messages to parents' individual needs. Group-based interventions do not.

As a starting point, ASTUTE staff looked to successful home visit strategies used in other countries. ASTUTE's home visits differ markedly from information sharing alone, which some parents may interpret as scolding. ASTUTE's approach—known as negotiating for behaviour change (or negotiation for short)—helps CHWs establish trust with parents. During negotiation, CHWs find out what parents are already doing (or not) to keep children well-nourished; the CHWs identify "small, do-able actions" parents can try; help them pick one action they can attempt this week; resolve barriers to behaviour change parents may experience; and set a time for a follow-up visit. For example, a father may believe that his infant cannot hear and thus there is no reason to speak to the child. He may say that he does not have time to play peek-a-boo or does not have ideas about how to stimulate the child. While discussing these challenges with the father, the CHW formulates options the father can try (imitating the infant's sounds to see if the baby reacts; playing peek-a-boo; or consulting other fathers to get ideas about how they stimulate their children). The CHW then asks the father to commit to one of the proposed actions and thereafter helping him try the new behaviour.

Home visits are not without challenges. ASTUTE has found that CHWs cannot possibly visit all 'thousand day' households (those with pregnant mothers and children less than two years of age). To address this issue, the project prioritised homes with infants three to nine months of age. This period is when mothers prematurely stop breastfeeding exclusively or offer their infants a diet made up of primarily of *ugali*. An additional challenge is that negotiation is complicated and it takes time for CHWs to master it. In addition to initial training, ASTUTE provides on-the-job mentoring during monthly supervisory meetings when CHWs have half a day each month to practise negotiation in the classroom and in the field.

To improve parents' nutrition-related behaviours, use action-oriented support groups: Similar to home visits, well-intentioned volunteers sometimes scold parents who attend support groups for not caring for their children's health properly. This is due, in part, to volunteers' lack of skills needed to bring about behaviour change. Not surprisingly, when volunteers see that parents' practices remain unchanged, they become demoralised in their work.

Unlike most support groups, ASTUTE trains CSO volunteers how to:

1. Personalise the support group topic that day to reflect the issues parents themselves want to talk about;
2. Discuss together and then brainstorm solutions to challenges parents face;
3. Have parents teach back what they understand each solution to be (otherwise, it is not clear that group members fully understand the solutions under consideration);
4. Collectively commit parents to each try one of several behaviours; and
5. Have parents tell others what they have learned and how, specifically, they have committed to improving their children's nutrition.

Subsequent support groups are used to:

Follow-up with parents to see whether they have been able to adopt the practice they committed to during the last meeting;

Congratulating all parents for trying new practices (regardless of whether or not they succeeded);

Resolving any barriers to behaviour change;

Sharing successes parents have had in changing their practices; and

Repeating the process with a new, small, do-able action.

2 Helen Keller International. Homestead food production: empowering women and feeding families. New York, New York, Author. No date.

Select a few priority behaviours for programmes to focus on; divide complex behaviours into small, doable actions: In its first year, ASTUTE and the GoT selected six cost-effective behaviours that, when practised, reduce stunting. Limiting the behavioural focus ensures government and CSO buy in to the behaviours and increases their ability to manage SBC interventions.

We often expect parents to adopt complex behaviours overnight. For example, we anticipate that a single support group will convince parents to wash their hands with soap and water at all five critical moments. In the Lake zone, CHWs and CSO volunteers have found greater success when they break complex behaviours into small, do-able actions. For example, during one support group, CSO volunteers might ask mothers to place a bar of soap and water next to the sink. In a subsequent meeting, volunteers may ask mothers to wash hands with soap and water before preparing food. In yet another meeting, volunteers might ask mothers to wash hands before feeding the child, and so on. We have found this approach to be more effective than expecting mothers to adopt all hand hygiene behaviours at once.

TOOLS AVAILABLE

The DFID ASTUTE Stunting Reduction Toolkit includes a number of tools that will improve behaviour change around stunting in Tanzania. These are labeled under the **Behaviour Change** section of the toolkit:

- Home visit dialogue guides for CHWs to help them effectively share evidence-based messages on exclusive breastfeeding, complementary feeding, WASH and women's workload based upon recent research.
- Small doable actions that CHWs and volunteers can recommend to families during home visits.
- Steps to negotiating behaviour change with households and individuals, as well as how to design an evidence-based SBC intervention to reduce stunting.
- Checklists and manuals for implementing and evaluating Positive Deviance/Hearth programming.
- Guidance on how to create compelling radio or TV messaging on nutrition and stunting.

DEVELOPMENT MEDIA INTERNATIONAL
TOOLKIT SATURATION +

DMI in Tanzania

Development Media International (www.developmentmedia.net) is a not-for-profit social enterprise that runs mass media campaigns to change behaviours and save lives in Africa. In Tanzania, DMI is part of the DFID-funded Addressing Stunting in Tanzania Early, or ASTUTE, programme. This consortium is led by IMA World Health, and brings together Partnership for Nutrition in Tanzania, Cornell University's Division of Nutritional Sciences, and Development Media International to build the capacity of local government authorities to address child stunting in in all districts of five regions of the Lake Zone—Kagera, Kigoma, Mwanza, Geita and Shinyanga—representing a collective population of 10.2 million and more than 750,000 stunted children. Childhood stunting—a result of inadequate feeding during a child's first 1,000 days; poor water, sanitation and hygiene practices; and inadequate access to health care—has serious long-term consequences.

Guidelines for Mass Media SBCC Campaign - Saturation+ (saturation, science, stories)

DMI's task in the ASTUTE campaign is reaching 3 million+ mothers, caregivers, and decision makers with evidenced-based child care and feeding information that helps create positive behavioural change. The ASTUTE mass media campaign uses the design and implementation laid out in DMI's Saturation+ approach. This approach has been developed by DMI and is based on over 20 years of experience in designing, implementing, and evaluating media campaigns.

The Saturation+ approach can be broken down into three themes: **saturation, science and stories** (Box 1). DMI ensures that all of its mass media campaigns have a healthy dose of each. The Saturation+ approach is a set of core transferable principles; it is not intended to be a standard, one-size-fits-all method, but rather an approach designed to maximise the impact of campaigns.

BOX 1. Core Principles Underlying the Saturation+ Approach to Behaviour Change

Saturation

- Analyze media penetration data to reach the largest possible proportion of the target audience.
- Develop partnerships with market-leading radio and TV stations.
- Devise radio/TV formats that can be produced at a rapid rate by the project to enable frequent broadcasts.
- Broadcast messages in local languages, several times a day, for a sustained period (6-12 times per day for radio spots, at least 3 times per day for TV spots, at least once a day for other formats).

Science

- Use mathematical modeling to estimate the health impact of each message.
- Design calendar of messages that prioritises highest-impact messages.
- Conduct formative research to understand target audience and barriers to behaviour change.
- Summarise research in one-page message briefs to inform the creative process.
- Pre-test spots to ensure message clarity and acceptability by target populations.
- Monitor audience reaction to broadcasts through qualitative feedback research.
- Conduct a robust quantitative evaluation to enable measurement and attribution of impact.

Stories

- Recruit talented local scriptwriters, using open competitions where appropriate.
- Build dramatic structures in which the emotional climax addresses the crucial barrier to behaviour change.
- Use an editorial process that ensures quality control while allowing space for creativity.

Saturation Theory

Intensity is key to any commercial advertising strategy, and yet it has been an underrated element of public health campaigning. Evidence suggests that achieving high exposure to messages is correlated with impact on behaviours, in a 'dose-response' relationship.[1] A systematic review of the effectiveness of mass media interventions for child survival in low- and middle-income countries reported that achieving adequate exposure is a key component of success, with campaigns needing to ''reach substantial proportions of the target audience with enough frequency to be recalled.''[2] Another review of the impact of media campaigns

on health behaviours proposed that investment in longer, better-funded campaigns is required to achieve frequent and widespread population expo- sure to messages, especially for habitual behaviours.[3] DMI's experience also indicates a link between the frequency of messaging and impact on behaviour change: a particularly successful campaign targeted hand washing in Ethiopia, with messages broadcast up to 14 times per day for 3 years.[4]

So how does exposure lead to behaviour change? There are several theories about the mechanisms or pathways by which high exposure drives behaviour change, summarised by Bob Hornik, including[5]:

Learning. People listen to the radio at different times each day and vary in their susceptibility or inclination to respond to a message. The more times a message is repeated, the more opportunities there are for people to hear and learn from the message when they are receptive to it.

Priming. Repeated exposure to a message affects its pertinence, so a stronger weight is attributed to the message when deciding whether to adopt the behaviour.[6]

Creating social norms. Repeated exposure to messages can create social expectations about behaviours. Such social norm pressures may persuade people to adopt behaviours.[7]

Diffusion effect. As more people are exposed to messages, more people will discuss these messages within their wider social networks, including people who have not seen or heard the media campaign.[8]

Indirect impact on policy. High exposure may alert policy makers to issues that are of public concern and thereby result in legislation or the implementation of policies that promote behaviour change.

Saturation

In order to achieve high exposure, the first thing to do is to identify your target audience as part of the broadcast/SBCC strategy. Where do they live? Are they male or female? How old are they? How much money do they have? The next step is to find data. It can be hard to get reliable audience data and it will never be perfect, but it is very important. You need audience survey results that give you information about your target audience. What is their preferred media (radio/television)? Which channels do they listen to? When do they consume media? What languages do they prefer to listen to? What type of programmes do they listen to?

These data are usually gathered by market research and advertising agencies. Once you have this information, you can decide which broadcast partner to work with, which language to broadcast in and when to schedule your spots or programmes. In DMI Tanzania's case, we worked with a local polling agency to conduct an audience survey in the target regions, as no recent surveys were available, followed by in-person visits to media partners to assess capacity (see Box 2).

BOX 2. Working with radio or television stations

There are some key questions to ask before negotiating partnerships with radio and television stations:

- Is the station self-sustainable? Does it have a reliable energy supply?
- How many weeks of the year is the station able to broadcast without 'falling off air'?
- Is the transmitter fully operational?
- Does the station have a business strategy that relies on raising income by charging for airtime?
- Does the station need technical and operational support?
- Does the station have a large audience? Is this audience loyal?
- What is the broadcast reach of the station? Which geographical area has reception?
- Are the radio station staff paid or are they volunteers? Is

Cost will also be a factor to achieve saturation. Saturation broadcasting can be achieved by paying the market-leading radio and television stations for airtime, but it can be easier and cheaper to achieve saturation broadcasting when one involves the broadcast industry as a core partner. Ideally one negotiates free airtime in exchange for on-the- job training and for production expenses.

The simplest way to achieve high intensity is to use short (e.g., 60-second) spots, as exemplified by the advertising industry. This format allows frequent daily broadcasts, across all peak listening times. It also allows for precise health messages, focused on a single behaviour or doable action. Repetition of the health messages is vital, so new spots can be produced efficiently to ensure that the programming remains fresh and engaging. The spots use emotion, humor, and dramatic techniques such as suspense to persuade our target audience to change behaviours. In the Tanzania campaign, after a start phase in June-July-August 2017, DMI broadcast a new spot every week, played at least 10 times per day, from September 2017 to December 2019, working with 5-6 radio stations (a 6th station was added in June 2018). ***By July 2019, the ASTUTE radio spots have been aired 35,000 times.***

How many spots should one broadcast each day? Broadcast each spots between 5 and 10 times per day - ideally 10 times.

Does it matter what time of day the spot is broadcast? Many messages can be broadcast at any time of day regardless of the message. But some messages are more appropriate at a certain time of the day.

Do seasons impact on timing? Yes. Some messages may depend on the season. The audience might listen to the radio at different times, e.g. during harvest-time, they might be out in the field and unable to listen to the radio.

Because of a significant proportion (29%) of the target regions reporting watching television, we added TV spots to the campaign to reach maximum exposure; using multiple communication channels is associated with greater impact.

Science

Message quality is also crucial, and qualitative research is a key element to ensuring this quality. Qualitative research includes formative research (to identify barriers to behaviour change), pretesting of radio spots (to judge comprehension and appeal), and feedback research (to find out whether people have heard and understood the messages and what the remaining obstacles to behaviour change are). The key, as argued below, is to link findings from such qualitative research as tightly as possible to the creative process.

DMI employs a team of in-house qualitative researchers, who conduct formative research at the start of the campaign. The research consists of semi-structured individual interviews and focus group discussions with mothers and fathers of young children and influential members of their entourage (spouses, grandparents), as well as individual interviews with key informants such as religious leaders, district medical officers, health center staff, midwives, and community health workers. For each health behaviour, we synthesise this research into a 1-page message brief that presents the key behaviours to promote including:

- Contextual information about the behaviour, including Ministry of Health policy and guidelines, and information drawn from guidance from the United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO)
- Analysis of key decision makers within the target audience for the specified behaviour
- Context-specific barriers to behaviour change
- Context-specific factors facilitating behaviour change

For the ASTUTE campaign, briefs focused on all nutrition-specific and nutrition-sensitive themes: maternal nutrition during pregnancy (plus reduced workload and ANC visits); exclusive breastfeeding; complementary feeding starting at 6 months; WASH (handwashing and environmental hygiene); and early childhood development. The SBCC strategy was shared and discussed with MoH nutrition staff (including Tanzania Food and Nutrition Centre), to ensure it adheres to official policies and guidelines.

DMI scriptwriters draw on these message briefs to create dozens of scripts. The best of these go through a validation process involving creative staff in both Tanzania and London before being produced. DMI pretests all spots in Swahili using focus groups (for clarity, popularity, and understanding) before selecting the spots and distributing them for broadcast. Pretesting is essential for ensuring messages are well received by the target audience.

DMI also conducts post-broadcast feedback research using focus groups to provide an understanding of audience reactions to our messages and to find out whether and why people who hear our messages have changed their behaviours (or not). After each trip, researchers feed back their findings to the creative team, forming a continual feedback loop. We use the information gathered through pretesting and feedback research to continually refine our message briefs and to tailor our messages to target existing barriers to behaviour change. The loop of pretesting and feedback is key to DMI's production process, whereby new spots are produced *throughout* the programme period.

Feedback Testimony
"After hearing a spot that a child should eat complementary food and should eat more meals, I started working on it. Here fish is scarce, but I try to get it for my child. I used to sell all the eggs in order to buy salt, but now I still sell and keep one for my child because I learnt that from the spot." (FGD, Mothers, Karagwe - Kagera Region)

Science also is needed to develop a message calendar, a plan/broadcasting schedule that weights the importance of each message on local health indicator. Each message will have a broadcast duration, frequency and placing within the calendar. To develop the message calendar, you will need to:

- Identify the behaviours that you want to change;
- Decide how frequently you want to vary your messages;
- Weight the messages according to their predicted impact on reducing child stunting, taking into account: the relative stunting burden, the susceptibility of the issue to behaviour change, and the availability and quality of related healthcare services or availability of nutrition-specific and nutrition-sensitive aspects.

Stories

Stories have resonated with human beings for thousands of years. We are drawn to drama in ways in which we are not drawn to data or facts. Stories allow us to identify emotionally with characters, and emotions—such as fear, status, and guilt—are powerful determinants of behaviour.[9] But how do stories work? And how are stories developed? Creativity is often the ''black box'' in theoretical discussions: it is difficult to define or measure. Nevertheless it is possible to use systems to understand and then enhance the creative process.

Understanding the structure of stories is important. Virtually every Hollywood film conforms to a 3-act structure:

- **Act I in which characters are given goals;**
- **Act II in which obstacles are thrown in front of the characters; and**
- **Act III in which the characters either change their goals or overcome the obstacles.**

This structure mimics life itself for most of us and also mimics the process of behaviour change. The emotional climax of most stories is at the end of Act II, the moment of decision for the main character when s/he must choose between competing emotions. Formative research, when conducted with this in mind, can therefore go further than simply identifying obstacles to behaviour change (e.g., cost, inconvenience). It can identify the most important emotion (e.g., fear or guilt) that prevents people from complying and the most important emotion (e.g., love) that motivates people to comply. The conflict between those two emotions can then be made the centerpiece of a story's dramatic climax at the end of Act II.

Choices about how we behave are often made in response to deep underlying human impulses to be accepted by others, to fit in with our peers, and to imitate people we respect. In Tanzania, our radio and television spots are based on engaging, realistic stories and characters that reach out to the audience, helping them to feel empathy for the characters and their situations. Our stories aim to move audiences to examine the health choices made in their own lives. Once people are thinking about making changes, the stories then provide concrete ideas and doable actions. Scripts need to fulfill three criteria:

- **Be creative, imaginative, entertaining and dramatically sound**
- **Promote an accurate health message**

- **Catalyse behaviour change**

Stories for public health programming must be driven by research, requiring the creative and research teams to work in close harmony—often a formidable challenge given that creative writers typically rely on their own judgment and imagination to create stories. This practical challenge is a microcosm of the wider challenge of bringing science and mass media together. One practical tool to enable collaboration is to develop succinct, 1-page message briefs that summarise the formative research, forming the foundation for the scriptwriters' work. Another method is to send scriptwriters to help lead focus groups in the field, while also involving qualitative researchers in the radio production process. In Tanzania, immersion through field visits motivates scriptwriters, provides new inspiration and ideas, and gives valuable insight into the realities of urban/rural Tanzanian life.

To maximise creativity and for quality assurance, we use multilevel systems of editorial control whereby, for example, 8-16 ideas per month are reduced to 6 for pretesting and production. It is important that after pretesting, as well as after broadcast, qualitative research is fed back to scriptwriters. This feedback loop ensures an evolving creative process that continually responds to the target audience. Grassroots recruitment of local scriptwriters is essential to develop a creative team that understands the language, context, and cultures of the target audience. Spots are produced in-house, using local staff and voice talent. This allows for full creative control of message quality (both health and dramatic content).

For more information on evidence-based saturation SBC methodologies, please visit www.developmentmedia.net/resources.html.

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[1] Hornik RC. Exposure: theory and evidence about all the ways it matters. Soc Mar Q. 2002;8(3): 31–37. CrossRef. Free full-text available from: http://repository.upenn.edu/cgi/viewcontent. cgi?article=1098&context=asc_papers

[2] Naugle DA, Hornik RC. Systematic review of the effectiveness of mass media interventions for child survival in low- and middle-income countries. J Health Commun. 2014;19 Suppl 1:190–215.

[3] Wakefield MA, Loken B, Hornik RC. Use of mass media campaigns to change health behavior. Lancet. 2010;376(9748): 1261–1271.

[4] Edwards T, Cumberland P, Hailu G, Todd J. Impact of health education on active trachoma in hyperendemic rural communities in Ethiopia. Ophthalmology. 2006;113(4): 548–555.

[5] Hornik RC. Exposure: theory and evidence about all the ways it matters. Soc Mar Q. 2002;8(3): 31–37. CrossRef. Free full-text available from: http://repository.upenn.edu/cgi/viewcontent. cgi?article=1098&context=asc_papers

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[7] Papa MJ, Singhal A, Law S, Pant S, Sood S, Rogers EM, et al. Entertainment-education and social change: an analysis of parasocial interaction, social learning, collective efficacy, and paradoxical communication. J Commun. 2000;50(4): 31–55.

[8] Kincaid DL. From innovation to social norm: bounded normative influence. J Health Commun. 2004;9 Suppl 1:37–57.

[9] Scott B, Curtis V, Rabie T, Garbrah-Aidoo N. Health in our hands, but not in our heads: understanding hygiene motivation in Ghana. Health Policy Plan. 2007;22(4): 225–233.

DMI-Fish (TV):
https://youtu.be/khskCv3LOU8

DMI-Tree (TV):
https://youtu.be/IGCZLmrVlnE

DMI-Chicken (TV):
https://youtu.be/Z-cRwSdRBjs

DMI-Fence (TV):
https://youtu.be/_RpWPYhbIZs

DMI-Investment (Radio)
https://youtu.be/aL0mIyrcTiM

DMI-PIkipiki (Radio)
https://youtu.be/h3EighOi7GU

COWS ON MILK STRIKE

[Voice of cows are heard]

Mwiza: Masanja, how many litres have you milked today? Orders have increased and Zebi is waiting here.

Masanja: Cows are on strike, I have only milked ten litres.

Mwiza: *[Harshly]* What?! I want to see those cows on strike today. I didn't expect them to do this to me.

Zebi: Mwiza, what will I mix in my child's porridge?

Mwiza: Aah! Zebi, is the milk for your child? I thought it's for you.

Zebi: I have been advised at the clinic to start feeding babies nutritious food from the age of 6 months. And my child is seven months old.

Mwiza: But there plenty of other nutritious foods.

Zebi: Really? Like what?

Mwiza: Cook a little bit of dagaa, amaranth and sweet potatoes, mash and feed him. Mix smashed groundnuts on his porridge and feed him.

Zebi: These foods aren't expensive and are available here at the village!!!

Mwiza: Yes. And continue breastfeeding.

Zebi: You have opened my eyes, let me go and cook sweet potatoes and dagaa for my child. I don't need to buy milk.

Once it's six months (old), a baby needs to be also fed different foods like fish, chicken, beans/lentils, dagaa, nuts, vegetables, fruits, and meat that is pounded, so that he/she gets enough nutrition.

COWS ON MILK STRIKE

[Sauti za ng'ombe zinasikika]

Mwiza: Masanja, umekamua lita ngapi leo? Oda ya maziwa imeongezeka, na Zebi anasubiria.

Masanja: Ng'ombe wamegoma, nimekamua lita kumi tu.

Mwiza: [Harshly] Nini! Nataka kuwaona hao ng'ombe waliogoma leo. Sikutegemea wanifanyie hivyo.

Zebi: Mwiza, nitachanganya nini kwenye uji wa mwanangu?!

Mwiza: Aah! Zebi, kwani maziwa ni kwa ajili ya mtoto? Nilifikiri ni ya kwako.

Zebi: Nimeshauriwa kliniki kuanza kulisha watoto chakula chenye virutubisho kuanzia umri wa miezi sita. Mwanangu ana miezi saba.

Mwiza: Mbona vyakula vyenye virutubisho ni vingi?

Zebi: Kweli, kama vipi?

Mwiza: Pika dagaa kidogo au mchicha au viazi vitamu pondaponda umlishe.Uji wake changanya na karanga zilizosagwa umlishe.

Zebi: Hivi vyakula si gharama, na vinapatikana hapa kijijini.

Mwiza: Ndiyo, pia endelea kumnyonyesha.

Zebi: Umenifumbua macho, ngoja nikampikie mwanangu viazi na dagaa. Sihitaji kununua maziwa.

Anapotimiza miezi sita, mtoto anapaswa kulishwa pia vyakula vya aina mbalimbali kama samaki, kuku, jamii ya kunde, dagaa, karanga, mbogamboga, matunda na nyama iliyopondwa, ili kumwezesha kupata virutubishi vya kutosha.

NIBEBE

[Sound of a baby crying loudly]

MOTHER: Khe Sara why is your child crying?

SARA: Mother, he doesn't want to be carried at the back, I am trying to do the washing but he is disturbing me.

MOTHER: Let him play while you are washing.

SARA: He is just a troublemaker that he also want to wash.

MOTHER: That's a good thing! It's because he's smart and wants to learn. Babies learn by copying what you are doing.

SARA: So playing with 8 month old baby is a good thing?

MOTHER: Yes, and you can do it even while you're working. Why don't you give him a can of water to play with while you are doing the washing. It will help him.

SARA: Really?

MOTHER: Yes, now my grandson take this can and play with it – are you going to do some washing too?

[Sound of the can and a voice of a happy baby}

MOTHER: Don't you see how he is happy and confident.

SARA: Is that the secret of having a smart baby?

MOTHER: It's part of the secret. You also have to talk, sing and play with him to build his intelligence.

SARA: Now I have understood, my child will be as intelligent as his grandmother.

Parents and caregivers, start talking, playing, singing and showing affection to your child right from birth. You help them develop their grow intelligence and you will have a smart child.

NIBEBE

[sauti ya mtoto akilia kwa nguvu]

MAMA: Khe sara mbona mwanao Analia.

SARA: Mama, Hataki nimbebe, nafua ananisumbua.

MAMA: Muache acheze wakati unaendelea kufua.

SARA: Ni msumbufu tu, eti na yeye anataka afue.

MAMA: Vizuri, ni kwasababu ana akili na anataka kujifunza. Watoto wanajifunza kwa kuiga vitu unavyofanya.

SARA: Kwahio kucheza na mtoto wa miezi nane ni kitu kizuri?

MAMA: Ndio, na unaweza kucheza nae hata ukiwa unafanya kazi zingine. Kwanini usimpe kopo la maji achezee ukiwa unafua itamsaidia.

SARA: Kweli?

MAMA: Ndio. haya mjukuu wangu chukua hili kopo uchezee,wewe unataka kufua?

[Sauti ya kopo likigongwa +Sauti ya mtoto akifurahi]

MAMA: Si unaona alivyo furahi na kujiamini.

SARA: Ndio siri ya kuwa na mtoto mwenye akili eh?

MAMA: Ni moja ya siri, pia unatakiwa uongee, kuimba na kucheza nae ili uijenge akili yake.

SARA: Sasa nimeelewa. Mwanangu atakua na akili kama bibi yake.

Wazazi na walezi, anza kuongea, kucheza, kuimba na kumwonyesha upendo mtoto tangu anapozaliwa. Unamsaidia kukua kiakili na atakuwa mtoto mwerevu.

World Vision

Sustainable Health

FACILITATORS
HANDOUTS

Training of Facilitators for **Positive Deviance/Hearth**

FIRST EDITION

Nutrition Centre of Expertise

World Vision

World Vision

Training of Facilitators for **Positive Deviance/Hearth**

FACILITATORS HANDOUTS

By Naomi Klaas,
Diane Baik and
Judiann McNulty

WVI Nutrition Centre of Expertise

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Orientation and Training Curriculum for Staff Backstopping Positive Deviance/Hearth Programmes. The publication of the original Facilitator's Guide was made possible by support of the United States Agency for International Development (USAID) under cooperative agreement FAO-A-00-98-00030.

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Table of Contents

PLEASE NOTE: There can be more than one page for a handout. Page counts appear in the item lines for any handouts having more than one page. Multiple page handouts are designated on their respective pages as "page # of # pages".

The (page #m) refers to where each handout appears in the PD/Hearth Facilitator Manual. You can reference the "#m" at the bottom of each handout page as well.

DAY 5

DAY 6

DAY 7

DAY 8

Goal

WV staff and partners develop knowledge, skill and competencies in PD/Hearth to

- train others
- provide technical support
- monitor implementation.

Training objectives

By the end of the workshop, participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level

Agenda for PD/Hearth Training of Facilitators

Day and Date	Session	Activities	Time
Day 1:			
1		Devotion	15 min
	1	Opening remarks Introductions (Ice breaker) Expectations and Objectives, Parking Lot Workshop Norms (Form Review Volunteer Groups) Target Evaluation Brief Overview of training (Evaluation method and go through overview/ field visits) Admin issues & logistics	90 min
	2	Pre-test	35 min
	3	What is Malnutrition? – Activity (3 types of malnutrition: underweight, stunting, wasting; Malnutrition cycle; Local terminologies)	95 min
		National prevalence (5 min) & ADP context (10 min)	15 min
	4	What is Good Nutrition?	30 min
	5	Overview of PD/Hearth – Goals/objectives; Definitions	45 min
	6	How PD/Hearth Addresses Malnutrition – Causes of malnutrition (UNICEF Framework (Problem Tree): Immediate, underlying, basic/root causes	45 min
		Key steps of PD/Hearth (20 min)	20 min
	7	(STEP 1) Determining the Feasibility of PD/Hearth Approach for the Target Community – Case study using ADP's communities (Identify existing other sectors in ADPs)	45 min
	8	Daily Summary and Evaluation	10 min
Day 2: *"Practicing to go out to the field" – Situation Analysis of the community*			
2		Devotion	30 min
	9	Review of Day 1 and Agenda for Day 2	30 min

Day and Date	Session	Activities	Time
2	10, 11, 12	(STEP 2) Community Mobilisation: Mobilization strategies for various PDH stakeholders (70 min) 1. Identifying stakeholders involved in child care and nutrition within the community (Venn Diagram); Outlining the Existing Local Health System Structure; Community Resources/Staffing Required for PDH implementation (WV & local NGOs) (50 mins) Creating Community Ownership 1. Preliminary steps: Meeting with leaders after receiving invitation (Practice through role play) (20 mins) 2. (STEP 2) Identifying and Selecting Volunteers – Mobilization strategies for various PDH stakeholders The players mobilization strategies (group work) (35 min) Learning Styles and Facilitation (45 min)	150 min
	13, 14, 15	(STEP 3) Situation Analysis with the community members 1. Wealth Ranking 2. Measuring nutritional status (underweight & wasting) of all children in the village (weighing scales – salter scales and MUAC) 3. Focus Group Discussions (pregnant women, father group, grandmother group, siblings group) (Role Play – Traditional & PD/ Hearth) 4. Community/Social Mapping & Transect Walk, (e.g. who is taking care of the children, what types of foods are people growing, do children wear shoes, look for latrines, etc.) 5. Market Survey & Seasonal Calendar (ask shop keepers how many bars of soap they sell per week)	220 min
		Feedback to the community – Practice how we will share children nutritional status with community	30 min
	16	(STEP 3) Preparing for Situational Analysis Field Visit: Review situation analysis formats and go through field logistics (assigning groups, tasks, schedule)	60 min
	17	Daily Summary and Evaluation	10 min

Day and Date	Session	Activities	Time
Day 3: Field Visit (Situational Analysis)			
3	18	Field Visit to Conduct Situational Analysis Travel to field (activities can run simultaneously) 1. Introduction to leaders and volunteers (30 mins) 2. Wealth ranking with community members including volunteers (40 mins) 3. Weigh children (Plot children on giant growth chart if wanted) (45 mins to 180 mins – depends on how many children are weighed) 4. Social Mapping (40 mins) &Transect Walk (45 mins) & Focus Group Discussion (Father group (45 mins), Mother-in-law groups (45 mins), mother groups (45 mins) 5. Seasonal Calendar (45 mins) & Market Survey (60 mins) Travel back to hotel	4.0 hours to 6.5 hours plus travel time (depends on how much time is spent weighing children and travel time to/ from the field)
Day 4:			
4		Devotion	30 min
	19	Review of Day 3 Field Visit and Agenda for Day 4 – Reflection of field work (what worked, what needs improvement, etc.)	45 min
	20	Analyzing Situational Analysis Data Brief orientation on Database Compile, summarize and document findings from field visit (flip chart, Excel templates) – Enter nutrition status/wealth ranking into Excel spreadsheets situation analysis Present findings: Nutritional profile of children - Initial assessment. Data interpretation Documentation of assets, current common practices & challenges	180 min
		How to conduct community feedbacks – Assign someone to share findings tomorrow. Have person practice for preparation of field visit in front of participants and receive feedback	30 min

Day and Date	Session	Activities	Time
4	21	(STEP 4) Identifying Positive Deviants – Selection criteria for PDs; Identification of NPDs, PDs, and ND households (Use findings from field visit to identify NPD, PDs, ND households)	60 min
	22	(STEP 4) Preparing for the Positive Deviance Inquiry (PDI) 1. Review and adapt generic tools 2. Do's & Don'ts for home visits 3. Further practice with tools (Role plays) 4. Logistics for home visits	105 min
Day 5: Field Visit (PDI)			
5	23	Field Visit to Conduct PDI Travel to field 1. Feedback to community on nutrition status findings (60 min) 2. PDIs in the field for ADP village (At least 4 PD HH & 2-4 NPD HHs & 2 ND per village) – home visits Travel back to hotel	4.5 to 6.5 hours plus travel time
One-day Break: Compile PDI data and post charts including results from situation analysis (compile in Excel Templates) and begin working on Action Plans			
Day 6:			
6		Devotion	30 min
	24	Review of Day 5 Field Visit and Agenda for Day 6 – Reflection of field work (what worked, what needs improvement, etc.)	45 min
	25	(STEP 4) PDI Interpretation and Feedback: Determining Positive Deviance and Identifying 6 Key Hearth Messages 1. Presentation of PDI findings – Identify PD behaviours & Non-PD behaviours 2. Develop 6 key Hearth messages based on PDI Findings & quotes from villagers	170 min

Day and Date	Session	Activities	Time
6	26	Community Feedback Meetings – Preparation to share PDI Findings 1. Exploration of ways to share PDI findings (eg. skits, cultural events) 2. Role plays	60 min
	27	(STEP 5) Promoting Behavioural Change	40 min
	28	(STEP 5) Designing Hearth Sessions	80 min
	29	Daily Summary and Evaluation	10 min
Day 7:			
7		Devotion	30 min
		Reflection of Day 6	30 min
	30	(STEP 5) Menu Design and Cooking 1. Use food composition tables 2. Menu to meet energy, protein, iron, Vitamin C, A & Zn requirements 3. Convert recipes from grams to home measures 4. Menu Calculation Tool Orientation (~30 min) Cooking practical – at training site Menu preparation, testing and selection of hearth menus Presentation of menus (60 min)	390 min
Day 8:			
8		Devotion	30 min
	31	Menu Calculation Assessment (60 min)	60min
	32	Essential Elements of PD/Hearth	55 min

Day and Date	Session	Activities	Time
8	33, 34	Setting up Hearth Sessions: 1. PD/Hearth participant selection, number of children per site 2. (STEP 6) Conducting the Hearth Session (40 min) 3. (STEP 7) Supporting New Behaviours through Reflection and Home Visits (60 min)	100 min
	35, 36	(STEP 8) Admission, Graduation, Repeating as Needed (75 min) (STEP 9) Expanding PD/Hearth (10 min) (Total 85 min) (STEP 8) Monitoring and Evaluation (Monitoring tools) (105 min) 1. Hearth rotation 2. Home visit protocols and Follow-up: HH follow-up visits 3. Referral to Health Centre 4. Overview of PDH Excel Database and Data Analysis (30 min)	220 min
Day 9:			
9		Devotions	30 min
		Review of Day 8 – Go through outstanding Parking Lot Topics	30 min
	37	Training Volunteers – review monitoring tools for volunteers and importance of community monitoring	60 min
	38	Post-test	35 min
	39	Integration and PD/Hearth – Integrating PD/Hearth with other sectors in ADP	60 min
	40	Factors for the Success of PD/Hearth	30 min
	41	PD/Hearth Action Plans	45 min
	42	Final Evaluation and Closing Target Evaluation, Workshop Evaluation	40 min
		Certificate Presentation & Closing Remarks	40 min

Flip Chart 6
Ten Key Steps in the PD/Hearth Approach

Note to trainers: *The amount of time for each step will depend on the local context (with the exception of Steps 6 and 7). An example of the timing is included for Steps 2–7 to guide discussion with planners. Each key step number is noted in the title of the relevant session in the curriculum. Monitoring and evaluation occurs throughout the process, as illustrated by the right hand column.*

	STEPS	**APPROXIMATE TIME REQUIRED**	
Step 1	Decide whether the PD/Hearth approach is feasible in the target community.		
Step 2	Begin mobilising the community (mobilise or create Village Health/ Hearth Committee or working group within the community); select and train staff.	Mobilising the community can take several months and takes place throughout the entire project period. Steps 2 to 4 can take approximately 2–3 weeks, including: 2 days of training 2 days for situational analysis 2 days for PDI 2 days for analysis and feedback to the community	Monitor and Evaluate
Step 3	Prepare for a PDI (situational analysis).		
Step 4	Conduct a PDI.		
Step 5	Design Hearth sessions.	2 days	
Step 6	Conduct Hearth sessions.	2 weeks	
Step 7	Support new behaviours through follow-up visits.	Every 2-3 days in the 2 weeks immediately after the Hearth session, and continuing less frequently after that	
Step 8	Repeat Hearth as needed. Monitor progress of Hearth graduates and track growth of all young children.		
Step 9	Expand the PD/Hearth programme to additional communities.		
Step 10	Exit strategy for once underweight is eliminated or ADP phases out		

Read and analyse the following cases. Decide whether PD/Hearth will work in each situation. If not, explain why not and think about an alternative approach. Suggest additional nutrition strategies and interventions needed from other sectors. If PD/Hearth is appropriate, but there are special challenges, please describe how to overcome them.

Case 1 – Coastal village – 12 per cent malnutrition but 35 children underweight

All the families make their living by fishing or selling fish. They live in a small village with houses very close together. The men are gone from before dawn until noon. When they return, they expect their big meal to be waiting. The women spend the afternoon cleaning fish and repairing the fishing nets. They work together on the beach and take their babies on their backs. Older children stay at the house with grandmothers or older siblings. There is plenty of fish to eat, but few fruits and vegetables most of the year. The health centre is in the next town, 15 minutes away by bus.

Case 2 – North interior – 35 per cent malnutrition

Families live in very small villages scattered through the tea estates. There are 10 to 20 families in each village. It can take between 30 minutes and one hour to walk over very hilly terrain to the main estate village. Nearly all the mothers work full time on the tea estates. The children from six months to three years spend nine hours a day in daycare with two paid employees. Food in the day care is provided by the estate. (After three years of age, children stay with grandparents during the day until they start school at age five.) The day care is located next to a good health clinic provided by the estate management. There is a joint management body made up of representatives of both workers and management.

Case 3 – Northeast – 32 per cent malnutrition

This good agricultural area produces grain, fruits and vegetables. The houses are dispersed, spread out over mounds. Grandmothers care for the small children when women go to the fields to work or the river to fish. There is a health centre in the nearest town, which is a four-hour walk for many families. When the rains come and water surrounds their mound, families cannot easily travel to other homes or villages. Some families have to move to higher ground for three or four months, which makes it difficult for them to raise poultry or livestock.

Case 4 – South farming community – 39 per cent malnutrition

Most of the children in this community are very short for their age. The families are engaged in farming, with most women at home except during harvest time. The village is very compact, and people work together on many community projects. Grandmothers decide when children should start getting water or food, often when they are one month old. There is a small Christian hospital, and government health workers bring vaccines and vitamin A.

Case 5 – Peri-urban – 20 per cent malnutrition

Families live in densely populated squatter settlements in simple houses with no sanitation. Water is fetched from central water taps some distance away. Families have easy access to health facilities. Because the houses are so small, most families do not cook at home. They buy cooked food from street vendors and snacks from the many small shops. Most women are at home during the day. Those who work leave their children in the care of older women. There are approximately 40 moderately and severely underweight children between the ages of 6-36 months.

PD/Hearth will not work everywhere. It is important to consider the following criteria when deciding if PD/Hearth is the right approach for a given community.

1. **Mild, moderate and severe malnutrition, based on weight for age, affects more than 30 per cent of children 6 to 36 months old or 30 underweight children between the ages of 6-36 months.** PD/Hearth is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include mild, moderate and severe malnutrition, but programmes concerned with cost efficiency may want to focus PD/Hearth activities on those who are moderately or severely malnourished and use less intensive methods to address the children with mild malnutrition. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely malnourished children in the 6–36 month age range.** Since it is unlikely that an implementing agency will have done a census-based nutritional assessment prior to deciding whether to implement the programme, the decision can be based on existing growth monitoring data, data from surveys of a representative sample of the population, or other existing data.

   Note: *PD/Hearth uses weight for age because that is the indicator most sensitive to change and does not require height measurements, which are difficult to collect. While mid-upper arm circumference (MUAC) is useful in screening for malnutrition in emergencies, it is not specific enough to identify all children who are also below weight for their age.*

2. ***Affordable food is available.*** A fundamental precept of PD/Hearth is that families can rehabilitate their children and prevent malnutrition with affordable, locally available food. If all poor families in the community are reliant on food aid or are eating only the staple food due to lack of anything else, other interventions to improve food security must come first.

3. ***Homes are located within a short distance of one another.*** Because caregivers are expected to come with their children to the Hearth session every day and the volunteers must make frequent home visits, the homes must be within easy walking distance from a central point.

4. ***There is a community commitment to overcome malnutrition.*** A commitment will serve to mobilise resources and pave the way for organising Hearth sessions and providing peer support to participating families. If there is no governing or civic body to work with, it may be necessary to form a village health committee. PD/Hearth has not been successful where populations are transient and lack a sense of community.

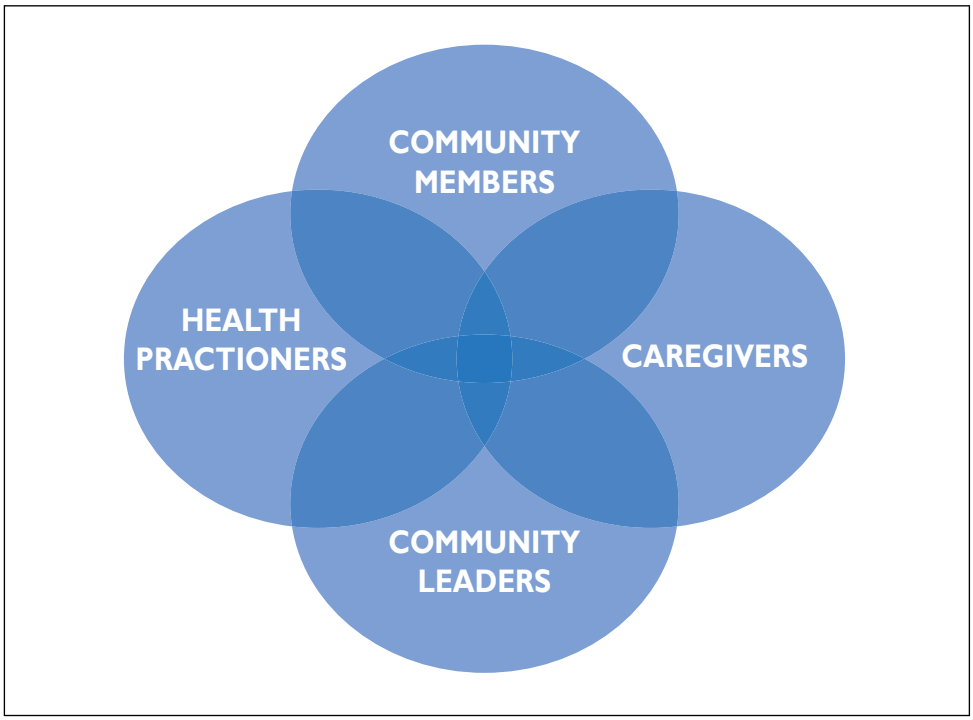
5. ***There is access to basic complementary health services.*** Health services are necessary for the children to receive inputs not available at the Hearth, such as deworming, immunisations, malaria treatment, micronutrient supplementation and referrals. Children receive the needed services ***before*** entering the Hearth and

may be referred for further evaluation and treatment if they do not show adequate weight gain after participating in the Hearth for two weeks with two more weeks of follow-up visits at home.

6. ***Systems for identifying and tracking malnourished children exist or can be developed.*** While such systems are not a prerequisite, they must be developed for the programme. The first step may be a door-to-door census and weighing of children, but then a routine monthly growth-monitoring system must be established not only to track the children who complete the Hearth sessions, but also to detect other children who may need to enter the programme. PD/Hearth is intended to be only one phase of a wider nutrition programme.

7. ***The presence of food aid in Hearth can be minimised with careful planning.*** Families need to learn to provide the nutrition their children need from local foods, rather than food aid, which is not a sustainable solution to malnutrition or food insecurity. Limited amounts of food aid, in the form of local staples (such as rice and oil) can be used in the Hearth menus, but the participating families must contribute the other foods in order to learn firsthand about their accessibility and affordability. The Hearth sessions emphasise using locally available foods.

8. ***Organisational commitment of the implementing agency is strong.*** This is essential. Because of the effort required to start a PD/Hearth programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PD/Hearth need to devote themselves full time to PD/Hearth, particularly in the start-up months. Projects should consider budgeting for additional staff and recruiting additional volunteers rather than expecting existing staff and volunteers to add the PD/Hearth to their existing responsibilities. Since PD/Hearth is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.



What is the role of the Ministry of Health? *(How is it incorporated?)*

The Ministry of Health provides support services such as immunisation, deworming, vitamin A supplementation; training; monitoring; and scale-up of learnings from PD/Hearth into existing health and nutrition message sharing systems).

What is the role of the Village Health Committee? *(Does a VHC exist? Does it need to be revived?)*

The VHC manages and coordinates health activities at the local level; sets criteria for, selects and supervises community health volunteers; and collaborates with the implementing organisation and district health staff (contextual depending on the country's existing Ministry of Health structure).

Can PD/Hearth be implemented without a Village Health Committee?

In the absence of a VHC, it is important to identify management resources at the grassroots level; build on existing resources. If possible, work to re-establish a non-functioning committee or establish a VHC or Village Hearth Committee.

What is the role of grandmothers?

In many cultures grandmothers are highly influential in the home as advisors on child care and feeding, and thus are important figures to engage throughout PD/Hearth. The following activity will help to illustrate the importance grandmothers have, especially in maternal and child care, and the necessity to include them in PD/Hearth.

Ask participants to identify ways to involve grandmothers in PD/Hearth. Ensure the following points are included:

- Consider grandmothers for leadership roles, including VHC and Hearth volunteer positions
- Consult grandmothers during situational analysis
- Interview grandmothers during PDI and/or involve grandmothers in conducting the PDI
- Engage grandmothers as participants in Hearth, either as caregivers, volunteers or part of caregiver-grandmother pairs
- Include grandmothers in follow up home visits, including review of child's progress and discussion of challenges to implementing PD practices at home

15 Min

2.

Divide into four groups (or as many groups as circles on the Venn diagram). Each group represents one community group. Come up with as many strategies as possible for:

- Maximising commitment and support; and
- Maintaining involvement throughout the project.

After a few minutes, call on volunteers to state the ideas their groups have come up with. *Note:* Listen to the participants' knowledge. *The solutions are in the group.*

Discuss the following questions:

How do you get maximum commitment and support?

Engage the community as the primary partner, with a role in selection criteria of volunteers. Be sure to involve in the process people who might raise barriers.

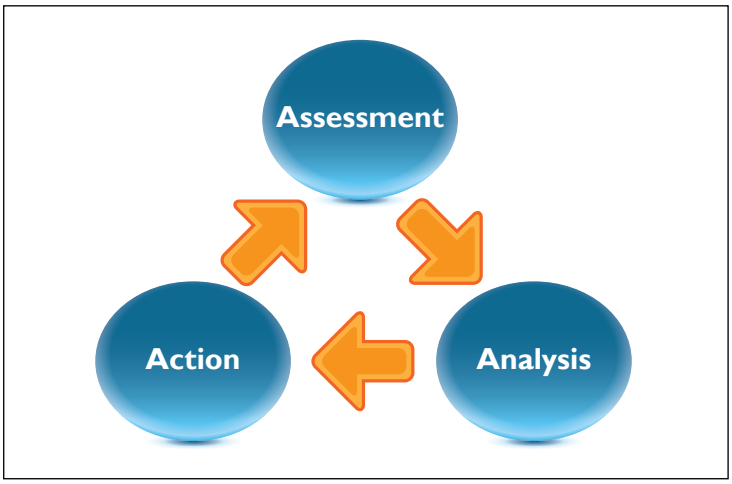
How do you keep this involvement throughout the project?

Establish a partnership with the community from the beginning and maintain it throughout.

See the **Triple A** cycle (assess, analyse, action) discussion on p. 29 of the *CORE PD/Hearth Guide*. Programme management is carried out in partnership with the community by assessing the problem, analysing its causes and taking action based on this analysis.

From the community mobilisation and ownership steps below, what activities might the community include in each circle (assessment, analysis, action)?

Discuss together key times when the community can be mobilised (based on the following steps).



STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP:

Step 1 Identify community leaders using existing community health volunteers and plan to meet with community leaders, religious leaders and women representatives.

Step 2A Ask community leaders for their permission and invitation to use the PD approach (finding existing solutions to malnutrition problems from within the community).

Step 2B Ask about the existing local health systems (e.g. Village Health and Sanitation Committee (VHSC), VHC (Village Health Commitee), etc.). Discuss a way to describe PD concepts in the local language (i.e. proverbs, stories). Discuss volunteer selection if a particular volunteer group does not already exist.

Step 3 Engage the community to define the problem (conduct wealth ranking); weigh all the children in the target group with community members, especially men (special GMP session). Involve community in focus group discussions, community mapping, seasonal calendar, transect walk, and market survey.

Step 4 Community Feedback Sessions: engage community members in discussion about the issue of childhood malnutrition; discuss its causes, common challenges and constraints, and ask for their ideas or suggestions for solutions. Involve men, grandmothers, mothers and all women who delivered the year before, include TBAs and traditional healers as well as religious leaders. Other very important activities to engage community members include: social mapping (include young men and women in this activity), seasonal calendar, market survey and wealth ranking.

Step 5 Second Community Feedback Session: Prepare and train leaders to carry out a meeting with the larger community to share the baseline information (results of the weighing) and the findings from group discussions as well as the PD concept from the visual poster to show nutritional assessment results. Also share the visuals of community created social mapping, seasonal calendar, market survey and wealth ranking. Discuss on the volunteer identification or if there are no volunteers yet, select volunteers.

Step 6 Plan and carry out PD inquiries with community members.

Step 7 Have community members (VHC) analyse and select key PD behaviours and have them share the PDI findings with the whole community, examining the PD behaviours and strategies with the community members; invite them to develop a plan of action that will include Hearth sessions.

Step 8 Involve or remain transparent to the community in selecting staff – such as a supervisor, village hearth committee members, and/or community health

volunteers – to contribute to the staff's credibility and to promote the community's ownership of the programme.

Step 9 Involve the community in monitoring monthly progress in the nutritional status of all children in the target group. (In Bangladesh a consolidated community growth monitoring chart is used for all children participating in PD/Hearth so the entire community can see the effectiveness of the programme.)

Step 10 Appreciation Day/Graduation Day

Step 11 Program Monitoring and Review

3.

For the community mobilisation and ownership Step 2, conduct a role play where you are meeting with the community leaders for the first time to talk about the following:

- Ask community leaders for permission to help the community overcome malnutrition
- Explain the concept of PDH without using technical language
- Explain the program of PDH (12 day long education session)
- Emphasize that we are here to learn from the community because there are positive behaviours that are allowing their children to stay healthy whether they are practicing the behaviours knowingly or not. We are here to identify those positive practices, especially from those households who do not have a big house and many cattle, yet they still have very healthy children
- Ask if there would be any members from the community who would like to help volunteer to run the program as this program cannot be run without the community taking the leadership

15 Min

4

Summarise some of the key challenges to community involvement and some of the solutions developed by the group. Refer participants to additional exercises for mobilising communities in the *CORE PD/Hearth Guide*, pp. 43–52. Answer any remaining questions. Note that we will be spending time throughout the remainder of the course working on each of these activities.

Note: *It is vitally important to understand fully the community players, conflicts, priorities, existing structures and resources.*

If hard copies of the resources for community participation listed above are available, suggest that participants look at these during breaks and/or list websites where participants can obtain them.

VARK Learning Styles Questionnaire

(http://www.vark-learn.com, used with permission)

Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ a chance to ask questions and talk about the camera's features.
   - ☐ examples of good and poor photos and how to improve them.
   - ☐ clear written instructions with lists and bullet points.
   - ☐ diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ make lists of what to do and what to buy for the party.
   - ☐ invite friends and just let it happen.
   - ☐ talk about it on the phone or text others.
   - ☐ imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ walk with them.
   - ☐ write down the directions as a list.
   - ☐ tell them the directions.
   - ☐ draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ class discussions, online discussion, online chat and guest speakers.
   - ☐ field trips, case studies, videos, labs and hands-on practical sessions.
   - ☐ a textbook and plenty of handouts.
   - ☐ an overview diagram, charts, labelled diagrams and maps.

5. You have a problem with your knee. Would you prefer that the doctor:
   - ☐ showed you a diagram of what was wrong.
   - ☐ described to you what was wrong
   - ☐ demonstrated what was wrong using a model of a knee.
   - ☐ gave you an article or brochure that explained knee injuries.

6. After reading a play you need to do a project. Would you prefer to:
   - ☐ act out a scene from the play.
   - ☐ read a speech from the play.
   - ☐ draw or sketch something that happened in the play.
   - ☐ write about the play.

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ describe the activities you will be doing in the programme.
   - ☐ start practicing the activities you will be doing in the programme.
   - ☐ show them the list of activities in the programme.
   - ☐ show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ things you can click on and do.
   - ☐ interesting design and visual effects.
   - ☐ audio channels for music, chat and discussion.
   - ☐ interesting information and articles in print.

9. You have to present your ideas to your colleagues. You would:
   - ☐ write out your speech and learn it by reading it again and again.
   - ☐ write a few key words and practise what to say again and again.
   - ☐ gather examples and stories to make it real and practical.
   - ☐ make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
    - ☐ that used a written description or table of your results.
    - ☐ that used examples of what you have done.
    - ☐ from somebody who discussed it with you.
    - ☐ that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
    - ☐ trying it.
    - ☐ the salesperson telling you about it.
    - ☐ it is the latest design and looks good.
    - ☐ reading the details about its features.

12. You are going to make something special for your family. You would:
    - ☐ make something you have made before.
    - ☐ find written instructions to make it.
    - ☐ look for ideas and plans in books and magazines.
    - ☐ talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
    - ☐ clues from the diagrams in the instructions.
    - ☐ listening to somebody explaining it and asking questions.
    - ☐ watching others do it first.
    - ☐ reading the instructions.

VARK Learning Styles Questionnaire ANSWER KEY

(http://www.vark-learn.com, used with permission)

Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ **A** a chance to ask questions and talk about the camera's features.
   - ☐ **V** examples of good and poor photos and how to improve them.
   - ☐ **R** clear written instructions with lists and bullet points.
   - ☐ **K** diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ **R** make lists of what to do and what to buy for the party.
   - ☐ **K** invite friends and just let it happen.
   - ☐ **A** talk about it on the phone or text others.
   - ☐ **V** imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ **K** walk with them.
   - ☐ **R** write down the directions as a list.
   - ☐ **A** tell them the directions.
   - ☐ **V** draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ **A** class discussions, online discussion, online chat and guest speakers.
   - ☐ **K** field trips, case studies, videos, labs and hands-on practical sessions.
   - ☐ **R** a textbook and plenty of handouts.
   - ☐ **V** an overview diagram, charts, labelled diagrams and maps.

5. You have a problem with your knee. Would you prefer that the doctor:
   - ☐ **V** showed you a diagram of what was wrong.
   - ☐ **A** described to you what was wrong
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6. After reading a play you need to do a project. Would you prefer to:
   - ☐ **K** act out a scene from the play.
   - ☐ **A** read a speech from the play.
   - ☐ **V** draw or sketch something that happened in the play.
   - ☐ **R** write about the play.

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ **A** describe the activities you will be doing in the programme.
   - ☐ **K** start practicing the activities you will be doing in the programme.
   - ☐ **R** show them the list of activities in the programme.
   - ☐ **V** show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ **K** things you can click on and do.
   - ☐ **V** interesting design and visual effects.
   - ☐ **A** audio channels for music, chat and discussion.
   - ☐ **R** interesting information and articles in print.

9. You have to present your ideas to your colleagues. You would:
   - ☐ **R** write out your speech and learn it by reading it again and again.
   - ☐ **A** write a few key words and practise what to say again and again.
   - ☐ **K** gather examples and stories to make it real and practical.
   - ☐ **V** make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
   - ☐ **R** that used a written description or table of your results.
   - ☐ **K** that used examples of what you have done.
   - ☐ **A** from somebody who discussed it with you.
   - ☐ **V** that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
   - ☐ **K** trying it.
   - ☐ **A** the salesperson telling you about it.
   - ☐ **V** it is the latest design and looks good.
   - ☐ **R** reading the details about its features.

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   - ☐ **K** make something you have made before.
   - ☐ **R** find written instructions to make it.
   - ☐ **V** look for ideas and plans in books and magazines.
   - ☐ **A** talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
   - ☐ **V** clues from the diagrams in the instructions.
   - ☐ **A** listening to somebody explaining it and asking questions.
   - ☐ **K** watching others do it first.
   - ☐ **R** reading the instructions.

Total Personal Score: Visual =_____ Aural =_____ Read/Write =_____ Kinaesthetic =_____

Case Examples for Wealth-Ranking Exercise

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	Poor
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	Poor
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	Non-Poor
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	Non-Poor
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	Poor
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	Non-Poor

Wealth Ranking for PD/Hearth

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

WEALTH STATUS	WEALTH CLASSIFICATION CRITERIA
POOR	
NON-POOR	

Community Assessment Monitoring Sheet

Community: Sunshine – ADP Light and Hope	**Date of Weighing:** March 11, 2011	
Total number of children under 36 months in community: **Total number of children under 36 months weighed:**		

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
1	M	6/3/2009	24	10.70	1	Non-Poor			
2	F	28/3/2010	11	6.8	4	Poor			
3	F	30/7/2009	19	7.1	6	Poor			
4	M	14/4/2008	35	10.1	1	Non-Poor			
5	F	3/8/2010	7	7.3	3	Poor			
6	M	3/10/2009	17	8.5	7 (twin)	Poor			
7	F	3/10/2009	17	10.7	7 (twin)	Poor			
8	M	20/5/2008	34	9.8	8	Poor			
9	F	21/111/2009	16	8.2	1	Poor			
10	F	8/2/2008	37	11.4	8	Non-Poor			
11	F	6/5/2010	10	8.6	3	Poor			
12	M	25/3/2010	12	7.4	6	Non-Poor			
13	F	25/9/2009	17	8.1	3	Poor			
14	F	25/9/2009	17	6.1	7	Poor			
15	F	23/7/2009	20	8.3	2	Poor			
16	M	9/12/2009	15	8.5	9	Poor			
17	F	28/8/2009	18	6.2	1	Poor		-4.20	
18	M	18/7/2009	20	8.4	1	Poor		-2.64	
19	M	15/5/2010	10	6.3	4	Poor		-3.33	

Community Assessment Monitoring Sheet

Day 2 Session 14

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
20	M	15/5/2010	10	8.3	3	Non-Poor		-0.87	
21	F	3/3/2009	24	11.5	5	Poor		-0.02	
22	F	22/10/2008	29	8.9	2	Poor		-2.80	
23	F	6/6/2009	21	9.4	4	Poor		-1.21	
24	F	3/2/2008	37	10.8	3	Poor		-2.13	
25	M	9/9/2009	18	8.1	5	Non-Poor		-2.69	
26	M	3/6/2009	21	10.1	1	Poor		-1.22	
27	M	22/9/2009	18	9.5	4	Poor		-1.20	
28	F	24/9/2010	6	9.5	3	Non-Poor		2.35	
29	M	17/3/2010	12	8.2	5	Poor		-1.44	
30	M	6/6/2010	9	8.7	3	Non-Poor		-0.25	
31	F	4/4/2009	23	11.2	2	Non-Poor		-0.08	
32	M	28/1/2010	13	10.6	10	Poor		0.57	
33	M	7/12/2008	27	9	1	Non-Poor		-3.02	
34	F	4/12/2008	27	11.0	6	Poor		-0.80	
35	M	8/9/2009	18	10.0	8	Poor		-0.81	
36	F	30/11/2008	27	9.2	6	Poor		-2.34	
37	F	16/12/2008	27	9.4	4	Non-Poor		-2.07	
38	M	10/11/2010	4	10.2	7	Poor		3.47	
39	F	21/11/2009	16	9.8	4	Poor		0.06	
40	M	10/3/2010	12	7.0	4	Non-Poor		-2.91	
41	F	12/9/2008	30	8.4	3	Poor		-3.44	

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)*											
BOYS						**GIRLS**					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	0	3.3	2.9	2.5	2.1	F	0	3.2	2.8	2.4	2.0
M	1	4.5	3.9	3.4	2.9	F	1	4.2	3.6	3.2	2.7
M	2	5.6	4.9	4.3	3.8	F	2	5.1	4.5	3.9	3.4
M	3	6.4	5.7	5.0	4.4	F	3	5.8	5.2	4.5	4.0
M	4	7.0	6.2	5.6	4.9	F	4	6.4	5.7	5.0	4.4
M	5	7.5	6.7	6.0	5.3	F	5	6.9	6.1	5.4	4.8
M	6	7.9	7.1	6.4	5.7	F	6	7.3	6.5	5.7	5.1
M	7	8.3	7.4	6.7	5.9	F	7	7.6	6.8	6.0	5.3
M	8	8.6	7.7	6.9	6.2	F	8	7.9	7.0	6.3	5.6
M	9	8.9	8.0	7.1	6.4	F	9	8.2	7.3	6.5	5.8
M	10	9.2	8.2	7.4	6.6	F	10	8.5	7.5	6.7	5.9
M	11	9.4	8.4	7.6	6.8	F	11	8.7	7.7	6.9	6.1
M	12	9.6	8.6	7.7	6.9	F	12	8.9	7.9	7.0	6.3
M	13	9.9	8.8	7.9	7.1	F	13	9.2	8.1	7.2	6.4
M	14	10.1	9.0	8.1	7.2	F	14	9.4	8.3	7.4	6.6
M	15	10.3	9.2	8.3	7.4	F	15	9.6	8.5	7.6	6.7
M	16	10.5	9.4	8.4	7.5	F	16	9.8	8.7	7.7	6.9
M	17	10.7	9.6	8.6	7.7	F	17	10.0	8.9	7.9	7.0
M	18	10.9	9.8	8.8	7.8	F	18	10.2	9.1	8.1	7.2
M	19	11.1	10.0	8.9	8.0	F	19	10.4	9.2	8.2	7.3
M	20	11.3	10.1	9.1	8.1	F	20	10.6	9.4	8.4	7.5
M	21	11.5	10.3	9.2	8.2	F	21	10.9	9.6	8.6	7.6
M	22	11.8	10.5	9.4	8.4	F	22	11.1	9.8	8.7	7.8
M	23	12.0	10.7	9.5	8.5	F	23	11.3	10.0	8.9	7.9
M	24	12.2	10.8	9.7	8.6	F	24	11.5	10.2	9.0	8.1
M	25	12.4	11.0	9.8	8.8	F	25	11.7	10.3	9.2	8.2
M	26	12.5	11.2	10.0	8.9	F	26	11.9	10.5	9.4	8.4
M	27	12.7	11.3	10.1	9.0	F	27	12.1	10.7	9.5	8.5
M	28	12.9	11.5	10.2	9.1	F	28	12.3	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)

BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.8
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	8.9
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.0
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.1
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.3
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.4
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.5
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.6
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.7
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.8
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	9.9
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)*									
BOYS					**GIRLS**				
Sex	**Age (mon)**	**Green (Normal)**	**Yellow (Moderate)**	**Red (Severe)**	**Sex**	**Age (mon)**	**Green (Normal)**	**Yellow (Moderate)**	**Red (Severe)**
M	0	2.9	2.5	2.1	F	0	2.8	2.4	2.0
M	1	3.9	3.4	2.9	F	1	3.6	3.2	2.7
M	2	4.9	4.3	3.8	F	2	4.5	3.9	3.4
M	3	5.7	5.0	4.4	F	3	5.2	4.5	4.0
M	4	6.2	5.6	4.9	F	4	5.7	5.0	4.4
M	5	6.7	6.0	5.3	F	5	6.1	5.4	4.8
M	6	7.1	6.4	5.7	F	6	6.5	5.7	5.1
M	7	7.4	6.7	5.9	F	7	6.8	6.0	5.3
M	8	7.7	6.9	6.2	F	8	7.0	6.3	5.6
M	9	8.0	7.1	6.4	F	9	7.3	6.5	5.8
M	10	8.2	7.4	6.6	F	10	7.5	6.7	5.9
M	11	8.4	7.6	6.8	F	11	7.7	6.9	6.1
M	12	8.6	7.7	6.9	F	12	7.9	7.0	6.3
M	13	8.8	7.9	7.1	F	13	8.1	7.2	6.4
M	14	9.0	8.1	7.2	F	14	8.3	7.4	6.6
M	15	9.2	8.3	7.4	F	15	8.5	7.6	6.7
M	16	9.4	8.4	7.5	F	16	8.7	7.7	6.9
M	17	9.6	8.6	7.7	F	17	8.9	7.9	7.0
M	18	9.8	8.8	7.8	F	18	9.1	8.1	7.2
M	19	10.0	8.9	8.0	F	19	9.2	8.2	7.3
M	20	10.1	9.1	8.1	F	20	9.4	8.4	7.5
M	21	10.3	9.2	8.2	F	21	9.6	8.6	7.6
M	22	10.5	9.4	8.4	F	22	9.8	8.7	7.8
M	23	10.7	9.5	8.5	F	23	10.0	8.9	7.9
M	24	10.8	9.7	8.6	F	24	10.2	9.0	8.1
M	25	11.0	9.8	8.8	F	25	10.3	9.2	8.2
M	26	11.2	10.0	8.9	F	26	10.5	9.4	8.4
M	27	11.3	10.1	9.0	F	27	10.7	9.5	8.5
M	28	11.5	10.2	9.1	F	28	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)

BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	29	11.7	10.4	9.2	F	29	11.1	9.8	8.8
M	30	11.8	10.5	9.4	F	30	11.2	10.0	8.9
M	31	12.0	10.7	9.5	F	31	11.4	10.1	9.0
M	32	12.1	10.8	9.6	F	32	11.6	10.3	9.1
M	33	12.3	10.9	9.7	F	33	11.7	10.4	9.3
M	34	12.4	11.0	9.8	F	34	11.9	10.5	9.4
M	35	12.6	11.2	9.9	F	35	12.0	10.7	9.5
M	36	12.7	11.3	10.0	F	36	12.2	10.8	9.6
M	37	12.9	11.4	10.1	F	37	12.4	10.9	9.7
M	38	13.0	11.5	10.2	F	38	12.5	11.1	9.8
M	39	13.1	11.6	10.3	F	39	12.7	11.2	9.9
M	40	13.3	11.8	10.4	F	40	12.8	11.3	10.1
M	41	13.4	11.9	10.5	F	41	13.0	11.5	10.2
M	42	13.6	12.0	10.6	F	42	13.1	11.6	10.3
M	43	13.7	12.1	10.7	F	43	13.3	11.7	10.4
M	44	13.8	12.2	10.8	F	44	13.4	11.8	10.5
M	45	14.0	12.4	10.9	F	45	13.6	12.0	10.6
M	46	14.1	12.5	11.0	F	46	13.7	12.1	10.7
M	47	14.3	12.6	11.1	F	47	13.9	12.2	10.8
M	48	14.4	12.7	11.2	F	48	14.0	12.3	10.9
M	49	14.5	12.8	11.3	F	49	14.2	12.4	11.0
M	50	14.7	12.9	11.4	F	50	14.3	12.6	11.1
M	51	14.8	13.1	11.5	F	51	14.5	12.7	11.2
M	52	15.0	13.2	11.6	F	52	14.6	12.8	11.3
M	53	15.1	13.3	11.7	F	53	14.8	12.9	11.4
M	54	15.2	13.4	11.8	F	54	14.9	13.0	11.5
M	55	15.4	13.5	11.9	F	55	15.1	13.2	11.6
M	56	15.5	13.6	12.0	F	56	15.2	13.3	11.7
M	57	15.6	13.7	12.1	F	57	15.3	13.4	11.8
M	58	15.8	13.8	12.2	F	58	15.5	13.5	11.9
M	59	15.9	14.0	12.3	F	59	15.6	13.6	12.0
M	60	16.0	14.1	12.4	F	60	15.8	13.7	12.1

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

No.	Date of Survey	Child's Name	Sex (M/F)	Caregiver's Name	DOB (dd/mm/yyyy)	Age (Months)	Birth Order	Odema (Y or N)	Weight (kg)	Nutritional Status Indicate Colour	MUAC (<115mm) (Green, Yellow, Red)	Wealth Rank (Poor, Non-Poor)	Classification (PD, ND, NPD)	PDI HHs
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														
21														
22														

75m

Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Child's Age	**Foods given,** including breastmilk and other liquids (name or pictures)	**Amounts** (bowl, cup, can, fist, spoonful)	**Frequency** (daily, weekly, rarely)	**Food taboos** (forbidden foods)	**Comments** Why?
Newborn					
0–5 months					
6–8 months					
9–11 months					
12–23 months					
≥24 months					
When child is sick					
When recovering					

Market Survey for PD/Hearth (Cost Variance)

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW						
	Units of Smallest Quantity Purchased	High Season (Months)	Cost during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Cost during Low Seasons ( )	Cost per 100 gram*

* NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Market Survey for PD/Hearth (Quantity Variance)

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW						
	Cost of Smallest Quantity Purchased	High Season (Months)	Quantity during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Quantity during Low Seasons ( )	Cost per 100 gram*

*NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Seasonal Calendar for PD/Hearth

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Items (e.g. foods available, diseases, etc.)	MONTHS												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

(Participants are to create their own questions and guidelines for use in the field visit.)

House Visits

1. Be wise; respect the family.
2. Don't ask why they are poor.
3. Point out that you are here to learn, not to criticise.
4. Introduce yourself, congratulate the family on its good work, and ask permission to observe.
5. Make sure the information collected regarding child information (e.g. age, birth order, wealth ranking, etc.) is correct to ensure the child is a PD child.
6. Spend two to three hours in each PD house. It is good to go during a meal time to observe the child's feeding practices, but ensure you do not disturb the family.
7. Try to engage both the caregiver and grandmother (if present) while conducting the visit.
8. Conduct a 24-hour diet recall on the food the child ate yesterday. Fill out form.

24-Hour Dietary Recall Question Guide

1. What is the first thing the child ate yesterday after waking up?
2. How much did you give (of each feed)? How much of it did the child eat? Can you show me the bowl the child used?
3. How did you prepare the food? Fried? Boiled? Steamed?
4. What did you add? Any oil? Vegetables?
5. Did the child eat anything else?
6. Did the child drink anything?
7. What is the next time the child ate? What? How much? How prepared? What else did the child eat?
8. Did the child get anything else between first and second meal? And between second and last meal? (Note: food quantity, frequency and consistency).

Good Food/Feeding

1. Is the child breastfeeding? If not, at what age did the mother wean the child?
2. What foods is the child being fed today?
3. Who decides what the child will eat? What role do other family members play in child feeding decisions?
4. How many times did you see the child eat or drink?
5. Where does the family buy food? Who buys the food? How much money is spent on food each day?
6. How many meals and snacks does the child eat a day?
7. Are there any foods the caregiver does *not* give the child?

Good Child Care (try to observe without asking)

1. Who is the primary caregiver of the child?
2. What roles do other family members play in caring for the child?
3. Who is in the house during the day?
4. Does the caregiver take the child to the vaccination post? How often? Is the child on schedule?
5. Does the caregiver or others play with the child? How? How often?
6. How is the child disciplined? By whom?
7. What does the caregiver do to encourage the child to eat if he or she doesn't want to?

Good Health Care (ask for health card, ask caregiver questions)

1. How do you know when your child is sick?
2. Was the child sick in the past six months? If so, how many times?
3. What illnesses has the child had?
4. When the child was sick, what did you do? Did you feed the child anything differently?
5. What steps do you take to prevent illnesses?

Good Hygiene (observe body, food and environment)

1. Is the house clean? Is the kitchen clean?
2. Are the people clean?
3. If there is a latrine, how does it look?
4. Make observations about the water source.
5. Do pigs, mules, dogs or other animals go in and out of the house?

Observation Checklist

Questions	Remarks
Personal Hygiene	
Wash hands before/after?	
Plates washed?	
Nails	
Shoes	
Clothes	
Food preparation	
Handwashing (Check for soap and running water)	
Washing the food before cutting or cooking	
Food/water covered (before and after cooking)	
Household measures used (e.g. size of cup, spoon sizes, do they use fist sizes?)	
Home Environment	
Food availability (gardens)	
Animals present (cage, play with children?)	
Storage facilities (for water, food)	
Household waste management	
Toilets (cleanliness, distance, type)	
Water (boiled/filtered, distance, source)	
Interaction between caregiver and child	
Loving and caring behaviour	
Playing with the child	
Feeding Practices	
Does child pick up food from ground and eat it?	
Do you help the child to eat and watch child eating?	
Amount of food the child is eating?	
How many times do you feed per day?	
Feeding Practices	
Health Seeking Practices	
Do you see any ORS packets?	
Do you see an ITN? Is it in good condition?	
Do you feed the child differently when the child is sick (e.g. more or less food; more or less liquid; feed more frequently)?	

Results and Observations from the PDI

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

PD Food/Feeding		**Non-PD Food/Feeding**	
PD Caring		**Non-PD Caring**	
PD Hygiene		**Non-PD Hygiene**	
PD Health Seeking		**Non-PD Health Seeking**	

Arrival of caregivers and children/attendance

- Volunteer gives positive reinforcement for good hygiene.
- Volunteer asks how things are going at home – troubleshoot and share observations.

Collect food contribution

Discuss:

- Cost and sources of nutritious food
- Food variety, healthy choices
- Safety of food, proper storage
- Where foods can be found, gathered
- Food production/home gardens

Hand washing/hygiene

Discuss:

- Modelling proper hand-washing technique
- Use of soap
- Times when hand-washing is important
- Reason to wash hands: bacteria/germs contribute to illness/diarrhoea
- Treatment of diarrhoea/illness, when to seek health care
- Immunisation, deworming
- Nail cutting
- Orientation to personal hygiene
- Latrine use
- Use of shoes

Snack

Discuss:

- Frequency of snacks and meals
- Why to feed children four to five times a day
- Healthy snacks that require little or no preparation
- Consistency of food
- Food groups and nutritional value of food
- Including a variety of food in a day
- Breastfeeding
- Food storage

Cooking the menu

Discuss:

- Nutritional value of food
- Sources of affordable food: food production/home gardens, barter, collecting wild fruits
- Variety of food
- Good cooking techniques
- Food hygiene and safety, storage
- Promoting thick consistency of food
- Palatability and appetising appearance
- Importance of feeding children four to five times a day
- Hearth is an extra meal

Child stimulation/play

Discuss:

- Modelling play and care of children
- Motor-skill development
- Cognitive development
- New ways to stimulate children – singing, dancing, clapping games, etc.
- Social skills/sharing/cooperation
- Appropriate touching/affection

Feeding children

Discuss:

- Active, responsive feeding
- Content of foods (colours, nutrients)
- PD foods and why they are good
- Importance of meal frequency (four to five times a day)
- Breastfeeding
- Portion sizes
- Troubleshooting feeding problems
- Food taboos
- Stimulating a child's appetite

Planning for the next day

Discuss:

- Local and affordable foods, including the PD foods.
- Quantity of food
- Food combinations – variety, colour
- Nutrient value of food – importance of variety
- Where to find foods
- Planning menus and budgets

Cleaning up

Discuss:

- Hygiene – clean surfaces and utensils
- Use of leftovers
- Food safety
- Food storage
- Reuse water, compost
- Latrine use and cleanliness

Calories: **600–800 (500–600*)**

Protein: **25–27g (18–20g*)**

Vitamin A: **300 µg RAE (RAE=retinol activity equivalent)**

Iron: **8–10mg**

Zinc: **3–5mg**

Vitamin C: **15–25mg**

*Amounts in parentheses are the minimum for a region with food insufficiency; recuperation will take longer with these amounts (see CORE PD/Hearth Guide, p. 114).

Note: *The vitamin A requirement has been updated since the publication of the CORE PD/Hearth Guide and PD/Hearth Addendum to use the currently accepted measure of Retinol Activity Equivalents (RAE). Make sure that the food composition tables you use lists vitamin content as µg RAE, not RE or IU (conversion rate: 1 µg RAE = 3.3 IU).*

Each group can go to the 'market area' (where the food and utensils are laid out) and take different foods for its menu. The menu includes one snack as well as the meal:

- Take the amount you think a small child would eat. Remember that a child's stomach is no larger than the child's fist.
- Note the cost per gram of the food you take.
- After weighing your group's choices, put the foods on a plate.
- Use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the CORE PD/Hearth Guide, page 116, which discusses how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Calculate the cost per gram used of each ingredient. Then add up the total cost of the menu for one child.
- Using common household measures, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.
- Convert the cooked amount of food to a raw amount. For rice, divide the cooked volume by 2 to get the uncooked measure. For example, 60g of cooked rice divided by 2 equals 30g of uncooked rice.

Conversion of cooked food in grams to raw food in grams:

Cooked rice, divide by 2

Cooked beans, lentils, pulses, divide by 2

Cooked porridge, divide by 2.5

Cooked green leaves, multiply by 1.4

- Change the gram amounts to household measures by measuring the quantity of each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.).
- For example, weigh out 30g of uncooked rice and put it into a cup that would be found in households or measure it by the handful, if that is more common.
- Write the household measure for each food on the calculation sheet.
- Each caregiver or caregiver-grandmother pair will contribute this amount of raw ingredients for their child(ren) at each Hearth session.
- When satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form to display with the plate.

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
1. Grains, Roots, and Tubers								
Cassava, boiled	165	1.2	1	13	1.4	0.2		1
Cassava, dried, raw	351	2.1	2	68	3.8	0.8		1
Cassava, raw	157	1.1	1	31	1.7	0.2		1
Maize flour, whole grain, yellow	361	6.93	11	0	2.4	1.7		5
Maize or Sorghum Ugali	110.3	3	2.1	0	1.3	0.5		7
Maize, white, whole, boiled	139	3.5	1	2	1.2	0.5		1
Maize, white, whole, dried, raw	363	9.2	3	8	3.2	1.4		1
Maize, yellow, boiled	136	3.6	35	1	1.6	0.6		1
Maize, yellow, dried, raw	354	9.4	101	4	4.2	1.7		1
Millet flour	373	10.75	0	0	3.9	2.6		5
Millet, whole grain, boiled	144	4.1	0	0	6.4	0.6		1
Potato, boiled	74	1.8	2	11	0.8	0.3		1
Rice Flake, water soaked	356	1.1	0	0	2.0	0.4		9
Rice noodle (mee suah)	320	9.10	0	0	1.6	0.7		10
Rice noodle, fermented	106	1.40	0	0	0.1	0.2		10
Rice steamed, white	131	2.20	0	0	0.4	0.6		10
Rice, brown, boiled	135	3	0	0	0.7	0.7		1
Rice, white, boiled	133	2.8	0	0	1.0	0.4		1
Rice, white, fried	370	6.81	0	0	1.6	1.2		10
Rice, white, raw	355	6.80	0	0	1.2	0.5		10
Rice, white, soaked	370	6.81	0	0	1.6	1.2		10
Sorghum flour	361	7.87	0	0	3.0	1.4		5
Sorghum, whole grain, boiled	153	4.6	2	0	3.6	0.6		1
Steamed sticky rice (white), grilled	229	4.60	0	0	0.1	0.2		10
sticky rice (white), steamed	229	4.60	0	0	0.3	1.0		10
Sweet Potato, boiled	101	1.7	789	15	1.7	0.3		1
Taro, boiled	100	1.9	4	3	0.9	0.2		1
Wheat flour, white	347	10.7	0	0	2.0	4.0		1
Wheat noodle (waiwai), instant	456	10.5	0	0	1.6	1.8		10
Yam, boiled	101	1.7	2	5	1.0	0.2		1
2. Legumes and Nuts								
Beans, kidney, boiled without salt	127	8.67	0	1	2.2	1.0		5
Beans, raw	32	2.4	54	18	1.0	0.3		1
Beans, yellow, cooked, boiled without salt	144	9.16	0	2	2.5	1.1		5
Cashewnut, raw	589	20	0	0	6.4	4.6		7
Chickpea, boiled without salt	164	8.86	1	1	2.9	1.5		5
Chickpea, dry	364	19.3	3	3	6.2	3.4		5
Coconut water	22	0.3	0	2	0.1	0.1		1
Coconut, mature, fresh, raw	387	3.2	0	2	2.5	0.9		1
Cowpea, Leafy tips, boiled and drained	22	4.67	29	18	1.1	0.2		5
Cowpea, seeds, black, dried, boiled	116	7.73	2	0	2.5	1.3		10
Groundnut, dried, raw	578	24.1	2	1	4.3	1.9		1
Groundnut, dried, roasted (also gnut flour)	567	25.8	0	0	4.6	1.7		6
Groundnut, fresh, boiled	236	10.8	0	0	1.9	1.0		6
Groundnut, fresh, roasted	374	17	0	0	3.0	1.1		6
Groundnut, seeds, dried, raw	577	24.8	0	1	2.3	2.8		1

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
2. Legumes and Nuts (continued)								
Lentils, boiled without salt	116	9.02	0	2	3.3	1.3		5
Lentils, raw	353	25.8	0	0	7.5	4.8		5
Mongogo Nut, Bok Nut	659	26.00	0	0	3.7	4.0		
Mung Bean, boiled without salt	105	7.02	1	1	1.4	0.8		5
Mung Bean, dried	324	22	19	0	8.0	0.8		2
Soya bean, boiled without salt	173	16.64	0	2	5.1	1.2		5
Soya bean, dried, raw	397	33.2	9	0	8.3	4.7		1
Soya bean, dry roasted	451	39.58	0	5	5.0	4.8		5
Soya bean, roasted without salt	471	35.22	0	2	3.9	3.1		5
3. Dairy Products (milk, yoghurt, cheese)								
Breastmilk, human, mature, raw	69	1.1	62	1	0.2	0.3		1
Milk UHT, Thaidenmark brand (non-fortified)	67	3.30	41	0	0.1	0.3		10
Milk, cow, powder, whole	492	25.3	295	12	0.7	4.0		1
Milk, cow, whole, raw	75	3.7	39	2	0.1	0.4		1
Milk, goat, whole, raw	69	3.4	35	2	0.1	4.0		1
Milk, instant, Anmum brand (fortified)	77	3.20	93	22	2.6	2.2		10
Yoghurt, drinking, foremost brand	84	1.50	14	3	0.1	0.3		10
Yoghurt, wholemilk, natural	75	3.5	33	1	0.1	4.0		1
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats)								
Anchovy (small fish), fillet, raw	123	18.4	15	0	3.3	1.7		1
Anchovy, fillet, grilled	668	27.6	20	2	3.8	2.5		1
Anchovy, fillet, steamed	542	22.4	16	2	2.9	2.1		1
Beef ball, blanched	84	16.5	7	1	5.0	0.0		10
Beef internal organ barbecue	94	14.0	2357	9	5.0	2.0		10
Beef intestine, raw	109	16.4	10	0	3.1	2.0		10
Beef liver, grilled	133	20.3	3841	18	10.1	3.9		10
Beef liver, pan-fried	175	26.52	7744	1	6.2	5.2		5
Beef liver, raw	135	20.36	4968	1	4.9	4.0		5
Beef lung, raw	84	16.0	95	6	6.1	1.7		10
Beef spleen, raw	95	18.2	103	29	0.7	2.1		10
Beef stomach, raw	102	11.0	0	0	1.9	1.3		10
Beef, blanched	150	20.0	2	0	3.0	5.0		10
Beef, dried, grilled	479	38.3	3	0	11.8	3.9		10
Beef, dry, fried	479	38.3	3	0	11.8	3.9		10
Beef, grilled	190	38.5	3	0	4.9	7.6		10
Beef, ground, 20% fat, pan-broiled	246	24.04	0	0	3.6	6.1		5
Beef, ground, 20% fat, raw	254	17.17	0	1	1.9	4.2		5
Beef, raw	273	17.2	3	0	2.3	5.3		10
Chicken, roasted	210	23.8	0	0	0.8	1.5		10
chicken gizzard, raw	102	20.2	34	3	3.1	3.2		10
Chicken heart	112	15.8	75	6	4.0	5.5		10
Chicken Liver	114	16.9	3296	18	9.0	2.5		9
Chicken liver, boiled	121	18.6	3178	14	7.3	3.2		10
Chicken liver, grilled	121	18.6	3273	14	7.3	3.1		10
Chicken liver, raw	121	18.6	3710	14	7.3	3.0		10
Chicken, boiled	193	28.6	5	1	0.6	1.0		10

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats) (continued)								
Chicken, cooked	285	26.9	39	0	1.4	1.8		6
Chicken, flesh only, raw	136	20.6	10	0	1.2	1.0		1
Chicken, raw	186	17.3	3	0	0.5	1.0		10
Cricket	127	12.90	0	0	9.5	0.0		11
Dried small fish *(usipa)*, cooked with salt	125	17	0	0	3.3	9.1		6
Duck, roasted	373	18.5	115	0	1.3	2.1		10
Fermented fish with bone	103	13.3	3	0	5.5	3.6		10
Fermented fish, sour, fried	108	19.5	1	0	2.1	2.4		10
Frog legs, raw	73	16.40	15	0	1.5	1.0		5
Lamb, composite of retail cuts, cooked	256	24.54	0	0	1.9	4.7		5
Lamb, meat, raw	217	17.2	10	0	2.3	3.1		1
Mackerel, Pacific and jack, cooked dry heat	201	25.73	23	2	1.5	0.9		5
Mackerel, raw	133	21.1	16	2	1.8	0.5		1
Mussels, boiled	33	3.1	208	0	2.9	1.9		2
Mutton/Lamb Liver	150	19.3	8250	20	6.3	4.0		9
Nile tilapia fish, raw	96	20.1	0	0	0.6	0.3		10
Nile tilapia, roasted	128	26.2	0	0	0.7	0.4		10
Pork blood, boiled	32	7.90	26	0	25.9	0.1		10
Pork liver, grilled	125	19.2	4242	19	15.5	5.3		10
Pork liver, raw	125	19.2	6291	25	15.5	5.6		10
Pork sausage, grilled	369	19.6	14	2	1.2	2.5		10
Pork skin, raw	320	19.8	6	0	2.1	0.3		10
Pork spleen, raw	87	16.1	241	26	1.0	2.3		10
Pork, boiled	204	33.0	0	0	1.5	1.3		10
Pork, fresh, cooked	201	27.51	1	0	1.0	0.1		5
Pork, grilled	249	26.2	0	0	2.5	1.8		10
Pork, meat, approx. 24% fat, raw	289	14.5	0	0	2.0	3.2		1
Pork, meat, approx. 40% fat, raw	405	12.6	0	0	1.9	3.2		1
Pork, raw	116	21.8	0	0	1.0	1.0		10
Pork, shreded, chinese style	357	43.1	0	0	17.8	1.3		10
Prawns or shrimps, cooked in moist heat	119	22.78	0	0	0.3	1.6		5
Rabbit, meat, raw	142	20.7	10	0	0.9	1.7		1
Rabbit, stewed	206	30.38	0	0	2.4	2.4		5
Short bodied mackerel fried	236	25.7	26	2	2.4	1.0		10
Short bodied mackerel, roasted	122	21.4	27	5	1.4	0.6		10
Siamese mud carp, grilled	124	21.1	9	1	0.6	1.5		10
Snail, pond, river	74	12.10	0	0	8.7	0.0		11
Tilapia, cooked dry heat	128	26.15	0	0	0.7	0.4		5
5. Eggs								
Egg, duck, whole, boiled	150	11.8	169	0	3.4	1.2		10
Egg, hardboiled	155	12.58	149	0	1.2	1.1		5
Egg, hen, whole	159	13.2	160	0	2.8	1.1		10
Egg, hen, whole, boiled	170	13.9	164	0	3.5	1.2		10
Egg, raw	139	12.1	207	0	2.4	1.3		1
Hen egg, fried	196	13.6	219	0	1.9	1.4		10
Omelet duck egg	183	12.6	365	0	3.2	1.0		10
Omelet hen egg	259	7.00	255	0	2.2	1.6		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
6. Vitamin-A Rich Fruits and Vegetables								
Amaranth, boiled	21	2.11	139	41	2.3	0.9		5
Bean leaves, fresh, cooked with salt	14	1.4	192	12	1.1	0.1		6
Carrot, boiled	33	0.9	1137	3	0.7	0.6		1
Carrot, raw	35	1	1201	7	0.9	0.8		1
Cassava, fresh leaves, cooked with salt	20	2	261	12	1.6	0.6		6
Cassava, fresh leaves, raw	98	0.9	1733	370	5.6	5.0		1
Chinese cabbage blanched	21	1.70	244	33	1.6	0.2		10
Dark Green Leaves, fresh	48	5	950	100	4.0	0.8		2
Dark Green Leaves, fresh, cooked with salt	18	1.1	401	17	0.5	0.1		6
Green amaranth, small, blanched	21	2.11	278	41	2.3	0.9		10
Green amaranth, small, fresh	35	3.60	510	49	3.1	1.2		10
Horse tamarind, young leaves	85	9.20	255	7	3.4	0.6		10
Mango, ripe, fruit, raw	62	0.6	427	35	1.0	0.6		1
Moringa leaves, boiled	91	8.8	699	0	4.8	0.7		1
Moringa leaves, raw	86	8.3	738	0	6.1	0.9		1
Morning glory/Swamp cabbage, blanched	20	2.08	520	16	1.3	0.2		10
Morning glory/Swamp cabbage, fresh	31	2.90	457	28	3.3	0.5		10
Mustard green blanched	19	2.27	708	14	1.1	0.2		10
Mustard green, fermented, sour	21	1.50	161	20	1.3	0.2		10
Mustard green, stem and leaves, boiled	22	1.70	249	43	1.5	0.1		10
Mustard leaves, fresh, cooked with salt	16	1.1	213	0	1.0	0.4		6
Mustard, fresh	28	2.20	317	57	2.5	0.2		10
Okra, leaves, cooked with salt	12	0.7	260	11	0.3	0.7		6
Papaya (paw paw), fruit, ripe, raw	38	0.5	355	59	0.7	1.4		1
Pumpkin, boiled	20	0.5	201	5	0.2	0.2		6
Pumpkin, fresh leaves, boiled	11	0.6	298	11	0.5	0.4		6
Pumpkin, mature, fresh	49	1.30	170	15	0.7	0.9		10
Pumpkin, raw	36	1	250	15	0.8	0.2		2
Squash, raw	47	0.4	240	1	0.3	0.2		2
Squash, winter, all varieties, cooked without salt	37	0.89	261	10	0.4	0.2		5
Tamarind, young leaf, fresh	68	3.80	381	32	1.5	0.5		10
Taro, leaves, cooked without salt	24	2.72	212	36	1.2	0.2		5
Taro, young leaves, raw	30	2.4	389	52	2.0	0.4		1
Wildbetal Leafbush	60	4.20	258	17	4.2	1.0		10
7. Other Fruits and Vegetables								
Apple, prink, fresh	63	0.50	14	2	0.2	0.0		10
Avocado, raw	149	1.6	20	16	1.1	0.6		1
Bamboo shoots, cooked, boiled, with salt	11	1.53	0	0	0.2	0.5		5
Bamboo shoots, cooked, boiled, without salt	12	1.53	0	0	0.2	0.5		5
Banana, flowers, fresh	38	1.60	34	10	1.1	0.3		10
Banana, ripe, raw	100	1.3	19	10	1.0	1.1		1
Banana, ripe, yellow	105	1.00	15	12	0.4	0.1		10
Banana, ripe, yellow, boiled	105	1.00	13	10	0.4	0.1		10
Bean sprouts, fresh	46	4.30	5	23	1.4	0.5		10
Cabbage, blanched	29	1.50	8	32	1.0	0.3		10
Cabbage, boiled	19.8	1.3	11	21	0.4	0.2		1
Cabbage, common, fresh	29	1.50	8	32	1.0	0.3		10

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Cabbage, raw	26	1.6	10	54	0.6	0.2		1
Cauliflower, boiled	28	2.7	1	47	0.8	0.4		9
Chayote, boiled	21	0.60	6	10	0.4	0.3		10
Chayote, fruit, fresh	21	0.60	6	10	0.4	0.7		10
Chilli pepper, hot, red, fresh	75	3.00	156	142	1.2	0.4		10
Cilantro	23	2.13	337	27	1.8	0.5		2
Coriander, fresh	33	2.50	431	34	2.6	0.2		10
Cucumber, fresh	23	0.80	9	12	0.4	0.2		10
Cumcumber	95.5	0.7	3	0	0.5	0.2		1
Dill, fresh	34	3.10	201	40	2.3	0.7		10
Eggplant, boiled without salt	35	0.83	2	1	0.3	0.1		5
Eggplant, raw	28	1.1	12	6	0.9	1.6		1
Eggplant/brinjal, green, fresh	37	1.50	10	8	0.9	0.2		10
Fennel common leaves, fresh	42	2.50	867	23	2.3	0.2		10
Fig, raw	78	1.4	79	15	6.0	1.5		1
Garlic, fresh	51	2.10	0	10	0.7	0.4		10
Garlic, raw	136	6.1	0	18	1.5	0.6		1
Ginger, raw	72	1.9	0	5	1.1	0.4		9
Guava, fruit, raw	58	1	95	281	1.4	1.8		1
Hairy basil, fresh	39	2.80	279	18	2.1	0.6		10
Jackfruit, raw	94	1.7	18	9	0.6	0.1		2
Lemon grass, fresh	78	0.80	3	1	2.0	0.5		10
Lemon, fruit, raw	36	0.7	2	46	0.6	0.1		1
Lemon, juice	29	1.1	3	53	0.6	0.1		4
Light/Pale Green Leaves, fresh	23	1.5	47	40	0.5	0.8		2
Mango, unripened, fruit, raw	55	0.5	10	86	1.4	0.6		1
Mint, leaf	42	2.90	467	84	4.1	0.8		10
Mushrooms, portabella, grilled	29	3.28	0	0	0.4	0.7		5
Okra, fresh, boiled	21	1.1	38	5	0.8	0.4		6
Okra, fresh, raw	31	1.7	72	29	0.9	3.0		1
Onion	50	1.60	0	8	0.7	0.2		10
onion, cooked	44	1.36	0	5	0.2	0.2		5
Onion, raw	32	1.1	1	7	0.5	0.2		1
Orange, raw	45	0.8	17	47	0.1	0.1		1
Orange, sweet, fresh	52	0.50	6	65	0.4	0.7		10
Pak kha yeng, raw	32	1.50	18	5	5.2	1.0		10
Passion Fruit	94	2.4	64	17	1.2	0.0		3
Pineapple, raw	56	0.4	15	31	0.5	2.2		1
Pomelo (grapefruit), raw	34	0.8	40	44	0.6	0.1		4
Radish, boiled	24	1.2	0	9	0.5	0.4		9
Radish, raw	18	0.9	0	17	0.4	0.4		9
Rumbutam, fresh	69	0.90	0	43	0.7	0.1		10
Shallot, bulb	67	1.70	1	9	0.9	0.3		10
Spring onion, fresh	44	2.20	475	42	2.3	0.4		10
Star fruit	32	0.60	10	29	0.7	0.0		11
Tamarind, fruit, raw	60	2.2	2	10	0.7	0.0		1
Tiliacora triandra diels	95	5.60	329	141	7.0	0.6		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Tomato, fresh	25	1.00	88	29	0.9	0.2		10
Tomato, raw	21	1	127	29	0.9	12.0		1
Tomato, red, ripe, cooked	18	0.95	24	23	0.7	0.1		5
Watermelon, fruit, raw	30	0.5	62	7	0.2	0.1		1
Yard long bean, green, fresh	40	2.60	41	20	0.8	0.5		10
8. Fats and Oils								
Butter, cow's milk	700	1	1060	0	0.2	0.1		1
Coconut oil	900	0	0	0	1.5	0.0		1
Ghee, cow	898	0	0	0	0.2	0.0		9
Groundnut oil	903	0	0	0	0.0	0.0		1
Mustard oil	900	0	0	0	0.0	0.0		9
Palm oil	895	0	0	0	0.4	0.0		1
Vegetable oil	884	0	0	0	0.0	0.0		4
9. Miscellaneous								
Fermented fish, liquid	13	1.20	3	0	2.9	0.1		10
Fish souce	48	5.40	5	1	2.4	0.2		10
Honey	322	0.3	0	2	0.6	2.0		1
Horse tamarind, seeds	152	11.8	34	2	4.3	1.4		10
Jaggery	383	0.4	160	0	11.1	0.0		8
Lemon, juice, fresh	24	0.50	1	25	0.1	0.1		10
Oyster sauce	73	2.90	6	7	1.1	0.1		10
Pumpkin seeds, without shell, roasted	594	25.6	0	0	6.0	8.0		11
Salt	0	0	0	0	0.3	0.1		5
Sesame seeds, white, roasted	682	26.1	0	0	13.0	7.2		10
Shrimp paste	85	4.60	21	0	2.2	1.1		10
Sprinkles (per sachet)	0	0	300	30	12.5	5.0		8
Sugar (white), not fortified	369	0	0	0	0.2	0.1		1
Tumeric, dried	335	6.9	1	0	33.2	3.8		9
Vinegar	27	0.2	0	0	0.5	0.0		1
10. Additional Foods								
Banana Porridge	105.3	0.6	65.6	9	0.4	0.1		7
Cassava Stiff Porridge	140	2.7	1.4	7	1.2	0.6		7
Coconut juice, fresh	37	0.10	0	5	0.1	0.2		10
Coconut milk	185	1.90	0	2	0.6	0.5		10
Deep fried banana with powder	373	2.00	11	8	0.4	0.1		10
Maize Porridge (with oil)	414.4	16.9	0.6	1	5.6	2.6		7
Porridge, white rice, boiled	59	4.10	0	0	0.1	0.2		10
Soy milk, Lactasoy brand	82	2.50	40	0	0.4	0.1		10

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Menu A:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

Menu B:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

The PD/Hearth Menu Calculation Tool is developed to aid in designing low cost and nutrient-dense menus for Hearth sessions using local foods/ingredients that are easily accessible and available to community members. Based on the PDI findings and the market survey, 2-4 Hearth menus with a snack and a meal for each menu will be developed for each community using PD food(s) and locally sourced ingredients. To quickly rehabilitate children from malnutrition, Hearth menus need to meet optimal calorie and nutrient requirements[1]. Particularly, this Tool is useful in checking whether the meal and snack meet the requirements. Also it simplifies other calculations such as the total cost and quantity of ingredients required for all the children attending Hearth as these can be generated automatically.

The PD/Hearth Menu Calculation Tool has six tabs/worksheets: Introduction; Instructions; Master; Menu Day 1; Menu Day 2; Menu Day 3.

Tab 1 – Introduction: Contains a background information on the rationale for the Tool including who should be using this Tool and how it should be used.

Tab 2 – Instructions: Contains a step-by-step detailed guide on how to use the Master and Menu worksheets. Please refer to this worksheet as you design the Hearth menus.

Tab 3 – Master: Contains a Food Composition Table with the nutritional breakdown of 100 grams of edible portions of foods in terms of energy (Kcal), protein (g), Vitamin A RAE (mcg), Iron (mg) and Zinc (mg). The foods are categorised in 10 food groups: 1. Grains, roots, and Tubers; 2. Legumes and nuts; 3. Dairy products; 4. Flesh foods; 5. Eggs; 6. Vitamin A rich fruits and vegetables; 7. Other fruits and vegetables; 8. Fats and oils; 9. Miscellaneous; and 10. Additional foods (In cases where local food items are missing from this Master list, missing foods can be added to 'Additional foods' group by copying the energy and nutrient values from another food composition table).

Tab 4 – Menu Day 1: Contains a Menu Planning Form (calculates the menu requirements for ONE CHILD) and a table that allows automatic calculation of the cost and quantity of each ingredient required in the menu to feed 'X' number of children, depending on the number of participating children in Hearth sessions. The total cost of the menu for all children is also given.

Tabs 5 and 6 – Menu Day 2 and Day 3: Contains additional worksheets (same format as Menu Day 1) to create different menus. Most Hearth sessions should have at least 2 Hearth menus. You should consider changes in food availability or affordability at different seasons (e.g. dry vs. rainy season) when designing Hearth menus. For example, you may want to create a menu for each season. Also, you could inform caregivers of foods you could replace certain ingredients with so that they will be able to continuously use the Hearth menu to feed their children during various seasons.

Step-by-Step Instructions:

Based on the PDI findings and the market survey results, create Hearth menus.

1. (Master worksheet) Enter cost of each food in Cost for Raw Foods column identified from the market survey. Please note that cost should be entered per 100g of edible portion of the raw food (See Step 1 of the Instructions sheet for an example).

1. Hearth menus should meet the following energy and nutrient requirements: Energy: 600-800 kcal; Protein: 25-27g; Vitamin A: 300 mcg RAE; Iron: 8-10 mg; Zinc: 3-5 mg; and Vitamin C: 15-25 mg.

2. (Menu Day 1 worksheet) In the Menu Planning Form, use the drop down option to select the food group of choice and then use the drop down option to select the ingredient/food under the Food column, placing each ingredient under appropriate headings (i.e. Meal or Snack).

3. (Menu Day 1 worksheet) Enter quantity in grams for each ingredient under the Quantity (grams) column. Please note that this amount is 'cooked' values in grams that will be used in the menu for ONE child. See Step 3 of the Instructions sheet for how to estimate the amount of ingredient keeping in mind the cook/raw conversions.

4. (Menu Day worksheet) Repeat Step 2 and 3 for each food you will use. You can also enter the household measure for the ingredients for the raw amounts indicated in the Raw Quantity (grams) column.

5. (Menu Day worksheet) Once you finish entering all the ingredients/foods for the menu, you can check at the bottom of the Menu Planning Form to see whether you have met or exceeded the Hearth menu requirements.

    a. The total values for each nutrient, cost, and 'cooked' quantity of ingredients in the menu for one child are calculated automatically in the row number 36. Depending on the values displayed under each column, you may need to adjust quantity of each ingredient or select different ingredient to develop optimal Hearth menus.

    b. You can check by comparing the total values for each column against what is displayed in each column heading. Or, in the subsequent row, any discrepancies or differences between the total value of each nutrient in the menu and the amount of the same nutrient required in Hearth menu are available. If the menu meets all the nutrient requirements, then all the numbers in red/bracket will be "0". Try to adjust the quantities and/or types of foods included in the menu until you reach something very close to the required amount of nutrient.

    c. The values in red/bracket indicate that these nutrients need to be increased by adding foods/ ingredients that are high in these nutrients. For example, if the cell under the Iron column has "(3.50)", then you would need to increase amount of iron by 3.50 mg, by increasing quantity or adding iron rich foods like chicken or fish, still being mindful of the cost.

    d. Also the total quantity of 'cooked' foods should not be too much considering that a child has a small stomach (the size of a child's fist) and will not be able to eat a large volume of food at one sitting. Thus, depending on the total quantity (grams), you may need to select more nutrient dense food. For example, instead of selecting rice you may opt to select groundnut which will have more calories and proteins per gram basis.

6. (Menu Day worksheet) To calculate the total cost and quantity of ingredients required for the total number of children participating in Hearth sessions, enter the number of children who will be eating in a designated cell in the table below the Menu Planning Form chart. Also, determine a household measure for raw food amounts required for each ingredient from the Raw Quantity in grams column so that volunteers will know how much of uncooked ingredients will be needed for the Hearth menu. See Step 5 of the Instructions sheet for additional details.

Several elements are essential to the implementation of an effective PD/Hearth project. Experience has shown that these elements cannot be adapted, modified, or omitted without seriously diminishing the effectiveness of the programme.

1. **Actively involve the community throughout the process.** Community leaders and a village health committee can provide support in organising the weighing of all children in the target age group; recruiting volunteers; conducting the PDI; contributing materials, utensils, and food for the sessions; assuring that eligible caregivers[1] attend the Hearth session regularly; and encouraging other community members, including key influencers like grandmothers, to support the families with malnourished children as they adopt new practices. Grandmothers[2] often play a major role in child care and feeding and act as advisors in this area to younger women who seek their advice and expertise. Engaging grandmothers from the start of the PD/Hearth implementation will facilitate the community's involvement and learning as grandmothers are key influencers in addressing child malnutrition. In the different steps of the PD/Hearth process, grandmothers can participate as mobilisers, hearth committee members and/or volunteers, participants in focus group discussions on child care and feeding, those being talked to and observed during the PDI, participants in Hearth sessions with the caregivers and children, key audience members in community feedback sessions, and supporters and advisors at home for the caregivers. The community can participate in monitoring project implementation and results. The higher the visibility of Hearth in the community, the greater the nutritional impact will be. Hearth sessions provide "living proof" that good nutrition practices help malnourished children. This raises the consciousness of community members and empowers them to prevent malnutrition within their community.

2. **Use growth monitoring to identify malnourished children and monitor the nutritional status of participants who have graduated from Hearth**. If a growth-monitoring and counselling programme does not exist in the community when PD/Hearth is initiated, it should be started in time to monitor the children who complete the Hearth session. The growth-monitoring programme must include good nutrition counselling and explanations of the child's growth for the caregivers. It is also an important tool for monitoring the progress of *all* the children in the target group over time, and it allows the integration of newly malnourished children into the second or third Hearth session.

3. **Use community members and staff in each and every community to conduct a Positive Deviance Inquiry.** The PDI is not simply a fact-finding exercise for the project staff. It is an opportunity for community members (e.g. Hearth volunteers, health staff, community leaders, grandmothers) to 'discover' that very poor families have certain good practices which enable them to prevent malnutrition and that these practices can be used by any family with similarly scarce resources. In order for a community to take ownership, the discovery process must take place in *that* community. Each community or communities within 40km radius with similar cultural practices, belief, and food availability need its own PDI to discover its positive deviance (PD) practices. Many programmes have tried to save time by using the PDI results from one community in another; doing

1. The term caregiver refers to anyone who has significant responsibility for the care and feeding of a young child. This may be a parent, grandparent and/or older sibling, depending on the cultural context and family situation. In some cases two caregivers, such as a mother-grandmother pair, may attend the Hearth sessions.
2. A grandmother refers to a senior woman (related or unrelated to the child) who lives in close proximity to the child and who has influence on child care.

so means that the second community loses the process of the discovery that results from the PDI. If there are no poor families with well-nourished children in a particular community, the PDI may need to look at families with only mildly malnourished children. Alternatively, if the community can identify a nearby community with the same culture, socioeconomic conditions and, perhaps, blood relationships, the volunteers can be taken there to identify PD families with whom to conduct the PDI. Since family coping may change with the seasons, it may be necessary to repeat the PDI during different seasons of the year.

The PDI consists both of questioning the family members, including caregivers and grandmothers, and of making careful observations of the situation. The list of questions that has been developed is best used as a discussion guide rather than as interview questions. With sufficient practice the PDI team should be able to visit the families without relying on the list of questions. A second or third person from the PDI team can concentrate on observing practices related to child care, hygiene, sanitation and food preparation, noting the roles of influential family members as well as what foods and materials are available in the home. Projects need to allow sufficient time to prepare for and conduct PDI visits to obtain the most useful information.

4. **Prior to the Hearth sessions, deworm all children, update immunisations and provide needed micronutrients.** Children are more likely to show quick recuperation when these important health interventions are taken care of before the Hearth session. Families should be referred for these services to the local health facility with whom the project is collaborating. These activities are kept separate from the Hearth session so that families do not attribute the child's improvement in nutritional status to these activities rather than to the food and feeding practices. During the Hearth session and follow-up home visits families will be encouraged to continue to access these and other preventive health services including growth monitoring and the use of insecticide-treated bed nets (ITNs), where needed. In areas of high malaria prevalence, children may need diagnosis and treatment before attending the Hearth sessions. If it becomes evident during the PDI that very poor families are using ITNs, it will be useful to discuss how they afford them in order to share that information with the Hearth participants. All children may be checked for underlying illness and/or anaemia before entering Hearth to screen for treatable conditions.

5. **Utilise community men and women as volunteers to conduct the Hearth sessions and the follow-up home visits.** Caregivers will learn best from those who normally provide child care advice and support within their culture and community, and who understand local customs and conditions. The volunteers can be any community members, including grandmothers, with a good reputation, credibility, healthy children and a willingness to take on the necessary responsibilities.

   Note: *PD caregivers are not necessarily Hearth volunteers. The PDI results in a collection of PD practices from multiple PD families; it is extremely rare that one family models all the PD practices. We are not looking for PD persons but PD practices. In many cultures identifying individuals or families as models (or somehow 'better') results in social rejection by their peers.*

6. **Design optimal Hearth menus based on locally available and affordable foods.** Participating families must be able to replicate meals in their own homes with limited resources. This is the only way they will be able to sustain the improved nutritional status of their children and prevent future malnutrition in the family. The affordability of foods is verified through the PDI, which

discovers the foods used by the poor families with well-nourished children, and the market survey, which explores the costs and nutritional content of foods available for purchase.

7. **Provide a special, nutrient-dense meal capable of ensuring the rapid recuperation of the child.** The daily Hearth menu includes an extra meal and snack, an addition to what the child normally eats at home in one day. This menu must contain the following nutrient levels for each child:

Calories:	600–800 kcal
Protein:	25–27 g
Vitamin A:	400–500 µg RE (retinol equivalent) or 300 µg RAE (retinol activity equivalent)
Iron:	8–10 mg (may need iron supplementation or a fortified product to meet this requirement)
Zinc:	3–5 mg
Vitamin C:	15–25 mg

These figures show the range of supplementary nutrient levels necessary to rehabilitate malnourished children. Specific levels for children of different ages are listed in the *CORE PD/Hearth Guide*. Consider the Hearth meal as 'medicine'; this is the dosage prescribed. If the Hearth supplemental meal does not meet this minimum standard, then weight gains are compromised. The meal is a supplement, not a meal substitute. The additional calories and protein are needed for 'catch-up' growth of the child. When the child is no longer underweight, this 'extra' energy and protein-rich meal is no longer necessary. However, to sustain the rehabilitation gains, regular family meals need to be more balanced and nutritious. Caregivers learn how to do this during the Hearth sessions.

8. **Ensure that caregivers bring a daily contribution of food and/or materials to the Hearth sessions.** One of the fundamentals of PD/Hearth is that families learn that they really can afford to feed their children nutritious food. The PDI revealed what poor families feed their well-nourished children. Obtaining and bringing the foods reinforces the use of these affordable foods. The community also realises it is able to rehabilitate its malnourished children without outside material support.

9. **Have caregivers present and actively involved every day of the Hearth sessions.** Involvement promotes ownership and active learning and builds self-confidence. Repetition of new skills and practices enables caregivers to learn and adopt new behaviours. Attendance and active involvement of caregivers each day of the Hearth sessions is necessary for children to achieve adequate weight gain.

10. **Conduct the Hearth session for 10–12 days within a two-week period.** Within 8–12 days of starting the Hearth sessions caregivers will see notable improvement in their children. They may need some guidance to recognise the changes in their child, such as improved appetite, increased activity, less irritability, higher level of alertness. Recognising these changes motivates the caregivers to adopt new feeding, caring and health practices. If a child is not fed the special extra meal over sequential days, recovery will be so slow that the caregiver will not have the satisfaction and motivation to continue the programme. There may be breaks of one or two days during the Hearth

sessions to allow for weekends, holidays, or market days *(e.g. 4 days + market day + 4 days + market day + 4 days)*. The family must be encouraged to prepare the special meal at home on the days off. This Hearth session may be repeated the next month as some children will not experience 'catch-up' growth within a month.

11. **Include follow-up visits at home every 2–3 days for two weeks after the Hearth session.** It takes an average of 21 days of practice for a new behaviour to become a habit. The caregivers will need continued support to implement the new practices in their own homes. During home visits the volunteers or staff can help caregivers think of solutions to any difficulties they are encountering or respond to concerns about the child's progress, and can support grandmothers in their role as household advisors to facilitate positive changes in child care and feeding. By continuing to practise these new behaviours, the improved nutritional status of the participating child will be sustained at home and malnutrition will be prevented among future children.

12. **Refer a child who doesn't gain weight after two 10–12 day sessions to a health facility to check for any underlying causes of illness such as tuberculosis, HIV/ AIDS, or other infection**. If the child does not have an illness, direct families to other social services or to income-generation projects. The average number of sessions it takes to graduate a child varies among programmes, but the number of sessions a caregiver can attend is normally limited to two; otherwise, caregivers may become dependent on Hearth and not internalise new behaviours. A sense of urgency to rehabilitate a malnourished child should be instilled and encouraged in the caregiver and family. However, some children may need more time to gain weight. (Some projects opt to have all children checked for underlying illness before entering Hearth to screen for treatable diseases.)

13. **Limit the number of participants in each Hearth session.** Having a limited number of participants provides a 'safe' environment in which rapport can be built, and it gives all caregivers an equal opportunity to participate in all activities. Experience has shown that Hearth sessions are most successful when limited to no more than ten caregivers or five caregiver-grandmother pairs.

14. **Monitor and evaluate progress.** At a minimum, projects should monitor Hearth attendance, admission and one-month weights, and the percent of children who graduate after one session or after two sessions. Depending on community goals and national protocols, graduation may be determined as 400g weight gain in one month; an upward growth trend on the growth curve during two months; moving up one level (e.g. from moderate to mild malnutrition); or achieving normal weight for age. Projects monitor the longer-term impact by measuring the weight gains of participants two months, six months and one year after graduation, and by tracking growth of younger siblings and the target age group over time. Projects may develop other indicators to monitor the quality of implementation, community support, and so forth. Many examples of such indicators are given in the *CORE PD/Hearth Guide*.

Essential Elements of PD/Hearth
Detailed Observations and Key Questions

Summary components and sample questions to guide discussion on essential elements

Essential PD/Hearth project elements	Key questions to consider
1. Actively involve the community throughout the process. Leaders and/or the village health committee (VHC) provide support in organising weighings, finding volunteers, conducting PDIs, contributing supplies and participate in monitoring implementation/results. Individuals with influence on child care and feeding, particularly grandmothers, are engaged as advisors, mobilisers, volunteers, Hearth participants etc. The higher the exposure and involvement, the greater the impact on community overall nutrition status. Raising the consciousness of the community is empowering.	• How was the community mobilised? • What did the community contribute to the project? • How were grandmother and other influential figures engaged? • What information was given back to the community? When? • Have structures/policies that support child nutrition changed? • Was PD/Hearth integrated with other programmes/ sectors? How was this achieved? What were the results?
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated. If growth monitoring is not already in place, begin monitoring those who complete Hearth sessions and all children in target group over time. Growth monitoring must include counselling and explanations of a child's growth.	• Is routine growth monitoring present in the community? • Is counselling included? • How are children monitored after graduation?
3. Conduct a PDI in every community. A PDI is an opportunity for the community to make discoveries, not just to provide information to WV. To ensure community ownership, integrate the PDI into the Hearth sessions. A PDI may need to be done at different seasons. The goal is to identify PD practices, not only PD person.	• How were the families to visit identified? • How was the PDI conducted? By whom? • How was information analysed? • Were PD foods/practices identified? • How were grandmothers involved? • How was the information utilised? Menus/ messages? • Was there sufficient technical skill to complete the PDI well?
4. Prior to sessions, deworm all children and provide immunisations and micronutrients. The purpose is to support rapid recuperation. Refer families to the local health centre before Hearth sessions so recuperation is not attributed to these activities. In endemic areas, malaria may need treatment before Hearth sessions.	• Was a situation analysis completed (nutritional assessment, feeding practices, expanded programme of immunisation coverage, vitamin A)? • Were all children under three years of age weighed? • Were children dewormed, immunised, vitamin A supplementation completed? • Were pre-existing underlying illnesses treated?

Essential Elements of PD/Hearth Detailed Observations and Key Questions

Essential PD/Hearth project elements	Key questions to consider
5. Use community volunteers to conduct sessions and follow-up home visits. Caregivers will be more comfortable and learn best from peers. A volunteer can be any community member, either male or female, who has a good reputation, is credible, has children in good health, and is willing to take on responsibilities.	• How were Hearth volunteers selected? • How were Hearth volunteers trained? • Were there gaps in the key competencies needed to implement the programme effectively?
6. Design Hearth session menus based on locally available and affordable foods. This is necessary to promote replication in home with limited resources in order to sustain improved nutritional status. Use foods confirmed through the PDI and verify the cost/ nutritional content through a market survey.	• Was a market survey completed? • Were PD foods identified? • Were the foods local, available and affordable?
7. Hearth session menus are nutrient dense to ensure rapid recuperation. Menu plus snack must contain required protein, calories and micronutrients to provide 'catch-up' growth The Hearth meal is 'medicine'. The extra meal is a supplement, not a meal substitute. To sustain the rehabilitation, families learn that meals need to be balanced and nutritious.	• Who decided on the menus? When? • Were menus nutrient dense (by programme standards)? • Who analysed the menus? • Were the menus followed in sessions? • Were the menu followed at home?
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth. This reinforces the fact that families can afford to feed nutritious food. The contributions make implementation possible without outside material support. Families providing resources ensures that the programme is non-paternalistic	• Were PD foods identified? • Did caregivers contribute PD foods? Other foods?
9. Have caregivers present and actively involved every day of the Hearth session. This promotes ownership, active learning and confidence. Repetition of practices builds habits that sustain rehabilitation and prevent malnutrition. Daily attendance is necessary to achieve weight gain.	• Was a caregiver involved with each child? Did caregiver-grandmother pairs work together where appropriate? • Did all caregivers participate in all the activities every day of the programme?

Essential PD/Hearth project elements	Key questions to consider
10. Conduct the Hearth session for 10–12 days within a two-week period. Eight to twelve days are needed to see changes in the child. Caregivers may need help to identify improvement in appetite, energy, alertness, less irritability, and so forth. Changes in the child motivate caregivers to adopt and continue the new practices. If the child is not fed an extra meal over sequential days, changes are too slow for the caregiver to notice.	• Were PD/Hearth sessions conducted for 10-12 days? • What were attendance rates? • Was time spent reflecting with caregivers about changes in child?
11. Include follow-up home visits (every 2–3 days) for two weeks after the session. Caregivers need continued support. It takes 21 days to change a behaviour into a habit. Home visits help find solutions to obstacles to adopting new practices that are being faced at home. Home visits provide opportunities to address questions families may have about the child's growth.	• What did follow-up visits include? How often did they occur? By whom? • Did volunteers have the information and skills to support families in overcoming obstacles to child feeding/growth?
12. If a child doesn't gain after two sessions, refer the child to the health centre. A child with no underlying health issues who is not gaining may need referral to other social-services or income-generation projects. A sense of urgency to rehabilitate the child is needed by caregivers, families and volunteers.	• What happened if a child became sick during the session(s)? • Under what circumstances was a child referred to the health centre?
13. Limit the number of participants in each Hearth session to ten or fewer. A limited number of participants provides a 'safe' environment where rapport can be built. Caregivers have an equal opportunity to participate in all activities.	• How many children attended the sessions? • How many caregivers or caregiver-grandmother pairs attended the sessions? • Did caregivers participate in all aspects of the sessions?
14. Monitor and evaluate progress. Record attendance, entering and one-month weight, the percent of children who graduate. Check the long-term impact by measuring weight gain at two or six months, one year, and monitor the weight of younger children.	• Were graduation criteria established? • Was monitoring information used to improve implementation? When? How? • Was there adequate technical support for managers? For volunteers? • Was supervision frequent enough? Was it adequate?

1st case: Aisha is three years old, and an only child. After two Hearth sessions, she has gained 800 grams but is still moderately malnourished. Her mother, who is pregnant, appears to be following the new PD behaviours and working hard to rehabilitate Aisha, but she is becoming discouraged. The grandmother is taking care of Aisha during her pregnancy and advising her to continue feeding Aisha with what they learned at Hearth. The grandmother is confused that her daughter-in-law is discouraged and that the volunteers say that Aisha is still malnourished when she is looking very healthy, active and growing well.

2nd case: Tobir Village has many malnourished children, and Hearth sessions are proceeding well. However, some segments of the population are semi-nomadic, moving with the seasons to find work. Though these caregivers have been enthusiastic participants, it is difficult to follow their children during the dry season. Many return during the rainy season having lost weight again.

3rd case: Daniel is 23 months old. He and his mother (who also has two older children) just completed one Hearth session. His weight has not improved. The supervisor suspects, from her home visits, that the mother is preparing some extra food but sharing it with the whole family. The grandmother may support sharing the extra food with the entire family too.

4th case: During the sessions Budi gained 500 grams. By the end of the follow-up period he had lost the 500 grams.

Checklist of Materials Needed for PD/Hearth Sessions

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice,fufu, yams)			
Oil			
Other ingredients			

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 3	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 5	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

No.	DAY 7	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
No.	**DAY 9**	INGREDIENTS	COOKING MATERIALS	ROLE	**DAY 10**	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
No.	**DAY 11**	INGREDIENTS	COOKING MATERIALS	ROLE	**DAY 12**	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Child Registration and Attendance Form

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates (dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Hearth Participant Child AND Primary Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Child Registration and Attendance Form (including Grandmothers)

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name/Grandmother Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Child and Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

#	**Attendance for Grandmother**											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Hearth Register and Monitoring Form

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

Child's Name										
Caregiver's Name										
CHILD		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Child's Sex (M/F)										
Date of Birth (dd/mm/yyyy)										
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')										
At Day 1 of Hearth	Date (dd/mm/yyyy)									
	Weight (Kg)*									
	Underweight Nutritional Status (Indicate colour)									
	MUAC (Green, yellow, red < 115mm)									
At Day 12 of Hearth	Date (dd/mm/yyyy)									
	Weight (Kg)*									
	Weight Gain (Day 12 - Day 1) in grams									
	Underweight Nutritional Status (Indicate colour)									
	MUAC (Optional)									

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Hearth Register and Monitoring Form

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

	CHILD	1	2	3	4	5	6	7	8	9	10
At Day 30 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight gain (Month 1 - Day 1 weight) in grams										
	Gained 400g+ (Y/N)										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 3 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	Change in Status (Y/N)										
	MUAC (Optional)										
At 6 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 12 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
	CHILD	1	2	3	4	5	6	7	8	9	10
	COMMENTS (Explain reason for default if child has defaulted due to death (D), migration (M), referred to hospital (H), etc.)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Volunteer Home Visit Form

ADP Name ..... Village Name .....Caregiver's Name .....

Child's Name ..... Dates of Sessions.....Name of Hearth .....Volunteer .....

OBSERVATION LIST	Day #	Day #	Day #	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.							
Drinking water from safe source (borehole or protected well)							
Water is treated (Boiled/ chlorine)							
Water is covered with fitted cover or lid							
Clean separate cup is used for pouring drinking water from the pot							
Handwashing station exists (e.g. tippy tap)							
Jerry cans or water storage containers are clean							
Toilet/latrine is available and used or hole is dug and covered for defecation							
House and/or kitchen is clean							
Food utensils are clean							
Handwashing with running water and soap is practised by: Caregivers							
Children							
Other family members							
Food prepared is nutrient dense as learned in Hearth (includes all 3 food groups: protective, body building and energy foods)							
Size of portion served is age appropriate							
Caregiver actively feeds the child							
Child is offered more food after finishing first portion							
Caregiver says child is fed 4 - 5 times / day (including snacks)							
Child uses separate (own) plate, bowl, or cup							
Caregiver is motivated by changes in the child							
Yesterday night, mosquito net was used by the primary caregiver and all children U5 in the household							
Caregiver can say what to do when child is sick (example: feeds more liquid when child has diarrhea and feeds more frequently)							
Caregiver expresses being able to continue practising what was learned in Hearth at home							
Problems and questions about child feeding and care is discussed with the volunteer							

Supervision of PD/Hearth Session

World Vision

HANDOUT 36.6

Day 8 Session 36

Village Name ..... Hearth Name .....

Volunteer's Name(s) .....Today's Date.....

OBSERVATION LIST	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.				
Location of Session:				
Water is from safe source (borehole or protected well or protected spring)				
Water is treated (Boiled/ chlorine)				
Toilet/latrine available				
Handwashing station with soap exists (e.g. tippy tap)				
House is clean				
Food utensils are clean				
Session Is conducted by volunteers and/or lead mother				
Primary caregivers are assigned roles during Hearth				
Primary caregivers are the ones cooking the meal				
Primary caregivers can tell you how to cook Hearth menu for one child (using household measures)				
Number of caregivers attending				
Number of children attending				
Evidence of community participation/support				
Hand Washing is practised: by caregivers				
by children				
Number of caregivers who bring contribution to meal				
Menu used based on local and affordable food				
Menu is nutrient dense				
Food is prepared according to menu				
Consistency of Hearth meal is thick enough to slowly run on a spoon (not runny like water)				
Snack is given to children as the caregivers cook the Hearth meal				
Caregivers can recite different types of protective, body building and energy-giving foods				
Number of caregivers present and actively participating:				
in food preparation				
in child care				
in discussion of key messages				
Size of portion served is age appropriate				
Number of caregivers who actively feed their child				
Number of children who eat entire portion				
Number of children who are offered more food				
Key message discussed during PD/Hearth supervision visit				
Caregivers express being motivated by changes in child				
Caregivers can say what to do when child is sick				

PD/Hearth Annual Report

World Vision

Day 8 Session 36

PD/Hearth ADP Facilitator _____	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Total
In PD/Hearth Session (12 days) Weight gain (in grams) # of children	# of children												
Catch up (graduation): ≥ 200g													
Inadequate: < 200g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
In Rotation at 1 month (12 days + 2 weeks follow up) Weight gain (in grams)	# of children												
Catch up (graduation): ≥ 400g													
Inadequate: <400g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 3 months post hearth	# of children												
Adequate weight gain ≥ 900g													
Inadequate weight gain < 900g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 6 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Follow up at 12 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Total number of Re-admissions													
Round/Session #2													
Round/Session #3													

Monitoring Case Study Data Sheet

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth			At Day 12 of Hearth				At Day 30 of Hearth				
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
1	Shadin	1	m	26/03/2005	24	12/03/2007	7.5		24/3/2007	8.3	0.8		12/4/2007	8.3				
2	Jenia	1	f	01/02/2006	13	12/03/2007	7		24/3/2007	7.6	0.6		12/4/2007	7.6				
3	Helena	1	f	27/08/2005	19	12/03/2007	9.8		24/3/2007	10.1	0.3		12/4/2007	9.9				
4	Kalpana	1	f	05/10/2005	17	12/03/2007	7.5		24/3/2007	7.5	0.0		12/4/2007	7.5				
5	Saidur	1	m	21/10/2005	17	12/03/2007	6.6		24/3/2007	7.2	0.6		12/4/2007	7.3				
6	Sumana	1	f	06/06/2006	9	12/03/2007	6		24/3/2007	6.2	0.2		12/4/2007	6.5	0.5			
7	Swourav	1	m	19/02/2005	25	12/03/2007	9		24/3/2007	9.3	0.3		12/4/2007	9.5	0.5			
8	Simul	1	m	17/02/2005	25	12/03/2007	7.6		24/3/2007	7.9	0.3		12/4/2007	7.5	-0.1			
9	Tanvir	1	m	15/08/2005	19	12/03/2007	8.5		24/3/2007	8.7	0.2		12/4/2007	9.0	0.5			
10	Ruman	1	m	28/04/2005	22	12/03/2007	8.9		24/3/2007	8.5	-0.4		12/4/2007	9.4	0.5			
11	Ritu	1	f	11/05/2004	34	12/03/2007	9.7	O	24/3/2007	9.9	0.2	Y	12/4/2007	10.2	0.5	Y	O	N
12	Zashim	1	m	29/01/2005	25	12/03/2007	8.7	R	24/3/2007	9.0	0.3	Y	12/4/2007	9.3	0.6	Y	O	Y
13	Bashakhi	1	f	29/04/2005	22	12/03/2007	8.8	Y	24/3/2007	9.0	0.2	Y	12/4/2007	9.2	0.4	Y	Y	N
14	Sritimoni	1	f	25/10/2005	17	12/03/2007	7.5	O	24/3/2007	7.8	0.3	Y	12/4/2007	7.8	0.3	N	O	N
15	Farjana	1	f	25/03/2006	12	12/03/2007	6	R	24/3/2007	6.5	0.5	Y	12/4/2007	7.1	1.1	Y	O	N
16	Riyon	1	m	25/01/2005	26	12/03/2007	7.9	R	24/3/2007	8.1	0.2	Y	12/4/2007	8.4	0.5	Y	R	N
17	Sharmin	1	m	23/10/2004	29	12/03/2007	9.5	O	24/3/2007	9.7	0.2	Y	12/4/2007	10.2	0.7	Y	O	N
18	Rabbi	1	f	03/09/2004	30	12/03/2007	10	Y	24/3/2007	10.3	0.3	N	12/4/2007	11.0	1.0	Y	Y	N
19	Kurban Ali	1	m	20/01/2006	14	12/03/2007	6.8	R	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	R	N
20	Himel	1	m	11/11/2005	16	12/03/2007	7.2	R	24/3/2007	7.2	0.0	N	12/4/2007	7	-0.2	N	R	N
21	Anika	1	f	29/03/2004	35	12/03/2007	9.8	O	24/3/2007	10.0	0.2	Y	12/4/2007	10.5	0.7	Y	O	N
22	Afra Abiyat	1	f	29/03/2004	35	12/03/2007	10.5	O	24/3/2007	10.8	0.3	Y	12/4/2007	10.9	0.4	Y	Y	Y
23	Laboni	1	f	25/11/2005	16	12/03/2007	7.3	O	24/3/2007	7.5	0.2	Y	12/4/2007	7.2	-0.1	N	O	N

Monitoring Case Study Data Sheet

Day 8 Session 36

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth				At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
24	Maruf	1	m	01/07/2006	8	12/03/2007	10.5	G	24/3/2007	10.3	-0.2	N	12/4/2007	10.9	0.4	Y	G	N
25	Shanta	1	f	04/02/2006	13	12/03/2007	6.6	R	24/3/2007	6.7	0.1	N	12/4/2007	7.0	0.4	Y	O	Y
26	Jesmin	1	f	27/09/2006	6	12/03/2007	6.8	G	24/3/2007	6.6	-0.2	N	12/4/2007	6.6	-0.2	N	Y	Y
27	Shakib	1	m	01/02/2006	13	12/03/2007	6.8	O	24/3/2007	6.9	0.1	N	12/4/2007	7.1	0.3	N	R	N
28	Shati	1	f	01/02/2006	13	12/03/2007	6.8	O	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	O	N
29	Nurjahan	1	m	01/04/2005	23	12/03/2007	7.4	R	24/3/2007	7.7	0.3	Y	12/4/2007	7.9	0.5	Y	R	N
30	Beauti	1	f	03/04/2005	23	12/03/2007	7.6	R	24/3/2007	7.7	0.1	N	12/4/2007	7.8	0.2	N	R	N
31	Salina	1	f	07/04/2005	23	12/03/2007	9	Y	24/3/2007	9.2	0.2	Y	12/4/2007	9.5	0.5	Y	Y	Y
32	Marjina	1	f	07/09/2004	30	12/03/2007	9.1	O	24/3/2007	6.0	-3.1	N	12/4/2007	9.1	0.0	N	R	Y
33	Alam	1	m	10/07/2004	32	12/03/2007	10.1	O	24/3/2007	10.3	0.2	Y	12/4/2007	10.6	0.5	Y	O	N
34	Shaila	1	f	18/10/2005	17	12/03/2007	7.3	O	24/3/2007	7.9	0.6	Y	12/4/2007	7.9	0.6	Y	O	N
35	Abir	1	m	14/01/2005	26	12/03/2007	9.1	O	24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	Y	O	N
36	Mim	1	f	05/04/2006	11	12/03/2007	6.1	R	24/3/2007	6	-0.1	N	12/4/2007	6.4	0.3	N	O	Y
37	Mamin	1	f	13/02/2006	13	12/03/2007	6.2	R	24/3/2007	6.5	0.3	Y	12/4/2007	6.7	0.5	Y	O	Y
38	Alika	1	f	27/12/2004	27	12/03/2007	8.5	R	24/3/2007	8.8	0.3	Y	12/4/2007	8.9	0.4	Y	O	N
39	Sumia	1	f	05/03/2006	12	12/03/2007	6.1	R	24/3/2007	6	-0.1	N	12/4/2007	6.0	-0.1	N	R	N
40	Nadia	1	f	03/04/2006	11	12/03/2007	10.3	G	24/3/2007	10.6	0.3	Y	12/4/2007	10.8	0.5	Y	G	N
41	Aklima	1	f	01/04/2004	35	12/03/2007	9.1	R	24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	Y	R	N
42	Lipa	1	f	20/04/2004	35	12/03/2007	9.6	R	24/3/2007	9.9	0.3	Y	12/4/2007	10.1	0.5	Y	O	N
43	Mahamuda	1	m	23/05/2004	34	12/03/2007	9.6	R	24/3/2007	9.8	0.2	Y	12/4/2007	9.9	0.3	N	O	Y
44	Shapna	1	f	21/03/2005	24	12/03/2007	9	O	24/3/2007	9.1	0.1	N	12/4/2007	9.5	0.5	Y	Y	N
45	Laboni	1	f	11/12/2004	27	12/03/2007	10	Y	24/3/2007	10.2	0.2	Y	12/4/2007	10.9	0.9	Y	Y	N
46	Maria mim	1	f	02/02/2004	37	12/03/2007	10.2	O	24/3/2007	10.5	0.3	Y	12/4/2007	10.9	0.7	Y	O	N
47	Arif	1	m	25/02/2005	25	12/03/2007	6.9	R	24/3/2007	7	0.1	N	12/4/2007	7.1	0.2	N	R	N
48	Rakkib	1	m	10/03/2004	36	12/03/2007	10	R	24/3/2007	11.2	1.2	Y	12/4/2007	11.1	1.1	Y	Y	Y
49	Sabekun	1	m	25/03/2005	24	12/03/2007	9	O	24/3/2007	10	1.0	Y	12/4/2007	9.6	0.6	Y	Y	Y

#	Name of Child	Child's Sex (M/F)	At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)			
			Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
1	Shadin	m	27	12/06/2007	8.9				12/09/2007	9.5		
2	Jenia	f	16	12/06/2007	8.2				12/09/2007	9.1		
3	Helena	f	22	12/06/2007	10.9				12/09/2007	11.7		
4	Kalpana	f	20	12/06/2007	8.8				12/09/2007	9.6		
5	Saidur	m	20	12/06/2007	6.7				12/09/2007	8.5		
6	Sumana	f	12	12/06/2007	6.9	0.90			12/09/2007	7.8		
7	Swourav	m	28	12/06/2007	10.3	1.30			12/09/2007	10.5		
8	Simul	m	28	12/06/2007	9.3	1.70			12/09/2007	9.8		
9	Tanvir	m	22	12/06/2007	9.6	1.10			12/09/2007	10.4		
10	Ruman	m	25	12/06/2007	9.6	0.70			12/09/2007	10.7		
11	Ritu	f	37	12/06/2007	11.2	1.50	Y	Y	12/09/2007	11.6	Y	N
12	Zashim	m	28	12/06/2007	10.4	1.70	Y	Y	12/09/2007	10.8	Y	N
13	Bashakhi	f	25	12/06/2007	9.7	0.90	Y	Y	12/09/2007	10.7	Y	N
14	Sritimoni	f	20	12/06/2007	8.5	1.00	Y	Y	12/09/2007	9.1	Y	N
15	Farjana	f	15	12/06/2007	7.2	1.20	Y	O	12/09/2007	7.8	O	N
16	Riyon	m	29	12/06/2007	8.9	1.00	Y	R	12/09/2007	10.4	O	N
17	Sharmin	m	32	12/06/2007	10.2	0.70	N	O	12/09/2007	10.8	O	N
18	Rabbi	f	33	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.6	Y	N
19	Kurban Ali	m	17	12/06/2007	8.3	1.50	Y	O	12/09/2007	9.5	Y	N
20	Himel	m	19	12/06/2007	7.8	0.60	N	R	12/09/2007	8.8	O	N
21	Anika	f	38	12/06/2007	11.1	1.30	Y	O	12/09/2007	12.0	Y	N
22	Afra Abiyat	f	38	12/06/2007	11.3	0.80	N	Y	12/09/2007	11.9	Y	N
23	Laboni	f	19	12/06/2007	7.7	0.40	N	O	12/09/2007	8.6	O	N

Monitoring Case Study Data Sheet

#	Name of Child	Child's Sex (M/F)	At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)				
			Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
24	Maruf	m	11	12/06/2007	10.6	0.10	N	G	12/09/2007	11.2	G	Y
25	Shanta	f	16	12/06/2007	8.3	1.70	Y	Y	12/09/2007	9.9	G	Y
26	Jesmin	f	9	12/06/2007	7.2	0.40	N	G	12/09/2007	8.3	G	Y
27	Shakib	m	16	12/06/2007	7.6	0.80	N	O	12/09/2007	8.3	O	N
28	Shati	f	16	12/06/2007	6.9	0.10	N	R	12/09/2007	7.9	O	N
29	Nurjahan	m	26	12/06/2007	9.9	2.50	Y	O	12/09/2007	11.0	Y	N
30	Beauti	f	26	12/06/2007	8.7	1.10	Y	O	12/09/2007	10.4	Y	N
31	Salina	f	26	12/06/2007	9.8	0.80	N	Y	12/09/2007	10.6	Y	N
32	Marjina	f	33	12/06/2007	9.5	0.40	N	O	12/09/2007	10.3	O	N
33	Alam	m	35	12/06/2007	11.2	1.10	Y	Y	12/09/2007	12.1	Y	N
34	Shaila	f	20	12/06/2007	8.5	1.20	Y	Y	12/09/2007	9.3	Y	N
35	Abir	m	29	12/06/2007	10.3	1.20	Y	O	12/09/2007	11.1	Y	N
36	Mim	f	14	12/06/2007	7.4	1.30	Y	O	12/09/2007	8.3	Y	N
37	Mamin	f	16	12/06/2007	7.9	1.70	Y	Y	12/09/2007	8.8	Y	N
38	Alika	f	30	12/06/2007	9.5	1.00	Y	O	12/09/2007	10.4	Y	N
39	Sumia	f	15	12/06/2007	6.8	0.70	N	O	12/09/2007	7.5	O	N
40	Nadia	f	14	12/06/2007	10.8	0.50	N	G	12/09/2007	11.6	G	Y
41	Aklima	f	38	12/06/2007	10.4	1.30	Y	O	12/09/2007	11.4	O	N
42	Lipa	f	38	12/06/2007	11.1	1.50	Y	Y	12/09/2007	12.3	Y	N
43	Mahamuda	m	37	12/06/2007	9.7	0.10	N	R	12/09/2007	11.2	O	N
44	Shapna	f	27	12/06/2007	10.4	1.40	Y	Y	12/09/2007	11.5	G	Y
45	Laboni	f	30	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.8	G	Y
46	Maria mim	f	40	12/06/2007	11.5	1.30	Y	Y	12/09/2007	11.9	Y	N
47	Arif	m	28	12/06/2007	8.4	1.50	Y	R	12/09/2007	9.7	O	N
48	Rakkib	m	39	12/06/2007	11.5	1.50	Y	O	12/09/2007	12.6	Y	N
49	Sabekun	m	27	12/06/2007	9.9	0.90	Y	O	12/09/2007	10.6	Y	N

1. Look carefully at the data sheet from the PD/Hearth sessions at Sunshine Village of Happiness & Light ADP. Children are measured at the beginning of the Hearth sessions. Complete the 'Nutrition Status' column for all children on Day 1.
    a. What questions do you have about this information?
    b. The children are weighed on Day 12, at the end of the sessions. Complete the 'Gained 200g+' column for each child.
    c. Calculate the number and percentage of children who have gained adequately during the Hearth sessions.
    d. What can you say about the Hearth sessions? What is going well? What needs improvement?
    e. Based on this data, what action would you take?

2. The children are measured again one month after the beginning of the Hearth sessions. Complete the 'Weight Gain' and the 'Catch-up' and the 'Nutrition Status' items in the one-month columns.
    a. Calculate the number and percentage of children who have gained adequately during the month.
    b. Calculate the number and percentage of children who have changed their nutrition status.
    c. What does the data tell you about the children?
    d. How many children would you recommend repeat the Hearth sessions?
    e. Choose two children and answer the following questions for each:
        - How has the child progressed? Is this satisfactory?
        - What changes (if any) would you recommend for the child over the next month?
        - How would you explain the child's progress to the caregiver?
    f. What does the data tell you about the Hearth programme?
    g. What action do you need to take?

3. The measurements are repeated three months after the Hearth session. Look at the results and complete the 'Nutrition Status' column using the WAZ (weight for age Z-scores).
    a. Calculate the number and percentage of children who have gained adequately.
    b. Do you see any trends that concern you? What does the data tell you about the programme?
    c. What action do you need to take?

PD/Hearth Monitoring Case Study Questions

4. The children are measured again six months after the hearth sessions. Calculate their nutritional status using WAZ.
    a. Choose two children and answer the following questions for each, using all the data provided in this case study:
        - Describe the child's progress throughout the monitoring period. What could be some reasons for the child's growth pattern?
        - Was the child successfully rehabilitated? How can you tell?
        - How would you follow up with this child?
        - How would you communicate the child's progress and current status to his or her caregiver?
    b. What is your opinion of the overall growth of the children involved in the programme?
    c. How many children were successfully rehabilitated? How can you tell?
    d. What might be some reasons for the growth pattern between three and six months?
    e. How would you follow up with this programme?

The PDH Excel Database is used to compile all the data collected during the initial assessment (situation analysis), PDH registration, and for monitoring and follow up of children in the PDH programme. This allows easier access and utilisation of data by staff. For example, clear summary tables are generated and available under different tabs. From the data collection forms (e.g. Child Registration, Hearth Register and Monitoring Form), staff can transfer recorded information into appropriate cells/columns in the PDH database. Some of the cells/columns contain a drop-down menu or a formula. This formatting is convenient and helps to reduce data entry or calculation errors. For example, child's age (months), underweight nutritional status, WAZ scores, and weight change (g) are calculated automatically.

In the PDH Excel Database, there are eight tabs or worksheets: Initial Assessment; Assessment Report; Monitoring Form; Table; Annual Report; Graph Follow-up; Graph Graduation & Weight Gain; and Graph Default. However, you only need to enter data under two tabs: Initial Assessment and Monitoring Form. All other tabs contain summary charts (e.g. tables, graphs) automatically generated from the compilation of inputted data. ***Please note, when entering the dates, follow the format provided i.e. DD/MM/YYYY.*** Make sure the default date on your computer is set as DD/MM/YYYY for smooth operation of the database. To change the default date format on your computer, see ***Note** below.

Tab 1 – Initial Assessment: Enter the registration, initial nutrition assessment and wealth-ranking data for PDH participant children under this tab. From this data, the PD, non-PD, and negative deviant households are identified and displayed under the "Classification" column.

- First, select an appropriate option for the Wealth Ranking Category (i.e. Very Poor, Poor, Rich or Poor, Non-Poor) and the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu for each at the top of the worksheet.
- Enter values under each column according to the headings. Enter values only in the "WHITE" cells as the values in grey-coloured cells (e.g. Current Age, Underweight Nutritional Status, Classification columns) are calculated automatically by the computer. For the Sex, Oedema, MUAC, Wealth Rank and PDI HHs columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 2 – Assessment Report: This tab contains a table and a pie chart which categorizes the total number of children from the initial assessment based on their underweight nutritional status (i.e. % of children who are normal weight or mildly, moderately or severely underweight). This gives a clear picture of the initial level of childhood malnutrition in the community.

Tab 3 – Monitoring Form: This tab contains a monitoring form to track changes in child's weight, weight-for-age Z score, and underweight nutritional status in the hearth sessions and the follow-ups, including reasons for default. Additional registration information, such as deworming, vitamin A supplementation, presence of oedema, and full immunisation status is also entered under this tab. Based on the child's nutritional status at 3 months, next course of action is identified for each child (i.e. not graduate and repeat hearth, or graduate and continue monitor).

- First, select an appropriate option for the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu at the top of the worksheet.
- Enter values under each column according to the heading. Enter values only in "WHITE" cells as the values in grey-coloured cells (i.e. Current Age, WAZ, Nutritional Status, Weight Change, Adequate Weight Gain columns) are calculated automatically by the computer. For the Oedema, Deworming, Vitamin A Supplementation, Full Immunisation, Sex, Round/Session # and Default Reason columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 4 – Table: This tab contains nine summary tables based on the monitoring data. The tables show the number of children (and %) based on underweight nutritional status at different time points (e.g. baseline, Day 12, Day 30, 3 months, 6 months and 1 year), number of children (and %) with adequate or inadequate weight gain and amount of average weight gain (at Day 12, 30 and 3 months), and number of children (and %) with improvement or no improvement in their nutritional status to mild/healthy status (at Day 12, 30 and 3 months), as well as the breakdown of the reasons for child default from PDH.

Tab 5 – Annual Report: This tab contains a PDH summary report for the selected fiscal year. The table contains information about number of children who gained adequate or inadequate weight in PDH session (Day 12) and at follow ups (1 and 3 months), as well as number of children in different underweight nutritional status categories (i.e. green, yellow, orange, red) at 6 and 12 months post-Hearth. Also, information about the total numbers of children weighed and those who defaulted is provided along with the breakdown of children based on their enrollment (i.e. 1st, 2nd or 3rd round/session).

- To generate a report, enter ADP name and use the drop-down menu to select or enter a fiscal year.

Tab 6 – GRAPH Follow-up: This tab contains a bar graph showing overall changes in underweight nutritional status of PDH participant children (%) at different time points (e.g. baseline/Day 1, 12, 30 of PDH, and 3, 6, 12 months of post-PDH).

Tab 7 – GRAPH Graduation & Weight Gain: This tab contains six pie charts. The first three charts show the percentage of children whose nutritional status improved (i.e. mild/healthy vs. still moderate/severe) at Day 12, Day 30 and 3 months. The last three charts show the percentage of children who gained adequate weight (i.e. ≥ 200g at Day 12; ≥ 400g at Day 30; ≥ 900g at 3 months).

Tab 8 – GRAPH Default: This tab contains a bar graph on child default rate. The breakdown of number of children based on reasons for default at different time points (at Day 12, 30, and 3, 6, 12 months) is given.

NOTE:

To change the default date format on your computer:

1. *Go to Control Panel, click Regional and Language Options.*
2. *Under the Formats tab, click Additional settings (or Customize this format) button.*
3. *Click the Date tab.*
4. *Use the drop-down menu to select "DD/MM/YYYY" as the default Short date format.*
5. *Click Apply and close.*

PD/Hearth Action Plan

Trainer's name:

Who will be trained?

Projected timetable of trainings:

Where trainings will take place? (number and names of communities that will implement this fiscal year):

Steps that will be taken to implement PD/Hearth (indicate rough timeline):

Support required to fulfil plan?

Workshop Evaluation: World Vision PD/Hearth Training of Facilitators Workshop

EVALUATION

Thank you for attending this year's PD/Hearth Training of Facilitators. We hope you enjoyed your time, and that the workshop was a meaningful experience for you. Please take a few minutes to complete this evaluation. Your feedback is valuable and provides helpful information that will be used to plan the next workshop.

1. What did you expect from the workshop?

   _____
   _____
   _____

2. What do you feel was the most helpful part of the workshop? (for example, a particular session, a working group, a contact you made, certain resource material you obtained)

   _____
   _____
   _____

3. Please share some specific ways that you and/or your programme will apply the helpful information you noted in question #2.

   _____
   _____
   _____

4. What do you feel was the least helpful part of the workshop?

   _____
   _____
   _____

5. What would you do to improve this?

   _____
   _____
   _____

6. What would recommend for the next workshop?

   _____
   _____
   _____

7. What themes or topics would you suggest that we focus on or go into in more detail?

   _____
   _____
   _____

8. Should more background information be provided at the beginning of the workshop/training? What information?

   _____
   _____
   _____

Workshop Evaluation: World Vision PD/Hearth Training of Facilitators Workshop

9. Other:

_____
_____
_____

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

For you, what was the highlight of this workshop?

_____
_____
_____

_____
_____
_____

Please share any other comments or suggestions to improve the next World Vision PD/Hearth TOF Workshop.

_____
_____
_____

_____
_____
_____

Thank you for your feedback!

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World Vision

Sustainable Health

FACILITATORS
MANUAL

Training of Facilitators for **Positive Deviance/Hearth**

FIRST EDITION

Nutrition Centre of Expertise

World Vision

Training of Facilitators for Positive Deviance/Hearth

FACILITATORS MANUAL

By Naomi Klaas,
Diane Baik and
Judiann McNulty

WVI Nutrition Centre of Expertise

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World Vision International would appreciate receiving details of any use made of this material in training, research or programme design, implementation or evaluation.

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Table of Contents

World Vision

PLEASE NOTE: There can be more than one page for a handout. Page counts appear in the item lines for any handouts having more than one page. Multiple page handouts are designated on their respective pages as "page # of # pages".

The (page H-#) refers to where each handout appears in the PD/Hearth TOF Handouts. You can reference the "#m" at the bottom of the same handout page as well.

DAY 2

DAY 3

DAY 4

DAY 9

List of Acronyms

ADP	Area Development Programme
ANC	Ante-Natal Care
AOP	Annual Operating Plan
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
DHS	Demographic & Health Survey
DIP	Detailed Implementation Plan
DME	Design, Monitoring & Evaluation
ECCD	Early Childhood Care & Development
EP	Edible Portion
FGD	Focus Group Discussion
GMP	Growth Monitoring Programme
GTRN	Global Technical Resource Network
HAZ	Height for Age Z-score
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
ITN	Insecticide-Treated Bednet
IU	International Units
IYCF	Infant & Young Child Feeding
KPC	Knowledge, Practice & Coverage
MOH	Ministry of Health
MN	Micronutrient
MT	Master Trainer

MUAC	Mid-Upper Arm Circumference
NCOE	Nutrition Centre of Expertise
NHC	Nutrition & Health Coordinator
NGO	Non-Governmental Organisation
OD	Operations Director
ORS	Oral Rehydration Solution
PD	Positive Deviance/Positive Deviant
PDI	Positive Deviant Inquiry
PLA	Participatory Learning for Action
PRA	Participatory Rapid Appraisal
RAE	Retinol Activity Equivalent
RE	Retinol Equivalent
TOF	Trainer of Facilitators/Training of Facilitators
TOT	Trainer of Trainers/Training of Trainers
UNICEF	United Nations Children's Fund
VARK	Visual, Aural, Read/write, Kinesthetic
VHC	Village Health Committee
VHSC	Village Health & Sanitation Committee
WASH	Water, Sanitation & Hygiene
WAZ	Weight-for Age Z-score
WHO	World Health Organisation
WHZ	Weight-for Height Z-score
WV	World Vision

Welcome to the Facilitation Manual for Training of Facilitators (TOFs) for Positive Deviance (PD)/Hearth

INTRODUCTION

Through increasing experience, World Vision (WV) has recognised the need to develop competent Trainers of Facilitators (ToFs) for Positive Deviance/Hearth (PD/Hearth) nutrition programmes implemented within the Area Development Programme (ADP) framework. This manual presents curriculum and exercises based on field experience in many countries representing all regions of the world. Adult learning methodologies – with practical examples, exercises, role plays and field visits – reinforce the principles of strong PD/Hearth programmes.

We trust this manual will enable Trainers to increase the understanding, skill and competency of WV staff and partners in order to rehabilitate malnourished children and prevent future malnutrition through the PD/Hearth programme.

For questions, comments or feedback contact the Nutrition Centre of Expertise:

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About the Curriculum

The training manual provides the framework and materials for a six-day, face-to-face course. It covers all components of the PD/Hearth programme, with emphasis on the essential elements of the methodology and the integration of PD/Hearth into the ADP context. There is more content included in this manual than can be covered in the six days. Facilitators will need to decide which activities are most relevant to the participants and organise their time accordingly.

Participants should have an existing understanding of PD/Hearth principles and concepts as well as experience in implementation. They are expected to personalise this curriculum throughout the course and to adapt the method of presentation for use in their particular context. A group size of 20 participants is recommended in order to maximise interaction and feedback.

Some sessions are held in a classroom setting; others are based in the field, collecting and using field information. Although not absolutely necessary, access to computers during the sessions on calculating nutritional status and the menu calculation exercise could be helpful. Access to a community where there are malnourished children and where community members are willing to work with training participants is necessary. This community, in any World Vision ADP, should be within close proximity to the training site (no more than one hour away).

Introduction

By the end of the course participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level
6. Complete a training curriculum adapted to their country context (National ToF Curriculum and Volunteer Training Curriculum.
7. Practise facilitation techniques for PD/Hearth volunteer training.

PD/Hearth Short Overview

PD/Hearth is an internationally proven community-based model for rehabilitating malnourished children in their own homes. It targets mildly, moderately and severely underweight children aged between 6 and 36 months.[1]

From birth to three years of age, children experience very rapid growth and development. Children who are malnourished during this stage of life will not develop to their full potential. Early malnutrition affects a child's physical, mental, and emotional capacity throughout their entire life. Malnourished children are one of the most vulnerable groups in any community.

'Positive deviance', means 'different in a positive way from what is usual practice'. 'Hearth' refers to the place within a house where food is cooked and served. Despite limited resources, some parents find ways to raise well-nourished children. Identifying and understanding what these 'positive deviant families' are doing differently in their feeding, hygiene, caring, and/or health-seeking practices from the parents of malnourished children in the same community is the foundation for this project. Then volunteers share this knowledge and teach these positive practices to caregivers with malnourished children in practical lessons called 'Hearth sessions'. In addition, two menus are designed for the Hearth session. Each menu is composed of locally available, accessible, and affordable foods that are nutrient dense. All the ingredients are brought to the Hearth session by the participant caregivers who practise cooking the foods at the Hearth session. Hearth lasts for 12 days, followed by a 2 week follow-up conducted by the volunteers through home visits. The purpose of these home visits is to encourage caregivers to continue the positive practices at home, but also to help overcome barriers caregivers may face trying to practise the positive behaviours at home.

1. Some projects expand this range to include children age 6-59 months, that is, all "children under-5", and include mildly underweight children as well.

PD/Hearth empowers communities to take responsibility for addressing the causes of malnutrition by helping to identify local solutions to overcome malnutrition. The PD/Hearth standard model has three main goals:

1. Quickly rehabilitate malnourished children
2. Enable families to sustain the rehabilitation of these children
3. Prevent future malnutrition among all children in the community.

PD/Hearth aligns with World Vision's strategic priorities of ensuring health and nutrition for children in areas in which WV works, as well as WV's commitment to empowerment and sustainability. As of 2013, PD/Hearth has been successfully implemented within WV contexts since 1999, in more than 40 countries, and in all four operational regions of WV.

PD/Hearth Training

The PD/Hearth Training is aimed at building the cadre of staff within World Vision who are qualified and certified as Trainers of Facilitators.

The level of staff targeted is not limited to Support Office (SO), Regional Office (RO), National Office (NO) or ADP, but is instead targeted to staff whose job description requires them to train others in this model. It is intended that this process will help to raise the standard of quality in PD/Hearth training and implementation, and so will contribute to alleviating the burden of undernutrition in WV ADPs.

The ToFs will extensively cover PD/Hearth Methodology, the use of PD/Hearth tools and the menu design. Participants are required to complete assignments during the training and may be expected to facilitate volunteer training sessions during the event that will be graded both by peers and the expert trainers in order to provide feedback on how to improve on facilitation skills[1].

To maintain good standard quality in PD/Hearth training and implementation, there are certain qualifications that need to be met before a participant is approved to become a Facilitator or Co-facilitator. These qualifications include:

The participant has:

a. Successfully completed a PD/Hearth Training of Facilitators (ToFs)
b. Demonstrated clear understanding of PD/Hearth methodology and key principles.
c. Successfully conducted PD/Hearth volunteer training under supervision of a Master Trainer.

1. For countries planning to introduce PD/Hearth, a National level Training of Facilitators for PD/Hearth should take place with facilitation by qualified Master Trainers, preferably from within the region (a list of recommended trainers can be provided upon request to the NCOE). Once training has occurred and experience in PD/Hearth is established then further training and facilitator needs can be planned and budgeted for. This may mean further training of staff, or use of the GTRN network to access qualified Master Trainers.

The number of participants in the ToFs course will be limited to 20 in order to maximise the learning potential of the initial face-to-face training.

At the end of the face-to-face event, each participant will have a one-on-one discussion with the Master Trainer to receive feedback on their performance, and to discuss follow up and requirements in order to complete the certification process.

Full Certification as a Facilitator or Co-facilitator in PD/Hearth will be earned upon:

1. Satisfactory completion of ToFs with a grade of 75% or higher (Facilitator certification with a final grade of 85% or higher; Co-facilitator certification with a final grade of 75-84%)
2. Demonstrate clear understanding of PD/Hearth Methodology and key principles
3. Satisfactory co-facilitation of a PD/Hearth volunteer training, supervised by a Master Trainer

Flow of Training (Refer to summary flow chart on pp. xxv):

Please note: *it is recommended that all PD/Hearth trainings are facilitated by at least 2 Master Trainers.*

National PD/Hearth Training of Facilitators Workshop (National and Sub –National Level):

Purpose: To train the national and sub-national level staff in PD/Hearth Methodology and implementation of the model[2]

Facilitator: Co-facilitated by a Master Trainer Level 3 and at least one other Master Trainer

Participants: National and Sub-national level staff responsible for implementing PD/Hearth in ADPs and training local level staff (See Handout 3.2 for more details). Participants must complete pre-workshop readings and pass two quizzes to qualify for PD/Hearth ToF Workshop.

Duration: 6-12 days of training close to a community/ADP planning to implement PD/Hearth or a community/ADP with PD/Hearth programming. There must be fieldwork incorporated into the training. The number of days required for training may vary depending on whether translation is required and the distance between training venue to the field.

Curriculum: Adapted ToF Curriculum with CORE PD/Hearth manual and orientation of PD/Hearth Volunteer Training manual

2. The first 2-3 days may be set up as an orientation to PD/Hearth, and include national level staff who are responsible for sectors that are integrated with PD/Hearth (examples: Agriculture, Food Security, Economic Development, M&E, Quality Programming, Gender, WASH, Education, Health & HIV/AIDS Coordinators)

Outcome: PD/Hearth ToFs – each participant will be evaluated as either a PD/Hearth Facilitator (able to independently lead PD/Hearth implementation trainings) or Co-facilitator (able to co-lead implementation trainings with a Facilitator).

Volunteer Trainings (Community level):

Purpose: To train community volunteers to fulfill their role in implementation of the PD/Hearth model

Facilitator: Facilitated by at least one PD/Hearth ToF (Facilitator) or co-facilitated by a PD/Hearth ToF (Facilitator) and a PD/Hearth ToF (Co-facilitator)

Participants: Volunteers responsible for implementing PD/Hearth

Duration: 8–10 days at ADP level

Curriculum: PD/H Volunteer Training Manual

Outcome: PD/Hearth Volunteers ready to implement PD/Hearth with all key essential elements

PD/Hearth Competencies

Four levels of PD/Hearth implementers are included:

- Volunteer
- ADP/District-level staff (e.g. Development facilitators, Health and Nutrition Officers, Ministry of Health, Local NGO partners, etc.)
- Regional or Provincial Health and Nutrition Coordinator
- National Health and Nutrition Coordinator

The competencies at each subsequent level are progressive. Each level requires competence in the previous level as well as the skills listed for the level.

PD/Hearth Volunteer

Skill	Volunteer	Knowledge required
Community mobilisation	• Motivational skills • Identify key stakeholders in community • Identify key locations to promote PD/Hearth (e.g. church setting, community meeting, communal gardens) • Mobilise a PD/Hearth Committee (consists of leaders, fathers, grandmothers of community)	• Understand Theory of PD/Hearth and importance of PD/Hearth • Various roles important to success of PD/Hearth in community • Who the decision-makers are at household level
Measuring growth	• Weigh children	• Importance of proper weighing technique • Ability to weigh properly
	• Plot weights on growth chart	• Plot and interpret growth lines
	• Counsel caregivers	• IYCF practices • Communicate effectively with caregivers
Active participation in PDI	• Observation skills	• Factors that contribute to good child growth
	• Semi-structured interview skills	• Asking questions
	• Guided identification of good/bad behaviours	• Reflection of information gathered and how it contributes to child growth
Menu Preparation	• Making menus for Hearth	• Basic food groups • 'Special' (PD) foods • Prep of recipes • Calculating portion size for children

Conduct Hearth sessions	• Motivate/organise children/caregivers to attend Hearth	• Goals of programme • What is a Hearth • How to set up a Hearth • Role of each person
	• Supervise caregivers in cooking meals / feeding children	• Active feeding • IYCF practices
	• Teach simple nutrition/health/hygiene/ caring • messages through example and talking	• Identify good/bad practices (IYCF, illness, care, hygiene) • How to give positive support
	• Monitor attendance, progress, food contributions	• Understand how to complete basic forms • Reflect on the information and what can be done to improve session
Conduct follow up home visits	• Household visits to support caregivers with new behaviours	• Purpose of home visit • Use of Home visit Observation Checklist form • Problem solving with caregiver
Communication	• Communicate concepts and methods with caregivers and community members in simple terms	
	• Report regularly to VHC	• Ability to communicate programme progress and results orally

ADP/District-level Staff

Skill	Supervisor	Knowledge required
Community mobilisation	• Motivational skills • Identify key stakeholders in community • Identify key locations to promote PD/Hearth (e.g. church setting, community meeting, communal gardens) • Mobilise a PD/Hearth Committee (consists of leaders, fathers, grandmothers of community)	• Understand Theory of PD/Hearth and importance of PD/Hearth • Various roles important to success of PD/Hearth in community • Who the decision-makers are at household level

Measuring growth	• Participate in identifying nutrition status of children to select participant children for PD/ Hearth programme (screening should be done monthly to identify new participants to be included in next round of Hearth)	• Motivation/mobilisation of village leaders
	• Teach volunteers to interpret growth charts and counsel caregivers	• GMP technical ability
		• Communication of IYCF practices in simple terms
Situational Analysis	• Nutrition situation • Health services • Market survey	• Participatory Rapid Appraisal (PRA) • UNICEF framework of Causes of Malnutrition
	• Communicate with MoH, village leaders, health providers, volunteers	• Community mobilisation skills
PDI	• Identify PD/NDP/ malnourished children • Assist in PDI	• Principles of PD/H • Concept of PD
	• Train volunteers in PDI	• Adult education principles • Facilitation skills • Participatory assessment skills
	• Lead participants in analysis of PDI information • Develop appropriate key messages and behaviours to promote in each Hearth session.	• Breastfeeding • Complementary Feeding • Hygiene • Illness Prevention and treatment • Early child stimulation • Meal preparation for families • Nutrition and HIV/AIDS
	• Train volunteers in 6 key Hearth messages	
Menu Preparation	• Development of nutrient dense menus-based on PDI • Train volunteers in menu preparation using household measures	• Use of food tables and menu calculation software • Calorie, protein and MN requirements • Basic nutrition principles to be able to substitute recipes

Hearth sessions	• Supervise Hearth sessions	• Assist volunteers in organising set-up of Hearth • Assist in mobilisation of caregivers to attend • Essential Elements of PD/Hearth • Use of 'Supervision Checklist form'
	• Train volunteers in helping caregivers prep meals, actively feed, etc.	
	• Train volunteers in development and presentation of key messages	• Awareness of alternate teaching methods (song, picture, hands-on, example)
	• Supervise and motivate volunteers who run Hearth sessions and PD/Hearth committee	
Monitoring	• Assure implementation of Hearth protocol (hygiene, snack, cooking, feeding, training)	• Use of monitoring sheets to analyse effectiveness of process
	• Create monthly plan for implementing Hearth in geographic area	• Budget development • Logframe development • DIP
	• Ensure Hearth sessions take place monthly	Use of Hearth monitoring form
	• Ensure Day 12, 30, 6 months, 12 month, and 24 month follow-up conducted	• Use of Hearth monitoring form and PD/Hearth database software
	• Ensure 2 week follow-up home visits are being conducted by volunteers after Hearth sessions	• Use of Home-visit Observation Checklist forms and track the submission of these forms by volunteers
	• Motivate village to take responsibility in monitoring growth of children (important for on-going screening of future PD/Hearth participant children)	• Community mobilisation skills • Communication skills • Community-based M+E techniques
	• Aggregate information from all Hearths in area	• Reflection and analysis
	• Competent in using PD/Hearth database software	• Familiar with MS Excel and internet
	• Analyse information and make appropriate programming decisions	• Decision making/problem solving skills

Communication	• Provide feedback to volunteers on their Hearth sessions, graduation rates, home visits, etc.	• Simplify technical findings and present in lay language
	• Report progress to supervisor/ ADP manager/ community leaders	• Written and verbal communication skills
	• Communicate to volunteers the next group of identified participant children for PD/ Hearth - should identify from monthly GMP results	• List of underweight children from most recent monthly GMP results (monthly screening required)

Regional/Provincial Health and Nutrition Coordinator

Skill	**Regional/Provincial Health and Nutrition Coordinators**	**Knowledge required**
Planning	• Analyse nutrition data • Identify geographic priority areas for PD/H • Communicate results to national partners/WV leadership/communities/ ADP staff	• Causes and consequences of malnutrition measure, calculate and classify malnutrition
	• Network with NGOs, government ministries, universities, international organisations (UNICEF etc)	• PD/H concepts, principles and practices • Role of diverse entities in PD/H implementation
	• Motivate participation of cross sectors specialists to contribute to PD/H • Lead multi-sector team in collaborative planning to integrate into PD/H programming	• Identification of gaps/key contributing factors and ways to address those.
	• Develop/adapt logframe for PD/H	
	• Develop DIP for PD/H	
	• Develop budget and workplan	

Monitoring	• Ensure all data is collected (no missing data) and entered into PD/H database • Analysis of aggregated data/Interpret findings • Make appropriate decisions based on data to strengthen programme	• Principles of monitoring systems for PD/H • Using tracking forms • Competent in PD/H Database • # of Hearth sites implemented per village
	• Support and supervision visits to Hearth projects • Mentor ADP/District staff	• PD/H menu requirements (meets nutrient requirements, low cost, use locally available foods, seasonal calendar considered)
	• Develop and implement evaluation plan for PD/H	
	• National level reporting (aggregated data) • Communication with partners	
Training	• Develop training materials • Train PD/Hearth Supervisors • Supervise and support PD/Hearth Supervisors and support Supervisors in training of volunteers	• Adult learning methodology • Ability to teach technical material in actively and in simple language • Facilitation skills

National Health and Nutrition Coordinator

	National Health and Nutrition Coordinator	**Knowledge/ skills required**
Skills	• Adult learning methodology • PD/H theory and methodology • Demonstrated ability in training others in PD/H, Hearth menu calculation tool/ software and PD/H Database • Is deployable	• In the various areas listed below is able to lead others in the processes and/or train others in practical, hands-on ways • Computer processing skills (Competent in MS Excel and Internet use)
Area of Expertise		
Basic Public Health Science	• Population health, disease prevalence, prevention, health determinants, promotion, improving health outcomes • Applies epidemiological knowledge, approaches, methodologies • Understands and uses research methodologies and scientific evidence for health problems	• Use of secondary and primary data to identify gaps in nutrition and recommend appropriate interventions • Ability to advise on other relevant health interventions that would support improvement in community nutritional status

Analytical/ Assessment	• Defines gaps and top priorities for health in country aligned with WV strategic direction	• Identify situations where PD/H methodology would be feasible and beneficial • Advise when PD/H would have limited applicability and not be recommended
	• Use of quantitative /qualitative data	• Identify areas where nutrition is a problem and PD/H could be relevant • Identify contributing factors to low nutritional status that would need to be addressed • Use of data to 'advocate' for PD/H programmes • Ability to advise on PD/H field research or evaluation
	• Selects and defines relevant variables	
	• Applies ethical principles to data collection, storage, use and reporting	• Ability to set up monitoring systems following WV and PD/H standards
	• Knowledge of standardised data collection and management process and computer systems.	
	• Knowledgeable of risks and benefits to communities through assessment and planning	
Programme Planning and Policy Development	• Translates assessment information and data into programmes • Able to assess feasibility, applicability, risk management for WV ADPs • Uses standard techniques in decision making and planning • Develops PD/H programme plans, goals, objectives, expected outcomes, implementation process • Knowledgeable of assumptions that affect PD/H	• Uses data to mentor staff in improved programming

Leadership	• Creates shared vision and team learning • Manages team information, contracts, external agreements • Manages staff; motivates, conflict resolution, performance monitoring • Identifies factors that may impact programme delivery • Facilitates collaboration with internal and external stakeholders • Represents PD/H at internal and external forums • Monitors and maintains ethical and organisational performance standards	• Able to build and lead multi-cultural team around common goals • Able to advocate and collaborate with relevant nutrition and PD/H networks
Communication at multi-country/ regional level	• Written and verbal communication of health issues Facilitates and participates in diverse cultural, educational and professional groups • Solicits input from relevant team members • Advocates for top priority health issues aligned with 7-11 programming • Presents demographic, statistical. scientific and programme information for lay and professional audience	• Able to communicate technical PD/H information simply and clearly to non-technical audiences • Ability to communicate with other technical experts in health/nutrition or other relevant disciplines. • A learner's attitude

Flow Chart of World Vision PD/Hearth Reporting Lines

Community Volunteers

- Selected by community
- Trained by PD/H Coordinators
- Run Hearth sessions
- Conduct follow up home visits
- Collect monitoring data

PD/Hearth Coordinators

- ADP or MOH H&N staff
- Trained by ToF or MT
- Train & supervise volunteers
- Prepare monitoring reports
- Enter data online database
- Coordinate with MOH, community leaders, zonal & provincial level WV staff

Zonal and/ or Provincial Coordinators

- Trained by ToF or MT
- Train & supervise PD/H coordinators
- Monitor projects
- Communicate with Regional & National WV and MOH entities

National Health & Nutrition Coordinator

- Trained by MT
- Train PD/H Coordinators
- Overall programme direction & monitoring
- Lead programme evaluation
- Communicate with national entities; WV Regional Nutrition Advisor
- Advocate for PD/H to MOH & MinAgri

Field Preparation Required for Situation Analysis and PDI:

Wealth Ranking:

5 or 7 community members (diverse group)

Initial Nutrition Assessment:

First, please ensure the Ministry of Health allows NGOs and non-government approved personnel to weigh children. If the government has strict protocols, please mobilize government approved personnel (e.g. health centre staff, CHWs, etc.) to help weigh children on the day of assessment.

Weigh all children 6-36 months of age in the community (you could mobilize the caregivers to one site/location or to several decentralized sites/locations in the community to increase coverage and ask caregivers to bring their children 6-36 months of age on a specific day and time). Weighing children house to house is most accurate, but may require more time and resources.

Community/Social Mapping:

4-5 community leaders (men and women) and 1-2 CHWs

Focus Group Discussions:

Three separate FGDs are recommended with mothers group, fathers group, and elderly women's group. There should be approximately 7-10 participants in the mothers group. It is advisable to include 2-3 mothers with children from each target age group: 0-6 months, 6-12 months, 12-24 months, and 1 mother from the age group 24 -59 months. A smaller group of 4-5 participants could be mobilized for fathers and elderly women (grandmothers). Ensure there are 2 facilitators in the FGD who are good with speaking the local language (for interviewing and recording). If different groups are leading different FGDs, you may require more facilitators who speak the local language.

Seasonal Calendar/Transect Walk:

Good to have 1-2 CHWs or volunteers who could help navigate in the village/community

Market Survey:

Done by the team

Good to find out when the big market day is and keep in mind when planning the agenda

Positive Deviance Inquiry:

From the initial nutrition assessment, select at least 4 PD households (at least 1 household from each target age group: 0-6 months, 6-12 months; 12-24 months), 2 negative deviant households, and 2-4 non-PD households. These will be the households that will be visited during the PDI. You could always select more PD and non-PD households if necessary, depending on the number of participants in the training. Divide participants into groups of 3 people. Arrange for each group to be supported by a volunteer or someone who is familiar with the village so that the groups could find the households easily. Ensure the volunteer or the person from the village is not in the way of getting honest answers from the caregivers. If translators are needed, make sure at least one person in the group could speak the local language.

Welcome, TOF Objectives, Agenda, Introductions

SESSION 1

60 MIN

DAY 1

By the end of the session participants will

1. Have reviewed the training goals and desired outcomes
2. Have been introduced to the hosting agency and facilitation team
3. Be able to summarise participant expectations and workshop norms
4. Be able to evaluate their learning needs as individuals and as a group in key objectives of PD/Hearth.

Preparation

- Prepare a flip chart with overall training goal and objectives as shown on Handout 1.1.
- Prepare two copies of Flip Chart 1, the 'Target Evaluation' diagram. One copy is used now, and one at the end of the course.

Materials

- Objectives (Handout 1.1)
- Agenda (Handout 1.2)
- Blank sheets of flip-chart paper
- 8 dot stickers for each participant

STEPS

5 Min

1.

The organisation hosting the event welcomes participants and introduces the lead facilitator as well as special guests attending the opening session.

10 Min

2.

Cover basic information such as the locations of bathrooms, timing of breaks, etc. With the group, develop ground rules (promptness, cell-phone etiquette, computer use, etc.). Use a flip chart that will be posted during the workshop. Encourage full participation in all discussions and small-group work.

5 Min

3.

Read the overall goal of the training and the training objectives. Based on these, ask what the participants expect. List responses on a separate sheet of flip-chart paper.

HANDOUT
1.1 – 4m/H 9

Welcome, TOF Objectives, Agenda, Introductions

DAY 1

5 Min

4.

HANDOUT
1.2 – 5m/H 10

Distribute the training agenda and briefly review the planned content. Note that the activities have been planned to encourage maximum discussion and 'hands-on' work by participants. Participants will spend time revising a training curriculum to make it suitable for their own context.

10 Min

5.

Introduce all facilitators and describe their involvement with PD/Hearth to date. Have all the participants briefly introduce themselves.

10 Min

6.

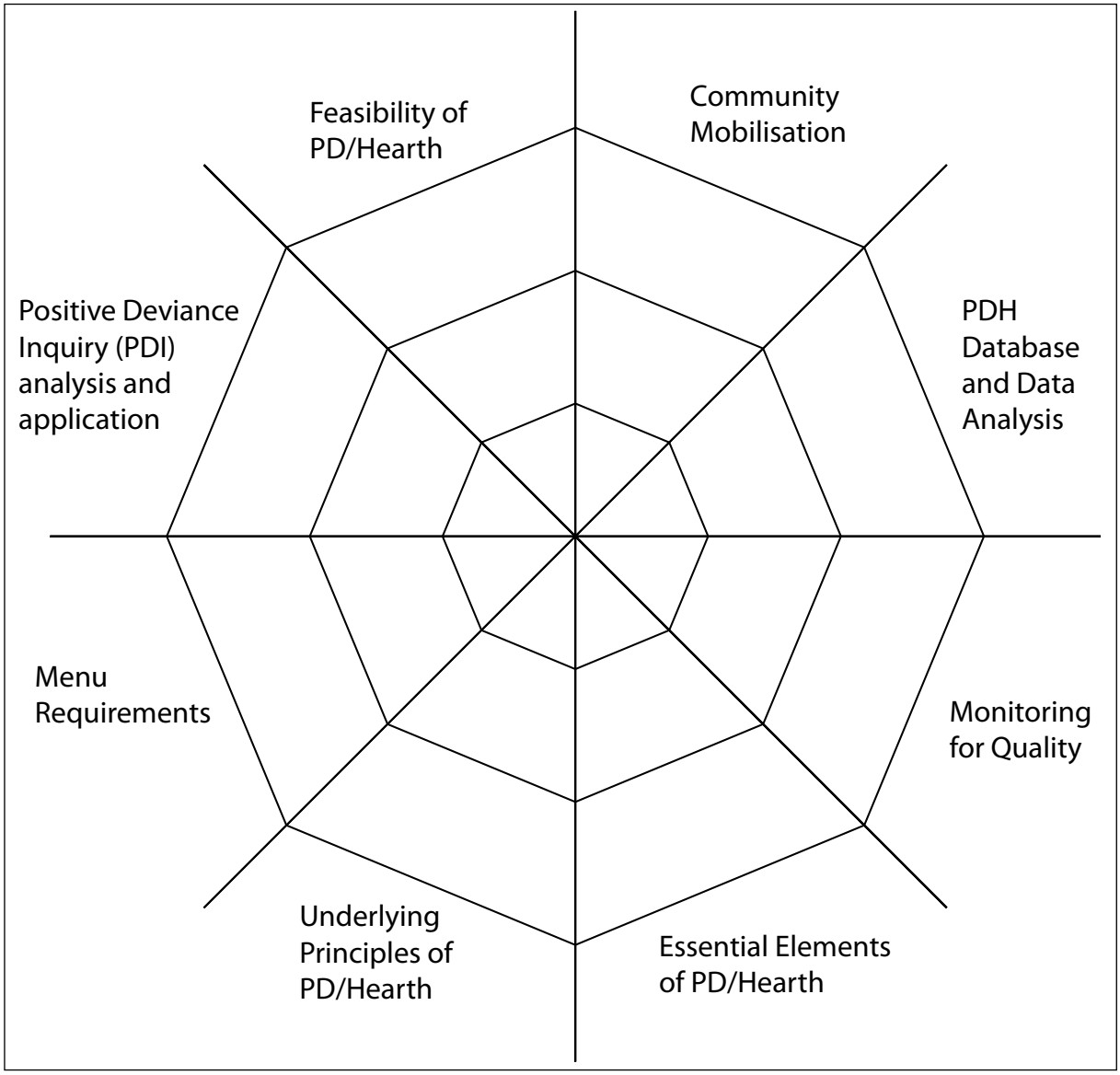
Review the group's expectations from step 3 and ask if anyone has questions on plans for the workshop.

15 Min

7.

Complete the first stage of the 'Target Evaluation Dart Board' described below.

Flip Chart 1
Target Evaluation Dart Board



- Give each participant eight stickers.
- Ask participants to think about their understanding and skill in each of the eight areas listed on the 'dartboard'. The more competent they feel in each area, the closer to the centre of the target they should place a sticker. If they feel less confident or knowledgeable about an area, they place their sticker closer to the outer edge.
- When all participants have placed their stickers, discuss together areas where the group has strengths and areas that group members hope to strengthen in this course.
- Save this sheet for comparison at the end of the course.

Objectives for PD/Hearth TOF

Goal

WV staff and partners develop knowledge, skill and competencies in PD/Hearth to

- train others
- provide technical support
- monitor implementation.

Training objectives

By the end of the workshop, participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level

Day and Date	Session	Activities	Time
Day 1:			
1		Devotion	15 min
	1	Opening remarks Introductions (Ice breaker) Expectations and Objectives, Parking Lot Workshop Norms (Form Review Volunteer Groups) Target Evaluation Brief Overview of training (Evaluation method and go through overview/ field visits) Admin issues & logistics	90 min
	2	Pre-test	35 min
	3	What is Malnutrition? – Activity (3 types of malnutrition: underweight, stunting, wasting; Malnutrition cycle; Local terminologies)	95 min
		National prevalence (5 min) & ADP context (10 min)	15 min
	4	What is Good Nutrition?	30 min
	5	Overview of PD/Hearth – Goals/objectives; Definitions	45 min
	6	How PD/Hearth Addresses Malnutrition – Causes of malnutrition (UNICEF Framework (Problem Tree): Immediate, underlying, basic/root causes	45 min
		Key steps of PD/Hearth (20 min)	20 min
	7	(STEP 1) Determining the Feasibility of PD/Hearth Approach for the Target Community – Case study using ADP's communities (Identify existing other sectors in ADPs)	45 min
	8	Daily Summary and Evaluation	10 min
Day 2: *"Practicing to go out to the field" - Situation Analysis of the community*			
2		Devotion	30 min
	9	Review of Day 1 and Agenda for Day 2	30 min

Day and Date	Session	Activities	Time
2	10, 11, 12	(STEP 2) Community Mobilisation: Mobilization strategies for various PDH stakeholders (70 min) 1. Identifying stakeholders involved in child care and nutrition within the community (Venn Diagram); Outlining the Existing Local Health System Structure; Community Resources/Staffing Required for PDH implementation (WV & local NGOs) (50 mins) Creating Community Ownership 1. Preliminary steps: Meeting with leaders after receiving invitation (Practice through role play) (20 mins) 2. (STEP 2) Identifying and Selecting Volunteers – Mobilization strategies for various PDH stakeholders The players mobilization strategies (group work) (35 min) Learning Styles and Facilitation (45 min)	150 min
	13, 14, 15	(STEP 3) Situation Analysis with the community members 1. Wealth Ranking 2. Measuring nutritional status (underweight & wasting) of all children in the village (weighing scales – salter scales and MUAC) 3. Focus Group Discussions (pregnant women, father group, grandmother group, siblings group) (Role Play – Traditional & PD/ Hearth) 4. Community/Social Mapping & Transect Walk, (e.g. who is taking care of the children, what types of foods are people growing, do children wear shoes, look for latrines, etc.) 5. Market Survey & Seasonal Calendar (ask shop keepers how many bars of soap they sell per week)	220 min
		Feedback to the community – Practice how we will share children nutritional status with community	30 min
	16	(STEP 3) Preparing for Situational Analysis Field Visit: Review situation analysis formats and go through field logistics (assigning groups, tasks, schedule)	60 min
	17	Daily Summary and Evaluation	10 min

Day and Date	Session	Activities	Time
Day 3: Field Visit (Situational Analysis)			
3	18	Field Visit to Conduct Situational Analysis Travel to field (activities can run simultaneously) 1. Introduction to leaders and volunteers (30 mins) 2. Wealth ranking with community members including volunteers (40 mins) 3. Weigh children (Plot children on giant growth chart if wanted) (45 mins to 180 mins – depends on how many children are weighed) 4. Social Mapping (40 mins) &Transect Walk (45 mins) & Focus Group Discussion (Father group (45 mins), Mother-in-law groups (45 mins), mother groups (45 mins)) 5. Seasonal Calendar (45 mins) & Market Survey (60 mins) Travel back to hotel	4.0 hours to 6.5 hours plus travel time (depends on how much time is spent weighing children and travel time to/ from the field)
Day 4:			
4		Devotion	30 min
	19	Review of Day 3 Field Visit and Agenda for Day 4 – Reflection of field work (what worked, what needs improvement, etc.)	45 min
	20	Analyzing Situational Analysis Data Brief orientation on Database Compile, summarize and document findings from field visit (flip chart, Excel templates) – Enter nutrition status/wealth ranking into Excel spreadsheets situation analysis Present findings: Nutritional profile of children – Initial assessment. Data interpretation Documentation of assets, current common practices & challenges	180 min
		How to conduct community feedbacks – Assign someone to share findings tomorrow. Have person practice for preparation of field visit in front of participants and receive feedback	30 min

Day and Date	Session	Activities	Time
4	21	(STEP 4) Identifying Positive Deviants – Selection criteria for PDs; Identification of NPDs, PDs, and ND households (Use findings from field visit to identify NPD, PDs, ND households)	60 min
	22	(STEP 4) Preparing for the Positive Deviance Inquiry (PDI) 1. Review and adapt generic tools 2. Do's & Don'ts for home visits 3. Further practice with tools (Role plays) 4. Logistics for home visits	105 min
Day 5: Field Visit (PDI)			
5	23	Field Visit to Conduct PDI Travel to field 1. Feedback to community on nutrition status findings (60 min) 2. PDIs in the field for ADP village (At least 4 PD HH & 2-4 NPD HHs & 2 ND per village) - home visits Travel back to hotel	4.5 to 6.5 hours plus travel time
One-day Break: Compile PDI data and post charts including results from situation analysis (compile in Excel Templates) and begin working on Action Plans			
Day 6:			
6		Devotion	30 min
	24	Review of Day 5 Field Visit and Agenda for Day 6 – Reflection of field work (what worked, what needs improvement, etc.)	45 min
	25	(STEP 4) PDI Interpretation and Feedback: Determining Positive Deviance and Identifying 6 Key Hearth Messages 1. Presentation of PDI findings – Identify PD behaviours & Non-PD behaviours 2. Develop 6 key Hearth messages based on PDI Findings & quotes from villagers	170 min

Day and Date	Session	Activities	Time
6	26	Community Feedback Meetings – Preparation to share PDI Findings 1. Exploration of ways to share PDI findings (eg. skits, cultural events) 2. Role plays	60 min
	27	(STEP 5) Promoting Behavioural Change	40 min
	28	(STEP 5) Designing Hearth Sessions	80 min
	29	Daily Summary and Evaluation	10 min
Day 7:			
7		Devotion	30 min
		Reflection of Day 6	30 min
	30	(STEP 5) Menu Design and Cooking 1. Use food composition tables 2. Menu to meet energy, protein, iron, Vitamin C, A & Zn requirements 3. Convert recipes from grams to home measures 4. Menu Calculation Tool Orientation (~30 min) Cooking practical – at training site Menu preparation, testing and selection of hearth menus Presentation of menus (60 min)	390 min
Day 8:			
8		Devotion	30 min
	31	Menu Calculation Assessment (60 min)	60min
	32	Essential Elements of PD/Hearth	55 min

Day and Date	Session	Activities	Time
8	33, 34	Setting up Hearth Sessions: 1. PD/Hearth participant selection, number of children per site 2. (STEP 6) Conducting the Hearth Session (40 min) 3. (STEP 7) Supporting New Behaviours through Reflection and Home Visits (60 min)	100 min
	35, 36	(STEP 8) Admission, Graduation, Repeating as Needed (75 min) (STEP 9) Expanding PD/Hearth (10 min) (Total 85 min) (STEP 8) Monitoring and Evaluation (Monitoring tools) (105 min) 1. Hearth rotation 2. Home visit protocols and Follow-up: HH follow-up visits 3. Referral to Health Centre 4. Overview of PDH Excel Database and Data Analysis (30 min)	220 min
Day 9:			
9		Devotions	30 min
		Review of Day 8 – Go through outstanding Parking Lot Topics	30 min
	37	Training Volunteers – review monitoring tools for volunteers and importance of community monitoring	60 min
	38	Post-test	35 min
	39	Integration and PD/Hearth – Integrating PD/Hearth with other sectors in ADP	60 min
	40	Factors for the Success of PD/Hearth	30 min
	41	PD/Hearth Action Plans	45 min
	42	Final Evaluation and Closing Target Evaluation, Workshop Evaluation	40 min
		Certificate Presentation & Closing Remarks	40 min

Pre-test

SESSION 2

35 MIN | DAY 1

Materials

- PD/Hearth Pre-test (Provided in the MS Word document in the Resource CD)

STEPS

1. Distribute Handout 2.1: Pre-test

2. Have the participants complete it and hand it in.

3. Facilitators mark the tests during the break. The marked pre-tests will be returned with the post-test results on the last day.

SESSION 3

What Is Malnutrition?

95 MIN | DAY 1

Purpose

- To learn what malnutrition looks like in children
- To learn some causes of malnutrition
- To learn the results of being malnourished

Materials

- two table-tennis balls, one perfectly round and the other crushed (or find a healthy branch of leaves and a dying branch of leaves)
- flip-chart paper and markers
- one litre boiled water
- a clean large bottle to mix oral rehydration solution
- a teaspoon
- salt
- sugar
- a small glass for each participant
- samples of healthy snack foods and 'junk foods' on a table

STEPS

15 Min

1. What does a malnourished child look like?

Ask the participants to think of a young child who is not growing well. What shows that the child is not well? Ask several participants to describe the child they are thinking of.
(listless, sad, irritable, sickly, no interest in playing, hesitant, thin arms and legs, may appear normal but be much older than the child looks)

The girl on the right is stunted. She is 52 months old (about 4 years), while the girl on the left is twenty-six months old (about 2 years). Child stunting is very common but often goes unrecognised. It is more common than other forms of malnutrition, such as being underweight (low weight for age) or wasting (low weight for height).

Explain: 'While these signs help, we can't always tell that a child is not growing well, so we need to measure. Tomorrow, we will learn how to measure weight and mid-upper arm circumference (MUAC) to tell if a child is growing well.'

3 Types of Malnutrition

1. Underweight (Weight-for-age less than - 2 SD from reference)

Identifies *children who are 'underweight', that is, they weigh less than a healthy, well-nourished child of the same age.* This may be because the child has not grown normally in height, weight, or both, or because he or she has lost weight. ***However, underweight children are not necessarily wasted (i.e. have lost a significant amount of weight in a short amount of time to the extent of apparent 'thinness') and their poor nutritional status may not be as visible as wasting because it is not as severe.***

Measuring the rate at which children increase in weight is a very good way to monitor individual children's growth. The advantage of underweight is that it *reflects both past and present undernutrition in a population;* the disadvantage is that it is unable to distinguish between the two. Therefore, if a population has a high rate of underweight, we do not know if the reason is a *recent* lack of food or illness in the population or *long-term* undernutrition. Underweight is also a good indicator for monitoring data. If underweight is used to target children who need IYCF counselling, you could prevent further stunting in the population and also wasting.

2. Stunting (Height/length-for-age less than - 2 SD from reference)

Identifies *children who are 'stunted' or shorter than expected for a healthy, well-nourished child of the same age.* If children are undernourished, their growth in height slows down. Children who are undernourished for a long time are shorter than they should be. We refer to this as '*chronic' or long-term undernutrition*. ***However, the stunted children are not necessarily wasted because a child that has been undernourished for a long period of time, may not have lost significant weight in a short amount of time. Thus, the child can be stunted, but not necessarily wasted.*** Stunting may be less visible than wasting or 'thinness' especially when the whole community has been affected by long-term undernutrition. In such case, shortness in height in children may have become a new 'norm' (i.e. many children are shorter than they should be and have not achieved normal heights) and may not be readily perceived as a critical problem.

Measuring the rate at which children increase in height is not a good way to monitor individual children's growth. However stunting is useful when we want to:

- **Assess the nutritional status of a population,** for example, when we do a survey of a community. Children's heights are an indicator of chronic malnutrition in the community and tell us if that community has been undernourished in the past or continues to be undernourished. This helps us to find which areas are most undernourished.
- **Measure changes in the nutritional situation of a community.** Height-for-age measurement of the children tells us whether, over a period of time, the nutrition situation is improving or getting worse. This is useful for our programme managers and planners who have to decide how to use funds and other resources, and for people who evaluate the effects of development projects.

Therefore, stunting is most useful for assessing overall community nutrition status and measuring long-term changes. Also, stunting does not vary by seasons over the year.

3. Wasting (Weight-for-height/length less than - 2 SD from reference or 'yellow or red' MUAC)

Identifies *children who are 'wasted', that is, thinner than expected for a healthy, well-nourished child of the same height.* These children have lost a significant amount of weight in a short period of time due to poor food security and nutrition and/or illness. ***This means wasted children will also be underweight, that is, they weigh less than a healthy, well-nourished child of the same age.*** Wasting *reflects recent, short-term (acute) malnutrition or illness.* It is a sign that a child is extremely undernourished and will die within several days to several hours if not addressed. A severely wasted (severe acute malnutrition) child must be referred to a health centre or hospital, but if the child is moderately wasted (moderate acute malnutrition) the parents can improve the child's nutrition at home and the child can recover from wasting.

Wasting is the most severe form of undernutrition out of the three nutrition indicators, including: wasting, stunting, and underweight. MUAC can also be used to enable health and nutrition workers to quickly identify a severe acutely malnourished child. It is useful for **screening or assessing nutritional status of individual children 6 - 59 months of age** as well as for **assessing the nutritional situation of a community in an emergency situation.** The proportion of wasted children in an area may vary by the season, due to annual periods of food insecurity or seasonal illness. Thus, wasting is appropriate for examining short-term effects such as seasonal changes in food supply or short-term nutritional stress brought on by illness. Wasting is addressed through treatment and preventive nutrition activities.

Triggers for Action for 3 Types of Malnutrition

% of children 0-59 months moderately and severely undernourished

	Acceptable	Attention Required	Critical
Underweight	< 10%	10-19%	≥ 20%
Stunting	< 20%	20-29%	≥ 30%
Wasting	< 5%	5-9%	≥ 10%

In sum, when children do not receive good nutrition (i.e. a variety of foods in adequate amount) and/or have an underlying illness, they will start to lose weight and can become underweight. If this continues for a longer period of time, children's growth in height will slow down and they will not be able to reach their normal heights. So these children will be shorter than their same-age peers, resulting in stunting. Children who lose a significant amount of weight in a short period of time may be identified as wasted. Wasting is the most severe form of undernutrition among the three indicators as severely acute malnourished (or severely wasted) children (identified by red MUAC or WHZ < -3) can die quickly if not treated soon.

15 Min

2. Why is malnutrition a problem?

If you have table tennis balls:

Use the two table-tennis balls to demonstrate how a well-nourished child has a healthy growing pattern compared to a malnourished child.

Ask two participants to take turns bouncing the balls on the floor. Other participants should observe which ball bounces higher.

Ask two other participants to draw on a flip chart the height and pattern of the bounce of each table-tennis ball. Why does the perfect ball bounce higher?

Discuss the exercise:

How does the perfect table-tennis ball compare to a healthy child? The healthy child has more regular and more 'well rounded' growth and shows more energy. A malnourished child is like the crushed ball. This child's growth is not regular and he or she has very little energy.

Why do we care if a child grows well? *(Answers will vary, but ensure that the points below are made)*

If you have a healthy and unhealthy branch of leaves:

Use the healthy and unhealthy branch of leaves to demonstrate how a well-nourished child has a healthy growing pattern compared to a malnourished child.

Ask one participant to draw a tree that has access to a lot of rain and sunlight. Ask another participant to draw a tree that does not receive rain and only receives sunlight.

Discuss the exercise:

How does the tree with access to a lot of rain and sunlight compare to a healthy child? The healthy child has more regular growth and is "greener". A malnourished child is like the unhealthy branch. The leaves have no strength and little energy, like a malnourished child.

Why do we care if a child grows well? *(Answers will vary, but ensure that the points below are made)*

Review the consequences of malnutrition:

The results of malnutrition are very great. Malnourished children do not have much energy, are not very active, may cry often or seem very sleepy. They are much more likely to be ill with infections such as diarrhoea, pneumonia, tuberculosis and malaria. They also have an increased risk of becoming infected with HIV. When a child is malnourished, infection or illness is more likely to become serious or even cause death.

Small and sickly children are more likely to be enrolled in school late – or never – and they tend to stay in school less time. These children struggle to learn and often do not do well at school. This lack of healthy growing, both physically and mentally, will affect them throughout their lives.

As these malnourished children become adolescents, they may not have the knowledge and skill they need to become independent adults. Over their lifetime

they will not be able to do as much work and will earn less than their friends who were well nourished as children. They will be less able to support their own children when they become parents. Girls will have difficulty with pregnancy or have small babies.

While all stages of a child's growth are important, the most critical time is earliest years of life. Thus children between 6–36 months who are malnourished come to the Hearth. Babies younger than six months need exclusive breastfeeding for healthy growth so are not included in Hearth.

15 Min

3. What causes a child to not grow well?

Tell the following story about Tomi. (Adapt the story to the community culture.)

Tomi is 15 months old. He is very small and very thin. Tomi has an older brother, Mo, who is 5 years old, and a sister, Sara, who is 3. Sara was born with low birth weight. Another sister was born very small and died soon after birth. Tomi's mother, Lila, is 27 years old. She is pregnant again. She breastfed all her babies, and –as the grandmother told her to - she also gives them tea and thin porridge. Lila works hard on a farm three miles from her home for a small wage. She finds the work very tiring, especially when she is pregnant. On the way back to the house she stops at the river to get a bucket of water. Once back at her house, she is too tired to do anything but cook the family's meal. Mo takes care of all the children while Lila is in the field. He tries hard to keep them clean and happy, but often Tomi has diarrhoea and a runny nose. They usually have tea for breakfast. At midday they eat whatever might be left over from the day before, but often there is nothing. In the evening the family eats maize or cassava and some green vegetables. They cannot afford meat or even beans.

Lead a discussion using the following questions:

- Who were the people in the story? What happened in the story? What was the problem? Why is Tomi too thin?

  Some of the reasons will not be clear in the story, but volunteers should think of possible causes for the problem. Have them call out reasons. You might need to ask them 'why?' to help them think more deeply. *(Tomi doesn't eat enough, not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, unclean water, worms, no shoes, grandmother tries to help but the tea and thin porridge are not good foods for babies)*

- Which is the biggest problem? Why? Does it happen in your community?

Summarise the discussion by saying there are many reasons children might not grow well. These can include practices related to:

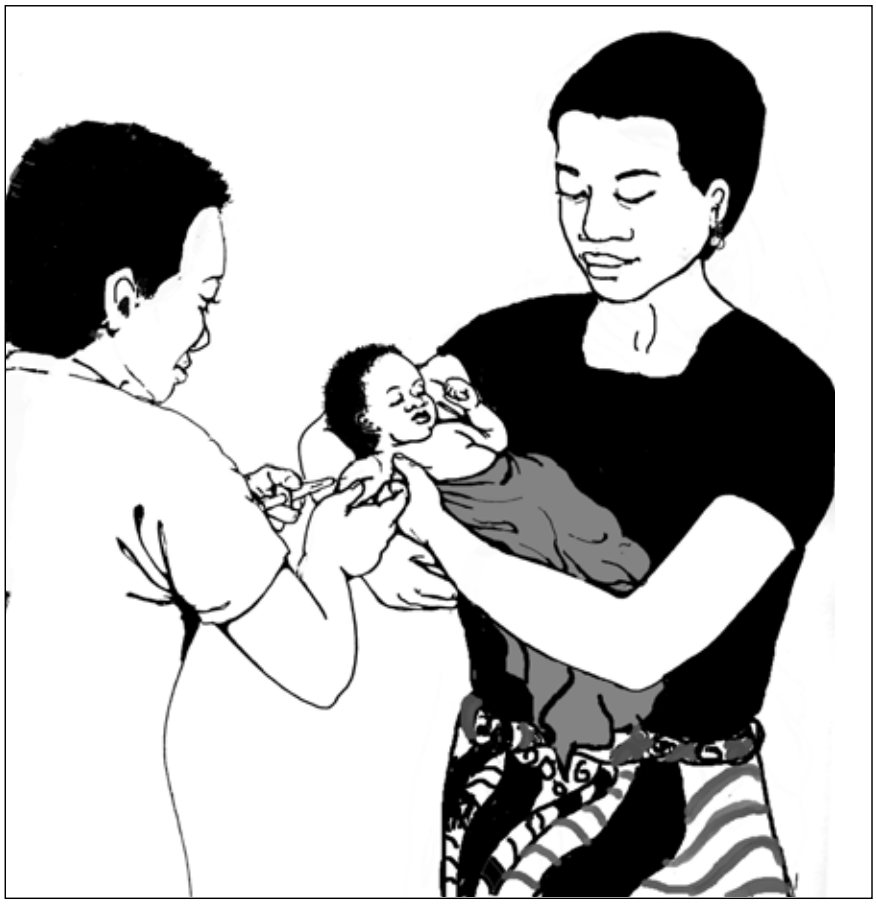
1. food
2. care
3. hygiene
4. health seeking behaviours

15 Min

4. Nutritional status is also affected by illness

Explain that the body needs food to fight infection, but illness makes the child not want to eat. When the child eats less, the illness lasts longer or gets worse and can even lead to death. Children who are sick also will not grow well. It is important to help children not to become sick or to help children get better quickly.

Lead a discussion on childhood illnesses in the local community:



What Is Malnutrition?

What illnesses do children in our community get?

(diarrhoea, colds, cough, fever, malaria, tuberculosis, pneumonia)

How can we help children not get sick?

Immunisation – When do children need to be immunised?

(refer to the Ministry of Health immunisation schedule)

Deworming – Why is deworming important?

(child may not feel like eating, body will not be able to use the food the child does eat, more loss of nutrients from the gut)

When do they need to be dewormed?

(refer to the Ministry of Health national protocol)

Vitamin A supplement – Why is this important?

(helps child see better, prevents blindness, helps fight infection and disease)

When do children need a vitamin A supplement?

(every six months, usually given at Health Post)

How do we treat children who are sick?

(continue to feed breast milk and give food and liquids during illness, go to the health post if the child is not getting better)

What do we do for a child with diarrhoea?

(give extra breastfeedings and other foods and liquids; give oral rehydration solution)

Review the method for mixing oral rehydration solution.

Before children enter the Hearth sessions, they should have completed their immunisations, received vitamin A supplements and been dewormed. This will give each child the best chance to recuperate from malnutrition. Volunteers will need to talk with the caregivers about this, and either send them or go with them to the health post to make sure each child has received all of these interventions.

30 Min

5. Prepare and eat snack together

Discuss the importance of hand washing and the importance of snacks. Make a display of common snack foods. Include both healthy snacks (banana, papaya, mango, cooked milk, coconut, egg, groundnut, corn, yam, tortilla) and unhealthy snacks (soda, sweets, candy, crisps, junk food).

One way to help children grow is to make sure they eat at least three to five times during the day. This includes meals and snacks. Lead a discussion using the following questions:

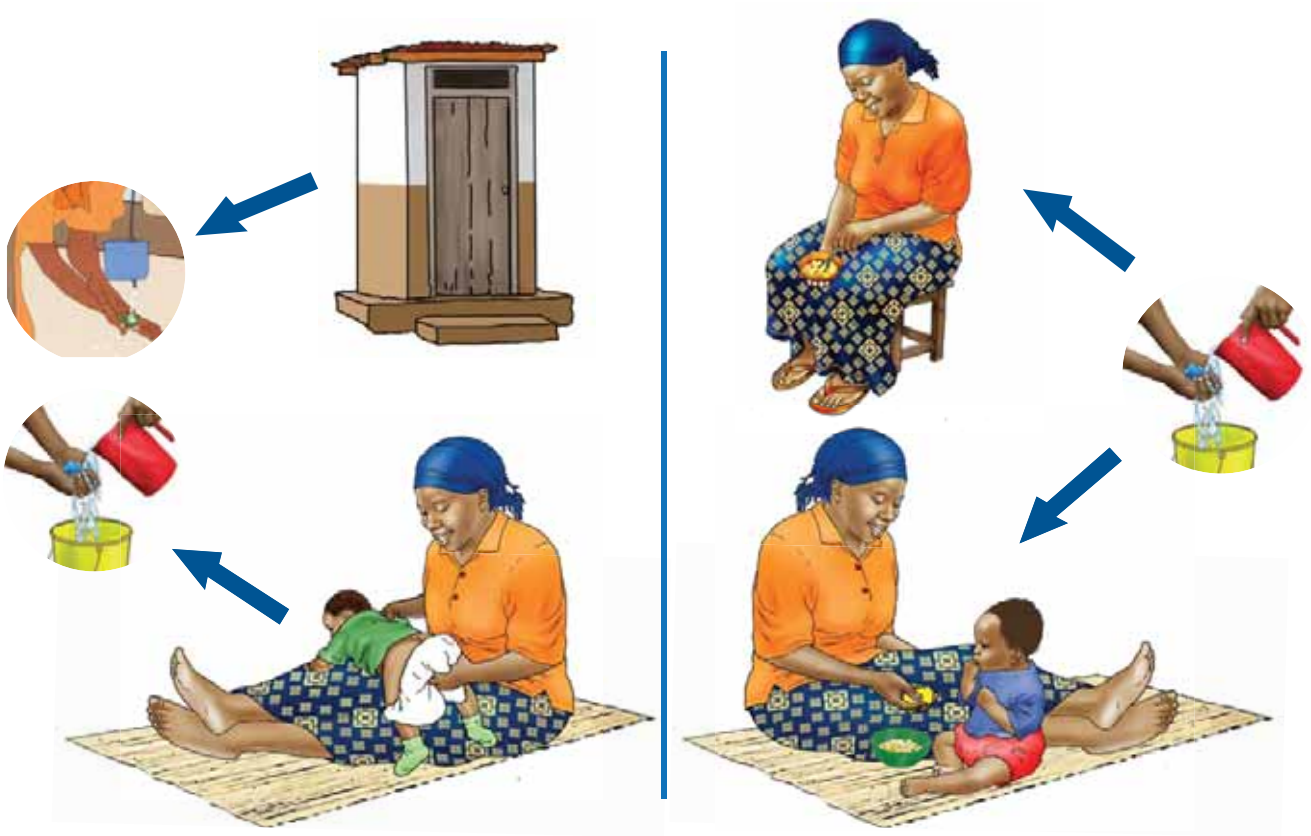
Why are snacks important for children?

(stomachs are small so they can only eat small amounts at once, it is a chance to give a variety of foods such as fruit)

Which of these snacks (on the table) are healthy and which are unhealthy? Why? Which are affordable?

Pick one of the healthy snacks, such as papaya, for the participants to prepare and eat together.

Have them wash their hands before preparing the snack. Discuss the reasons for hand washing together.



How do we wash hands? *(soap/ash and water, rub well, rinse)*

Why is it important to wash hands? *(to keep germs from spreading, getting into our food, mouths, making us sick)*

When do we need to wash our hands? *(before preparing food, before eating, after using latrine, after changing a diaper, after helping a child use the toilet, after helping a sick child)*

Prepare and eat the snack together. Wash fruit even if you are going to peel it so germs and dirt are not transferred to the flesh of the fruit, and cut with a clean knife

5 Min

6.

Ask participants to think of one new thing they learned today.

Ask them to name the three goals of PD/Hearth. *(to rehabilitate malnourished children quickly, to help families keep their children healthy and to prevent malnutrition from happening in the future)*

Ask them to name the four main reasons why children may not grow well. *(inadequate food, care, hygiene, health-seeking behaviours)*

What Is Good Nutrition?

SESSION 4

30 MIN | DAY 1

Purpose

- To learn about a variety of foods needed to help children grow well

Materials

- A variety of food available in the community set on a table. Make sure there are eggs, protein sources, fruit, vegetables, nuts, oil and staple foods. If food is unavailable, use pictures. Use examples of foods that were found to be locally available and affordable in the community.
- a cooking pot
- three large stones, each with a large label: GO GROW GLOW
- a large cooking pot
- a variety of healthy and unhealthy snacks
- hand-washing facilities (basin, water, soap or ash)

STEPS

5 Min

1. Explain

'To grow well children need to have good food and to be free from illness. Children need enough food and a variety of different types of food. We will look at what types of food to eat and how to treat illness.'

10 Min

2.

Have participants call out what types of food they eat in their community.

1. What is the main food they eat? (rice, maize, millet)
2. What are other foods they eat? (any foods they list)
3. Why do we need to eat different types of food? (they taste good, some help us not get sick, some help us not to get hungry, they help children grow)

10 Min

3.

Set up a cooking pot that rests on three large stones, with the names on the stones turned to the inside. Discuss this cooking method.

Use the cooking pot and stones to explain. What happens if we have fewer than three stones? (Take out a stone to demonstrate.)

To make sure our cooking pot does not spill we need to place it on three stones.

If we take away one stone, the pot will fall over. For us to be healthy and not 'fall', we need different types of food. We are going to call each stone a different name to remind us of the types of food we need: Energy Giving, Body Building, and Protective (GO, GROW and GLOW). (Turn the stones so they can see the names.)

What foods give us GO, that is, energy to work and walk and play? (maize, rice, millet, wheat, cassava, oil, ghee, sugars, coconut, olives). Note that both staple foods and high-fat foods are part of the Energy Giving or GO group.

Can our pot balance on one stone? *(no)*

What happens to it? *(falls over, puts out the fire, spills the food)*

We need all three stones to keep the pot balanced. Another stone is called

Body Building (GROW). What do you think Body Building or GROW foods do? *(help our bodies build muscles and nerves and grow strong)*

These foods often come from animals.

Which foods on the table are Body Building (GROW) foods? *(eggs, milk, fish, fowl, meat, groundnuts, beans, peas, nuts, seeds)*

Can our pot stand on two stones? *(no)*

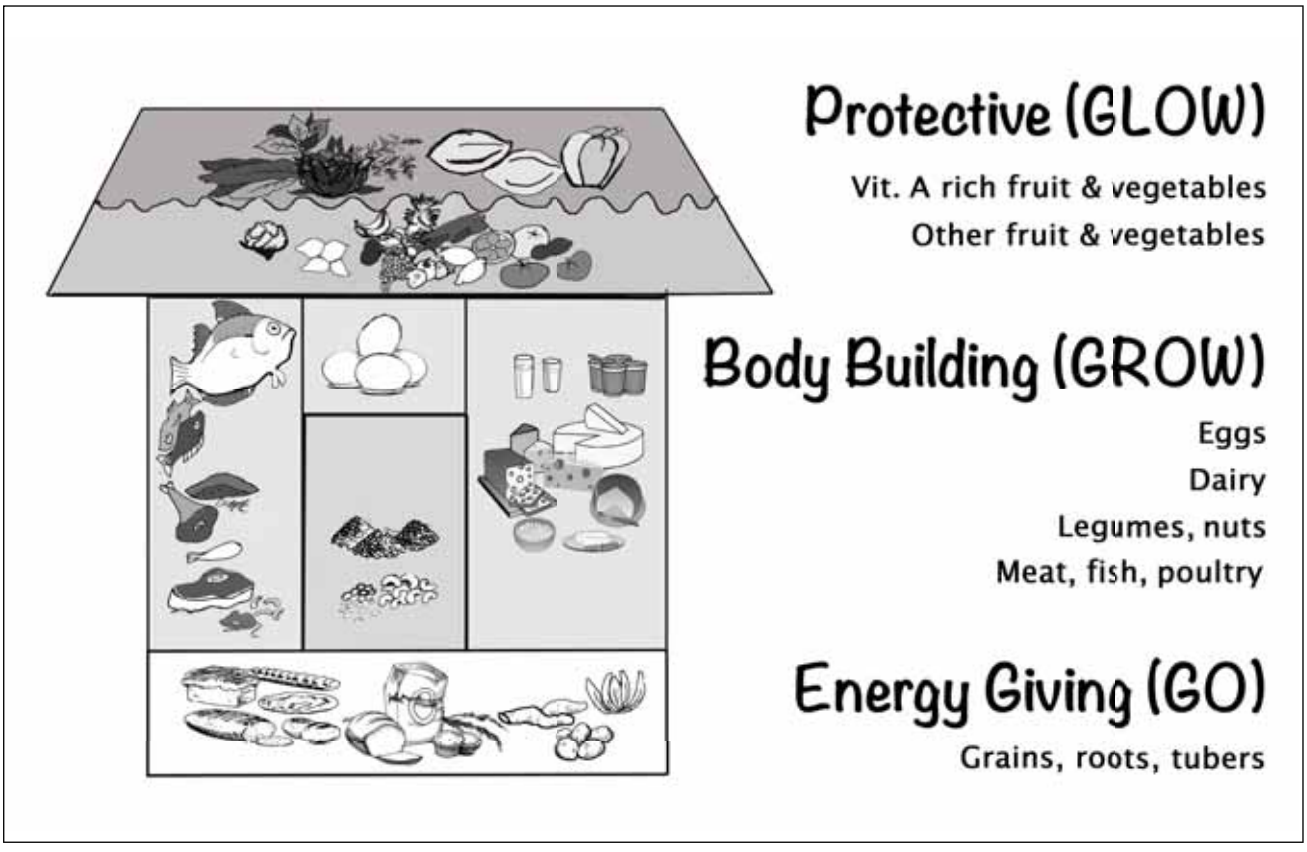
We need another stone. This one is called Protective (GLOW). What do you think Protective or GLOW foods do? *(protect our bodies from illness, make our hair, eyes and skin glow).*

They are often fruits and vegetables.

Which foods on the table are Protective (GLOW) foods?' *(carrots, pumpkin, tomatoes, dark-green leafy vegetables, papayas, mangos, oranges)*

Have each participant pick different types of food from the table. Make sure all the foods are taken. Now have the participants place the foods they picked by the proper stone.

When all the foods are placed, ask if all the foods are in the right places. Gently make any corrections.



What Is Good Nutrition?

DAY 1

Discuss how most people eat a low-cost staple food that forms the main part of the meal and provides energy. In many homes not much else is eaten. But to be healthy more than just this main food must be eaten. It is very important to also eat other foods in the Energy Giving (GO), Body Building (GROW), and Protective (GLOW) groups.

Discuss one food not included yet which is very important for babies and small children:

What is it? *(breast milk)*

Why is breast milk important?

(It contains exactly what a baby needs to be healthy and grow. For six months a baby does not need any other food or water.)

Why not give a baby other food or water before six months?

(baby is more likely to get diarrhoea, will take less breast milk and that will cause the supply of breast milk to decrease)

When do babies need to start to eat other foods? *(at six months)*

How long do babies need breast milk? *(up to 24 months)*

Why do babies need food at six months?

(they are more active, they need more energy and nutrients than they can get in breast milk, their gut has developed more and they can digest other food)

What happens if a baby does not get other foods at six months?

(will stop gaining weight and growing well, may not be interested in other foods later)

Overview of Positive Deviance/Hearth

SESSION 5

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe the PD/Hearth approach in simple English
2. Explain how PD/Hearth is different from traditional nutrition education
3. List the three goals of PD/Hearth.

Reference in *CORE PD/Hearth Guide*: *pp. 1–14*

Preparation

- Prepare a flip chart with the three goals of PD/Hearth

Materials

- Flip-chart paper
- Fresh foods (e.g. vegetables, eggs), plates, cooking pot, etc. for role play
- Glass half filled with water

STEPS

10 Min

1.

PD/Hearth combines two approaches proven to successfully reduce child malnutrition and promote the normal development of the child at the community level.

Positive Deviance is based on the premise that some solutions to community problems already exist within the community and just need to be discovered. In the Hearth approach, community volunteers and caregivers of malnourished children practice new cooking, feeding, hygiene, caring, and health-seeking behaviours shown to be successful for rehabilitating malnourished children.

The common belief is that poor households will have malnourished children and rich households will have healthy children. However, you will find in any community that there are poor households with healthy children. These are the positive deviants. We want to learn the key positive behaviours in feeding, hygiene, caring, and health-seeking practices that are allowing these positive deviant children to be healthy. These few number of positive and affordable practices are the key messages we want to share during a 10-12 Days Hearth session with 6-10 caregivers of malnourished children. During the Hearth session, the caregivers will be asked to bring an ingredient and will be the ones who cook a nutritious Hearth meal, and as they are feeding their malnourished children, a key Hearth message is shared. At the end of the 10-12 Days of Hearth, the caregivers will learn 6 key Hearth messages and how to cook 2 nutrient-dense meals. Then volunteers will conduct home follow-up visits to re-enforce and encourage caregivers to continue the positive practices at home and to help overcome any barriers that are preventing them from practicing at home. The follow-up visits are conducted 2-3 times a week for two weeks.

Key Definitions for PD/Hearth

Positive Deviants (PD): Healthy children from poor households (Additional criteria will be elaborated in Session on Identifying Positive Deviants)

Negative Deviants (ND): Malnourished children from rich households

Non-positive Deviants (NPD or non-PD): Malnourished children from poor households and healthy children from rich households

Ask participants what they know about PD/Hearth. Ask them to state the three goals of PD/Hearth. Show them the prepared flip chart.

2.

Ask how each of the three goals is accomplished through PD/Hearth.

1. ***Quickly rehabilitate malnourished children:*** *Hearth sessions feed a nutrient-dense menu for 12 days plus provide two weeks of follow up; caregivers learn and practise new skills, knowledge*
2. ***Sustain rehabilitation:*** *Follow-up visits ensure continuation of new habits learned; use of local, affordable foods; and involvement in production projects or other interventions that help address underlying causes of malnutrition*
3. ***Prevent future malnutrition:*** *A growth-monitoring programme ensures that the child continues growing well and identifies those who become malnourished; community involvement, including key influencers like grandmothers, builds understanding of causes and solutions to malnutrition and promotes adoption of new behaviours to change norms*

3.

Ask how PD/Hearth differs from more traditional nutrition-education efforts:

(Solutions come from within the community; bottom-up, not top-down programme; uses local, available and affordable resources; learning by doing; community 'owns' the problem and is involved in the solution, recognises the role of grandmothers as household advisors to child care and feeding).

Overview of Positive Deviance/Hearth

The following table outlines some of the differences that you may wish to discuss.

Traditional Approach	Positive Deviance Approach
***Needs*-based: 'What is "wrong" here?' Based on **missing** resources**	***Asset*-based: 'What is right here?' Based on **existing** resources**
Assessment surveys can take up to ***six months***	Positive deviance inquiry (PDI) can take up to ***two weeks***
Depends on supply from outside	Generated by participants and community
Teaching what is ***not*** currently known	***Discovery*** of what ***is*** already known and practised by some individuals (positive deviance)
Solutions from ***outside*** the community	Solutions from ***within*** the community
Outside culture intervention; not always culturally appropriate	Culturally acceptable; based on ***indigenous knowledge***
Dependency, non-participatory; participants are **beneficiaries**	Empowering, participatory; participants are **actors** in their own development
Top down, vertical directives	***Bottom up,*** horizontal integration, variety of stakeholders
Design by ***donors, institutions and NGO***	Equal partnership, in which ***community, caregivers and NGO*** partner to manage and implement project
External inputs not sustained after programme completion; impact diminishes	***Inputs from community*** sustained; impact sustained as well
Centre-based rehabilitation of malnutrition	***Home-based*** rehabilitation and practice; community-based
Expensive, in context of duration of benefits	***Low cost,*** in context of sustained rehabilitation, malnutrition and deaths averted
Run by outside ***experts*** and programme staff	Run by ***community*** and community volunteers and caregivers themselves with training and support from programme staff
NGO or health-agency owned	***Community-owned***

Traditional Approach	Positive Deviance Approach
Teachers/nutritionist from ***outside***; health providers	***Local*** peer educators; volunteer providers
Passive recipients: caregivers of malnourished children	***Active participants:*** caregivers of malnourished children and family/community decision makers
Individual-focussed: considers caregiver isolated from cultural context and enjoys full decision-making power over his/her child	***Family-focussed:*** considers caregiver in the context of the family and cultural system and recognises grandmother's influential role as household advisors related to child care and feeding
KAP: Knowledge, Attitude, Practice Knowledge change approach	***PAK:*** Practice, Attitude, Knowledge Behavioural change approach
Short-term impact	Sustained impact

Pass around a glass that is half filled with water. Ask participants to say how they view the glass (half full or half empty). One can choose to look at a problem in terms of what is lacking or in terms of what is present.

How PD/Hearth Addresses Malnutrition

SESSION 6

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Name the steps in the PD/Hearth approach
2. Explain how PD/Hearth addresses different causes of malnutrition
3. List the components of child care.

Reference in *CORE PD/Hearth Guide*: pp. 1–14

Preparation

- Adapt the story of Tomi to the community context
- Make title cards for the wall labelled IMMEDIATE, ROOT and BASIC
- Write 'Key Steps in the PD/Hearth Approach' on a flip chart or use Handout 6.1: Flip Chart 6 – Ten Key Steps in the PD/Hearth Approach

Materials

- Two table tennis balls: one round, one crushed
- UNICEF model of malnutrition (refer to *CORE PD/Hearth Guide*, pp. 11–12, or print as a handout)
- Flip chart and markers
- Handout 6.1: Flip Chart 6 – Ten Key Steps in the PD/Hearth Approach
- Sticky notes and markers for participants

STEPS

5 Min

1.

Ask participants to think of a young child who is not growing well. Ask several participants to describe the child to the group. What things tell you that the child is not well? *(listless, sad, irritable, often sleepy, may cry a lot, sickly, no interest in playing, hesitant, thin arms and legs, much older than he or she looks)*

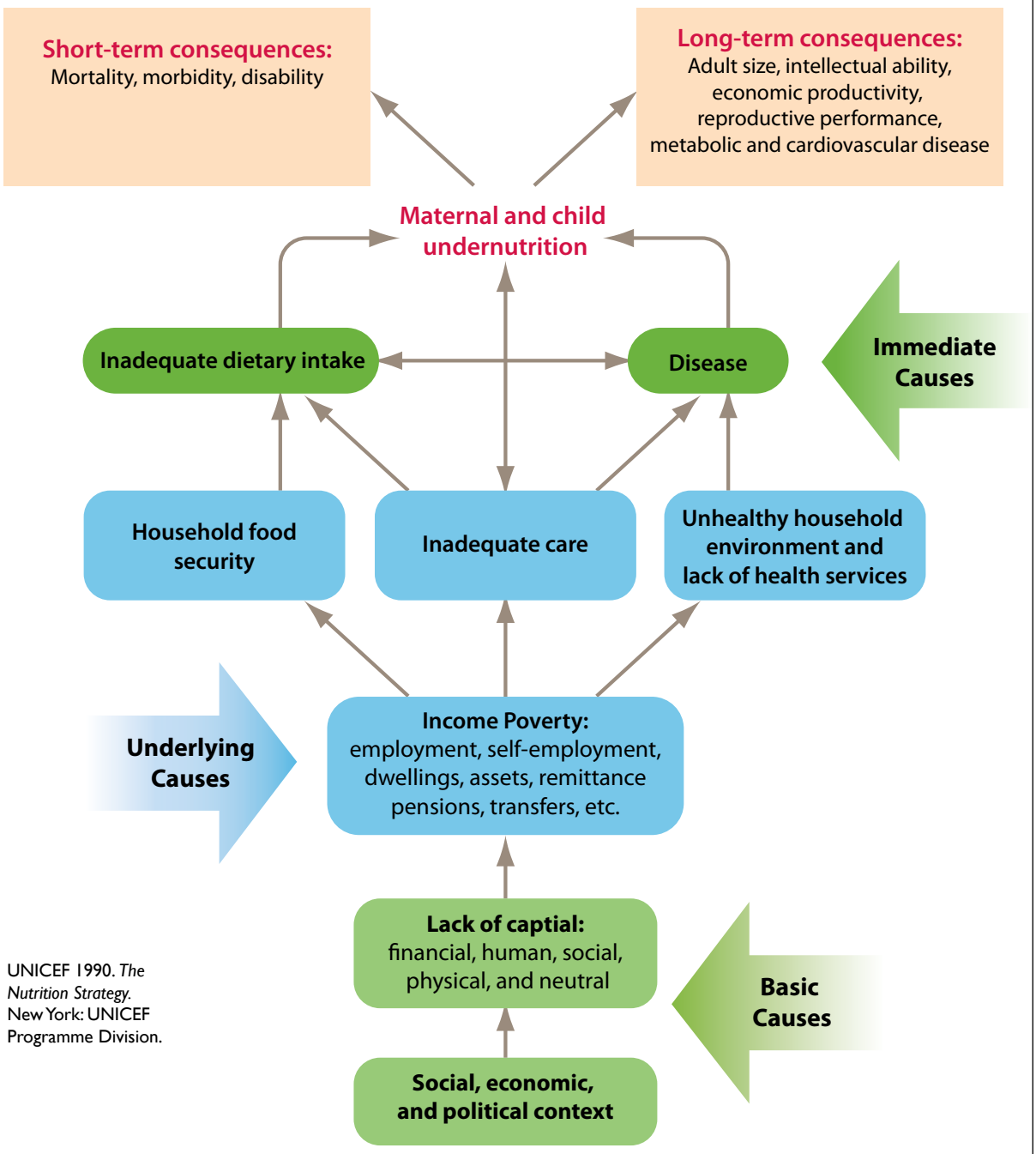
5 Min

2.

Why do we care if children do not grow well? (Ensure that the following points come out: *more likely to be ill with infections such as diarrhoea, pneumonia, tuberculosis and malaria; increased risk of becoming infected with HIV; infection/ illness more likely to become serious or even cause death; learn more slowly and do not achieve well at school; lack of growing, both physically and mentally, will affect them throughout their lives; over their lifetime they will not be able to do as much work and will earn much less than those who were well nourished as children; will be less able to support their own children when they become parents; girls will have difficulty with pregnancy when they are grown women or they will have small babies)*

10 Min

3. Refer to the UNICEF model of malnutrition (Figure 1).



UNICEF 1990. *The Nutrition Strategy.* New York: UNICEF Programme Division.

Figure 1: The UNICEF Conceptual Framework Depicting the Causes of Child Malnutrition.

The causes of malnutrition can be broken into three levels: immediate, underlying and basic. Briefly review what factors come under each level of causes of malnutrition. Post the cards with these headings to the wall with space between each heading for participants to add sticky notes.

Tell the following story about Tomi and ask participants to think about why Tomi is not growing well. Some of the reasons will not be clear in the story, but they can think about what might be causes related to the three levels in the diagram. Adapt the story to the community culture.

> Tomi is 15 months old. He is very small and very thin. Tomi has an older brother, Mo, who is 5 years old, and a sister, Sara, who is 3. Sara was born with low birth weight. Another sister was born very small and died soon after birth. Tomi's mother, Lila, is 27 years old. She is pregnant again. She breastfed all her babies, and—as the grandmother told her to—she also gives them tea and thin porridge. Lila works hard on a farm three miles from her home for a small wage. She finds the work very tiring, especially when she is pregnant. On the way back to the house she stops at the river to get a bucket of water. Once back at her house, she is too tired to do anything but cook the family's meal. Mo takes care of all the children while Lila is in the field. He tries hard to keep them clean and happy, but often Tomi has diarrhoea and a runny nose. They usually have tea for breakfast. At midday they eat whatever might be left over from the day before, but often there is nothing. In the evening the family eats maize or cassava and some green vegetables. They cannot afford meat or even beans.

Lead a discussion using the following questions: What are some reasons Tomi is not growing well? As participants give reasons, ask them why each might be a problem. Dig deeper, asking 'And why is that? And why?' to help them think of underlying causes of malnutrition. Have them write each reason on a sticky note and post it under the appropriate label on the wall. Move this part along quickly.

Ask which of these reasons is the biggest problem. Why? Does this happen in the communities where participants have worked?

Summarise the discussion by saying that there are many reasons that children do not grow well. These can include behaviour related to food, care, hygiene and health.

5 Min

4.

Discuss 'inadequate care' and the topics related to it on the UNICEF chart. Note that the PD/Hearth approach emphasises four components of child care:

- Feeding practices
- Caring practices (affection/attention), including psycho-social and family-child interaction/stimulation)
- Hygiene practices
- Health-care practices (including preventive health practices, home management of illness and health seeking).

Others causes of malnutrition depend on the cultural and local context and may include cattle disease (Southern Sudan), low birth weight, gender bias, and limited access to water, among others.

20 Min

5.

HANDOUT
6.1 – 35m/H 16

Introduce the key steps to PD/Hearth using a prepared flip chart (see below). This chart will be referred to while working through each step of the programme. Each key step number is noted in the title of the relevant session in the curriculum.

6.

Summarise the session, emphasising that the PD/Hearth approach seeks sustainable behaviour change, at the individual and family level as well as at the community level, in order to achieve the three goals of PD/Hearth *(to rehabilitate malnourished children quickly, to sustain rehabilitation, and to prevent future malnutrition)*.

Note to trainers: *The amount of time for each step will depend on the local context (with the exception of Steps 6 and 7). An example of the timing is included for Steps 2–7 to guide discussion with planners. Each key step number is noted in the title of the relevant session in the curriculum. Monitoring and evaluation occurs throughout the process, as illustrated by the right hand column.*

<table>
<tr><th></th><th>STEPS</th><th>APPROXIMATE TIME REQUIRED</th><th rowspan="11">Monitor

and

Evaluate</th></tr>
<tr><td>Step 1</td><td>Decide whether the PD/Hearth approach is feasible in the target community.</td><td></td></tr>
<tr><td>Step 2</td><td>Begin mobilising the community (mobilise or create Village Health/ Hearth Committee or working group within the community); select and train staff.</td><td rowspan="3">Mobilising the community can take several months and takes place throughout the entire project period.
Steps 2 to 4 can take approximately 2–3 weeks, including:
2 days of training
2 days for situational analysis
2 days for PDI
2 days for analysis and feedback to the community</td></tr>
<tr><td>Step 3</td><td>Prepare for a PDI (situational analysis).</td></tr>
<tr><td>Step 4</td><td>Conduct a PDI.</td></tr>
<tr><td>Step 5</td><td>Design Hearth sessions.</td><td>2 days</td></tr>
<tr><td>Step 6</td><td>Conduct Hearth sessions.</td><td>2 weeks</td></tr>
<tr><td>Step 7</td><td>Support new behaviours through follow-up visits.</td><td>Every 2-3 days in the 2 weeks immediately after the Hearth session, and continuing less frequently after that</td></tr>
<tr><td>Step 8</td><td>Repeat Hearth as needed.
Monitor progress of Hearth graduates and track growth of all young children.</td><td></td></tr>
<tr><td>Step 9</td><td>Expand the PD/Hearth programme to additional communities.</td><td></td></tr>
<tr><td>Step 10</td><td>Exit strategy for once underweight is eliminated or ADP phases out</td><td></td><td></td></tr>
</table>

SESSION 7

Determining the Feasibility of the PD/Hearth Approach for the Target Community (STEP 1)

World Vision

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe the assessment process and essential considerations for determining if PD/Hearth is a possible approach in a target area
2. Evaluate if PD/Hearth is a good approach for a target community (case study)
3. Review alternative approaches to use when PD/Hearth is not feasible or appropriate.

Reference in *CORE PD/Hearth Guide*: pp. 17–25

Preparation

- Flip chart for step 1. Write on the top: 'Essential Considerations for PD/Hearth Programme'
- Flip chart (1 for each small group) with the questions for the exercise in step 2 written on it
- Print out Handout 7.1and 7.2

Materials

- Handout 7.1: Case Studies: Is PD/Hearth Appropriate for These Settings?
- Handout 7.2: Where to Implement PD/Hearth

STEPS

10 Min

1.

Emphasise that PD/Hearth does not work everywhere. Quickly introduce the following criteria (Refer to Handout 7.2) for determining when PD/Hearth is appropriate:

1. **Mild, moderate and severe malnutrition, based on weight for age, affects more than 30 per cent of children 6 to 36 months old o*r* 30 underweight children between the ages of 6-36 months.** PD/Hearth is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include mild, moderate and severe malnutrition, but programmes concerned with cost efficiency may want to focus PD/Hearth activities on those who are moderately or severely malnourished and use less intensive methods to address the children with mild malnutrition. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely malnourished children in the 6–36 month age range.** Since it is unlikely that an implementing agency will have done a census-based nutritional assessment prior to deciding whether to implement the programme, the decision can be based on existing growth monitoring data, data from surveys of a representative sample of the population, or other existing data.

Note: *PD/Hearth uses weight for age because that is the indicator most sensitive to change and does not require height measurements, which are difficult to collect. While mid-upper arm circumference (MUAC) is useful in screening for malnutrition in emergencies, it is not specific enough to identify all children who are also below weight for their age.*

2. ***Affordable food is available.*** A fundamental precept of PD/Hearth is that families can rehabilitate their children and prevent malnutrition with affordable, locally available food. If all poor families in the community are reliant on food aid or are eating only the staple food due to lack of anything else, other interventions to improve food security must come first.

3. ***Homes are located within a short distance of one another***. Because caregivers are expected to come with their children to the Hearth session every day and the volunteers must make frequent home visits, the homes must be within easy walking distance from a central point.

4. ***There is a community commitment to overcome malnutrition.*** A commitment will serve to mobilise resources and pave the way for organising Hearth sessions and providing peer support to participating families. If there is no governing or civic body to work with, it may be necessary to form a village health committee. PD/Hearth has not been successful where populations are transient and lack a sense of community.

5. ***There is access to basic complementary health services.*** Health services are necessary for the children to receive inputs not available at the Hearth, such as deworming, immunisations, malaria treatment, micronutrient supplementation and referrals. Children receive the needed services ***before*** entering the Hearth and may be referred for further evaluation and treatment if they do not show adequate weight gain after participating in the Hearth for two weeks with two more weeks of follow-up visits at home.

6. ***Systems for identifying and tracking malnourished children exist or can be developed.*** While such systems are not a prerequisite, they must be developed for the programme. The first step may be a door-to-door census and weighing of children, but then a routine monthly growth-monitoring system must be established not only to track the children who complete the Hearth sessions, but also to detect other children who may need to enter the programme. PD/Hearth is intended to be only one phase of a wider nutrition programme.

7. ***The presence of food aid in Hearth can be minimised with careful planning.*** Families need to learn to provide the nutrition their children need from local foods, rather than food aid, which is not a sustainable solution to malnutrition or food insecurity. Limited amounts of food aid, in the form of local staples (such as rice and

oil) can be used in the Hearth menus, but the participating families must contribute the other foods in order to learn firsthand about their accessibility and affordability. The Hearth sessions emphasise using locally available foods.

8. ***Organisational commitment of the implementing agency is strong.*** This is essential. Because of the effort required to start a PD/Hearth programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PD/Hearth need to devote themselves full time to PD/Hearth, particularly in the start-up months. Projects should consider budgeting for additional staff and recruiting additional volunteers rather than expecting existing staff and volunteers to add the PD/Hearth to their existing responsibilities. Since PD/Hearth is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.

10 Min

2.

HANDOUT
7.1 – 40m/H 17
7.2 – 41m/H 18

Divide participants into small groups and pass out the case studies (Handout 7.1), the implementation criteria (Handout 7.2) and a flip chart with the following questions to each group. For each case the group should answer the following questions and summarise for the large-group discussion:

- Does this case meet the criteria for a PD/Hearth programme?
- What are the strengths that would help PD/Hearth succeed in this community? Advantages?
- What are the challenges of doing PD/Hearth in this community? Disadvantages?
- If PD/Hearth is not appropriate, what other approaches could address the nutrition problem?

20 Min

3.

Return to the large group. Allow each small group to discuss the case studies informally and to present its conclusions about the appropriateness of PD/Hearth. Ask for comments and discussion by the large group. Be sure to discuss alternative strategies if PD/Hearth is considered inappropriate.

Case study notes:

Coast village – level of malnutrition does not warrant the effort of PD/Hearth.

North interior – PD/Hearth is not appropriate; work is needed with the daycare, not the home.

Northeast mounds – Homes are too dispersed. Use creative approaches to promote appropriate breastfeeding and complementary feeding at clinics, markets, by radio, and so forth.

South Farming Community – PD/Hearth would be appropriate; grandmothers could be asked to run the Hearth sessions. Children will need to be screened for stunting.

Peri-urban slums – This situation has some potential for successful PD/Hearth; however, it may be more important to put together menus of street foods since women don't cook at home. Although underweight level are less than 30 per cent, there are still greater than 30 malnourished children in a densely populated community.

5 Min

4.

Recap the important criteria and take questions from the group on PD/Hearth Step 1 (determining the feasibility of PD/Hearth).

Case Studies: Is PD/Hearth Appropriate for These Settings?

Read and analyse the following cases. Decide whether PD/Hearth will work in each situation. If not, explain why not and think about an alternative approach. Suggest additional nutrition strategies and interventions needed from other sectors. If PD/Hearth is appropriate, but there are special challenges, please describe how to overcome them.

Case 1 – Coastal village – 12 per cent malnutrition but 35 children underweight

All the families make their living by fishing or selling fish. They live in a small village with houses very close together. The men are gone from before dawn until noon. When they return, they expect their big meal to be waiting. The women spend the afternoon cleaning fish and repairing the fishing nets. They work together on the beach and take their babies on their backs. Older children stay at the house with grandmothers or older siblings. There is plenty of fish to eat, but few fruits and vegetables most of the year. The health centre is in the next town, 15 minutes away by bus.

Case 2 – North interior – 35 per cent malnutrition

Families live in very small villages scattered through the tea estates. There are 10 to 20 families in each village. It can take between 30 minutes and one hour to walk over very hilly terrain to the main estate village. Nearly all the mothers work full time on the tea estates. The children from six months to three years spend nine hours a day in daycare with two paid employees. Food in the day care is provided by the estate. (After three years of age, children stay with grandparents during the day until they start school at age five.) The day care is located next to a good health clinic provided by the estate management. There is a joint management body made up of representatives of both workers and management.

Case 3 – Northeast – 32 per cent malnutrition

This good agricultural area produces grain, fruits and vegetables. The houses are dispersed, spread out over mounds. Grandmothers care for the small children when women go to the fields to work or the river to fish. There is a health centre in the nearest town, which is a four-hour walk for many families. When the rains come and water surrounds their mound, families cannot easily travel to other homes or villages. Some families have to move to higher ground for three or four months, which makes it difficult for them to raise poultry or livestock.

Case 4 – South farming community – 39 per cent malnutrition

Most of the children in this community are very short for their age. The families are engaged in farming, with most women at home except during harvest time. The village is very compact, and people work together on many community projects. Grandmothers decide when children should start getting water or food, often when they are one month old. There is a small Christian hospital, and government health workers bring vaccines and vitamin A.

Case 5 – Peri-urban – 20 per cent malnutrition

Families live in densely populated squatter settlements in simple houses with no sanitation. Water is fetched from central water taps some distance away. Families have easy access to health facilities. Because the houses are so small, most families do not cook at home. They buy cooked food from street vendors and snacks from the many small shops. Most women are at home during the day. Those who work leave their children in the care of older women. There are approximately 40 moderately and severely underweight children between the ages of 6-36 months.

PD/Hearth will not work everywhere. It is important to consider the following criteria when deciding if PD/Hearth is the right approach for a given community.

1. **Mild, moderate and severe malnutrition, based on weight for age, affects more than 30 per cent of children 6 to 36 months old or 30 underweight children between the ages of 6-36 months.** PD/Hearth is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include mild, moderate and severe malnutrition, but programmes concerned with cost efficiency may want to focus PD/Hearth activities on those who are moderately or severely malnourished and use less intensive methods to address the children with mild malnutrition. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely malnourished children in the 6–36 month age range.** Since it is unlikely that an implementing agency will have done a census-based nutritional assessment prior to deciding whether to implement the programme, the decision can be based on existing growth monitoring data, data from surveys of a representative sample of the population, or other existing data.

2. ***Note:*** *PD/Hearth uses weight for age because that is the indicator most sensitive to change and does not require height measurements, which are difficult to collect. While mid-upper arm circumference (MUAC) is useful in screening for malnutrition in emergencies, it is not specific enough to identify all children who are also below weight for their age.*

3. ***Affordable food is available.*** A fundamental precept of PD/Hearth is that families can rehabilitate their children and prevent malnutrition with affordable, locally available food. If all poor families in the community are reliant on food aid or are eating only the staple food due to lack of anything else, other interventions to improve food security must come first.

4. ***Homes are located within a short distance of one another***. Because caregivers are expected to come with their children to the Hearth session every day and the volunteers must make frequent home visits, the homes must be within easy walking distance from a central point.

5. ***There is a community commitment to overcome malnutrition.*** A commitment will serve to mobilise resources and pave the way for organising Hearth sessions and providing peer support to participating families. If there is no governing or civic body to work with, it may be necessary to form a village health committee. PD/Hearth has not been successful where populations are transient and lack a sense of community.

6. ***There is access to basic complementary health services.*** Health services are necessary for the children to receive inputs not available at the Hearth, such as deworming, immunisations, malaria treatment, micronutrient supplementation and referrals. Children receive the needed services ***before*** entering the Hearth and

may be referred for further evaluation and treatment if they do not show adequate weight gain after participating in the Hearth for two weeks with two more weeks of follow-up visits at home.

7. ***Systems for identifying and tracking malnourished children exist or can be developed.*** While such systems are not a prerequisite, they must be developed for the programme. The first step may be a door-to-door census and weighing of children, but then a routine monthly growth-monitoring system must be established not only to track the children who complete the Hearth sessions, but also to detect other children who may need to enter the programme. PD/Hearth is intended to be only one phase of a wider nutrition programme.

8. ***The presence of food aid in Hearth can be minimised with careful planning.*** Families need to learn to provide the nutrition their children need from local foods, rather than food aid, which is not a sustainable solution to malnutrition or food insecurity. Limited amounts of food aid, in the form of local staples (such as rice and oil) can be used in the Hearth menus, but the participating families must contribute the other foods in order to learn firsthand about their accessibility and affordability. The Hearth sessions emphasise using locally available foods.

9. ***Organisational commitment of the implementing agency is strong.*** This is essential. Because of the effort required to start a PD/Hearth programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PD/Hearth need to devote themselves full time to PD/Hearth, particularly in the start-up months. Projects should consider budgeting for additional staff and recruiting additional volunteers rather than expecting existing staff and volunteers to add the PD/Hearth to their existing responsibilities. Since PD/Hearth is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.

Daily Summary and Evaluation

SESSION 8

10 MIN | DAY 1

By the end of this session, participants will be able to

1. Evaluate their personal learning for the day.

Preparation

- Make a flip chart with the daily evaluation questions (listed below)

Materials

- Half sheet of paper for each person

STEPS

1.

Each participant will reflect on the day's sessions thus far and write in his or her curriculum ideas to improve or adapt the various methods of presenting the material so they are more appropriate for his or her culture. Ask the participants to be ready to share any good ideas they might have.

2. Daily Evaluation

Distribute a half sheet of paper to each participant. Ask them to respond to the three phrases written on the flip chart.

1. Something I learned today that I will apply in our PD/Hearth programme is

_____.

2. Something new that I learned about PD/Hearth today is

_____.

3. Something I'm still confused about is

_____.

Note: *The facilitators will review these evaluations at the end of each day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.*

3.

Thank the participants for their good work. Mention any highlights of the day. Remind them of the time for the next meeting.

SESSION 9

Review of Day 1 and Agenda for Day 2

30 MIN | DAY 2

By the end of this session, participants will be able to

1. Review Day 1 content
2. Outline what will be covered today.

Preparation

- Review questions for Day 1.

Materials

- Ball
- Prizes for winning team members

STEPS

1.

Ask the participants to form two lines facing each other. Ask a question. Throw the ball to a person, who must then answer the question. If the answer is correct, ask another question. If it is incorrect, repeat the question. The person holding the ball throws it to a person on the other team, who must answer the question. The team that answers the most questions correctly wins.

Possible questions:

- What is one goal of PD/Hearth? (ask the question three times; people give different goals)
- What is one of the ten key steps in the PD/Hearth Approach?
- What is a criterion to determine if PD/Hearth is feasible?
- What is a responsibility of a Facilitator?

2.

Review agenda for today.

Community Mobilisation (STEP 2)

SESSION 10

70 MIN | DAY 2

By the end of this session, participants will be able to

1. Describe successful community mobilisation methods for involving key stakeholders and community members
2. Identify key stakeholders.

Preparation

- Print out Handout 10.1
- Prepare one flip chart titled 'Whom do you need to mobilise for PD/Hearth?' with a simple Venn diagram on it.
- Prepare one flip chart with the Triple A cycle (see below).
- Prepare a flip chart with the following discussion questions:
  - What is the role of the Ministry of Health?
  - What is the role of the Village Health Committee?
  - How do you get maximum buy-in and support? How do you keep this involvement?

Materials

- 10.1 Handout: Community Mobilsation (STEP 2)

STEPS

30 Min

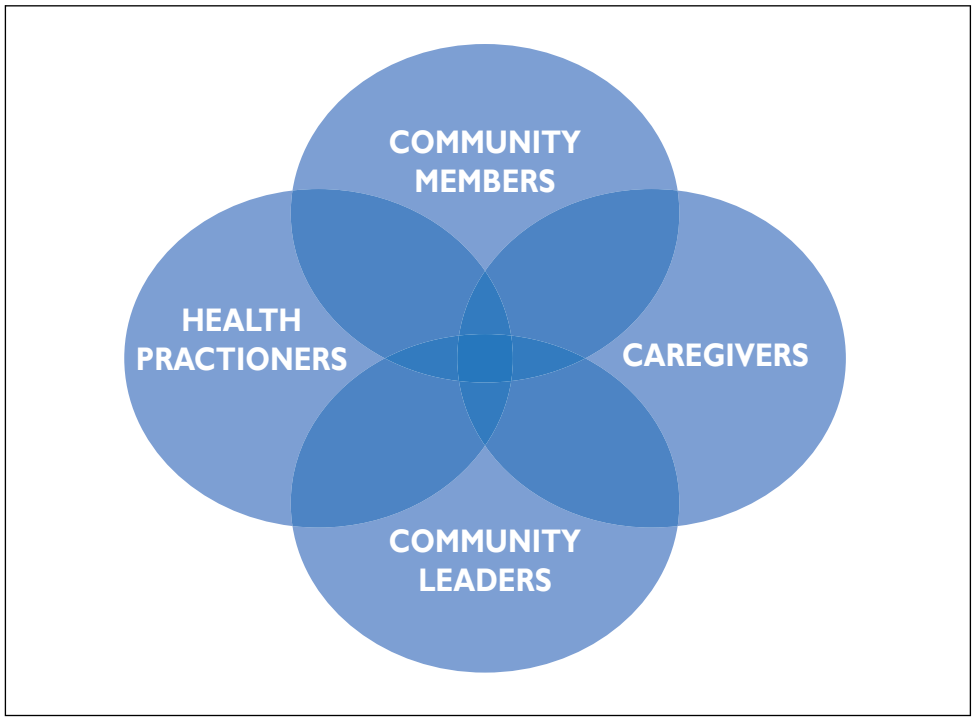
1. Introduce PD/Hearth Step 2

Stress the importance of community mobilisation. PD/Hearth needs involvement by the community in order to succeed. This is a very important component that is often overlooked but necessary to deliver sustainable impact and prevent malnutrition in younger siblings. PD/Hearth Facilitators should have a solid background in community mobilisation. Indicate that community mobilisation is a big topic, and many participants have a lot of experience with it. The discussions in this course will focus on the context of community mobilisation for PD/Hearth, but will also pull from the expertise of the group. Use key questions to brainstorm and guide discussion, writing group input on flip charts. *(**Note:** uncover the previously written questions one at a time.)*

HANDOUT
10.1 – 47m/H 20

Whom do you need to mobilise for PD/Hearth? Show the participants the diagram of overlapping circles (Venn diagram) on a flip chart. Each large circle represents a group of people in the community who may need to be mobilised for PD/Hearth. Ask participants who in the community needs to be mobilised.

As they call out answers write one group of people in each circle. Ask who are people within each of these groups who should be included? Add these groups to the smaller overlapping circles to show that there are many stakeholders who need to be mobilised for PD/Hearth *(community leaders; fathers, grandmothers, mothers and other caregivers; health staff, volunteers and their families [large time commitment]; traditional healers; traditional birth attendants; schoolteachers; and many others can contribute to the success of a PD/Hearth programme)*.



What is the role of the Ministry of Health? *(How is it incorporated?)*

The Ministry of Health provides support services such as immunisation, deworming, vitamin A supplementation; training; monitoring; and scale-up of learnings from PD/Hearth into existing health and nutrition message sharing systems).

What is the role of the Village Health Committee? *(Does a VHC exist? Does it need to be revived?)*

The VHC manages and coordinates health activities at the local level; sets criteria for, selects and supervises community health volunteers; and collaborates with the implementing organisation and district health staff (contextual depending on the country's existing Ministry of Health structure).

Can PD/Hearth be implemented without a Village Health Committee?

In the absence of a VHC, it is important to identify management resources at the grassroots level; build on existing resources. If possible, work to re-establish a non-functioning committee or establish a VHC or Village Hearth Committee.

What is the role of grandmothers?

In many cultures grandmothers are highly influential in the home as advisors on child care and feeding, and thus are important figures to engage throughout PD/Hearth. The following activity will help to illustrate the importance grandmothers have, especially in maternal and child care, and the necessity to include them in PD/Hearth.

Ask participants to identify ways to involve grandmothers in PD/Hearth. Ensure the following points are included:

- Consider grandmothers for leadership roles, including VHC and Hearth volunteer positions
- Consult grandmothers during situational analysis
- Interview grandmothers during PDI and/or involve grandmothers in conducting the PDI
- Engage grandmothers as participants in Hearth, either as caregivers, volunteers or part of caregiver-grandmother pairs
- Include grandmothers in follow up home visits, including review of child's progress and discussion of challenges to implementing PD practices at home

15 Min

2.

Divide into four groups (or as many groups as circles on the Venn diagram). Each group represents one community group. Come up with as many strategies as possible for:

- Maximising commitment and support; and
- Maintaining involvement throughout the project.

After a few minutes, call on volunteers to state the ideas their groups have come up with. *Note:* Listen to the participants' knowledge. *The solutions are in the group.*

Discuss the following questions:

How do you get maximum commitment and support?

Engage the community as the primary partner, with a role in selection criteria of volunteers. Be sure to involve in the process people who might raise barriers.

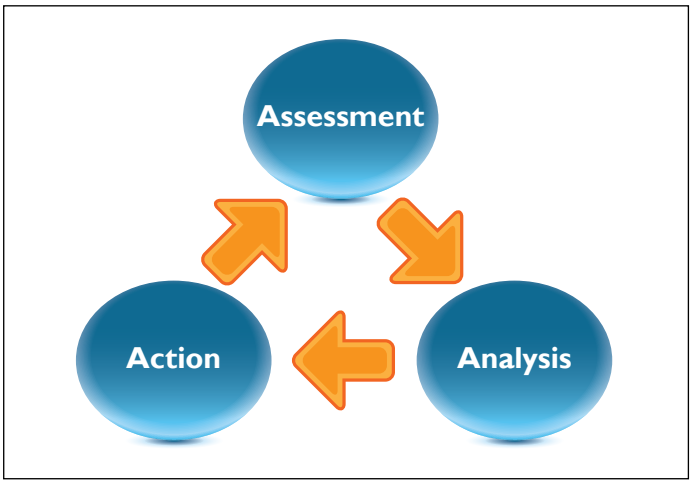
How do you keep this involvement throughout the project?

Establish a partnership with the community from the beginning and maintain it throughout.

See the **Triple A** cycle (assess, analyse, action) discussion on p. 29 of the *CORE PD/Hearth Guide*. Programme management is carried out in partnership with the community by assessing the problem, analysing its causes and taking action based on this analysis.

From the community mobilisation and ownership steps below, what activities might the community include in each circle (assessment, analysis, action)?

Discuss together key times when the community can be mobilised (based on the following steps).



STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP:

Step 1 Identify community leaders using existing community health volunteers and plan to meet with community leaders, religious leaders and women representatives.

Step 2A Ask community leaders for their permission and invitation to use the PD approach (finding existing solutions to malnutrition problems from within the community).

Step 2B Ask about the existing local health systems (e.g. Village Health and Sanitation Committee (VHSC), VHC (Village Health Commitee), etc.). Discuss a way to describe PD concepts in the local language (i.e. proverbs, stories). Discuss volunteer selection if a particular volunteer group does not already exist.

Step 3 Engage the community to define the problem (conduct wealth ranking); weigh all the children in the target group with community members, especially men (special GMP session). Involve community in focus group discussions, community mapping, seasonal calendar, transect walk, and market survey.

Step 4 Community Feedback Sessions: engage community members in discussion about the issue of childhood malnutrition; discuss its causes, common challenges and constraints, and ask for their ideas or suggestions for solutions. Involve men, grandmothers, mothers and all women who delivered the year before, include TBAs and traditional healers as well as religious leaders. Other very important activities to engage community members include: social mapping (include young men and women in this activity), seasonal calendar, market survey and wealth ranking.

Step 5 Second Community Feedback Session: Prepare and train leaders to carry out a meeting with the larger community to share the baseline information (results of the weighing) and the findings from group discussions as well as the PD concept from the visual poster to show nutritional assessment results. Also share the visuals of community created social mapping, seasonal calendar, market survey and wealth ranking. Discuss on the volunteer identification or if there are no volunteers yet, select volunteers.

Step 6 Plan and carry out PD inquiries with community members.

Step 7 Have community members (VHC) analyse and select key PD behaviours and have them share the PDI findings with the whole community, examining the PD behaviours and strategies with the community members; invite them to develop a plan of action that will include Hearth sessions.

Step 8 Involve or remain transparent to the community in selecting staff – such as a supervisor, village hearth committee members, and/or community health

volunteers – to contribute to the staff's credibility and to promote the community's ownership of the programme.

Step 9 Involve the community in monitoring monthly progress in the nutritional status of all children in the target group. (In Bangladesh a consolidated community growth monitoring chart is used for all children participating in PD/Hearth so the entire community can see the effectiveness of the programme.)

Step 10 Appreciation Day/Graduation Day

Step 11 Program Monitoring and Review

3.

For the community mobilisation and ownership Step 2, conduct a role play where you are meeting with the community leaders for the first time to talk about the following:

- Ask community leaders for permission to help the community overcome malnutrition
- Explain the concept of PDH without using technical language
- Explain the program of PDH (12 day long education session)
- Emphasize that we are here to learn from the community because there are positive behaviours that are allowing their children to stay healthy whether they are practicing the behaviours knowingly or not. We are here to identify those positive practices, especially from those households who do not have a big house and many cattle, yet they still have very healthy children
- Ask if there would be any members from the community who would like to help volunteer to run the program as this program cannot be run without the community taking the leadership

15 Min

4.

Summarise some of the key challenges to community involvement and some of the solutions developed by the group. Refer participants to additional exercises for mobilising communities in the *CORE PD/Hearth Guide*, pp. 43–52. Answer any remaining questions. Note that we will be spending time throughout the remainder of the course working on each of these activities.

Note: *It is vitally important to understand fully the community players, conflicts, priorities, existing structures and resources.*

If hard copies of the resources for community participation listed above are available, suggest that participants look at these during breaks and/or list websites where participants can obtain them.

Identifying and Selecting Volunteers (STEP 2)

SESSION 11

35 MIN | DAY 2

By the end of this session, participants will be able to

1. Describe the roles and responsibilities of staff and volunteers required for PD/Hearth, with an overview of the organisational structure.

References in *CORE PD/Hearth Guide*: pp. 20–24, 31–35, 39–42, 50–56

Materials

- Organisation chart (See p. 24 in the *CORE PD/Hearth Guide*)
- Flip chart with the title 'What PD/Hearth Volunteers Do'
- Flip chart with the title 'Skills Needed by Volunteers'
- Flip chart with blank paper

STEPS

5 Min

1. Reiterate that PD/Hearth is a human resource–intensive programme. Though the programme does not require large investments in infrastructure, the hard work and commitment of staff and volunteers are critical to its success.

2. Discuss the importance of having the commitment of WV leadership and the support of key sectors for PD/Hearth. How can the participants begin to achieve this commitment? *(use data to raise awareness of levels of malnutrition; give orientation on principles of PD/Hearth; stress importance of other sectors to address underlying causes and how this contributes to child well-being; include all sector leaders in discussions, planning and trainings)*

3. Briefly describe the roles of Hearth manager/lead trainer (e.g. National Office level Health and Nutrition Coordinator), supervisor/trainer (e.g. ADP level Health, Nutrition and HIV/AIDS Officer), village health committee (VHC), and Hearth volunteer. Review each position and its corresponding responsibilities, based on the text in the *CORE PD/Hearth Guide*. Ask what titles the participants use for the staff members who fill these positions in their ADPs. Refer to the sample job descriptions in the *CORE PD/Hearth Guide* (pp. 39–42) and ask participants to read these as homework.

5 Min

4. Discuss the total number of volunteers/staff and beneficiaries, using the chart in the *CORE PD/Hearth Guide* (p. 24) or give practical examples from your experience of implementing PD/Hearth. Ask participants and other facilitators to suggest circumstances that might lead to adapting these suggested numbers and/or roles.

SESSION 12

Learning Styles and Facilitation

World Vision

45 MIN | DAY 2

By the end of this session, participants will be able to

1. Describe their learning style preference
2. Explain how their teaching style can be adapted to include other learning styles.

Reference in *CORE PD/Hearth Guide*: pp. 1–14

Preparation

- Print Handout 12.1 and 12.2

Materials

- Handout 12.1: VARK Learning Styles Questionnaire
- Handout 12.2: VARK Learning Styles Questionnaire ANSWER KEY

STEPS

10Min

1.

HANDOUT
12.1 – 54m/H 24
12.2 – 56m/H 26

Explain the four learning styles: **V**isual, **A**ural, **R**ead/write, **K**inesthetic (movement). Everyone has preferred ways to learn. Some people learn best using all four styles equally. They are called multi-modal learners and will be in the fifth group. Distribute the VARK questionnaire and ask each participant to complete it. Distribute the VARK answer key and allow each person to mark his or her questionnaire and total the scores in each section. Ask each to determine his or her overall learning style.

25 Min

2.

Group the participants by their preferred learning styles. There will be five groups. Ask each group to discuss these questions:

- How do you learn best? Be prepared to share with the large group two examples of how you learn best.
- How do you adapt when the teaching style does not match your preferred learning style? Be prepared to share with the large group two ways to compensate.

- How can you adapt your teaching to accommodate the different learning styles of your students? Be prepared to share one way you can do this. In the large-group discussion you will discuss with the other groups if this way of adapting would help them learn.
- Share and discuss the examples in the large group.

5 Min

3.

Good facilitation requires adapting one's preferred learning style to include methods that will help people with different learning styles to learn.

List together on a flip chart different methods that can be used. Be sure to include a wide variety of creative teaching styles *(role play, case studies, song, drama, reading, writing, games, stories, drawing, etc.)*.

5 Min

4.

Summarise the discussion. Emphasise the need to be creative and to use a wide variety of methodologies in facilitation of PD/Hearth courses.

VARK Learning Styles Questionnaire

(http://www.vark-learn.com, used with permission)

Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ a chance to ask questions and talk about the camera's features.
   - ☐ examples of good and poor photos and how to improve them.
   - ☐ clear written instructions with lists and bullet points.
   - ☐ diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ make lists of what to do and what to buy for the party.
   - ☐ invite friends and just let it happen.
   - ☐ talk about it on the phone or text others.
   - ☐ imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ walk with them.
   - ☐ write down the directions as a list.
   - ☐ tell them the directions.
   - ☐ draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ class discussions, online discussion, online chat and guest speakers.
   - ☐ field trips, case studies, videos, labs and hands-on practical sessions.
   - ☐ a textbook and plenty of handouts.
   - ☐ an overview diagram, charts, labelled diagrams and maps.

5. You have a problem with your knee. Would you prefer that the doctor:
   - ☐ showed you a diagram of what was wrong.
   - ☐ described to you what was wrong
   - ☐ demonstrated what was wrong using a model of a knee.
   - ☐ gave you an article or brochure that explained knee injuries.

6. After reading a play you need to do a project. Would you prefer to:
   - ☐ act out a scene from the play.
   - ☐ read a speech from the play.
   - ☐ draw or sketch something that happened in the play.
   - ☐ write about the play.

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ describe the activities you will be doing in the programme.
   - ☐ start practicing the activities you will be doing in the programme.
   - ☐ show them the list of activities in the programme.
   - ☐ show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ things you can click on and do.
   - ☐ interesting design and visual effects.
   - ☐ audio channels for music, chat and discussion.
   - ☐ interesting information and articles in print.

9. You have to present your ideas to your colleagues. You would:
   - ☐ write out your speech and learn it by reading it again and again.
   - ☐ write a few key words and practise what to say again and again.
   - ☐ gather examples and stories to make it real and practical.
   - ☐ make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
    - ☐ that used a written description or table of your results.
    - ☐ that used examples of what you have done.
    - ☐ from somebody who discussed it with you.
    - ☐ that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
    - ☐ trying it.
    - ☐ the salesperson telling you about it.
    - ☐ it is the latest design and looks good.
    - ☐ reading the details about its features.

12. You are going to make something special for your family. You would:
    - ☐ make something you have made before.
    - ☐ find written instructions to make it.
    - ☐ look for ideas and plans in books and magazines.
    - ☐ talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
    - ☐ clues from the diagrams in the instructions.
    - ☐ listening to somebody explaining it and asking questions.
    - ☐ watching others do it first.
    - ☐ reading the instructions.

(http://www.vark-learn.com, used with permission)

Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ **A** a chance to ask questions and talk about the camera's features.
   - ☐ **V** examples of good and poor photos and how to improve them.
   - ☐ **R** clear written instructions with lists and bullet points.
   - ☐ **K** diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ **R** make lists of what to do and what to buy for the party.
   - ☐ **K** invite friends and just let it happen.
   - ☐ **A** talk about it on the phone or text others.
   - ☐ **V** imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ **K** walk with them.
   - ☐ **R** write down the directions as a list.
   - ☐ **A** tell them the directions.
   - ☐ **V** draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ **A** class discussions, online discussion, online chat and guest speakers.
   - ☐ **K** field trips, case studies, videos, labs and hands-on practical sessions.
   - ☐ **R** a textbook and plenty of handouts.
   - ☐ **V** an overview diagram, charts, labelled diagrams and maps.

5. You have a problem with your knee. Would you prefer that the doctor:
   - ☐ **V** showed you a diagram of what was wrong.
   - ☐ **A** described to you what was wrong
   - ☐ **K** demonstrated what was wrong using a model of a knee.
   - ☐ **R** gave you an article or brochure that explained knee injuries.

6. After reading a play you need to do a project. Would you prefer to:
   - ☐ **K** act out a scene from the play.
   - ☐ **A** read a speech from the play.
   - ☐ **V** draw or sketch something that happened in the play.
   - ☐ **R** write about the play.

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ **A** describe the activities you will be doing in the programme.
   - ☐ **K** start practicing the activities you will be doing in the programme.
   - ☐ **R** show them the list of activities in the programme.
   - ☐ **V** show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ **K** things you can click on and do.
   - ☐ **V** interesting design and visual effects.
   - ☐ **A** audio channels for music, chat and discussion.
   - ☐ **R** interesting information and articles in print.

9. You have to present your ideas to your colleagues. You would:
   - ☐ **R** write out your speech and learn it by reading it again and again.
   - ☐ **A** write a few key words and practise what to say again and again.
   - ☐ **K** gather examples and stories to make it real and practical.
   - ☐ **V** make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
   - ☐ **R** that used a written description or table of your results.
   - ☐ **K** that used examples of what you have done.
   - ☐ **A** from somebody who discussed it with you.
   - ☐ **V** that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
   - ☐ **K** trying it.
   - ☐ **A** the salesperson telling you about it.
   - ☐ **V** it is the latest design and looks good.
   - ☐ **R** reading the details about its features.

12. You are going to make something special for your family. You would:
   - ☐ **K** make something you have made before.
   - ☐ **R** find written instructions to make it.
   - ☐ **V** look for ideas and plans in books and magazines.
   - ☐ **A** talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
   - ☐ **V** clues from the diagrams in the instructions.
   - ☐ **A** listening to somebody explaining it and asking questions.
   - ☐ **K** watching others do it first.
   - ☐ **R** reading the instructions.

Total Personal Score: Visual =____ Aural =____ Read/Write =_____ Kinaesthetic =____

SESSION 13

Situational Analysis – Wealth Ranking (STEP 3)

World Vision

30 MIN | DAY 2

By the end of this session, participants will be able to

1. Explain the purpose and process of wealth ranking using community criteria
2. Use pre-defined criteria to rank households by wealth status
3. Complete filling out and compiling of wealth-ranking data on Situational Analysis Excel template.

Reference in *CORE PD/Hearth Guide*: pp. 65–66

Preparation

- Print copies of Handout 13.1, 13.2 and 13.3
- Provide participants with soft copy of Situational Analysis (refer to Resource CD).

Materials

- Small objects in two different variations, such as stones of different colours
- Print copies of Handout 13.1 and 13.2 for each participant
- Handout 13.1: Case Examples for Wealth-Ranking Exercise
- Handout 13.2: Case Examples for Wealth-Ranking Exercise ANSWER KEY
- Handout 13.3: Wealth Ranking for PD/Hearth
- Soft copy of Situational Analysis Excel template.

STEPS

5 Min

1.

Wealth Ranking/Nutritional Assessment

Wealth ranking and initial nutritional assessment are used to identify the PD, non-PD, and ND households, it is important to identify these households in order to conduct PDIs. During the PDI, it is strongly recommended to visit 4 PD households, 2 ND households and 2-4 non-PD households.

Ask how many participants have done a wealth-ranking exercise. Explain that it is a way to identify the different socioeconomic classes within a community.

Why do we need to do this to prepare for implementing Hearth in a given community?

It is necessary to determine the poorest families in order to identify positive deviants among them. To believe that the practices of the PD families can be done by the poorest in the community, the volunteers, caregivers and others in the community must believe that the PD families are truly among the poorest.

Explain that it is important to do this exercise with community members because only they know how to define *poorest* in their community. They must agree with the final assignment of families in order to believe later that there are PD families.

The objective of the wealth-ranking exercise is to understand the way the community classifies its economic differences and to determine criteria for classifying extended families or households. If people share food, resources and income in nuclear units, then wealth ranking is done by household. If the food, resources and other income are shared across multiple, related households, then wealth ranking must consider the extended family instead.

15 Min

2.

Divide participants into two groups, each representing a village. Included are leaders, representatives of different ethnic groups, women and men, and all socioeconomic classes. Facilitators represent the PD/Hearth staff who will lead a 'village' through a wealth-ranking exercise. Explain that we want to learn how some families with few resources keep their children healthy. Community members know which families have few resources and which are better off. We would like their help to identify the poorest families.

Choose two different versions of an object, for example, two stones of different colours. Lay the stones out on the ground with some distance between them. Explain that one stone represents the non-poor families and the second represents the poorest people. Have everyone look at the non-poor stone and reflect silently on which families in their community would go with this stone. Ask participants how they know these families are not poor. What do these families have that families in the poor category (stone) don't have? List all the characteristics. Prompt them to think about housing, farm implements, livestock, clothing, transport, occupations, amount of land owned, and so on. Does everyone agree that families in the poor category don't have these characteristics?

Now focus attention on the second stone. Remind participants that these are the poorest people. What don't they have that the non-poor families have? What income do they have? What about their houses? jobs? clothing? Do they own any livestock? What kind and how many? It may be necessary to add a third stone if the participants say there is another group which is even poorer. If so, ask for characteristics of those people.

To validate the criteria, ask the participants to think silently about the poorest family they know. Do these families meet the criteria for poorest that were just agreed upon?

Situational Analysis – Wealth Ranking (STEP 3)

DAY 2

10 Min

3.

HANDOUT
13.1 – 61m/H28

The PD/Hearth team can now use these criteria to identify the wealth status of each child it has weighed and determine whether or not a family is positive deviant.

Distribute Handout 13.1 and have each participant work through the examples of identifying the wealth status of each child. Discuss the answers together.

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	

Case Examples for Wealth-Ranking Exercise ANSWER KEY

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	Poor
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	Poor
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	Non-Poor
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	Non-Poor
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	Poor
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	Non-Poor

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

WEALTH STATUS	WEALTH CLASSIFICATION CRITERIA
POOR	
NON-POOR	

Situational Analysis – Nutritional Assessment (Weighing All the Children in the Target Community) (STEP 3)

95 MIN | DAY 2

By the end of this session, participants will be able to

1. Explain the importance of and methods for conducting the nutrition baseline and ongoing monitoring activities
2. Describe the methods to measure child growth recommended for use within PD/Hearth activities and cite important issues for proper weighing technique
3. Use Excel-based PD/Hearth database to calculate Z-scores..

Reference in *CORE PD/Hearth Guide*: pp. 57–66, 70–83

Preparation

- Gather country and/or regional nutrition information
- Obtain growth cards (country-specific and/or others used in the region); if unavailable use the WHO growth charts, one for each participant
- Print Handout 14.1 and 14.2
- Review 'Training of PD/Hearth Volunteers Curriculum' before training - use Anthro Job Aids if necessary
- Soft copy of Excel-based PD/Hearth database (found in resource CD)
- Refer to Handout 36.10
- Each participant will take MUAC and weight of 1 child.

Materials

- Local growth-monitoring chart or

  WHO Growth Charts for Girls: http://www.who.int/childgrowth/standards/cht s_wfa_girls_z/en/index.hHl

  WHO Growth Charts for Boys: http://www.who.int/childgrowth/standards/cht s_wfa_boys_z/en/index.hHl
- Handout 14.1: Community Assessment Monitoring Sheet
- Handout 14.2: WHO Weight-for-Age Reference Table
- Handout 14.3: Initial Assessment Worksheet
- WHO Guidelines for Inpatient Treatment of Severely Malnourished Children: http://www.who.int/nutrition/publications/guide_inpatient_text.pdf
- Training of PD/Hearth Volunteers Curriculum and its job aids for taking ANTHROs
- Blank flip charts
- Soft copy of Excel-based PD/Hearth database

- Hanging scales and weighing pan
- MUAC tapes
- Pencils
- Recording chart
- a copy of the NCOE Measuring and Promoting Child Growth tool (available from nutrition@wvi.org)
- weight monitoring charts, Anthro tables, and attendance charts (these will be used in the Hearth sessions)
- A picture of a healthy child and a picture of a malnourished child
- Sheets of flip-chart paper, cut or torn in half, one for each group of three or four volunteers
- Paper cut into a circle, one for each volunteer

STEPS

1.

Refer to the steps on Handout 1.2: 'Agenda for PD/Hearth training of Facilitators and explain that Step 3 consists of the (1) nutrition baseline assessment; and (2) situation analysis (e.g. FGDs, transect walk, social mapping, market survey), including wealth ranking. These will help to provide a comprehensive understanding of the current situation in the community. Each of these components will be discussed in detail.

10 Min

2. Nutrition Assessment

Initial nutritional assessment and wealth ranking are used to identify the PD, non-PD, and ND households, it is important to identify these households in order to conduct PDIs. During the PDI, it is strongly recommended to visit 4 PD households, 2 ND households and 2-4 non-PD households.

Ask what the three different types of malnutrition are. How are they measured? Write the words for classifying malnutrition and the abbreviations on a flip chart and be sure participants understand the definitions.

- *underweight* is measured by weight-for-age (WA)
- *stunting* is measured by height-for-age (HA)
- *wasting* is measured by weight-for-height (WH)

Show an example of a growth chart (if a local growth chart is not available, use the WHO Growth Chart as a model). Hand out one local growth card or WHO growth chart to each participant.

Methods for determining age: *Ask caregivers for child health/growth cards or certificates. If they do not have them, work with the community to establish a calendar of locally important events to help determine when each child was born.*

Why PD/Hearth uses weight-for-age: Weight-for-age is the easiest measure to take accurately and is the most sensitive to change. It is also the measurement that most Ministries of Health use, so both health workers and caregivers are familiar with it.

The goal of PD/Hearth is to quickly rehabilitate children who are malnourished according to weight-for-age measurements. Weight-for-age is used to determine which children are well nourished. We will be able to learn from those families what they do to keep their children growing well. Weight-for-age is also used to determine which children are malnourished. All children 6-59 months who are mildly, moderately or severely underweight (despite the household's wealth ranking or socioeconomic status) will enter the PD/Hearth sessions. Priority should be given to children that are poor and severely underweight. Children with oedema, kwashiorkor or other medical complications should ***not*** be included in the PD/Hearth programme, but instead be referred to a health facility or hospital.

Each participant should have a copy of a growth chart. Ask what measurement is used for these growth charts (*weight-for-age*). **Look at the growth chart from your country. How can you tell a child is growing well?** *(he or she is in the green zone)*

What do the lines on the chart indicate? *The rate of growth for a child. We want to see children following the 'normal' trend of weight gain. If they grow slower, their line will curve down or be flat. This is not good.*

During the Hearth sessions children need to achieve 'catch-up growth'. What is catch-up growth? *Catch-up growth occurs when a child who is malnourished gains weight at an accelerated rate so that he or she is 'catching-up' to the normal-rate-of-growth line for his or her age.*

Draw a large growth chart on a flip chart. Draw a line for a malnourished child's growth and then a sharp spike up in the line when the child enters the Hearth session. The aim is to achieve this fast growth in order to boost the child into being well nourished. It is also important for children to continue growing well after the Hearth sessions by having the caregiver continue the practices learned in the Hearth sessions. A child may not recover completely from malnutrition in one Hearth session, especially if he or she was moderately or severely malnourished. The child may need to repeat Hearth sessions.

5 Min

3. Nutrition Baseline Discussion

Outline the background information for the nutritional assessment used in PD/Hearth based on the following questions:

What determines the target age group? Only include children older than six months (before that, exclusive breastfeeding is strongly promoted); the upper limit on the target age may go up to two, three or five years, depending on 'anticipated load' and budget. However, special emphasis should be placed on children 6–36 months of age because that is the period when the greatest impact can be made. Age determination can be identified using a growth chart, birth certificate or calendar of events.

Why are growth-monitoring data not sufficient? Growth-monitoring data does not capture all children, and those most likely to be missed are the poorest or those from the most at-risk families.

Where does growth monitoring fit into Hearth? Growth monitoring may help raise awareness of adequate growth and is an ongoing monitoring tool. The growth-monitoring programme serves to identify additional malnourished children over time and to support maintenance of rehabilitated children. *This very important element is often overlooked in PD/Hearth implementation.*

What about severely malnourished children and Hearth? Children who are severely malnourished with complications such as oedema, kwashiorkor or other health complications need more specialised medical treatment. These children should be referred to a health care provider. Refer to the WHO *Guidelines for Inpatient Treatment of Severely Malnourished Children* to clarify the protocol for the most severely malnourished children (not Hearth). If available, refer participants to the TALC publication *Caring for Severely Malnourished Children* (Ashworth and Burgess, 2003) , Training of PD/Hearth Volunteers Curriculum and its job aids for taking ANTHROs or provide the website for obtaining this useful reference: www.talcuk.org/a-z_booklist.hH.

5 Min

4. Weighing Techniques

Refer to the **Training of PD/Hearth Volunteers Curriculum** and its job aids for taking anthros or the NCOE *Measuring and Promoting Child Growth Tool* (http://www.wvi.org/nutrition/publication/measuring-and-promoting-child-growth) for specifics on proper weighing techniques. Briefly discuss types of scales and weighing issues (calibration, disrobing children, alternatives to the sling), drawing on participants' experiences.

Situational Analysis – Nutritional Assessment (Weighing All the Children in the Target Community) (STEP 3)

DAY 2

25 Min

5. Calculating Nutritional Status of Children

HANDOUT
14.1 – 69m/H31

Distribute a copy of the 'Community Assessment Data' handout (Handout 14.1). Assign one child (from rows 1-16) to each participant. First plot the child's weight-for-age on the growth chart that was previously distributed in step 2 above. Next, fill in the child's nutritional status by colour in the colour column on Handout 14.1. Is the child growing well? Read out the nutritional status answers for each child on Handout 14.1, as participants check their results.

If computers are available, teach participants to use Excel-based PD/Hearth database to calculate Z-scores and obtain the nutritional status of children (Refer to Resource CD). Refer to Handout 36.10: User Guide for the PD/Hearth Excel Database.

25 Min

6.

HANDOUT
14.2 – 71m/H 33

Distribute Handout 14.2 (WHO Anthro Tables). Explain that another way to calculate weight-for-age is by using the WHO weight-for-age reference tables (Handout 14.2), which are more precise than the community assessment form (Handout 14.1) because they also include the 'mild' status, while the WHO Growth Charts (handed out in step 2 above) only include normal, moderate and severe. Have the participants find the Z-score for the child they are assigned.

Compare the Z-score value to the colour in the 'Community Assessment Monitoring Sheet'. Are they the same? Which is easiest for caregivers to understand? Which would be used to monitor the programme?

25 Min

7.

Divide into pairs and practise counselling the caregiver about the growth of the child. Remember to be encouraging, to explain how the child is growing, to ask what the child has been like at home. Agree on one thing the caregiver could do at home to help the child's growth. Make sure each person has a chance to practise each role. Ask one or two pairs to role play their scenario for the whole group. Discuss the role plays together.

8.

HANDOUT
14.3 – 75m/H 37

Distribute Handout 14.3 and go through the indicators. Explain that this will be the handout we use when we go out to the field to collect the Nutrition Assessment Data of the community. **Point out that the community wealth ranking exercise must be completed before weighing of children begins so that the wealth ranking of the households could be completed while weighing the children.**

The last two columns of Handout 14.3 ("Classification of PD, NPD, and Non-PD" and "Nutritional Status") should be filled out back in the training room, after all the data is collected and not during the field work to save time.

Community Assessment Monitoring Sheet

Community: Sunshine – ADP Light and Hope	**Date of Weighing:** March 11, 2011	
Total number of children under 36 months in community: **Total number of children under 36 months weighed:**		

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)	
1	M	6/3/2009	24	10.70	1	Non-Poor				
2	F	28/3/2010	11	6.8	4	Poor				
3	F	30/7/2009	19	7.1	6	Poor				
4	M	14/4/2008	35	10.1	1	Non-Poor				
5	F	3/8/2010	7	7.3	3	Poor				
6	M	3/10/2009	17	8.5	7 (twin)	Poor				
7	F	3/10/2009	17	10.7	7 (twin)	Poor				
8	M	20/5/2008	34	9.8	8	Poor				
9	F	21/111/2009	16	8.2	1	Poor				
10	F	8/2/2008	37	11.4	8	Non-Poor				
11	F	6/5/2010	10	8.6	3	Poor				
12	M	25/3/2010	12	7.4	6	Non-Poor				
13	F	25/9/2009	17	8.1	3	Poor				
14	F	25/9/2009	17	6.1	7	Poor				
15	F	23/7/2009	20	8.3	2	Poor				
16	M	9/12/2009	15	8.5	9	Poor				
17	F	28/8/2009	18	6.2	1	Poor		-4.20		
18	M	18/7/2009	20	8.4	1	Poor		-2.64		
19	M	15/5/2010	10	6.3	4	Poor		-3.33		

Community Assessment Monitoring Sheet

Day 2 Session 14

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
20	M	15/5/2010	10	8.3	3	Non-Poor		-0.87	
21	F	3/3/2009	24	11.5	5	Poor		-0.02	
22	F	22/10/2008	29	8.9	2	Poor		-2.80	
23	F	6/6/2009	21	9.4	4	Poor		-1.21	
24	F	3/2/2008	37	10.8	3	Poor		-2.13	
25	M	9/9/2009	18	8.1	5	Non-Poor		-2.69	
26	M	3/6/2009	21	10.1	1	Poor		-1.22	
27	M	22/9/2009	18	9.5	4	Poor		-1.20	
28	F	24/9/2010	6	9.5	3	Non-Poor		2.35	
29	M	17/3/2010	12	8.2	5	Poor		-1.44	
30	M	6/6/2010	9	8.7	3	Non-Poor		-0.25	
31	F	4/4/2009	23	11.2	2	Non-Poor		-0.08	
32	M	28/1/2010	13	10.6	10	Poor		0.57	
33	M	7/12/2008	27	9	1	Non-Poor		-3.02	
34	F	4/12/2008	27	11.0	6	Poor		-0.80	
35	M	8/9/2009	18	10.0	8	Poor		-0.81	
36	F	30/11/2008	27	9.2	6	Poor		-2.34	
37	F	16/12/2008	27	9.4	4	Non-Poor		-2.07	
38	M	10/11/2010	4	10.2	7	Poor		3.47	
39	F	21/11/2009	16	9.8	4	Poor		0.06	
40	M	10/3/2010	12	7.0	4	Non-Poor		-2.91	
41	F	12/9/2008	30	8.4	3	Poor		-3.44	

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)*											
BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	0	3.3	2.9	2.5	2.1	F	0	3.2	2.8	2.4	2.0
M	1	4.5	3.9	3.4	2.9	F	1	4.2	3.6	3.2	2.7
M	2	5.6	4.9	4.3	3.8	F	2	5.1	4.5	3.9	3.4
M	3	6.4	5.7	5.0	4.4	F	3	5.8	5.2	4.5	4.0
M	4	7.0	6.2	5.6	4.9	F	4	6.4	5.7	5.0	4.4
M	5	7.5	6.7	6.0	5.3	F	5	6.9	6.1	5.4	4.8
M	6	7.9	7.1	6.4	5.7	F	6	7.3	6.5	5.7	5.1
M	7	8.3	7.4	6.7	5.9	F	7	7.6	6.8	6.0	5.3
M	8	8.6	7.7	6.9	6.2	F	8	7.9	7.0	6.3	5.6
M	9	8.9	8.0	7.1	6.4	F	9	8.2	7.3	6.5	5.8
M	10	9.2	8.2	7.4	6.6	F	10	8.5	7.5	6.7	5.9
M	11	9.4	8.4	7.6	6.8	F	11	8.7	7.7	6.9	6.1
M	12	9.6	8.6	7.7	6.9	F	12	8.9	7.9	7.0	6.3
M	13	9.9	8.8	7.9	7.1	F	13	9.2	8.1	7.2	6.4
M	14	10.1	9.0	8.1	7.2	F	14	9.4	8.3	7.4	6.6
M	15	10.3	9.2	8.3	7.4	F	15	9.6	8.5	7.6	6.7
M	16	10.5	9.4	8.4	7.5	F	16	9.8	8.7	7.7	6.9
M	17	10.7	9.6	8.6	7.7	F	17	10.0	8.9	7.9	7.0
M	18	10.9	9.8	8.8	7.8	F	18	10.2	9.1	8.1	7.2
M	19	11.1	10.0	8.9	8.0	F	19	10.4	9.2	8.2	7.3
M	20	11.3	10.1	9.1	8.1	F	20	10.6	9.4	8.4	7.5
M	21	11.5	10.3	9.2	8.2	F	21	10.9	9.6	8.6	7.6
M	22	11.8	10.5	9.4	8.4	F	22	11.1	9.8	8.7	7.8
M	23	12.0	10.7	9.5	8.5	F	23	11.3	10.0	8.9	7.9
M	24	12.2	10.8	9.7	8.6	F	24	11.5	10.2	9.0	8.1
M	25	12.4	11.0	9.8	8.8	F	25	11.7	10.3	9.2	8.2
M	26	12.5	11.2	10.0	8.9	F	26	11.9	10.5	9.4	8.4
M	27	12.7	11.3	10.1	9.0	F	27	12.1	10.7	9.5	8.5
M	28	12.9	11.5	10.2	9.1	F	28	12.3	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)											
BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.8
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	8.9
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.0
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.1
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.3
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.4
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.5
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.6
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.7
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.8
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	9.9
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)*									
BOYS					**GIRLS**				
Sex	**Age (mon)**	**Green (Normal)**	**Yellow (Moderate)**	**Red (Severe)**	**Sex**	**Age (mon)**	**Green (Normal)**	**Yellow (Moderate)**	**Red (Severe)**
M	0	2.9	2.5	2.1	F	0	2.8	2.4	2.0
M	1	3.9	3.4	2.9	F	1	3.6	3.2	2.7
M	2	4.9	4.3	3.8	F	2	4.5	3.9	3.4
M	3	5.7	5.0	4.4	F	3	5.2	4.5	4.0
M	4	6.2	5.6	4.9	F	4	5.7	5.0	4.4
M	5	6.7	6.0	5.3	F	5	6.1	5.4	4.8
M	6	7.1	6.4	5.7	F	6	6.5	5.7	5.1
M	7	7.4	6.7	5.9	F	7	6.8	6.0	5.3
M	8	7.7	6.9	6.2	F	8	7.0	6.3	5.6
M	9	8.0	7.1	6.4	F	9	7.3	6.5	5.8
M	10	8.2	7.4	6.6	F	10	7.5	6.7	5.9
M	11	8.4	7.6	6.8	F	11	7.7	6.9	6.1
M	12	8.6	7.7	6.9	F	12	7.9	7.0	6.3
M	13	8.8	7.9	7.1	F	13	8.1	7.2	6.4
M	14	9.0	8.1	7.2	F	14	8.3	7.4	6.6
M	15	9.2	8.3	7.4	F	15	8.5	7.6	6.7
M	16	9.4	8.4	7.5	F	16	8.7	7.7	6.9
M	17	9.6	8.6	7.7	F	17	8.9	7.9	7.0
M	18	9.8	8.8	7.8	F	18	9.1	8.1	7.2
M	19	10.0	8.9	8.0	F	19	9.2	8.2	7.3
M	20	10.1	9.1	8.1	F	20	9.4	8.4	7.5
M	21	10.3	9.2	8.2	F	21	9.6	8.6	7.6
M	22	10.5	9.4	8.4	F	22	9.8	8.7	7.8
M	23	10.7	9.5	8.5	F	23	10.0	8.9	7.9
M	24	10.8	9.7	8.6	F	24	10.2	9.0	8.1
M	25	11.0	9.8	8.8	F	25	10.3	9.2	8.2
M	26	11.2	10.0	8.9	F	26	10.5	9.4	8.4
M	27	11.3	10.1	9.0	F	27	10.7	9.5	8.5
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M	30	11.8	10.5	9.4	F	30	11.2	10.0	8.9
M	31	12.0	10.7	9.5	F	31	11.4	10.1	9.0
M	32	12.1	10.8	9.6	F	32	11.6	10.3	9.1
M	33	12.3	10.9	9.7	F	33	11.7	10.4	9.3
M	34	12.4	11.0	9.8	F	34	11.9	10.5	9.4
M	35	12.6	11.2	9.9	F	35	12.0	10.7	9.5
M	36	12.7	11.3	10.0	F	36	12.2	10.8	9.6
M	37	12.9	11.4	10.1	F	37	12.4	10.9	9.7
M	38	13.0	11.5	10.2	F	38	12.5	11.1	9.8
M	39	13.1	11.6	10.3	F	39	12.7	11.2	9.9
M	40	13.3	11.8	10.4	F	40	12.8	11.3	10.1
M	41	13.4	11.9	10.5	F	41	13.0	11.5	10.2
M	42	13.6	12.0	10.6	F	42	13.1	11.6	10.3
M	43	13.7	12.1	10.7	F	43	13.3	11.7	10.4
M	44	13.8	12.2	10.8	F	44	13.4	11.8	10.5
M	45	14.0	12.4	10.9	F	45	13.6	12.0	10.6
M	46	14.1	12.5	11.0	F	46	13.7	12.1	10.7
M	47	14.3	12.6	11.1	F	47	13.9	12.2	10.8
M	48	14.4	12.7	11.2	F	48	14.0	12.3	10.9
M	49	14.5	12.8	11.3	F	49	14.2	12.4	11.0
M	50	14.7	12.9	11.4	F	50	14.3	12.6	11.1
M	51	14.8	13.1	11.5	F	51	14.5	12.7	11.2
M	52	15.0	13.2	11.6	F	52	14.6	12.8	11.3
M	53	15.1	13.3	11.7	F	53	14.8	12.9	11.4
M	54	15.2	13.4	11.8	F	54	14.9	13.0	11.5
M	55	15.4	13.5	11.9	F	55	15.1	13.2	11.6
M	56	15.5	13.6	12.0	F	56	15.2	13.3	11.7
M	57	15.6	13.7	12.1	F	57	15.3	13.4	11.8
M	58	15.8	13.8	12.2	F	58	15.5	13.5	11.9
M	59	15.9	14.0	12.3	F	59	15.6	13.6	12.0
M	60	16.0	14.1	12.4	F	60	15.8	13.7	12.1

Initial Assessment Worksheet

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

No.	Date of Survey	Child's Name	Sex (M/F)	Caregiver's Name	DOB (dd/mm/yyyy)	Age (Months)	Birth Order	Odema (Y or N)	Weight (kg)	Nutritional Status Indicate Colour	MUAC (<115mm) (Green, Yellow, Red)	Wealth Rank (Poor, Non-Poor)	Classification (PD, ND, NPD)	PDI HHs
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														
21														
22														

SESSION 15

Situational Analysis – Focus-Group Discussions (FGDs), Transect Walk, Community Mapping, Market Survey (STEP 3)

World Vision

95 MIN | DAY 2

By the end of this session, participants will be able to

1. Describe a situational analysis, identify potential sources of information, and know how to collect information through FGDs, transect walks, community mapping, and market surveys.
2. Identify the standards for and challenges of conducting a wealth-ranking exercise.

Reference in *CORE PD/Hearth Guide*: pp. 62–75

Preparation

- Prepare a flip chart with a matrix to record FGD on feeding practices
- Print Handout 15.1 15.2A, 15.2B and 15.3.
- Soft copy of Situational Analysis Excel template (refer to Resource CD)

Materials

- Handout 15.1: Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years
- Handout 15.2A: Market Survey for PD/Hearth (Cost Variance)
- Handout 15.2B: Market Survey for PD/Hearth (Quantity Variance)
- Handout 15.3: Seasonal Calendar for PD/Hearth
- Blank flip charts and coloured markers
- 60 stones or leaves or other common material to use as markers
- Soft copy of Situational Analysis Excel template

STEPS

10 Min

1.

The situation analysis activities are generally used to understand the context of the community such as existing resources, the functionality of resources, the seasonality foods available, existing common diseases and sicknesses, the common practices within the households, food taboos, and other myths associated with child feeding and caring practices, etc. It is important to involve the community through this process of discovery to mobilize the community and to create community ownership for the program and it is an effective tool to help the community discover the resources that already exist so that they are empowered and motivated to overcome the problem of malnutrition as a community.

Use the following questions to generate a discussion of situational analysis:

What kinds of information do we need in order to know what is normal in the community?

Programmers need general information on health, including immunisation coverage; incidence and case management of major childhood illnesses; micronutrient situation/supplementation; care-seeking; levels and causes of under-five mortality; current beliefs and behaviours.

Who are sources for this information?

In addition to volunteers and health staff, consult grandmothers, mothers and other caregivers, community leaders, fathers, grandfathers, vendors. Volunteers and health staff may have misinformation or lack information. They may be of slightly higher socioeconomic status than caregivers, so be cautious about 'information' that may be based on stereotypes. *Community members themselves have the best information about the local situation.*

How can we gather information?

Look for quantitative information, e.g. health-system documents, KPC and other surveys, as well as qualitative information such as interviews with key informants, group discussions, and PLA/PRA. (Participatory Learning for Action and Participatory Rapid Appraisal – PLA/PRA – are the two names commonly applied to participatory assessment methodology.) See *CORE PD/Hearth Guide* (p. 62) and the specific list of methodologies (p. 64).

How can we and the community learn the common feeding and health practices of families with malnourished children?

We can either conduct household interviews and observations using the same tools we will use for the PDI, or we can conduct guided group discussions with many poor non-PD caregivers and/or families to learn what are the existing practices, what are the existing beliefs (e.g. food taboos). Such discussions allow us to get a sense of the 'norm' within the community. This will later help to identify the PD practices.

10 Min

2. Focus Group Discussions

Focus group discussions help implementers understand the existing practices and beliefs of caregivers, fathers, and elderly women around child feeding, caring, hygiene, and health seeking practices. The information given during the focus group discussion may not be 100% true and many times correct answers are given and not necessarily the true behaviors that are being practiced. For example, mothers may say they exclusive breastfeed their children up to 6 months, but in reality when you conduct household interviews during the PDIs or transect walks,

majority of women may still feed water, porridge, and other foods starting at 3 months of age. Thus, it is important to grasp what statements are questionable and verify those facts during the PDIs and household interviews on the transect walks. Three separate FGDs are recommended with mothers' group, fathers' group, and elderly women's group. There should be approximately 7-10 participants in each group. It is advisable to include 2-3 mothers with children from each target age group: 0-6 months, 6-12 months, 12-24 months, and 24 -59 months.

Gather the participants in a group. C*hoose one person to act as your recorder.* Explain that the remainder of the participants are 'community members', 'caregivers' and 'grandmothers'. Role play a **Focus Group Discussion** (FGD), using the following questions to guide the discussion to learn what are the existing practices, what are the existing beliefs (e.g. food taboos). Such discussions aloow us to get a sense of the 'norm' within the community. This will help later to identify the PD practices.

My name is _____. I am so glad you all came today to talk with us. We would like you to help us understand how families in this village feed their children. We would like to discuss this together. Everyone is welcome to say something. We'll go around the group so each of you can tell me your name and how many children you have. Would you mind if _____ takes some notes?

Point to a newborn child. What do people in this community feed newborn children? How often? How much? What else?

Point to a child that is 0–5 months of age. What do people in this community feed a baby of this age? How often? What else do they eat? Who feeds them?

Point to a child 6–8 months of age. What do people in this community feed a baby of this age? How often? What else do they eat? Who feeds them?

Point to a child 9–11 months of age. What do people feed a child this age? How much? Show me the amount with a fist or pile of rocks. How often?

Do the same for a child 12–24 months and then a child older than 24 months.

Are there any foods that you don't give children?

What do you feed a sick child?

Use probing questions to encourage group members to give more details. The goal is a flow of information that will allow us to capture the 'norm' within the community in feeding practices so we can easily identify PD practices during the PDIs. Conclude by thanking the participants for taking part. Point out that they have helped us understand how they feed children in this village.

Note: *In this practice FGD it will not be possible to discuss all the questions. The purpose is to give the participants an idea of how to ask questions and then probe further.*

10 Min

3. Discuss the Role Play

FGDs are not simply question-and-answer sessions. The facilitator needs to present a set of carefully chosen key issues. Remember to:

- Introduce yourself and have the participants introduce themselves.
- Create a comfortable atmosphere with a joke or casual talk.
- State the topic of the conversation or use a visual aid to begin the conversation.
- Request permission to use a cassette recorder or to take notes during the discussion.
- Do not ask simple 'yes/no' question, but ask open-ended questions instead.

HANDOUT
15.1 – 84m/H 38

The facilitator can use pictures, storytelling and other techniques in addition to asking questions to promote a lively discussion. The goal is for the group to discuss the issues rather than simply answering questions. Encourage all the participants to voice their ideas and opinions.

Review the questions used to guide the discussion. (List them on a flip chart.)

The recorder might use a chart like the one in Handout 15.1 to list the points made in the discussion.

Discuss the following questions with the group:

- What other information might you discover through a focus-group discussion? *(common childhood illnesses, levels of malnutrition, immunisation, health services available, attendance at GMP)*
- With whom might you have a FGD to discover that information? *(health practitioners, traditional birth attendants, caregivers, leaders, VHC)*

5 Min

4. Transect Walk

The transect walks are used to verify the information in the community mapping and also to get additional information about the existing resources. For example, if the community map shows 3 bore holes, the transect walk would help verify whether 3 bore holes are functioning well or if 2 are functioning and 1 requires repair. Thus the transect walk helps implementers to understand the current contexts of the community. It is also useful to visit 1 or 2 households on the transect walk and to get a glimpse of what the 'norm' is in the community such as seeing what the community grows in the gardens, whether it is common for fathers to work in the city, mothers to work in the garden, and mother-in-laws to primarily take care of children at home, etc.

Ask if anyone has done a transect walk. Ask one person to describe how it is done. (If no one has done this, explain it yourself.) What is the purpose of a transect walk? *(to work with some community members to orient us to the community; to observe what resources are in the community , to understand what some of the challenges might be, to note especially those factors that might affect nutrition and health of children for good or bad practices. It is also good to conduct one household visit while on the transect walk to observe what is being planted in the gardens' of the households and to observe general hygiene and child caring practices. Please refer to the table below for positive feeding, caring, hygiene and health seeking practices.)*

Review the main reasons a child might not be growing well, as discussed on Day 1. Ask participants to name the ones they can remember.

(not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, unclean water, worms, no shoes, grandmother tries to help but doesn't always give good advice on practices)

Show the pictures of the two children. Which child looks healthy? unhealthy?

Post the picture of the healthy child on the wall.

Ask what feeding/food, caring, hygiene and health practices would have helped this child be healthy. Probe to help participants come up with as many positive behaviours as possible.

Feeding/Food	Caring	Hygiene	Health
Continued, frequent breastfeeding of infants up to 24 months	Positive interaction between child and others	Use of latrine and latrine cover	Complete immunisations (preventive)
Introduce other foods at six months	Supervision at all times	Hand washing with soap or ash after toilet, before eating, before food preparation	Mosquito nets used in malaria endemic areas
Feed 3–5 times / day	Father providing attention /affection	Safe water (boiled, covered)	Regular deworming, wearing of shoes
Variety in food; giving snacks between meals	Grandmother supports caregiver with good advice and practical care	Use of drying rack	Home treatment of sick child for minor illnesses
Active feeding	Father provides money to buy good foods for children	Keeping kitchen clean	Use of oral rehydration solution during diarrhoea
Continued breastfeeding along with appropriate liquids and foods during and after diarrhoea		Using windows and doors to air out the rooms during the day	Child is promptly taken to the health post for illnesses not responding to home treatment

20 Min

5. Community Mapping

Community/social mapping is used to mobilize the community and create community ownership of the program, as is wealth ranking. Community/social mapping is also used to help the community identify the existing resources within their surroundings such as the water sources, major roads where the market, farms, schools, and health centres are. It also helps the PD/Hearth implementers to understand the environment and the community existing resources and needs. The community map can be used to guide the Transect Walk.

Ask if anyone has done community mapping. If so, ask one person to describe the process. What information can be depicted on a community map?

Break into four groups. Each member of the group is from the same imaginary village. Work with them to develop a community map. Mark main landmarks, water points, fields, houses. Show which parts of the community have malnourished children. Remember to develop a key.

Discuss how these maps might be used for PD/Hearth. *Mark where malnourished children live; locate where PD families live; locate where volunteers live; select children for Hearth sessions by how close they live to the volunteer; change the colour of the house when the child becomes well nourished, and so on.*

Ensure the following landmarks and resources are mapped:

- water sources (such as ponds, rivers, lakes, swamps, boreholes/boleholes, wells, and springs)
- gardens or farms
- school
- health centres
- latrines
- markets and shops
- church or other religious buildings
- mountains or other geological barriers
- houses of children under 59 months of age
- houses of volunteers
- roads (major roads and smaller paths)

30 Min

6. Seasonal Calendar

The seasonal calendar is also useful for mobilizing the community and creating ownership of the program by involving the community in the program design. The seasonal calendar helps implementers understand what types of foods are available during various seasons and what sicknesses and diseases are common in certain seasons. By understanding what foods are available during certain seasons this information can be taken into account when conducting market survey and in the menu design. The sickness and disease information could be used to ask questions during the PDI especially to the PD households and how they seek health care services or how they treat children for these sicknesses or illnesses at home.

HANDOUT
15.3 – 87m/H 41

Demonstrate how to make a seasonal calendar to show what foods are available to families throughout the year. Ask the participants if they know the food groups (for example, cereals, proteins, fruits, vegetables, fats). For each food group list the foods that the community grows. Do one food group at a time. Mark a grid of 12 months on the ground. Down the left side pile a sample of each of these foods (cereals: maize, sorghum, millet). Give the group a pile of 60 stones. Ask the group to distribute the stones to show the proportion of households with access to the different food items during the year. For example, if no families have a crop in certain months, there are no stones in those squares; if a food is available to families at all times of year in the same quantity, then each month would have an equal number of stones. Do this for all cereal crops and then for each of the other food groups. Create the seasonal calendar with the food groups the country uses. Make sure the results are recorded on a piece of paper after drawing on the ground.

Distribute Handout 15.3 and advise to use it to record the results. Write out the food items commonly used in the country and the common diseases that exist. Indicate with an 'x' as to when they are in high season for the various months.

5 Min

7. Market Survey

HANDOUT
15.2A – 85m/H 39
15.2B – 86m/H 40

The market survey is used to identify the approximate cost and variability in cost or quantity of certain foods during different seasons. This information can be used to design a low cost and affordable Hearth menu. It can also help in the menu design so foods that are easily accessible and available included in the Hearth meal. The market survey is recommended to be conducted during different seasons. For example, if there is a rainy season and a dry season, a market survey should be conducted once during the rainy season and once during the dry season. The nutrient-dense, low cost foods available during the dry season could be used for Hearth menu A and the nutrient dense, low cost foods available during the rainy season could be used for Hearth menu B.

A market survey provides information on the availability and price of foods in the community. It is carried out by visiting the market where the community buys its food and recording information in Handouts 15.2A and 15.2B.

5 Min

8.

Discuss together the expected outcomes for situational analysis:

- Community involvement and commitment
- All activities done with community members
- Learn the common illnesses, health services and practices
- Learn the normal feeding practices and be able to highlight existing good/best practices
- Learn what harmful practices affect child health and nutrition
- Learn about the community's understanding of causes of malnutrition in its children
- Learn about food availability and affordability.

Tell participants that the next step in community mobilisation is to feed back all this information to the community. This will be discussed later in the course.

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years

Child's Age	**Foods given,** including breastmilk and other liquids (name or pictures)	**Amounts** (bowl, cup, can, fist, spoonful)	**Frequency** (daily, weekly, rarely)	**Food taboos** (forbidden foods)	**Comments** Why?
Newborn					
0–5 months					
6–8 months					
9–11 months					
12–23 months					
≥24 months					
When child is sick					
When recovering					

Market Survey for PD/Hearth (Cost Variance)

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW						
	Units of Smallest Quantity Purchased	High Season (Months)	Cost during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Cost during Low Seasons ( )	Cost per 100 gram*

* NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW						
	Cost of Smallest Quantity Purchased	High Season (Months)	Quantity during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Quantity during Low Seasons ( )	Cost per 100 gram*

NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Seasonal Calendar for PD/Hearth

World Vision

HANDOUT 15.3

Day 2 Session 15

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Items (e.g. foods available, diseases, etc.)	MONTHS												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Preparing for Situational Analysis Field Visit (STEP 3)

60 MIN | DAY 2

By the end of this session, participants will have

1. Prepared questionnaires and tools for collecting data in the community in various ways.

Reference in CORE PD/Hearth Guide: pp 62–112

Preparation

- The host country staff will need to prepare communities for this activity. Ideally, these will be new ADP communities which will begin PD/Hearth for the first time. Select one community for every five workshop participants. In each community conduct a nutrition baseline of weights of at least 20 children, selected randomly, between the ages of 6 and 36 months. With existing community health volunteers and community leaders, conduct a wealth-ranking exercise. Using this information, classify the children who were weighed according to their family's wealth ranking. This information must be ready by the start of the training. Host country staff need to arrange with the community for a field visit on the third day of the training. They need to organise a focus group of caregivers, invite community leaders to a brief meeting during the visit, and ask if participants can visit selected families.

Field Preparation Required for Situation Analysis:

Wealth Ranking:

5 or 7 community members (diverse group)

Initial Nutrition Assessment:

First, please ensure the Ministry of Health allows NGOs and non-government approved personnel to weigh children. If the government has strict protocols, please mobilize government approved personnel (e.g. health centre staff, CHWs, etc.) to help weigh children on the day of assessment.

Weigh all children 6-36 months of age in the community (you could mobilize the caregivers to one site/location or to several decentralized sites/locations in the community to increase coverage and ask caregivers to bring their children 6-36 months of age on a specific day and time). Weighing children house to house is most accurate, but may require more time and resources.

Community/Social Mapping:

4-5 community leaders (men and women) and 1-2 CHWs

Focus Group Discussions:

Three separate FGDs are recommended with mothers group, fathers group, and elderly women's group. There should be approximately 7-10 participants in the

mothers group. It is advisable to include 2-3 mothers with children from each target age group: 0-6 months, 6-12 months, 12-24 months, and 1 mother from the age group 24 -59 months. A smaller group of 4-5 participants could be mobilized for fathers and elderly women (grandmothers). Ensure there are 2 facilitators in the FGD who are good with speaking the local language (for interviewing and recording). If different groups are leading different FGDs, you may require more facilitators who speak the local language.

Seasonal Calendar/Transect Walk:

Good to have 1-2 CHWs or volunteers who could help navigate in the village/ community

Market Survey:

Done by the team

Good to find out when the big market day is and keep in mind when planning the agenda

Materials

- Local growth chart for plotting weights, or WHO ANTHRO software to calculate nutritional status
- Flip chart with blank paper

STEPS

5 Min

1.

Explain to the workshop participants that we are going to conduct a situational analysis in actual communities the next day of the course. Explain that the National Office and cooperating ADP have already weighed children and conducted a wealth ranking. Based on their work, we can identify PD families to visit. We need to prepare the questionnaires and tools we will use for the activities we will conduct. Write the activities on a flip chart:

- **Wealth ranking and nutrition assessments**
- **Focus group** – We will investigate existing social norms and practices related to feeding and care of small children in a focus group with caregivers and family members, particularly grandmothers, from poor households who have children under three years of age.
- **Market survey** – We will take a market survey to assess food costs and what foods are available in markets and shops.
- **Social mapping and transect walk** – Social mapping and a transect walk with a few community leaders will help us identify local resources related to health and nutrition (availability of piped water and latrines, wild foods, health

services etc.). The map should include health risk factors such as standing water where mosquitoes breed, garbage dumps etc., as well as the services available and their locations relative to the houses of the poor.

- **Seasonal calendar** – A seasonal calendar created with a few community members will identify the availability of food sources for families at different times of year.

2.

Divide the participants into five groups. Each group will develop questionnaires, observation forms and tools to conduct one of five different activities in the community. If they type these and a printer is available, they may print out the materials. If a printer is not available, ensure that each small group has at least one copy of each of the questionnaires, forms and tools. The facilitators circulate among the groups to provide guidance and support.

3.

Divide the participants into groups of no more than three people. These are the groups in which they will conduct the household visits tomorrow. Two small groups may join together for the other activities, such as the focus group discussions, the market survey, seasonal calendar and transect walk.

4.

Explain the departure time and transportation arrangements for the next day and quickly outline the agenda for the afternoon session following the field trip.

Remind participants the order of the exercises that will take place tomorrow during the field visit. 1 group will conduct the FGD with the caregivers, 1 group will conduct the FGD with the grandmothers, and 1 group will conduct the FGD with the father group. Simultaneously 1-2 groups will be conducting the wealth ranking exercise with a diverse group of community members. Once the FGD and wealth ranking is complete, the wealth ranking criteria should be shared with the rest of the participants so everyone knows the wealth ranking criteria prior to weighing the children (if weighing of children is needed). Transect walk and seasonal calendar could be completed at any time, and all participants should get an opportunity to conduct a market survey after the weighing of children.

Daily Summary and Evaluation

SESSION 17

10 MIN | DAY 2

By the end of this session, participants will be able to

1. Evaluate personal learning for the day

Preparation

- Make a flip chart with the daily evaluation sentence starters listed below.

Materials

- Half sheet of paper for each participant

STEPS

1.

Each participant reflects on the day's sessions and writes down ideas to improve or adapt the various presentations so they are more appropriate for the participant's specific culture. This is done by adapting case studies, games and hands-on exercises, developing role plays and including local stories. Ask the participants to be ready to share some of their good ideas.

2.

Daily evaluation. Distribute a half sheet of paper to each participant. Ask the participants to respond to the three phrases written on the flip chat:

- Something I learned today that I will apply in our PD/Hearth programme is

_____.

- Something new that I learned about PD/Hearth today is

_____.

- Something I'm still confused about is

_____.

Facilitators will review these evaluations at the end of the day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.

3.

Thank participants for good work today. Mention any highlights of the day. Remind them of the departure time for tomorrow's field visit.

SESSION 18

Field Visit to Conduct Situational Analysis

World Vision

4.0 to 6.5 hours plus travel time

DAY 3

Total field visit time of 4.0 to 6.5 hours plus transportation time

By the end of this session, participants will be able to

1. Confidently conduct a FGD, wealth ranking transect walk, market survey and household visits.

Materials

- Questionnaires and tools created by each group the previous day or Print out Handouts 13.3,14.3, 15.1, 15.2A, 15.2B, and 15.3

STEPS

4.5 Hours

1. Field Visit

HANDOUT
13.3 – 63m/H 30
14.3 – 75m/H 37
15.1 – 84m/H 38
15.2A – 85m/H 39
15.2B – 86m/H 40
15.3 – 87m/H 41

Distribute copies of Handouts 13.3, 14.3, 15.1, 15.2A, 15.2B, and 15.3 to each participant and remind them in how to fill-out the Handouts. Also, remind participants to refer children with 'red' coloured MUAC (severe acute malnutrition/wasting) to Health Centres or OTPs.

Review of Day 3 Field Visit and Agenda for Day 4

SESSION 19

45 MIN | DAY 4

STEPS

1.

Engage participants in a discussion based on questions such as

- How did you feel about the visit yesterday?
- What did you find easy?
- What did you find difficult?

2. Address any issues that may arise.

3. Review the agenda for today.

SESSION 20

Analyzing Situational Analysis Data

180 MIN | DAY 4

By the end of this session, participants will be able to

1. Analyze situational analysis data
2. Practice using the situational analysis template and PD/Hearth Excel database.

Reference in *CORE PD/Hearth Guide*: pp. 62–75

Preparation

- Distribute soft copy of Excel-based situational analysis template found in Resource CD
- Distribute soft copy of Excel-based PD/Hearth database found in Resource CD
- Refer to Handout 36.10: User Guide for the PD/Hearth Excel Database

Materials

- Resource CD
- LCD projector
- Flip chart and markers

STEPS

60 Min

1.

Provide groups with time to consolidate situational analysis findings into situational analysis template Excel document.

90 Min

2.

Have each group present their situational analysis findings about overall initial assessment (nutritional profile of community), and feeding, hygiene, caring and health-seeking practices. Have groups emphasize on the community's existing resources, common practices and beliefs, and challenges that may be contributing to the community's overall high rates of malnutrition.

30 Min

3.

Review and discuss the overall findings as a group. Identify the major challenges and/or poor behaviours in feeding, hygiene, caring and health-seeking practices that are contributing to the high rates of malnutrition in the community. Write the challenges out on a flip chart.

Inform the participants that they must keep these challenges in mind when conducting the PDIs in PD households. They must identify how the PD households overcome these challenges in order to find the local solutions during the PDI visits.

You will refer to these challenges especially when identifying PD practices and to design the 6 key Hearth messages in future sessions (Please keep these filp chart in a safe place so you can refer to them later on).

SESSION 21

Identifying Positive Deviants (Step 4)

World Vision

60 MIN | DAY 4

By the end of this session, participants will be able to

1. Explain the criteria and process for selecting PD families
2. Practise selecting PD families utilising nutrition-baseline and wealth-ranking-exercise data.

Reference in *CORE PD/Hearth Guide:* p. 68

Preparation

- If using data from a local village, be sure it is correct and that there are positive deviants.
- Write the definition of positive deviants on flip chart (see definition below).
- Make several large copies of the optical illusion pictures below.
- Print Handout 14.1

Materials

- Flip chart with definition of positive deviants:

  Positive deviants are individuals or groups (families, clans) whose special or uncommon practices and behaviours enable them to find better ways to prevent malnutrition than neighbours who share the same resources and face the same risks.

- Handout 14.1: Community Assessment Monitoring Sheet (from Session 14)

STEPS

5 Min

1.

Review the definition of positive deviants on the flip chart. In terms of nutrition,

Who are positive deviants? *Positive deviants are well-nourished children from poor families.*

Who cannot be positive deviants? *Only children, first-born children, a well-nourished child with malnourished siblings, children with atypical social or health problems, food-aid families, a child younger than seven months (the child's nutritional status is most likely due to breastfeeding), and/or children from non-poor families. See the list in the CORE PD/Hearth Guide (p. 68).*

Who identifies the positive deviants? *Supervisors and volunteers identify positive deviants.*

Identifying Positive Deviants (Step 4)

How can positive deviants be identified? *We can refer to the weighing and wealth status data collected during nutritional assessment.*

5 Min

2.

HANDOUT
14.1 – 69m/H 31

Review the criteria for identifying PD families, that is, good nutritional status *and* low wealth ranking. Divide the participants into pairs. Using Handout 14.1: 'Community Assessment Monitoring Sheet,' each pair decides which children are positive deviants by considering their weight, wealth ranking and birth order.

3.

This will provide a list of the potential PD children. However, the information needs to be confirmed by looking at the children's growth cards. Children who are truly PD will have been well nourished throughout their lives. If a child's growth card shows that he or she has only recently become well nourished or is not consistently growing well, do not accept that child as a PD.

An alternative way to teach this is to use data from the community to be visited during the course. If the ADP has done the nutritional assessment before the course, use the data collected on nutritional status and wealth ranking. Enter the data in the same format as Handout 14.1 and use the information to identify the PDs.

15 Min

4.

Discuss the list of potential PD children as a group. Be sure to cover the following:

- **Who knows which families are PD? Who has access to this information?** Only the staff should have this information, and staff members should not share it because there is a risk that PD families will be socially rejected.
- **What if there are no PD families in the community?** At least one PD family is needed. If none is identified, it will be necessary to conduct the PDI in an adjacent, very similar community using the team from the target community. If there are many PD families, choose a few that are most appropriate for conducting the PDI.

Preparing for the Positive Deviance Inquiry (PDI) (STEP 4)

By the end of this session, participants will be able to

1. Describe the process, tools and methods for conducting the PDI
2. Identify resource tools for semi-structured interviews and observations during visits to PD households
3. Discuss the behaviours that influence the nutritional status of children
4. Develop a logistical plan for training and conducting the PDI.

Reference in *CORE PD/Hearth Guide*: pp. 85–89, 94–103

Preparation

- Print copies of Handout 22.1, 22.2, and 22.3.
- Identify and orient trainers who will conduct the structured role play.
- Have three or four participants prepare the skit on visiting skills.
- Print and cut apart two sets of 24 behaviour cards (see sample in Step 4).

Field Preparation Required for PDI

From the initial nutrition assessment, select at least 4 PD households (at least 1 household from each target age group: 0-6 months, 6-12 months; 12-24 months), 2 negative deviant households, and 2-4 non-PD households. These will be the households that will be visited during the PDI. You could always select more PD and non-PD households if necessary, depending on the number of participants in the training.

Please assign at least 1 non-PD household and 1 PD household to each group. By first visiting the non-PD household, each group will understand what the 'norm' is in the community and be able to identify the challenges they face in keeping their children healthy. By visiting the PD household after the non-PD household, the groups will be able to better identify the Positive Deviant behaviours by asking questions of how the PD household overcomes the challenges that the non-PD households face. The positive practices that address these challenges will become key Positive Practices that need to be promoted during the Hearth session. In addition, the interviewers and observers could look out for the PD foods (low cost and nutrient dense) that are being fed only in the PD households, that were not being fed in the non-PD or negative deviant households. These foods should be included in the Hearth menu and promoted during the Hearth sessions.

Divide groups into groups of 3-4 people, assign one role of observer, interviewer, recorder, and translator (if needed) to each member of the team. Assign the role of a team leader for each group. To the team leaders, provide weighing scales, weighing pants, a hook, a rope (for weighing scale), a MUAC tape, PDI questionnaires (Handout 22.1), observation forms (Handouts 22.2 and 22.3),

pencils/pens, notebooks for recording interview, and a list of households to visit (include back up households to visit in case caregiver and/or child is not home). Arrange for each group to be supported by a volunteer or someone who is familiar with the village so that the groups could find the households easily. Ensure the volunteer or the person from the village is not in the way of getting honest answers from the caregivers. If translators are needed, make sure at least one person in the group could speak the local language.

Materials

.Print copies of Handout 22.1, 22.2, and 22.3.

STEPS

5 Min

1.

Brief the participants on the PDI process: 'We will be visiting families in our community to learn from them how they feed and care for their children who are under three years old. We will visit during the time that the caregivers feed their children. That way we can observe how they feed them, the care they give them and the relationship between the caregiver and other members of the family. We want to talk to the caregivers and observe what they do. But we will not make any comments. We need to have open minds and look for unexpected practices or ways of doing things. The positive deviance inquiry is intended to help discover that which is right in front of us. We expect to find something positive; we are like detectives looking for clues, and we need to get rid of any preconceived notions.' *(**Note:** Volunteers may not be able to lead the PDI visit but will be valuable observers on the team.)*

5 Min

2.

Discuss the kinds of information that will help us learn about feeding and caring practices. We will discover with community members foods which poor families use to keep their children healthy and strong. These foods are 'good foods'. We will discover the 'good care' these families give to their children. In the same way we will discover 'good health care' and 'good hygiene'.

By learning about these 'good' things from poor families with healthy children, we will be helping address the community's nutrition problems with solutions from its own people. These solutions will help other families in the community learn and understand how to help their children to be healthy and strong.

- **What categories of home-based behaviours are we looking at?** (*feeding practices; caring practices; hygiene practices; and health-care practices).* Ask participants for an example of a positive practice for each category. (Refer to pp. 90–91 in the *CORE PD/Hearth Guide*.)

- **What are we trying to discover through the PDI?** The PDI seeks to identify unusual, successful and culturally acceptable behaviours and strategies practised by very poor families which can be more widely practised by others in the community who have similar resources. How does the PD family overcome the challenges and constraint that it shares with other families? For example, saving for health expenses is a positive but uncommon practice. The PDI should answer the question: How is *this* family able to save money?
- **The content for each category can be different according to cultural context. What are some examples of issues in feeding, caring, hygiene and health-seeking practices that are culturally specific?** Issues identified during the PDI can be explored for cultural appropriateness during the later process of sharing with the community (see Session 20, 'PDI Interpretation and Feedback').
- **Who should explore these?** The PD team and local partners.
- **Who is required on the PDI team?** The volunteers and supervisors must be on the team. Additional participants might include VHC members or Ministry of Health staff. It is very important that volunteers be part of the PDI team because they are most familiar with the community. Some of them may not be comfortable or have the skills to lead the interviews. With good training, however, they will become valuable team members who help us understand important community information. When selecting personnel, look for the following characteristics: belief in the approach, openness to learning from one less educated, and willingness to be led instead of leading. Note that PDI requires a change in attitude for Hearth managers and trainer; they are going to the community as learners, not as experts.
- **The PDI has an interviewer and observers.** Both roles are important. The interviewer may be a community member, a PD/Hearth volunteer, or a trainer/supervisor.
- **Training the PDI team.** Training should emphasise communication skills, listening skills and observation skills. It is particularly important to be able to probe into the issues in a culturally acceptable manner. Use role plays to practise skills and also to practise a home visit in the neighbourhood with a feedback session. The role of observer is awkward. Training is important to increase the comfort level.
- **What are some cultural filters that influence behaviours and how we view them?** In searching for behaviours that are positive and those that are problematic, the PDI team needs to look through the lens of local culture. Team members should look at family structure; socio-cultural norms; food taboos; patterns of decision making; traditional practices or customs; religion; beliefs; gender; and presence of informal or traditional health systems. The role of grandmother may be particularly relevant to understanding the behaviours practised within the home. It is important to observe and engage the grandmother in the visit.

The following exercise helps participants understand behaviours and skills that are important to the nutritional status of children.

5 Min

3. Divide participants into two teams. Each team gets one set of 24 behaviour cards. Have the team members separate the cards into two piles: those with behaviours that *directly* affect the nutritional status of children, and those that do not. Tell them to be prepared to justify their choices.

10 Min

4. Bring the teams together. Call out each behaviour and have the team members put both hands in the air if the behaviour directly influences the nutritional status of children or put their hands behind their back if it does not. Have team members explain their choices, especially when there is disagreement about the behaviours.

Behaviour cards sample

Make two sets of cards. Write one behaviour on each card.

Thanks given for food	Nails are clipped	Use of home remedies for illness	Child is bathed every day	Boils water for children under six months old	Child eats five times a day
Mother tells stories and sings to child	Use of soap to wash hands	Child is given fruit for snack	Child breastfeeds during the day	Grandmother cares for child	Adds oil to porridge
Child is dewormed	Seeks medical help when ill	Eggs, snails, watercress, groundnuts are included in meal	Parent hits the child for not obeying	Kitchen pots are washed and left to dry on rack	Child feeds often during illness
Brushes child's teeth	Someone helps the child eat	Sleeps with window open	Child eats from own bowl	Washes hands after using latrine	Child wears sandals

5 Min

5.

What tools can be used to gather information about child-care behaviours (feeding, health-seeking, caring and hygiene)? Refer the participants to the 'Observation Checklist for PDI' and the sample 'Semi-structured Interview' in *the CORE PD/Hearth Guide* (pp. 99–103). Allow a few minutes for them to look these over.

Observation Exercise. Have the participants stand in pairs, facing each other. Each person carefully observes his or her partner for 30 seconds. Then tell the partners to turn and stand back to back. Each partner is to change one thing about his or her appearance (take off an earring, put on glasses, button a cuff, etc.). Then ask the partners to face each other again. Each is to tell the partner what has changed. Ask how many were able to identify the change. Emphasise the importance of *good observation* in order to explore behaviours through the cultural lens of the community.

10 Min

6. A simplified 24-hour recall exercise

The purpose of this exercise is to find out from the caregiver everything the child ate in the last 24 hours.

Demonstrate this method with a participant who acts as the caregiver of a young child. Ask the 'caregiver' what the child ate when he or she got up the previous day. Probe for more information, asking about amounts the child ate (ask to see the bowl), how the caregiver prepared the food, whether she added anything else, whether the child ate or drank anything else. Then ask about the next thing the child ate. Did the child eat anything between the first meal and the second? Continue with these probing questions until the full day has been covered. Be sure the observer is taking notes on the foods, quantities and frequencies.

HANDOUT
22.1 – 106m/H 42

Distribute Handout 22.1 and divide the participants into pairs. Have them practise doing a 24-hour recall with one acting as 'caregiver' and the other as 'interviewer'.

10 Min

7.

Use the following role play to demonstrate and practise the skills necessary for conducting a PDI. Begin with three facilitators for scenario 1 (interviewer with questionnaire; mother of child; older sibling; may use doll or additional facilitator as PD child).

Scenario 1: This role play portrays part of a PDI; during the part shown, the interviewer is focusing on feeding practises. The PD child is a well-nourished, 30-month-old girl. Her mother says the child eats only during the two daily meals. However, a sibling in the room is sharing a snack with the child (who is fed

constantly by older siblings, her grandmother and neighbours). The mother talks very little. While the mother is being interviewed, the sibling washes the child's hands, scolds the child when she drops something and tries to pick it up to eat it, plays with the child, gives the child a drink, etc. (The interviewer and mother don't interact with the child or sibling during this time.)

After the role play, lead participants in discussing what is necessary for a successful PDI:

- The quality of the interviewer's probing skills. Note that probing was needed when information from the caregiver was not consistent with observation. It is all right to ask what the family does for a healthy child. But there should be no leading questions and no pre-formed ideas about what is 'right'. Listen to what family members say.
- The importance of knowing local languages and customs.
- Conducting the inquiry without a questionnaire in hand. Small talk can be employed to create a comfort level (this role play was brief, but an actual PDI is more often a two-hour visit in the village). Encourage caregivers to continue with whatever tasks they need to do. The interviewer may even help (getting water, stirring pot, playing with the child, etc.).
- Role of the observer. The second person/observer (a supervisor, volunteer or other community leader) may recognise positive behaviours that the interviewer from the community does not see or recognise.
- Seeking strategies, not just behaviours. Carefully probe to learn how the family manages to practise a behaviour that their peers seem unable to practise. For example, if the family is feeding the child an egg frequently, how do they afford this? If the house and children are very clean in spite of lack of water, how does the caregiver accomplish this good hygiene?

10 Min

8. Role play

Ask three or four participants to prepare a skit using all the wrong approaches to a visit. There should be two interviewers and a mother. The interviewer uses comments like 'We know you are poor and want to find out why'. The mother is busy and asks the interviewers to return at another time. They invite themselves in anyway. The interviewers are eating candy and talking on their cell phones. They use big words and ask offensive questions. They are not respectful. The mother is obviously annoyed, upset and then angry.

Ask participants how the interviewers could improve their visiting skills. Summarise the skills that are important for conducting a PDI home visit: probing in a culturally acceptable manner; mixing observation with conversation; good interaction to put the caregiver at ease.

10 Min

9.

HANDOUT
22.1 – 106m/H 42
22.2 – 108m/H 44

Give out Handout 22.2. Divide into groups of four or five people. Using Handouts 22.1 (interviewer) and 22.2 (observer), tell participants to role play a home visit with two participants acting as 'interviewer' and 'observer', and the others being 'family members'. Practise until the participants feel comfortable talking about the four 'goods' – feeding practices; caring practices; hygiene practices; and health-care practices – without referring to a list on a sheet of paper. Try to get the conversation to flow. Observe what the family members are doing as well as what they are saying.

10.

HANDOUT
22.3 – 109m/H 45

Ask participants to develop a logistical plan for the PDI in their country context, as a homework exercise. Distribute Handout 22.3 and instruct the participants to use Handout 22.3 to summarise the PDI findings of all households from the upcoming PDI field visit.

Purpose of a PDI

Through the situational analysis (FGDs, market survey, seasonal calendar, transect walk and community mapping), we now know what resources are available in the community and understand the common feeding, hygiene, caring, and health seeking practices. Overall, the findings provide us with a better knowledge of what the 'norm' is in the community.

By conducting a PDI in non-PD households, we can further identify:

- common practices, both good and poor behaviours,
- what are the barriers and challenges households face in practicing positive behaviours,
- what is the reasoning for some of their behavioural or food choices.

Once the reasoning, challenges and barriers are identified and understood, the PDI in PD households is used to observe and identify how the PD households overcome those very challenges and barriers that everyone else in their community cannot overcome. It is also an opportunity to understand the PD caregivers' thinking and reasoning behind the practices. Sometimes the PD caregivers will be practicing positive practices without any knowledge of it being a positive behaviour; it may just be a decision made because of family circumstances. Thus, PDI in PD households is used to find the local solutions.

The 24-hour recall during the PDI is also used to identify the PD foods. PD foods are the foods that only PD households feed their children and non-PD households do not feed their children. It is important to understand why non-PD households do not feed their children the PD foods and why the PD households

do. This understanding could be used to explain why it is important to feed the children the PD foods during the Hearth session. PD foods are nutrient-dense, locally available, low in cost, and easily accessible in various seasons or even all year round.

(Participants are to create their own questions and guidelines for use in the field visit.)

House Visits

1. Be wise; respect the family.
2. Don't ask why they are poor.
3. Point out that you are here to learn, not to criticise.
4. Introduce yourself, congratulate the family on its good work, and ask permission to observe.
5. Make sure the information collected regarding child information (e.g. age, birth order, wealth ranking, etc.) is correct to ensure the child is a PD child.
6. Spend two to three hours in each PD house. It is good to go during a meal time to observe the child's feeding practices, but ensure you do not disturb the family.
7. Try to engage both the caregiver and grandmother (if present) while conducting the visit.
8. Conduct a 24-hour diet recall on the food the child ate yesterday. Fill out form.

24-Hour Dietary Recall Question Guide

1. What is the first thing the child ate yesterday after waking up?
2. How much did you give (of each feed)? How much of it did the child eat? Can you show me the bowl the child used?
3. How did you prepare the food? Fried? Boiled? Steamed?
4. What did you add? Any oil? Vegetables?
5. Did the child eat anything else?
6. Did the child drink anything?
7. What is the next time the child ate? What? How much? How prepared? What else did the child eat?
8. Did the child get anything else between first and second meal? And between second and last meal? (Note: food quantity, frequency and consistency).

Good Food/Feeding

1. Is the child breastfeeding? If not, at what age did the mother wean the child?
2. What foods is the child being fed today?
3. Who decides what the child will eat? What role do other family members play in child feeding decisions?
4. How many times did you see the child eat or drink?
5. Where does the family buy food? Who buys the food? How much money is spent on food each day?
6. How many meals and snacks does the child eat a day?
7. Are there any foods the caregiver does *not* give the child?

Good Child Care (try to observe without asking)

1. Who is the primary caregiver of the child?
2. What roles do other family members play in caring for the child?
3. Who is in the house during the day?
4. Does the caregiver take the child to the vaccination post? How often? Is the child on schedule?
5. Does the caregiver or others play with the child? How? How often?
6. How is the child disciplined? By whom?
7. What does the caregiver do to encourage the child to eat if he or she doesn't want to?

Good Health Care (ask for health card, ask caregiver questions)

1. How do you know when your child is sick?
2. Was the child sick in the past six months? If so, how many times?
3. What illnesses has the child had?
4. When the child was sick, what did you do? Did you feed the child anything differently?
5. What steps do you take to prevent illnesses?

Good Hygiene (observe body, food and environment)

1. Is the house clean? Is the kitchen clean?
2. Are the people clean?
3. If there is a latrine, how does it look?
4. Make observations about the water source.
5. Do pigs, mules, dogs or other animals go in and out of the house?

Observation Checklist

Day 4 Session 22

Questions	Remarks
Personal Hygiene	
Wash hands before/after?	
Plates washed?	
Nails	
Shoes	
Clothes	
Food preparation	
Handwashing (Check for soap and running water)	
Washing the food before cutting or cooking	
Food/water covered (before and after cooking)	
Household measures used (e.g. size of cup, spoon sizes, do they use fist sizes?)	
Home Environment	
Food availability (gardens)	
Animals present (cage, play with children?)	
Storage facilities (for water, food)	
Household waste management	
Toilets (cleanliness, distance, type)	
Water (boiled/filtered, distance, source)	
Interaction between caregiver and child	
Loving and caring behaviour	
Playing with the child	
Feeding Practices	
Does child pick up food from ground and eat it?	
Do you help the child to eat and watch child eating?	
Amount of food the child is eating?	
How many times do you feed per day?	
Feeding Practices	
Health Seeking Practices	
Do you see any ORS packets?	
Do you see an ITN? Is it in good condition?	
Do you feed the child differently when the child is sick (e.g. more or less food; more or less liquid; feed more frequently)?	

Results and Observations from the PDI

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

PD Food/Feeding		Non-PD Food/Feeding	
PD Caring		**Non-PD Caring**	
PD Hygiene		**Non-PD Hygiene**	
PD Health Seeking		**Non-PD Health Seeking**	

SESSION 23

Field Visit to Conduct PDI

4.5 to 6.5 hours plus travel time

DAY 5

Total field visit time of 1 hour to 1.5 hours per PDI HH. Usually the field visit should take approximately 4.5 to 6.5 hours plus travel time to and from the field.

By the end of this session, participants will be able to

1. Confidently conduct household visits and PDIs.
2. Identify PD and Non-PD Behaviours during a PDI.

Materials

- Questionnaires, observation forms and tools created by each group the previous day or Print out Handouts 22.1 and 22.2

STEPS

1. Field Visit

Distribute copies of Handouts 22.1 and 22.2 to each participant and remind them in how to use or fill-out the Handouts.

Review of Day 5 Field Visit and Agenda for Day 6

SESSION 24

45 MIN | DAY 6

STEPS

1.

Engage participants in a discussion based on questions such as

- How did you feel about the PDI field visit?
- What did you find easy?
- What did you find difficult?

2. Address any issues that may arise.

3. Review the agenda for today.

SESSION 25

PDI Interpretation and Feedback: Determining Positive Deviance and Identifying 6 Key Hearth Messages (STEP 4)

World Vision

170 MIN | DAY 6

By the end of this session, participants will be able to

1. Describe the categories of behaviours identified during the PDI analysis
2. Describe the participatory processes for analysing PDI data and selecting PD feeding, caring, hygiene and health-seeking behaviours to be used in PD/Hearth sessions
3. Demonstrate skills for sharing the PDI findings with the community.

Reference in CORE PD/Hearth Guide: *pp 89–98, 104–12.*

Materials

- Flip chart
- Matrix for each small group to record PD and non-PD behaviours

PD Food/Feeding	PD Caring	PD Hygiene	PD Health Seeking
Non-PD Food/Feeding	**Non-PD Caring**	**Non-PD Hygiene**	**Non-PD Health Seeking**

STEPS

30 Min

1.

Each group posts its field-visit summary sheet on the wall. The groups circulate around the room to read the behaviours/practices discovered by each group. In small groups the participants discuss each behaviour and place it in the matrix under the appropriate column for the PD families and then for the non-PD families for contrast. If a behaviour is repeated by more than one family, the group should highlight it and indicate how many times that behaviour was observed. This serves to illustrate common threads among the PD families and non-PD families.

Do not include positive practices that non-PD households practise and common practices that everyone practises. The key is to identify the unique positive practices that only PD households are practising that allow their children to be healthy. Especially point out local solutions that the PD households are practising.

100 Min

2.

Ask each group to explain the findings of its PD data in the large group. Show what behaviours were found in the PD families' homes and what behaviours were found in the non-PD homes. Answer the following questions:

1. What are the different practices between PD and NPD/ND? (record findings in format shown in Handout 22.3)
2. What are some of the challenges faced in the community? (e.g. don't like feeding Sprinkles, breastfeeding but only up to 3 months, only feed rice porridge)?
3. What is the PD household doing to address these challenges at home? Identify the local solution for these challenges.

Use Question 1 to fill out the entire table on Handout 22.3 and use Question 2 to add important findings into the non-PD practices section of the table on Handout 22.3. Use Question 3 to add important findings into the PD practices section. Put a star beside the PD foods listed under 'PD Food/Feeding' on Handout 223

For those behaviours that are considered positive, lead the group to select whether the behaviour could be practised by a poor family or only by a non-poor family. Is it feasible, easily replicable, affordable? Point out to participants how this exercise mirrors the process used in the community to analyse information from the PDI. Together, develop a summary chart of PD behaviours/skills/practices/messages that will need to be emphasised in Hearth sessions. Looking at the major challenges faced in the community, select 6 key PD practices that will address the challenges and directly affect the nutritional status of a child. For example, if exclusive breastfeeding was not commonly being practiced up to 6 months, this will be a major challenge faced in the community. However, if you found the PD households are practicing exclusive breastfeeding up to 6 months of age, make this one of the 6 key Hearth messages. Ensure the PD foods are used in the menu design in session 30.

30 Min

3.

Have each small group role play how to give this information back to the community. This will help to develop community ownership and enable community members to identify immediately accessible solutions to childhood malnutrition. Have at least one group present its role play and discuss it afterward with the large group. What was positive? What was difficult? What other ways could have the information been communicated?

Point out that by leading a group of villagers to identify uncommon good behaviours, you have facilitated community validation of choices ('buy-in').

Note: *Village volunteers may need help in analysing which behaviours are beneficial and which are harmful.*

10 Min

4.

Briefly summarise the steps in the PDI. Use this opportunity to repeat and clarify important points and answer any questions. The steps in the PDI are the following:

- Select the PDI team.
- Train the team (include lots of role play).
- Select sample PD households and conduct a practice PDI. These households are informed in advance, and the PDI team has the opportunity to practise and share notes.
- Conduct the PDI (may also conduct the PDI in non-PD and negative-deviant households for comparison purposes).
- Compile the findings.
- Share the findings with the community
- Plan the Hearth sessions using the information discovered about food (Hearth menu), active feeding, hygiene around eating/food, child development games, role of men (perhaps invite fathers to one Hearth day), role of grandmothers and other family members.
- Document other community initiatives resulting from the sharing with the community.

Community Feedback Meetings

SESSION 26

60 MIN | DAY 6

By the end of the session, participants will be able to

1. Identify times to give information back to the community
2. Practise creative ways of presenting information to the community.

Materials

- A flip chart
- A brightly-coloured marker
- Maize or other plant leaves (several healthy green ones and several unhealthy yellow ones)
- Thirty or so stones
- A large 'Road to Health' card and coloured markers

STEPS

10 Min

1.

As discussed in the community mobilisation session on the second day, it is important to give information back to the community. When should information be given to the community? Develop a flip chart with the group (see sample below). Use a brightly-coloured marker to highlight the different times information is given back to the community.

STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP

Step 1: Ask for the community's permission and **invitation** to use the PD approach (finding existing solutions to malnutrition problems within the community).

Discuss a way to describe the PD concept in local language, using proverbs or stories.

Step 2: Engage the community in defining the problem. Weigh *all* the children in the target group.

Step 3: Share the results of the weighing with the whole community.

Step 4: Discuss childhood malnutrition with community members: its causes, and common challenges and constraints. Ask for their ideas or suggestions for solutions.

Step 5: Have a community meeting to share the baseline information (results of weighing) again and to give feedback on the findings from the group discussions (community analysis). Explore together with the community members the links between the information discovered

in the focus group discussion and the number of malnourished or well nourished children.

Step 6: Invite community members to participate in the PDI.

Step 7: Share the PDI findings with the whole community, examine the PD behaviours and strategies identified, and invite them to develop a plan of action that will include Hearth sessions.

At different times different information needs to be shared. This is extremely important in building community ownership and commitment. What are some ways to communicate with the community? *(Engage their attention, build on their ideas, and communicate in ways they can understand. Object lessons, skits, dance and song can be effective.)*

20 Min

2.

Divide into four groups. Assign each group one step (steps 3, 4, 5, 7) from the Community Mobilisation and Ownership Steps. Each group must come up with a creative presentation of the information gathered from the community. Circulate and help the groups.

STEPS FOR PRESENTING DATA ON LEVELS OF MALNUTRITION IN THE COMMUNITY AND DISCUSSIN POSSIBLE CAUSES

Step 1

Use green and yellow maize leaves to show healthy and unhealthy plants. Discuss why the yellow leaves are unhealthy and ways to make the plants healthy. *(use manure, weed them, space them properly, fertilise them)*

Link the maize leaves with children. Some children are growing well, and some are not. Why? (*not fed enough, not fed often enough, births not well spaced, sickly, not enough variety of food, parents absent)*

Use stones to show proportion of children who are like yellow leaves (malnourished) and those who are like green leaves (well nourished). What makes the difference between these groups of children? How have caregivers in the community tried to help their children grow better? What do some families do to keep their children well nourished?

Step 2

Make a very large 'Road to Health' card. Plot every child that was weighed in the community on the chart. Use the colours green, yellow and red to show the difference in levels of malnutrition. Talk to the community about how

healthy children's growth follows the curve. Ask how many children there are. How many are not growing well? How can they tell? Why do they think they are not growing well? What have they tried before to help children grow better?

Are any children growing well? Why do they think that is? Are there things these families do that we could learn from? What have they tried? What has worked? Introduce PD/Hearth – discovering together what these families do so all can have well-nourished children.

PRESENTING INFORMATION COMPARING COMMUNITY NORMS WITH THE PDI INFORMATION

Step 1

Present two skits. The first shows a family with children who are sick. The family demonstrates poor behaviours *(caregiver goes to the field in the morning without feeding the children, eat only maize without washing hands, poor overall hygiene, grandmother tells mother not to feed the child when s/he has diarrhoea).* Include behaviours that are seen in the community. Exaggerate to make the skit funny.

The second skit shows a family with happy, healthy children demonstrating good practices (*feeding a variety of foods, washing hands, helping child eat, giving snacks, talking to children, grandmother supports caregiver's active feeding of children, gives separate bowl for young child to eat).* Include any practices that have been discovered in the PDI.

Talk with the community about how poor families with good practices have been able to keep their children healthy. Talk about the practices discovered in the PDI. Do they contribute to children being healthy? Could every family in the community do them?

Step 2

Hold a discussion with the community to create an action plan, including a discussion to identify mothers who will volunteer for the first PD/Hearth session in the community (among families with either underweight or healthy children).

30 Min

3.

Have the groups present the skits to the others. Discuss the presentations and encourage the participants to offer as many ideas as possible.

Promoting Behavourial Change (STEP 5)

40 MIN | DAY 6

By the end of this session, participants will be able to

1. Describe the stages of change
2. Relate to behavioural change from the perspective of an adopter and of a change agent
3. Give examples of motivating factors and barriers to change
4. List the key principles for behavioural change.

Reference in CORE PD/Hearth Guide: pp. 141, 143–45.

Detailed reference on behaviour change: http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

Preparation

- Write the following on a flip chart:

  'We behave our way into a new way of thinking.
  We do not think our way into a new way of behaving!'

- Prepare a flip chart with the questions asked in step 2 below.

Materials

- Blank flip charts

STEPS

5 Min

1.

Ask participants to think individually of one thing they have tried to change in their life. Ask them to try to remember what they did to make that change. What motivated them to try to change? How easy or hard was it? What things made it easier to adopt the new practice? What made it hard to adopt the new practice? How does a person adopt a new behaviour? (alone, with friends or a support group, with family). Ask if anyone is willing to tell the group whether he or she was successful in making the change. Why or why not? The facilitator should also talk about a change he or she made or failed to make.

5 Min

2.

Behaviour is embedded in culture and social context. Individual behaviours are motivated and influenced by the group, tribe, caste, beliefs, etc. Divide into groups of about five people. In the small groups think of a time when a community tried to change and then answer these questions: What motivated the community to

try to change? How easy or hard was it? What made it easier to adopt the new practice? What made it hard to adopt the new practice? Was the community successful in making the change? Why or why not? Have each group records its answers on a flip chart.

10 Min

3. Each group presents its flip chart with its example.

5 Min

4. As a group, look at all the charts. Can we identify stages in the change process? (The following are possible answers):

- We don't know what we want.
- We think we know what we want, but we can't do it.
- We are motivated to try something.
- We try/fail/reflect/try again, and so on.
- The new behaviour becomes a habit.
- We teach others about the new practice.

How fast do you think people progress through the stages to adopting a new behaviour? *(depends on the behaviour; depends on how desirable it is; depends on how complex it is to learn; depends on the cost in money, time, or energy; depends on whether other people approve or disapprove of the behaviour; depends on what obstacles get in the way)*

5 Min

5. Does knowledge or awareness equal behaviour change? Post the flip chart:

We behave our way into a new way of thinking.

We do not think our way into a new way of behaving!

Discuss together the meaning of this saying. Brainstorm about possible factors that enable or inhibit the behavioural change. Note these on a flip chart.

Factors That Enable Behavioural Change	Barriers That Inhibit Behavioural Change

5 Min

6.

Can you think of an example in PD/Hearth when a barrier might need to be removed before caregivers can feed their children different types of foods? What barriers might exist in the minds of caregivers? Note that we can only guess; to know for sure we have to ask the caregivers.

People take action when they believe it will benefit them; barriers keep people from taking action. A programme's activities should maximise the most important benefits and help overcome the most significant barriers.

What activities in PD/Hearth promote behavioural change?

Examples:

- From the PDI, we can learn what some families have done to overcome barriers and share that information through the Hearth sessions with the participants.
- It is important (from a behavioural change point of view) to stress that it is the community that needs to discover what works (the PD behaviours and strategies), not the PD facilitator.
- The PDI findings can be examined with the community at a community meeting, setting the stage for better adoption of sometimes controversial (unconventional) behaviours.
- Caregivers build skills and self-confidence as they practise feeding and cooking every day.
- The volunteers and community leaders give approval to caregivers for participation and for their children recovering.
- Caregivers get support from grandmothers, the other caregivers and the volunteers in trying the new practices.

5 Min

7.

Summarise the key points the participants have discovered about behavioural change and how it might influence how they implement PD/Hearth.

Designing Hearth Sessions (STEP 5)

SESSION 28

80 MIN | DAY 6

By the end of this session, participants will be able to

1. Describe what happens in a Hearth session
2. List the activities that occur during Hearth sessions
3. Describe lessons caregivers will learn during different Hearth activities.

Reference in the CORE PD/Hearth Guide:
Hearth Session Protocols, pp. 135–40

Preparation

- Review Handout 28.1.
- Prepare one flip chart for each of the activities of a Hearth session.
- Review the equipment list on page 136 in the CORE PD/Hearth Guide. Ask several participants to develop a role play of what happens in a Hearth session.
- Ask participants to prepare a skit demonstrating what a Hearth session is like. Ask a person who has experience with Hearth sessions to act as the 'volunteer' (or a facilitator can be the 'volunteer'). Be sure to include greeting caregivers and their children, collecting the food contributions and mentioning how these can help children to grow well, handwashing and snack, food preparation, games with children, handwashing and feeding children, discussion of what each caregiver or caregiver-grandmother pair will bring the next day, and cleanup.

Materials

- Flip-chart paper
- A marker for each participant
- Handout 28.1: Examples of Learning Opportunities Through PD/Hearth Activities

STEPS

5 Min

1.

What are some strengths of the PD/Hearth approach?

Remind the participants to keep these two goals in mind:

Goal 1: The malnourished child will recuperate.

Goal 2: The child's caregiver(s) will learn new behaviours (so that rehabilitation is sustained at home).

Discovers existing strengths: The approach helps identify positive behaviours and strengths that exist in the community and builds upon them. Each community's practices are different, so the health-education messages built around those practices will likewise be different for each village.

The PD/Hearth approach follows a three-step process for behavioural change:

1. Discovery (PDI)
2. Demonstration (Hearth sessions)
3. Doing (in Hearth sessions and at home, with follow-up visits to reinforce learning).

Promotes role modelling: If the Hearth volunteer is a PD caregiver (e.g. mother, grandmother, father, grandfather), he or she becomes an excellent role model.

Is experiential: Hearth sessions avoid lecture-style teaching; instead, caregivers are involved in all steps (hands-on style of learning).

Is based on cultural/social norms: Norms are reinforced with community support. Interventions are culturally appropriate and often use songs and/or stories that are part of the culture. In Haiti, a contest was held during training to develop songs for Hearth. This was very successful; it animated the training process and enhanced Hearth education.

15 Min

2.

Present the role play that illustrates the different activities of a Hearth session. Discuss the role play, covering the following topics:

What activities take place during a Hearth session?
(Caregivers and volunteers work together to prepare food, feed and entertain the children. Children – and perhaps siblings – receive a small snack and have supervised play while the meal is being prepared.)

Where should the Hearth session be held?
(The session requires a central, adequate space, preferably a house. While the 'hearth' should be large enough to accommodate the group, it should not be very different from the homes of the participating families.)

Time required
(A session takes two to three hours each day. Caregivers participating in PD/Hearth programme should decide a time that is convenient for all of them. Caregivers must meet for 12 days: six consecutive days followed by one day break and another six consecutive days.)

Are there basic requirements at the site?
(The site should have a latrine; water for drinking, cooking, and washing hands; and shade.)

What equipment needs to be at the site?
(See the list on page 137 in the CORE PD/Hearth Guide.)

5 Min

3. Ask one participant to describe the order of activities during a Hearth session.

Briefly review the activities of Hearth. Have each of the following activities listed on flip chart paper, one activity per sheet, and post the sheets around the room.

- Arrival of caregivers and children; take attendance and track contributions for the day (e.g. menu and cooking materials)
- Weigh children on first and last days of the programme. Collect child growth cards to obtain immunisation, supplementation and deworming information for each child; if child has not been fully immunised, dewormed or received vitamin A supplementation, refer the child to the nearest health facility for proper treatment before joining the Hearth session.
- Collect food contribution
- Hand washing/hygiene
- Snack
- Cook
- Play games with children
- Feed children
- Decide on menu and cooking material contributions and assign roles for next day
- Clean up.

10 Min

4. Hearth presents many informal learning opportunities for caregivers such as modelling, conversation and learning by doing. The topics in the examples below do not need to be taught through talks; rather, the volunteer reinforces these practices each day through conversations with the caregivers during the activities. Give each participant a marker and have them walk around the room where the Hearth activities are posted on flip chart paper. Ask them to list on the papers what caregivers can learn during each of these activities.

30 Min

5. In addition to the 6 key Hearth messages that were designed what other feeding and nutrition, caring, hygiene and health-seeking messaging could be shared throughout the Hearth sessions at the different stations, including cooking station, handwashing station and caring station.

HANDOUT
28.1 – 125m/H 46

As a group, review each activity and add other learning opportunities. (See Handout 28.1.) Discuss other lessons caregivers might need to learn and grandmothers can support. Consider especially practices and messages from the PDI. How will caregivers and grandmothers have an opportunity to learn these? During which activities? What activities can contribute to early childhood stimulation? Emphasise that lectures or other formal teaching methods are not used during Hearth; instead, all the messages are conveyed through conversation and learning while doing.

10 Min

6.

Ask the first group to finish its song to prepare a 5–10 minute role play on how a first day of Hearth unfolds (refer to CORE PD/Hearth Guide, p. 138).

5 Min

7.

Clarify any questions about Hearth sessions, for example, variations from programme experience

- Food contributions – An extremely poor caregiver may be asked to bring firewood or water, an extra pot, or another item. Or staff may make a contract with families before Hearth, detailing expectations and including a pre-Hearth work up and list of contributions. Or, in a peri-urban area, in order to reduce the caregiver's time commitment, all the caregivers (or caregiver-grandmother pairs) bring food, two people stay to cook, and the others return with the children at meal time.
- Obtaining equipment for the Hearth sessions – If the volunteer does not have pots or dishes, each caregiver can bring the equipment for her own child(ren). Or the community might provide a sitting mat, a large pot, and so on.
- Finding an appropriate Hearth setting – If one volunteer cannot host all 12 days, the sessions may rotate among several homes.
- Prior visit to health centre – The volunteer can accompany each caregiver and child to the health centre in order to establish comfort and ensure compliance.
- Assuring fuel for Hearth – Fuel scarcity can influence the types of food cooked. Fuel can be the community's contribution to lessen the burden on individual caregivers or the volunteer.

Arrival of caregivers and children/attendance

- Volunteer gives positive reinforcement for good hygiene.
- Volunteer asks how things are going at home – troubleshoot and share observations.

Collect food contribution

Discuss:

- Cost and sources of nutritious food
- Food variety, healthy choices
- Safety of food, proper storage
- Where foods can be found, gathered
- Food production/home gardens

Hand washing/hygiene

Discuss:

- Modelling proper hand-washing technique
- Use of soap
- Times when hand-washing is important
- Reason to wash hands: bacteria/germs contribute to illness/diarrhoea
- Treatment of diarrhoea/illness, when to seek health care
- Immunisation, deworming
- Nail cutting
- Orientation to personal hygiene
- Latrine use
- Use of shoes

Snack

Discuss:

- Frequency of snacks and meals
- Why to feed children four to five times a day
- Healthy snacks that require little or no preparation
- Consistency of food
- Food groups and nutritional value of food
- Including a variety of food in a day
- Breastfeeding
- Food storage

Cooking the menu

Discuss:

- Nutritional value of food
- Sources of affordable food: food production/home gardens, barter, collecting wild fruits
- Variety of food
- Good cooking techniques
- Food hygiene and safety, storage
- Promoting thick consistency of food
- Palatability and appetising appearance
- Importance of feeding children four to five times a day
- Hearth is an extra meal

Child stimulation/play

Discuss:

- Modelling play and care of children
- Motor-skill development
- Cognitive development
- New ways to stimulate children – singing, dancing, clapping games, etc.
- Social skills/sharing/cooperation
- Appropriate touching/affection

Feeding children

Discuss:

- Active, responsive feeding
- Content of foods (colours, nutrients)
- PD foods and why they are good
- Importance of meal frequency (four to five times a day)
- Breastfeeding
- Portion sizes
- Troubleshooting feeding problems
- Food taboos
- Stimulating a child's appetite

Planning for the next day

Discuss:

- Local and affordable foods, including the PD foods.
- Quantity of food
- Food combinations – variety, colour
- Nutrient value of food – importance of variety
- Where to find foods
- Planning menus and budgets

Cleaning up

Discuss:

- Hygiene – clean surfaces and utensils
- Use of leftovers
- Food safety
- Food storage
- Reuse water, compost
- Latrine use and cleanliness

Daily Summary and Evaluation

SESSION 29

10 MIN | DAY 6

By the end of this session, participants will be able to

1. Evaluate personal learning for the day.

Preparation

- Write the daily evaluation questions on a flip chart.

Materials

- Half sheet of paper for each person

STEPS

1.

Ask each participant to reflect on the day's sessions. They will write in their curriculum ideas to improve or adapt the various presentations methodologies so they are more appropriate for their own contexts. Participants should be ready to share any good ideas they might have.

2. Daily Evaluation

Distribute a half sheet of paper to each participant. Ask the participants to complete the three phrases written on the flip chart.

1. Something I learned today that I will apply in our PD/Hearth programme is

_____.

2. Something new that I learned about PD/Hearth today is

_____.

3. Something I'm still confused about is

_____.

The facilitators will review these evaluations at the end of each day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.

3.

Thank the participants for their good work during the day. Mention any highlights of the day. Remind them of the meeting time for the next session.

Menu Design and Cooking (STEP 5)

390 MIN OR 6.5 HRS

DAY 7

By the end of this session, participants will be able to

1. Describe important elements of planning nutritionally and culturally appropriate menus for Hearth sessions
2. Calculate calorie and nutrient requirements to determine optimal Hearth menu recipes/meals.
3. Prepare and cook Hearth meals using the Hearth menu recipes.

Reference in *CORE PD/Hearth Guide*: pp. 114–19

Preparation

- Purchase a 'market basket' of local foods from the market and set out these foods
- Review the PD food or dishes/meals identified during the PDI.
- Use actual prices to calculate the cost per gram of each food item and post this next to the food.
- Electronic or non-digital weighing scales that measure to 1 g.
- Obtain copies of and familiarise yourself with the national/regional 'Food Composition Table'.
- Provide copies of the Excel spreadsheet 'Menu Calculation Tool' for participants to install on their computers (if available). Know how to use this programme.
- Print copies of 30.1, 30.2, 30.3, 30.4 and 30.5
- Prepare basic cooking materials such as cooking pots, frying pans, bowls, cutting boards and cooking utensils.

Materials

- Flip chart 30 (below): Nutrients Required in the Meal
- Blank flip-chart paper
- Market-survey findings
- Local, national, or regional food composition (if available)
- Handout 30.1: Flip Chart 30 – Nutrients Required in the Meal
- Handout 30.2: Directions for the Menu-Planning Exercise
- Handout 30.3: PD/Hearth Menu Exercise – Food Composition Table
- Handout 30.4: Sample Menu-Planning Form
- Handout 30.5: User Guide for the PD/Hearth Menu Calculation Tool
- Plates, spoons for dividing bulk foods, a sharp knife, and small containers (little plastic cups)

- Electronic or non-digital weighing scales that measure to 1 g.
- Basic cooking materials such as cooking pots, frying pans, bowls, cutting boards and cooking utensils

STEPS

10 Min

1.

Hearth is held for 12 days (six days a week), followed by two weeks of follow-up visits. The first goal of the two-week Hearth session is to rehabilitate the malnourished child. The hands-on nature of the session sets the stage for sustained behaviour change which will be reinforced during the follow-up home visits (and later by the community). Keep the goal in mind while reviewing the following points.

Importance of the extra meal

At each session, ask the caregiver what she fed the child at regular meals in order to be sure the Hearth meal is 'extra'. After the child's recuperation the caregiver, supported by the grandmother, should enrich regular meals on a permanent basis, for example, with PD foods.

Importance of a snack during the Hearth session

A snack provides nourishment for children while they play and the caregivers cook, reinforces the idea that children need to eat small amounts frequently, and supplements the nutrients provided by the main menu.

When to weigh children and why

Children should be weighed on Day 1, Day 12 and Day 30. It is also important to ensure that a community growth-monitoring programme (GMP) continues; weighing helps to confirm nutritional rehabilitation and to reinforce the new behaviours.

10 Min

2. Menu Preparation

HANDOUT
30.1 – 136m/H 48

Based on the PDI findings and the market survey, menus will be designed which enable children to be rehabilitated quickly from malnutrition. Emphasise that the menu must be 'extra', must include a snack, and must include sufficient intake of protein and calories.

Show Flip chart 30, 'Nutrients Required in the Meal'. Emphasise the importance of Hearth menus meeting these requirements. Explain the motivational effect when caregivers see dramatic improvements in the child's health and behaviour. The child's appetite will return and overall mood and energy improve within 10

to 12 days. Families begin to see that food and caring are making a difference. This encourages them to continue the new practices.

Explain that the first step in menu planning is for the volunteer or supervisor to do a market survey. The purpose of this is twofold: (1) to reinforce the idea that the PD and other nutritious foods are affordable; and (2) to ensure that the menus planned will be affordable for caregivers to prepare at home. The market survey results will be used to create menus. Food composition tables (preferably country-specific ones) are also needed for menu preparation. *These may be available through the local UNICEF office or the Ministry of Health; for a fairly comprehensive table, see* http://ndb.nal.usda.gov/ndb/foods/list

30 Min

3.

HANDOUT
30.3 – 138m/H 50

Distribute a sample page from the national/regional food composition table or if this is not available, refer to Handout 30.3: PD/Hearth Menu Exercise – Food Composition Table. Explore together how the table is set up (based on 100g of the foods listed; the table tells whether the food is fresh or cooked; if not specified, it means 100g of raw food; EP stands for edible portion (for example, we don't eat the shells of eggs, so they aren't part of the edible portion) divided by food groups or alphabetically; foods are listed down the left-hand column and the nutrients across the top (some tables have macronutrients like kcal and proteins divided from micronutrients such as iron, zinc, vitamin A and vitamin C).

Using a flip chart based on Handout 30.3, ask the participants to locate a specific food/ingredient (for example, fresh fig leaves). Guide them through filling out the chart for 100g of this food. Fill in the chart together. For now, don't worry about the columns named 'home measure' and 'cost/amount'.

Pick another ingredient and this time complete the chart for 140g of the food. Help the participants decide how to fill in the table for the nutrients. For example, 140g of whole grain millet:

100g = 361kcal

(level of nutrient in food = amount of nutrient in 100 g * number of grams used)

$$140g = \frac{361kcal * 140g}{100g}$$

$$= 505.4kcal$$

Fill in the rest of the values, making sure that the participants understand how to do the calculations.

Choose one more ingredient and show the same calculation using a quantity less than 100g. For example, 40g of fresh camel meat:

100g = 188kcal

$$40g = \frac{188kcal * 40g}{100g} = 75.2kcal$$

Fill in the remaining values for camel meat. Make sure that the participants understand how to do the calculations.

Add the total values for each of the nutrients. Compare the totals with the requirements for the optimal Hearth menu. What is missing in this sample menu? What foods might supply those nutrients? Look on the food tables under Vitamin A for foods high in that vitamin. Are any of those foods available and affordable in the community?

A child's stomach has the capacity of about 200–250g (the size of a child's fist). The total quantity of the menu cannot exceed that amount. Remember that the menu must also include a snack as well as the meal. What could be added to this meal?

What follows is not a sample menu to be copied for PD/H menu designs, it is only to be used as an example for menu calculation.

Food	Home Measure	Quantity g	Calories Kcal	Protein g	Vit. A µg RAE	Vit. C mg	Iron mg	Zinc mg	Cost/ amount
Fig leaf, fresh, EP*		100	22	1	13	20	0.2	0.1	
Millet, whole grain		140	505.4	16.24	28	0	11.2	4.34	
Camel meat, fresh		40	75.2	6.96	0	0	.48	1.16	
TOTAL		280	602.6	24.2	41	20	11.88	5.51	
Hearth Requirements		200–250	600–800	25–27	300	15–25	10	3–5	

* Edible Portion

In addition to selecting high calorie, protein, vitamin, or mineral-rich foods, various cooking methods could be promoted to improve the nutrient value of certain foods (e.g. boiling vs. drying/roasting).

Examples:

Germination:

1. Sort and clean cereal grains.
2. Soak for 1 day.
3. Drain and place in a sack or covered container.
4. Store in dark, warm place for 2-3 days until grain sprouts.
5. Dry sprouted grains in sun.
6. Grind and sieve the flour.

Fermentation:

1. Grind cereal grain into flour.
2. Soak flour in water (3 cups of flour to 7 cups of water).
3. Leave to ferment for 2-3 days.
4. Cook into porridge.

4.5 Hours

4.

HANDOUT
30.2 – 137m/H 49
30.3 – 138m/H 50
30.4 – 144m/H 56
30.5 – 145m/H 57

Small-group menu-preparation and cooking activity. Divide the participants into groups of three or four.

Provide each small group with Handout 30.2: Directions for Menu Preparation, Handout 30.4: Sample Menu-planning form and Handout 30.5: User Guide for the PD/Hearth Menu Calculation Tool. The national/regional food composition table or Handout 30.3: PD/Hearth Menu Exercise – Food Composition Table may be shared among the groups.

- Each group goes to the 'market area' (the place where the food is spread out along with the containers and utensils) and takes foods for the menu it created based on the PDI findings and the market survey. The menu includes one snack and the meal.
- Groups use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the *CORE PD/Hearth Guide*, page 116, on how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Each group takes the amount they think a small child would eat. (Remember that a child's stomach is no larger than the child's fist.)
- Have a group member note the cost per gram of the food the group takes. Multiple the cost per gram of each food item by the number of grams used. Calculate the cost of the menu.

- After weighing the group's choices, place them on a plate.
- Using common household measures, such as bowls, cups, tins, and spoons, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.

Note: *If participants have computers and work in Excel, they can do the menu calculation using the spreadsheet provided. However, all participants must be able to use the 'Food Composition Table' and do the calculations manually, because they will be training others who will not have computer access. Ensure that local foods are entered into the spreadsheet before it is distributed to participants to load onto their computers.*

Excel instructions: Use a LCD projector to introduce the Menu Calculation Tool (Excel document) and to orient participants in how to use the tool. See Handout 30.5 'User Guide for the PD/Hearth Menu Calculation Tool' for instructions. Ensure that the cost of ingredients (per 100 grams) in the master sheet is updated based on the local market survey. Click on the worksheet Menu Day 01 and use drop down option to insert food group and ingredients. Then enter the quantity of each ingredient to be used. The levels of nutrients will be calculated. Compare the total amounts for each nutrient with the requirements of Hearth menus noted in red. Make adjustments to the menu as needed to adjust the levels of nutrients.

Allow groups to develop their menus before explaining the next steps.

- *Convert the cooked amount of food to a raw amount.* Demonstrate how to do this. When cooked, some foods either increase or decrease greatly in volume. For example, cooked rice has a volume about two times greater than raw rice; cooked beans, lentils and pulses about two times greater than raw. To convert cooked food in grams to raw food in grams, divide or multiply by the difference factor; for example,

  100g of cooked rice ÷ 2 = 50g of uncooked rice

Each group should convert all the ingredients in their menu to raw amounts using conversion factors found in Handout 30.2.

- *Calculate the cost of the ingredients using the cost per gram of each food, then add up the total cost for the entire menu.* If the cost seems too high for a household, look for less expensive sources of food. For example, replace chicken, which might be too costly, with groundnuts or another source of protein commonly available in the community.
- *Change the weights of the ingredients to household measures.* When cooking at home, people do not usually talk about grams or weigh foods. So, the grams must be changed to household measures. Measure the quantity of

each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.). Demonstrate how to do this with one ingredient, such as rice. Weigh 50g of raw rice and put it into a household measure. Write the household measure on the calculation sheet. Do the same for each ingredient.

This is the amount of the raw ingredients required for each child at each Hearth session. To calculate the total amount of ingredients required for *all* the children, multiply the measure of each ingredient by the number of children in the Hearth session.

Example: There are six children in one Hearth session. The menu uses 50 g uncooked rice per child – one large handful of uncooked rice. The whole recipe would require six large handfuls of uncooked rice (1 handful of rice x 6 children).

When all group members are satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form (Handout 30.4) to display with the plate.

Facilitators should work actively with the groups to guide the development of a menu and calculate nutritional composition (micronutrients, calories and protein) for each menu. Verify that each proposed menu meets nutrient requirements for recuperative feeding. (If laptops are available, each group may have one person calculate the menus with the Excel programme while others do the manual calculation.)

After the groups have finalized their Hearth menus, they can start cooking/ preparing the meal and snack using the menus they developed.

60 Min

5.

Gather in a large group once all small groups have finished cooking. Ask each group to measure out the portion (serving size) for one child using local measures that the caregivers will use to serve each child during the Hearth sessions. Have each small group show their final plate and menu-planning form, explain their menu, and point out the difficulties they encountered and the possible solutions they identified. Guide discussion on each proposal.

- Does the menu contain the correct protein, calorie and micronutrient composition?
- Is the quantity (volume) of food in the proposed menu a realistic amount for a child to eat? *(This has to be visualised, recalling that a child's stomach is the size of the child's fist.)*
- Does the menu include PD foods?
- Does the menu include locally available and accessible foods?

- Does the menu include a snack?
- Is the cost per serving realistic for a very poor family? *(While caregivers are not necessarily expected to replicate the exact menu at home, they should be able to afford all the ingredients in order to serve them regularly to the child.)*
- If a child finishes all the food served, should he or she be offered more? *(Yes, but not another whole portion. Also, the volunteer should visit the home and talk to the caregiver to assure that the child is receiving three other meals and another snack at home each day while attending Hearth. When not attending Hearth, a child 6–8 months of age should be receiving two meals and two snacks plus breastfeeding each day, and a child 9–24 months of age should receive three meals and two snacks daily plus breastfeeding. The Hearth meal is an extra meal.)*
- Considering that some children may need an extra small serving when they finish their first portion, how much extra food should be cooked? *(Cook an extra amount equivalent to two full portions.)*

Following the discussion, have the participants taste the menus and select the two best menus as a group, considering criteria listed in Step 6.

***Note**: Caregivers and grandmothers from the community can be asked to join the menu tasting as a way of introducing them to what they will learn in the Hearth sessions.*

6.

A good Hearth menu should:

1. Include PD foods (based on PDI findings)
2. Be low in cost (affordable based on PDI and market survey)
3. Meet nutrient, calorie and protein requirements
4. Be small enough in volume that child could eat another meal at home soon after (250g–300g)
5. Include a snack (to increase child's appetite)
6. Based on local context and culturally acceptable (use locally available and accessible foods)
7. Have good consistency (doesn't run off of spoon like water, but is thicker)
8. Not consist of foods that are too chunky or bulky, as that makes it difficult for children to consume.

Calories: **600–800 (500–600*)**

Protein: **25–27g (18–20g*)**

Vitamin A: **300 µg RAE (RAE=retinol activity equivalent)**

Iron: **8–10mg**

Zinc: **3–5mg**

Vitamin C: **15–25mg**

*Amounts in parentheses are the minimum for a region with food insufficiency; recuperation will take longer with these amounts (see CORE PD/Hearth Guide, p. 114).

Note: *The vitamin A requirement has been updated since the publication of the CORE PD/Hearth Guide and PD/Hearth Addendum to use the currently accepted measure of Retinol Activity Equivalents (RAE). Make sure that the food composition tables you use lists vitamin content as µg RAE, not RE or IU (conversion rate: 1 µg RAE = 3.3 IU).*

Each group can go to the 'market area' (where the food and utensils are laid out) and take different foods for its menu. The menu includes one snack as well as the meal:

- Take the amount you think a small child would eat. Remember that a child's stomach is no larger than the child's fist.
- Note the cost per gram of the food you take.
- After weighing your group's choices, put the foods on a plate.
- Use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the CORE PD/Hearth Guide, page 116, which discusses how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Calculate the cost per gram used of each ingredient. Then add up the total cost of the menu for one child.
- Using common household measures, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.
- Convert the cooked amount of food to a raw amount. For rice, divide the cooked volume by 2 to get the uncooked measure. For example, 60g of cooked rice divided by 2 equals 30g of uncooked rice.

Conversion of cooked food in grams to raw food in grams:

Cooked rice, divide by 2

Cooked beans, lentils, pulses, divide by 2

Cooked porridge, divide by 2.5

Cooked green leaves, multiply by 1.4

- Change the gram amounts to household measures by measuring the quantity of each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.).
- For example, weigh out 30g of uncooked rice and put it into a cup that would be found in households or measure it by the handful, if that is more common.
- Write the household measure for each food on the calculation sheet.
- Each caregiver or caregiver-grandmother pair will contribute this amount of raw ingredients for their child(ren) at each Hearth session.
- When satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form to display with the plate.

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
1. Grains, Roots, and Tubers								
Cassava, boiled	165	1.2	1	13	1.4	0.2		1
Cassava, dried, raw	351	2.1	2	68	3.8	0.8		1
Cassava, raw	157	1.1	1	31	1.7	0.2		1
Maize flour, whole grain, yellow	361	6.93	11	0	2.4	1.7		5
Maize or Sorghum Ugali	110.3	3	2.1	0	1.3	0.5		7
Maize, white, whole, boiled	139	3.5	1	2	1.2	0.5		1
Maize, white, whole, dried, raw	363	9.2	3	8	3.2	1.4		1
Maize, yellow, boiled	136	3.6	35	1	1.6	0.6		1
Maize, yellow, dried, raw	354	9.4	101	4	4.2	1.7		1
Millet flour	373	10.75	0	0	3.9	2.6		5
Millet, whole grain, boiled	144	4.1	0	0	6.4	0.6		1
Potato, boiled	74	1.8	2	11	0.8	0.3		1
Rice Flake, water soaked	356	1.1	0	0	2.0	0.4		9
Rice noodle (mee suah)	320	9.10	0	0	1.6	0.7		10
Rice noodle, fermented	106	1.40	0	0	0.1	0.2		10
Rice steamed, white	131	2.20	0	0	0.4	0.6		10
Rice, brown, boiled	135	3	0	0	0.7	0.7		1
Rice, white, boiled	133	2.8	0	0	1.0	0.4		1
Rice, white, fried	370	6.81	0	0	1.6	1.2		10
Rice, white, raw	355	6.80	0	0	1.2	0.5		10
Rice, white, soaked	370	6.81	0	0	1.6	1.2		10
Sorghum flour	361	7.87	0	0	3.0	1.4		5
Sorghum, whole grain, boiled	153	4.6	2	0	3.6	0.6		1
Steamed sticky rice (white), grilled	229	4.60	0	0	0.1	0.2		10
sticky rice (white), steamed	229	4.60	0	0	0.3	1.0		10
Sweet Potato, boiled	101	1.7	789	15	1.7	0.3		1
Taro, boiled	100	1.9	4	3	0.9	0.2		1
Wheat flour, white	347	10.7	0	0	2.0	4.0		1
Wheat noodle (waiwai), instant	456	10.5	0	0	1.6	1.8		10
Yam, boiled	101	1.7	2	5	1.0	0.2		1
2. Legumes and Nuts								
Beans, kidney, boiled without salt	127	8.67	0	1	2.2	1.0		5
Beans, raw	32	2.4	54	18	1.0	0.3		1
Beans, yellow, cooked, boiled without salt	144	9.16	0	2	2.5	1.1		5
Cashewnut, raw	589	20	0	0	6.4	4.6		7
Chickpea, boiled without salt	164	8.86	1	1	2.9	1.5		5
Chickpea, dry	364	19.3	3	3	6.2	3.4		5
Coconut water	22	0.3	0	2	0.1	0.1		1
Coconut, mature, fresh, raw	387	3.2	0	2	2.5	0.9		1
Cowpea, Leafy tips, boiled and drained	22	4.67	29	18	1.1	0.2		5
Cowpea, seeds, black, dried, boiled	116	7.73	2	0	2.5	1.3		10
Groundnut, dried, raw	578	24.1	2	1	4.3	1.9		1
Groundnut, dried, roasted (also gnut flour)	567	25.8	0	0	4.6	1.7		6
Groundnut, fresh, boiled	236	10.8	0	0	1.9	1.0		6
Groundnut, fresh, roasted	374	17	0	0	3.0	1.1		6
Groundnut, seeds, dried, raw	577	24.8	0	1	2.3	2.8		1

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
2. Legumes and Nuts (continued)								
Lentils, boiled without salt	116	9.02	0	2	3.3	1.3		5
Lentils, raw	353	25.8	0	0	7.5	4.8		5
Mongogo Nut, Bok Nut	659	26.00	0	0	3.7	4.0		
Mung Bean, boiled without salt	105	7.02	1	1	1.4	0.8		5
Mung Bean, dried	324	22	19	0	8.0	0.8		2
Soya bean, boiled without salt	173	16.64	0	2	5.1	1.2		5
Soya bean, dried, raw	397	33.2	9	0	8.3	4.7		1
Soya bean, dry roasted	451	39.58	0	5	5.0	4.8		5
Soya bean, roasted without salt	471	35.22	0	2	3.9	3.1		5
3. Dairy Products (milk, yoghurt, cheese)								
Breastmilk, human, mature, raw	69	1.1	62	1	0.2	0.3		1
Milk UHT, Thaidenmark brand (non-fortified)	67	3.30	41	0	0.1	0.3		10
Milk, cow, powder, whole	492	25.3	295	12	0.7	4.0		1
Milk, cow, whole, raw	75	3.7	39	2	0.1	0.4		1
Milk, goat, whole, raw	69	3.4	35	2	0.1	4.0		1
Milk, instant, Anmum brand (fortified)	77	3.20	93	22	2.6	2.2		10
Yoghurt, drinking, foremost brand	84	1.50	14	3	0.1	0.3		10
Yoghurt, wholemilk, natural	75	3.5	33	1	0.1	4.0		1
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats)								
Anchovy (small fish), fillet, raw	123	18.4	15	0	3.3	1.7		1
Anchovy, fillet, grilled	668	27.6	20	2	3.8	2.5		1
Anchovy, fillet, steamed	542	22.4	16	2	2.9	2.1		1
Beef ball, blanched	84	16.5	7	1	5.0	0.0		10
Beef internal organ barbecue	94	14.0	2357	9	5.0	2.0		10
Beef intestine, raw	109	16.4	10	0	3.1	2.0		10
Beef liver, grilled	133	20.3	3841	18	10.1	3.9		10
Beef liver, pan-fried	175	26.52	7744	1	6.2	5.2		5
Beef liver, raw	135	20.36	4968	1	4.9	4.0		5
Beef lung, raw	84	16.0	95	6	6.1	1.7		10
Beef spleen, raw	95	18.2	103	29	0.7	2.1		10
Beef stomach, raw	102	11.0	0	0	1.9	1.3		10
Beef, blanched	150	20.0	2	0	3.0	5.0		10
Beef, dried, grilled	479	38.3	3	0	11.8	3.9		10
Beef, dry, fried	479	38.3	3	0	11.8	3.9		10
Beef, grilled	190	38.5	3	0	4.9	7.6		10
Beef, ground, 20% fat, pan-broiled	246	24.04	0	0	3.6	6.1		5
Beef, ground, 20% fat, raw	254	17.17	0	1	1.9	4.2		5
Beef, raw	273	17.2	3	0	2.3	5.3		10
Chicken, roasted	210	23.8	0	0	0.8	1.5		10
chicken gizzard, raw	102	20.2	34	3	3.1	3.2		10
Chicken heart	112	15.8	75	6	4.0	5.5		10
Chicken Liver	114	16.9	3296	18	9.0	2.5		9
Chicken liver, boiled	121	18.6	3178	14	7.3	3.2		10
Chicken liver, grilled	121	18.6	3273	14	7.3	3.1		10
Chicken liver, raw	121	18.6	3710	14	7.3	3.0		10
Chicken, boiled	193	28.6	5	1	0.6	1.0		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats) (continued)								
Chicken, cooked	285	26.9	39	0	1.4	1.8		6
Chicken, flesh only, raw	136	20.6	10	0	1.2	1.0		1
Chicken, raw	186	17.3	3	0	0.5	1.0		10
Cricket	127	12.90	0	0	9.5	0.0		11
Dried small fish *(usipa)*, cooked with salt	125	17	0	0	3.3	9.1		6
Duck, roasted	373	18.5	115	0	1.3	2.1		10
Fermented fish with bone	103	13.3	3	0	5.5	3.6		10
Fermented fish, sour, fried	108	19.5	1	0	2.1	2.4		10
Frog legs, raw	73	16.40	15	0	1.5	1.0		5
Lamb, composite of retail cuts, cooked	256	24.54	0	0	1.9	4.7		5
Lamb, meat, raw	217	17.2	10	0	2.3	3.1		1
Mackerel, Pacific and jack, cooked dry heat	201	25.73	23	2	1.5	0.9		5
Mackerel, raw	133	21.1	16	2	1.8	0.5		1
Mussels, boiled	33	3.1	208	0	2.9	1.9		2
Mutton/Lamb Liver	150	19.3	8250	20	6.3	4.0		9
Nile tilapia fish, raw	96	20.1	0	0	0.6	0.3		10
Nile tilapia, roasted	128	26.2	0	0	0.7	0.4		10
Pork blood, boiled	32	7.90	26	0	25.9	0.1		10
Pork liver, grilled	125	19.2	4242	19	15.5	5.3		10
Pork liver, raw	125	19.2	6291	25	15.5	5.6		10
Pork sausage, grilled	369	19.6	14	2	1.2	2.5		10
Pork skin, raw	320	19.8	6	0	2.1	0.3		10
Pork spleen, raw	87	16.1	241	26	1.0	2.3		10
Pork, boiled	204	33.0	0	0	1.5	1.3		10
Pork, fresh, cooked	201	27.51	1	0	1.0	0.1		5
Pork, grilled	249	26.2	0	0	2.5	1.8		10
Pork, meat, approx. 24% fat, raw	289	14.5	0	0	2.0	3.2		1
Pork, meat, approx. 40% fat, raw	405	12.6	0	0	1.9	3.2		1
Pork, raw	116	21.8	0	0	1.0	1.0		10
Pork, shreded, chinese style	357	43.1	0	0	17.8	1.3		10
Prawns or shrimps, cooked in moist heat	119	22.78	0	0	0.3	1.6		5
Rabbit, meat, raw	142	20.7	10	0	0.9	1.7		1
Rabbit, stewed	206	30.38	0	0	2.4	2.4		5
Short bodied mackerel fried	236	25.7	26	2	2.4	1.0		10
Short bodied mackerel, roasted	122	21.4	27	5	1.4	0.6		10
Siamese mud carp, grilled	124	21.1	9	1	0.6	1.5		10
Snail, pond, river	74	12.10	0	0	8.7	0.0		11
Tilapia, cooked dry heat	128	26.15	0	0	0.7	0.4		5
5. Eggs								
Egg, duck, whole, boiled	150	11.8	169	0	3.4	1.2		10
Egg, hardboiled	155	12.58	149	0	1.2	1.1		5
Egg, hen, whole	159	13.2	160	0	2.8	1.1		10
Egg, hen, whole, boiled	170	13.9	164	0	3.5	1.2		10
Egg, raw	139	12.1	207	0	2.4	1.3		1
Hen egg, fried	196	13.6	219	0	1.9	1.4		10
Omelet duck egg	183	12.6	365	0	3.2	1.0		10
Omelet hen egg	259	7.00	255	0	2.2	1.6		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
6. Vitamin-A Rich Fruits and Vegetables								
Amaranth, boiled	21	2.11	139	41	2.3	0.9		5
Bean leaves, fresh, cooked with salt	14	1.4	192	12	1.1	0.1		6
Carrot, boiled	33	0.9	1137	3	0.7	0.6		1
Carrot, raw	35	1	1201	7	0.9	0.8		1
Cassava, fresh leaves, cooked with salt	20	2	261	12	1.6	0.6		6
Cassava, fresh leaves, raw	98	0.9	1733	370	5.6	5.0		1
Chinese cabbage blanched	21	1.70	244	33	1.6	0.2		10
Dark Green Leaves, fresh	48	5	950	100	4.0	0.8		2
Dark Green Leaves, fresh, cooked with salt	18	1.1	401	17	0.5	0.1		6
Green amaranth, small, blanched	21	2.11	278	41	2.3	0.9		10
Green amaranth, small, fresh	35	3.60	510	49	3.1	1.2		10
Horse tamarind, young leaves	85	9.20	255	7	3.4	0.6		10
Mango, ripe, fruit, raw	62	0.6	427	35	1.0	0.6		1
Moringa leaves, boiled	91	8.8	699	0	4.8	0.7		1
Moringa leaves, raw	86	8.3	738	0	6.1	0.9		1
Morning glory/Swamp cabbage, blanched	20	2.08	520	16	1.3	0.2		10
Morning glory/Swamp cabbage, fresh	31	2.90	457	28	3.3	0.5		10
Mustard green blanched	19	2.27	708	14	1.1	0.2		10
Mustard green, fermented, sour	21	1.50	161	20	1.3	0.2		10
Mustard green, stem and leaves, boiled	22	1.70	249	43	1.5	0.1		10
Mustard leaves, fresh, cooked with salt	16	1.1	213	0	1.0	0.4		6
Mustard, fresh	28	2.20	317	57	2.5	0.2		10
Okra, leaves, cooked with salt	12	0.7	260	11	0.3	0.7		6
Papaya (paw paw), fruit, ripe, raw	38	0.5	355	59	0.7	1.4		1
Pumpkin, boiled	20	0.5	201	5	0.2	0.2		6
Pumpkin, fresh leaves, boiled	11	0.6	298	11	0.5	0.4		6
Pumpkin, mature, fresh	49	1.30	170	15	0.7	0.9		10
Pumpkin, raw	36	1	250	15	0.8	0.2		2
Squash, raw	47	0.4	240	1	0.3	0.2		2
Squash, winter, all varieties, cooked without salt	37	0.89	261	10	0.4	0.2		5
Tamarind, young leaf, fresh	68	3.80	381	32	1.5	0.5		10
Taro, leaves, cooked without salt	24	2.72	212	36	1.2	0.2		5
Taro, young leaves, raw	30	2.4	389	52	2.0	0.4		1
Wildbetal Leafbush	60	4.20	258	17	4.2	1.0		10
7. Other Fruits and Vegetables								
Apple, prink, fresh	63	0.50	14	2	0.2	0.0		10
Avocado, raw	149	1.6	20	16	1.1	0.6		1
Bamboo shoots, cooked, boiled, with salt	11	1.53	0	0	0.2	0.5		5
Bamboo shoots, cooked, boiled, without salt	12	1.53	0	0	0.2	0.5		5
Banana, flowers, fresh	38	1.60	34	10	1.1	0.3		10
Banana, ripe, raw	100	1.3	19	10	1.0	1.1		1
Banana, ripe, yellow	105	1.00	15	12	0.4	0.1		10
Banana, ripe, yellow, boiled	105	1.00	13	10	0.4	0.1		10
Bean sprouts, fresh	46	4.30	5	23	1.4	0.5		10
Cabbage, blanched	29	1.50	8	32	1.0	0.3		10
Cabbage, boiled	19.8	1.3	11	21	0.4	0.2		1
Cabbage, common, fresh	29	1.50	8	32	1.0	0.3		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Cabbage, raw	26	1.6	10	54	0.6	0.2		1
Cauliflower, boiled	28	2.7	1	47	0.8	0.4		9
Chayote, boiled	21	0.60	6	10	0.4	0.3		10
Chayote, fruit, fresh	21	0.60	6	10	0.4	0.7		10
Chilli pepper, hot, red, fresh	75	3.00	156	142	1.2	0.4		10
Cilantro	23	2.13	337	27	1.8	0.5		2
Coriander, fresh	33	2.50	431	34	2.6	0.2		10
Cucumber, fresh	23	0.80	9	12	0.4	0.2		10
Cumcumber	95.5	0.7	3	0	0.5	0.2		1
Dill, fresh	34	3.10	201	40	2.3	0.7		10
Eggplant, boiled without salt	35	0.83	2	1	0.3	0.1		5
Eggplant, raw	28	1.1	12	6	0.9	1.6		1
Eggplant/brinjal, green, fresh	37	1.50	10	8	0.9	0.2		10
Fennel common leaves, fresh	42	2.50	867	23	2.3	0.2		10
Fig, raw	78	1.4	79	15	6.0	1.5		1
Garlic, fresh	51	2.10	0	10	0.7	0.4		10
Garlic, raw	136	6.1	0	18	1.5	0.6		1
Ginger, raw	72	1.9	0	5	1.1	0.4		9
Guava, fruit, raw	58	1	95	281	1.4	1.8		1
Hairy basil, fresh	39	2.80	279	18	2.1	0.6		10
Jackfruit, raw	94	1.7	18	9	0.6	0.1		2
Lemon grass, fresh	78	0.80	3	1	2.0	0.5		10
Lemon, fruit, raw	36	0.7	2	46	0.6	0.1		1
Lemon, juice	29	1.1	3	53	0.6	0.1		4
Light/Pale Green Leaves, fresh	23	1.5	47	40	0.5	0.8		2
Mango, unripened, fruit, raw	55	0.5	10	86	1.4	0.6		1
Mint, leaf	42	2.90	467	84	4.1	0.8		10
Mushrooms, portabella, grilled	29	3.28	0	0	0.4	0.7		5
Okra, fresh, boiled	21	1.1	38	5	0.8	0.4		6
Okra, fresh, raw	31	1.7	72	29	0.9	3.0		1
Onion	50	1.60	0	8	0.7	0.2		10
onion, cooked	44	1.36	0	5	0.2	0.2		5
Onion, raw	32	1.1	1	7	0.5	0.2		1
Orange, raw	45	0.8	17	47	0.1	0.1		1
Orange, sweet, fresh	52	0.50	6	65	0.4	0.7		10
Pak kha yeng, raw	32	1.50	18	5	5.2	1.0		10
Passion Fruit	94	2.4	64	17	1.2	0.0		3
Pineapple, raw	56	0.4	15	31	0.5	2.2		1
Pomelo (grapefruit), raw	34	0.8	40	44	0.6	0.1		4
Radish, boiled	24	1.2	0	9	0.5	0.4		9
Radish, raw	18	0.9	0	17	0.4	0.4		9
Rumbutam, fresh	69	0.90	0	43	0.7	0.1		10
Shallot, bulb	67	1.70	1	9	0.9	0.3		10
Spring onion, fresh	44	2.20	475	42	2.3	0.4		10
Star fruit	32	0.60	10	29	0.7	0.0		11
Tamarind, fruit, raw	60	2.2	2	10	0.7	0.0		1
Tiliacora triandra diels	95	5.60	329	141	7.0	0.6		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Tomato, fresh	25	1.00	88	29	0.9	0.2		10
Tomato, raw	21	1	127	29	0.9	12.0		1
Tomato, red, ripe, cooked	18	0.95	24	23	0.7	0.1		5
Watermelon, fruit, raw	30	0.5	62	7	0.2	0.1		1
Yard long bean, green, fresh	40	2.60	41	20	0.8	0.5		10
8. Fats and Oils								
Butter, cow's milk	700	1	1060	0	0.2	0.1		1
Coconut oil	900	0	0	0	1.5	0.0		1
Ghee, cow	898	0	0	0	0.2	0.0		9
Groundnut oil	903	0	0	0	0.0	0.0		1
Mustard oil	900	0	0	0	0.0	0.0		9
Palm oil	895	0	0	0	0.4	0.0		1
Vegetable oil	884	0	0	0	0.0	0.0		4
9. Miscellaneous								
Fermented fish, liquid	13	1.20	3	0	2.9	0.1		10
Fish souce	48	5.40	5	1	2.4	0.2		10
Honey	322	0.3	0	2	0.6	2.0		1
Horse tamarind, seeds	152	11.8	34	2	4.3	1.4		10
Jaggery	383	0.4	160	0	11.1	0.0		8
Lemon, juice, fresh	24	0.50	1	25	0.1	0.1		10
Oyster sauce	73	2.90	6	7	1.1	0.1		10
Pumpkin seeds, without shell, roasted	594	25.6	0	0	6.0	8.0		11
Salt	0	0	0	0	0.3	0.1		5
Sesame seeds, white, roasted	682	26.1	0	0	13.0	7.2		10
Shrimp paste	85	4.60	21	0	2.2	1.1		10
Sprinkles (per sachet)	0	0	300	30	12.5	5.0		8
Sugar (white), not fortified	369	0	0	0	0.2	0.1		1
Tumeric, dried	335	6.9	1	0	33.2	3.8		9
Vinegar	27	0.2	0	0	0.5	0.0		1
10. Additional Foods								
Banana Porridge	105.3	0.6	65.6	9	0.4	0.1		7
Cassava Stiff Porridge	140	2.7	1.4	7	1.2	0.6		7
Coconut juice, fresh	37	0.10	0	5	0.1	0.2		10
Coconut milk	185	1.90	0	2	0.6	0.5		10
Deep fried banana with powder	373	2.00	11	8	0.4	0.1		10
Maize Porridge (with oil)	414.4	16.9	0.6	1	5.6	2.6		7
Porridge, white rice, boiled	59	4.10	0	0	0.1	0.2		10
Soy milk, Lactasoy brand	82	2.50	40	0	0.4	0.1		10

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Sample Menu-Planning Form

Menu A:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

Menu B:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

The PD/Hearth Menu Calculation Tool is developed to aid in designing low cost and nutrient-dense menus for Hearth sessions using local foods/ingredients that are easily accessible and available to community members. Based on the PDI findings and the market survey, 2-4 Hearth menus with a snack and a meal for each menu will be developed for each community using PD food(s) and locally sourced ingredients. To quickly rehabilitate children from malnutrition, Hearth menus need to meet optimal calorie and nutrient requirements[1]. Particularly, this Tool is useful in checking whether the meal and snack meet the requirements. Also it simplifies other calculations such as the total cost and quantity of ingredients required for all the children attending Hearth as these can be generated automatically.

The PD/Hearth Menu Calculation Tool has six tabs/worksheets: Introduction; Instructions; Master; Menu Day 1; Menu Day 2; Menu Day 3.

Tab 1 – Introduction: Contains a background information on the rationale for the Tool including who should be using this Tool and how it should be used.

Tab 2 – Instructions: Contains a step-by-step detailed guide on how to use the Master and Menu worksheets. Please refer to this worksheet as you design the Hearth menus.

Tab 3 – Master: Contains a Food Composition Table with the nutritional breakdown of 100 grams of edible portions of foods in terms of energy (Kcal), protein (g), Vitamin A RAE (mcg), Iron (mg) and Zinc (mg). The foods are categorised in 10 food groups: 1. Grains, roots, and Tubers; 2. Legumes and nuts; 3. Dairy products; 4. Flesh foods; 5. Eggs; 6. Vitamin A rich fruits and vegetables; 7. Other fruits and vegetables; 8. Fats and oils; 9. Miscellaneous; and 10. Additional foods (In cases where local food items are missing from this Master list, missing foods can be added to 'Additional foods' group by copying the energy and nutrient values from another food composition table).

Tab 4 – Menu Day 1: Contains a Menu Planning Form (calculates the menu requirements for ONE CHILD) and a table that allows automatic calculation of the cost and quantity of each ingredient required in the menu to feed 'X' number of children, depending on the number of participating children in Hearth sessions. The total cost of the menu for all children is also given.

Tabs 5 and 6 – Menu Day 2 and Day 3: Contains additional worksheets (same format as Menu Day 1) to create different menus. Most Hearth sessions should have at least 2 Hearth menus. You should consider changes in food availability or affordability at different seasons (e.g. dry vs. rainy season) when designing Hearth menus. For example, you may want to create a menu for each season. Also, you could inform caregivers of foods you could replace certain ingredients with so that they will be able to continuously use the Hearth menu to feed their children during various seasons.

Step-by-Step Instructions:

Based on the PDI findings and the market survey results, create Hearth menus.

1. (Master worksheet) Enter cost of each food in Cost for Raw Foods column identified from the market survey. Please note that cost should be entered per 100g of edible portion of the raw food (See Step 1 of the Instructions sheet for an example).

1. Hearth menus should meet the following energy and nutrient requirements: Energy: 600-800 kcal; Protein: 25-27g; Vitamin A: 300 mcg RAE; Iron: 8-10 mg; Zinc: 3-5 mg; and Vitamin C: 15-25 mg.

2. (Menu Day 1 worksheet) In the Menu Planning Form, use the drop down option to select the food group of choice and then use the drop down option to select the ingredient/food under the Food column, placing each ingredient under appropriate headings (i.e. Meal or Snack).

3. (Menu Day 1 worksheet) Enter quantity in grams for each ingredient under the Quantity (grams) column. Please note that this amount is 'cooked' values in grams that will be used in the menu for ONE child. See Step 3 of the Instructions sheet for how to estimate the amount of ingredient keeping in mind the cook/raw conversions.

4. (Menu Day worksheet) Repeat Step 2 and 3 for each food you will use. You can also enter the household measure for the ingredients for the raw amounts indicated in the Raw Quantity (grams) column.

5. (Menu Day worksheet) Once you finish entering all the ingredients/foods for the menu, you can check at the bottom of the Menu Planning Form to see whether you have met or exceeded the Hearth menu requirements.

    a. The total values for each nutrient, cost, and 'cooked' quantity of ingredients in the menu for one child are calculated automatically in the row number 36. Depending on the values displayed under each column, you may need to adjust quantity of each ingredient or select different ingredient to develop optimal Hearth menus.

    b. You can check by comparing the total values for each column against what is displayed in each column heading. Or, in the subsequent row, any discrepancies or differences between the total value of each nutrient in the menu and the amount of the same nutrient required in Hearth menu are available. If the menu meets all the nutrient requirements, then all the numbers in red/bracket will be "0". Try to adjust the quantities and/or types of foods included in the menu until you reach something very close to the required amount of nutrient.

    c. The values in red/bracket indicate that these nutrients need to be increased by adding foods/ ingredients that are high in these nutrients. For example, if the cell under the Iron column has "(3.50)", then you would need to increase amount of iron by 3.50 mg, by increasing quantity or adding iron rich foods like chicken or fish, still being mindful of the cost.

    d. Also the total quantity of 'cooked' foods should not be too much considering that a child has a small stomach (the size of a child's fist) and will not be able to eat a large volume of food at one sitting. Thus, depending on the total quantity (grams), you may need to select more nutrient dense food. For example, instead of selecting rice you may opt to select groundnut which will have more calories and proteins per gram basis.

6. (Menu Day worksheet) To calculate the total cost and quantity of ingredients required for the total number of children participating in Hearth sessions, enter the number of children who will be eating in a designated cell in the table below the Menu Planning Form chart. Also, determine a household measure for raw food amounts required for each ingredient from the Raw Quantity in grams column so that volunteers will know how much of uncooked ingredients will be needed for the Hearth menu. See Step 5 of the Instructions sheet for additional details.

Menu Calculation Assessment

SESSION 31

60 MIN | DAY 8

By the end of this session, participants will be able to

1. Review and demonstrate understanding of menu calculation process

Preparation

- Print menu calculation test (found in Resource CD) for each participant

STEPS

1. Hand out menu calculation tests for participants to complete. Collect the completed tests which will be marked by the facilitatiors and returned to the participants on the final day of the training.

2. Review agenda for today.

SESSION 32

Essential Elements of PD/Hearth

55 MIN | DAY 8

By the end of this session, participants will be able to

1. List the 14 essential elements for PD/Hearth implementation
2. Explain the importance of and reasons these elements are essential.

Reference: *Positive Deviance/Hearth Essential Elements, A Resource Guide for Sustainably Rehabilitating Malnourished Children (Addendum)*, June 2005 http://www.coregroup.org/storage/documents/Diffusion_of_Innovation/PD_Hearth_Addendum_Jun_2009.pdf

Preparation

- Review Handout 32.1 and 32.2

Materials

- Handout 32.1: Positive Deviance/Hearth Essential Elements
- Handout 32.2: PD/Hearth Essential Elements – Detailed Observations and Key Questions
- Flip-chart paper, cut or torn in half
- A paper circle for each participant (four circles should fit easily on the half sheet of flip-chart paper without overlapping)

STEPS

5 Min

1.

Explain that certain features of the PD/Hearth approach are essential for success. Because children quickly recover, their families are motivated to continue the new behaviours. Ask participants to name any of these essential elements.

10 Min

2.

HANDOUT
32.1 – 150m/H 59

Distribute Handout 32.1 and ensure that all 14 essential elements have been named. Divide into pairs. Assign two essential elements to each pair. Each pair is to list the reasons its two elements are essential. Those who finish early can look at the other essential elements and discuss the reasoning behind them.

20 Min

3.

Each pair explains to the group its two elements and the reasons they are essential.

10 Min

4.

HANDOUT
32.2 – 154m/H 63

Discuss who is responsible for assuring that PD/Hearth in each community adheres to the essential elements. *(ADP staff that supervises, community Hearth committee, or volunteers, depending on the element).* Ask for examples. Present Handout 32.2: PD/Hearth Essential Elements – Detailed Observations and Key Questions, which can be used as a tool to monitor essential elements in a Hearth project.

10 Min

5.

Based on the essential elements, have the participants respond to the following challenges:

- The ADP wants to provide the food for PD/Hearth sessions.
- Caregivers are busy, so they want to send their children but not attend the Hearth sessions themselves.
- Volunteers, caregivers, or grandmothers change the menu based on what they have at home and would like to cook.
- Children 5–7 years old are included in PD/Hearth.

Several elements are essential to the implementation of an effective PD/Hearth project. Experience has shown that these elements cannot be adapted, modified, or omitted without seriously diminishing the effectiveness of the programme.

1. **Actively involve the community throughout the process.** Community leaders and a village health committee can provide support in organising the weighing of all children in the target age group; recruiting volunteers; conducting the PDI; contributing materials, utensils, and food for the sessions; assuring that eligible caregivers[1] attend the Hearth session regularly; and encouraging other community members, including key influencers like grandmothers, to support the families with malnourished children as they adopt new practices. Grandmothers[2] often play a major role in child care and feeding and act as advisors in this area to younger women who seek their advice and expertise. Engaging grandmothers from the start of the PD/Hearth implementation will facilitate the community's involvement and learning as grandmothers are key influencers in addressing child malnutrition. In the different steps of the PD/Hearth process, grandmothers can participate as mobilisers, hearth committee members and/or volunteers, participants in focus group discussions on child care and feeding, those being talked to and observed during the PDI, participants in Hearth sessions with the caregivers and children, key audience members in community feedback sessions, and supporters and advisors at home for the caregivers. The community can participate in monitoring project implementation and results. The higher the visibility of Hearth in the community, the greater the nutritional impact will be. Hearth sessions provide "living proof" that good nutrition practices help malnourished children. This raises the consciousness of community members and empowers them to prevent malnutrition within their community.

2. **Use growth monitoring to identify malnourished children and monitor the nutritional status of participants who have graduated from Hearth**. If a growth-monitoring and counselling programme does not exist in the community when PD/Hearth is initiated, it should be started in time to monitor the children who complete the Hearth session. The growth-monitoring programme must include good nutrition counselling and explanations of the child's growth for the caregivers. It is also an important tool for monitoring the progress of *all* the children in the target group over time, and it allows the integration of newly malnourished children into the second or third Hearth session.

3. **Use community members and staff in each and every community to conduct a Positive Deviance Inquiry.** The PDI is not simply a fact-finding exercise for the project staff. It is an opportunity for community members (e.g. Hearth volunteers, health staff, community leaders, grandmothers) to 'discover' that very poor families have certain good practices which enable them to prevent malnutrition and that these practices can be used by any family with similarly scarce resources. In order for a community to take ownership, the discovery process must take place in *that* community. Each community or communities within 40km radius with similar cultural practices, belief, and food availability need its own PDI to discover its positive deviance (PD) practices. Many programmes have tried to save time by using the PDI results from one community in another; doing

1. The term caregiver refers to anyone who has significant responsibility for the care and feeding of a young child. This may be a parent, grandparent and/or older sibling, depending on the cultural context and family situation. In some cases two caregivers, such as a mother-grandmother pair, may attend the Hearth sessions.
2. A grandmother refers to a senior woman (related or unrelated to the child) who lives in close proximity to the child and who has influence on child care.

so means that the second community loses the process of the discovery that results from the PDI. If there are no poor families with well-nourished children in a particular community, the PDI may need to look at families with only mildly malnourished children. Alternatively, if the community can identify a nearby community with the same culture, socioeconomic conditions and, perhaps, blood relationships, the volunteers can be taken there to identify PD families with whom to conduct the PDI. Since family coping may change with the seasons, it may be necessary to repeat the PDI during different seasons of the year.

The PDI consists both of questioning the family members, including caregivers and grandmothers, and of making careful observations of the situation. The list of questions that has been developed is best used as a discussion guide rather than as interview questions. With sufficient practice the PDI team should be able to visit the families without relying on the list of questions. A second or third person from the PDI team can concentrate on observing practices related to child care, hygiene, sanitation and food preparation, noting the roles of influential family members as well as what foods and materials are available in the home. Projects need to allow sufficient time to prepare for and conduct PDI visits to obtain the most useful information.

4. **Prior to the Hearth sessions, deworm all children, update immunisations and provide needed micronutrients.** Children are more likely to show quick recuperation when these important health interventions are taken care of before the Hearth session. Families should be referred for these services to the local health facility with whom the project is collaborating. These activities are kept separate from the Hearth session so that families do not attribute the child's improvement in nutritional status to these activities rather than to the food and feeding practices. During the Hearth session and follow-up home visits families will be encouraged to continue to access these and other preventive health services including growth monitoring and the use of insecticide-treated bed nets (ITNs), where needed. In areas of high malaria prevalence, children may need diagnosis and treatment before attending the Hearth sessions. If it becomes evident during the PDI that very poor families are using ITNs, it will be useful to discuss how they afford them in order to share that information with the Hearth participants. All children may be checked for underlying illness and/or anaemia before entering Hearth to screen for treatable conditions.

5. **Utilise community men and women as volunteers to conduct the Hearth sessions and the follow-up home visits.** Caregivers will learn best from those who normally provide child care advice and support within their culture and community, and who understand local customs and conditions. The volunteers can be any community members, including grandmothers, with a good reputation, credibility, healthy children and a willingness to take on the necessary responsibilities.

   Note: *PD caregivers are not necessarily Hearth volunteers. The PDI results in a collection of PD practices from multiple PD families; it is extremely rare that one family models all the PD practices. We are not looking for PD persons but PD practices. In many cultures identifying individuals or families as models (or somehow 'better') results in social rejection by their peers.*

6. **Design optimal Hearth menus based on locally available and affordable foods.** Participating families must be able to replicate meals in their own homes with limited resources. This is the only way they will be able to sustain the improved nutritional status of their children and prevent future malnutrition in the family. The affordability of foods is verified through the PDI, which

discovers the foods used by the poor families with well-nourished children, and the market survey, which explores the costs and nutritional content of foods available for purchase.

7. **Provide a special, nutrient-dense meal capable of ensuring the rapid recuperation of the child.** The daily Hearth menu includes an extra meal and snack, an addition to what the child normally eats at home in one day. This menu must contain the following nutrient levels for each child:

Calories:	600–800 kcal
Protein:	25–27 g
Vitamin A:	400–500 µg RE (retinol equivalent) or 300 µg RAE (retinol activity equivalent)
Iron:	8–10 mg (may need iron supplementation or a fortified product to meet this requirement)
Zinc:	3–5 mg
Vitamin C:	15–25 mg

These figures show the range of supplementary nutrient levels necessary to rehabilitate malnourished children. Specific levels for children of different ages are listed in the *CORE PD/Hearth Guide*. Consider the Hearth meal as 'medicine'; this is the dosage prescribed. If the Hearth supplemental meal does not meet this minimum standard, then weight gains are compromised. The meal is a supplement, not a meal substitute. The additional calories and protein are needed for 'catch-up' growth of the child. When the child is no longer underweight, this 'extra' energy and protein-rich meal is no longer necessary. However, to sustain the rehabilitation gains, regular family meals need to be more balanced and nutritious. Caregivers learn how to do this during the Hearth sessions.

8. **Ensure that caregivers bring a daily contribution of food and/or materials to the Hearth sessions.** One of the fundamentals of PD/Hearth is that families learn that they really can afford to feed their children nutritious food. The PDI revealed what poor families feed their well-nourished children. Obtaining and bringing the foods reinforces the use of these affordable foods. The community also realises it is able to rehabilitate its malnourished children without outside material support.

9. **Have caregivers present and actively involved every day of the Hearth sessions.** Involvement promotes ownership and active learning and builds self-confidence. Repetition of new skills and practices enables caregivers to learn and adopt new behaviours. Attendance and active involvement of caregivers each day of the Hearth sessions is necessary for children to achieve adequate weight gain.

10. **Conduct the Hearth session for 10–12 days within a two-week period.** Within 8–12 days of starting the Hearth sessions caregivers will see notable improvement in their children. They may need some guidance to recognise the changes in their child, such as improved appetite, increased activity, less irritability, higher level of alertness. Recognising these changes motivates the caregivers to adopt new feeding, caring and health practices. If a child is not fed the special extra meal over sequential days, recovery will be so slow that the caregiver will not have the satisfaction and motivation to continue the programme. There may be breaks of one or two days during the Hearth

sessions to allow for weekends, holidays, or market days *(e.g. 4 days + market day + 4 days + market day + 4 days)*. The family must be encouraged to prepare the special meal at home on the days off. This Hearth session may be repeated the next month as some children will not experience 'catch-up' growth within a month.

11. **Include follow-up visits at home every 2–3 days for two weeks after the Hearth session.** It takes an average of 21 days of practice for a new behaviour to become a habit. The caregivers will need continued support to implement the new practices in their own homes. During home visits the volunteers or staff can help caregivers think of solutions to any difficulties they are encountering or respond to concerns about the child's progress, and can support grandmothers in their role as household advisors to facilitate positive changes in child care and feeding. By continuing to practise these new behaviours, the improved nutritional status of the participating child will be sustained at home and malnutrition will be prevented among future children.

12. **Refer a child who doesn't gain weight after two 10–12 day sessions to a health facility to check for any underlying causes of illness such as tuberculosis, HIV/AIDS, or other infection**. If the child does not have an illness, direct families to other social services or to income-generation projects. The average number of sessions it takes to graduate a child varies among programmes, but the number of sessions a caregiver can attend is normally limited to two; otherwise, caregivers may become dependent on Hearth and not internalise new behaviours. A sense of urgency to rehabilitate a malnourished child should be instilled and encouraged in the caregiver and family. However, some children may need more time to gain weight. (Some projects opt to have all children checked for underlying illness before entering Hearth to screen for treatable diseases.)

13. **Limit the number of participants in each Hearth session.** Having a limited number of participants provides a 'safe' environment in which rapport can be built, and it gives all caregivers an equal opportunity to participate in all activities. Experience has shown that Hearth sessions are most successful when limited to no more than ten caregivers or five caregiver-grandmother pairs.

14. **Monitor and evaluate progress.** At a minimum, projects should monitor Hearth attendance, admission and one-month weights, and the percent of children who graduate after one session or after two sessions. Depending on community goals and national protocols, graduation may be determined as 400g weight gain in one month; an upward growth trend on the growth curve during two months; moving up one level (e.g. from moderate to mild malnutrition); or achieving normal weight for age. Projects monitor the longer-term impact by measuring the weight gains of participants two months, six months and one year after graduation, and by tracking growth of younger siblings and the target age group over time. Projects may develop other indicators to monitor the quality of implementation, community support, and so forth. Many examples of such indicators are given in the *CORE PD/Hearth Guide*.

Essential Elements of PD/Hearth Detailed Observations and Key Questions

Summary components and sample questions to guide discussion on essential elements

Essential PD/Hearth project elements	Key questions to consider
1. Actively involve the community throughout the process. Leaders and/or the village health committee (VHC) provide support in organising weighings, finding volunteers, conducting PDIs, contributing supplies and participate in monitoring implementation/results. Individuals with influence on child care and feeding, particularly grandmothers, are engaged as advisors, mobilisers, volunteers, Hearth participants etc. The higher the exposure and involvement, the greater the impact on community overall nutrition status. Raising the consciousness of the community is empowering.	• How was the community mobilised? • What did the community contribute to the project? • How were grandmother and other influential figures engaged? • What information was given back to the community? When? • Have structures/policies that support child nutrition changed? • Was PD/Hearth integrated with other programmes/ sectors? How was this achieved? What were the results?
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated. If growth monitoring is not already in place, begin monitoring those who complete Hearth sessions and all children in target group over time. Growth monitoring must include counselling and explanations of a child's growth.	• Is routine growth monitoring present in the community? • Is counselling included? • How are children monitored after graduation?
3. Conduct a PDI in every community. A PDI is an opportunity for the community to make discoveries, not just to provide information to WV. To ensure community ownership, integrate the PDI into the Hearth sessions. A PDI may need to be done at different seasons. The goal is to identify PD practices, not only PD person.	• How were the families to visit identified? • How was the PDI conducted? By whom? • How was information analysed? • Were PD foods/practices identified? • How were grandmothers involved? • How was the information utilised? Menus/ messages? • Was there sufficient technical skill to complete the PDI well?
4. Prior to sessions, deworm all children and provide immunisations and micronutrients. The purpose is to support rapid recuperation. Refer families to the local health centre before Hearth sessions so recuperation is not attributed to these activities. In endemic areas, malaria may need treatment before Hearth sessions.	• Was a situation analysis completed (nutritional assessment, feeding practices, expanded programme of immunisation coverage, vitamin A)? • Were all children under three years of age weighed? • Were children dewormed, immunised, vitamin A supplementation completed? • Were pre-existing underlying illnesses treated?

Essential PD/Hearth project elements	Key questions to consider
5. Use community volunteers to conduct sessions and follow-up home visits. Caregivers will be more comfortable and learn best from peers. A volunteer can be any community member, either male or female, who has a good reputation, is credible, has children in good health, and is willing to take on responsibilities.	• How were Hearth volunteers selected? • How were Hearth volunteers trained? • Were there gaps in the key competencies needed to implement the programme effectively?
6. Design Hearth session menus based on locally available and affordable foods. This is necessary to promote replication in home with limited resources in order to sustain improved nutritional status. Use foods confirmed through the PDI and verify the cost/ nutritional content through a market survey.	• Was a market survey completed? • Were PD foods identified? • Were the foods local, available and affordable?
7. Hearth session menus are nutrient dense to ensure rapid recuperation. Menu plus snack must contain required protein, calories and micronutrients to provide 'catch-up' growth The Hearth meal is 'medicine'. The extra meal is a supplement, not a meal substitute. To sustain the rehabilitation, families learn that meals need to be balanced and nutritious.	• Who decided on the menus? When? • Were menus nutrient dense (by programme standards)? • Who analysed the menus? • Were the menus followed in sessions? • Were the menu followed at home?
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth. This reinforces the fact that families can afford to feed nutritious food. The contributions make implementation possible without outside material support. Families providing resources ensures that the programme is non-paternalistic	• Were PD foods identified? • Did caregivers contribute PD foods? Other foods?
9. Have caregivers present and actively involved every day of the Hearth session. This promotes ownership, active learning and confidence. Repetition of practices builds habits that sustain rehabilitation and prevent malnutrition. Daily attendance is necessary to achieve weight gain.	• Was a caregiver involved with each child? Did caregiver-grandmother pairs work together where appropriate? • Did all caregivers participate in all the activities every day of the programme?

Essential Elements of PD/Hearth Detailed Observations and Key Questions

Essential PD/Hearth project elements	Key questions to consider
10. Conduct the Hearth session for 10–12 days within a two-week period. Eight to twelve days are needed to see changes in the child. Caregivers may need help to identify improvement in appetite, energy, alertness, less irritability, and so forth. Changes in the child motivate caregivers to adopt and continue the new practices. If the child is not fed an extra meal over sequential days, changes are too slow for the caregiver to notice.	• Were PD/Hearth sessions conducted for 10-12 days? • What were attendance rates? • Was time spent reflecting with caregivers about changes in child?
11. Include follow-up home visits (every 2–3 days) for two weeks after the session. Caregivers need continued support. It takes 21 days to change a behaviour into a habit. Home visits help find solutions to obstacles to adopting new practices that are being faced at home. Home visits provide opportunities to address questions families may have about the child's growth.	• What did follow-up visits include? How often did they occur? By whom? • Did volunteers have the information and skills to support families in overcoming obstacles to child feeding/growth?
12. If a child doesn't gain after two sessions, refer the child to the health centre. A child with no underlying health issues who is not gaining may need referral to other social-services or income-generation projects. A sense of urgency to rehabilitate the child is needed by caregivers, families and volunteers.	• What happened if a child became sick during the session(s)? • Under what circumstances was a child referred to the health centre?
13. Limit the number of participants in each Hearth session to ten or fewer. A limited number of participants provides a 'safe' environment where rapport can be built. Caregivers have an equal opportunity to participate in all activities.	• How many children attended the sessions? • How many caregivers or caregiver-grandmother pairs attended the sessions? • Did caregivers participate in all aspects of the sessions?
14. Monitor and evaluate progress. Record attendance, entering and one-month weight, the percent of children who graduate. Check the long-term impact by measuring weight gain at two or six months, one year, and monitor the weight of younger children.	• Were graduation criteria established? • Was monitoring information used to improve implementation? When? How? • Was there adequate technical support for managers? For volunteers? • Was supervision frequent enough? Was it adequate?

Conducting the Hearth Session (STEP 6)

SESSION 33

40 MIN | DAY 8

By the end of the session, participants will be able to

1. Identify key factors that have contributed to the success of Hearth sessions
2. Discuss adaptations to meet contextual needs in successful Hearth programmes.

Reference in *CORE PD/Hearth Guide*: pp. 135–39 and 143–45

Preparation

- Ask participants with PD/Hearth experience to take part in a panel discussion.
- Have the flip chart with the PD/Hearth objectives at the front of the room.

STEPS

10 Min

1.

Review together what takes place in a typical Hearth session. Ask participants to list the activities that take place. Mention that there are several days when other activities happen. The day before the Hearth sessions begin the volunteer must gather the caregivers in his or her session together. They will discuss what PD/Hearth is about, what each caregiver or caregiver-grandmother pair needs to bring, time and place to meet, and so on. Sometimes caregivers are invited to come after the volunteers have practised making the menu. The caregivers taste the food and discuss how they will learn to make these foods to help their children grow well.

On Day 1 and Day 12 all the children in the session will be weighed before they eat the food. The weights are recorded on the monitoring sheets. This will enable volunteers, supervisors, and caregivers to see whether each child is gaining sufficient weight.

5 Min

2.

Introduce the session, explaining the need to adapt the programme and to remain flexible while still focusing on the purpose of Hearth. Refer to the flip chart with the PD/Hearth objectives, and briefly go over the importance of adequate food intake, of local feasible interventions, and of the caregivers' participation. Introduce the panellists.

20 Min

3.

Ask participants to do a role play of the first day of Hearth. Make sure the role play includes the following:

- have 1-2 volunteer(s) meet with participant caregivers to decide on a time and place to meet for Hearth (ensure Hearth site has a latrine)
- assign roles to participant caregivers and ask caregivers to bring a bowl and spoon for the children to eat from
- ask primary caregivers which of the ingredients from the Menu A they could possibly bring and assign caregivers to bring various ingredients

Next day within the role play:

Act out the Day 1 of a Hearth session. Make sure the role play includes the following:

- registering of the children
- correct weighing and reading of MUAC of children
- collection of ingredients
- dividing up of caring station, handwashing station, and cooking station
- mothers taking on various roles that were assigned to them previously
- handwashing of children before being given snacks
- children being given snacks while waiting for caregivers to cook Hearth meal
- children singing a song about handwashing
- volunteers providing various messages at the 3 different stations
- volunteer sharing menu for cooking caregivers (prepare giant menu chart)
- after cooking is complete, caregivers feeding the children
- volunteer sharing the key Hearth message while caregivers are feeding children Hearth meal
- end with caregivers standing up to clean up the dishes and cooking utensils

5–10 Min

4.

Questions from participants.

Which elements of the programme might need to be tailored? What considerations might prompt adaptations? Ideas? (See the situations detailed in the *CORE PD/Hearth Guide*, pp. 143–45. The discussion should include

examples of ways to follow up defaulters; how to avoid the stigma of participation; and methods to incorporate working mothers, grandmothers and/or multiple caregivers.)

Discuss the following adaptations, as well as any mentioned in earlier sessions that merit further discussion:

- The Haiti programme placed a volunteer in a local hospital to create a better link between the community and the hospital (for referrals and for other health services).
- In many urban settings the homes do not have sufficient space to hold a Hearth session. In India, plastic sheets were used to create a 'roof' over a dead-end alleyway between houses, thus creating a space to hold the sessions.
- Some NGOs are experimenting with ways to use Hearth along with food-distribution programmes. In Indonesia, volunteers are paid 'food for work' and the rice and oil are used in the sessions. These are staples all families have, so the emphasis is still on the caregivers contributing the PD foods. The sessions show families how they can feed their children well without donated rations.
- In Mali, one programme has each participating caregiver lead the Hearth session one day. On the previous afternoon the staff person visits the home to help the caregiver prepare the session. There is no volunteer.

SESSION 34

Supporting New Behaviours through Reflection and Home Visits (STEP 7)

World Vision

60 MIN | DAY 8

By the end of the session, participants will be able to

1. Help caregivers reflect on changes in their child to motivate on-going practice
2. Summarise the objectives, activities and frequency of home visits
3. Explain the objective and activities for providing community feedback.

Reference in *CORE PD/Hearth Guide*: pp. 141, 143–45

Further training on counselling for behaviour change is covered in the World Vision CHW/TTC training materials (available by contacting nutrition@wvi.org).

Preparation

- Ask six participants to act as 'caregivers' in the reflection skit.

STEPS

5 Min

1. Learning new habits takes time

Caregivers get a good start during the Hearth sessions, but need help to recognise the changes they see in their children and relate those changes to the extra food and care they are giving them. This can be done this having a reflection time together on the last day of Hearth. They also need to be encouraged to continue the new practices, so volunteers will visit caregivers in their homes during the two weeks after the Hearth sessions. These visits are intended to help caregivers overcome any problems they might be having in following the new practices.

10 Min

2. Role play a reflection time

Gather all the 'caregivers' in a circle on a mat. Point out that this is the last day of Hearth. Ask the 'caregivers' what they think, allowing time for them to answer. 'What did you like about Hearth?' 'What was your child like before the Hearth sessions started?' 'What is your child like now?' 'What do you think has made the difference?' 'Do you think you will be able to continue these same practices at home?' 'What obstacles do you think you might have?' Congratulate them on their great work.

5 Min

3. Discuss the role play together

Brainstorm for ways to solve the problems that caregivers might have. What do we want caregivers to learn from the reflection time? Why?

5 Min

4.

Explain the importance of practicing a new behaviour over a sufficient length of time for the behaviour to become a habit. The Hearth approach includes two weeks of Hearth followed by home visits during the two weeks after the Hearth session to reinforce the behaviours learned during the sessions. Each caregiver or caregiver-grandmother pair is briefly visited every two or three days by the volunteer to be sure the child continues to receive the 'extra' food and that the other PD behaviours are being practised. Reiterate the importance of the follow-up home visits.

10 Min

5.

Present the following scenario to demonstrate a home visit:

The volunteer 'drops in', chats with the mother and grandmother about neighbourhood news, and inquires about the child. (The child is playing at a neighbour's house.) The volunteer points out to the mother and grandmother that the child's newfound energy and interest in playing are signs of recovery. The mother mentions that the child had a bout of diarrhoea. When the volunteer asks how she treated it, she says she had oral rehydration solution but gave tea instead because she couldn't remember how to prepare the solution and the grandmother couldn't either and so suggested tea. The volunteer explains how to prepare ORS both to the mother and grandmother and asks them to repeat the directions. The volunteer asks whether the child's appetite is good, and the mother says yes and that she is giving the child extra food. The volunteer says she will check in the day after tomorrow, reminds the mother and grandmother of the final weigh-in on the following Friday, and congratulates them for their efforts to make their child healthy.

10 Min

6.

After the role play, ask participants:

- What was the purpose of the home visit? (*encourage caregivers to continue feeding and caring practices; encourage grandmother to support and advise caregivers of the practices; see that the child is continuing well; help caregiver and grandmother think of solutions to challenges)*

- What examples of positive reinforcement did you see?
- How did the volunteer help the mother and grandmother see the change in their child?
- How long was this home visit? *(brief, 10–15 minutes)* How often are caregivers visited by the volunteer? *(every two or three days)* How many visits can a volunteer could do in one day? *(two or three)*

Repeat yet again the importance of the follow-up visits in behaviour change and helping families find solutions.

15 Min

7.

Ask participants what challenges caregivers might have in practicing Hearth behaviours at home. Brainstorm possible solutions to each situation. Possible problems include:

- Forgetting what was taught
- Not having the ingredients for the menu
- Not knowing where to get affordable fish or vegetables
- Having a husband or mother-in-law who is resistant
- Having a child who is sick
- Having a child who refuses to eat.

By the end of the session, participants will be able to

1. Discuss considerations for children graduating from or repeating the Hearth sessions (Hearth protocols)
2. Discuss ways to work with the community to design an exit strategy and/or to link Hearth with other programmes.

Reference in *CORE PD/Hearth Guide*: pp. 124–28, 142

Preparation

- Print Handout 35.1
- Refer to Handout 14.2
- Blank flip chart

Materials

- Handout 14.2: WHO Weight-for-Age Reference Table
- Handout 35.1: Follow-up Cases

STEPS

50 Min

1.

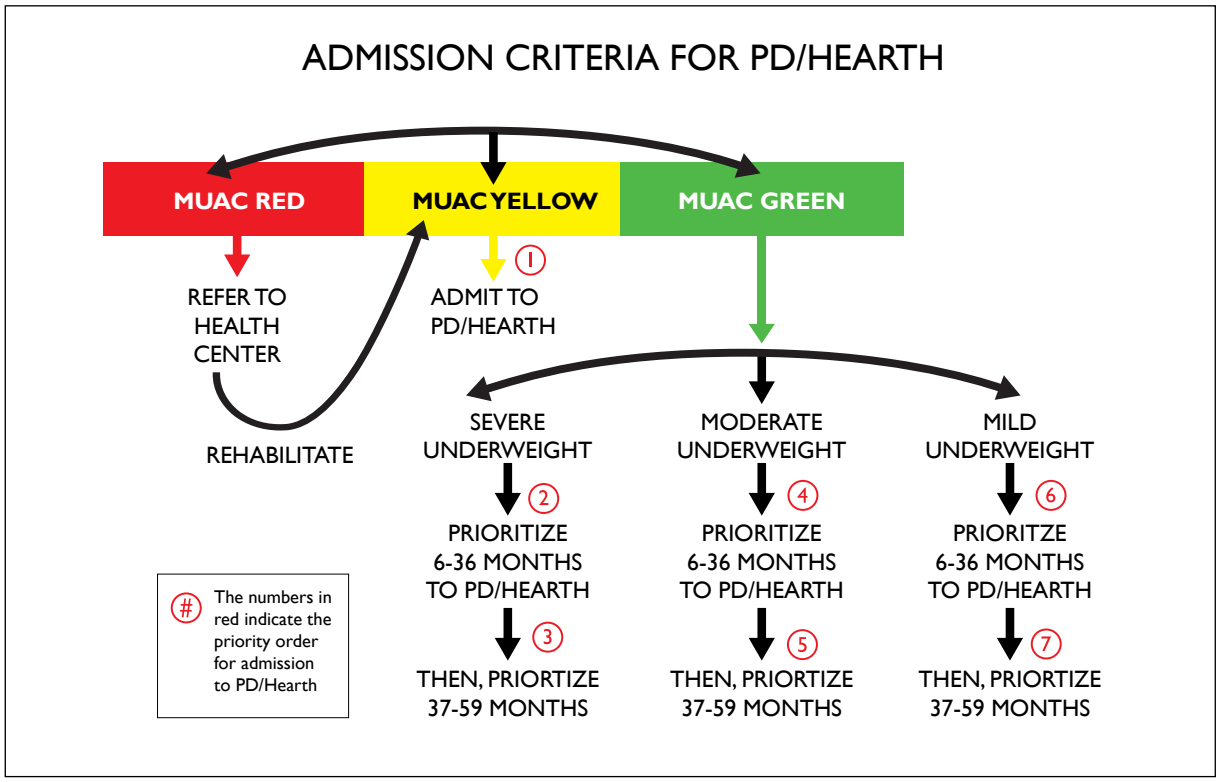
Please explain PD/Hearth Admission Criteria to the participants. If a child's MUAC is red, refer him/her to a health centre, otherwise follow this table for the order of admission.

PD/Hearth Admission Criteria

Priority	MUAC	Underweight	Age
1	Yellow (Moderate)	Severe	6-59 months
2	Green (Healthy)	Severe	6-36 months
3	Green (Healthy)	Severe	37-59 months
4	Green (Healthy)	Moderate	6-36 months
5	Green (Healthy)	Moderate	37-59 months
6	Green (Healthy)	Mild	6-36 months
7	Green (Healthy)	Mild	37-59 months

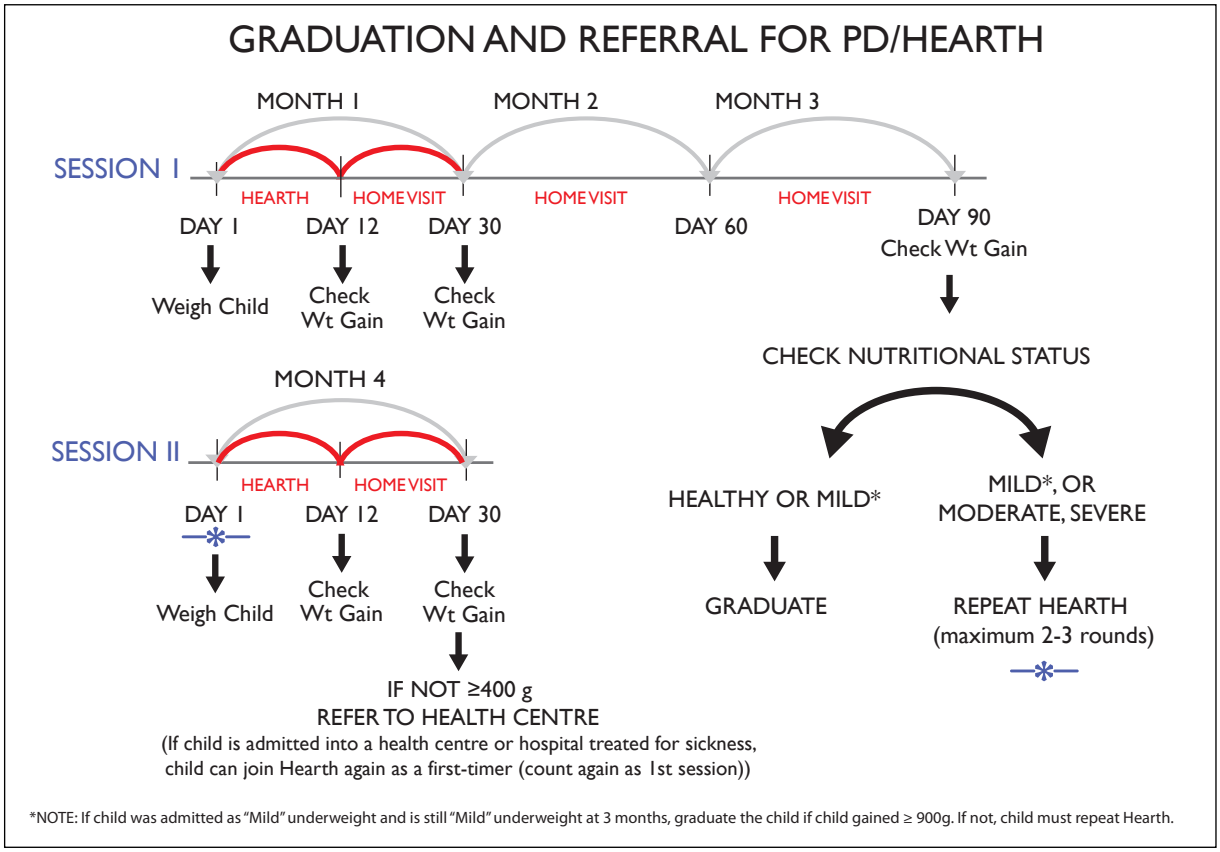
Admission, Graduation, Repeating Hearth Sessions as Needed (STEP 8) Expanding PD/Hearth (STEP 9)

DAY 8



Please explain PD/Hearth graduation criteria to the participants.

PD/Hearth Graduation Criteria



1. Graduation Criteria (Graduation declared at 3 months follow-up)

- **Nutritional Status Graduation Criteria**
  - **3 months:** Must be **"Healthy or Mild"** for underweight nutritional status for children to graduate, regardless of weight gain. If child is still "Moderate" or "Severe" underweight, repeat Hearth after 3 months(can be part of Hearth session, maximum 3 times – depends on the country; we recommend 2)
  - **3 months:** If child was admitted as "Mild" underweight, but child is "Healthy" nutritional status, graduate the child. If child was admitted as "Mild" underweight and is still "Mild" underweight at 3 months, graduate the child if child gained ≥ 900g. If not, child must repeat Hearth.
- **Weight gain requirements (encourage mothers are doing a good job if they meet these requirements, but it is not used for graduation criteria):**
  - **12 Days:** ≥ 200g
  - **30 Days:** ≥ 400g (If child did not gain close to 400g at 30 days, ensure mother is practicing the positive practices encouraged during Hearth session. If child seems to be sick, refer child to health centre)
  - **3 months:** ≥ 900g

2. For Home Follow-up Visits (Frequency during 2 weeks after Hearth; 2 years after Hearth; Monitoring of weights with GMP – also what to do with children who don't attend)

- Conduct home visits for 2 weeks after 12-days of Hearth session (2-3 times a week)
- Visit HH of PD/Hearth participants every month after 30 days for up to 1 year (if possible)
- Conduct "Health meeting" led by community every 1-3 months for community monitoring of PD Children's growth, share Health/Nutrition messages and meet with PDH participant caregivers after meeting
- Pay a special visit to HH to check weight of child and provide counseling as needed for children who have MUAC 'yellow' and for children severely underweight

3. When to Refer child for medical attention?

- During Initial Assessment or 1st Day of Hearth, if child is found to be "RED" for MUAC, refer to health centre and do not admit into PD/Hearth (follow-up with

child and admit into PD/Hearth after child returns from Health Centre is and "YELLOW" or "GREEN" for MUAC

- If before Hearth, child has not received full immunization, Vitamin A supplementation and was not dewormed 6 months ago (need to make sure child is given all 3 before being admitted into Hearth)
- During **Hearth session**, child becomes ill (if child is referred to health centre, once child is back, reset the number of times child was in Hearth session)
- During **Follow-up visits**, child becomes ill (if child is referred to health centre, once child is back, reset the number of times child was in Hearth session)
- **Child doesn't gain at least 400g of weight after 2 consecutive Hearth sessions in 30 days, refer child to Health Centre for medical check-up**

4. Age limits for Participation in Hearth (how to deal with siblings not identified for Hearth)

- 6-59 months (Prioritize children 6-36 months of age first)


HANDOUT
14.2 – 71m/H 33

It is important to monitor not only the child's weight gain, but also to calculate the child's nutritional status using either the 'Road to Growth' charts or the WHO Anthro Table (Handout 14.2). A malnourished child is expected to gain 400 grams in one month with one Hearth session. If a child's nutritional status advances to green (normal) in one session, the child must continue to grow at the average expected rate (approximately 200–250 grams a month, depending on the child's age). Thus after 3 months the child should have gained 900 grams.

A 400 gram gain in Hearth will usually not move a child from one level of malnutrition to another, especially if the child is moderately or severely malnourished. The average gain needed to change from moderately malnourished to mildly malnourished is about 1.2 kilograms. This can be demonstrated with the WHO Weight-for-Age Reference (refer to Handout 14.2, 18 months for girls or boys). Look at the weight in the moderately malnourished column and subtract the weight in the mildly malnourished column. This is the amount of weight a child needs to gain to move from moderately malnourished to mildly malnourished. Notice that as the child gets older, more weight is needed to 'cross' from one level of nutrition to another.

A PD/Hearth programme needs to ensure that children are not only gaining the initial 400 grams in one month but are continuing to gain weight in a pattern consistent with the growth charts. This means that the programme does not expect the nutritional status of the child to improve (e.g. continuous catch-up growth) at home, but only to maintain healthy growth after the initial catch-up growth with the Hearth session. However, if catch-up growth is seen at home, that is a commendable achievement and the household's strategy to do this could be shared with others in the community. In many programmes children who gain

400 grams but are still malnourished enter another Hearth session in order to continue their catch-up growth.

When a child is not gaining adequate weight, this should be assessed together with the caregiver and family members. There may be understandable causes (for example, child may have had diarrhoea which prevented adequate weight gain of 400g in one month or 900g in three months). Continue to monitor the child at home. In some cases there may seem to be no clear reasons why the child has not gained adequate weight. In this situation, it may be decided together with the caregiver and family that it would be best to repeat the Hearth sessions in order to reinforce new skills and practices and allow the child to have another period of accelerated growth. If the child does not gain the graduation weight in the second round of Hearth (i.e. 400 g or more by the end of the month), the child should be referred to the local health facility to assess for underlying diseases.

Each child's situation is unique and graduation should be assessed individually.

What other elements might the community include in its Hearth protocol?

Be sure the important points from the *PD/Hearth Guide* (pp. 124–27) are highlighted. Include:

- A limit to the number of times a child may repeat Hearth
- When to refer the child for medical intervention
- What to do if attendance is poor
- Micronutrient and other supplemental activities
- Expectations for participation in growth monitoring programmes
- Age limits.

15 Min

2.

HANDOUT
35.1 – 169m/H 66

Break participants into small groups and assign each group one of the case studies (Handout 35.1). Participants should discuss the conditions for enrolling a child in Hearth and for graduating a child or having the child repeat Hearth. What action is indicated in the case of a chronic underachiever?

During the final five minutes, have each group briefly explain its case and recommendations.

10 Min

3.

Discuss the importance of a growth monitoring programme in the community, and note that a Hearth project may be developed in response to observations from the growth monitoring programme or vice-versa. Ask participants to suggest other community programmes that might lead to the development of a PD/Hearth project. List these on a flip chart, and discuss issues that might arise with the addition of PD/Hearth to existing programmes. Continue with a discussion of integrating PD/Hearth with other programmes, either existing ones or new ones added as a result of the community mobilisation for PD/Hearth. *(Examples could include a water system, as a result of promotion of hand washing and overall hygiene; small business support or agricultural projects to supplement income and/or food supply; breastfeeding support groups, etc.)*

10 Min

4.

At what time should PD/Hearth be replicated? Where and how? *(It is important that PD/Hearth implementers learn in a small pilot project. Once one project is successful, consider replicating it in other communities or other ADPs. One very successful project could become a learning centre to train other communities and staff. Do not proceed too quickly or replicate weak or unsuccessful projects.)*

1st case: Aisha is three years old, and an only child. After two Hearth sessions, she has gained 800 grams but is still moderately malnourished. Her mother, who is pregnant, appears to be following the new PD behaviours and working hard to rehabilitate Aisha, but she is becoming discouraged. The grandmother is taking care of Aisha during her pregnancy and advising her to continue feeding Aisha with what they learned at Hearth. The grandmother is confused that her daughter-in-law is discouraged and that the volunteers say that Aisha is still malnourished when she is looking very healthy, active and growing well.

2nd case: Tobir Village has many malnourished children, and Hearth sessions are proceeding well. However, some segments of the population are semi-nomadic, moving with the seasons to find work. Though these caregivers have been enthusiastic participants, it is difficult to follow their children during the dry season. Many return during the rainy season having lost weight again.

3rd case: Daniel is 23 months old. He and his mother (who also has two older children) just completed one Hearth session. His weight has not improved. The supervisor suspects, from her home visits, that the mother is preparing some extra food but sharing it with the whole family. The grandmother may support sharing the extra food with the entire family too.

4th case: During the sessions Budi gained 500 grams. By the end of the follow-up period he had lost the 500 grams.

By the end of the session, participants will be able to

1. Identify several key quality indicators for monitoring PD/Hearth activities
2. Describe supervision tools that are available to ensure the quality of PD/Hearth activities.

Reference in *CORE PD/Hearth Guide*: pp 140, 146–48, 157–84

Preparation

- Write each of the 3 Hearth goals on separate pieces of flip chart paper.
- Prepare a flip chart to show the Triple 'A' Cycle (**A**ction-**A**ssessment-**A**nalysis) – see page 168 of the *CORE PD/Hearth Guide*.
- Print copies of 36.1, 36.2, 36.3A, 36.3B, 36.4, 36.5, 36.6, 36.7, 36.8,36.9 and 36.10

Materials

- Handout 36.1: Checklist of Materials Needed for PD/Hearth Sessions
- Handout 36.2: PD/Hearth Menu and Cooking Materials Tracking Sheet
- Handout 36.3A: Child Registration and Attendance Form
- Handout 36.3B: Child Registration and Attendance Form (including Grandmothers)
- Handout 36.4: PD/Hearth Register and Monitoring Form
- Handout 36.5: Volunteer Home Visit Form
- Handout 36.6: Supervision of PD/Hearth Session
- Handout 36.7: PD/Hearth Annual Report
- Handout 36.8: Monitoring Case Study Data Sheet
- Handout 36.9: PD/Hearth Monitoring Case Study Questions
- Blank flip chart
- Handout 36.10: User Guide for the PD/Hearth Excel Database
- LCD Projector
- Soft copy of Excel-based PD/Hearth database (found in Resource CD)

STEPS

20 Min

1.

Remind the participants of the three goals of PD/Hearth and ask them to discuss together some indicators that can be used to monitor and evaluate progress toward each of the three goals. Write each suggested indicator on the flip

chart for the goal to which it applies and indicate whether it is a qualitative or quantitative indicator.

Goal One: Malnourished Children Are Rehabilitated

Observe during the household visit if the child is eating PD foods. Caregivers may report a change (qualitative); measure weight gain (quantitative).

Note that PD/Hearth is a time-limited activity compared to other types of child-survival programmes. Therefore, monitoring and evaluation can lead to direct, immediate and simple modifications to the programme. For example, in Haiti the percentage of those attending was low. Therefore, after the first cycle, the staff interviewed both women who didn't attend and those who participated fully. The programme was modified for the second cycle to correct issues identified in the interviews.

Goal Two: Families Are Able to Sustain Rehabilitation at Home

Are PD behaviours maintained after six months (for example, if five key behaviours were discovered in the PDI, are caregivers still practising at least three of them) with the PD child and with siblings (qualitative)? Measure for sustained weight gain at three months, six months, 12 months etc. (quantitative). Identify the percentage of children who regularly attend the growth-monitoring programme and/or immunisation programmes (quantitative).

Goal Three: Future Malnutrition Is Prevented (Community Level)

Gather information through informal interviews with neighbours and friends (qualitative); gather data through a review of community weights or other nutritional assessment (quantitative). PD families that have graduated from the Hearth programme may formally mentor incoming participants (this, too, can be monitored/measured).

What External Factors Might be Monitored?

The quality of the existing health-care system can be evaluated for impact from the PD/Hearth programme: increased attendance; increased immunisation coverage; improved/more accurate weighing in the growth monitoring programme; referrals, etc. Indicators of community mobilisation and social change can be evaluated as well (new leadership, involvement of disadvantaged population, conflict resolutions, impact beyond nutrition, etc.).

Note: *The local hospital may need to budget for recuperation of severely malnourished children, because they will be more readily detected and referred early in the programme. Keep apprised of Ministry of Health policies for rehabilitation that may include community-based management of acute malnutrition (CMAM) which might be coordinated with PD/Hearth. After severely*

malnourished (wasted) children have completed the CMAM programme, they should participate in a PD/Hearth session so that their caregivers will learn new behaviours necessary to sustain the recuperation.

Who Monitors? The ADP/NGO monitors PD/Hearth activity; the community monitors the volunteer; and the volunteer monitors the caregivers and children.

Why Monitor?

- Supervision helps to ensure quality and consistency in the programme; is useful for troubleshooting; and provides an opportunity to reinforce training and strengthen skills.
- Supervision is an ongoing process. It helps motivate people, reinforces good performance, creates a sense of achievement, and serves as a way to share good ideas.
- Supervision provides an opportunity for adapting to situations as they occur. For example, participant attendance was found to be a problem in Haiti. In response, the supervisor determined that for the next session, the participant contribution would be dropped off early in the morning of the session. This allowed time for the supervisor to locate anyone who did not show up and encourage them to attend the session.

What to Monitor?

Monitor volunteer skills, communication skills, and adherence to Hearth protocols; menus (taste, consistency, nutritionally adequate, affordable, use of PD foods); food safety; caregivers' attendance all 12 days; recording of weights and other appropriate activities. Assessments are made through observation, conversations with volunteers, caregivers and grandmothers, and verification of records. The protocol for a supervisory visit includes:

- Observation
- Sharing in conversation
- Applying information – provide feedback

Analysis should be shared during a feedback session with the volunteer and with the Village Health Committee. Stress the positive first. Dwell on the outcome – How many children graduated? Look at key quality indicators together. *Remember: positive feedback, analysis of problems, identification of solutions and follow up.*

5 Min

2.

Ask participants to list potential indicators of behavioural change in Hearth. Write these on a blank flip chart.

- Observe practices during the visit (see the PDI questions/checklist in Session 22).
- Talk with the caregiver and grandmother for information on practices and if child is receiving extra food.
- Check for better health-seeking behaviours (what does the caregiver do and/or grandmother advise when the child is sick: attendance at health post, extra feeding, etc.).
- Verify weight gain (at one month, three months, six months, and twelve months following the Hearth session).
- Observe the health status of any new siblings.

Ask which of the indicators can be observed during home visits. Put an asterisk (*) next to these. Ask whether the supervisor or the volunteer would be more likely to observe and document these indicators.

20 Min

3.

HANDOUT
36.1 – 175m/H 67
36.2 – 176m/H 68
36.3A – 178m/H 7 0
36.3B – 179m/H 71
36.4 – 180m/H 72
36.5 – 181m/H 73
36.6 – 183m/H 75
36.7 – 184m/H 76

Distribute the sample checklists and monitoring forms (Handouts 36.1 to 36.8). Review these together. Volunteers will use the following forms:

- Handout 36.1 as a checklist of the materials needed for the PD/Hearth sessions
- Handout 36.2 to track caregivers' menus and cooking materials
- Handouts 36.3A/B and 36.5 to keep track of Hearth attendance and home visits, respectively.

Discuss options if literacy is a challenge for volunteers. (*older child could help with forms, develop pictorial forms, pair volunteers with at least one person who is literate)*

The supervisor of the volunteers (usually the trainer) will use the following monitoring forms:

- Handouts 36.4, 36.6, and 36.7 to track PD/Hearth programmes.

5 Min

4.

Refer to the Triple 'A' Cycle (on the flip chart) to demonstrate the continuous monitoring process. Emphasise the importance of feedback to volunteers and supervisors as well as to the community. Sharing results with the community increases ownership, encourages discussion and problem solving, and celebrates achievement.

How Can This Information be Used to Improve Programme Quality?

Seek mutual solutions, monitor the community taking charge, and provide refresher training.

Frequency of Supervision?

Supervise a new site frequently at first; try to be present on the last day of Hearth.

Implication for Budgeting (transport and time spent in the field)?

Supervision is time consuming. It is important to budget sufficient staff time.

10 Min

5.

Reiterate the importance of community involvement and community-wide change for success with sustaining the achievements of Hearth. Ask the participants to suggest ways to incorporate feedback to the community as part of the process of reinforcing the long-term practice of PD/Hearth behaviours. Note that attention to community-level indicators reflects the Hearth goal of affecting non-participants. Add examples of these indicators to the flip chart.

Community level

- Talk with neighbours (ask whether the PD/Hearth caregiver has talked about Hearth).
- Review the weights of the children in the community over time (from the GMP). Invite the community health committee to share the results of the GMP with the entire community on a regular basis. Help the committee develop posters to show progress (to promote social change).
- Meet with community leaders to share Hearth outcomes.
- Document success stories and share them within the village and beyond.

45 Min

6. Monitoring Case Study

HANDOUT
36.8 – 185m/H 77
36.9 – 189m/H 81

Distribute Handout 36.8, 'Monitoring Case Study Data Sheet' and Handout 36.9, 'PD/Hearth Monitoring Case Study Questions'. Ask the participants to work on and discuss each section before moving on to the next section. Work through all the sections.

30 Min

7.

HANDOUT
32.10 – 191m/H 83

Please briefly go over the PD/Hearth Excel Database with the participants. Refer to Handout 36.10: User Guide for the PD/Hearth Excel Database.

Checklist of Materials Needed for PD/Hearth Sessions

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice,fufu, yams)			
Oil			
Other ingredients			

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 3	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 5	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 7	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 9	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 10	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 11	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 12	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Child Registration and Attendance Form

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates (dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Hearth Participant Child AND Primary Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Child Registration and Attendance Form (including Grandmothers)

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name/Grandmother Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Child and Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

#	**Attendance for Grandmother**											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

HANDOUT 36.4

Hearth Register and Monitoring Form

World Vision

Day 8 Session 36

1 OF 2

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

CHILD		1	2	3	4	5	6	7	8	9	10
Child's Name											
Caregiver's Name											
Child's Sex (M/F)											
Date of Birth (dd/mm/yyyy)											
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')											
At Day 1 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Green, yellow, red < 115mm)										
At Day 12 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight Gain (Day 12 - Day 1) in grams										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Hearth Register and Monitoring Form

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

	CHILD	1	2	3	4	5	6	7	8	9	10
At Day 30 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight gain (Month 1 - Day 1 weight) in grams										
	Gained 400g+ (Y/N)										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 3 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	Change in Status (Y/N)										
	MUAC (Optional)										
At 6 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 12 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
	CHILD	1	2	3	4	5	6	7	8	9	10
	COMMENTS (Explain reason for default if child has defaulted due to death (D), migration (M), referred to hospital (H), etc.)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

ADP Name ..... Village Name .....Caregiver's Name .....

Child's Name ..... Dates of Sessions.....Name of Hearth .....Volunteer .....

OBSERVATION LIST	Day #	Day #	Day #	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.							
Drinking water from safe source (borehole or protected well)							
Water is treated (Boiled/ chlorine)							
Water is covered with fitted cover or lid							
Clean separate cup is used for pouring drinking water from the pot							
Handwashing station exists (e.g. tippy tap)							
Jerry cans or water storage containers are clean							
Toilet/latrine is available and used or hole is dug and covered for defecation							
House and/or kitchen is clean							
Food utensils are clean							
Handwashing with running water and soap is practised by: Caregivers							
Children							
Other family members							
Food prepared is nutrient dense as learned in Hearth (includes all 3 food groups: protective, body building and energy foods)							
Size of portion served is age appropriate							
Caregiver actively feeds the child							
Child is offered more food after finishing first portion							
Caregiver says child is fed 4 - 5 times / day (including snacks)							
Child uses separate (own) plate, bowl, or cup							
Caregiver is motivated by changes in the child							
Yesterday night, mosquito net was used by the primary caregiver and all children U5 in the household							
Caregiver can say what to do when child is sick (example: feeds more liquid when child has diarrhea and feeds more frequently)							
Caregiver expresses being able to continue practising what was learned in Hearth at home							
Problems and questions about child feeding and care is discussed with the volunteer							

Supervision of PD/Hearth Session

World Vision

HANDOUT 36.6

Day 8 Session 36

Village Name ..... Hearth Name .....

Volunteer's Name(s) .....Today's Date.....

OBSERVATION LIST	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.				
Location of Session:				
Water is from safe source (borehole or protected well or protected spring)				
Water is treated (Boiled/ chlorine)				
Toilet/latrine available				
Handwashing station with soap exists (e.g. tippy tap)				
House is clean				
Food utensils are clean				
Session Is conducted by volunteers and /or lead mother				
Primary caregivers are assigned roles during Hearth				
Primary caregivers are the ones cooking the meal				
Primary caregivers can tell you how to cook Hearth menu for one child (using household measures)				
Number of caregivers attending				
Number of children attending				
Evidence of community participation/support				
Hand Washing is practised: by caregivers				
by children				
Number of caregivers who bring contribution to meal				
Menu used based on local and affordable food				
Menu is nutrient dense				
Food is prepared according to menu				
Consistency of Hearth meal is thick enough to slowly run on a spoon (not runny like water)				
Snack is given to children as the caregivers cook the Hearth meal				
Caregivers can recite different types of protective, body building and energy-giving foods				
Number of caregivers present and actively participating:				
in food preparation				
in child care				
in discussion of key messages				
Size of portion served is age appropriate				
Number of caregivers who actively feed their child				
Number of children who eat entire portion				
Number of children who are offered more food				
Key message discussed during PD/Hearth supervision visit				
Caregivers express being motivated by changes in child				
Caregivers can say what to do when child is sick				

PD/Hearth Annual Report

World Vision

Day 8 Session 36

PD/Hearth ADP Facilitator _____	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Total
In PD/Hearth Session (12 days) Weight gain (in grams) # of children	# of children												
Catch up (graduation): ≥ 200g													
Inadequate: < 200g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
In Rotation at 1 month (12 days + 2 weeks follow up) Weight gain (in grams)	# of children												
Catch up (graduation): ≥ 400g													
Inadequate: <400g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 3 months post hearth	# of children												
Adequate weight gain ≥ 900g													
Inadequate weight gain < 900g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 6 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Follow up at 12 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Total number of Re-admissions													
Round/Session #2													
Round/Session #3													

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth			At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day 12 - Day 1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
1	Shadin	1	m	26/03/2005	24	12/03/2007	7.5		24/3/2007	8.3	0.8		12/4/2007	8.3				
2	Jenia	1	f	01/02/2006	13	12/03/2007	7		24/3/2007	7.6	0.6		12/4/2007	7.6				
3	Helena	1	f	27/08/2005	19	12/03/2007	9.8		24/3/2007	10.1	0.3		12/4/2007	9.9				
4	Kalpana	1	f	05/10/2005	17	12/03/2007	7.5		24/3/2007	7.5	0.0		12/4/2007	7.5				
5	Saidur	1	m	21/10/2005	17	12/03/2007	6.6		24/3/2007	7.2	0.6		12/4/2007	7.3				
6	Sumana	1	f	06/06/2006	9	12/03/2007	6		24/3/2007	6.2	0.2		12/4/2007	6.5	0.5			
7	Swourav	1	m	19/02/2005	25	12/03/2007	9		24/3/2007	9.3	0.3		12/4/2007	9.5	0.5			
8	Simul	1	m	17/02/2005	25	12/03/2007	7.6		24/3/2007	7.9	0.3		12/4/2007	7.5	-0.1			
9	Tanvir	1	m	15/08/2005	19	12/03/2007	8.5		24/3/2007	8.7	0.2		12/4/2007	9.0	0.5			
10	Ruman	1	m	28/04/2005	22	12/03/2007	8.9		24/3/2007	8.5	-0.4		12/4/2007	9.4	0.5			
11	Ritu	1	f	11/05/2004	34	12/03/2007	9.7	O	24/3/2007	9.9	0.2	Y	12/4/2007	10.2	0.5	Y	O	N
12	Zashim	1	m	29/01/2005	25	12/03/2007	8.7	R	24/3/2007	9.0	0.3	Y	12/4/2007	9.3	0.6	Y	O	Y
13	Bashakhi	1	f	29/04/2005	22	12/03/2007	8.8	Y	24/3/2007	9.0	0.2	Y	12/4/2007	9.2	0.4	Y	Y	N
14	Sritimoni	1	f	25/10/2005	17	12/03/2007	7.5	O	24/3/2007	7.8	0.3	Y	12/4/2007	7.8	0.3	N	O	N
15	Farjana	1	f	25/03/2006	12	12/03/2007	6	R	24/3/2007	6.5	0.5	Y	12/4/2007	7.1	1.1	Y	O	N
16	Riyon	1	m	25/01/2005	26	12/03/2007	7.9	R	24/3/2007	8.1	0.2	Y	12/4/2007	8.4	0.5	Y	R	N
17	Sharmin	1	m	23/10/2004	29	12/03/2007	9.5	O	24/3/2007	9.7	0.2	Y	12/4/2007	10.2	0.7	Y	O	N
18	Rabbi	1	f	03/09/2004	30	12/03/2007	10	Y	24/3/2007	10.3	0.3	N	12/4/2007	11.0	1.0	Y	Y	N
19	Kurban Ali	1	m	20/01/2006	14	12/03/2007	6.8	R	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	R	N
20	Himel	1	m	11/11/2005	16	12/03/2007	7.2	R	24/3/2007	7.2	0.0	N	12/4/2007	7	-0.2	N	R	N
21	Anika	1	f	29/03/2004	35	12/03/2007	9.8	O	24/3/2007	10.0	0.2	Y	12/4/2007	10.5	0.7	Y	O	N
22	Afra Abiyat	1	f	29/03/2004	35	12/03/2007	10.5	O	24/3/2007	10.8	0.3	Y	12/4/2007	10.9	0.4	Y	Y	Y
23	Laboni	1	f	25/11/2005	16	12/03/2007	7.3	O	24/3/2007	7.5	0.2	Y	12/4/2007	7.2	-0.1	N	O	N

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth			At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
24	Maruf	1	m	01/07/2006	8	12/03/2007	10.5	G	24/3/2007	10.3	-0.2	N	12/4/2007	10.9	0.4	Y	G	N
25	Shanta	1	f	04/02/2006	13	12/03/2007	6.6	R	24/3/2007	6.7	0.1	N	12/4/2007	7.0	0.4	Y	O	Y
26	Jesmin	1	f	27/09/2006	6	12/03/2007	6.8	G	24/3/2007	6.6	-0.2	N	12/4/2007	6.6	-0.2	N	Y	Y
27	Shakib	1	m	01/02/2006	13	12/03/2007	6.8	O	24/3/2007	6.9	0.1	N	12/4/2007	7.1	0.3	N	R	N
28	Shati	1	f	01/02/2006	13	12/03/2007	6.8	O	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	O	N
29	Nurjahan	1	m	01/04/2005	23	12/03/2007	7.4	R	24/3/2007	7.7	0.3	Y	12/4/2007	7.9	0.5	Y	R	N
30	Beauti	1	f	03/04/2005	23	12/03/2007	7.6	R	24/3/2007	7.7	0.1	N	12/4/2007	7.8	0.2	N	R	N
31	Salina	1	f	07/04/2005	23	12/03/2007	9	Y	24/3/2007	9.2	0.2	Y	12/4/2007	9.5	0.5	Y	Y	Y
32	Marjina	1	f	07/09/2004	30	12/03/2007	9.1	O	24/3/2007	6.0	-3.1	N	12/4/2007	9.1	0.0	N	R	Y
33	Alam	1	m	10/07/2004	32	12/03/2007	10.1	O	24/3/2007	10.3	0.2	Y	12/4/2007	10.6	0.5	Y	O	N
34	Shaila	1	f	18/10/2005	17	12/03/2007	7.3	O	24/3/2007	7.9	0.6	Y	12/4/2007	7.9	0.6	Y	O	N
35	Abir	1	m	14/01/2005	26	12/03/2007	9.1	O	24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	Y	O	N
36	Mim	1	f	05/04/2006	11	12/03/2007	6.1	R	24/3/2007	6	-0.1	N	12/4/2007	6.4	0.3	N	O	Y
37	Mamin	1	f	13/02/2006	13	12/03/2007	6.2	R	24/3/2007	6.5	0.3	Y	12/4/2007	6.7	0.5	Y	O	Y
38	Alika	1	f	27/12/2004	27	12/03/2007	8.5	R	24/3/2007	8.8	0.3	Y	12/4/2007	8.9	0.4	Y	O	N
39	Sumia	1	f	05/03/2006	12	12/03/2007	6.1	R	24/3/2007	6	-0.1	N	12/4/2007	6.0	-0.1	N	R	N
40	Nadia	1	f	03/04/2006	11	12/03/2007	10.3	G	24/3/2007	10.6	0.3	Y	12/4/2007	10.8	0.5	Y	G	N
41	Aklima	1	f	01/04/2004	35	12/03/2007	9.1	R	24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	Y	R	N
42	Lipa	1	f	20/04/2004	35	12/03/2007	9.6	R	24/3/2007	9.9	0.3	Y	12/4/2007	10.1	0.5	Y	O	N
43	Mahamuda	1	m	23/05/2004	34	12/03/2007	9.6	R	24/3/2007	9.8	0.2	Y	12/4/2007	9.9	0.3	N	O	Y
44	Shapna	1	f	21/03/2005	24	12/03/2007	9	O	24/3/2007	9.1	0.1	N	12/4/2007	9.5	0.5	Y	Y	N
45	Laboni	1	f	11/12/2004	27	12/03/2007	10	Y	24/3/2007	10.2	0.2	Y	12/4/2007	10.9	0.9	Y	Y	N
46	Maria mim	1	f	02/02/2004	37	12/03/2007	10.2	O	24/3/2007	10.5	0.3	Y	12/4/2007	10.9	0.7	Y	O	N
47	Arif	1	m	25/02/2005	25	12/03/2007	6.9	R	24/3/2007	7	0.1	N	12/4/2007	7.1	0.2	N	R	N
48	Rakkib	1	m	10/03/2004	36	12/03/2007	10	R	24/3/2007	11.2	1.2	Y	12/4/2007	11.1	1.1	Y	Y	Y
49	Sabekun	1	m	25/03/2005	24	12/03/2007	9	O	24/3/2007	10	1.0	Y	12/4/2007	9.6	0.6	Y	Y	Y

#	Name of Child	Child's Sex (M/F)	At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)			
			Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
1	Shadin	m	27	12/06/2007	8.9				12/09/2007	9.5		
2	Jenia	f	16	12/06/2007	8.2				12/09/2007	9.1		
3	Helena	f	22	12/06/2007	10.9				12/09/2007	11.7		
4	Kalpana	f	20	12/06/2007	8.8				12/09/2007	9.6		
5	Saidur	m	20	12/06/2007	6.7				12/09/2007	8.5		
6	Sumana	f	12	12/06/2007	6.9	0.90			12/09/2007	7.8		
7	Swourav	m	28	12/06/2007	10.3	1.30			12/09/2007	10.5		
8	Simul	m	28	12/06/2007	9.3	1.70			12/09/2007	9.8		
9	Tanvir	m	22	12/06/2007	9.6	1.10			12/09/2007	10.4		
10	Ruman	m	25	12/06/2007	9.6	0.70			12/09/2007	10.7		
11	Ritu	f	37	12/06/2007	11.2	1.50	Y	Y	12/09/2007	11.6	Y	N
12	Zashim	m	28	12/06/2007	10.4	1.70	Y	Y	12/09/2007	10.8	Y	N
13	Bashakhi	f	25	12/06/2007	9.7	0.90	Y	Y	12/09/2007	10.7	Y	N
14	Sritimoni	f	20	12/06/2007	8.5	1.00	Y	Y	12/09/2007	9.1	Y	N
15	Farjana	f	15	12/06/2007	7.2	1.20	Y	O	12/09/2007	7.8	O	N
16	Riyon	m	29	12/06/2007	8.9	1.00	Y	R	12/09/2007	10.4	O	N
17	Sharmin	m	32	12/06/2007	10.2	0.70	N	O	12/09/2007	10.8	O	N
18	Rabbi	f	33	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.6	Y	N
19	Kurban Ali	m	17	12/06/2007	8.3	1.50	Y	O	12/09/2007	9.5	Y	N
20	Himel	m	19	12/06/2007	7.8	0.60	N	R	12/09/2007	8.8	O	N
21	Anika	f	38	12/06/2007	11.1	1.30	Y	O	12/09/2007	12.0	Y	N
22	Afra Abiyat	f	38	12/06/2007	11.3	0.80	N	Y	12/09/2007	11.9	Y	N
23	Laboni	f	19	12/06/2007	7.7	0.40	N	O	12/09/2007	8.6	O	N

Monitoring Case Study Data Sheet

Day 8 Session 36

			At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)				
#	Name of Child	Child's Sex (M/F)	Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
24	Maruf	m	11	12/06/2007	10.6	0.10	N	G	12/09/2007	11.2	G	Y
25	Shanta	f	16	12/06/2007	8.3	1.70	Y	Y	12/09/2007	9.9	G	Y
26	Jesmin	f	9	12/06/2007	7.2	0.40	N	G	12/09/2007	8.3	G	Y
27	Shakib	m	16	12/06/2007	7.6	0.80	N	O	12/09/2007	8.3	O	N
28	Shati	f	16	12/06/2007	6.9	0.10	N	R	12/09/2007	7.9	O	N
29	Nurjahan	m	26	12/06/2007	9.9	2.50	Y	O	12/09/2007	11.0	Y	N
30	Beauti	f	26	12/06/2007	8.7	1.10	Y	O	12/09/2007	10.4	Y	N
31	Salina	f	26	12/06/2007	9.8	0.80	N	Y	12/09/2007	10.6	Y	N
32	Marjina	f	33	12/06/2007	9.5	0.40	N	O	12/09/2007	10.3	O	N
33	Alam	m	35	12/06/2007	11.2	1.10	Y	Y	12/09/2007	12.1	Y	N
34	Shaila	f	20	12/06/2007	8.5	1.20	Y	Y	12/09/2007	9.3	Y	N
35	Abir	m	29	12/06/2007	10.3	1.20	Y	O	12/09/2007	11.1	Y	N
36	Mim	f	14	12/06/2007	7.4	1.30	Y	O	12/09/2007	8.3	Y	N
37	Mamin	f	16	12/06/2007	7.9	1.70	Y	Y	12/09/2007	8.8	Y	N
38	Alika	f	30	12/06/2007	9.5	1.00	Y	O	12/09/2007	10.4	Y	N
39	Sumia	f	15	12/06/2007	6.8	0.70	N	O	12/09/2007	7.5	O	N
40	Nadia	f	14	12/06/2007	10.8	0.50	N	G	12/09/2007	11.6	G	Y
41	Aklima	f	38	12/06/2007	10.4	1.30	Y	O	12/09/2007	11.4	O	N
42	Lipa	f	38	12/06/2007	11.1	1.50	Y	Y	12/09/2007	12.3	Y	N
43	Mahamuda	m	37	12/06/2007	9.7	0.10	N	R	12/09/2007	11.2	O	N
44	Shapna	f	27	12/06/2007	10.4	1.40	Y	Y	12/09/2007	11.5	G	Y
45	Laboni	f	30	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.8	G	Y
46	Maria mim	f	40	12/06/2007	11.5	1.30	Y	Y	12/09/2007	11.9	Y	N
47	Arif	m	28	12/06/2007	8.4	1.50	Y	R	12/09/2007	9.7	O	N
48	Rakkib	m	39	12/06/2007	11.5	1.50	Y	O	12/09/2007	12.6	Y	N
49	Sabekun	m	27	12/06/2007	9.9	0.90	Y	O	12/09/2007	10.6	Y	N

1. Look carefully at the data sheet from the PD/Hearth sessions at Sunshine Village of Happiness & Light ADP. Children are measured at the beginning of the Hearth sessions. Complete the 'Nutrition Status' column for all children on Day 1.
    a. What questions do you have about this information?
    b. The children are weighed on Day 12, at the end of the sessions. Complete the 'Gained 200g+' column for each child.
    c. Calculate the number and percentage of children who have gained adequately during the Hearth sessions.
    d. What can you say about the Hearth sessions? What is going well? What needs improvement?
    e. Based on this data, what action would you take?

2. The children are measured again one month after the beginning of the Hearth sessions. Complete the 'Weight Gain' and the 'Catch-up' and the 'Nutrition Status' items in the one-month columns.
    a. Calculate the number and percentage of children who have gained adequately during the month.
    b. Calculate the number and percentage of children who have changed their nutrition status.
    c. What does the data tell you about the children?
    d. How many children would you recommend repeat the Hearth sessions?
    e. Choose two children and answer the following questions for each:
        - How has the child progressed? Is this satisfactory?
        - What changes (if any) would you recommend for the child over the next month?
        - How would you explain the child's progress to the caregiver?
    f. What does the data tell you about the Hearth programme?
    g. What action do you need to take?

3. The measurements are repeated three months after the Hearth session. Look at the results and complete the 'Nutrition Status' column using the WAZ (weight for age Z-scores).
    a. Calculate the number and percentage of children who have gained adequately.
    b. Do you see any trends that concern you? What does the data tell you about the programme?
    c. What action do you need to take?

4. The children are measured again six months after the hearth sessions. Calculate their nutritional status using WAZ.
    a. Choose two children and answer the following questions for each, using all the data provided in this case study:
        - Describe the child's progress throughout the monitoring period. What could be some reasons for the child's growth pattern?
        - Was the child successfully rehabilitated? How can you tell?
        - How would you follow up with this child?
        - How would you communicate the child's progress and current status to his or her caregiver?
    b. What is your opinion of the overall growth of the children involved in the programme?
    c. How many children were successfully rehabilitated? How can you tell?
    d. What might be some reasons for the growth pattern between three and six months?
    e. How would you follow up with this programme?

The PDH Excel Database is used to compile all the data collected during the initial assessment (situation analysis), PDH registration, and for monitoring and follow up of children in the PDH programme. This allows easier access and utilisation of data by staff. For example, clear summary tables are generated and available under different tabs. From the data collection forms (e.g. Child Registration, Hearth Register and Monitoring Form), staff can transfer recorded information into appropriate cells/columns in the PDH database. Some of the cells/columns contain a drop-down menu or a formula. This formatting is convenient and helps to reduce data entry or calculation errors. For example, child's age (months), underweight nutritional status, WAZ scores, and weight change (g) are calculated automatically.

In the PDH Excel Database, there are eight tabs or worksheets: Initial Assessment; Assessment Report; Monitoring Form; Table; Annual Report; Graph Follow-up; Graph Graduation & Weight Gain; and Graph Default. However, you only need to enter data under two tabs: Initial Assessment and Monitoring Form. All other tabs contain summary charts (e.g. tables, graphs) automatically generated from the compilation of inputted data. ***Please note, when entering the dates, follow the format provided i.e. DD/MM/YYYY.*** Make sure the default date on your computer is set as DD/MM/YYYY for smooth operation of the database. To change the default date format on your computer, see ***Note** below.

Tab 1 – Initial Assessment: Enter the registration, initial nutrition assessment and wealth-ranking data for PDH participant children under this tab. From this data, the PD, non-PD, and negative deviant households are identified and displayed under the "Classification" column.

- First, select an appropriate option for the Wealth Ranking Category (i.e. Very Poor, Poor, Rich or Poor, Non-Poor) and the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu for each at the top of the worksheet.
- Enter values under each column according to the headings. Enter values only in the "WHITE" cells as the values in grey-coloured cells (e.g. Current Age, Underweight Nutritional Status, Classification columns) are calculated automatically by the computer. For the Sex, Oedema, MUAC, Wealth Rank and PDI HHs columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 2 – Assessment Report: This tab contains a table and a pie chart which categorizes the total number of children from the initial assessment based on their underweight nutritional status (i.e. % of children who are normal weight or mildly, moderately or severely underweight). This gives a clear picture of the initial level of childhood malnutrition in the community.

Tab 3 – Monitoring Form: This tab contains a monitoring form to track changes in child's weight, weight-for-age Z score, and underweight nutritional status in the hearth sessions and the follow-ups, including reasons for default. Additional registration information, such as deworming, vitamin A supplementation, presence of oedema, and full immunisation status is also entered under this tab. Based on the child's nutritional status at 3 months, next course of action is identified for each child (i.e. not graduate and repeat hearth, or graduate and continue monitor).

- First, select an appropriate option for the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu at the top of the worksheet.
- Enter values under each column according to the heading. Enter values only in "WHITE" cells as the values in grey-coloured cells (i.e. Current Age, WAZ, Nutritional Status, Weight Change, Adequate Weight Gain columns) are calculated automatically by the computer. For the Oedema, Deworming, Vitamin A Supplementation, Full Immunisation, Sex, Round/Session # and Default Reason columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 4 – Table: This tab contains nine summary tables based on the monitoring data. The tables show the number of children (and %) based on underweight nutritional status at different time points (e.g. baseline, Day 12, Day 30, 3 months, 6 months and 1 year), number of children (and %) with adequate or inadequate weight gain and amount of average weight gain (at Day 12, 30 and 3 months), and number of children (and %) with improvement or no improvement in their nutritional status to mild/healthy status (at Day 12, 30 and 3 months), as well as the breakdown of the reasons for child default from PDH.

Tab 5 – Annual Report: This tab contains a PDH summary report for the selected fiscal year. The table contains information about number of children who gained adequate or inadequate weight in PDH session (Day 12) and at follow ups (1 and 3 months), as well as number of children in different underweight nutritional status categories (i.e. green, yellow, orange, red) at 6 and 12 months post-Hearth. Also, information about the total numbers of children weighed and those who defaulted is provided along with the breakdown of children based on their enrollment (i.e. 1st, 2nd or 3rd round/session).

- To generate a report, enter ADP name and use the drop-down menu to select or enter a fiscal year.

Tab 6 – GRAPH Follow-up: This tab contains a bar graph showing overall changes in underweight nutritional status of PDH participant children (%) at different time points (e.g. baseline/Day 1, 12, 30 of PDH, and 3, 6, 12 months of post-PDH).

Tab 7 – GRAPH Graduation & Weight Gain: This tab contains six pie charts. The first three charts show the percentage of children whose nutritional status improved (i.e. mild/healthy vs. still moderate/severe) at Day 12, Day 30 and 3 months. The last three charts show the percentage of children who gained adequate weight (i.e. ≥ 200g at Day 12; ≥ 400g at Day 30; ≥ 900g at 3 months).

Tab 8 – GRAPH Default: This tab contains a bar graph on child default rate. The breakdown of number of children based on reasons for default at different time points (at Day 12, 30, and 3, 6, 12 months) is given.

NOTE:

To change the default date format on your computer:

1. *Go to Control Panel, click Regional and Language Options.*
2. *Under the Formats tab, click Additional settings (or Customize this format) button.*
3. *Click the Date tab.*
4. *Use the drop-down menu to select "DD/MM/YYYY" as the default Short date format.*
5. *Click Apply and close.*

By the end of the session, participants will be able to

1. Describe the roles and responsibilities of volunteers required for PD/Hearth.

Materials

- Flip chart with the title 'What PD/Hearth Volunteers Do'
- Flip chart with the title 'Skills Needed by Volunteers'
- Flip chart with blank papers

STEPS

10 Min

1.

Ask participants what PD/Hearth volunteers are expected to do. Write their answers on the flip chart under the title 'What PD/Hearth Volunteers Do'. (manage Hearth Sessions; conduct follow-up household visits; encourage caregivers to continue practicing new behaviours; help caregivers find solutions to challenges they face)

PD/Hearth Volunteer

Skill	Volunteer	Knowledge required
Community mobilisation	• Motivational skills • Identify key stakeholders in community • Identify key locations to promote PD/Hearth (e.g. church setting, community meeting, communal gardens) • Mobilise a PD/Hearth Committee (consists of leaders, fathers, grandmothers of community)	• Understand Theory of PD/Hearth and importance of PD/Hearth • Various roles important to success of PD/Hearth in community • Who the decision-makers are at household level
Measuring growth	• Weigh children	• Importance of proper weighing technique • Ability to weigh properly
	• Plot weights on growth chart	• Plot and interpret growth lines
	• Counsel caregivers	• IYCF practices • Communicate effectively with caregivers
Active participation in PDI	• Observation skills	• Factors that contribute to good child growth
	• Semi-structured interview skills	• Asking questions
	• Guided identification of good/bad behaviours	• Reflection of information gathered and how it contributes to child growth

Menu Preparation	• Making menus for Hearth	• Basic food groups • 'Special' (PD) foods • Prep of recipes • Calculating portion size for children
Conduct Hearth sessions	• Motivate/organise children/caregivers to attend Hearth	• Goals of programme • What is a Hearth • How to set up a Hearth • Role of each person
	• Supervise caregivers in cooking meals / feeding children	• Active feeding • IYCF practices
	• Teach simple nutrition/health/hygiene/caring • messages through example and talking	• Identify good/bad practices (IYCF, illness, care, hygiene) • How to give positive support
	• Monitor attendance, progress, food contributions	• Understand how to complete basic forms • Reflect on the information and what can be done to improve session
Follow Up Home Visits	• Household visits to support caregivers with new behaviours	• Purpose of home visit • Use of Home visit Observation Checklist form • Problem solving with caregiver
Communication	• Communicate concepts and methods with caregivers and community members in simple terms	
	• Report regularly to VHC	• Ability to communicate programme progress and results orally

10 Min

2. Ask what skills PD/Hearth Volunteers need to be able to do these tasks. Write their answers on a flip chart under the title 'Skills Needed by Volunteers'. *(train caregivers; demonstrate good practices; monitor and weigh children; follow up with home visits; record information; give messages, counsel and support)*

Based on the answers to the questions in the above steps, ask how volunteers should be selected. Probing questions could include the following (all of these may not be needed):

- Who should select the volunteers? (*community members and leaders)*
- What qualifications does a volunteer need*? (able to read and write, live in the community, committed, good behaviour, respected by the community, familiar with the area)*
- Is it possible to find someone with these qualifications in your community? (*selected by community as part of community-mobilisation process)*
- Are the people who have these qualifications in a 'higher' social group, and might that make it more difficult for them to interact with poor caregivers?
- If no women in the community are literate, what might be an alternative way to fill out the register and reports? *(enlist a literate adolescent girl to assist her; one of her own children might be able to help with the writing; in some communities women are not available or have died of AIDS and fathers are volunteers)*
- Does the volunteer have to be a mother of a child under age two? (*No. Experience has shown that it is actually better if the woman's children are older so that she isn't preoccupied with caring for her own small child. Grandmothers may be a good choice for this reason and because of their influential role in they care and feeding of young children.)*
- Why do we not automatically recommend that the mother of the PD child be the volunteer? *(in some cultures this could cause her to become socially isolated, may not have the qualifications, may not necessarily be a model in all ways).*

10 Min

3.

Ask participants how volunteers will learn the necessary skills. Ask them to put an 'E' beside those skills they will learn through experience and a 'T' beside those skills they will learn through training. Emphasise that volunteers will learn primarily through doing and practise. For example, they will discover unusual and good practices that contribute to good health and nutrition by participating in the PDI, and they will learn good cooking and feeding by practising cooking the menu together.

10 Min

4.

Discuss the following questions with the group:

- What is the best way to ensure that volunteers can conduct PD/Hearth with confidence? *(ADP staff can accompany them every day for the first week or ten days to offer support and encouragement while the volunteers lead the activities.)*

- During the next rotation of PD/Hearth, how often might staff need to visit the Hearth session or accompany the volunteer during home visits? *(At least once a week.)*

Refer to supervision tools found in Session 36.

SESSION 38

Post-test

35 MIN | DAY 9

Materials

PD/Hearth Post-test (provided in Resource CD)

STEPS

1. Distribute Post-test provided in the MS Word document.

2. Have the participants complete it and hand it in.

3. Facilitators mark the tests while the participants complete their PD/Hearth Action Plans (Session 41). The marked post-tests will be returned with the pre-test results.

Integration and PD/Hearth

SESSION 39

60 MIN | DAY 9

By the end of this session, participants will be able to

1. Describe how PD/Hearth can be integrated in the ADP
2. Plan how to advocate with managers for integration.

STEPS

45 Min

1.

Discuss with the participants the following questions:

- What is an overall goal for your ADP, community partners and/or CSOs?
- What projects does your ADP have to reach that goal?
- What special projects do you have within your ADP?
- How does each of these projects contribute to the overall goal?
- What happens when each of those projects is planned and implemented as a separate entity? (*there is less impact; the overall goal of the ADP may not be affected as greatly; there is competition among projects*)

Additional Questions for Discussion

- With whom does PD/Hearth need to collaborate or network? *(local health authority, international non-governmental organisation [INGO], local NGO, local leaders, local networks [formal and informal], community-based organisations, non-government health services [mission hospitals])*
- What are the advantages of networking? *(sharing human resources, information, materials and facilitation; joint targeting – for example, if another group is doing WASH, orient the group to PD/Hearth and work in same area to increase impact; referral of cases)*
- How can you ensure learnings from the PDIs, and other key health and nutrition messages are shared with the entire community on an on-going basis?
    - Through community feedback sessions
    - Partner and involve the Ministry of Health and health facility staff during the community mobilisation and training of volunteers (even PD/Hearth TOFs is possible) to ensure key messages and unique findings from PDIs are incorporated into the existing system for sharing Health and Nutrition messages (selection of only six key messages for a 12-day PD/Hearth Session may be limiting so it would be good to scale-up the learnings from PD/Hearth)
    - Share with community during visits to the health facility, counselling sessions for caregivers, mother care groups, breastfeeding support groups, and/or regular monthly GMP sessions (if system is in place)

- Advocate, educate and remind the community on an on-going basis through community/district radio messages

- How can you develop the commitment and support of leaders within WV?

  - Advocate – within WV with supervisors, ADP managers and Zonal/National Office leadership, as well as with community members and other entities such as the Ministry of Health.

  - Use real data – from your assessments, PDIs, and so forth to inform leaders about the extent of nutrition problems and the potential positive outcomes using resources already in the community.

15 Min

2.

At what stages can we integrate PD/Hearth into the ADP?

- design
- redesign
- training
- selection of target families – have all sectors target the same community/ families to ensure they receive the support they need to change behaviour
- preparation of annual operating plan (AOP)
- implementation
- planning – develop joint plan of action
- completion of the PDI (the data gathered shows where we are) – meet with participants in working groups for DME (design, monitoring and evaluation), economic development, food security, health, special projects, etc.; present the findings and discuss together how each sector can address the underlying issues that affect nutrition.

Factors for the Success of PD/Hearth

SESSION 40

30 MIN | DAY 9

By the end of this session, participants will be able to

1. Identify success factors for PD/Hearth
2. Receive solutions to their challenges from other participants
3. Develop an 'elevator speech' to promote key issues with National Office staff

STEPS

10 Min

1.

Ask participants what they believe the factors for the success of PD/Hearth might be. Make sure the following points are discussed:

- Commitment and support from the Regional Office, National Office, Support Office and ADPs.
- A small start. Initiate just one PD/Hearth in one community to learn from that experience before starting others in other communities.
- Frequent supportive supervision of volunteers – perhaps daily during their first rotation and then weekly.
- Quality training at each level.
- Integration of PD/Hearth with other sectors in the ADP to work together to address some of the underlying issues affecting the nutrition status of children; collaboration and support from other sector specialists; a team of people working collaboratively.
- Networks with government and non-governmental organisations that will work together to address nutrition issues for children.
- Change in community social norms through nutrition activities that involve all caregivers of young children, regardless of the children's nutritional status, and also the older women who influence them. This can include growth monitoring with good counselling, cooking and feeding demonstrations, breastfeeding support groups, grandmother groups, nutrition messages targeted to fathers and community leaders, health fairs, etc. PD/Hearth changes to behaviour will not 'last' if the community social norms with regard to child feeding do not also change.

20 Min

2.

Ask participants to think about their own programmes in light of the factors of success and the course so far if they have experience in implementing PD/Hearth. Each participant should write one main activity that would enable their programme to be more successful. If participants do not have PD/Hearth implementation experience then ask participants to think of one challenge they may face in implementing PD/Hearth and a possible solution. Example: 'The menus for the Hearth sessions need to be improved to meet the nutrient requirements' or 'The community needs to be better informed of PD practices'.

SESSION 41

PD/Hearth Action Plan

45 MIN | DAY 9

By the end of the session, participants will be able to

1. Draft a ADP or district or region/province group PD/Hearth action plan
2. Receive feedback on their plans from national adviser and facilitators.

Preparation

- Print Handout 41.1

Materials

- Handout 41.1: PD/Hearth Action Plan

STEPS

15 Min

1.

HANDOUT
41.1 – 203m/H 86

Participants from each ADP or district or region/province group work together to develop an action plan based on the questions on Handout 41.1: 'PD/Hearth Action Plan'.

30 Min

2.

Each ADP or district or region/province group briefly presents its action plan. Participants and facilitators give feedback on the plan.

PD/Hearth Action Plan

Trainer's name:

Who will be trained?

Projected timetable of trainings:

Where trainings will take place? (number and names of communities that will implement this fiscal year):

Steps that will be taken to implement PD/Hearth (indicate rough timeline):

Support required to fulfil plan?

SESSION 42

Final Evaluation and Closing

World Vision

40 MIN | DAY 9

By the end of the session, participants will have

1. Identified key areas of learning
2. Provide feedback on the training
3. Received a certificate of participation.

Preparation

- Flip chart with 'Target Evaluation Dart Board'
- Print Handout 42.1
- Certificates for all participants

Materials

- 'Target Evaluation' flip chart from Day 1 for comparison
- Eight small stickers for each participant
- Handout 42.1: Workshop Evaluation

STEPS

10 Min

1.

Repeat the 'Target Evaluation' exercise from Day 1.

- Give each participant eight stickers. Ask the participants to consider their understanding and skill in each of the eight areas on the 'Target Evaluation Dart Board' (Flip Chart 42). The more competent they feel in an area, the closer to the centre of that area they place a sticker. For areas in which they feel less confident or knowledgeable, the closer to the outer edge they place a sticker.
- Compare the first day's chart with the final day's chart. Discuss where participants feel they have grown in knowledge and skill. Congratulate them on their great work.

10 Min

2.

HANDOUT
42.1 – 206m/H 87

Have participants fill out Handout 42.1: 'Evaluation Form' (an evaluation form for the course).

10 Min

3.

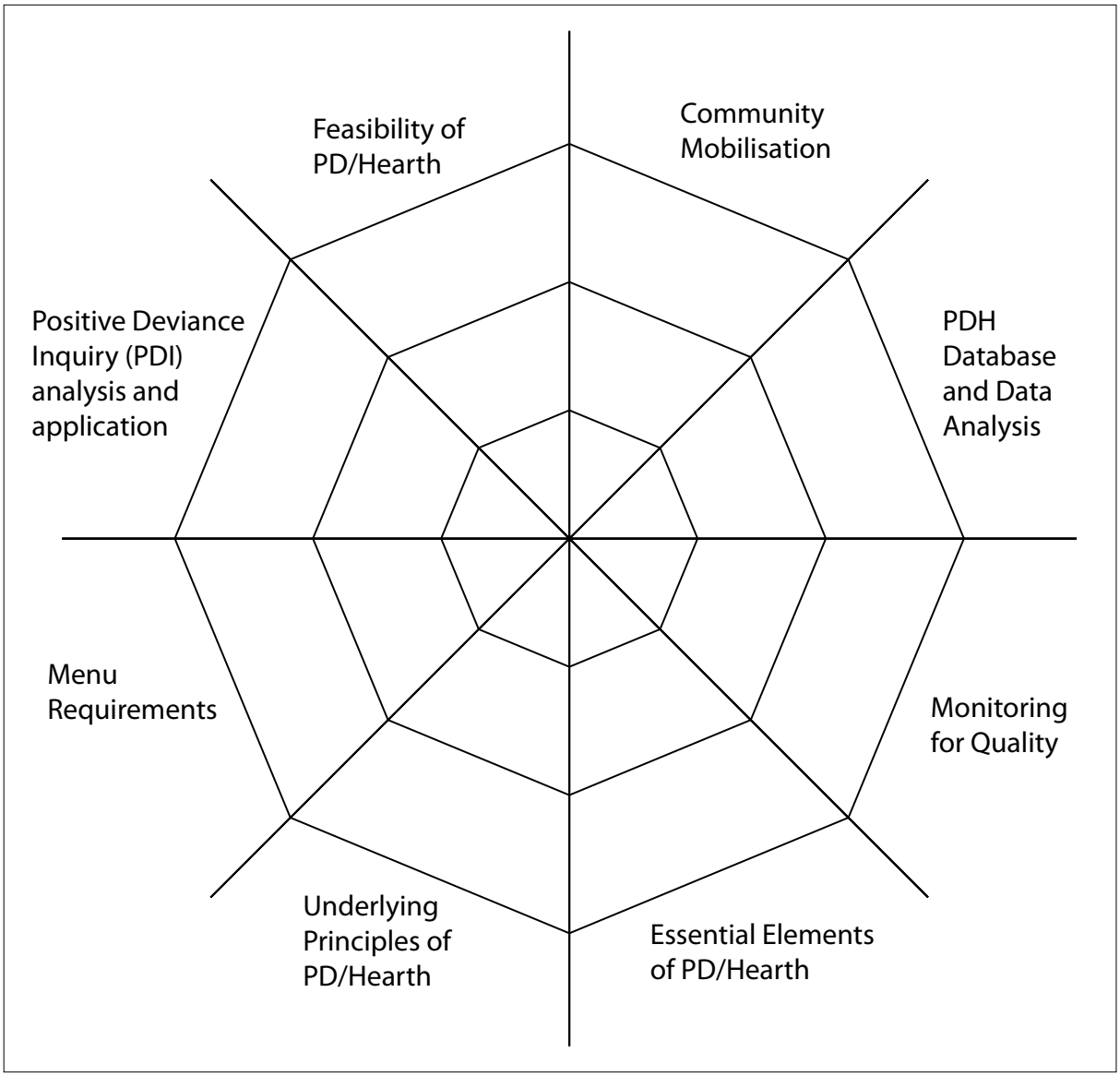
Explain the next steps in TOF training:

- Each participant will submit to the national adviser his or her action plans.
- Each participant will receive his or her final marks and next steps from the national office.

Flip Chart 42
Target Evaluation Dart Board

4.

Thank the host country, planners and logistics people. Thank participants for their great work.



Workshop Evaluation: World Vision PD/Hearth Training of Facilitators Workshop

Day 9 Session 42

EVALUATION

Thank you for attending this year's PD/Hearth Training of Facilitators. We hope you enjoyed your time, and that the workshop was a meaningful experience for you. Please take a few minutes to complete this evaluation. Your feedback is valuable and provides helpful information that will be used to plan the next workshop.

1. What did you expect from the workshop?

   _____
   _____
   _____

2. What do you feel was the most helpful part of the workshop? (for example, a particular session, a working group, a contact you made, certain resource material you obtained)

   _____
   _____
   _____

3. Please share some specific ways that you and/or your programme will apply the helpful information you noted in question #2.

   _____
   _____
   _____

4. What do you feel was the least helpful part of the workshop?

   _____
   _____
   _____

5. What would you do to improve this?

   _____
   _____
   _____

6. What would recommend for the next workshop?

   _____
   _____
   _____

7. What themes or topics would you suggest that we focus on or go into in more detail?

   _____
   _____
   _____

8. Should more background information be provided at the beginning of the workshop/training? What information?

   _____
   _____
   _____

9. Other:

_____
_____
_____

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

For you, what was the highlight of this workshop?

_____
_____
_____

_____
_____
_____

Please share any other comments or suggestions to improve the next World Vision PD/Hearth TOF Workshop.

_____
_____
_____

_____
_____
_____

Thank you for your feedback!

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MASTER TRAINERS
HANDOUTS

By Naomi Klaas,
Diane Baik and
Judiann McNulty

WVI Nutrition Centre of Expertise

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Christina Gruenewald

Positive Deviance Initiative
Monique Sternin

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Table of Contents

PLEASE NOTE: There can be more than one page for a handout. Page counts appear in the item lines for any handouts having more than one page. Multiple page handouts are designated on their respective pages as "page # of # pages".

The (page #m) refers to where each handout appears in the PD/Hearth Master Trainer Manual. You can reference the "#m" at the bottom of each handout page as well.

DAY 1

DAY 2

DAY 3

DAY 4

DAY 5

DAY 6

Goal

WV staff and partners develop knowledge, skill and competencies in PD/Hearth to

- train others
- provide technical support
- monitor implementation.

Training objectives

By the end of the workshop, participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level
6. Complete a training curriculum adapted to their country context.

Agenda for PD/Hearth Training of Trainers

Day and Date	Session	Topics	Time
		DAY 1	
1		Devotion	15 min
	1	Welcome Ice breaker Workshop rules (parking lot) Introductions and expectations Overview of workshop purpose, objectives and agenda Target Evaluation TOT methodology and curriculum adaptation	60 min
	2	Pre-test	30 min
	3	Defining the roles of a PD/Hearth Master Trainer	30 min
	4	Learning styles and facilitation	45 min
	5	Overview of PD/Hearth	45 min
	6	Essential elements and key principles	60 min
	7	How PD/Hearth addresses malnutrition	45 min
	8	Step 1 – Determining the feasibility of PD/Hearth	45 min
	9	Integration and PD/Hearth	60 min
	10	Personalise the training curriculum, daily summary, evaluation	45 min
		DAY 2	
2		Devotion	30 min
	11	Review Day 1 and present the Day 2 agenda	15 min
	12	Step 2 – Community mobilisation	60 min
	13	Step 2 – Staffing needs; selecting and training volunteers	45 min
	14	Step 3 – Situational analysis - Wealth ranking	30 min
	15	Step 3 – Situational analysis – Nutritional Assessment	95 min
	16	Step 3 – Situational analysis – transect walk, household visits, focus-group discussions (FGDs), market survey	95 min
	17	Step 4 – Identifying positive deviants	30 min
	18	Step 4 – Preparing for the positive deviant inquiry (PDI)	75 min
	19	Step 4 – Preparing for the field visit to conduct the situational analysis and PDI	60 min
	20	Personalise the training curriculum, daily summary, evaluation	30 min

Day and Date	Session	Topics	Time
		DAY 3 – FIELD VISIT	
3		Review Day 2 and explain details for field visit	15 min
	21	Field visit (PDI, FGD, transect walk, market survey, household visits)	4.5 hours incl. travel time
		Compile results of PDI on flip charts	120 min
		DAY 4	
4		Devotion	30 min
	22	Review Day 3 field visit and present Day 4 agenda	15 min
	23	Step 4 – PDI interpretation and feedback	80 min
	24	Promoting behavioural change	40 min
	25	Step 5 – Designing Hearth sessions (Incorporating positive deviance behaviours)	120 min
	26	Step 5 – Menu planning	245 min
		DAY 5	
5		Devotion	30 min
	27	Review Day 4 and present the Day 5 agenda	35 min
	28	Community feedback meetings	60 min
	29	Step 6 – Conducting Hearth sessions	40 min
	30	Step 7 – Supporting new behaviours through reflection and home visits	60 min
	31	Step 8 – Admission and graduation criteria and repeating Hearth sessions Exit strategy and reaching the rest of the community	45 min
		Step 9 – Expanding PD/Hearth	
	32	Monitoring and evaluation	120 min
	33	Personalise the training curriculum , daily summary, evaluation	30 min
		DAY 6	
6		Devotion	30 min
	34	Review Day 5 and present the Day 6 agenda	30 min
	35	Factors for the success of PD/Hearth	45 min
	36	Post-test	30 min
	37	Training plan	45 min
	38	Personalising the TOT curriculum – review by facilitators	90 min
	39	Final evaluation and workshop closing	30 min

PD/Hearth Competencies

Principles of PD/Hearth

- Goals of PD/Hearth
- Adult learning principles
- Behaviour-change theory
- Community mobilisation and ownership in PD/Hearth

Training skills

- Criteria for selecting Hearth volunteers and staff
- Training PD/Hearth volunteers
- Training PD/Hearth supervisors
- Facilitation based on learning styles

Community mobilisation skills

- Tools for PD/Hearth community assessment
- Nutrition baselines in PD/Hearth
- Wealth-ranking exercises
- Identifying positive deviant households
- Market surveys
- Community mapping in PD/Hearth
- Conducting positive deviant inquiries
- Tools used in community feedback meetings
- Engaging grandmothers and others with influence on child care and feeding

Critical thinking skills

- How to determine if PD/Hearth is appropriate in a community
- Analysis of positive deviance inquiry
- Designing Hearth sessions
- How to develop PD/Hearth messages

Technical skills

- Use of food composition tables to calculate Hearth menus
- Converting metric measures into home measures
- Conducting Hearth sessions
- Characteristics of complementary feeding for a child of 6–36 months
- Graduation criteria for PD/Hearth
- Integration with other sectors, e.g. Agriculture, WASH (water, sanitation, hygiene)

Communication skills

- Supporting new behaviours and confidence-building skills
- Counselling skills in PD/Hearth

Project management skills

- Monitoring and evaluating PD/Hearth activities
- Analysis and reporting

Flow Chart of World Vision PD/Hearth Reporting Lines

Community Volunteers

- Selected by community
- Trained by PD/H Coordinators
- Run Hearth sessions
- Conduct follow up home visits
- Collect monitoring data

PD/Hearth Coordinators

- ADP or MOH H&N staff
- Trained by ToF or MT
- Train & supervise volunteers
- Prepare monitoring reports
- Enter data online database
- Coordinate with MOH, community leaders, zonal & provincial level WV staff

Zonal and/ or Provincial Coordinators

- Trained by ToF or MT
- Train & supervise PD/H coordinators
- Monitor projects
- Communicate with Regional & National WV and MOH entities

National Health & Nutrition Coordinator

- Trained by MT
- Train PD/H Coordinators
- Overall programme direction & monitoring
- Lead programme evaluation
- Communicate with national entities; WV Regional Nutrition Advisor
- Advocate for PD/H to MOH & MinAgri

(http://www.vark-learn.com, used with permission)

Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ a chance to ask questions and talk about the camera's features.
   - ☐ examples of good and poor photos and how to improve them.
   - ☐ clear written instructions with lists and bullet points.
   - ☐ diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ make lists of what to do and what to buy for the party.
   - ☐ invite friends and just let it happen.
   - ☐ talk about it on the phone or text others.
   - ☐ imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ walk with them.
   - ☐ write down the directions as a list.
   - ☐ tell them the directions.
   - ☐ draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ class discussions, online discussion, online chat and guest speakers.
   - ☐ field trips, case studies, videos, labs and hands-on practical sessions.
   - ☐ a textbook and plenty of handouts.
   - ☐ an overview diagram, charts, labelled diagrams and maps.

5. You have a problem with your knee. Would you prefer that the doctor:
   - ☐ showed you a diagram of what was wrong.
   - ☐ described to you what was wrong
   - ☐ demonstrated what was wrong using a model of a knee.
   - ☐ gave you an article or brochure that explained knee injuries.

6. After reading a play you need to do a project. Would you prefer to:
   - ☐ act out a scene from the play.
   - ☐ read a speech from the play.
   - ☐ draw or sketch something that happened in the play.
   - ☐ write about the play.

VARK Learning Styles Questionnaire

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ describe the activities you will be doing in the programme.
   - ☐ start practicing the activities you will be doing in the programme.
   - ☐ show them the list of activities in the programme.
   - ☐ show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ things you can click on and do.
   - ☐ interesting design and visual effects.
   - ☐ audio channels for music, chat and discussion.
   - ☐ interesting information and articles in print.

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   - ☐ write out your speech and learn it by reading it again and again.
   - ☐ write a few key words and practise what to say again and again.
   - ☐ gather examples and stories to make it real and practical.
   - ☐ make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
    - ☐ that used a written description or table of your results.
    - ☐ that used examples of what you have done.
    - ☐ from somebody who discussed it with you.
    - ☐ that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
    - ☐ trying it.
    - ☐ the salesperson telling you about it.
    - ☐ it is the latest design and looks good.
    - ☐ reading the details about its features.

12. You are going to make something special for your family. You would:
    - ☐ make something you have made before.
    - ☐ find written instructions to make it.
    - ☐ look for ideas and plans in books and magazines.
    - ☐ talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
    - ☐ clues from the diagrams in the instructions.
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    - ☐ **R** reading the instructions.

Total Personal Score: Visual =_____ Aural =_____ Read/Write =_____ Kinaesthetic =_____

Observation of a PD/Hearth Session

Observe the strengths and challenges of PD/Hearth sessions. You will not be able to observe the essential components shaded in grey. Ask the Hearth volunteer or supervisor to determine if these elements were included.

Identify variations or innovations that have been implemented and how that may have affected results.

Essential PD/Hearth Project Components	Check for yes	Strengths	Challenges
1. Actively involve the community, including grandmothers, throughout the process (including integration with other sectors).			
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated.			
3. Conduct a PDI in every community. Incorporate findings into the Hearth (menu, message and tips, storytelling about what already works).			
4. Prior to sessions, deworm all children and provide immunisations and micronutrients.			
5. Use community volunteers to conduct sessions/follow-up home visits.			
6. Design Hearth-session menus based on locally available and affordable foods.			
7. The Hearth-session menus are nutrient-dense enough to ensure rapid recuperation.			
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth.			
9. Have caregivers present and actively involved every day of the Hearth session.			
10. Conduct the Hearth session for 10–12 days within a two-week period.			
11. Include follow-up home visits for two weeks after the session (every 1–2 days).			
12. If a child does not gain weight after two sessions, refer the child to a health centre.			
13. Limit the number of participant caregivers in each Hearth session to ten or fewer. (If working with caregiver-grandmother pairs, five pairs or fewer is preferred.)			
14. Monitor and evaluate progress.			

Several elements are essential to the implementation of an effective PD/Hearth project. Experience has shown that these elements cannot be adapted, modified, or omitted without seriously diminishing the effectiveness of the programme.

1. **Actively involve the community throughout the process.** Community leaders and a village health committee can provide support in organising the weighing of all children in the target age group; recruiting volunteers; conducting the PDI; contributing materials, utensils, and food for the sessions; assuring that eligible caregivers[1] attend the Hearth session regularly; and encouraging other community members, including key influencers like grandmothers, to support the families with malnourished children as they adopt new practices. Grandmothers[2] often play a major role in child care and feeding and act as advisors in this area to younger women who seek their advice and expertise. Engaging grandmothers from the start of the PD/Hearth implementation will facilitate the community's involvement and learning as grandmothers are key influencers in addressing child malnutrition. In the different steps of the PD/Hearth process, grandmothers can participate as mobilisers, hearth committee members and/or volunteers, participants in focus group discussions on child care and feeding, those being talked to and observed during the PDI, participants in Hearth sessions with the caregivers and children, key audience members in community feedback sessions, and supporters and advisors at home for the caregivers. The community can participate in monitoring project implementation and results. The higher the visibility of Hearth in the community, the greater the nutritional impact will be. Hearth sessions provide "living proof" that good nutrition practices help malnourished children. This raises the consciousness of community members and empowers them to prevent malnutrition within their community.

2. **Use growth monitoring to identify malnourished children and monitor the nutritional status of participants who have graduated from Hearth**. If a growth-monitoring and counselling programme does not exist in the community when PD/Hearth is initiated, it should be started in time to monitor the children who complete the Hearth session. The growth-monitoring programme must include good nutrition counselling and explanations of the child's growth for the caregivers. It is also an important tool for monitoring the progress of *all* the children in the target group over time, and it allows the integration of newly malnourished children into the second or third Hearth session.

3. **Use community members and staff in each and every community to conduct a Positive Deviance Inquiry.** The PDI is not simply a fact-finding exercise for the project staff. It is an opportunity for community members (e.g. Hearth volunteers, health staff, community leaders, grandmothers) to 'discover' that very poor families have certain good practices which enable them to prevent malnutrition and that these practices can be used by any family with similarly scarce resources. In order for a community to take ownership, the discovery process must take place in *that* community. Each community or communities within 40km radius with similar cultural practices, belief, and food availability need its own PDI to discover its positive deviance (PD) practices. Many programmes have tried to save time by using the PDI results from one community in another; doing

1. The term caregiver refers to anyone who has significant responsibility for the care and feeding of a young child. This may be a parent, grandparent and/or older sibling, depending on the cultural context and family situation. In some cases two caregivers, such as a mother-grandmother pair, may attend the Hearth sessions.
2. A grandmother refers to a senior woman (related or unrelated to the child) who lives in close proximity to the child and who has influence on child care.

so means that the second community loses the process of the discovery that results from the PDI. If there are no poor families with well-nourished children in a particular community, the PDI may need to look at families with only mildly malnourished children. Alternatively, if the community can identify a nearby community with the same culture, socioeconomic conditions and, perhaps, blood relationships, the volunteers can be taken there to identify PD families with whom to conduct the PDI. Since family coping may change with the seasons, it may be necessary to repeat the PDI during different seasons of the year.

The PDI consists both of questioning the family members, including caregivers and grandmothers, and of making careful observations of the situation. The list of questions that has been developed is best used as a discussion guide rather than as interview questions. With sufficient practice the PDI team should be able to visit the families without relying on the list of questions. A second or third person from the PDI team can concentrate on observing practices related to child care, hygiene, sanitation and food preparation, noting the roles of influential family members as well as what foods and materials are available in the home. Projects need to allow sufficient time to prepare for and conduct PDI visits to obtain the most useful information.

4. **Prior to the Hearth sessions, deworm all children, update immunisations and provide needed micronutrients.** Children are more likely to show quick recuperation when these important health interventions are taken care of before the Hearth session. Families should be referred for these services to the local health facility with whom the project is collaborating. These activities are kept separate from the Hearth session so that families do not attribute the child's improvement in nutritional status to these activities rather than to the food and feeding practices. During the Hearth session and follow-up home visits families will be encouraged to continue to access these and other preventive health services including growth monitoring and the use of insecticide-treated bed nets (ITNs), where needed. In areas of high malaria prevalence, children may need diagnosis and treatment before attending the Hearth sessions. If it becomes evident during the PDI that very poor families are using ITNs, it will be useful to discuss how they afford them in order to share that information with the Hearth participants. All children may be checked for underlying illness and/or anaemia before entering Hearth to screen for treatable conditions.

5. **Utilise community men and women as volunteers to conduct the Hearth sessions and the follow-up home visits.** Caregivers will learn best from those who normally provide child care advice and support within their culture and community, and who understand local customs and conditions. The volunteers can be any community members, including grandmothers, with a good reputation, credibility, healthy children and a willingness to take on the necessary responsibilities.

   Note: *PD caregivers are not necessarily Hearth volunteers. The PDI results in a collection of PD practices from multiple PD families; it is extremely rare that one family models all the PD practices. We are not looking for PD persons but PD practices. In many cultures identifying individuals or families as models (or somehow 'better') results in social rejection by their peers.*

6. **Design optimal Hearth menus based on locally available and affordable foods.** Participating families must be able to replicate meals in their own homes with limited resources. This is the only way they will be able to sustain the improved nutritional status of their children and prevent future malnutrition in the family. The affordability of foods is verified through the PDI, which

discovers the foods used by the poor families with well-nourished children, and the market survey, which explores the costs and nutritional content of foods available for purchase.

7. **Provide a special, nutrient-dense meal capable of ensuring the rapid recuperation of the child.** The daily Hearth menu includes an extra meal and snack, an addition to what the child normally eats at home in one day. This menu must contain the following nutrient levels for each child:

Calories:	600–800 kcal
Protein:	25–27 g
Vitamin A:	400–500 µg RE (retinol equivalent) or 300 µg RAE (retinol activity equivalent)
Iron:	8–10 mg (may need iron supplementation or a fortified product to meet this requirement)
Zinc:	3–5 mg
Vitamin C:	15–25 mg

These figures show the range of supplementary nutrient levels necessary to rehabilitate malnourished children. Specific levels for children of different ages are listed in the *CORE PD/Hearth Guide*. Consider the Hearth meal as 'medicine'; this is the dosage prescribed. If the Hearth supplemental meal does not meet this minimum standard, then weight gains are compromised. The meal is a supplement, not a meal substitute. The additional calories and protein are needed for 'catch-up' growth of the child. When the child is no longer underweight, this 'extra' energy and protein-rich meal is no longer necessary. However, to sustain the rehabilitation gains, regular family meals need to be more balanced and nutritious. Caregivers learn how to do this during the Hearth sessions.

8. **Ensure that caregivers bring a daily contribution of food and/or materials to the Hearth sessions.** One of the fundamentals of PD/Hearth is that families learn that they really can afford to feed their children nutritious food. The PDI revealed what poor families feed their well-nourished children. Obtaining and bringing the foods reinforces the use of these affordable foods. The community also realises it is able to rehabilitate its malnourished children without outside material support.

9. **Have caregivers present and actively involved every day of the Hearth sessions.** Involvement promotes ownership and active learning and builds self-confidence. Repetition of new skills and practices enables caregivers to learn and adopt new behaviours. Attendance and active involvement of caregivers each day of the Hearth sessions is necessary for children to achieve adequate weight gain.

10. **Conduct the Hearth session for 10–12 days within a two-week period.** Within 8–12 days of starting the Hearth sessions caregivers will see notable improvement in their children. They may need some guidance to recognise the changes in their child, such as improved appetite, increased activity, less irritability, higher level of alertness. Recognising these changes motivates the caregivers to adopt new feeding, caring and health practices. If a child is not fed the special extra meal over sequential days, recovery will be so slow that the caregiver will not have the satisfaction and motivation to continue the programme. There may be breaks of one or two days during the Hearth

sessions to allow for weekends, holidays, or market days *(e.g. 4 days + market day + 4 days + market day + 4 days)*. The family must be encouraged to prepare the special meal at home on the days off. This Hearth session may be repeated the next month as some children will not experience 'catch-up' growth within a month.

11. **Include follow-up visits at home every 2–3 days for two weeks after the Hearth session.** It takes an average of 21 days of practice for a new behaviour to become a habit. The caregivers will need continued support to implement the new practices in their own homes. During home visits the volunteers or staff can help caregivers think of solutions to any difficulties they are encountering or respond to concerns about the child's progress, and can support grandmothers in their role as household advisors to facilitate positive changes in child care and feeding. By continuing to practise these new behaviours, the improved nutritional status of the participating child will be sustained at home and malnutrition will be prevented among future children.

12. **Refer a child who doesn't gain weight after two 10–12 day sessions to a health facility to check for any underlying causes of illness such as tuberculosis, HIV/ AIDS, or other infection**. If the child does not have an illness, direct families to other social services or to income-generation projects. The average number of sessions it takes to graduate a child varies among programmes, but the number of sessions a caregiver can attend is normally limited to two; otherwise, caregivers may become dependent on Hearth and not internalise new behaviours. A sense of urgency to rehabilitate a malnourished child should be instilled and encouraged in the caregiver and family. However, some children may need more time to gain weight. (Some projects opt to have all children checked for underlying illness before entering Hearth to screen for treatable diseases.)

13. **Limit the number of participants in each Hearth session.** Having a limited number of participants provides a 'safe' environment in which rapport can be built, and it gives all caregivers an equal opportunity to participate in all activities. Experience has shown that Hearth sessions are most successful when limited to no more than ten caregivers or five caregiver-grandmother pairs.

14. **Monitor and evaluate progress.** At a minimum, projects should monitor Hearth attendance, admission and one-month weights, and the percent of children who graduate after one session or after two sessions. Depending on community goals and national protocols, graduation may be determined as 400g weight gain in one month; an upward growth trend on the growth curve during two months; moving up one level (e.g. from moderate to mild malnutrition); or achieving normal weight for age. Projects monitor the longer-term impact by measuring the weight gains of participants two months, six months and one year after graduation, and by tracking growth of younger siblings and the target age group over time. Projects may develop other indicators to monitor the quality of implementation, community support, and so forth. Many examples of such indicators are given in the *CORE PD/Hearth Guide*.

Essential PD/Hearth Elements Detailed Observations and Key Questions

Summary components and sample questions to guide discussion on essential elements

Essential PD/Hearth project elements	Key questions to consider
1. Actively involve the community throughout the process. Leaders and/or the village health committee (VHC) provide support in organising weighings, finding volunteers, conducting PDIs, contributing supplies and participate in monitoring implementation/results. Individuals with influence on child care and feeding, particularly grandmothers, are engaged as advisors, mobilisers, volunteers, Hearth participants etc. The higher the exposure and involvement, the greater the impact on community overall nutrition status. Raising the consciousness of the community is empowering.	• How was the community mobilised? • What did the community contribute to the project? • How were grandmother and other influential figures engaged? • What information was given back to the community? When? • Have structures/policies that support child nutrition changed? • Was PD/Hearth integrated with other programmes/ sectors? How was this achieved? What were the results?
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated. If growth monitoring is not already in place, begin monitoring those who complete Hearth sessions and all children in target group over time. Growth monitoring must include counselling and explanations of a child's growth.	• Is routine growth monitoring present in the community? • Is counselling included? • How are children monitored after graduation?
3. Conduct a PDI in every community. A PDI is an opportunity for the community to make discoveries, not just to provide information to WV. To ensure community ownership, integrate the PDI into the Hearth sessions. A PDI may need to be done at different seasons. The goal is to identify PD practices, not only PD persons.	• How were the families to visit identified? • How was the PDI conducted? By whom? • How was information analysed? • Were PD foods/practices identified? • How were grandmothers involved? • How was the information utilised? Menus/ messages? • Was there sufficient technical skill to complete the PDI well?
4. Prior to sessions, deworm all children and provide immunisations and micronutrients. The purpose is to support rapid recuperation. Refer families to the local health centre before Hearth sessions so recuperation is not attributed to these activities. In endemic areas, malaria may need treatment before Hearth sessions.	• Was a situation analysis completed (nutritional assessment, feeding practices, expanded programme of immunisation coverage, vitamin A)? • Were all children under three years of age weighed? • Were children dewormed, immunised, vitamin A supplementation completed? • Were pre-existing underlying illnesses treated?

Essential PD/Hearth project elements	Key questions to consider
5. Use community volunteers to conduct sessions and follow-up home visits. Caregivers will be more comfortable and learn best from peers. A volunteer can be any community member, either male or female, who has a good reputation, is credible, has children in good health, and is willing to take on responsibilities.	• How were Hearth volunteers selected? • How were Hearth volunteers trained? • Were there gaps in the key competencies needed to implement the programme effectively?
6. Design Hearth session menus based on locally available and affordable foods. This is necessary to promote replication in home with limited resources in order to sustain improved nutritional status. Use foods confirmed through the PDI and verify the cost/ nutritional content through a market survey.	• Was a market survey completed? • Were PD foods identified? • Were the foods local, available and affordable?
7. Hearth session menus are nutrient dense to ensure rapid recuperation. Menu plus snack must contain required protein, calories and micronutrients to provide 'catch-up' growth The Hearth meal is 'medicine'. The extra meal is a supplement, not a meal substitute. To sustain the rehabilitation, families learn that meals need to be balanced and nutritious.	• Who decided on the menus? When? • Were menus nutrient dense (by programme standards)? • Who analysed the menus? • Were the menus followed in sessions? • Were the menu followed at home?
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth. This reinforces the fact that families can afford to feed nutritious food. The contributions make implementation possible without outside material support. Families providing resources ensures that the programme is non-paternalistic	• Were PD foods identified? • Did caregivers contribute PD foods? Other foods?
9. Have caregivers present and actively involved every day of the Hearth session. This promotes ownership, active learning and confidence. Repetition of practices builds habits that sustain rehabilitation and prevent malnutrition. Daily attendance is necessary to achieve weight gain.	• Was a caregiver involved with each child? Did caregiver-grandmother pairs work together where appropriate? • Did all caregivers participate in all the activities every day of the programme?

Essential PD/Hearth Elements Detailed Observations and Key Questions

Essential PD/Hearth project elements	Key questions to consider
10. Conduct the Hearth session for 10–12 days within a two-week period. Eight to twelve days are needed to see changes in the child. Caregivers may need help to identify improvement in appetite, energy, alertness, less irritability, and so forth. Changes in the child motivate caregivers to adopt and continue the new practices. If the child is not fed an extra meal over sequential days, changes are too slow for the caregiver to notice.	• Were PD/Hearth sessions conducted for 10-12 days? • What were attendance rates? • Was time spent reflecting with caregivers about changes in child?
11. Include follow-up home visits (every 2–3 days) for two weeks after the session. Caregivers need continued support. It takes 21 days to change a behaviour into a habit. Home visits help find solutions to obstacles to adopting new practices that are being faced at home. Home visits provide opportunities to address questions families may have about the child's growth.	• What did follow-up visits include? How often did they occur? By whom? • Did volunteers have the information and skills to support families in overcoming obstacles to child feeding/growth?
12. If a child doesn't gain after two sessions, refer the child to the health centre. A child with no underlying health issues who is not gaining may need referral to other social-services or income-generation projects. A sense of urgency to rehabilitate the child is needed by caregivers, families and volunteers.	• What happened if a child became sick during the session(s)? • Under what circumstances was a child referred to the health centre?
13. Limit the number of participants in each Hearth session to ten or fewer. A limited number of participants provides a 'safe' environment where rapport can be built. Caregivers have an equal opportunity to participate in all activities.	• How many children attended the sessions? • How many caregivers or caregiver-grandmother pairs attended the sessions? • Did caregivers participate in all aspects of the sessions?
14. Monitor and evaluate progress. Record attendance, entering and one-month weight, the percent of children who graduate. Check the long-term impact by measuring weight gain at two or six months, one year, and monitor the weight of younger children.	• Were graduation criteria established? • Was monitoring information used to improve implementation? When? How? • Was there adequate technical support for managers? For volunteers? • Was supervision frequent enough? Was it adequate?

Note to trainers: The amount of time for each step will depend on the local context (with the exception of Steps 6 and 7). An example of the timing is included for Steps 2–7 to guide discussion with planners. Each key step number is noted in the title of the relevant session in the curriculum. Monitoring and evaluation occurs throughout the process, as illustrated by the right hand column.

	STEPS	**APPROXIMATE TIME REQUIRED**	
Step 1	Decide whether the PD/Hearth approach is feasible in the target community.		
Step 2	Begin mobilising the community (mobilise or create Village Health/ Hearth Committee or working group within the community); select and train staff.	Mobilising the community can take several months and takes place throughout the entire project period. Steps 2 to 4 can take approximately 2–3 weeks, including: 2 days of training 2 days for situational analysis 2 days for PDI 2 days for analysis and feedback to the community	Monitor and Evaluate
Step 3	Prepare for a PDI (situational analysis).		
Step 4	Conduct a PDI.		
Step 5	Design Hearth sessions.	2 days	
Step 6	Conduct Hearth sessions.	2 weeks	
Step 7	Support new behaviours through follow-up visits.	Every 2-3 days in the 2 weeks immediately after the Hearth session, and continuing less frequently after that	
Step 8	Repeat Hearth as needed. Monitor progress of Hearth graduates and track growth of all young children.		
Step 9	Expand the PD/Hearth programme to additional communities.		
Step 10	Exit strategy for once underweight is eliminated or ADP phases out		

Case Studies: Is PD/Hearth Appropriate for These Settings?

Read and analyse the following cases. Decide whether PD/Hearth will work in each situation. If not, explain why not and think about an alternative approach. Suggest additional nutrition strategies and interventions needed from other sectors. If PD/Hearth is appropriate, but there are special challenges, please describe how to overcome them.

Case 1 – Coastal village – 12 per cent malnutrition but 35 children underweight

All the families make their living by fishing or selling fish. They live in a small village with houses very close together. The men are gone from before dawn until noon. When they return, they expect their big meal to be waiting. The women spend the afternoon cleaning fish and repairing the fishing nets. They work together on the beach and take their babies on their backs. Older children stay at the house with grandmothers or older siblings. There is plenty of fish to eat, but few fruits and vegetables most of the year. The health centre is in the next town, 15 minutes away by bus.

Case 2 – North interior – 35 per cent malnutrition

Families live in very small villages scattered through the tea estates. There are 10 to 20 families in each village. It can take between 30 minutes and one hour to walk over very hilly terrain to the main estate village. Nearly all the mothers work full time on the tea estates. The children from six months to three years spend nine hours a day in daycare with two paid employees. Food in the day care is provided by the estate. (After three years of age, children stay with grandparents during the day until they start school at age five.) The day care is located next to a good health clinic provided by the estate management. There is a joint management body made up of representatives of both workers and management.

Case 3 – Northeast – 32 per cent malnutrition

This good agricultural area produces grain, fruits and vegetables. The houses are dispersed, spread out over mounds. Grandmothers care for the small children when women go to the fields to work or the river to fish. There is a health centre in the nearest town, which is a four-hour walk for many families. When the rains come and water surrounds their mound, families cannot easily travel to other homes or villages. Some families have to move to higher ground for three or four months, which makes it difficult for them to raise poultry or livestock.

Case 4 – South farming community – 39 per cent malnutrition

Most of the children in this community are very short for their age. The families are engaged in farming, with most women at home except during harvest time. The village is very compact, and people work together on many community projects. Grandmothers decide when children should start getting water or food, often when they are one month old. There is a small Christian hospital, and government health workers bring vaccines and vitamin A.

Case 5 – Peri-urban – 20 per cent malnutrition

Families live in densely populated squatter settlements in simple houses with no sanitation. Water is fetched from central water taps some distance away. Families have easy access to health facilities. Because the houses are so small, most families do not cook at home. They buy cooked food from street vendors and snacks from the many small shops. Most women are at home during the day. Those who work leave their children in the care of older women. There are approximately 40 moderately and severely underweight children between the ages of 6-36 months.

PD/Hearth will not work everywhere. It is important to consider the following criteria when deciding if PD/Hearth is the right approach for a given community.

1. **Mild, moderate and severe malnutrition, based on weight for age, affects more than 30 per cent of children 6 to 36 months old or 30 underweight children between the ages of 6-36 months.** PD/Hearth is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include mild, moderate and severe malnutrition, but programmes concerned with cost efficiency may want to focus PD/Hearth activities on those who are moderately or severely malnourished and use less intensive methods to address the children with mild malnutrition. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely malnourished children in the 6–36 month age range.** Since it is unlikely that an implementing agency will have done a census-based nutritional assessment prior to deciding whether to implement the programme, the decision can be based on existing growth monitoring data, data from surveys of a representative sample of the population, or other existing data.

   Note: *PD/Hearth uses weight for age because that is the indicator most sensitive to change and does not require height measurements, which are difficult to collect. While mid-upper arm circumference (MUAC) is useful in screening for malnutrition in emergencies, it is not specific enough to identify all children who are also below weight for their age.*

2. ***Affordable food is available.*** A fundamental precept of PD/Hearth is that families can rehabilitate their children and prevent malnutrition with affordable, locally available food. If all poor families in the community are reliant on food aid or are eating only the staple food due to lack of anything else, other interventions to improve food security must come first.

3. ***Homes are located within a short distance of one another***. Because caregivers are expected to come with their children to the Hearth session every day and the volunteers must make frequent home visits, the homes must be within easy walking distance from a central point.

4. ***There is a community commitment to overcome malnutrition.*** A commitment will serve to mobilise resources and pave the way for organising Hearth sessions and providing peer support to participating families. If there is no governing or civic body to work with, it may be necessary to form a village health committee. PD/Hearth has not been successful where populations are transient and lack a sense of community.

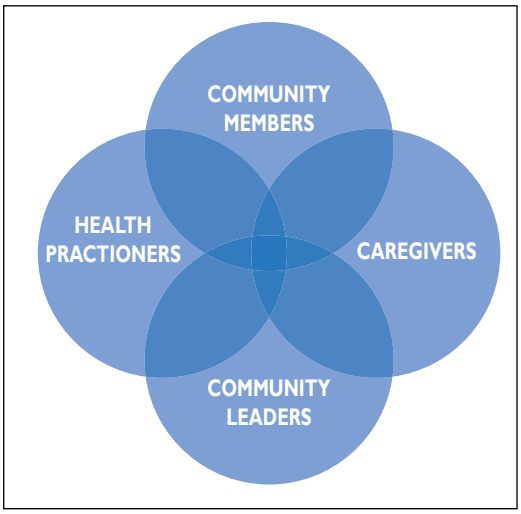
5. ***There is access to basic complementary health services.*** Health services are necessary for the children to receive inputs not available at the Hearth, such as

deworming, immunisations, malaria treatment, micronutrient supplementation and referrals. Children receive the needed services ***before*** entering the Hearth and may be referred for further evaluation and treatment if they do not show adequate weight gain after participating in the Hearth for two weeks with two more weeks of follow-up visits at home.

6. ***Systems for identifying and tracking malnourished children exist or can be developed.*** While such systems are not a prerequisite, they must be developed for the programme. The first step may be a door-to-door census and weighing of children, but then a routine monthly growth-monitoring system must be established not only to track the children who complete the Hearth sessions, but also to detect other children who may need to enter the programme. PD/Hearth is intended to be only one phase of a wider nutrition programme.

7. ***The presence of food aid in Hearth can be minimised with careful planning.*** Families need to learn to provide the nutrition their children need from local foods, rather than food aid, which is not a sustainable solution to malnutrition or food insecurity. Limited amounts of food aid, in the form of local staples (such as rice and oil) can be used in the Hearth menus, but the participating families must contribute the other foods in order to learn firsthand about their accessibility and affordability. The Hearth sessions emphasise using locally available foods.

8. ***Organisational commitment of the implementing agency is strong.*** This is essential. Because of the effort required to start a PD/Hearth programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PD/Hearth need to devote themselves full time to PD/Hearth, particularly in the start-up months. Projects should consider budgeting for additional staff and recruiting additional volunteers rather than expecting existing staff and volunteers to add the PD/Hearth to their existing responsibilities. Since PD/Hearth is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.



What is the role of the Ministry of Health? *(How is it incorporated?)*

The Ministry of Health provides support services such as immunisation, deworming, vitamin A supplementation; training; monitoring; and scale-up of learnings from PD/Hearth into existing health and nutrition message sharing systems).

What is the role of the Village Health Committee? *(Does a VHC exist? Does it need to be revived?)*

The VHC manages and coordinates health activities at the local level; sets criteria for, selects and supervises community health volunteers; and collaborates with the implementing organisation and district health staff (contextual depending on the country's existing Ministry of Health structure).

Can PD/Hearth be implemented without a Village Health Committee?

In the absence of a VHC, it is important to identify management resources at the grassroots level; build on existing resources. If possible, work to re-establish a non-functioning committee or establish a VHC or Village Hearth Committee.

What is the role of grandmothers?

In many cultures grandmothers are highly influential in the home as advisors on child care and feeding, and thus are important figures to engage throughout PD/Hearth. The following activity will help to illustrate the importance grandmothers have, especially in maternal and child care, and the necessity to include them in PD/Hearth.

Ask participants to write down on small pieces of paper what areas a grandmother would have a role/influence within a family in their community. For example, a grandmother would give advice to young women about marriage and how to manage their household. Use the pieces of paper to form a tree of the multi-faceted roles of grandmothers in the family and community.

Ask participants to identify ways to involve grandmothers in PD/Hearth. Ensure the following points are included:

- Consider grandmothers for leadership roles, including VHC and Hearth volunteer positions
- Consult grandmothers during situational analysis
- Interview grandmothers during PDI and/or involve grandmothers in conducting the PDI
- Engage grandmothers as participants in Hearth, either as caregivers, volunteers or part of caregiver-grandmother pairs

- Include grandmothers in follow up home visits, including review of child's progress and discussion of challenges to implementing PD practices at home

15 Min

3.

Divide into four groups (or as many groups as circles on the Venn diagram). Each group represents one community group. Come up with as many strategies as possible for:

- Maximising commitment and support; and
- Maintaining involvement throughout the project.

After a few minutes, call on volunteers to state the ideas their groups have come up with. ***Note:*** Listen to the participants' knowledge. *The solutions are in the group.*

Discuss the following questions:

How do you get maximum commitment and support?

Engage the community as the primary partner, with a role in selection criteria of volunteers. Be sure to involve in the process people who might raise barriers.

How do you keep this involvement throughout the project?

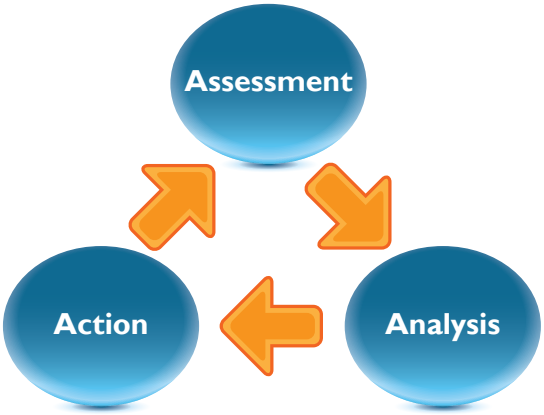
Establish a partnership with the community from the beginning and maintain it throughout.

See the **Triple A** cycle (assess, analyse, action) discussion on p. 29 of the *CORE PD/Hearth Guide*. Programme management is carried out in partnership with the community by assessing the problem, analysing its causes and taking action based on this analysis.

From the community mobilisation steps below, what activities might the community include in each circle (assessment, analysis, action)?

Discuss together key times when the community can be mobilised (based on the following steps).

STEPS



FOR COMMUNITY MOBILISATION AND OWNERSHIP:

Step 1 Identify community leaders using existing community health volunteers and plan to meet with community leaders, religious leaders and women representatives.

Step 2A Ask community leaders for their permission and invitation to use the PD approach (finding existing solutions to malnutrition problems from within the community).

Step 2B Ask about the existing local health systems (e.g. Village Health and Sanitation Committee (VHSC), VHC (Village Health Commitee), etc.). Discuss a way to describe PD concepts in the local language (i.e. proverbs, stories). Discuss volunteer selection if a particular volunteer group does not already exist.

Step 3 Engage the community to define the problem (conduct wealth ranking); weigh all the children in the target group with community members, especially men (special GMP session). Involve community in focus group discussions, community mapping, seasonal calendar, transect walk, and market survey.

Step 4 Community Feedback Sessions: engage community members in discussion about the issue of childhood malnutrition; discuss its causes, common challenges and constraints, and ask for their ideas or suggestions for solutions. Involve men, grandmothers, mothers and all women who delivered the year before, include TBAs and traditional healers as well as religious leaders. Other very important activities to engage community members include: social mapping (include young men and women in this activity), seasonal calendar, market survey and wealth ranking.

Step 5 Second Community Feedback Session: Prepare and train leaders to carry out a meeting with the larger community to share the baseline information (results of the weighing) and the findings from group discussions as well as the PD concept from the visual poster to show nutritional assessment results. Also share the visuals of community created social mapping, seasonal calendar, market survey and wealth ranking. Discuss on the volunteer identification or if there are no volunteers yet, select volunteers.

Step 6 Plan and carry out PD inquiries with community members.

Step 7 Have community members (VHC) analyse and select key PD behaviours and have them share the PDI findings with the whole community, examining the PD behaviours and strategies with the community members; invite them to develop a plan of action that will include Hearth sessions.

Step 8 Involve or remain transparent to the community in selecting staff – such as a supervisor, village hearth committee members, and/or community health volunteers – to contribute to the staff's credibility and to promote the community's ownership of the programme.

Step 9 Involve the community in monitoring monthly progress in the nutritional status of all children in the target group. (In Bangladesh a consolidated community growth monitoring chart is used for all children participating in PD/Hearth so the entire community can see the effectiveness of the programme.)

Step 10 Appreciation Day/Graduation Day

Step 11 Program Monitoring and Review

4.

For the community mobilisation and ownership Step 2, conduct a role play where you are meeting with the community leaders for the first time to talk about the following:

- Ask community leaders for permission to help the community overcome malnutrition
- Explain the concept of PDH without using technical language
- Explain the program of PDH (12 day long education session)
- Emphasize that we are here to learn from the community because there are positive behaviours that are allowing their children to stay healthy whether they are practicing the behaviours knowingly or not. We are here to identify those positive practices, especially from those households who do not have a big house and many cattle, yet they still have very healthy children
- Ask if there would be any members from the community who would like to help volunteer to run the program as this program cannot be run without the community taking the leadership.

5 Min

5.

Summarise some of the key challenges to community involvement and some of the solutions developed by the group. Refer participants to additional exercises for mobilising communities in the *CORE PD/Hearth Guide*, pp. 43–52. Answer any remaining questions. Note that we will be spending time throughout the remainder of the course working on each of these activities.

Note: *It is vitally important to understand fully the community players, conflicts, priorities, existing structures and resources.*

If hard copies of the resources for community participation listed above are available, suggest that participants look at these during breaks and/or list websites where participants can obtain them.

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	

Case Examples for Wealth-Ranking Exercise ANSWER KEY

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	Poor
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	Poor
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	Non-Poor
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	Non-Poor
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	Poor
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	Non-Poor

Wealth Ranking for PD/Hearth

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

WEALTH STATUS	WEALTH CLASSIFICATION CRITERIA
POOR	
NON–POOR	

Community Assessment Monitoring Sheet

Community: Sunshine – ADP Light and Hope	**Date of Weighing:** March 11, 2011	
Total number of children under 36 months in community: **Total number of children under 36 months weighed:**		

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
1	M	6/3/2009	24	10.70	1	Non-Poor			
2	F	28/3/2010	11	6.8	4	Poor			
3	F	30/7/2009	19	7.1	6	Poor			
4	M	14/4/2008	35	10.1	1	Non-Poor			
5	F	3/8/2010	7	7.3	3	Poor			
6	M	3/10/2009	17	8.5	7 (twin)	Poor			
7	F	3/10/2009	17	10.7	7 (twin)	Poor			
8	M	20/5/2008	34	9.8	8	Poor			
9	F	21/111/2009	16	8.2	1	Poor			
10	F	8/2/2008	37	11.4	8	Non-Poor			
11	F	6/5/2010	10	8.6	3	Poor			
12	M	25/3/2010	12	7.4	6	Non-Poor			
13	F	25/9/2009	17	8.1	3	Poor			
14	F	25/9/2009	17	6.1	7	Poor			
15	F	23/7/2009	20	8.3	2	Poor			
16	M	9/12/2009	15	8.5	9	Poor			
17	F	28/8/2009	18	6.2	1	Poor		-4.20	
18	M	18/7/2009	20	8.4	1	Poor		-2.64	
19	M	15/5/2010	10	6.3	4	Poor		-3.33	

Community Assessment Monitoring Sheet

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
20	M	15/5/2010	10	8.3	3	Non-Poor		-0.87	
21	F	3/3/2009	24	11.5	5	Poor		-0.02	
22	F	22/10/2008	29	8.9	2	Poor		-2.80	
23	F	6/6/2009	21	9.4	4	Poor		-1.21	
24	F	3/2/2008	37	10.8	3	Poor		-2.13	
25	M	9/9/2009	18	8.1	5	Non-Poor		-2.69	
26	M	3/6/2009	21	10.1	1	Poor		-1.22	
27	M	22/9/2009	18	9.5	4	Poor		-1.20	
28	F	24/9/2010	6	9.5	3	Non-Poor		2.35	
29	M	17/3/2010	12	8.2	5	Poor		-1.44	
30	M	6/6/2010	9	8.7	3	Non-Poor		-0.25	
31	F	4/4/2009	23	11.2	2	Non-Poor		-0.08	
32	M	28/1/2010	13	10.6	10	Poor		0.57	
33	M	7/12/2008	27	9	1	Non-Poor		-3.02	
34	F	4/12/2008	27	11.0	6	Poor		-0.80	
35	M	8/9/2009	18	10.0	8	Poor		-0.81	
36	F	30/11/2008	27	9.2	6	Poor		-2.34	
37	F	16/12/2008	27	9.4	4	Non-Poor		-2.07	
38	M	10/11/2010	4	10.2	7	Poor		3.47	
39	F	21/11/2009	16	9.8	4	Poor		0.06	
40	M	10/3/2010	12	7.0	4	Non-Poor		-2.91	
41	F	12/9/2008	30	8.4	3	Poor		-3.44	

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)*

BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	0	3.3	2.9	2.5	2.1	F	0	3.2	2.8	2.4	2.0
M	1	4.5	3.9	3.4	2.9	F	1	4.2	3.6	3.2	2.7
M	2	5.6	4.9	4.3	3.8	F	2	5.1	4.5	3.9	3.4
M	3	6.4	5.7	5.0	4.4	F	3	5.8	5.2	4.5	4.0
M	4	7.0	6.2	5.6	4.9	F	4	6.4	5.7	5.0	4.4
M	5	7.5	6.7	6.0	5.3	F	5	6.9	6.1	5.4	4.8
M	6	7.9	7.1	6.4	5.7	F	6	7.3	6.5	5.7	5.1
M	7	8.3	7.4	6.7	5.9	F	7	7.6	6.8	6.0	5.3
M	8	8.6	7.7	6.9	6.2	F	8	7.9	7.0	6.3	5.6
M	9	8.9	8.0	7.1	6.4	F	9	8.2	7.3	6.5	5.8
M	10	9.2	8.2	7.4	6.6	F	10	8.5	7.5	6.7	5.9
M	11	9.4	8.4	7.6	6.8	F	11	8.7	7.7	6.9	6.1
M	12	9.6	8.6	7.7	6.9	F	12	8.9	7.9	7.0	6.3
M	13	9.9	8.8	7.9	7.1	F	13	9.2	8.1	7.2	6.4
M	14	10.1	9.0	8.1	7.2	F	14	9.4	8.3	7.4	6.6
M	15	10.3	9.2	8.3	7.4	F	15	9.6	8.5	7.6	6.7
M	16	10.5	9.4	8.4	7.5	F	16	9.8	8.7	7.7	6.9
M	17	10.7	9.6	8.6	7.7	F	17	10.0	8.9	7.9	7.0
M	18	10.9	9.8	8.8	7.8	F	18	10.2	9.1	8.1	7.2
M	19	11.1	10.0	8.9	8.0	F	19	10.4	9.2	8.2	7.3
M	20	11.3	10.1	9.1	8.1	F	20	10.6	9.4	8.4	7.5
M	21	11.5	10.3	9.2	8.2	F	21	10.9	9.6	8.6	7.6
M	22	11.8	10.5	9.4	8.4	F	22	11.1	9.8	8.7	7.8
M	23	12.0	10.7	9.5	8.5	F	23	11.3	10.0	8.9	7.9
M	24	12.2	10.8	9.7	8.6	F	24	11.5	10.2	9.0	8.1
M	25	12.4	11.0	9.8	8.8	F	25	11.7	10.3	9.2	8.2
M	26	12.5	11.2	10.0	8.9	F	26	11.9	10.5	9.4	8.4
M	27	12.7	11.3	10.1	9.0	F	27	12.1	10.7	9.5	8.5
M	28	12.9	11.5	10.2	9.1	F	28	12.3	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)											
BOYS						**GIRLS**					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.9
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	9.0
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.1
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.3
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.4
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.5
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.6
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.7
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.8
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.9
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	10.1
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)*									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	0	2.9	2.5	2.1	F	0	2.8	2.4	2.0
M	1	3.9	3.4	2.9	F	1	3.6	3.2	2.7
M	2	4.9	4.3	3.8	F	2	4.5	3.9	3.4
M	3	5.7	5.0	4.4	F	3	5.2	4.5	4.0
M	4	6.2	5.6	4.9	F	4	5.7	5.0	4.4
M	5	6.7	6.0	5.3	F	5	6.1	5.4	4.8
M	6	7.1	6.4	5.7	F	6	6.5	5.7	5.1
M	7	7.4	6.7	5.9	F	7	6.8	6.0	5.3
M	8	7.7	6.9	6.2	F	8	7.0	6.3	5.6
M	9	8.0	7.1	6.4	F	9	7.3	6.5	5.8
M	10	8.2	7.4	6.6	F	10	7.5	6.7	5.9
M	11	8.4	7.6	6.8	F	11	7.7	6.9	6.1
M	12	8.6	7.7	6.9	F	12	7.9	7.0	6.3
M	13	8.8	7.9	7.1	F	13	8.1	7.2	6.4
M	14	9.0	8.1	7.2	F	14	8.3	7.4	6.6
M	15	9.2	8.3	7.4	F	15	8.5	7.6	6.7
M	16	9.4	8.4	7.5	F	16	8.7	7.7	6.9
M	17	9.6	8.6	7.7	F	17	8.9	7.9	7.0
M	18	9.8	8.8	7.8	F	18	9.1	8.1	7.2
M	19	10.0	8.9	8.0	F	19	9.2	8.2	7.3
M	20	10.1	9.1	8.1	F	20	9.4	8.4	7.5
M	21	10.3	9.2	8.2	F	21	9.6	8.6	7.6
M	22	10.5	9.4	8.4	F	22	9.8	8.7	7.8
M	23	10.7	9.5	8.5	F	23	10.0	8.9	7.9
M	24	10.8	9.7	8.6	F	24	10.2	9.0	8.1
M	25	11.0	9.8	8.8	F	25	10.3	9.2	8.2
M	26	11.2	10.0	8.9	F	26	10.5	9.4	8.4
M	27	11.3	10.1	9.0	F	27	10.7	9.5	8.5
M	28	11.5	10.2	9.1	F	28	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	29	11.7	10.4	9.2	F	29	11.1	9.8	8.8
M	30	11.8	10.5	9.4	F	30	11.2	10.0	8.9
M	31	12.0	10.7	9.5	F	31	11.4	10.1	9.0
M	32	12.1	10.8	9.6	F	32	11.6	10.3	9.1
M	33	12.3	10.9	9.7	F	33	11.7	10.4	9.3
M	34	12.4	11.0	9.8	F	34	11.9	10.5	9.4
M	35	12.6	11.2	9.9	F	35	12.0	10.7	9.5
M	36	12.7	11.3	10.0	F	36	12.2	10.8	9.6
M	37	12.9	11.4	10.1	F	37	12.4	10.9	9.7
M	38	13.0	11.5	10.2	F	38	12.5	11.1	9.8
M	39	13.1	11.6	10.3	F	39	12.7	11.2	9.9
M	40	13.3	11.8	10.4	F	40	12.8	11.3	10.1
M	41	13.4	11.9	10.5	F	41	13.0	11.5	10.2
M	42	13.6	12.0	10.6	F	42	13.1	11.6	10.3
M	43	13.7	12.1	10.7	F	43	13.3	11.7	10.4
M	44	13.8	12.2	10.8	F	44	13.4	11.8	10.5
M	45	14.0	12.4	10.9	F	45	13.6	12.0	10.6
M	46	14.1	12.5	11.0	F	46	13.7	12.1	10.7
M	47	14.3	12.6	11.1	F	47	13.9	12.2	10.8
M	48	14.4	12.7	11.2	F	48	14.0	12.3	10.9
M	49	14.5	12.8	11.3	F	49	14.2	12.4	11.0
M	50	14.7	12.9	11.4	F	50	14.3	12.6	11.1
M	51	14.8	13.1	11.5	F	51	14.5	12.7	11.2
M	52	15.0	13.2	11.6	F	52	14.6	12.8	11.3
M	53	15.1	13.3	11.7	F	53	14.8	12.9	11.4
M	54	15.2	13.4	11.8	F	54	14.9	13.0	11.5
M	55	15.4	13.5	11.9	F	55	15.1	13.2	11.6
M	56	15.5	13.6	12.0	F	56	15.2	13.3	11.7
M	57	15.6	13.7	12.1	F	57	15.3	13.4	11.8
M	58	15.8	13.8	12.2	F	58	15.5	13.5	11.9
M	59	15.9	14.0	12.3	F	59	15.6	13.6	12.0
M	60	16.0	14.1	12.4	F	60	15.8	13.7	12.1

Initial Assessment Worksheet

Day 2 Session 15

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

No.	Date of Survey	Child's Name	Sex (M/F)	Caregiver's Name	DOB (dd/mm/yyyy)	Age (Months)	Birth Order	Odema (Y or N)	Weight (kg)	Nutritional Status (Indicate Colour)	MUAC (<115mm) (Green, Yellow, Red)	Wealth Rank (Poor, Non-Poor)	Classification (PD, ND, NPD)	PDI HHs
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														
21														
22														

Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Child's Age	**Foods given,** including breastmilk and other liquids (name or pictures)	**Amounts** (bowl, cup, can, fist, spoonful)	**Frequency** (daily, weekly, rarely)	**Food taboos** (forbidden foods)	**Comments** Why?
Newborn					
0–5 months					
6–8 months					
9–11 months					
12–23 months					
≥24 months					
When child is sick					
When recovering					

Market Survey for PD/Hearth (Cost Variance)

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW						
	Units of Smallest Quantity Purchased	High Season (Months)	Cost during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Cost during Low Seasons ( )	Cost per 100 gram*

* NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Market Survey for PD/Hearth (Quantity Variance)

World Vision

HANDOUT 16.2B

Day 2 Session 16

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW							
	Cost of Smallest Quantity Purchased	High Season (Months)	Quantity during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Quantity during Low Seasons ( )	Cost per 100 gram*

NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Seasonal Calendar for PD/Hearth

World Vision

Day 2 Session 16

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Items (e.g. foods available, diseases, etc.)	MONTHS												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	

(Participants are to create their own questions and guidelines for use in the field visit.)

House Visits

1. Be wise; respect the family.
2. Don't ask why they are poor.
3. Point out that you are here to learn, not to criticise.
4. Introduce yourself, congratulate the family on its good work, and ask permission to observe.
5. Make sure the information collected regarding child information (e.g. age, birth order, wealth ranking, etc.) is correct to ensure the child is a PD child.
6. Spend two to three hours in each PD house. It is good to go during a meal time to observe the child's feeding practices, but ensure you do not disturb the family.
7. Try to engage both the caregiver and grandmother (if present) while conducting the visit.
8. Conduct a 24-hour diet recall on the food the child ate yesterday. Fill out form.

24-Hour Dietary Recall Question Guide

1. What is the first thing the child ate yesterday after waking up?
2. How much did you give (of each feed)? How much of it did the child eat? Can you show me the bowl the child used?
3. How did you prepare the food? Fried? Boiled? Steamed?
4. What did you add? Any oil? Vegetables?
5. Did the child eat anything else?
6. Did the child drink anything?
7. What is the next time the child ate? What? How much? How prepared? What else did the child eat?
8. Did the child get anything else between first and second meal? And between second and last meal? (Note: food quantity, frequency and consistency).

Good Food/Feeding

1. Is the child breastfeeding? If not, at what age did the mother wean the child?
2. What foods is the child being fed today?
3. Who decides what the child will eat? What role do other family members play in child feeding decisions?
4. How many times did you see the child eat or drink?
5. Where does the family buy food? Who buys the food? How much money is spent on food each day?
6. How many meals and snacks does the child eat a day?
7. Are there any foods the caregiver does *not* give the child?

Sample Guiding Questions for Conducting a PDI

Good Child Care (try to observe without asking)

1. Who is the primary caregiver of the child?
2. What roles do other family members play in caring for the child?
3. Who is in the house during the day?
4. Does the caregiver take the child to the vaccination post? How often? Is the child on schedule?
5. Does the caregiver or others play with the child? How? How often?
6. How is the child disciplined? By whom?
7. What does the caregiver do to encourage the child to eat if he or she doesn't want to?

Good Health Care (ask for health card, ask caregiver questions)

1. How do you know when your child is sick?
2. Was the child sick in the past six months? If so, how many times?
3. What illnesses has the child had?
4. When the child was sick, what did you do? Did you feed the child anything differently?
5. What steps do you take to prevent illnesses?

Good Hygiene (observe body, food and environment)

1. Is the house clean? Is the kitchen clean?
2. Are the people clean?
3. If there is a latrine, how does it look?
4. Make observations about the water source.
5. Do pigs, mules, dogs or other animals go in and out of the house?

Questions	Remarks
Personal Hygiene	
Wash hands before/after?	
Plates washed?	
Nails	
Shoes	
Clothes	
Food preparation	
Handwashing (Check for soap and running water)	
Washing the food before cutting or cooking	
Food/water covered (before and after cooking)	
Household measures used (e.g. size of cup, spoon sizes, do they use fist sizes?)	
Home Environment	
Food availability (gardens)	
Animals present (cage, play with children?)	
Storage facilities (for water, food)	
Household waste management	
Toilets (cleanliness, distance, type)	
Water (boiled/filtered, distance, source)	
Interaction between caregiver and child	
Loving and caring behaviour	
Playing with the child	
Feeding Practices	
Does child pick up food from ground and eat it?	
Do you help the child to eat and watch child eating?	
Amount of food the child is eating?	
How many times do you feed per day?	
Feeding Practices **Health Seeking Practices**	
Do you see any ORS packets?	
Do you see an ITN? Is it in good condition?	
Do you feed the child differently when the child is sick (e.g. more or less food; more or less liquid; feed more frequently)?	

Results and Observations from the PDI

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

PD Food/Feeding		**Non-PD Food/Feeding**	
PD Caring		**Non-PD Caring**	
PD Hygiene		**Non-PD Hygiene**	
PD Health Seeking		**Non-PD Health Seeking**	

Arrival of caregivers and children/attendance

- Volunteer gives positive reinforcement for good hygiene.
- Volunteer asks how things are going at home – troubleshoot and share observations.

Collect food contribution

Discuss:

- Cost and sources of nutritious food
- Food variety, healthy choices
- Safety of food, proper storage
- Where foods can be found, gathered
- Food production/home gardens

Hand washing/hygiene

Discuss:

- Modelling proper hand-washing technique
- Use of soap
- Times when hand-washing is important
- Reason to wash hands: bacteria/germs contribute to illness/diarrhoea
- Treatment of diarrhoea/illness, when to seek health care
- Immunisation, deworming
- Nail cutting
- Orientation to personal hygiene
- Latrine use
- Use of shoes

Snack

Discuss:

- Frequency of snacks and meals
- Why to feed children four to five times a day
- Healthy snacks that require little or no preparation
- Consistency of food
- Food groups and nutritional value of food
- Including a variety of food in a day
- Breastfeeding
- Food storage

Cooking the menu

Discuss:

- Nutritional value of food
- Sources of affordable food: food production/home gardens, barter, collecting wild fruits
- Variety of food
- Good cooking techniques
- Food hygiene and safety, storage
- Promoting thick consistency of food
- Palatability and appetising appearance
- Importance of feeding children four to five times a day
- Hearth is an extra meal

Child stimulation/play

Discuss:

- Modelling play and care of children
- Motor-skill development
- Cognitive development
- New ways to stimulate children – singing, dancing, clapping games, etc.
- Social skills/sharing/cooperation
- Appropriate touching/affection

Feeding children

Discuss:

- Active, responsive feeding
- Content of foods (colours, nutrients)
- PD foods and why they are good
- Importance of meal frequency (four to five times a day)
- Breastfeeding
- Portion sizes
- Troubleshooting feeding problems
- Food taboos
- Stimulating a child's appetite

Planning for the next day

Discuss:

- Local and affordable foods, including the PD foods.
- Quantity of food
- Food combinations – variety, colour
- Nutrient value of food – importance of variety
- Where to find foods
- Planning menus and budgets

Cleaning up

Discuss:

- Hygiene – clean surfaces and utensils
- Use of leftovers
- Food safety
- Food storage
- Reuse water, compost
- Latrine use and cleanliness

Calories: **600–800 (500–600*)**

Protein: **25–27g (18–20g*)**

Vitamin A: **300 µg RAE (RAE=retinol activity equivalent)**

Iron: **8–10mg**

Zinc: **3–5mg**

Vitamin C: **15–25mg**

*Amounts in parentheses are the minimum for a region with food insufficiency; recuperation will take longer with these amounts (see CORE PD/Hearth Guide, p. 114).

Note: *The vitamin A requirement has been updated since the publication of the CORE PD/Hearth Guide and PD/Hearth Addendum to use the currently accepted measure of Retinol Activity Equivalents (RAE). Make sure that the food composition tables you use lists vitamin content as µg RAE, not RE or IU (conversion rate: 1 µg RAE = 3.3 IU).*

Directions for the Menu-Preparation Exercise

Each group can go to the 'market area' (where the food and utensils are laid out) and take different foods for its menu. The menu includes one snack as well as the meal:

- Take the amount you think a small child would eat. Remember that a child's stomach is no larger than the child's fist.
- Note the cost per gram of the food you take.
- After weighing your group's choices, put the foods on a plate.
- Use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the CORE PD/Hearth Guide, page 116, which discusses how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Calculate the cost per gram used of each ingredient. Then add up the total cost of the menu for one child.
- Using common household measures, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.
- Convert the cooked amount of food to a raw amount. For rice, divide the cooked volume by 2 to get the uncooked measure. For example, 60g of cooked rice divided by 2 equals 30g of uncooked rice.

Conversion of cooked food in grams to raw food in grams:

Cooked rice, divide by 2

Cooked beans, lentils, pulses, divide by 2

Cooked porridge, divide by 2.5

Cooked green leaves, multiply by 1.4

- Change the gram amounts to household measures by measuring the quantity of each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.).
- For example, weigh out 30g of uncooked rice and put it into a cup that would be found in households or measure it by the handful, if that is more common.
- Write the household measure for each food on the calculation sheet.
- Each caregiver or caregiver-grandmother pair will contribute this amount of raw ingredients for their child(ren) at each Hearth session.
- When satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form to display with the plate.

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
1. Grains, Roots, and Tubers								
Cassava, boiled	165	1.2	1	13	1.4	0.2		1
Cassava, dried, raw	351	2.1	2	68	3.8	0.8		1
Cassava, raw	157	1.1	1	31	1.7	0.2		1
Maize flour, whole grain, yellow	361	6.93	11	0	2.4	1.7		5
Maize or Sorghum Ugali	110.3	3	2.1	0	1.3	0.5		7
Maize, white, whole, boiled	139	3.5	1	2	1.2	0.5		1
Maize, white, whole, dried, raw	363	9.2	3	8	3.2	1.4		1
Maize, yellow, boiled	136	3.6	35	1	1.6	0.6		1
Maize, yellow, dried, raw	354	9.4	101	4	4.2	1.7		1
Millet flour	373	10.75	0	0	3.9	2.6		5
Millet, whole grain, boiled	144	4.1	0	0	6.4	0.6		1
Potato, boiled	74	1.8	2	11	0.8	0.3		1
Rice Flake, water soaked	356	1.1	0	0	2.0	0.4		9
Rice noodle (mee suah)	320	9.10	0	0	1.6	0.7		10
Rice noodle, fermented	106	1.40	0	0	0.1	0.2		10
Rice steamed, white	131	2.20	0	0	0.4	0.6		10
Rice, brown, boiled	135	3	0	0	0.7	0.7		1
Rice, white, boiled	133	2.8	0	0	1.0	0.4		1
Rice, white, fried	370	6.81	0	0	1.6	1.2		10
Rice, white, raw	355	6.80	0	0	1.2	0.5		10
Rice, white, soaked	370	6.81	0	0	1.6	1.2		10
Sorghum flour	361	7.87	0	0	3.0	1.4		5
Sorghum, whole grain, boiled	153	4.6	2	0	3.6	0.6		1
Steamed sticky rice (white), grilled	229	4.60	0	0	0.1	0.2		10
sticky rice (white), steamed	229	4.60	0	0	0.3	1.0		10
Sweet Potato, boiled	101	1.7	789	15	1.7	0.3		1
Taro, boiled	100	1.9	4	3	0.9	0.2		1
Wheat flour, white	347	10.7	0	0	2.0	4.0		1
Wheat noodle (waiwai), instant	456	10.5	0	0	1.6	1.8		10
Yam, boiled	101	1.7	2	5	1.0	0.2		1
2. Legumes and Nuts								
Beans, kidney, boiled without salt	127	8.67	0	1	2.2	1.0		5
Beans, raw	32	2.4	54	18	1.0	0.3		1
Beans, yellow, cooked, boiled without salt	144	9.16	0	2	2.5	1.1		5
Cashewnut, raw	589	20	0	0	6.4	4.6		7
Chickpea, boiled without salt	164	8.86	1	1	2.9	1.5		5
Chickpea, dry	364	19.3	3	3	6.2	3.4		5
Coconut water	22	0.3	0	2	0.1	0.1		1
Coconut, mature, fresh, raw	387	3.2	0	2	2.5	0.9		1
Cowpea, Leafy tips, boiled and drained	22	4.67	29	18	1.1	0.2		5
Cowpea, seeds, black, dried, boiled	116	7.73	2	0	2.5	1.3		10
Groundnut, dried, raw	578	24.1	2	1	4.3	1.9		1
Groundnut, dried, roasted (also gnut flour)	567	25.8	0	0	4.6	1.7		6
Groundnut, fresh, boiled	236	10.8	0	0	1.9	1.0		6
Groundnut, fresh, roasted	374	17	0	0	3.0	1.1		6
Groundnut, seeds, dried, raw	577	24.8	0	1	2.3	2.8		1

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
2. Legumes and Nuts (continued)								
Lentils, boiled without salt	116	9.02	0	2	3.3	1.3		5
Lentils, raw	353	25.8	0	0	7.5	4.8		5
Mongogo Nut, Bok Nut	659	26.00	0	0	3.7	4.0		
Mung Bean, boiled without salt	105	7.02	1	1	1.4	0.8		5
Mung Bean, dried	324	22	19	0	8.0	0.8		2
Soya bean, boiled without salt	173	16.64	0	2	5.1	1.2		5
Soya bean, dried, raw	397	33.2	9	0	8.3	4.7		1
Soya bean, dry roasted	451	39.58	0	5	5.0	4.8		5
Soya bean, roasted without salt	471	35.22	0	2	3.9	3.1		5
3. Dairy Products (milk, yoghurt, cheese)								
Breastmilk, human, mature, raw	69	1.1	62	1	0.2	0.3		1
Milk UHT, Thaidenmark brand (non-fortified)	67	3.30	41	0	0.1	0.3		10
Milk, cow, powder, whole	492	25.3	295	12	0.7	4.0		1
Milk, cow, whole, raw	75	3.7	39	2	0.1	0.4		1
Milk, goat, whole, raw	69	3.4	35	2	0.1	4.0		1
Milk, instant, Anmum brand (fortified)	77	3.20	93	22	2.6	2.2		10
Yoghurt, drinking, foremost brand	84	1.50	14	3	0.1	0.3		10
Yoghurt, wholemilk, natural	75	3.5	33	1	0.1	4.0		1
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats)								
Anchovy (small fish), fillet, raw	123	18.4	15	0	3.3	1.7		1
Anchovy, fillet, grilled	668	27.6	20	2	3.8	2.5		1
Anchovy, fillet, steamed	542	22.4	16	2	2.9	2.1		1
Beef ball, blanched	84	16.5	7	1	5.0	0.0		10
Beef internal organ barbecue	94	14.0	2357	9	5.0	2.0		10
Beef intestine, raw	109	16.4	10	0	3.1	2.0		10
Beef liver, grilled	133	20.3	3841	18	10.1	3.9		10
Beef liver, pan-fried	175	26.52	7744	1	6.2	5.2		5
Beef liver, raw	135	20.36	4968	1	4.9	4.0		5
Beef lung, raw	84	16.0	95	6	6.1	1.7		10
Beef spleen, raw	95	18.2	103	29	0.7	2.1		10
Beef stomach, raw	102	11.0	0	0	1.9	1.3		10
Beef, blanched	150	20.0	2	0	3.0	5.0		10
Beef, dried, grilled	479	38.3	3	0	11.8	3.9		10
Beef, dry, fried	479	38.3	3	0	11.8	3.9		10
Beef, grilled	190	38.5	3	0	4.9	7.6		10
Beef, ground, 20% fat, pan-broiled	246	24.04	0	0	3.6	6.1		5
Beef, ground, 20% fat, raw	254	17.17	0	1	1.9	4.2		5
Beef, raw	273	17.2	3	0	2.3	5.3		10
Chicken, roasted	210	23.8	0	0	0.8	1.5		10
chicken gizzard, raw	102	20.2	34	3	3.1	3.2		10
Chicken heart	112	15.8	75	6	4.0	5.5		10
Chicken Liver	114	16.9	3296	18	9.0	2.5		9
Chicken liver, boiled	121	18.6	3178	14	7.3	3.2		10
Chicken liver, grilled	121	18.6	3273	14	7.3	3.1		10
Chicken liver, raw	121	18.6	3710	14	7.3	3.0		10
Chicken, boiled	193	28.6	5	1	0.6	1.0		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats) (continued)								
Chicken, cooked	285	26.9	39	0	1.4	1.8		6
Chicken, flesh only, raw	136	20.6	10	0	1.2	1.0		1
Chicken, raw	186	17.3	3	0	0.5	1.0		10
Cricket	127	12.90	0	0	9.5	0.0		11
Dried small fish *(usipa)*, cooked with salt	125	17	0	0	3.3	9.1		6
Duck, roasted	373	18.5	115	0	1.3	2.1		10
Fermented fish with bone	103	13.3	3	0	5.5	3.6		10
Fermented fish, sour, fried	108	19.5	1	0	2.1	2.4		10
Frog legs, raw	73	16.40	15	0	1.5	1.0		5
Lamb, composite of retail cuts, cooked	256	24.54	0	0	1.9	4.7		5
Lamb, meat, raw	217	17.2	10	0	2.3	3.1		1
Mackerel, Pacific and jack, cooked dry heat	201	25.73	23	2	1.5	0.9		5
Mackerel, raw	133	21.1	16	2	1.8	0.5		1
Mussels, boiled	33	3.1	208	0	2.9	1.9		2
Mutton/Lamb Liver	150	19.3	8250	20	6.3	4.0		9
Nile tilapia fish, raw	96	20.1	0	0	0.6	0.3		10
Nile tilapia, roasted	128	26.2	0	0	0.7	0.4		10
Pork blood, boiled	32	7.90	26	0	25.9	0.1		10
Pork liver, grilled	125	19.2	4242	19	15.5	5.3		10
Pork liver, raw	125	19.2	6291	25	15.5	5.6		10
Pork sausage, grilled	369	19.6	14	2	1.2	2.5		10
Pork skin, raw	320	19.8	6	0	2.1	0.3		10
Pork spleen, raw	87	16.1	241	26	1.0	2.3		10
Pork, boiled	204	33.0	0	0	1.5	1.3		10
Pork, fresh, cooked	201	27.51	1	0	1.0	0.1		5
Pork, grilled	249	26.2	0	0	2.5	1.8		10
Pork, meat, approx. 24% fat, raw	289	14.5	0	0	2.0	3.2		1
Pork, meat, approx. 40% fat, raw	405	12.6	0	0	1.9	3.2		1
Pork, raw	116	21.8	0	0	1.0	1.0		10
Pork, shreded, chinese style	357	43.1	0	0	17.8	1.3		10
Prawns or shrimps, cooked in moist heat	119	22.78	0	0	0.3	1.6		5
Rabbit, meat, raw	142	20.7	10	0	0.9	1.7		1
Rabbit, stewed	206	30.38	0	0	2.4	2.4		5
Short bodied mackerel fried	236	25.7	26	2	2.4	1.0		10
Short bodied mackerel, roasted	122	21.4	27	5	1.4	0.6		10
Siamese mud carp, grilled	124	21.1	9	1	0.6	1.5		10
Snail, pond, river	74	12.10	0	0	8.7	0.0		11
Tilapia, cooked dry heat	128	26.15	0	0	0.7	0.4		5
5. Eggs								
Egg, duck, whole, boiled	150	11.8	169	0	3.4	1.2		10
Egg, hardboiled	155	12.58	149	0	1.2	1.1		5
Egg, hen, whole	159	13.2	160	0	2.8	1.1		10
Egg, hen, whole, boiled	170	13.9	164	0	3.5	1.2		10
Egg, raw	139	12.1	207	0	2.4	1.3		1
Hen egg, fried	196	13.6	219	0	1.9	1.4		10
Omelet duck egg	183	12.6	365	0	3.2	1.0		10
Omelet hen egg	259	7.00	255	0	2.2	1.6		10

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
6. Vitamin-A Rich Fruits and Vegetables								
Amaranth, boiled	21	2.11	139	41	2.3	0.9		5
Bean leaves, fresh, cooked with salt	14	1.4	192	12	1.1	0.1		6
Carrot, boiled	33	0.9	1137	3	0.7	0.6		1
Carrot, raw	35	1	1201	7	0.9	0.8		1
Cassava, fresh leaves, cooked with salt	20	2	261	12	1.6	0.6		6
Cassava, fresh leaves, raw	98	0.9	1733	370	5.6	5.0		1
Chinese cabbage blanched	21	1.70	244	33	1.6	0.2		10
Dark Green Leaves, fresh	48	5	950	100	4.0	0.8		2
Dark Green Leaves, fresh, cooked with salt	18	1.1	401	17	0.5	0.1		6
Green amaranth, small, blanched	21	2.11	278	41	2.3	0.9		10
Green amaranth, small, fresh	35	3.60	510	49	3.1	1.2		10
Horse tamarind, young leaves	85	9.20	255	7	3.4	0.6		10
Mango, ripe, fruit, raw	62	0.6	427	35	1.0	0.6		1
Moringa leaves, boiled	91	8.8	699	0	4.8	0.7		1
Moringa leaves, raw	86	8.3	738	0	6.1	0.9		1
Morning glory/Swamp cabbage, blanched	20	2.08	520	16	1.3	0.2		10
Morning glory/Swamp cabbage, fresh	31	2.90	457	28	3.3	0.5		10
Mustard green blanched	19	2.27	708	14	1.1	0.2		10
Mustard green, fermented, sour	21	1.50	161	20	1.3	0.2		10
Mustard green, stem and leaves, boiled	22	1.70	249	43	1.5	0.1		10
Mustard leaves, fresh, cooked with salt	16	1.1	213	0	1.0	0.4		6
Mustard, fresh	28	2.20	317	57	2.5	0.2		10
Okra, leaves, cooked with salt	12	0.7	260	11	0.3	0.7		6
Papaya (paw paw), fruit, ripe, raw	38	0.5	355	59	0.7	1.4		1
Pumpkin, boiled	20	0.5	201	5	0.2	0.2		6
Pumpkin, fresh leaves, boiled	11	0.6	298	11	0.5	0.4		6
Pumpkin, mature, fresh	49	1.30	170	15	0.7	0.9		10
Pumpkin, raw	36	1	250	15	0.8	0.2		2
Squash, raw	47	0.4	240	1	0.3	0.2		2
Squash, winter, all varieties, cooked without salt	37	0.89	261	10	0.4	0.2		5
Tamarind, young leaf, fresh	68	3.80	381	32	1.5	0.5		10
Taro, leaves, cooked without salt	24	2.72	212	36	1.2	0.2		5
Taro, young leaves, raw	30	2.4	389	52	2.0	0.4		1
Wildbetal Leafbush	60	4.20	258	17	4.2	1.0		10
7. Other Fruits and Vegetables								
Apple, prink, fresh	63	0.50	14	2	0.2	0.0		10
Avocado, raw	149	1.6	20	16	1.1	0.6		1
Bamboo shoots, cooked, boiled, with salt	11	1.53	0	0	0.2	0.5		5
Bamboo shoots, cooked, boiled, without salt	12	1.53	0	0	0.2	0.5		5
Banana, flowers, fresh	38	1.60	34	10	1.1	0.3		10
Banana, ripe, raw	100	1.3	19	10	1.0	1.1		1
Banana, ripe, yellow	105	1.00	15	12	0.4	0.1		10
Banana, ripe, yellow, boiled	105	1.00	13	10	0.4	0.1		10
Bean sprouts, fresh	46	4.30	5	23	1.4	0.5		10
Cabbage, blanched	29	1.50	8	32	1.0	0.3		10
Cabbage, boiled	19.8	1.3	11	21	0.4	0.2		1
Cabbage, common, fresh	29	1.50	8	32	1.0	0.3		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Cabbage, raw	26	1.6	10	54	0.6	0.2		1
Cauliflower, boiled	28	2.7	1	47	0.8	0.4		9
Chayote, boiled	21	0.60	6	10	0.4	0.3		10
Chayote, fruit, fresh	21	0.60	6	10	0.4	0.7		10
Chilli pepper, hot, red, fresh	75	3.00	156	142	1.2	0.4		10
Cilantro	23	2.13	337	27	1.8	0.5		2
Coriander, fresh	33	2.50	431	34	2.6	0.2		10
Cucumber, fresh	23	0.80	9	12	0.4	0.2		10
Cumcumber	95.5	0.7	3	0	0.5	0.2		1
Dill, fresh	34	3.10	201	40	2.3	0.7		10
Eggplant, boiled without salt	35	0.83	2	1	0.3	0.1		5
Eggplant, raw	28	1.1	12	6	0.9	1.6		1
Eggplant/brinjal, green, fresh	37	1.50	10	8	0.9	0.2		10
Fennel common leaves, fresh	42	2.50	867	23	2.3	0.2		10
Fig, raw	78	1.4	79	15	6.0	1.5		1
Garlic, fresh	51	2.10	0	10	0.7	0.4		10
Garlic, raw	136	6.1	0	18	1.5	0.6		1
Ginger, raw	72	1.9	0	5	1.1	0.4		9
Guava, fruit, raw	58	1	95	281	1.4	1.8		1
Hairy basil, fresh	39	2.80	279	18	2.1	0.6		10
Jackfruit, raw	94	1.7	18	9	0.6	0.1		2
Lemon grass, fresh	78	0.80	3	1	2.0	0.5		10
Lemon, fruit, raw	36	0.7	2	46	0.6	0.1		1
Lemon, juice	29	1.1	3	53	0.6	0.1		4
Light/Pale Green Leaves, fresh	23	1.5	47	40	0.5	0.8		2
Mango, unripened, fruit, raw	55	0.5	10	86	1.4	0.6		1
Mint, leaf	42	2.90	467	84	4.1	0.8		10
Mushrooms, portabella, grilled	29	3.28	0	0	0.4	0.7		5
Okra, fresh, boiled	21	1.1	38	5	0.8	0.4		6
Okra, fresh, raw	31	1.7	72	29	0.9	3.0		1
Onion	50	1.60	0	8	0.7	0.2		10
onion, cooked	44	1.36	0	5	0.2	0.2		5
Onion, raw	32	1.1	1	7	0.5	0.2		1
Orange, raw	45	0.8	17	47	0.1	0.1		1
Orange, sweet, fresh	52	0.50	6	65	0.4	0.7		10
Pak kha yeng, raw	32	1.50	18	5	5.2	1.0		10
Passion Fruit	94	2.4	64	17	1.2	0.0		3
Pineapple, raw	56	0.4	15	31	0.5	2.2		1
Pomelo (grapefruit), raw	34	0.8	40	44	0.6	0.1		4
Radish, boiled	24	1.2	0	9	0.5	0.4		9
Radish, raw	18	0.9	0	17	0.4	0.4		9
Rumbutam, fresh	69	0.90	0	43	0.7	0.1		10
Shallot, bulb	67	1.70	1	9	0.9	0.3		10
Spring onion, fresh	44	2.20	475	42	2.3	0.4		10
Star fruit	32	0.60	10	29	0.7	0.0		11
Tamarind, fruit, raw	60	2.2	2	10	0.7	0.0		1
Tiliacora triandra diels	95	5.60	329	141	7.0	0.6		10

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Tomato, fresh	25	1.00	88	29	0.9	0.2		10
Tomato, raw	21	1	127	29	0.9	12.0		1
Tomato, red, ripe, cooked	18	0.95	24	23	0.7	0.1		5
Watermelon, fruit, raw	30	0.5	62	7	0.2	0.1		1
Yard long bean, green, fresh	40	2.60	41	20	0.8	0.5		10
8. Fats and Oils								
Butter, cow's milk	700	1	1060	0	0.2	0.1		1
Coconut oil	900	0	0	0	1.5	0.0		1
Ghee, cow	898	0	0	0	0.2	0.0		9
Groundnut oil	903	0	0	0	0.0	0.0		1
Mustard oil	900	0	0	0	0.0	0.0		9
Palm oil	895	0	0	0	0.4	0.0		1
Vegetable oil	884	0	0	0	0.0	0.0		4
9. Miscellaneous								
Fermented fish, liquid	13	1.20	3	0	2.9	0.1		10
Fish souce	48	5.40	5	1	2.4	0.2		10
Honey	322	0.3	0	2	0.6	2.0		1
Horse tamarind, seeds	152	11.8	34	2	4.3	1.4		10
Jaggery	383	0.4	160	0	11.1	0.0		8
Lemon, juice, fresh	24	0.50	1	25	0.1	0.1		10
Oyster sauce	73	2.90	6	7	1.1	0.1		10
Pumpkin seeds, without shell, roasted	594	25.6	0	0	6.0	8.0		11
Salt	0	0	0	0	0.3	0.1		5
Sesame seeds, white, roasted	682	26.1	0	0	13.0	7.2		10
Shrimp paste	85	4.60	21	0	2.2	1.1		10
Sprinkles (per sachet)	0	0	300	30	12.5	5.0		8
Sugar (white), not fortified	369	0	0	0	0.2	0.1		1
Tumeric, dried	335	6.9	1	0	33.2	3.8		9
Vinegar	27	0.2	0	0	0.5	0.0		1
10. Additional Foods								
Banana Porridge	105.3	0.6	65.6	9	0.4	0.1		7
Cassava Stiff Porridge	140	2.7	1.4	7	1.2	0.6		7
Coconut juice, fresh	37	0.10	0	5	0.1	0.2		10
Coconut milk	185	1.90	0	2	0.6	0.5		10
Deep fried banana with powder	373	2.00	11	8	0.4	0.1		10
Maize Porridge (with oil)	414.4	16.9	0.6	1	5.6	2.6		7
Porridge, white rice, boiled	59	4.10	0	0	0.1	0.2		10
Soy milk, Lactasoy brand	82	2.50	40	0	0.4	0.1		10

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Menu A:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

Menu B:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

User Guide for the PD/Hearth Menu Calculation Tool

The PD/Hearth Menu Calculation Tool is developed to aid in designing low cost and nutrient-dense menus for Hearth sessions using local foods/ingredients that are easily accessible and available to community members. Based on the PDI findings and the market survey, 2-4 Hearth menus with a snack and a meal for each menu will be developed for each community using PD food(s) and locally sourced ingredients. To quickly rehabilitate children from malnutrition, Hearth menus need to meet optimal calorie and nutrient requirements[1]. Particularly, this Tool is useful in checking whether the meal and snack meet the requirements. Also it simplifies other calculations such as the total cost and quantity of ingredients required for all the children attending Hearth as these can be generated automatically.

The PD/Hearth Menu Calculation Tool has six tabs/worksheets: Introduction; Instructions; Master; Menu Day 1; Menu Day 2; Menu Day 3.

Tab 1 – Introduction: Contains a background information on the rationale for the Tool including who should be using this Tool and how it should be used.

Tab 2 – Instructions: Contains a step-by-step detailed guide on how to use the Master and Menu worksheets. Please refer to this worksheet as you design the Hearth menus.

Tab 3 – Master: Contains a Food Composition Table with the nutritional breakdown of 100 grams of edible portions of foods in terms of energy (Kcal), protein (g), Vitamin A RAE (mcg), Iron (mg) and Zinc (mg). The foods are categorised in 10 food groups: 1. Grains, roots, and Tubers; 2. Legumes and nuts; 3. Dairy products; 4. Flesh foods; 5. Eggs; 6. Vitamin A rich fruits and vegetables; 7. Other fruits and vegetables; 8. Fats and oils; 9. Miscellaneous; and 10. Additional foods (In cases where local food items are missing from this Master list, missing foods can be added to 'Additional foods' group by copying the energy and nutrient values from another food composition table).

Tab 4 – Menu Day 1: Contains a Menu Planning Form (calculates the menu requirements for ONE CHILD) and a table that allows automatic calculation of the cost and quantity of each ingredient required in the menu to feed 'X' number of children, depending on the number of participating children in Hearth sessions. The total cost of the menu for all children is also given.

Tabs 5 and 6 – Menu Day 2 and Day 3: Contains additional worksheets (same format as Menu Day 1) to create different menus. Most Hearth sessions should have at least 2 Hearth menus. You should consider changes in food availability or affordability at different seasons (e.g. dry vs. rainy season) when designing Hearth menus. For example, you may want to create a menu for each season. Also, you could inform caregivers of foods you could replace certain ingredients with so that they will be able to continuously use the Hearth menu to feed their children during various seasons.

Step-by-Step Instructions:

Based on the PDI findings and the market survey results, create Hearth menus.

1. (Master worksheet) Enter cost of each food in Cost for Raw Foods column identified from the market survey. Please note that cost should be entered per 100g of edible portion of the raw food (See Step 1 of the Instructions sheet for an example).

2. (Menu Day 1 worksheet) In the Menu Planning Form, use the drop down option to select the food group of choice and then use the drop down option to select the ingredient/food under the Food column, placing each ingredient under appropriate headings (i.e. Meal or Snack).

3. (Menu Day 1 worksheet) Enter quantity in grams for each ingredient under the Quantity (grams) column. Please note that this amount is 'cooked' values in grams that will be used in the menu for ONE child. See Step 3 of the Instructions sheet for how to estimate the amount of ingredient keeping in mind the cook/raw conversions.

4. (Menu Day worksheet) Repeat Step 2 and 3 for each food you will use. You can also enter the household measure for the ingredients for the raw amounts indicated in the Raw Quantity (grams) column.

5. (Menu Day worksheet) Once you finish entering all the ingredients/foods for the menu, you can check at the bottom of the Menu Planning Form to see whether you have met or exceeded the Hearth menu requirements.

    a. The total values for each nutrient, cost, and 'cooked' quantity of ingredients in the menu for one child are calculated automatically in the row number 36. Depending on the values displayed under each column, you may need to adjust quantity of each ingredient or select different ingredient to develop optimal Hearth menus.

    b. You can check by comparing the total values for each column against what is displayed in each column heading. Or, in the subsequent row, any discrepancies or differences between the total value of each nutrient in the menu and the amount of the same nutrient required in Hearth menu are available. If the menu meets all the nutrient requirements, then all the numbers in red/bracket will be "0". Try to adjust the quantities and/or types of foods included in the menu until you reach something very close to the required amount of nutrient.

    c. The values in red/bracket indicate that these nutrients need to be increased by adding foods/ ingredients that are high in these nutrients. For example, if the cell under the Iron column has "(3.50)", then you would need to increase amount of iron by 3.50 mg, by increasing quantity or adding iron rich foods like chicken or fish, still being mindful of the cost.

    d. Also the total quantity of 'cooked' foods should not be too much considering that a child has a small stomach (the size of a child's fist) and will not be able to eat a large volume of food at one sitting. Thus, depending on the total quantity (grams), you may need to select more nutrient dense food. For example, instead of selecting rice you may opt to select groundnut which will have more calories and proteins per gram basis.

6. (Menu Day worksheet) To calculate the total cost and quantity of ingredients required for the total number of children participating in Hearth sessions, enter the number of children who will be eating in a designated cell in the table below the Menu Planning Form chart. Also, determine a household measure for raw food amounts required for each ingredient from the Raw Quantity in grams column so that volunteers will know how much of uncooked ingredients will be needed for the Hearth menu. See Step 5 of the Instructions sheet for additional details.

1st case: Aisha is three years old, and an only child. After two Hearth sessions, she has gained 800 grams but is still moderately malnourished. Her mother, who is pregnant, appears to be following the new PD behaviours and working hard to rehabilitate Aisha, but she is becoming discouraged. The grandmother is taking care of Aisha during her pregnancy and advising her to continue feeding Aisha with what they learned at Hearth. The grandmother is confused that her daughter-in-law is discouraged and that the volunteers say that Aisha is still malnourished when she is looking very healthy, active and growing well.

2nd case: Tobir Village has many malnourished children, and Hearth sessions are proceeding well. However, some segments of the population are semi-nomadic, moving with the seasons to find work. Though these caregivers have been enthusiastic participants, it is difficult to follow their children during the dry season. Many return during the rainy season having lost weight again.

3rd case: Daniel is 23 months old. He and his mother (who also has two older children) just completed one Hearth session. His weight has not improved. The supervisor suspects, from her home visits, that the mother is preparing some extra food but sharing it with the whole family. The grandmother may support sharing the extra food with the entire family too.

4th case: During the sessions Budi gained 500 grams. By the end of the follow-up period he had lost the 500 grams.

Checklist of Materials Needed for PD/Hearth Sessions

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice,fufu, yams)			
Oil			
Other ingredients			

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 3	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 5	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

No.	DAY 7	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 9	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 10	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 11	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 12	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Child Registration and Attendance Form

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates (dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....
.....

#	Name of Child	Caregiver's Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Hearth Participant Child AND Primary Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Child Registration and Attendance Form (including Grandmothers)

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name/Grandmother Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Child and Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

#	**Attendance for Grandmother**											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Hearth Register and Monitoring Form

World Vision

Day 5 Session 32

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

Child's Name										
Caregiver's Name										
CHILD		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Child's Sex (M/F)										
Date of Birth (dd/mm/yyyy)										
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')										
At Day 1 of Hearth	Date (dd/mm/yyyy)									
	Weight (Kg)*									
	Underweight Nutritional Status(Indicate colour)									
	MUAC (Green, yellow, red < 115mm)									
At Day 12 of Hearth	Date (dd/mm/yyyy)									
	Weight (Kg)*									
	Weight Gain (Day 12 - Day 1) in grams									
	Underweight Nutritional Status (Indicate colour)									
	MUAC (Optional)									

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Hearth Register and Monitoring Form

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

	CHILD	1	2	3	4	5	6	7	8	9	10
At Day 30 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight gain (Month 1 - Day 1 weight) in grams										
	Gained 400g+ (Y/N)										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 3 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	Change in Status (Y/N)										
	MUAC (Optional)										
At 6 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 12 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
	CHILD	1	2	3	4	5	6	7	8	9	10
	COMMENTS (Explain reason for default if child has defaulted due to death (D), migration (M), referred to hospital (H), etc.)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Volunteer Home Visit Form

ADP Name ..... Village Name .....Caregiver's Name .....

Child's Name ..... Dates of Sessions.....Name of Hearth .....Volunteer .....

OBSERVATION LIST	Day #	Day #	Day #	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.							
Drinking water from safe source (borehole or protected well)							
Water is treated (Boiled/ chlorine)							
Water is covered with fitted cover or lid							
Clean separate cup is used for pouring drinking water from the pot							
Handwashing station exists (e.g. tippy tap)							
Jerry cans or water storage containers are clean							
Toilet/latrine is available and used or hole is dug and covered for defecation							
House and/or kitchen is clean							
Food utensils are clean							
Handwashing with running water and soap is practised by: Caregivers							
Children							
Other family members							
Food prepared is nutrient dense as learned in Hearth (includes all 3 food groups: protective, body building and energy foods)							
Size of portion served is age appropriate							
Caregiver actively feeds the child							
Child is offered more food after finishing first portion							
Caregiver says child is fed 4 - 5 times / day (including snacks)							
Child uses separate (own) plate, bowl, or cup							
Caregiver is motivated by changes in the child							
Yesterday night, mosquito net was used by the primary caregiver and all children U5 in the household							
Caregiver can say what to do when child is sick (example: feeds more liquid when child has diarrhea and feeds more frequently)							
Caregiver expresses being able to continue practising what was learned in Hearth at home							
Problems and questions about child feeding and care is discussed with the volunteer							

Supervision of PD/Hearth Session

Day 5 Session 32

Village Name ..... Hearth Name .....

Volunteer's Name(s) .....Today's Date.....

OBSERVATION LIST	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.				
Location of Session:				
Water is from safe source (borehole or protected well or protected spring)				
Water is treated (Boiled/ chlorine)				
Toilet/latrine available				
Handwashing station with soap exists (e.g. tippy tap)				
House is clean				
Food utensils are clean				
Session Is conducted by volunteers and/or lead mother				
Primary caregivers are assigned roles during Hearth				
Primary caregivers are the ones cooking the meal				
Primary caregivers can tell you how to cook Hearth menu for one child (using household measures)				
Number of caregivers attending				
Number of children attending				
Evidence of community participation/support				
Hand Washing is practised: by caregivers				
by children				
Number of caregivers who bring contribution to meal				
Menu used based on local and affordable food				
Menu is nutrient dense				
Food is prepared according to menu				
Consistency of Hearth meal is thick enough to slowly run on a spoon (not runny like water)				
Snack is given to children as the caregivers cook the Hearth meal				
Caregivers can recite different types of protective, body building and energy-giving foods				
Number of caregivers present and actively participating:				
in food preparation				
in child care				
in discussion of key messages				
Size of portion served is age appropriate				
Number of caregivers who actively feed their child				
Number of children who eat entire portion				
Number of children who are offered more food				
Key message discussed during PD/Hearth supervision visit				
Caregivers express being motivated by changes in child				
Caregivers can say what to do when child is sick				

PD/Hearth Annual Report

Day 5 Session 32

PD/Hearth ADP Facilitator _____	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Total
In PD/Hearth Session (12 days) Weight gain (in grams) # of children	# of children												
Catch up (graduation): ≥ 200g													
Inadequate: < 200g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
In Rotation at 1 month (12 days + 2 weeks follow up) Weight gain (in grams)	# of children												
Catch up (graduation): ≥ 400g													
Inadequate: <400g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 3 months post hearth	# of children												
Adequate weight gain ≥ 900g													
Inadequate weight gain < 900g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 6 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Follow up at 12 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Total number of Re-admissions													
Round/Session #2													
Round/Session #3													

Monitoring Case Study Data Sheet

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth			At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
1	Shadin	1	m	26/03/2005	24	12/03/2007	7.5		24/3/2007	8.3	0.8		12/4/2007	8.3				
2	Jenia	1	f	01/02/2006	13	12/03/2007	7		24/3/2007	7.6	0.6		12/4/2007	7.6				
3	Helena	1	f	27/08/2005	19	12/03/2007	9.8		24/3/2007	10.1	0.3		12/4/2007	9.9				
4	Kalpana	1	f	05/10/2005	17	12/03/2007	7.5		24/3/2007	7.5	0.0		12/4/2007	7.5				
5	Saidur	1	m	21/10/2005	17	12/03/2007	6.6		24/3/2007	7.2	0.6		12/4/2007	7.3				
6	Sumana	1	f	06/06/2006	9	12/03/2007	6		24/3/2007	6.2	0.2		12/4/2007	6.5	0.5			
7	Swourav	1	m	19/02/2005	25	12/03/2007	9		24/3/2007	9.3	0.3		12/4/2007	9.5	0.5			
8	Simul	1	m	17/02/2005	25	12/03/2007	7.6		24/3/2007	7.9	0.3		12/4/2007	7.5	-0.1			
9	Tanvir	1	m	15/08/2005	19	12/03/2007	8.5		24/3/2007	8.7	0.2		12/4/2007	9.0	0.5			
10	Ruman	1	m	28/04/2005	22	12/03/2007	8.9		24/3/2007	8.5	-0.4		12/4/2007	9.4	0.5			
11	Ritu	1	f	11/05/2004	34	12/03/2007	9.7	O	24/3/2007	9.9	0.2	Y	12/4/2007	10.2	0.5	Y	O	N
12	Zashim	1	m	29/01/2005	25	12/03/2007	8.7	R	24/3/2007	9.0	0.3	Y	12/4/2007	9.3	0.6	Y	O	Y
13	Bashakhi	1	f	29/04/2005	22	12/03/2007	8.8	Y	24/3/2007	9.0	0.2	Y	12/4/2007	9.2	0.4	Y	Y	N
14	Sritimoni	1	f	25/10/2005	17	12/03/2007	7.5	O	24/3/2007	7.8	0.3	Y	12/4/2007	7.8	0.3	N	O	N
15	Farjana	1	f	25/03/2006	12	12/03/2007	6	R	24/3/2007	6.5	0.5	Y	12/4/2007	7.1	1.1	Y	O	N
16	Riyon	1	m	25/01/2005	26	12/03/2007	7.9	R	24/3/2007	8.1	0.2	Y	12/4/2007	8.4	0.5	Y	R	N
17	Sharmin	1	m	23/10/2004	29	12/03/2007	9.5	O	24/3/2007	9.7	0.2	Y	12/4/2007	10.2	0.7	Y	O	N
18	Rabbi	1	f	03/09/2004	30	12/03/2007	10	Y	24/3/2007	10.3	0.3	N	12/4/2007	11.0	1.0	Y	Y	N
19	Kurban Ali	1	m	20/01/2006	14	12/03/2007	6.8	R	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	R	N
20	Himel	1	m	11/11/2005	16	12/03/2007	7.2	R	24/3/2007	7.2	0.0	N	12/4/2007	7	-0.2	N	R	N
21	Anika	1	f	29/03/2004	35	12/03/2007	9.8	O	24/3/2007	10.0	0.2	Y	12/4/2007	10.5	0.7	Y	O	N
22	Afra Abiyat	1	f	29/03/2004	35	12/03/2007	10.5	O	24/3/2007	10.8	0.3	Y	12/4/2007	10.9	0.4	Y	Y	Y
23	Laboni	1	f	25/11/2005	16	12/03/2007	7.3	O	24/3/2007	7.5	0.2	Y	12/4/2007	7.2	-0.1	N	O	N

Monitoring Case Study Data Sheet

Day 5 Session 32

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth				At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)		Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
24	Maruf	1	m	01/07/2006	8	12/03/2007	10.5	G		24/3/2007	10.3	-0.2	N	12/4/2007	10.9	0.4	Y	G	N
25	Shanta	1	f	04/02/2006	13	12/03/2007	6.6	R		24/3/2007	6.7	0.1	N	12/4/2007	7.0	0.4	Y	O	Y
26	Jesmin	1	f	27/09/2006	6	12/03/2007	6.8	G		24/3/2007	6.6	-0.2	N	12/4/2007	6.6	-0.2	N	Y	Y
27	Shakib	1	m	01/02/2006	13	12/03/2007	6.8	O		24/3/2007	6.9	0.1	N	12/4/2007	7.1	0.3	N	R	N
28	Shati	1	f	01/02/2006	13	12/03/2007	6.8	O		24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	O	N
29	Nurjahan	1	m	01/04/2005	23	12/03/2007	7.4	R		24/3/2007	7.7	0.3	Y	12/4/2007	7.9	0.5	Y	R	N
30	Beauti	1	f	03/04/2005	23	12/03/2007	7.6	R		24/3/2007	7.7	0.1	N	12/4/2007	7.8	0.2	N	R	N
31	Salina	1	f	07/04/2005	23	12/03/2007	9	Y		24/3/2007	9.2	0.2	Y	12/4/2007	9.5	0.5	Y	Y	Y
32	Marjina	1	f	07/09/2004	30	12/03/2007	9.1	O		24/3/2007	6.0	-3.1	N	12/4/2007	9.1	0.0	N	R	Y
33	Alam	1	m	10/07/2004	32	12/03/2007	10.1	O		24/3/2007	10.3	0.2	Y	12/4/2007	10.6	0.5	Y	O	N
34	Shaila	1	f	18/10/2005	17	12/03/2007	7.3	O		24/3/2007	7.9	0.6	Y	12/4/2007	7.9	0.6	Y	O	N
35	Abir	1	m	14/01/2005	26	12/03/2007	9.1	O		24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	Y	O	N
36	Mim	1	f	05/04/2006	11	12/03/2007	6.1	R		24/3/2007	6	-0.1	N	12/4/2007	6.4	0.3	N	O	Y
37	Mamin	1	f	13/02/2006	13	12/03/2007	6.2	R		24/3/2007	6.5	0.3	Y	12/4/2007	6.7	0.5	Y	O	Y
38	Alika	1	f	27/12/2004	27	12/03/2007	8.5	R		24/3/2007	8.8	0.3	Y	12/4/2007	8.9	0.4	Y	O	N
39	Sumia	1	f	05/03/2006	12	12/03/2007	6.1	R		24/3/2007	6	-0.1	N	12/4/2007	6.0	-0.1	N	R	N
40	Nadia	1	f	03/04/2006	11	12/03/2007	10.3	G		24/3/2007	10.6	0.3	Y	12/4/2007	10.8	0.5	Y	G	N
41	Aklima	1	f	01/04/2004	35	12/03/2007	9.1	R		24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	Y	R	N
42	Lipa	1	f	20/04/2004	35	12/03/2007	9.6	R		24/3/2007	9.9	0.3	Y	12/4/2007	10.1	0.5	Y	O	N
43	Mahamuda	1	m	23/05/2004	34	12/03/2007	9.6	R		24/3/2007	9.8	0.2	Y	12/4/2007	9.9	0.3	N	O	Y
44	Shapna	1	f	21/03/2005	24	12/03/2007	9	O		24/3/2007	9.1	0.1	N	12/4/2007	9.5	0.5	Y	Y	N
45	Laboni	1	f	11/12/2004	27	12/03/2007	10	Y		24/3/2007	10.2	0.2	Y	12/4/2007	10.9	0.9	Y	Y	N
46	Maria mim	1	f	02/02/2004	37	12/03/2007	10.2	O		24/3/2007	10.5	0.3	Y	12/4/2007	10.9	0.7	Y	O	N
47	Arif	1	m	25/02/2005	25	12/03/2007	6.9	R		24/3/2007	7	0.1	N	12/4/2007	7.1	0.2	N	R	N
48	Rakkib	1	m	10/03/2004	36	12/03/2007	10	R		24/3/2007	11.2	1.2	Y	12/4/2007	11.1	1.1	Y	Y	Y
49	Sabekun	1	m	25/03/2005	24	12/03/2007	9	O		24/3/2007	10	1.0	Y	12/4/2007	9.6	0.6	Y	Y	Y

#	Name of Child	Child's Sex (M/F)	At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)				
			Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
1	Shadin	m	27	12/06/2007	8.9				12/09/2007	9.5		
2	Jenia	f	16	12/06/2007	8.2				12/09/2007	9.1		
3	Helena	f	22	12/06/2007	10.9				12/09/2007	11.7		
4	Kalpana	f	20	12/06/2007	8.8				12/09/2007	9.6		
5	Saidur	m	20	12/06/2007	6.7				12/09/2007	8.5		
6	Sumana	f	12	12/06/2007	6.9	0.90			12/09/2007	7.8		
7	Swourav	m	28	12/06/2007	10.3	1.30			12/09/2007	10.5		
8	Simul	m	28	12/06/2007	9.3	1.70			12/09/2007	9.8		
9	Tanvir	m	22	12/06/2007	9.6	1.10			12/09/2007	10.4		
10	Ruman	m	25	12/06/2007	9.6	0.70			12/09/2007	10.7		
11	Ritu	f	37	12/06/2007	11.2	1.50	Y	Y	12/09/2007	11.6	Y	N
12	Zashim	m	28	12/06/2007	10.4	1.70	Y	Y	12/09/2007	10.8	Y	N
13	Bashakhi	f	25	12/06/2007	9.7	0.90	Y	Y	12/09/2007	10.7	Y	N
14	Sritimoni	f	20	12/06/2007	8.5	1.00	Y	Y	12/09/2007	9.1	Y	N
15	Farjana	f	15	12/06/2007	7.2	1.20	Y	O	12/09/2007	7.8	O	N
16	Riyon	m	29	12/06/2007	8.9	1.00	Y	R	12/09/2007	10.4	O	N
17	Sharmin	m	32	12/06/2007	10.2	0.70	N	O	12/09/2007	10.8	O	N
18	Rabbi	f	33	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.6	Y	N
19	Kurban Ali	m	17	12/06/2007	8.3	1.50	Y	O	12/09/2007	9.5	Y	N
20	Himel	m	19	12/06/2007	7.8	0.60	N	R	12/09/2007	8.8	O	N
21	Anika	f	38	12/06/2007	11.1	1.30	Y	O	12/09/2007	12.0	Y	N
22	Afra Abiyat	f	38	12/06/2007	11.3	0.80	N	Y	12/09/2007	11.9	Y	N
23	Laboni	f	19	12/06/2007	7.7	0.40	N	O	12/09/2007	8.6	O	N

#	Name of Child	Child's Sex (M/F)	At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)			
			Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
24	Maruf	m	11	12/06/2007	10.6	0.10	N	G	12/09/2007	11.2	G	Y
25	Shanta	f	16	12/06/2007	8.3	1.70	Y	Y	12/09/2007	9.9	G	Y
26	Jesmin	f	9	12/06/2007	7.2	0.40	N	G	12/09/2007	8.3	G	Y
27	Shakib	m	16	12/06/2007	7.6	0.80	N	O	12/09/2007	8.3	O	N
28	Shati	f	16	12/06/2007	6.9	0.10	N	R	12/09/2007	7.9	O	N
29	Nurjahan	m	26	12/06/2007	9.9	2.50	Y	O	12/09/2007	11.0	Y	N
30	Beauti	f	26	12/06/2007	8.7	1.10	Y	O	12/09/2007	10.4	Y	N
31	Salina	f	26	12/06/2007	9.8	0.80	N	Y	12/09/2007	10.6	Y	N
32	Marjina	f	33	12/06/2007	9.5	0.40	N	O	12/09/2007	10.3	O	N
33	Alam	m	35	12/06/2007	11.2	1.10	Y	Y	12/09/2007	12.1	Y	N
34	Shaila	f	20	12/06/2007	8.5	1.20	Y	Y	12/09/2007	9.3	Y	N
35	Abir	m	29	12/06/2007	10.3	1.20	Y	O	12/09/2007	11.1	Y	N
36	Mim	f	14	12/06/2007	7.4	1.30	Y	O	12/09/2007	8.3	Y	N
37	Mamin	f	16	12/06/2007	7.9	1.70	Y	Y	12/09/2007	8.8	Y	N
38	Alika	f	30	12/06/2007	9.5	1.00	Y	O	12/09/2007	10.4	Y	N
39	Sumia	f	15	12/06/2007	6.8	0.70	N	O	12/09/2007	7.5	O	N
40	Nadia	f	14	12/06/2007	10.8	0.50	N	G	12/09/2007	11.6	G	Y
41	Aklima	f	38	12/06/2007	10.4	1.30	Y	O	12/09/2007	11.4	O	N
42	Lipa	f	38	12/06/2007	11.1	1.50	Y	Y	12/09/2007	12.3	Y	N
43	Mahamuda	m	37	12/06/2007	9.7	0.10	N	R	12/09/2007	11.2	O	N
44	Shapna	f	27	12/06/2007	10.4	1.40	Y	Y	12/09/2007	11.5	G	Y
45	Laboni	f	30	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.8	G	Y
46	Maria mim	f	40	12/06/2007	11.5	1.30	Y	Y	12/09/2007	11.9	Y	N
47	Arif	m	28	12/06/2007	8.4	1.50	Y	R	12/09/2007	9.7	O	N
48	Rakkib	m	39	12/06/2007	11.5	1.50	Y	O	12/09/2007	12.6	Y	N
49	Sabekun	m	27	12/06/2007	9.9	0.90	Y	O	12/09/2007	10.6	Y	N

1. Look carefully at the data sheet from the PD/Hearth sessions at Sunshine Village of Happiness & Light ADP. Children are measured at the beginning of the Hearth sessions. Complete the 'Nutrition Status' column for all children on Day 1.
    a. What questions do you have about this information?
    b. The children are weighed on Day 12, at the end of the sessions. Complete the 'Gained 200g+' column for each child.
    c. Calculate the number and percentage of children who have gained adequately during the Hearth sessions.
    d. What can you say about the Hearth sessions? What is going well? What needs improvement?
    e. Based on this data, what action would you take?

2. The children are measured again one month after the beginning of the Hearth sessions. Complete the 'Weight Gain' and the 'Catch-up' and the 'Nutrition Status' items in the one-month columns.
    a. Calculate the number and percentage of children who have gained adequately during the month.
    b. Calculate the number and percentage of children who have changed their nutrition status.
    c. What does the data tell you about the children?
    d. How many children would you recommend repeat the Hearth sessions?
    e. Choose two children and answer the following questions for each:
        - How has the child progressed? Is this satisfactory?
        - What changes (if any) would you recommend for the child over the next month?
        - How would you explain the child's progress to the caregiver?
    f. What does the data tell you about the Hearth programme?
    g. What action do you need to take?

3. The measurements are repeated three months after the Hearth session. Look at the results and complete the 'Nutrition Status' column using the WAZ (weight for age Z-scores).

    a. Calculate the number and percentage of children who have gained adequately.

    b. Do you see any trends that concern you? What does the data tell you about the programme?

    c. What action do you need to take?

4. The children are measured again six months after the hearth sessions. Calculate their nutritional status using WAZ.

    a. Choose two children and answer the following questions for each, using all the data provided in this case study:

        - Describe the child's progress throughout the monitoring period. What could be some reasons for the child's growth pattern?
        - Was the child successfully rehabilitated? How can you tell?
        - How would you follow up with this child?
        - How would you communicate the child's progress and current status to his or her caregiver?

    b. What is your opinion of the overall growth of the children involved in the programme?

    c. How many children were successfully rehabilitated? How can you tell?

    d. What might be some reasons for the growth pattern between three and six months?

    e. How would you follow up with this programme?

The PDH Excel Database is used to compile all the data collected during the initial assessment (situation analysis), PDH registration, and for monitoring and follow up of children in the PDH programme. This allows easier access and utilisation of data by staff. For example, clear summary tables are generated and available under different tabs. From the data collection forms (e.g. Child Registration, Hearth Register and Monitoring Form), staff can transfer recorded information into appropriate cells/columns in the PDH database. Some of the cells/columns contain a drop-down menu or a formula. This formatting is convenient and helps to reduce data entry or calculation errors. For example, child's age (months), underweight nutritional status, WAZ scores, and weight change (g) are calculated automatically.

In the PDH Excel Database, there are eight tabs or worksheets: Initial Assessment; Assessment Report; Monitoring Form; Table; Annual Report; Graph Follow-up; Graph Graduation & Weight Gain; and Graph Default. However, you only need to enter data under two tabs: Initial Assessment and Monitoring Form. All other tabs contain summary charts (e.g. tables, graphs) automatically generated from the compilation of inputted data. ***Please note, when entering the dates, follow the format provided i.e. DD/MM/YYYY.*** Make sure the default date on your computer is set as DD/MM/YYYY for smooth operation of the database. To change the default date format on your computer, see ***Note** below.

Tab 1 – Initial Assessment: Enter the registration, initial nutrition assessment and wealth-ranking data for PDH participant children under this tab. From this data, the PD, non-PD, and negative deviant households are identified and displayed under the "Classification" column.

- First, select an appropriate option for the Wealth Ranking Category (i.e. Very Poor, Poor, Rich or Poor, Non-Poor) and the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu for each at the top of the worksheet.
- Enter values under each column according to the headings. Enter values only in the "WHITE" cells as the values in grey-coloured cells (e.g. Current Age, Underweight Nutritional Status, Classification columns) are calculated automatically by the computer. For the Sex, Oedema, MUAC, Wealth Rank and PDI HHs columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 2 – Assessment Report: This tab contains a table and a pie chart which categorizes the total number of children from the initial assessment based on their underweight nutritional status (i.e. % of children who are normal weight or mildly, moderately or severely underweight). This gives a clear picture of the initial level of childhood malnutrition in the community.

Tab 3 – Monitoring Form: This tab contains a monitoring form to track changes in child's weight, weight-for-age Z score, and underweight nutritional status in the hearth sessions and the follow-ups, including reasons for default. Additional registration information, such as deworming, vitamin A supplementation, presence of oedema, and full immunisation status is also entered under this tab. Based on the child's nutritional status at 3 months, next course of action is identified for each child (i.e. not graduate and repeat hearth, or graduate and continue monitor).

- First, select an appropriate option for the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu at the top of the worksheet.
- Enter values under each column according to the heading. Enter values only in "WHITE" cells as the values in grey-coloured cells (i.e. Current Age, WAZ, Nutritional Status, Weight Change, Adequate Weight Gain columns) are calculated automatically by the computer. For the Oedema, Deworming, Vitamin A Supplementation, Full Immunisation, Sex, Round/Session # and Default Reason columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 4 – Table: This tab contains nine summary tables based on the monitoring data. The tables show the number of children (and %) based on underweight nutritional status at different time points (e.g. baseline, Day 12, Day 30, 3 months, 6 months and 1 year), number of children (and %) with adequate or inadequate weight gain and amount of average weight gain (at Day 12, 30 and 3 months), and number of children (and %) with improvement or no improvement in their nutritional status to mild/healthy status (at Day 12, 30 and 3 months), as well as the breakdown of the reasons for child default from PDH.

Tab 5 – Annual Report: This tab contains a PDH summary report for the selected fiscal year. The table contains information about number of children who gained adequate or inadequate weight in PDH session (Day 12) and at follow ups (1 and 3 months), as well as number of children in different underweight nutritional status categories (i.e. green, yellow, orange, red) at 6 and 12 months post-Hearth. Also, information about the total numbers of children weighed and those who defaulted is provided along with the breakdown of children based on their enrollment (i.e. 1st, 2nd or 3rd round/session).

- To generate a report, enter ADP name and use the drop-down menu to select or enter a fiscal year.

Tab 6 – GRAPH Follow-up: This tab contains a bar graph showing overall changes in underweight nutritional status of PDH participant children (%) at different time points (e.g. baseline/Day 1, 12, 30 of PDH, and 3, 6, 12 months of post-PDH).

Tab 7 – GRAPH Graduation & Weight Gain: This tab contains six pie charts. The first three charts show the percentage of children whose nutritional status improved (i.e. mild/healthy vs. still moderate/severe) at Day 12, Day 30 and 3 months. The last three charts show the percentage of children who gained adequate weight (i.e. ≥ 200g at Day 12; ≥ 400g at Day 30; ≥ 900g at 3 months).

Tab 8 – GRAPH Default: This tab contains a bar graph on child default rate. The breakdown of number of children based on reasons for default at different time points (at Day 12, 30, and 3, 6, 12 months) is given.

NOTE:

To change the default date format on your computer:

1. *Go to Control Panel, click Regional and Language Options.*
2. *Under the Formats tab, click Additional settings (or Customize this format) button.*
3. *Click the Date tab.*
4. *Use the drop-down menu to select "DD/MM/YYYY" as the default Short date format.*
5. *Click Apply and close.*

PD/Hearth Training Plan

Trainer's name:

Who will be trained?

Projected timetable of trainings:

Where trainings will take place? (number and names of ADPs currently implementing in this fiscal year):

Support required to fulfil plan?

PD/Hearth Agenda and Methodologies		
Day	**Topics**	**Methodology**
Day 1		
	Devotion	
	Welcome Ice breaker Workshop rules (parking lot) Introductions and expectations Overview of workshop purpose, objectives and agenda Target evaluation	
	Pre-test	
	Defining the role of a PD/Hearth Master Trainer	
	Learning styles and facilitation	
	Overview of PD/Hearth	
	Essential elements and key principles	
	How PD/Hearth addresses malnutrition	
	Step 1 – Determining the Feasibility of PD/Hearth	
	Integration and PD/Hearth	
	Personalise the training curriculum	
	Daily Summary and Evaluation	
Day 2		
	Devotion	
	Review of Day 1 and present Day 2 agenda	
	Step 2 – Community Mobilisation	
	Step 2 – Staffing Needs; selecting and training volunteers	
	Step 3 – Situational Analysis – wealth ranking	
	Step 3 – Situational Analysis – nutritional assessment	
	Step 3 – Situational Analysis – transect walk, household visits, focus-group discussions, market survey	
	Step 4 – Identifying Positive Deviants	
	Step 4 – Preparing for the PDI: home visits, 24-hour recall, observation	
	Step 4 – Conducting the PDI	
	Personalise the training curriculum	
	Daily Summary and Evaluation	

Day	Topics	Methodology
Day 3	Field Visit	
	Review of Day 2 and explain logistics for field visit	
	Field Visit – PDI, FGD, transect walk, market survey, household visits	
	Compile results of PDI on flip charts	
Day 4		
	Devotion	
	Review of Day 3 field visit and present day 4 agenda	
	Step 4 – PDI interpretation and feedback	
	Promoting behavioural change	
	Step 5 – Designing Hearth Sessions (Incorporating PD behaviours)	
	Step 5 – Menu planning	
Day 5		
	Devotion	
	Review of Day 4 and present Day 5 agenda	
	Community feedback meetings	
	Step 6 – Conducting Hearth sessions	
	Step 7 – Supporting new behaviours through reflection and home visits	
	Step 8 – Admission and graduation criteria and repeating Hearth sessions Exit strategy and reaching the rest of the community	
	Step 9 – Expanding PD/Hearth	
	Monitoring and evaluation	
	Personalise the training curriculum	
	Daily Summary and Evaluation	
Day 6		
	Devotion	
	Review of Day 5 and present Day 6 agenda	
	Factors for the success of PD/Hearth	
	Post-test	
	Training plan	
	Personalise the TOT training curriculum – review by facilitators	
	Target evaluation, final evaluation	
	Workshop Closing	

Workshop Evaluation: World Vision PD/Hearth Master Training of Trainers Workshop

EVALUATION

Thank you for attending this year's PD/Hearth Master Training of Trainers Workshop. We hope you enjoyed your time, and that the workshop was a meaningful experience for you. Please take a few minutes to complete this evaluation. Your feedback is valuable and provides helpful information that will be used to plan the next workshop.

1. What did you expect from the workshop?

   _____
   _____
   _____

2. What do you feel was the most helpful part of the workshop? (for example, a particular session, a working group, a contact you made, certain resource material you obtained)

   _____
   _____
   _____

3. Please share some specific ways that you and/or your programme will apply the helpful information you noted in question #2.

   _____
   _____
   _____

4. What do you feel was the least helpful part of the workshop?

   _____
   _____
   _____

5. What would you do to improve this?

   _____
   _____
   _____

6. What would recommend for the next workshop?

   _____
   _____
   _____

7. What themes or topics would you suggest that we focus on or go into in more detail?

   _____
   _____
   _____

8. Should more background information be provided at the beginning of the workshop/training? What information?

   _____
   _____
   _____

Workshop Evaluation: World Vision PD/Hearth Master Training of Trainers Workshop

9. Other:

_____
_____
_____

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

For you, what was the highlight of this workshop?

_____
_____
_____

_____
_____
_____

Please share any other comments or suggestions to improve the next World Vision PD/Hearth Master TOT Workshop.

_____
_____
_____

_____
_____
_____

Thank you for your feedback!

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Sustainable Health

MASTER TRAINERS
MANUAL

Training of Master Trainers for **Positive Deviance/Hearth**

FIRST EDITION

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Training of Master Trainers for **Positive Deviance/Hearth**

MASTER TRAINERS
MANUAL

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WVI Nutrition Centre of Expertise

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Table of Contents

PLEASE NOTE: There can be more than one page for a handout. Page counts appear in the item lines for any handouts having more than one page. Multiple page handouts are designated on their respective pages as "page # of # pages".

The (page H#) refers to where each handout appears in the PD/Hearth Master Training Handouts. You can reference the "#m" at the bottom of the handout page as well.

DAY 2

ADP	Area Development Programme
ANC	Ante-Natal Care
AOP	Annual Operating Plan
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
DHS	Demographic & Health Survey
DIP	Detailed Implementation Plan
DME	Design, Monitoring & Evaluation
ECCD	Early Childhood Care & Development
EP	Edible Portion
FGD	Focus Group Discussion
GMP	Growth Monitoring Programme
GTRN	Global Technical Resource Network
HAZ	Height for Age Z-score
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
ITN	Insecticide-Treated Bednet
IU	International Units
IYCF	Infant & Young Child Feeding
KPC	Knowledge, Practice & Coverage
MOH	Ministry of Health
MN	Micronutrient
MT	Master Trainer
MUAC	Mid-Upper Arm Circumference
NCOE	Nutrition Centre of Expertise

NHC	Nutrition & Health Coordinator
NGO	Non-Governmental Organisation
OD	Operations Director
ORS	Oral Rehydration Solution
PD	Positive Deviance/Positive Deviant
PDI	Positive Deviant Inquiry
PLA	Participatory Learning for Action
PRA	Participatory Rapid Appraisal
RAE	Retinol Activity Equivalent
RE	Retinol Equivalent
TOF	Trainer of Facilitators/Training of Facilitators
TOT	Trainer of Trainers/Training of Trainers
UNICEF	United Nations Children's Fund
VARK	Visual, Aural, Read/write, Kinesthetic
VHC	Village Health Committee
VHSC	Village Health & Sanitation Committee
WASH	Water, Sanitation & Hygiene
WAZ	Weight-for Age Z-score
WHO	World Health Organisation
WHZ	Weight-for Height Z-score
WV	World Vision

Welcome to the Facilitation Manual for Master Trainers for

Positive Deviance (PD)/Hearth

INTRODUCTION

Through increasing experience, World Vision (WV) has recognised the need to develop competent Master Trainers of Trainers (TOTs) for Positive Deviance/Hearth (PD/Hearth) nutrition programmes implemented within the Area Development Programme (ADP) framework. This manual presents curriculum and exercises based on field experience in many countries representing all regions of the world. Adult learning methodologies – with practical examples, exercises, role plays and field visits – reinforce the principles of strong PD/Hearth programmes.

We trust this manual will enable Master Trainers to increase the understanding, skill and competency of WV staff and partners in order to rehabilitate malnourished children and prevent future malnutrition through the PD/Hearth programme.

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About the Curriculum

The training manual provides the framework and materials for a six-day, face-to-face course. It covers all components of the PD/Hearth programme, with emphasis on the essential elements of the methodology and the integration of PD/Hearth into the ADP context. There is more content included in this manual than can be covered in the six days. Facilitators will need to decide which activities are most relevant to the participants and organise their time accordingly.

Participants should have an existing understanding of PD/Hearth principles and concepts as well as experience in implementation. They are expected to personalise this curriculum throughout the course and to adapt the method of presentation for use in their particular context. A group size of 20 participants is recommended in order to maximise interaction and feedback.

Some sessions are held in a classroom setting; others are based in the field, collecting and using field information. Although not absolutely necessary, access to computers during the sessions on calculating nutritional status and the menu calculation exercise could be helpful. Access to a community where there are malnourished children and where community members are willing to work with training participants is necessary. This community, in any World Vision ADP, should be within close proximity to the training site (no more than one hour away).

Introduction

By the end of the course participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level
6. Complete a training curriculum adapted to their country context (National ToF Curriculum and Volunteer Training Curriculum.

PD/Hearth Short Overview

PD/Hearth is an internationally proven community-based model for rehabilitating malnourished children in their own homes. It targets moderately and severely underweight children aged between 6 and 36 months.[1]

From birth to three years of age, children experience very rapid growth and development. Children who are malnourished during this stage of life will not develop to their full potential. Early malnutrition affects a child's physical, mental, and emotional capacity throughout their entire life. Malnourished children are one of the most vulnerable groups in any community.

'Positive deviance', means 'different in a positive way from what is usual practice'. 'Hearth' refers to the place within a house where food is cooked and served. Despite limited resources, some parents find ways to raise well-nourished children. Identifying and understanding what these 'positive deviant families' are doing differently in their feeding, hygiene, caring, and/or health-seeking practices from the parents of malnourished children in the same community is the foundation for this project. Then volunteers share this knowledge and teach these positive practices to caregivers with malnourished children in practical lessons called 'Hearth sessions'. In addition, two menus are designed for the Hearth session. Each menu is composed of locally available, accessible, and affordable foods that are nutrient dense. All the ingredients are brought to the Hearth session by the participant caregivers who practise cooking the foods at the Hearth session. Hearth lasts for 12 days, followed by a 2 week follow-up conducted by the volunteers through home visits. The purpose of these home visits is to encourage caregivers to continue the positive practices at home, but also to help overcome barriers caregivers may face trying to practise the positive behaviours at home.

1. Some projects expand this range to include children age 6-59 months, that is, all "children under-5", and include mildly underweight children as well.

PD/Hearth empowers communities to take responsibility for addressing the causes of malnutrition by helping to identify local solutions to overcome malnutrition. The PD/Hearth standard model has three main goals:

1. Quickly rehabilitate malnourished children
2. Enable families to sustain the rehabilitation of these children
3. Prevent future malnutrition among all children in the community.

PD/Hearth aligns with World Vision's strategic priorities of ensuring health and nutrition for children in areas in which WV works, as well as WV's commitment to empowerment and sustainability. As of 2013, PD/Hearth has been successfully implemented within WV contexts since 1999, in more than 40 countries, and in all four operational regions of WV.

PD/Hearth Master Training

The PD/Hearth Master Training is aimed at building the cadre of staff within World Vision who are qualified and certified as Project Model Trainers.

The level of staff targeted is not limited to Support Office (SO), Regional Office (RO), National Office (NO) or ADP, but is instead targeted to staff whose job description requires them to train others in this model. It is intended that this process will help to raise the standard of quality in PD/Hearth training and implementation, and so will contribute to alleviating the burden of undernutrition in WV ADPs.

The Master Training does not teach PD/Hearth Methodology, but teaches how to teach it using appropriate adult learning methodology. Participants are required to complete assignments before the training and are expected to facilitate sessions during the event that will be graded both by peers and the expert trainers in order to provide feedback on how to improve on facilitation skills[1].

Because of the approach being taken, there are certain qualifications that need to be met before a participant is approved to begin the Master Trainer process. These qualifications include:

1. Facilitating learning in PD/Hearth is included as part of the participant's job description.
2. Sending office has plans and budget to support PD/Hearth training, and roll out of PD/Hearth implementation

1. For countries planning to introduce PD/Hearth, a National level Training of Facilitators for PD/Hearth should take place with facilitation by qualified Master Trainers, preferably from within the region (a list of recommended trainers can be provided upon request to the NCOE). Once training has occurred and experience in PD/Hearth is established then further training and facilitator needs can be planned and budgeted for. This may mean further training of staff, or use of the GTRN network to access qualified Master Trainers.

3. The participant has experience in implementing PD/Hearth:
    a. They have successfully completed a PD/Hearth training and
    b. They can demonstrate clear understanding of PD/Hearth methodology and key principles.
4. Sending office has implementation of PD/Hearth as part of national level nutrition and health strategy, or support of PD/Hearth implementation for a RO/SO level staff.
5. Sending office is committed to support building capacity of their own staff, as demonstrated by ensuring adequate time is available for staff members to complete the Master Trainer process, and budget allocated for supporting this process.

    Note:

    In some cases, the participant will proceed to fulfill the requirements to become a GTRN Level 2 Subject Matter Expert (SME).

A letter, signed by the participant's supervisor, must be sent ahead of time to the training organisers endorsing the proposed participant and ensuring that the above qualifications have been met. Supervisors will also be required to submit the participant's Job Description, and a strategy document that includes plans for implementation of PD/Hearth.

The number of participants in the Master Trainer course will be limited to 20 in order to maximise the learning potential of the initial face-to-face training.

At the end of the face-to-face event, each participant will have a one-on-one discussion with the expert facilitator to receive feedback on their performance, and to discuss follow up and requirements in order to complete the certification process. This feedback, Master Trainer Level and final grade will be provided via email to the participant, the participant's supervisor, and regional technical advisor.

Full Certification as a Master Trainer in PD/Hearth will be earned upon:

1. Satisfactory completion of recommendations made by expert consultants at the end of the Master Training face-to-face session
2. Satisfactory co-facilitation of a PD/Hearth training event, evaluated by a Level 3 Master Trainer
3. Recommendation by supervisor

Flow of Training (Refer to summary flow chart on pp. 14, Handout 3.2):

Please note: it is recommended that all PD/Hearth trainings are facilitated by at least 2 Master Trainers.

Master Trainer Level 3

The 'go-to' person for PD/Hearth trainings in the region

Can train in PD/Hearth cross-regionally with another facilitator

Master Trainer Level 2

Can train in PD/Hearth within their region with a Level 3 Master Trainer

Master Trainer Level 1

Can train in PD/Hearth within their country with a Level 3 Master Trainer

PD/Hearth Master Training Workshop (Regional Level):

Purpose: To build up a cadre of Master Trainers to improve PD/Hearth programme quality

Facilitator: International expert/Master Trainer Level 3

Participants: Master Training Candidates from within the region

Duration: 6 days at a regional location

Curriculum: WV PD/Hearth Master Training Curriculum

Outcome: Master Trainer Candidates – each participant will receive a grade and level of certification (Level 1, 2 or 3). They will also receive recommendations regarding areas of strength, and areas to work on.

National PD/Hearth Training of Facilitators Workshop (National and Sub – National Level):

Purpose: To train the national and sub-national level staff in PD/Hearth Methodology and implementation of the model[2]

Facilitator: Co-facilitated by a Master Trainer Level 3 and at least one other Master Trainer

Participants: National and Sub-national level staff responsible for implementing PD/Hearth in ADPs and training local level staff (See Handout 3.2 for more details). Participants must

2. The first 2-3 days may be set up as an orientation to PD/Hearth, and include national level staff who are responsible for sectors that are integrated with PD/Hearth (examples: Agriculture, Food Security, Economic Development, M&E, Quality Programming, Gender, WASH, Education, Health & HIV/AIDS Coordinators)

complete pre-workshop readings and pass two quizzes to qualify for PD/Hearth ToF Workshop.

Duration: 10–12 days of training close to a community/ADP planning to implement PD/Hearth or a community/ADP with PD/Hearth programming. There must be fieldwork incorporated into the training.

Curriculum: Adapted MT Curriculum with CORE PD/Hearth manual and orientation of PD/Hearth Volunteer Training manual

Outcome: PD/Hearth ToFs – each participant will be evaluated as either a PD/Hearth Facilitator (able to independently lead PD/Hearth implementation trainings) or Co-facilitator (able to co-lead implementation trainings with a Facilitator).

Volunteer Trainings (Community level):

Purpose: To train community volunteers to fulfill their role in implementation of the PD/Hearth model

Facilitator: Facilitated by at least one PD/Hearth ToF (Facilitator) or co-facilitated by a PD/Hearth ToF (Facilitator) and a PD/Hearth ToF (Co-facilitator)

Participants: Volunteers responsible for implementing PD/Hearth

Duration: 8–10 days at ADP level

Curriculum: PD/H Volunteer Training Manual

Outcome: PD/Hearth Volunteers ready to implement PD/Hearth with all key essential elements

PD/Hearth Competencies

Four levels of PD/Hearth implementers are included:

- Volunteer
- ADP/District-level staff (e.g. Development facilitators, Health and Nutrition Officers)

- Regional or Provincial Health and Nutrition Coordinator
- National Health and Nutrition Coordinator

The competencies at each subsequent level are progressive. Each level requires competence in the previous level as well as the skills listed for the level.

PD/Hearth Volunteer

Skill	Volunteer	Knowledge required
Community mobilisation	• Motivational skills • Identify key stakeholders in community • Identify key locations to promote PD/Hearth (e.g. church setting, community meeting, communal gardens) • Mobilise a PD/Hearth Committee (consists of leaders, fathers, grandmothers of community)	• Understand Theory of PD/Hearth and importance of PD/Hearth • Various roles important to success of PD/Hearth in community • Who the decision-makers are at household level
Measuring growth	• Weigh children	• Importance of proper weighing technique • Ability to weigh properly
	• Plot weights on growth chart	• Plot and interpret growth lines
	• Counsel caregivers	• IYCF practices • Communicate effectively with caregivers
Active participation in PDI	• Observation skills	• Factors that contribute to good child growth
	• Semi-structured interview skills	• Asking questions
	• Guided identification of good/bad behaviours	• Reflection of information gathered and how it contributes to child growth
Menu Preparation	• Making menus for Hearth	• Basic food groups • 'Special' (PD) foods • Prep of recipes • Calculating portion size for children

Conduct Hearth sessions	• Motivate/organise children/caregivers to attend Hearth	• Goals of programme • What is a Hearth • How to set up a Hearth • Role of each person
	• Supervise caregivers in cooking meals / feeding children	• Active feeding • IYCF practices
	• Teach simple nutrition/health/hygiene/caring • messages through example and talking	• Identify good/bad practices (IYCF, illness, care, hygiene) • How to give positive support
	• Monitor attendance, progress, food contributions	• Understand how to complete basic forms • Reflect on the information and what can be done to improve session
Conduct follow up home visits	• Household visits to support caregivers with new behaviours	• Purpose of home visit • Use of Home visit Observation Checklist form • Problem solving with caregiver
Communication	• Communicate concepts and methods with caregivers and community members in simple terms	
	• Report regularly to VHC	• Ability to communicate programme progress and results orally

ADP/District-level Staff

Skill	Supervisor	Knowledge required
Measuring growth	• Participate in identifying nutrition status of children to select participant children for PD/Hearth programme (screening should be done monthly to identify new participants to be included in next round of Hearth)	• Motivation/mobilisation of village leaders
	• Teach volunteers to interpret growth charts and counsel caregivers	• GMP technical ability
		• Communication of IYCF practices in simple terms

Situational Analysis	• Nutrition situation • Health services • Market survey	• Participatory Rapid Appraisal (PRA) • UNICEF framework of Causes of Malnutrition
	• Communicate with MoH, village leaders, health providers, volunteers	• Community mobilisation skills
PDI	• Identify PD/NDP/ malnourished children • Assist in PDI	• Principles of PD/H • Concept of PD
	• Train volunteers in PDI	• Adult education principles • Facilitation skills • Participatory assessment skills
	• Lead participants in analysis of PDI information • Develop appropriate key messages and behaviours to promote in each Hearth session.	• Breastfeeding • Complementary Feeding • Hygiene • Illness Prevention and treatment • Early child stimulation • Meal preparation for families • Nutrition and HIV/AIDS
	• Train volunteers in 6 key Hearth messages	
Menu Preparation	• Development of nutrient dense menus-based on PDI • Train volunteers in menu preparation using household measures	• Use of food tables and menu calculation software • Calorie, protein and MN requirements • Basic nutrition principles to be able to substitute recipes
Hearth sessions	• Supervise Hearth sessions	• Assist volunteers in organising set-up of Hearth • Assist in mobilisation of caregivers to attend • Essential Elements of PD/Hearth • Use of 'Supervision Checklist form'
	• Train volunteers in helping caregivers prep meals, actively feed, etc.	
	• Train volunteers in development and presentation of key messages	• Awareness of alternate teaching methods (song, picture, hands-on, example)
	• Supervise and motivate volunteers who run Hearth sessions and PD/Hearth committee	

Monitoring	• Assure implementation of Hearth protocol (hygiene, snack, cooking, feeding, training)	• Use of monitoring sheets to analyse effectiveness of process
	• Create monthly plan for implementing Hearth in geographic area	• Budget development • Logframe development • DIP
	• Ensure Hearth sessions take place monthly	Use of Hearth monitoring form
	• Ensure Day 12, 30, 6 months, 12 month, and 24 month follow-up conducted	• Use of Hearth monitoring form and PD/ Hearth database software
	• Ensure 2 week follow-up home visits are being conducted by volunteers after Hearth sessions	• Use of Home-visit Observation Checklist forms and track the submission of these forms by volunteers
	• Motivate village to take responsibility in monitoring growth of children (important for on-going screening of future PD/Hearth participant children)	• Community mobilisation skills • Communication skills • Community-based M+E techniques
	• Aggregate information from all Hearths in area	• Reflection and analysis
	• Competent in using PD/Hearth database software	• Familiar with MS Excel and internet
	• Analyse information and make appropriate programming decisions	• Decision making/problem solving skills
Communication	• Provide feedback to volunteers on their Hearth sessions, graduation rates, home visits, etc.	• Simplify technical findings and present in lay language
	• Report progress to supervisor/ADP manager/ community leaders	• Written and verbal communication skills
	• Communicate to volunteers the next group of identified participant children for PD/ Hearth - should identify from monthly GMP results	• List of underweight children from most recent monthly GMP results (monthly screening required)

Regional/Provincial Health and Nutrition Coordinator

Skill	Regional/Provincial Health and Nutrition Coordinators	Knowledge required
Planning	• Analyse nutrition data • Identify geographic priority areas for PD/H • Communicate results to national partners/ WV leadership/communities/ADP staff	• Causes and consequences of malnutrition measure, calculate and classify malnutrition
	• Network with NGOs, government ministries, universities, international organisations (UNICEF etc)	• PD/H concepts, principles and practices • Role of diverse entities in PD/H implementation
	• Motivate participation of cross sectors specialists to contribute to PD/H • Lead multi-sector team in collaborative planning to integrate into PD/H programming	• Identification of gaps/key contributing factors and ways to address those.
	• Develop/adapt logframe for PD/H	
	• Develop DIP for PD/H	
	• Develop budget and workplan	
Monitoring	• Ensure all data is collected (no missing data) and entered into PD/H database • Analysis of aggregated data/Interpret findings • Make appropriate decisions based on data to strengthen programme	• Principles of monitoring systems for PD/H • Using tracking forms • Competent in PD/H Database • # of Hearth sites implemented per village
	• Support and supervision visits to Hearth projects • Mentor ADP/District staff	• PD/H menu requirements (meets nutrient requirements, low cost, use locally available foods, seasonal calendar considered)
	• Develop and implement evaluation plan for PD/H	
	• National level reporting (aggregated data) • Communication with partners	
Training	• Develop training materials • Train PD/Hearth Supervisors • Supervise and support PD/Hearth Supervisors and support Supervisors in training of volunteers	• Adult learning methodology • Ability to teach technical material in actively and in simple language • Facilitation skills

National Health and Nutrition Coordinator

	National Health and Nutrition Coordinator	**Knowledge/ skills required**
Skills	• Adult learning methodology • PD/H theory and methodology • Demonstrated ability in training others in PD/H, Hearth menu calculation tool/software and PD/H Database • Is deployable	• In the various areas listed below is able to lead others in the processes and/or train others in practical, hands-on ways • Computer processing skills (Competent in MS Excel and Internet use)
Area of Expertise		
Basic Public Health Science	• Population health, disease prevalence, prevention, health determinants, promotion, improving health outcomes • Applies epidemiological knowledge, approaches, methodologies • Understands and uses research methodologies and scientific evidence for health problems	• Use of secondary and primary data to identify gaps in nutrition and recommend appropriate interventions • Ability to advise on other relevant health interventions that would support improvement in community nutritional status
Analytical/ Assessment	• Defines gaps and top priorities for health in country aligned with WV strategic direction	• Identify situations where PD/H methodology would be feasible and beneficial • Advise when PD/H would have limited applicability and not be recommended
	• Use of quantitative /qualitative data	• Identify areas where nutrition is a problem and PD/H could be relevant • Identify contributing factors to low nutritional status that would need to be addressed • Use of data to 'advocate' for PD/H programmes • Ability to advise on PD/H field research or evaluation
	• Selects and defines relevant variables	
	• Applies ethical principles to data collection, storage, use and reporting	• Ability to set up monitoring systems following WV and PD/H standards
	• Knowledge of standardised data collection and management process and computer systems.	
	• Knowledgeable of risks and benefits to communities through assessment and planning	

National Health and Nutrition Coordinator – continued

Programme Planning and Policy Development	• Translates assessment information and data into programmes • Able to assess feasibility, applicability, risk management for WV ADPs • Uses standard techniques in decision making and planning • Develops PD/H programme plans, goals, objectives, expected outcomes, implementation process • Knowledgeable of assumptions that affect PD/H	• Uses data to mentor staff in improved programming
Leadership	• Creates shared vision and team learning • Manages team information, contracts, external agreements • Manages staff; motivates, conflict resolution, performance monitoring • Identifies factors that may impact programme delivery • Facilitates collaboration with internal and external stakeholders • Represents PD/H at internal and external forums • Monitors and maintains ethical and organisational performance standards	• Able to build and lead multi-cultural team around common goals • Able to advocate and collaborate with relevant nutrition and PD/H networks
Communication at multi-country/ regional level	• Written and verbal communication of health issues Facilitates and participates in diverse cultural, educational and professional groups • Solicits input from relevant team members • Advocates for top priority health issues aligned with 7-11 programming • Presents demographic, statistical. scientific and programme information for lay and professional audience	• Able to communicate technical PD/H information simply and clearly to non-technical audiences • Ability to communicate with other technical experts in health/nutrition or other relevant disciplines. • A learner's attitude

Flow Chart of World Vision PD/Hearth Reporting Lines

Community Volunteers

- Selected by community
- Trained by PD/H Coordinators
- Run Hearth sessions
- Conduct follow up home visits
- Collect monitoring data

PD/Hearth Coordinators

- ADP or MOH H&N staff
- Trained by ToF or MT
- Train & supervise volunteers
- Prepare monitoring reports
- Enter data online database
- Coordinate with MOH, community leaders, zonal & provincial level WV staff

Zonal and/ or Provincial Coordinators

- Trained by ToF or MT
- Train & supervise PD/H coordinators
- Monitor projects
- Communicate with Regional & National WV and MOH entities

National Health & Nutrition Coordinator

- Trained by MT
- Train PD/H Coordinators
- Overall programme direction & monitoring
- Lead programme evaluation
- Communicate with national entities; WV Regional Nutrition Advisor
- Advocate for PD/H to MOH & MinAgri

Wealth Ranking:
5 or 7 community members (diverse group)

Initial Nutrition Assessment:
First, please ensure the Ministry of Health allows NGOs and non-government approved personnel to weigh children. If the government has strict protocols, please mobilize government approved personnel (e.g. health centre staff, CHWs, etc.) to help weigh children on the day of assessment.

Weigh all children 6-36 months of age in the community (you could mobilize the caregivers to one site/location or to several decentralized sites/locations in the community to increase coverage and ask caregivers to bring their children 6-36 months of age on a specific day and time). Weighing children house to house is most accurate, but may require more time and resources.

Community/Social Mapping:
4-5 community leaders (men and women) and 1-2 CHWs

Focus Group Discussions:
Three separate FGDs are recommended with mothers group, fathers group, and elderly women's group. There should be approximately 7-10 participants in the mothers group. It is advisable to include 2-3 mothers with children from each target age group: 0-6 months, 6-12 months, 12-24 months, and 1 mother from the age group 24 -59 months. A smaller group of 4-5 participants could be mobilized for fathers and elderly women (grandmothers). Ensure there are 2 facilitators in the FGD who are good with speaking the local language (for interviewing and recording). If different groups are leading different FGDs, you may require more facilitators who speak the local language.

Seasonal Calendar/Transect Walk:
Good to have 1-2 CHWs or volunteers who could help navigate in the village/community

Market Survey:
Done by the team
Good to find out when the big market day is and keep in mind when planning the agenda

Positive Deviance Inquiry:
From the initial nutrition assessment, select at least 4 PD households (at least 1 household from each target age group: 0-6 months, 6-12 months; 12-24 months), 2 negative deviant households, and 2-4 non-PD households. These will be the households that will be visited during the PDI. You could always select more PD and non-PD households if necessary, depending on the number of participants in the training. Divide participants into groups of 3 people. Arrange for each group to be supported by a volunteer or someone who is familiar with the village so that the groups could find the households easily. Ensure the volunteer or the person from the village is not in the way of getting honest answers from the caregivers. If translators are needed, make sure at least one person in the group could speak the local language.

Welcome, TOT Objectives, Agenda, Introductions

SESSION 1

60 MIN | DAY 1

By the end of the session participants will

1. Have reviewed the training goals and desired outcomes
2. Have been introduced to the hosting agency and facilitation team
3. Be able to summarise participant expectations and workshop norms
4. Be able to evaluate their learning needs as individuals and as a group in key objectives of PD/Hearth.

Preparation

- Prepare a flip chart with overall training goal and objectives as shown on Handout 1.1.
- Prepare two copies of Flip Chart 1, the 'Target Evaluation' diagram. One copy is used now, and one at the end of the course.

Materials

- Objectives (Handout 1.1)
- Agenda (Handout 1.2)
- Blank sheets of flip-chart paper
- 8 dot stickers for each participant

STEPS

5 Min

1. The organisation hosting the event welcomes participants and introduces the lead facilitator as well as special guests attending the opening session.

10 Min

2. Cover basic information such as the locations of bathrooms, timing of breaks, etc. With the group, develop ground rules (promptness, cell-phone etiquette, computer use, etc.). Use a flip chart that will be posted during the workshop. Encourage full participation in all discussions and small-group work.

5 Min

3. Read the overall goal of the training and the training objectives. Based on these, ask what the participants expect. List responses on a separate sheet of flip-chart paper.

HANDOUT
1.1 – 4m/H 9

Welcome, TOT Objectives, Agenda, Introductions

DAY 1

5 Min

4.

HANDOUT
1.2 – 5m/H 10

Distribute the training agenda and briefly review the planned content. Note that the activities have been planned to encourage maximum discussion and 'hands-on' work by participants. Participants will spend time revising a training curriculum to make it suitable for their own context.

10 Min

5.

Introduce all facilitators and describe their involvement with PD/Hearth to date. Have all the participants briefly introduce themselves.

10 Min

6.

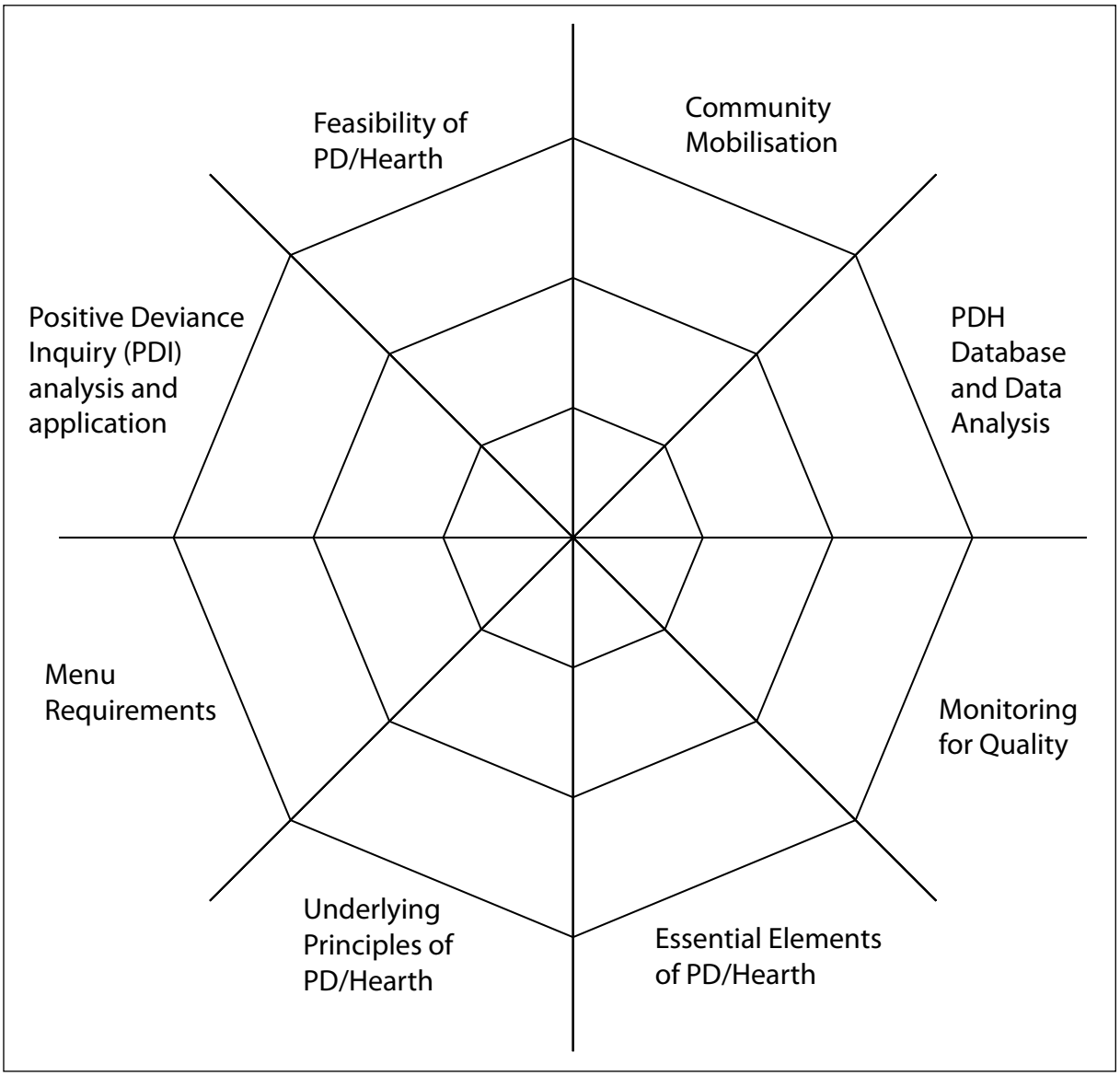
Review the group's expectations from step 3 and ask if anyone has questions on plans for the workshop.

15 Min

7.

Complete the first stage of the 'Target Evaluation Dart Board' described below.

Flip Chart 1
Target Evaluation Dart Board



- Give each participant eight stickers.
- Ask participants to think about their understanding and skill in each of the eight areas listed on the 'dartboard'. The more competent they feel in each area, the closer to the centre of the target they should place a sticker. If they feel less confident or knowledgeable about an area, they place their sticker closer to the outer edge.
- When all participants have placed their stickers, discuss together areas where the group has strengths and areas that group members hope to strengthen in this course.
- Save this sheet for comparison at the end of the course.

Objectives for PD/Hearth Master Training

Goal

WV staff and partners develop knowledge, skill and competencies in PD/Hearth to

- train others
- provide technical support
- monitor implementation.

Training objectives

By the end of the workshop, participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level
6. Complete a training curriculum adapted to their country context.

Agenda for PD/Hearth Training of Trainers

Day and Date	Session	Topics	Time
		DAY 1	
1		Devotion	15 min
	1	Welcome Ice breaker Workshop rules (parking lot) Introductions and expectations Overview of workshop purpose, objectives and agenda Target Evaluation TOT methodology and curriculum adaptation	60 min
	2	Pre-test	30 min
	3	Defining the roles of a PD/Hearth Master Trainer	30 min
	4	Learning styles and facilitation	45 min
	5	Overview of PD/Hearth	45 min
	6	Essential elements and key principles	60 min
	7	How PD/Hearth addresses malnutrition	45 min
	8	Step 1 – Determining the feasibility of PD/Hearth	45 min
	9	Integration and PD/Hearth	60 min
	10	Personalise the training curriculum, daily summary, evaluation	45 min
		DAY 2	
2		Devotion	30 min
	11	Review Day 1 and present the Day 2 agenda	15 min
	12	Step 2 – Community mobilisation	60 min
	13	Step 2 – Staffing needs; selecting and training volunteers	45 min
	14	Step 3 – Situational analysis – Wealth ranking	95 min
	15	Step 3 – Situational analysis – Nutritional Assessment	95 min
	16	Step 3 – Situational analysis – transect walk, household visits, focus-group discussions (FGDs), market survey	30 min
	17	Step 4 – Identifying positive deviants	30 min
	18	Step 4 – Preparing for the positive deviant inquiry (PDI)	75 min
	19	Step 4 – Preparing for the field visit to conduct the situational analysis and PDI	60 min
	20	Personalise the training curriculum, daily summary, evaluation	30 min

Agenda for PD/Hearth Training of Trainers

Day and Date	Session	Topics	Time
		DAY 3 – FIELD VISIT	
3		Review Day 2 and explain details for field visit	15 min
	21	Field visit (PDI, FGD, transect walk, market survey, household visits)	4.5 hours incl. travel time
		Compile results of PDI on flip charts	120 min
		DAY 4	
4		Devotion	30 min
	22	Review Day 3 field visit and present Day 4 agenda	15 min
	23	Step 4 – PDI interpretation and feedback	80 min
	24	Promoting behavioural change	40 min
	25	Step 5 – Designing Hearth sessions (Incorporating positive deviance behaviours)	120 min
	26	Step 5 – Menu planning	245 min
		DAY 5	
5		Devotion	30 min
	27	Review Day 4 and present the Day 5 agenda	35 min
	28	Community feedback meetings	60 min
	29	Step 6 – Conducting Hearth sessions	40 min
	30	Step 7 – Supporting new behaviours through reflection and home visits	60 min
	31	Step 8 – Admission and graduation criteria and repeating Hearth sessions Exit strategy and reaching the rest of the community	45 min
		Step 9 – Expanding PD/Hearth	
	32	Monitoring and evaluation	120 min
	33	Personalise the training curriculum , daily summary, evaluation	30 min
		DAY 6	
6		Devotion	30 min
	34	Review Day 5 and present the Day 6 agenda	30 min
	35	Factors for the success of PD/Hearth	45 min
	36	Post-test	30 min
	37	Training plan	45 min
	38	Personalising the TOT curriculum – review by facilitators	90 min
	39	Final evaluation and workshop closing	30 min

Pre-test

SESSION 2

30 MIN | DAY 1

Materials

- PD/Hearth Pre-test (Provided in the MS Word document called "MT Trainers' Package"

STEPS

1.

File Named "MT Trainers' Package"

Distribute Handout 2.1: Pre-test

2.

Have the participants complete it and hand it in.

3.

Facilitators mark the tests while the participants complete their Learning Styles Questionnaire (Session 3) and personalise their training curriculum (Session 9). The marked pre-tests will be returned with the post-test results on the last day.

SESSION 3

Defining the Roles of a PD/Hearth Master Trainer

World Vision

30 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe their roles as a Master Trainer for PD/Hearth.

Preparation

- Print Handout 3.1 and 3.2

Materials

- Blank sheets of flip-chart paper
- Handout 3.1: PD/Hearth Competencies
- Handout 3.2: Flow Chart of WV PD/Hearth Reporting Lines

STEPS

5 Min

1. 

Ask participants what qualities a Master Trainer should have. List these on a flip chart. *(understand context, communicate clearly, be able to mobilise the community, be creative in working together, prepare well, apply adult learning methodologies, listen to participants' responses)*

10 Min

2. Divide the participants into small groups of four to five people. Ask them to discuss and come to agreement on what PD/Hearth trainers should be able to do. They should designate one person in the group to report back.

10 Min

3. Ask each group's representative, in turn, to state one of the roles his or her group discussed. Write these on a flip chart. Go around more than once if the representatives have more to offer. Make sure that all of the points shown below are listed by asking for additional suggestions.

- Place PD/Hearth in context
- Develop a curriculum and training materials
- Develop a training plan
- Review participants' pre-work
- Conduct training
- Monitor and evaluate progress after training
- Provide technical support for training and quality implementation
- Evaluate and reflect

- Promote PD/Hearth with leadership
- Plan and coordinate with partners
- Work with other sectors to address underlying issues that affect malnutrition
- Be involved in programme design
- Be consistent about the PD/Hearth concept
- Develop methodology
- Conduct training needs assessment
- Develop in-country training of trainers
- Apply adult education principles and skills
- Resolve barriers and challenges that affect improvement in nutrition status

5 Min

4.

HANDOUT
3.1 – 10m/H 12
3.2 – 12m/H 14

In order to fulfil these various roles, PD/Hearth trainers need to develop certain skills and competencies. Refer the participants to the completed list of competencies in Handout 3.1. Ask participants to briefly consider which of these competencies they feel comfortable with and to put a check mark beside those skills or areas of knowledge they need to develop more. These competencies will be developed throughout the course.

Distribute Handout 3.2 as a reference for participants to understand the roles of different personnel in PD/Hearth implementation.

PD/Hearth Competencies

Principles of PD/Hearth

- Goals of PD/Hearth
- Adult learning principles
- Behaviour-change theory
- Community mobilisation and ownership in PD/Hearth

Training skills

- Criteria for selecting Hearth volunteers and staff
- Training PD/Hearth volunteers
- Training PD/Hearth supervisors
- Facilitation based on learning styles

Community mobilisation skills

- Tools for PD/Hearth community assessment
- Nutrition baselines in PD/Hearth
- Wealth-ranking exercises
- Identifying positive deviant households
- Market surveys
- Community mapping in PD/Hearth
- Conducting positive deviant inquiries
- Tools used in community feedback meetings
- Engaging grandmothers and others with influence on child care and feeding

Critical thinking skills

- How to determine if PD/Hearth is appropriate in a community
- Analysis of positive deviance inquiry
- Designing Hearth sessions
- How to develop PD/Hearth messages

Technical skills

- Use of food composition tables to calculate Hearth menus
- Converting metric measures into home measures
- Conducting Hearth sessions
- Characteristics of complementary feeding for a child of 6–36 months
- Graduation criteria for PD/Hearth
- Integration with other sectors, e.g. Agriculture, WASH (water, sanitation, hygiene)

Communication skills

- Supporting new behaviours and confidence-building skills
- Counselling skills in PD/Hearth

Project management skills

- Monitoring and evaluating PD/Hearth activities
- Analysis and reporting

Flow Chart of World Vision PD/Hearth Reporting Lines

Community Volunteers

- Selected by community
- Trained by PD/H Coordinators
- Run Hearth sessions
- Conduct follow up home visits
- Collect monitoring data

PD/Hearth Coordinators

- ADP or MOH H&N staff
- Trained by ToF or MT
- Train & supervise volunteers
- Prepare monitoring reports
- Enter data online database
- Coordinate with MOH, community leaders, zonal & provincial level WV staff

Zonal and/ or Provincial Coordinators

- Trained by ToF or MT
- Train & supervise PD/H coordinators
- Monitor projects
- Communicate with Regional & National WV and MOH entities

National Health & Nutrition Coordinator

- Trained by MT
- Train PD/H Coordinators
- Overall programme direction & monitoring
- Lead programme evaluation
- Communicate with national entities; WV Regional Nutrition Advisor
- Advocate for PD/H to MOH & MinAgri

Learning Styles and Facilitation

SESSION 4

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe their learning style preference
2. Explain how their teaching style can be adapted to include other learning styles.

Reference in *CORE PD/Hearth Guide*: pp. 1–14

Preparation

- Print Handout 4.1 and 4.2

Materials

- Handout 4.1: VARK questionnaire.
- Handout 4.2: VARK answer key.

STEPS

10Min

1.

HANDOUT
4.1 – 15m/H 15
4.2 – 17m18/H 17

Explain the four learning styles: **V**isual, **A**ural, **R**ead/write, **K**inesthetic (movement). Everyone has preferred ways to learn. Some people learn best using all four styles equally. They are called multi-modal learners and will be in the fifth group. Distribute the VARK questionnaire and ask each participant to complete it. Distribute the VARK answer key and allow each person to mark his or her questionnaire and total the scores in each section. Ask each to determine his or her overall learning style.

25 Min

2.

Group the participants by their preferred learning styles. There will be five groups. Ask each group to discuss these questions:

- How do you learn best? Be prepared to share with the large group two examples of how you learn best.
- How do you adapt when the teaching style does not match your preferred learning style? Be prepared to share with the large group two ways to compensate.

- How can you adapt your teaching to accommodate the different learning styles of your students? Be prepared to share one way you can do this. In the large-group discussion you will discuss with the other groups if this way of adapting would help them learn.
- Share and discuss the examples in the large group.

5 Min

3.

Good facilitation requires adapting one's preferred learning style to include methods that will help people with different learning styles to learn.

List together on a flip chart different methods that can be used. Be sure to include a wide variety of creative teaching styles *(role play, case studies, song, drama, reading, writing, games, stories, drawing, etc.)*.

5 Min

4.

Summarise the discussion. Emphasise the need to be creative and to use a wide variety of methodologies in facilitation of PD/Hearth courses.

(http://www.vark-learn.com, used with permission)

Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ a chance to ask questions and talk about the camera's features.
   - ☐ examples of good and poor photos and how to improve them.
   - ☐ clear written instructions with lists and bullet points.
   - ☐ diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ make lists of what to do and what to buy for the party.
   - ☐ invite friends and just let it happen.
   - ☐ talk about it on the phone or text others.
   - ☐ imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ walk with them.
   - ☐ write down the directions as a list.
   - ☐ tell them the directions.
   - ☐ draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ class discussions, online discussion, online chat and guest speakers.
   - ☐ field trips, case studies, videos, labs and hands-on practical sessions.
   - ☐ a textbook and plenty of handouts.
   - ☐ an overview diagram, charts, labelled diagrams and maps.

5. You have a problem with your knee. Would you prefer that the doctor:
   - ☐ showed you a diagram of what was wrong.
   - ☐ described to you what was wrong
   - ☐ demonstrated what was wrong using a model of a knee.
   - ☐ gave you an article or brochure that explained knee injuries.

6. After reading a play you need to do a project. Would you prefer to:
   - ☐ act out a scene from the play.
   - ☐ read a speech from the play.
   - ☐ draw or sketch something that happened in the play.
   - ☐ write about the play.

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ describe the activities you will be doing in the programme.
   - ☐ start practicing the activities you will be doing in the programme.
   - ☐ show them the list of activities in the programme.
   - ☐ show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ things you can click on and do.
   - ☐ interesting design and visual effects.
   - ☐ audio channels for music, chat and discussion.
   - ☐ interesting information and articles in print.

9. You have to present your ideas to your colleagues. You would:
   - ☐ write out your speech and learn it by reading it again and again.
   - ☐ write a few key words and practise what to say again and again.
   - ☐ gather examples and stories to make it real and practical.
   - ☐ make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
    - ☐ that used a written description or table of your results.
    - ☐ that used examples of what you have done.
    - ☐ from somebody who discussed it with you.
    - ☐ that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
    - ☐ trying it.
    - ☐ the salesperson telling you about it.
    - ☐ it is the latest design and looks good.
    - ☐ reading the details about its features.

12. You are going to make something special for your family. You would:
    - ☐ make something you have made before.
    - ☐ find written instructions to make it.
    - ☐ look for ideas and plans in books and magazines.
    - ☐ talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
    - ☐ clues from the diagrams in the instructions.
    - ☐ listening to somebody explaining it and asking questions.
    - ☐ watching others do it first.
    - ☐ reading the instructions.

(http://www.vark-learn.com, used with permission)

Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ **A** a chance to ask questions and talk about the camera's features.
   - ☐ **V** examples of good and poor photos and how to improve them.
   - ☐ **R** clear written instructions with lists and bullet points.
   - ☐ **K** diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ **R** make lists of what to do and what to buy for the party.
   - ☐ **K** invite friends and just let it happen.
   - ☐ **A** talk about it on the phone or text others.
   - ☐ **V** imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ **K** walk with them.
   - ☐ **R** write down the directions as a list.
   - ☐ **A** tell them the directions.
   - ☐ **V** draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ **A** class discussions, online discussion, online chat and guest speakers.
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   - ☐ **V** draw or sketch something that happened in the play.
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   - ☐ **A** describe the activities you will be doing in the programme.
   - ☐ **K** start practicing the activities you will be doing in the programme.
   - ☐ **R** show them the list of activities in the programme.
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   - ☐ **K** gather examples and stories to make it real and practical.
   - ☐ **V** make diagrams or get graphs to help explain your ideas.

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   - ☐ **R** that used a written description or table of your results.
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   - ☐ **V** that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
   - ☐ **K** trying it.
   - ☐ **A** the salesperson telling you about it.
   - ☐ **V** it is the latest design and looks good.
   - ☐ **R** reading the details about its features.

12. You are going to make something special for your family. You would:
   - ☐ **K** make something you have made before.
   - ☐ **R** find written instructions to make it.
   - ☐ **V** look for ideas and plans in books and magazines.
   - ☐ **A** talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
   - ☐ **V** clues from the diagrams in the instructions.
   - ☐ **A** listening to somebody explaining it and asking questions.
   - ☐ **K** watching others do it first.
   - ☐ **R** reading the instructions.

Total Personal Score: Visual =_____ Aural =_____ Read/Write =_____ Kinaesthetic =_____

Overview of Positive Deviance/Hearth

SESSION 5

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe the PD/Hearth approach in simple English
2. Explain how PD/Hearth is different from traditional nutrition education
3. List the three goals of PD/Hearth.

Reference in *CORE PD/Hearth Guide*: *pp. 1–14*

Preparation

- Prepare a flip chart with the three goals of PD/Hearth
- Print Handout 5.1

Materials

- Handout 5.1: Observation of a PD/Hearth Session
- Flip-chart paper
- Fresh foods (e.g. vegetables, eggs), plates, cooking pot, etc. for role play
- Glass half filled with water

STEPS

10 Min

1. Ask participants what they know about PD/Hearth. Ask them to state the three goals of PD/Hearth. Show them the prepared flip chart.

2. Ask how each of the three goals is accomplished through PD/Hearth.

1. ***Quickly rehabilitate malnourished children:*** *Hearth sessions feed a nutrient-dense menu for 12 days plus provide two weeks of follow up; caregivers learn and practise new skills, knowledge*
2. ***Sustain rehabilitation:*** *Follow-up visits ensure continuation of new habits learned; use of local, affordable foods; and involvement in production projects or other interventions that help address underlying causes of malnutrition*
3. ***Prevent future malnutrition:*** *A growth-monitoring programme ensures that the child continues growing well and identifies those who become malnourished; community involvement, including key influencers like grandmothers, builds understanding of causes and solutions to malnutrition and promotes adoption of new behaviours to change norms*

3.

Ask how PD/Hearth differs from more traditional nutrition-education efforts:

(Solutions come from within the community; bottom-up, not top-down programme; uses local, available and affordable resources; learning by doing; community 'owns' the problem and is involved in the solution, recognises the role of grandmothers as household advisors to child care and feeding).

The following table outlines some of the differences that you may wish to discuss.

Traditional Approach	Positive Deviance Approach
Needs-based: 'What is "wrong" here?' Based on **missing** resources	***Asset***-based: 'What is right here?' Based on **existing** resources
Assessment surveys can take up to ***six months***	Positive deviance inquiry (PDI) can take up to ***two weeks***
Depends on supply from outside	Generated by participants and community
Teaching what is ***not*** currently known	***Discovery*** of what ***is*** already known and practised by some individuals (positive deviance)
Solutions from ***outside*** the community	Solutions from ***within*** the community
Outside culture intervention; not always culturally appropriate	Culturally acceptable; based on ***indigenous knowledge***
Dependency, non-participatory; participants are **beneficiaries**	Empowering, participatory; participants are **actors** in their own development
Top down, vertical directives	***Bottom up,*** horizontal integration, variety of stakeholders
Design by ***donors, institutions and NGO***	Equal partnership, in which ***community, caregivers and NGO*** partner to manage and implement project
External inputs not sustained after programme completion; impact diminishes	***Inputs from community*** sustained; impact sustained as well
Centre-based rehabilitation of malnutrition	***Home-based*** rehabilitation and practice; community-based
Expensive, in context of duration of benefits	***Low cost,*** in context of sustained rehabilitation, malnutrition and deaths averted
Run by outside ***experts*** and programme staff	Run by ***community*** and community volunteers and caregivers themselves with training and support from programme staff
NGO or health-agency owned	***Community-owned***

Overview of Positive Deviance/Hearth

Traditional Approach	Positive Deviance Approach
Teachers/nutritionist from ***outside***; health providers	***Local*** peer educators; volunteer providers
Passive recipients: caregivers of malnourished children	***Active participants:*** caregivers of malnourished children and family/community decision makers
Individual-focussed: considers caregiver isolated from cultural context and enjoys full decision-making power over his/her child	***Family-focussed:*** considers caregiver in the context of the family and cultural system and recognises grandmother's influential role as household advisors related to child care and feeding
KAP: Knowledge, Attitude, Practice Knowledge change approach	***PAK:*** Practice, Attitude, Knowledge Behavioural change approach
Short-term impact	Sustained impact

Pass around a glass that is half filled with water. Ask participants to say how they view the glass (half full or half empty). One can choose to look at a problem in terms of what is lacking or in terms of what is present.

10 Min

4.

Ask the participants to prepare a role play to illustrate a PD/Hearth session using the food and other materials provided. They must come to agreement on what to illustrate, and each participant must have a speaking role.

10 Min

5.

Participants present the role play.

15 Min

6.

Review the role play. Ask participants to name the key elements they agreed to illustrate. Why is each of these elements important? Were there other elements that might (or should) have been included in the role play?

2 – 4 Hours

7. Alternative Approach to Steps 4–6 above

HANDOUT
5.1 – 23m/H 19

This overview session can be accomplished effectively by visiting a Hearth session that is in progress. If a community close to the training location is presently implementing PD/Hearth, plan a visit to observe a Hearth session. Distribute Handout 5.1: Observation of a PD/Hearth Session. Observe each of these elements in the visit. The grey boxes indicate elements that you will not be able to

observe. Talk to the Hearth Volunteer or the Hearth Supervisor, if possible, to decide if these elements were completed.

Upon return to the training location, discuss key elements, why they are important, and if any components were missing. Reflect on the observations. Include questions such as 'Why do you believe the PD/Hearth approach is appropriate?' or 'Do you ever feel that communities don't have local solutions?' Discuss how the PD/Hearth approach to rehabilitating malnourished children differs from more traditional approaches.

Observation of a PD/Hearth Session

Observe the strengths and challenges of PD/Hearth sessions. You will not be able to observe the essential components shaded in grey. Ask the Hearth volunteer or supervisor to determine if these elements were included.

Identify variations or innovations that have been implemented and how that may have affected results.

Essential PD/Hearth Project Components	Check for yes	Strengths	Challenges
1. Actively involve the community, including grandmothers, throughout the process (including integration with other sectors).			
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated.			
3. Conduct a PDI in every community. Incorporate findings into the Hearth (menu, message and tips, storytelling about what already works).			
4. Prior to sessions, deworm all children and provide immunisations and micronutrients.			
5. Use community volunteers to conduct sessions/follow-up home visits.			
6. Design Hearth-session menus based on locally available and affordable foods.			
7. The Hearth-session menus are nutrient-dense enough to ensure rapid recuperation.			
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth.			
9. Have caregivers present and actively involved every day of the Hearth session.			
10. Conduct the Hearth session for 10–12 days within a two-week period.			
11. Include follow-up home visits for two weeks after the session (every 1–2 days).			
12. If a child does not gain weight after two sessions, refer the child to a health centre.			
13. Limit the number of participant caregivers in each Hearth session to ten or fewer. (If working with caregiver-grandmother pairs, five pairs or fewer is preferred.)			
14. Monitor and evaluate progress.			

SESSION 6

Essential Elements

60 MIN | DAY 1

By the end of this session, participants will be able to

1. List the 14 essential elements for PD/Hearth implementation
2. Explain the importance of and reasons these elements are essential.

Reference: *Positive Deviance/Hearth Essential Elements, A Resource Guide for Sustainably Rehabilitating Malnourished Children (Addendum),* June 2005 http://www.coregroup.org/storage/documents/Diffusion_of_Innovation/PD_Hearth_Addendum_Jun_2009.pdf

Preparation

- Review Handout 6.1 and 6.2

Materials

- Handout 6.1: Positive Deviance/Hearth Essential Elements
- Handout 6.2: PD/Hearth Essential Elements – Detailed Observations and Key Questions
- Flip-chart paper, cut or torn in half
- A paper circle for each participant (four circles should fit easily on the half sheet of flip-chart paper without overlapping)

STEPS

5 Min

1. Shrinking Paper Exercise

Divide the participants into groups of three or four, and give each group half a sheet of flip-chart paper and one circle for each team member. Each team member places his or her circle on the half sheet of flip-chart paper without overlapping another member's circle.

Then, ask them to remove their circles, fold the flip-chart paper in half, and repeat the exercise. Keep doing this until the papers grow so small that there is room for only one team member's paper circle.

Ask participants to explain how this game might relate to PD/Hearth. How do people manage when resources are few? What coping skills do some individuals or groups develop? What are the characteristics of a PD behaviour? (*PD – positive deviance – solutions are behaviours and strategies that are local, simple, cheap, easy to replicate or adopt, and sustainable because they already exist before the intervention starts.)*

5 Min

2.

Explain that certain features of the PD/Hearth approach are essential for success. Because children quickly recover, their families are motivated to continue the new behaviours. Ask participants to name any of these essential elements.

10 Min

3.

HANDOUT
6.1 – 26m/H 20

Distribute Handout 6.1 and ensure that all 14 essential elements have been named. Divide into pairs. Assign two essential elements to each pair. Each pair is to list the reasons its two elements are essential. Those who finish early can look at the other essential elements and discuss the reasoning behind them.

20 Min

4.

Each pair explains to the group its two elements and the reasons they are essential.

10 Min

5.

HANDOUT
6.2 – m30/H 24

Discuss who is responsible for assuring that PD/Hearth in each community adheres to the essential elements. *(ADP staff that supervises, community Hearth committee, or volunteers, depending on the element).* Ask for examples. Present Handout 6.2: PD/Hearth Essential Elements – Detailed Observations and Key Questions, which can be used as a tool to monitor essential elements in a Hearth project.

10 Min

6.

Based on the essential elements, have the participants respond to the following challenges:

- The ADP wants to provide the food for PD/Hearth sessions.
- Caregivers are busy, so they want to send their children but not attend the Hearth sessions themselves.
- Volunteers, caregivers, or grandmothers change the menu based on what they have at home and would like to cook.
- Children 5–7 years old are included in PD/Hearth.

Several elements are essential to the implementation of an effective PD/Hearth project. Experience has shown that these elements cannot be adapted, modified, or omitted without seriously diminishing the effectiveness of the programme.

1. **Actively involve the community throughout the process.** Community leaders and a village health committee can provide support in organising the weighing of all children in the target age group; recruiting volunteers; conducting the PDI; contributing materials, utensils, and food for the sessions; assuring that eligible caregivers[1] attend the Hearth session regularly; and encouraging other community members, including key influencers like grandmothers, to support the families with malnourished children as they adopt new practices. Grandmothers[2] often play a major role in child care and feeding and act as advisors in this area to younger women who seek their advice and expertise. Engaging grandmothers from the start of the PD/Hearth implementation will facilitate the community's involvement and learning as grandmothers are key influencers in addressing child malnutrition. In the different steps of the PD/Hearth process, grandmothers can participate as mobilisers, hearth committee members and/or volunteers, participants in focus group discussions on child care and feeding, those being talked to and observed during the PDI, participants in Hearth sessions with the caregivers and children, key audience members in community feedback sessions, and supporters and advisors at home for the caregivers. The community can participate in monitoring project implementation and results. The higher the visibility of Hearth in the community, the greater the nutritional impact will be. Hearth sessions provide "living proof" that good nutrition practices help malnourished children. This raises the consciousness of community members and empowers them to prevent malnutrition within their community.

2. **Use growth monitoring to identify malnourished children and monitor the nutritional status of participants who have graduated from Hearth**. If a growth-monitoring and counselling programme does not exist in the community when PD/Hearth is initiated, it should be started in time to monitor the children who complete the Hearth session. The growth-monitoring programme must include good nutrition counselling and explanations of the child's growth for the caregivers. It is also an important tool for monitoring the progress of *all* the children in the target group over time, and it allows the integration of newly malnourished children into the second or third Hearth session.

3. **Use community members and staff in each and every community to conduct a Positive Deviance Inquiry.** The PDI is not simply a fact-finding exercise for the project staff. It is an opportunity for community members (e.g. Hearth volunteers, health staff, community leaders, grandmothers) to 'discover' that very poor families have certain good practices which enable them to prevent malnutrition and that these practices can be used by any family with similarly scarce resources. In order for a community to take ownership, the discovery process must take place in *that* community. Each community or communities within 40km radius with similar cultural practices, belief, and food availability need its own PDI to discover its positive deviance (PD) practices. Many programmes have tried to save time by using the PDI results from one community in another; doing

1. The term caregiver refers to anyone who has significant responsibility for the care and feeding of a young child. This may be a parent, grandparent and/or older sibling, depending on the cultural context and family situation. In some cases two caregivers, such as a mother-grandmother pair, may attend the Hearth sessions.
2. A grandmother refers to a senior woman (related or unrelated to the child) who lives in close proximity to the child and who has influence on child care.

so means that the second community loses the process of the discovery that results from the PDI. If there are no poor families with well-nourished children in a particular community, the PDI may need to look at families with only mildly malnourished children. Alternatively, if the community can identify a nearby community with the same culture, socioeconomic conditions and, perhaps, blood relationships, the volunteers can be taken there to identify PD families with whom to conduct the PDI. Since family coping may change with the seasons, it may be necessary to repeat the PDI during different seasons of the year.

The PDI consists both of questioning the family members, including caregivers and grandmothers, and of making careful observations of the situation. The list of questions that has been developed is best used as a discussion guide rather than as interview questions. With sufficient practice the PDI team should be able to visit the families without relying on the list of questions. A second or third person from the PDI team can concentrate on observing practices related to child care, hygiene, sanitation and food preparation, noting the roles of influential family members as well as what foods and materials are available in the home. Projects need to allow sufficient time to prepare for and conduct PDI visits to obtain the most useful information.

4. **Prior to the Hearth sessions, deworm all children, update immunisations and provide needed micronutrients.** Children are more likely to show quick recuperation when these important health interventions are taken care of before the Hearth session. Families should be referred for these services to the local health facility with whom the project is collaborating. These activities are kept separate from the Hearth session so that families do not attribute the child's improvement in nutritional status to these activities rather than to the food and feeding practices. During the Hearth session and follow-up home visits families will be encouraged to continue to access these and other preventive health services including growth monitoring and the use of insecticide-treated bed nets (ITNs), where needed. In areas of high malaria prevalence, children may need diagnosis and treatment before attending the Hearth sessions. If it becomes evident during the PDI that very poor families are using ITNs, it will be useful to discuss how they afford them in order to share that information with the Hearth participants. All children may be checked for underlying illness and/or anaemia before entering Hearth to screen for treatable conditions.

5. **Utilise community men and women as volunteers to conduct the Hearth sessions and the follow-up home visits.** Caregivers will learn best from those who normally provide child care advice and support within their culture and community, and who understand local customs and conditions. The volunteers can be any community members, including grandmothers, with a good reputation, credibility, healthy children and a willingness to take on the necessary responsibilities.

   Note: *PD caregivers are not necessarily Hearth volunteers. The PDI results in a collection of PD practices from multiple PD families; it is extremely rare that one family models all the PD practices. We are not looking for PD persons but PD practices. In many cultures identifying individuals or families as models (or somehow 'better') results in social rejection by their peers.*

6. **Design optimal Hearth menus based on locally available and affordable foods.** Participating families must be able to replicate meals in their own homes with limited resources. This is the only way they will be able to sustain the improved nutritional status of their children and prevent future malnutrition in the family. The affordability of foods is verified through the PDI, which discovers the foods used by the poor families with well-nourished children, and the market survey, which explores the costs and nutritional content of foods available for purchase.

7. **Provide a special, nutrient-dense meal capable of ensuring the rapid recuperation of the child.** The daily Hearth menu includes an extra meal and snack, an addition to what the child normally eats at home in one day. This menu must contain the following nutrient levels for each child:

Calories:	600–800 kcal
Protein:	25–27 g
Vitamin A:	400–500 µg RE (retinol equivalent) or 300 µg RAE (retinol activity equivalent)
Iron:	8–10 mg (may need iron supplementation or a fortified product to meet this requirement)
Zinc:	3–5 mg
Vitamin C:	15–25 mg

These figures show the range of supplementary nutrient levels necessary to rehabilitate malnourished children. Specific levels for children of different ages are listed in the *CORE PD/Hearth Guide*. Consider the Hearth meal as 'medicine'; this is the dosage prescribed. If the Hearth supplemental meal does not meet this minimum standard, then weight gains are compromised. The meal is a supplement, not a meal substitute. The additional calories and protein are needed for 'catch-up' growth of the child. When the child is no longer underweight, this 'extra' energy and protein-rich meal is no longer necessary. However, to sustain the rehabilitation gains, regular family meals need to be more balanced and nutritious. Caregivers learn how to do this during the Hearth sessions.

8. **Ensure that caregivers bring a daily contribution of food and/or materials to the Hearth sessions.** One of the fundamentals of PD/Hearth is that families learn that they really can afford to feed their children nutritious food. The PDI revealed what poor families feed their well-nourished children. Obtaining and bringing the foods reinforces the use of these affordable foods. The community also realises it is able to rehabilitate its malnourished children without outside material support.

9. **Have caregivers present and actively involved every day of the Hearth sessions.** Involvement promotes ownership and active learning and builds self-confidence. Repetition of new skills and practices enables caregivers to learn and adopt new behaviours. Attendance and active involvement of caregivers each day of the Hearth sessions is necessary for children to achieve adequate weight gain.

10. **Conduct the Hearth session for 10–12 days within a two-week period.** Within 8–12 days of starting the Hearth sessions caregivers will see notable improvement in their children. They may need some guidance to recognise the changes in their child, such as improved appetite, increased

activity, less irritability, higher level of alertness. Recognising these changes motivates the caregivers to adopt new feeding, caring and health practices. If a child is not fed the special extra meal over sequential days, recovery will be so slow that the caregiver will not have the satisfaction and motivation to continue the programme. There may be breaks of one or two days during the Hearth sessions to allow for weekends, holidays, or market days *(e.g. 4 days + market day + 4 days + market day + 4 days)*. The family must be encouraged to prepare the special meal at home on the days off. This Hearth session may be repeated the next month as some children will not experience 'catch-up' growth within a month.

11. **Include follow-up visits at home every 2–3 days for two weeks after the Hearth session.** It takes an average of 21 days of practice for a new behaviour to become a habit. The caregivers will need continued support to implement the new practices in their own homes. During home visits the volunteers or staff can help caregivers think of solutions to any difficulties they are encountering or respond to concerns about the child's progress, and can support grandmothers in their role as household advisors to facilitate positive changes in child care and feeding. By continuing to practise these new behaviours, the improved nutritional status of the participating child will be sustained at home and malnutrition will be prevented among future children.

12. **Refer a child who doesn't gain weight after two 10–12 day sessions to a health facility to check for any underlying causes of illness such as tuberculosis, HIV/ AIDS, or other infection**. If the child does not have an illness, direct families to other social services or to income-generation projects. The average number of sessions it takes to graduate a child varies among programmes, but the number of sessions a caregiver can attend is normally limited to two; otherwise, caregivers may become dependent on Hearth and not internalise new behaviours. A sense of urgency to rehabilitate a malnourished child should be instilled and encouraged in the caregiver and family. However, some children may need more time to gain weight. (Some projects opt to have all children checked for underlying illness before entering Hearth to screen for treatable diseases.)

13. **Limit the number of participants in each Hearth session.** Having a limited number of participants provides a 'safe' environment in which rapport can be built, and it gives all caregivers an equal opportunity to participate in all activities. Experience has shown that Hearth sessions are most successful when limited to no more than ten caregivers or five caregiver-grandmother pairs.

14. **Monitor and evaluate progress.** At a minimum, projects should monitor Hearth attendance, admission and one-month weights, and the percent of children who graduate after one session or after two sessions. Depending on community goals and national protocols, graduation may be determined as 400g weight gain in one month; an upward growth trend on the growth curve during two months; moving up one level (e.g. from moderate to mild malnutrition); or achieving normal weight for age. Projects monitor the longer-term impact by measuring the weight gains of participants two months, six months and one year after graduation, and by tracking growth of younger siblings and the target age group over time. Projects may develop other indicators to monitor the quality of implementation, community support, and so forth. Many examples of such indicators are given in the *CORE PD/Hearth Guide*.

Essential PD/Hearth Elements Detailed Observations and Key Questions

Summary components and sample questions to guide discussion on essential elements

Essential PD/Hearth project elements	Key questions to consider
1. Actively involve the community throughout the process. Leaders and/or the village health committee (VHC) provide support in organising weighings, finding volunteers, conducting PDIs, contributing supplies and participate in monitoring implementation/results. Individuals with influence on child care and feeding, particularly grandmothers, are engaged as advisors, mobilisers, volunteers, Hearth participants etc. The higher the exposure and involvement, the greater the impact on community overall nutrition status. Raising the consciousness of the community is empowering.	• How was the community mobilised? • What did the community contribute to the project? • How were grandmother and other influential figures engaged? • What information was given back to the community? When? • Have structures/policies that support child nutrition changed? • Was PD/Hearth integrated with other programmes/ sectors? How was this achieved? What were the results?
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated. If growth monitoring is not already in place, begin monitoring those who complete Hearth sessions and all children in target group over time. Growth monitoring must include counselling and explanations of a child's growth.	• Is routine growth monitoring present in the community? • Is counselling included? • How are children monitored after graduation?
3. Conduct a PDI in every community. A PDI is an opportunity for the community to make discoveries, not just to provide information to WV. To ensure community ownership, integrate the PDI into the Hearth sessions. A PDI may need to be done at different seasons. The goal is to identify PD practices, not only PD persons.	• How were the families to visit identified? • How was the PDI conducted? By whom? • How was information analysed? • Were PD foods/practices identified? • How were grandmothers involved? • How was the information utilised? Menus/ messages? • Was there sufficient technical skill to complete the PDI well?
4. Prior to sessions, deworm all children and provide immunisations and micronutrients. The purpose is to support rapid recuperation. Refer families to the local health centre before Hearth sessions so recuperation is not attributed to these activities. In endemic areas, malaria may need treatment before Hearth sessions.	• Was a situation analysis completed (nutritional assessment, feeding practices, expanded programme of immunisation coverage, vitamin A)? • Were all children under three years of age weighed? • Were children dewormed, immunised, vitamin A supplementation completed? • Were pre-existing underlying illnesses treated?

Essential PD/Hearth Elements
Detailed Observations and Key Questions

Essential PD/Hearth project elements	Key questions to consider
5. Use community volunteers to conduct sessions and follow-up home visits. Caregivers will be more comfortable and learn best from peers. A volunteer can be any community member, either male or female, who has a good reputation, is credible, has children in good health, and is willing to take on responsibilities.	• How were Hearth volunteers selected? • How were Hearth volunteers trained? • Were there gaps in the key competencies needed to implement the programme effectively?
6. Design Hearth session menus based on locally available and affordable foods. This is necessary to promote replication in home with limited resources in order to sustain improved nutritional status. Use foods confirmed through the PDI and verify the cost/ nutritional content through a market survey.	• Was a market survey completed? • Were PD foods identified? • Were the foods local, available and affordable?
7. Hearth session menus are nutrient dense to ensure rapid recuperation. Menu plus snack must contain required protein, calories and micronutrients to provide 'catch-up' growth The Hearth meal is 'medicine'. The extra meal is a supplement, not a meal substitute. To sustain the rehabilitation, families learn that meals need to be balanced and nutritious.	• Who decided on the menus? When? • Were menus nutrient dense (by programme standards)? • Who analysed the menus? • Were the menus followed in sessions? • Were the menu followed at home?
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth. This reinforces the fact that families can afford to feed nutritious food. The contributions make implementation possible without outside material support. Families providing resources ensures that the programme is non-paternalistic	• Were PD foods identified? • Did caregivers contribute PD foods? Other foods?
9. Have caregivers present and actively involved every day of the Hearth session. This promotes ownership, active learning and confidence. Repetition of practices builds habits that sustain rehabilitation and prevent malnutrition. Daily attendance is necessary to achieve weight gain.	• Was a caregiver involved with each child? Did caregiver-grandmother pairs work together where appropriate? • Did all caregivers participate in all the activities every day of the programme?

Essential PD/Hearth Elements Detailed Observations and Key Questions

Essential PD/Hearth project elements	Key questions to consider
10. Conduct the Hearth session for 10–12 days within a two-week period. Eight to twelve days are needed to see changes in the child. Caregivers may need help to identify improvement in appetite, energy, alertness, less irritability, and so forth. Changes in the child motivate caregivers to adopt and continue the new practices. If the child is not fed an extra meal over sequential days, changes are too slow for the caregiver to notice.	• Were PD/Hearth sessions conducted for 10-12 days? • What were attendance rates? • Was time spent reflecting with caregivers about changes in child?
11. Include follow-up home visits (every 2–3 days) for two weeks after the session. Caregivers need continued support. It takes 21 days to change a behaviour into a habit. Home visits help find solutions to obstacles to adopting new practices that are being faced at home. Home visits provide opportunities to address questions families may have about the child's growth.	• What did follow-up visits include? How often did they occur? By whom? • Did volunteers have the information and skills to support families in overcoming obstacles to child feeding/growth?
12. If a child doesn't gain after two sessions, refer the child to the health centre. A child with no underlying health issues who is not gaining may need referral to other social-services or income-generation projects. A sense of urgency to rehabilitate the child is needed by caregivers, families and volunteers.	• What happened if a child became sick during the session(s)? • Under what circumstances was a child referred to the health centre?
13. Limit the number of participants in each Hearth session to ten or fewer. A limited number of participants provides a 'safe' environment where rapport can be built. Caregivers have an equal opportunity to participate in all activities.	• How many children attended the sessions? • How many caregivers or caregiver-grandmother pairs attended the sessions? • Did caregivers participate in all aspects of the sessions?
14. Monitor and evaluate progress. Record attendance, entering and one-month weight, the percent of children who graduate. Check the long-term impact by measuring weight gain at two or six months, one year, and monitor the weight of younger children.	• Were graduation criteria established? • Was monitoring information used to improve implementation? When? How? • Was there adequate technical support for managers? For volunteers? • Was supervision frequent enough? Was it adequate?

How PD/Hearth Addresses Malnutrition

SESSION 7

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Name the steps in the PD/Hearth approach
2. Explain how PD/Hearth addresses different causes of malnutrition
3. List the components of child care.

Reference in *CORE PD/Hearth Guide*: pp. 1–14

Preparation

- Adapt the story of Tomi to the community context
- Make title cards for the wall labelled IMMEDIATE, ROOT and BASIC
- Write 'Key Steps in the PD/Hearth Approach' on a flip chart or use Handout 7.1: Flip Chart 7 – Ten Key Steps in the PD/Hearth Approach

Materials

- Two table tennis balls: one round, one crushed
- UNICEF model of malnutrition (refer to *CORE PD/Hearth Guide*, pp. 11–12, or print as a handout)
- Flip chart and markers
- Handout 7.1: Flip Chart 7 – Ten Key Steps in the PD/Hearth Approach
- Sticky notes and markers for participants

STEPS

5 Min

1.

Ask participants to think of a young child who is not growing well. Ask several participants to describe the child to the group. What things tell you that the child is not well? *(listless, sad, irritable, often sleepy, may cry a lot, sickly, no interest in playing, hesitant, thin arms and legs, much older than he or she looks)*

5 Min

2.

Demonstrate the healthy growing pattern of a well-nourished child compared to a malnourished child by using two table tennis balls. One ball is perfect, and the other is crushed. Ask two participants to bounce the balls on the floor, one at a time. Other participants should observe which ball bounces higher. Discuss this. Ask two other participants to draw on a flip chart the height and pattern of the bounce of each table tennis ball. Discuss reasons why the perfect ball bounces higher. Point out that a healthy child is like the perfect table-tennis ball. The healthy child has more regular and more 'well rounded' growth and shows more energy. A malnourished child is like the crushed ball. His or her growth is not regular and s/he has very little energy.

5 Min

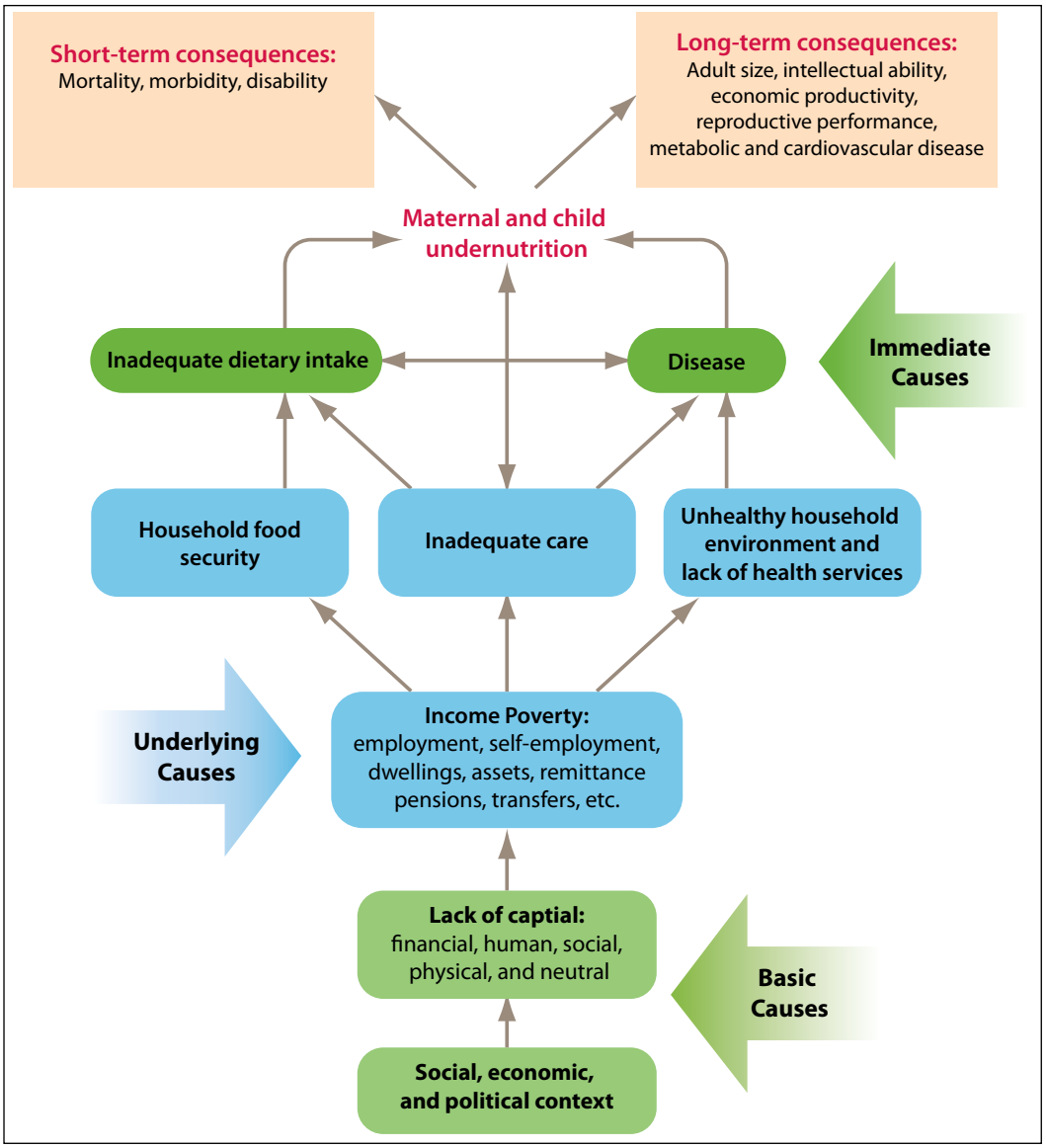
3.

Why do we care if children do not grow well? (Ensure that the following points come out: *more likely to be ill with infections such as diarrhoea, pneumonia, tuberculosis and malaria; increased risk of becoming infected with HIV; infection/ illness more likely to become serious or even cause death; learn more slowly and do not achieve well at school; lack of growing, both physically and mentally, will affect them throughout their lives; over their lifetime they will not be able to do as much work and will earn much less than those who were well nourished as children; will be less able to support their own children when they become parents; girls will have difficulty with pregnancy when they are grown women or they will have small babies)*

10 Min

4.

Refer to the UNICEF model of malnutrition (Figure 1).



Tell the following story about Tomi and ask participants to think about why Tomi is not growing well. Some of the reasons will not be clear in the story, but they can think about what might be causes related to the three levels in the diagram. Adapt the story to the community culture.

> Tomi is 15 months old. He is very small and very thin. Tomi has an older brother, Mo, who is 5 years old, and a sister, Sara, who is 3. Sara was born with low birth weight. Another sister was born very small and died soon after birth. Tomi's mother, Lila, is 27 years old. She is pregnant again. She breastfed all her babies, and—as the grandmother told her to—she also gives them tea and thin porridge. Lila works hard on a farm three miles from her home for a small wage. She finds the work very tiring, especially when she is pregnant. On the way back to the house she stops at the river to get a bucket of water. Once back at her house, she is too tired to do anything but cook the family's meal. Mo takes care of all the children while Lila is in the field. He tries hard to keep them clean and happy, but often Tomi has diarrhoea and a runny nose. They usually have tea for breakfast. At midday they eat whatever might be left over from the day before, but often there is nothing. In the evening the family eats maize or cassava and some green vegetables. They cannot afford meat or even beans.

Lead a discussion using the following questions: What are some reasons Tomi is not growing well? As participants give reasons, ask them why each might be a problem. Dig deeper, asking 'And why is that? And why?' to help them think of underlying causes of malnutrition. Have them write each reason on a sticky note and post it under the appropriate label on the wall. Move this part along quickly.

Ask which of these reasons is the biggest problem. Why? Does this happen in the communities where participants have worked?

Summarise the discussion by saying that there are many reasons that children do not grow well. These can include behaviour related to food, care, hygiene and health.

5 Min

5.

In the small groups have the participants use the levels of malnutrition to discuss how PD/Hearth addresses the causes of malnutrition. *(PD/Hearth is a short-term/immediate intervention addressing immediate causes. It responds especially to the first level of the illustration: immediate causes – inadequate dietary intake and disease. At the second level – underlying causes – the impact of the PD/Hearth approach is more limited. Discuss the implications on PD/Hearth from (1) insufficient household food security; (2) insufficient health services (creates demand) and unhealthy environment; and (3) insufficient maternal care and child care. Some root causes may also need to be addressed to solve the problems leading to malnutrition. PD/Hearth does not directly work on these issues. It is important to integrate with other sectors to address some of these basic and underlying factors.)*

5 Min

6.

Ask each group to explain to the whole group one level of the diagram. Ask for added input from others.

Ask participants what percentage of children under the age of 3 is malnourished in their district. How do they react to that? Choose to see the positive side of the situation. If 45 per cent of children are malnourished, with PD we look at the 55 per cent of children who are *not* malnourished to find solutions to the problem of malnutrition.

5 Min

7.

Discuss 'inadequate care' and the topics related to it on the UNICEF chart. Note that the PD/Hearth approach emphasises four components of child care:

- Feeding practices
- Caring practices (affection/attention), including psycho-social and family-child interaction/stimulation)
- Hygiene practices
- Health-care practices (including preventive health practices, home management of illness and health seeking).

Others causes of malnutrition depend on the cultural and local context and may include cattle disease (Southern Sudan), low birth weight, gender bias, and limited access to water, among others.

5 Min

8. 3 Types of Malnutrition

1. Underweight (Weight-for-age less than - 2 SD from reference)

Identifies *children who are 'underweight', that is, they weigh less than a healthy, well-nourished child of the same age.* This may be because the child has not grown normally in height, weight, or both, or because he or she has lost weight. ***However, underweight children are not necessarily wasted (i.e. have lost a significant amount of weight in a short amount of time to the extent of apparent 'thinness') and their poor nutritional status may not be as visible as wasting because it is not as severe.***

Measuring the rate at which children increase in weight is a very good way to monitor individual children's growth. The advantage of underweight is that it *reflects both past and present undernutrition in a population;* the disadvantage is that it is unable to distinguish between the two. Therefore, if a population has a high rate of underweight, we do not know if the reason is a ***recent*** lack of food or illness in the population or ***long-term*** undernutrition. Underweight is also a good indicator for monitoring data. If underweight is used

to target children who need IYCF counselling, you could prevent further stunting in the population and also wasting.

2. Stunting (Height/length-for-age less than - 2 SD from reference)

Identifies *children who are 'stunted' or shorter than expected for a healthy, well-nourished child of the same age.* If children are undernourished, their growth in height slows down. Children who are undernourished for a long time are shorter than they should be. We refer to this as '*chronic' or long-term undernutrition*. ***However, the stunted children are not necessarily wasted because a child that has been undernourished for a long period of time, may not have lost significant weight in a short amount of time. Thus, the child can be stunted, but not necessarily wasted.*** Stunting may be less visible than wasting or 'thinness' especially when the whole community has been affected by long-term undernutrition. In such case, shortness in height in children may have become a new 'norm' (i.e. many children are shorter than they should be and have not achieved normal heights) and may not be readily perceived as a critical problem.

Measuring the rate at which children increase in height is not a good way to monitor individual children's growth. However stunting is useful when we want to:

- **Assess the nutritional status of a population,** for example, when we do a survey of a community. Children's heights are an indicator of chronic malnutrition in the community and tell us if that community has been undernourished in the past or continues to be undernourished. This helps us to find which areas are most undernourished.
- **Measure changes in the nutritional situation of a community.** Height-for-age measurement of the children tells us whether, over a period of time, the nutrition situation is improving or getting worse. This is useful for our programme managers and planners who have to decide how to use funds and other resources, and for people who evaluate the effects of development projects.

Therefore, stunting is most useful for assessing overall community nutrition status and measuring long-term changes. Also, stunting does not vary by seasons over the year.

3. Wasting (Weight-for-height/length less than - 2 SD from reference or 'yellow or red' MUAC)

Identifies *children who are 'wasted', that is, thinner than expected for a healthy, well-nourished child of the same height.* These children have lost a significant amount of weight in a short period of time due to poor food security and nutrition and/or illness. ***This means wasted children will also be underweight, that is, they weigh less than a healthy, well-nourished child of the same age.*** Wasting *reflects recent, short-term (acute) malnutrition or illness.* It is a sign that a child is extremely undernourished and will die within several days to several hours if not

addressed. A severely wasted (severe acute malnutrition) child must be referred to a health centre or hospital, but if the child is moderately wasted (moderate acute malnutrition) the parents can improve the child's nutrition at home and the child can recover from wasting.

Wasting is the most severe form of undernutrition out of the three nutrition indicators, including: wasting, stunting, and underweight. MUAC can also be used to enable health and nutrition workers to quickly identify a severe acutely malnourished child. It is useful for **screening or assessing nutritional status of individual children** as well as for **assessing the nutritional situation of a community in an emergency situation.** The proportion of wasted children in an area may vary by the season, due to annual periods of food insecurity or seasonal illness. Thus, wasting is appropriate for examining short-term effects such as seasonal changes in food supply or short-term nutritional stress brought on by illness. Wasting is addressed through treatment and preventive nutrition activities.

Triggers for Action for 3 Types of Malnutrition

% of children 0-59 months moderately and severely undernourished

	Acceptable	Attention Required	Critical
Underweight	< 10%	10-19%	≥ 20%
Stunting	< 20%	20-29%	≥ 30%
Wasting	< 5%	5-9%	≥ 10%

In sum, when children do not receive good nutrition (i.e. a variety of foods in adequate amount) and/or have an underlying illness, they will start to lose weight and can become underweight. If this continues for a longer period of time, children's growth in height will slow down and they will not be able to reach their normal heights. So these children will be shorter than their same-age peers, resulting in stunting. Children who lose a significant amount of weight in a short period of time may be identified as wasted. Wasting is the most severe form of undernutrition among the three indicators as severely acute malnourished (or severely wasted) children (identified by red MUAC or WHZ < -3) can die quickly if not treated soon.

5 Min

9.

HANDOUT
7.1 – 40m/H 27

Introduce the key steps to PD/Hearth using a prepared flip chart (see below). This chart will be referred to while working through each step of the programme. Each key step number is noted in the title of the relevant session in the curriculum.

10.

Summarise the session, emphasising that the PD/Hearth approach seeks sustainable behaviour change, at the individual and family level as well as at the community level, in order to achieve the three goals of PD/Hearth *(to rehabilitate malnourished children quickly, to sustain rehabilitation, and to prevent future malnutrition)*.

Flip Chart 7
Ten Key Steps in the PD/Hearth Approach

Note to trainers: *The amount of time for each step will depend on the local context (with the exception of Steps 6 and 7). An example of the timing is included for Steps 2–7 to guide discussion with planners. Each key step number is noted in the title of the relevant session in the curriculum. Monitoring and evaluation occurs throughout the process, as illustrated by the right hand column.*

	STEPS	**APPROXIMATE TIME REQUIRED**	
Step 1	Decide whether the PD/Hearth approach is feasible in the target community.		
Step 2	Begin mobilising the community (mobilise or create Village Health/ Hearth Committee or working group within the community); select and train staff.	Mobilising the community can take several months and takes place throughout the entire project period. Steps 2 to 4 can take approximately 2–3 weeks, including: 2 days of training 2 days for situational analysis 2 days for PDI 2 days for analysis and feedback to the community	Monitor and Evaluate
Step 3	Prepare for a PDI (situational analysis).		
Step 4	Conduct a PDI.		
Step 5	Design Hearth sessions.	2 days	
Step 6	Conduct Hearth sessions.	2 weeks	
Step 7	Support new behaviours through follow-up visits.	Every 2-3 days in the 2 weeks immediately after the Hearth session, and continuing less frequently after that	
Step 8	Repeat Hearth as needed. Monitor progress of Hearth graduates and track growth of all young children.		
Step 9	Expand the PD/Hearth programme to additional communities.		
Step 10	Exit strategy for once underweight is eliminated or ADP phases out		

Determining the Feasibility of the PD/Hearth Approach for the Target Community (STEP 1)

SESSION 8

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe the assessment process and essential considerations for determining if PD/Hearth is a possible approach in a target area
2. Evaluate if PD/Hearth is a good approach for a target community (case study)
3. Review alternative approaches to use when PD/Hearth is not feasible or appropriate.

Reference in *CORE PD/Hearth Guide*: pp. 17–25

Preparation

- Flip chart for step 1. Write on the top: 'Essential Considerations for PD/Hearth Programme'
- Flip chart (1 for each small group) with the questions for the exercise in step 2 written on it
- Print out Handout 8.1 and 8.2

Materials

- Handout 8.1: Case Studies. Is PD/Hearth Appropriate for These Settings?
- Handout 8.2: Where to Implement PD/Hearth

STEPS

10 Min

1.

Emphasise that PD/Hearth does not work everywhere. Quickly introduce the following criteria for determining when PD/Hearth is appropriate:

a. **Malnutrition levels of approximately 30 per cent or higher (or > 30 children).** For the purposes of PD/Hearth, malnutrition is defined as low weight for age.

   How would you know the general level of malnutrition without doing your own assessment? *(Seek existing sources of information, such as an ongoing growth monitoring programme (GMP); national or local assessments; survey information – DHS data for the region, KPC baseline from a child survival programme; or even visual assessment in an acute situation.)*

   Experience shows that a rate of 30 per cent malnutrition does not apply to all situations. There may be a low overall malnutrition rate in a community, but a very high rate in one neighbourhood, for example, with 30 malnourished children under three years of age. (This situation also warrants starting a PD/Hearth programme.)

b. **Availability of affordable food.** Note that working in famine situations is difficult.

c. **Geographic proximity of homes.** It is easier for caregivers to attend Hearth and for volunteers to follow up with home visits when distances are not significant.

d. **Urban vs. Rural.** Cite some advantages and disadvantages of urban and rural programmes. Urban setting/slums require a rethinking of the Hearth approach because families often do not cook at home but resort to street vendors. The PD concept can be applied by looking at PD street vendors in addition to PD families.

e. **Community commitment.** Look for evidence of peer support, leadership, sense of community. (Note that transient populations—refugees, internally displaced persons (IDPs)—may lack a sense of community.) It may be necessary to form a village health committee (VHC) if there is no existing committee to work with.

f. **Complementary health services.** A functioning health centre, for example, can provide important inputs that are not available at the Hearth, such as deworming, immunisations, micronutrient supplementation (especially Vitamin A) and referrals.

g. **Systems for identifying and tracking malnourished children.** A growth monitoring programme (GMP) is not a precondition, but it may need to be added.

h. **Limited reliance on food aid.** Food aid can pose an issue for programme sustainability. PD/Hearth can be implemented if affordable, local foods are available and the food aid ignored. If food aid is provided for the entire community, PD/Hearth could be incorporated into the context, educating caregivers in how to use the resources received from food aid to enrich their meals. However, it is important to emphasise that in most months where food security exists, local foods could be used to overcome malnutrition.

i. **Organisational commitment of the implementing agency.** This will ensure access to financial, training and technical support as it is needed.

10 Min

2.

HANDOUT
8.1 – 44m/H 28
8.2 – 45m/H 29

Divide participants into small groups and pass out the case studies (Handout 8.1), the implementation criteria (Handout 8.2) and a flip chart with the following questions to each group. For each case the group should answer the following questions and summarise for the large-group discussion:

- Does this case meet the criteria for a PD/Hearth programme?
- What are the strengths that would help PD/Hearth succeed in this community? Advantages?

- What are the challenges of doing PD/Hearth in this community? Disadvantages?
- If PD/Hearth is not appropriate, what other approaches could address the nutrition problem?

20 Min

3.

Return to the large group. Allow each small group to discuss the case studies informally and to present its conclusions about the appropriateness of PD/Hearth. Ask for comments and discussion by the large group. Be sure to discuss alternative strategies if PD/Hearth is considered inappropriate.

Case study notes:

Coast village – level of malnutrition does not warrant the effort of PD/Hearth.

North interior – PD/Hearth is not appropriate; work is needed with the daycare, not the home.

Northeast mounds – Homes are too dispersed. Use creative approaches to promote appropriate breastfeeding and complementary feeding at clinics, markets, by radio, and so forth.

South Farming Community – PD/Hearth would be appropriate; grandmothers could be asked to run the Hearth sessions. Children will need to be screened for stunting.

Peri-urban slums – This situation has some potential for successful PD/Hearth; however, it may be more important to put together menus of street foods since women don't cook at home.

5 Min

4.

Recap the important criteria and take questions from the group on PD/Hearth Step 1 (determining the feasibility of PD/Hearth).

Case Studies:Is PD/Hearth Appropriate for These Settings?

Read and analyse the following cases. Decide whether PD/Hearth will work in each situation. If not, explain why not and think about an alternative approach. Suggest additional nutrition strategies and interventions needed from other sectors. If PD/Hearth is appropriate, but there are special challenges, please describe how to overcome them.

Case 1 – Coastal village – 12 per cent malnutrition but 35 children underweight

All the families make their living by fishing or selling fish. They live in a small village with houses very close together. The men are gone from before dawn until noon. When they return, they expect their big meal to be waiting. The women spend the afternoon cleaning fish and repairing the fishing nets. They work together on the beach and take their babies on their backs. Older children stay at the house with grandmothers or older siblings. There is plenty of fish to eat, but few fruits and vegetables most of the year. The health centre is in the next town, 15 minutes away by bus.

Case 2 – North interior – 35 per cent malnutrition

Families live in very small villages scattered through the tea estates. There are 10 to 20 families in each village. It can take between 30 minutes and one hour to walk over very hilly terrain to the main estate village. Nearly all the mothers work full time on the tea estates. The children from six months to three years spend nine hours a day in daycare with two paid employees. Food in the day care is provided by the estate. (After three years of age, children stay with grandparents during the day until they start school at age five.) The day care is located next to a good health clinic provided by the estate management. There is a joint management body made up of representatives of both workers and management.

Case 3 – Northeast – 32 per cent malnutrition

This good agricultural area produces grain, fruits and vegetables. The houses are dispersed, spread out over mounds. Grandmothers care for the small children when women go to the fields to work or the river to fish. There is a health centre in the nearest town, which is a four-hour walk for many families. When the rains come and water surrounds their mound, families cannot easily travel to other homes or villages. Some families have to move to higher ground for three or four months, which makes it difficult for them to raise poultry or livestock.

Case 4 – South farming community – 39 per cent malnutrition

Most of the children in this community are very short for their age. The families are engaged in farming, with most women at home except during harvest time. The village is very compact, and people work together on many community projects. Grandmothers decide when children should start getting water or food, often when they are one month old. There is a small Christian hospital, and government health workers bring vaccines and vitamin A.

Case 5 – Peri-urban – 20 per cent malnutrition

Families live in densely populated squatter settlements in simple houses with no sanitation. Water is fetched from central water taps some distance away. Families have easy access to health facilities. Because the houses are so small, most families do not cook at home. They buy cooked food from street vendors and snacks from the many small shops. Most women are at home during the day. Those who work leave their children in the care of older women. There are approximately 40 moderately and severely underweight children between the ages of 6-36 months.

PD/Hearth will not work everywhere. It is important to consider the following criteria when deciding if PD/Hearth is the right approach for a given community.

1. **Mild, moderate and severe malnutrition, based on weight for age, affects more than 30 per cent of children 6 to 36 months old or 30 underweight children between the ages of 6-36 months.** PD/Hearth is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include mild, moderate and severe malnutrition, but programmes concerned with cost efficiency may want to focus PD/Hearth activities on those who are moderately or severely malnourished and use less intensive methods to address the children with mild malnutrition. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely malnourished children in the 6–36 month age range.** Since it is unlikely that an implementing agency will have done a census-based nutritional assessment prior to deciding whether to implement the programme, the decision can be based on existing growth monitoring data, data from surveys of a representative sample of the population, or other existing data.

   Note: *PD/Hearth uses weight for age because that is the indicator most sensitive to change and does not require height measurements, which are difficult to collect. While mid-upper arm circumference (MUAC) is useful in screening for malnutrition in emergencies, it is not specific enough to identify all children who are also below weight for their age.*

2. ***Affordable food is available.*** A fundamental precept of PD/Hearth is that families can rehabilitate their children and prevent malnutrition with affordable, locally available food. If all poor families in the community are reliant on food aid or are eating only the staple food due to lack of anything else, other interventions to improve food security must come first.

3. ***Homes are located within a short distance of one another.*** Because caregivers are expected to come with their children to the Hearth session every day and the volunteers must make frequent home visits, the homes must be within easy walking distance from a central point.

4. ***There is a community commitment to overcome malnutrition.*** A commitment will serve to mobilise resources and pave the way for organising Hearth sessions and providing peer support to participating families. If there is no governing or civic body to work with, it may be necessary to form a village health committee. PD/Hearth has not been successful where populations are transient and lack a sense of community.

5. ***There is access to basic complementary health services.*** Health services are necessary for the children to receive inputs not available at the Hearth, such as deworming, immunisations, malaria treatment, micronutrient supplementation and referrals. Children receive the needed services ***before*** entering the Hearth and may be referred for further evaluation and treatment if they do not show adequate weight gain after participating in the Hearth for two weeks with two more weeks of follow-up visits at home.

6. ***Systems for identifying and tracking malnourished children exist or can be developed.*** While such systems are not a prerequisite, they must be developed for the programme. The first step may be a door-to-door census and weighing of children, but then a routine monthly growth-monitoring system must be established not only to track the children who complete the Hearth sessions, but also to detect other children who may need to enter the programme. PD/Hearth is intended to be only one phase of a wider nutrition programme.

7. ***The presence of food aid in Hearth can be minimised with careful planning.*** Families need to learn to provide the nutrition their children need from local foods, rather than food aid, which is not a sustainable solution to malnutrition or food insecurity. Limited amounts of food aid, in the form of local staples (such as rice and oil) can be used in the Hearth menus, but the participating families must contribute the other foods in order to learn firsthand about their accessibility and affordability. The Hearth sessions emphasise using locally available foods.

8. ***Organisational commitment of the implementing agency is strong.*** This is essential. Because of the effort required to start a PD/Hearth programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PD/Hearth need to devote themselves full time to PD/Hearth, particularly in the start-up months. Projects should consider budgeting for additional staff and recruiting additional volunteers rather than expecting existing staff and volunteers to add the PD/Hearth to their existing responsibilities. Since PD/Hearth is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.

Integration and PD/Hearth

SESSION 9

60 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe how PD/Hearth can be integrated in the ADP
2. Plan how to advocate with managers for integration.

Preparation

- Ask several participants to prepare ahead of time a five-minute skit on advocating with their WV supervisors for PD/Hearth

  Skit 1: Advocating with WV supervisors

  The national health and nutrition coordinator (NHC) is meeting with the operational director (OD). The OD is resistant to spending the time or money to implement PD/Hearth, saying it is too expensive to train people, takes too much staff time to implement and is too technical. The NHC presents the OD with facts about the situation: 45 per cent malnutrition will mean that these children are often sick; it will take more resources to try and keep them in good health; they will not develop well mentally, and when they go to school they will not learn well; as adults they will not have the physical or mental capacity to be productive and to care for their own families. PD/Hearth helps the community be responsible for its children and to discover the knowledge and resources to keep its children healthy. Focusing on empowering families and communities to rehabilitate their malnourished children now solves a present problem and builds towards a productive future for the community.

  Result: They agree to try a pilot PD/Hearth project in one community.

- Ask several participants to prepare ahead of time a five-minute skit on establishing networks for PD/Hearth with the local Ministry of Health

  Skit 2: Establishing networks with the local Ministry of Health

  The ADP manager and regional health advisor pay a visit to the local health officer. The health officer is constantly interrupted (the phone, someone bringing tea, someone bringing a paper to be signed) and is obviously very distracted. The ADP manager and regional health advisor tell the health officer about the high levels of malnutrition in the community and how the children are suffering (sick, don't grow), which will result in higher health costs, lower productivity and continued health costs in the future. They present the idea of PD/Hearth to address these issues *now* and ask for support from the local health officer, who agrees that these issues are important but very hard to address.

  Result: They agree to meet again and discuss what they might do together.

- Make two large puzzles out of heavy paper. Use a different colour for each puzzle. Cut each puzzle apart so there is one puzzle piece for each participant plus a few extra pieces. Label each of the pieces for the participants with one sector name from the list in step 2 below (you might have to add or subtract sectors to have the right number). Leave several puzzle pieces blank.

STEPS

5 Min

1.

Discuss with the participants the following questions:

- What is an overall goal for your ADP?
- What projects does your ADP have to reach that goal?
- What special projects do you have within your ADP?
- How does each of these projects contribute to the overall goal?
- What happens when each of those projects is planned and implemented as a separate entity? (*there is less impact; the overall goal of the ADP may not be affected as greatly; there is competition among projects*)

15 Min

2.

Divide the group in half. Give each group the labelled pieces of one of the puzzles, one piece for each person. Do not give out any of the blank pieces. Possible sectors include:

Food security
Health
Economic development
Disability
DME (design, monitoring, evaluation)
Special projects
Gender
Peace and reconciliation
Education/ECCD (early child care and development)
Livelihoods

The participants work together to assemble the puzzle, but each group will find it is missing some pieces. Have each group discuss examples of how PD/Hearth can be integrated with the sectors in their puzzle. What other sectors might need to collaborate with PD/Hearth to make it more effective? (*Examples: Communications, Advocacy, Agriculture*).

Imagine the group is the ADP staff and each person is the specialist for the sector on his or her puzzle piece. Direct each group to come up with a plan for integrating the various sectors with PD/Hearth in order to achieve its ADP's overall goal. *(Examples: **Education**: support hand-washing behaviours from PDI – stimulate children as agent of change in their homes. **Economic development**: support to increase the amount of family income available to spend on food; use resources they have available; create income-generating projects. **Food security**: preserve food (drying, pickling, etc.). **Livelihoods:** caregivers who comply with key behaviours being monitored receive benefits (hens, seeds, etc.); for example, if a pregnant women attends all her ANC visits – or takes her iron/folate supplements, or displays other positive behaviours specified – she receives benefits from the ADP food security project)*

10 Min

3. Have the two groups share their plans.

10 Min

4. At what stages can we integrate PD/Hearth into the ADP?

- design
- redesign
- training
- selection of target families – have all sectors target the same community/ families to ensure they receive the support they need to change behaviour
- preparation of annual operating plan (AOP)
- implementation
- planning – develop joint plan of action
- completion of the PDI (the data gathered shows where we are) – meet with participants in working groups for DME (design, monitoring and evaluation), economic development, food security, health, special projects, etc.; present the findings and discuss together how each sector can address the underlying issues that affect nutrition.

20 Min

5. Have the groups present the skits on how to advocate with World Vision leadership and how to advocate with the Ministry of Health.

Discuss the following questions:

- With whom does PD/Hearth need to collaborate or network? *(local health authority, international non-governmental organisation [INGO], local NGO, local leaders, local networks [formal and informal], community-based organisations, non-government health services [mission hospitals])*
- What are the advantages of networking? *(sharing human resources, information, materials and facilitation; joint targeting – for example, if another group is doing WASH, orient the group to PD/Hearth and work in same area to increase impact; referral of cases)*
- How can you ensure learnings from the PDIs, and other key health and nutrition messages are shared with the entire community on an on-going basis?
    - Through community feedback sessions
    - Partner and involve the Ministry of Health and health facility staff during the community mobilisation and training of volunteers (even PD/Hearth TOTs is possible) to ensure key messages and unique findings from PDIs are incorporated into the existing system for sharing Health and Nutrition messages (selection of only six key messages for a 12-day PD/Hearth Session may be limiting so it would be good to scale-up the learnings from PD/Hearth)
    - Share with community during visits to the health facility, counselling sessions for caregivers, mother care groups, breastfeeding support groups, and/or regular monthly GMP sessions (if system is in place)
    - Advocate, educate and remind the community on an on-going basis through community/district radio messages
- How can you develop the commitment and support of leaders within WV?
    - Advocate – within WV with supervisors, ADP managers and Zonal/National Office leadership, as well as with community members and other entities such as the Ministry of Health.
    - Use real data – from your assessments, PDIs, and so forth to inform leaders about the extent of nutrition problems and the potential positive outcomes using resources already in the community.By the end of this session, participants will be able to

Personalise the Curriculum
Daily Summary and Evaluation

SESSION 10

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Adapt the content of this day's sessions to their own culture
2. Reflect on the concept of PD/Hearth
3. Evaluate their personal learning for the day.

Preparation

- Practise telling the 'Stone Soup' story
- Make a flip chart with the daily evaluation questions (listed below)

Materials

- Half sheet of paper for each person

STEPS

30 Min

1.

Each participant will reflect on the day's sessions thus far and write in his or her curriculum ideas to improve or adapt the various methods of presenting the material so they are more appropriate for his or her culture. Ask the participants to be ready to share any good ideas they might have.

5 Min

2. Tell the 'Stone Soap' story

A kindly, old stranger was walking through the land when he came upon a village. As he entered, the villagers moved into their homes, locking doors and windows. The stranger smiled and asked, 'Why are you all so frightened? I am a simple traveller, looking for a warm place to stay for the night and a place for a meal.'

'There's not a bite to eat in the whole province,' he was told. 'We are weak, and our children are starving. Better keep moving on.'

'Oh, I have everything I need,' he said. 'In fact, I was thinking of making some stone soup to share with all of you.' He pulled an iron cauldron from his cloak, filled it with water, and built a fire under it. Then, with great ceremony, he drew an ordinary-looking stone from a silken bag and dropped it into the water.

By now, hearing the rumour of food, most of the villagers had come out of their homes or were watching from their windows. As the stranger sniffed the 'broth' and licked his lips in anticipation, hunger began to overcome their fear.

'Ah,' the stranger said to himself rather loudly, 'I do like a tasty stone soup. Of course, stone soup with cabbage – that's hard to beat.' Soon a villager

approached hesitantly, holding a small cabbage he'd retrieved from its hiding place, and added it to the pot.

'Wonderful!' cried the stranger. 'You know, I once had stone soup with cabbage and a bit of dried fish as well, and it was fit for a king.'

Another villager managed to find some dried fish . . . and so it went, through potatoes, onions, carrots, mushrooms, and so on, until there was indeed a delicious meal for everyone in the village to share.

The village elder offered the stranger a great deal of money for the 'magic' stone, but he refused to sell it and travelled on the next day. As he left, the stranger came upon a group of village children standing near the road. He gave the silken bag containing the stone to the youngest child, whispering to the group, 'It was not the stone, but the villagers who performed the magic.'

5 Min

3. Discuss with Participants

How do you think this story is like PD/Hearth? *(community works together; everybody contributes what he or she can; uses what is available in community; learn from one another; helps the growth of children)*

5 Min

4. Daily Evaluation

Distribute a half sheet of paper to each participant. Ask them to respond to the three phrases written on the flip chart.

1. Something I learned today that I will apply in our PD/Hearth programme is

_____.

2. Something new that I learned about PD/Hearth today is

_____.

3. Something I'm still confused about is

_____.

Note: *The facilitators will review these evaluations at the end of each day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.*

2 Min

5.

Thank the participants for their good work. Mention any highlights of the day. Remind them of the time for the next meeting.

Review of Day 1 and Agenda for Day 2

SESSION 1 1

15 MIN | DAY 2

By the end of this session, participants will be able to

1. Review Day 1 content
2. Outline what will be covered today.

Preparation

- Review questions for Day 1.

Materials

- Ball
- Prizes for winning team members

STEPS

10 Min

1.

Ask the participants to form two lines facing each other. Ask a question. Throw the ball to a person, who must then answer the question. If the answer is correct, ask another question. If it is incorrect, repeat the question. The person holding the ball throws it to a person on the other team, who must answer the question. The team that answers the most questions correctly wins.

Possible questions:

- What is one goal of PD/Hearth? (ask the question three times; people give different goals)
- What is one of the essential elements of PD/Hearth? (possibility of 14 answers)
- What is a criterion to determine if PD/Hearth is feasible?
- What is a responsibility of a Master Trainer?

5 Min

2.

Review agenda for today.

Community Mobilisation (STEP 2)

60 MIN | DAY 2

By the end of this session, participants will be able to

1. Describe successful community mobilisation methods for involving key stakeholders and community members
2. Identify key stakeholders.

Reference in *CORE PD/Hearth Guide*: pp. 27-–29, 43–59; see also p. 185.

Resources for Community Participation:

Lisa Howard-Grabman and G. Snetro, *How to Mobilise Communities for Health and Social Change (*Baltimore: Johns Hopkins University Center for Communication Programs, 2003).

Judiann McNulty, S. Mason, and Judi Aubel, *Participation for Empowerment (*Atlanta: CARE, 2001). Available: www.coregroup.org/imci/CoreItemDetail.asp?ID=18

Karen Schoonmaker-Freudenberger, *Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A Manual for CRS Field Workers and Partners (*Baltimore: Catholic Relief Services, 1999). Available: www.catholicrelief.org/what/overseas/rra_manual.cfm.

Preparation

- Print out Handout 12.1
- Prepare one flip chart titled 'Whom do you need to mobilise for PD/Hearth?' with a simple Venn diagram on it.
- Prepare one flip chart with the Triple A cycle (see below).
- Prepare a flip chart with the following discussion questions:
  - What is the role of the Ministry of Health?
  - What is the role of the Village Health Committee?
  - How do you get maximum buy-in and support? How do you keep this involvement?

Materials

- If possible, copies of the resources listed above for participants to examine
- A brick (or other 'base') for each group of four; these need to be identical
- 12.1 Handout: Community Mobilsation (STEP 2)

STEPS

10 Min

1. Building to the Sky Game

Divide participants into groups of four. Give each group an identical base (brick or book, for example) on which to build a tower. They will have two minutes to build a tower on the base using anything available in the room. At the end of two minutes, look at the towers. Congratulate those with the highest. Then lead a discussion on which is highest, strongest, most pleasing, and so on. After this brief discussion, remove the base of the winning tower. What happens? Ask participants how this illustrates PD/Hearth and working in the community *(base needs to be stable; base needs to be strong; use what is available; each tower is unique; without the base, the tower is unstable)*

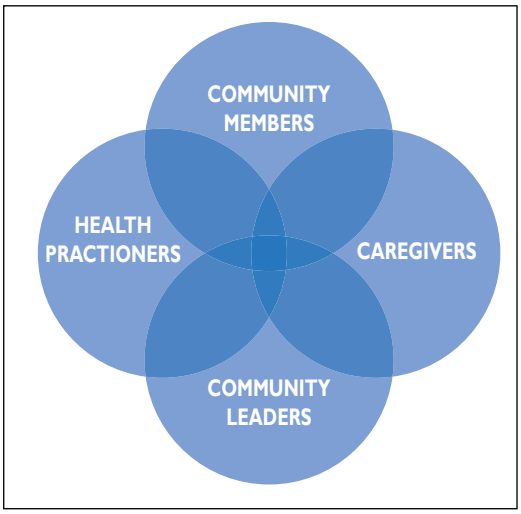
30 Min

2. Introduce PD/Hearth Step 2

Stress the importance of community mobilisation. PD/Hearth needs involvement by the community in order to succeed. This is a very important component that is often overlooked but necessary to deliver sustainable impact and prevent malnutrition in younger siblings. Master PD/Hearth Trainers should have a solid background in community mobilisation. Indicate that community mobilisation is a big topic, and many participants have a lot of experience with it. The discussions in this course will focus on the context of community mobilisation for PD/Hearth, but will also pull from the expertise of the group. Use key questions to brainstorm and guide discussion, writing group input on flip charts. (*Note:* uncover the previously written questions one at a time.)

HANDOUT
12.1 – 56m/H 31

Whom do you need to mobilise for PD/Hearth? Show the participants the diagram of overlapping circles (Venn diagram) below. Each large circle represents a group of people in the community who may need to be mobilised for PD/Hearth. Ask participants who in the community needs to be mobilised. As they call out answers write one group of people in each circle. Ask who are people within each of these groups who should be included? Add these groups to the smaller overlapping circles to show that there are many stakeholders who need to be mobilised for PD/Hearth *(community leaders; fathers, grandmothers, mothers and other caregivers; health staff, volunteers and their families [large time commitment]; traditional healers; traditional birth attendants; schoolteachers; and many others can contribute to the success of a PD/Hearth programme)*.



What is the role of the Ministry of Health? *(How is it incorporated?)*

The Ministry of Health provides support services such as immunisation, deworming, vitamin A supplementation; training; monitoring; and scale-up of learnings from PD/Hearth into existing health and nutrition message sharing systems).

What is the role of the Village Health Committee? *(Does a VHC exist? Does it need to be revived?)*

The VHC manages and coordinates health activities at the local level; sets criteria for, selects and supervises community health volunteers; and collaborates with the implementing organisation and district health staff (contextual depending on the country's existing Ministry of Health structure).

Can PD/Hearth be implemented without a Village Health Committee?

In the absence of a VHC, it is important to identify management resources at the grassroots level; build on existing resources. If possible, work to re-establish a non-functioning committee or establish a VHC or Village Hearth Committee.

What is the role of grandmothers?

In many cultures grandmothers are highly influential in the home as advisors on child care and feeding, and thus are important figures to engage throughout PD/Hearth. The following activity will help to illustrate the importance grandmothers have, especially in maternal and child care, and the necessity to include them in PD/Hearth.

Ask participants to write down on small pieces of paper what areas a grandmother would have a role/influence within a family in their community. For example, a grandmother would give advice to young women about marriage and how to manage their household. Use the pieces of paper to form a tree of the multi-faceted roles of grandmothers in the family and community.

Ask participants to identify ways to involve grandmothers in PD/Hearth. Ensure the following points are included:

- Consider grandmothers for leadership roles, including VHC and Hearth volunteer positions
- Consult grandmothers during situational analysis
- Interview grandmothers during PDI and/or involve grandmothers in conducting the PDI
- Engage grandmothers as participants in Hearth, either as caregivers, volunteers or part of caregiver-grandmother pairs

- Include grandmothers in follow up home visits, including review of child's progress and discussion of challenges to implementing PD practices at home

15 Min

3.

Divide into four groups (or as many groups as circles on the Venn diagram). Each group represents one community group. Come up with as many strategies as possible for:

- Maximising commitment and support; and
- Maintaining involvement throughout the project.

After a few minutes, call on volunteers to state the ideas their groups have come up with. *Note:* Listen to the participants' knowledge. *The solutions are in the group.*

Discuss the following questions:

How do you get maximum commitment and support?

Engage the community as the primary partner, with a role in selection criteria of volunteers. Be sure to involve in the process people who might raise barriers.

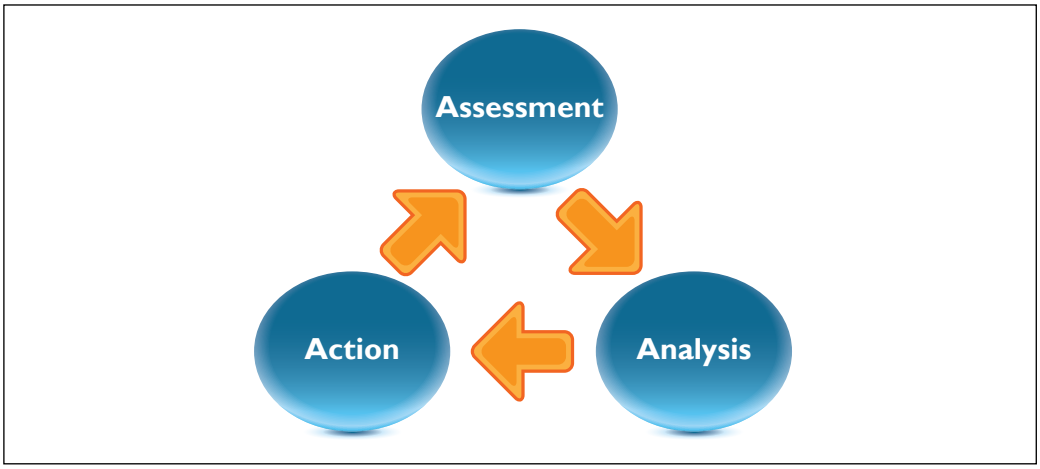
How do you keep this involvement throughout the project?

Establish a partnership with the community from the beginning and maintain it throughout.

See the **Triple A** cycle (assess, analyse, action) discussion on p. 29 of the *CORE PD/Hearth Guide*. Programme management is carried out in partnership with the community by assessing the problem, analysing its causes and taking action based on this analysis.

From the community mobilisation steps below, what activities might the community include in each circle (assessment, analysis, action)?

Discuss together key times when the community can be mobilised (based on the following steps).



STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP:

Step 1 Identify community leaders using existing community health volunteers and plan to meet with community leaders, religious leaders and women representatives.

Step 2A Ask community leaders for their permission and invitation to use the PD approach (finding existing solutions to malnutrition problems from within the community).

Step 2B Ask about the existing local health systems (e.g. Village Health and Sanitation Committee (VHSC), VHC (Village Health Commitee), etc.). Discuss a way to describe PD concepts in the local language (i.e. proverbs, stories). Discuss volunteer selection if a particular volunteer group does not already exist.

Step 3 Engage the community to define the problem (conduct wealth ranking); weigh all the children in the target group with community members, especially men (special GMP session). Involve community in focus group discussions, community mapping, seasonal calendar, transect walk, and market survey.

Step 4 Community Feedback Sessions: engage community members in discussion about the issue of childhood malnutrition; discuss its causes, common challenges and constraints, and ask for their ideas or suggestions for solutions. Involve men, grandmothers, mothers and all women who delivered the year before, include TBAs and traditional healers as well as religious leaders. Other very important activities to engage community members include: social mapping (include young men and women in this activity), seasonal calendar, market survey and wealth ranking.

Step 5 Second Community Feedback Session: Prepare and train leaders to carry out a meeting with the larger community to share the baseline information (results of the weighing) and the findings from group discussions as well as the PD concept from the visual poster to show nutritional assessment results. Also share the visuals of community created social mapping, seasonal calendar, market survey and wealth ranking. Discuss on the volunteer identification or if there are no volunteers yet, select volunteers.

Step 6 Plan and carry out PD inquiries with community members.

Step 7 Have community members (VHC) analyse and select key PD behaviours and have them share the PDI findings with the whole community, examining the PD behaviours and strategies with the community members; invite them to develop a plan of action that will include Hearth sessions.

Step 8 Involve or remain transparent to the community in selecting staff – such as a supervisor, village hearth committee members, and/or community health volunteers – to contribute to the staff's credibility and to promote the community's ownership of the programme.

Step 9 Involve the community in monitoring monthly progress in the nutritional status of all children in the target group. (In Bangladesh a consolidated community growth monitoring chart is used for all children participating in PD/Hearth so the entire community can see the effectiveness of the programme.)

Step 10 Appreciation Day/Graduation Day

Step 11 Program Monitoring and Review

4.

For the community mobilisation and ownership Step 2, conduct a role play where you are meeting with the community leaders for the first time to talk about the following:

- Ask community leaders for permission to help the community overcome malnutrition
- Explain the concept of PDH without using technical language
- Explain the program of PDH (12 day long education session)
- Emphasize that we are here to learn from the community because there are positive behaviours that are allowing their children to stay healthy whether they are practicing the behaviours knowingly or not. We are here to identify those positive practices, especially from those households who do not have a big house and many cattle, yet they still have very healthy children
- Ask if there would be any members from the community who would like to help volunteer to run the program as this program cannot be run without the community taking the leadership

5 Min

5.

Summarise some of the key challenges to community involvement and some of the solutions developed by the group. Refer participants to additional exercises for mobilising communities in the *CORE PD/Hearth Guide*, pp. 43–52. Answer any remaining questions. Note that we will be spending time throughout the remainder of the course working on each of these activities.

Note: *It is vitally important to understand fully the community players, conflicts, priorities, existing structures and resources.*

If hard copies of the resources for community participation listed above are available, suggest that participants look at these during breaks and/or list websites where participants can obtain them.

SESSION 13

Staffing Needs
Selecting and Training Volunteers (STEP 2)

World Vision

45 MIN | DAY 2

By the end of this session, participants will be able to

1. Describe the roles and responsibilities of staff and volunteers required for PD/Hearth, with an overview of the organisational structure.

References in *CORE PD/Hearth Guide*: pp. 20–24, 31–35, 39–42, 50–56

Materials

- Organisation chart (See p. 24 in the *CORE PD/Hearth Guide*)
- Flip chart with the title 'What PD/Hearth Volunteers Do'
- Flip chart with the title 'Skills Needed by Volunteers'
- Flip chart with blank paper

STEPS

5 Min

1.

Reiterate that PD/Hearth is a human resource–intensive programme. Though the programme does not require large investments in infrastructure, the hard work and commitment of staff and volunteers are critical to its success.

2.

Discuss the importance of having the commitment of WV leadership and the support of key sectors for PD/Hearth. How can the participants begin to achieve this commitment? *(use data to raise awareness of levels of malnutrition; give orientation on principles of PD/Hearth; stress importance of other sectors to address underlying causes and how this contributes to child well-being; include all sector leaders in discussions, planning and trainings)*

3.

Briefly describe the roles of Hearth manager/lead trainer (e.g. National Office level Health and Nutrition Coordinator), supervisor/trainer (e.g. ADP level Health, Nutrition and HIV/AIDS Officer), village health committee (VHC), and Hearth volunteer. Review each position and its corresponding responsibilities, based on the text in the *CORE PD/Hearth Guide*. Ask what titles the participants use for the staff members who fill these positions in their ADPs. Refer to the sample job descriptions in the *CORE PD/Hearth Guide* (pp. 39–42) and ask participants to read these as homework.

5 Min

4.

Discuss the total number of volunteers/staff and beneficiaries, using the chart in the *CORE PD/Hearth Guide* (p. 24) or give practical examples from your

experience of implementing PD/Hearth. Ask participants and other facilitators to suggest circumstances that might lead to adapting these suggested numbers and/or roles.

5 Min

5.

Use the remaining time to discuss other questions, including:

- **Can the programme manager have other non-Hearth responsibilities?** *Yes.*
- **Can the trainer/supervisors have other non-Hearth responsibilities?** *While the Hearth is being actively implemented, these people will be unable to have other responsibilities.*
- **Can the volunteer health worker be a Hearth volunteer?** *Yes, but he or she must have sufficient time to devote to the full Hearth session (training, baseline assessment through preparation, PDI and Hearth). This job provides immediate satisfaction, which might motivate a Hearth volunteer for a future role in the community.*
- **Do the staff need to be full-time from the start?** *Yes.*
- **Why are community involvement and transparency in selection of staff (for example, supervisors) and volunteers important?** *Community involvement and the way staff are selected contribute to the credibility of these people in the eyes of the community.*
- **What is the role of a Health/Hearth Committee or Working Group?** *To ensure there is a clean water source; ensure GMP conducted and all children under five years attend; monitor vital community events; supervise Community Health Workers (country contextual – in some countries the Village Health/Hearth Committee or working group may support the Community Health Workers rather than supervise); and oversee Hearth sessions.*

5 Min

6.

Ask participants what PD/Hearth volunteers are expected to do. Write their answers on the flip chart under the title 'What PD/Hearth Volunteers Do'. (*manage Hearth Sessions; conduct follow-up household visits; encourage caregivers to continue practicing new behaviours; help caregivers find solutions to challenges they face)*

5 Min

7.

Ask what skills PD/Hearth Volunteers need to be able to do these tasks. Write their answers on a flip chart under the title 'Skills Needed by Volunteers'. *(train caregivers; demonstrate good practices; monitor and weigh children; follow up with home visits; record information; give messages, counsel and support)*

Based on the answers to the questions in the above steps, ask how volunteers should be selected. Probing questions could include the following (all of these may not be needed):

- Who should select the volunteers? (*community members and leaders)*
- What qualifications does a volunteer need*? (able to read and write, live in the community, committed, good behaviour, respected by the community, familiar with the area)*
- Is it possible to find someone with these qualifications in your community? (s*elected by community as part of community-mobilisation process)*
- Are the people who have these qualifications in a 'higher' social group, and might that make it more difficult for them to interact with poor caregivers?
- If no women in the community are literate, what might be an alternative way to fill out the register and reports? *(enlist a literate adolescent girl to assist her; one of her own children might be able to help with the writing; in some communities women are not available or have died of AIDS and fathers are volunteers)*
- Does the volunteer have to be a mother of a child under age two? (*No. Experience has shown that it is actually better if the woman's children are older so that she isn't preoccupied with caring for her own small child. Grandmothers may be a good choice for this reason and because of their influential role in they care and feeding of young children.)*
- Why do we not automatically recommend that the mother of the PD child be the volunteer? *(in some cultures this could cause her to become socially isolated, may not have the qualifications, may not necessarily be a model in all ways).*

5 Min

8.

Ask participants how volunteers will learn the necessary skills. Ask them to put an 'E' beside those skills they will learn through experience and a 'T' beside those skills they will learn through training. Emphasise that volunteers will learn primarily through doing and practise. For example, they will discover unusual and good practices that contribute to good health and nutrition by participating in the PDI, and they will learn good cooking and feeding by practising cooking the menu together.

9.

Ask the following questions:

- Who will train the volunteers? *(a trainer trained at the ADP staff level)*
- Who will train the trainer? *(National Office/technical staff)*
- Who will train the ADP staff person? *(National Office/technical staff)*
- Who will train the National Office/technical staff? *(PD/Hearth Master Trainer or recognised international trainer)*

This process is called cascade training.

5 Min

10.

Ask participants to line up in one straight line (or in a circle if the room is small). The facilitator whispers a sentence in the ear of one participant, who whispers the sentence to the next person, and so on, to the last person in the line. Each person says the sentence only once. The last person says the sentence aloud for all to hear. (Possible sentences: '_____ is the most beautiful country in the world' or 'Healthy children are active and eat well'. The sentence must be original, not a common phrase or saying.)

After the last person repeats aloud what he or she heard, the facilitator says the original sentence aloud to compare. Repeat the exercise with another sentence. Did the sentences become distorted? Participants may return to their seats at this point to consider the following questions.

- Can this kind of 'distortion' happen with cascade training?
- What can we do to ensure that volunteers learn the same information as those who will train as TOTs?
- How will the training methodology for volunteers differ from that for TOTs? Why? What examples can you share from your experiences in the ADPs?

Refer participants to the *Training of PD/Hearth Volunteers Curriculum* as well as the *CORE PD/Hearth Guide* (pp. 53–56) for examples of methods used to train volunteers. All training curricula require adaptation to local contexts.

10 Min

11.

Discuss the following questions with the group:

- What is the best way to ensure that volunteers can conduct PD/Hearth with confidence? *(ADP staff can accompany them every day for the first week or ten days to offer support and encouragement while the volunteers lead the activities.)*
- During the next rotation of PD/Hearth, how often might staff need to visit the Hearth session or accompany the volunteer during home visits? *(At least once a week.)*

Explain that supervision and supervision tools will be discussed in a later session.

Situational Analysis – Wealth Ranking (STEP 3)

30 MIN | DAY 2

By the end of this session, participants will be able to

1. Explain the purpose and process of wealth ranking using community criteria
2. Use pre-defined criteria to rank households by wealth status
3. Complete filling out and compiling of wealth-ranking data on Situational Analysis Excel template.

Reference in *CORE PD/Hearth Guide*: pp. 65–66

Preparation

- Print copies of Handout 14.1, 14.2 and 14.3
- Provide participants with soft copy of Situational Analysis (refer to Resource CD)

Materials

- Small objects in two different variations, such as stones of different colours
- Print copies of Handout 14.1 and 14.2 for each participant
- Handout 14.1: Case Examples for Wealth-Ranking Exercise
- Handout 14.2: Case Examples for Wealth-Ranking Exercise ANSWER KEY
- Handout 14.3: Wealth Ranking for PD/Hearth
- Soft copy of Situational Analysis Excel template.

STEPS

1. 5 Min

Ask how many participants have done a wealth-ranking exercise. Explain that it is a way to identify the different socioeconomic classes within a community.

Why do we need to do this to prepare for implementing Hearth in a given community?

It is necessary to determine the poorest families in order to identify positive deviants among them. To believe that the practices of the PD families can be done by the poorest in the community, the volunteers, caregivers and others in the community must believe that the PD families are truly among the poorest.

Explain that it is important to do this exercise with community members because only they know how to define *poorest* in their community. They must agree with the final assignment of families in order to believe later that there are PD families.

The objective of the wealth-ranking exercise is to understand the way the community classifies its economic differences and to determine criteria for

classifying extended families or households. If people share food, resources and income in nuclear units, then wealth ranking is done by household. If the food, resources and other income are shared across multiple, related households, then wealth ranking must consider the extended family instead.

15 Min

2.

Divide participants into two groups, each representing a village. Included are leaders, representatives of different ethnic groups, women and men, and all socioeconomic classes. Facilitators represent the PD/Hearth staff who will lead a 'village' through a wealth-ranking exercise. Explain that we want to learn how some families with few resources keep their children healthy. Community members know which families have few resources and which are better off. We would like their help to identify the poorest families.

Choose two different versions of an object, for example, two stones of different colours. Lay the stones out on the ground with some distance between them. Explain that one stone represents the non-poor families and the second represents the poorest people. Have everyone look at the non-poor stone and reflect silently on which families in their community would go with this stone. Ask participants how they know these families are not poor. What do these families have that families in the poor category (stone) don't have? List all the characteristics. Prompt them to think about housing, farm implements, livestock, clothing, transport, occupations, amount of land owned, and so on. Does everyone agree that families in the poor category don't have these characteristics?

Now focus attention on the second stone. Remind participants that these are the poorest people. What don't they have that the non-poor families have? What income do they have? What about their houses? jobs? clothing? Do they own any livestock? What kind and how many? It may be necessary to add a third stone if the participants say there is another group which is even poorer. If so, ask for characteristics of those people.

To validate the criteria, ask the participants to think silently about the poorest family they know. Do these families meet the criteria for poorest that were just agreed upon?

10 Min

3.

HANDOUT
14.1 – 66m/H 35

The PD/Hearth team can now use these criteria to identify the wealth status of each child it has weighed and determine whether or not a family is positive deviant.

Distribute Handout 14.1 and have each participant work through the examples of identifying the wealth status of each child. Discuss the answers together.

Case Examples for Wealth-Ranking Exercise

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	Poor
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	Poor
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	Non-Poor
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	Non-Poor
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	Poor
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	Non-Poor

Wealth Ranking for PD/Hearth

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

WEALTH STATUS	WEALTH CLASSIFICATION CRITERIA
POOR	
NON–POOR	

Situational Analysis – Nutritional Assessment (Weighing All the Children in the Target Community) (STEP 3)

SESSION 15

95 MIN | DAY 2

By the end of this session, participants will be able to

1. Explain the importance of and methods for conducting the nutrition baseline and ongoing monitoring activities
2. Describe the methods to measure child growth recommended for use within PD/Hearth activities and cite important issues for proper weighing technique
3. Use Excel-based PD/Hearth database to calculate Z-scores.

Reference in *CORE PD/Hearth Guide*: pp. 57–66, 70–83

Preparation

- Gather country and/or regional nutrition information
- Obtain growth cards (country-specific and/or others used in the region); if unavailable use the WHO growth charts, one for each participant
- Print Handout 15.1 and 15.2
- Review 'Training of PD/Hearth Volunteers Curriculum' before training - use Anthro Job Aids if necessary
- Soft copy of Excel-based PD/Hearth database (found in Resource CD)
- Refer to Handout 36.10
- Each participant will take MUAC and weight of 1 child.

Materials

- Local growth-monitoring chart or

  WHO Growth Charts for Girls: http://www.who.int/childgrowth/standards/cht_wfa_girls_z/en/index.hHl

  WHO Growth Charts for Boys: http://www.who.int/childgrowth/standards/cht_wfa_boys_z/en/index.hHl
- Handout 15.1: Community Assessment Monitoring Sheet
- Handout 15.2: WHO Weight-for-Age Reference Table
- Handout 15.3: Initial Assessment Worksheet
- WHO Guidelines for Inpatient Treatment of Severely Malnourished Children: http://www.who.int/nutrition/publications/guide_inpatient_text.pdf
- Training of PD/Hearth Volunteers Curriculum and its job aids for taking ANTHROs
- Blank flip charts

Situational Analysis – Nutritional Assessment (Weighing All the Children in the Target Community) (STEP 3)

DAY 2

- Soft copy of Excel-based PD/Hearth database
- Hanging scales and weighing pants
- MUAC tapes
- Pencils
- Recording chart
- a copy of the NCOE Measuring and Promoting Child Growth tool (available from nutrition@wvi.org)
- weight monitoring charts, Anthro tables, and attendance charts (these will be used in the Hearth sessions)
- A picture of a healthy child and a picture of a malnourished child
- Sheets of flip-chart paper, cut or torn in half, one for each group of three or four volunteers
- Paper cut into a circle, one for each volunteer

STEPS

1.

Refer to the steps on Handout 1.2: 'Agenda for PD/Hearth training of trainers' and explain that Step 3 consists of the (1) nutrition baseline assessment; and (2) situation analysis (e.g. FGDs, transect walk, social mapping, market survey), including wealth ranking. These will help to provide a comprehensive understanding of the current situation in the community. Each of these components will be discussed in detail.

10 Min

2. Nutrition Assessment

Ask what the three different types of malnutrition are. How are they measured? Write the words for classifying malnutrition and the abbreviations on a flip chart and be sure participants understand the definitions.

- *underweight* is measured by weight-for-age (WA)
- *stunting* is measured by height-for-age (HA)
- *wasting* is measured by weight-for-height (WH)

Show an example of a growth chart (if a local growth chart is not available, use the WHO Growth Chart as a model). Hand out one local growth card or WHO growth chart to each participant.

Methods for determining age: *Ask caregivers for child health/growth cards or certificates. If they do not have them, work with the community to establish a calendar of locally important events to help determine when each child was born.*

Why PD/Hearth uses weight-for-age: Weight-for-age is the easiest measure to take accurately and is the most sensitive to change. It is also the measurement that most Ministries of Health use, so both health workers and caregivers are familiar with it.

The goal of PD/Hearth is to quickly rehabilitate children who are malnourished according to weight-for-age measurements. Weight-for-age is used to determine which children are well nourished. We will be able to learn from those families what they do to keep their children growing well. Weight-for-age is also used to determine which children are malnourished. All children 6-59 months who are mildly, moderately or severely underweight (despite the household's wealth ranking or socioeconomic status) will enter the PD/Hearth sessions. Priority should be given to children that are poor and severely underweight. Children with oedema, kwashiorkor or other medical complications should ***not*** be included in the PD/Hearth programme, but instead be referred to a health facility or hospital.

Each participant should have a copy of a growth chart. Ask what measurement is used for these growth charts (*weight-for-age*). **Look at the growth chart from your country. How can you tell a child is growing well?** *(he or she is in the green zone)*

What do the lines on the chart indicate? *The rate of growth for a child. We want to see children following the 'normal' trend of weight gain. If they grow slower, their line will curve down or be flat. This is not good.*

During the Hearth sessions children need to achieve 'catch-up growth'. What is catch-up growth? *Catch-up growth occurs when a child who is malnourished gains weight at an accelerated rate so that he or she is 'catching-up' to the normal-rate-of-growth line for his or her age.*

Draw a large growth chart on a flip chart. Draw a line for a malnourished child's growth and then a sharp spike up in the line when the child enters the Hearth session. The aim is to achieve this fast growth in order to boost the child into being well nourished. It is also important for children to continue growing well after the Hearth sessions by having the caregiver continue the practices learned in the Hearth sessions. A child may not recover completely from malnutrition in one Hearth session, especially if he or she was moderately or severely malnourished. The child may need to repeat Hearth sessions.

5 Min

3. Nutrition Baseline Discussion

Outline the background information for the nutritional assessment used in PD/Hearth based on the following questions:

What determines the target age group? Only include children older than six months (before that, exclusive breastfeeding is strongly promoted); the upper limit on the target age may go up to two, three or five years, depending on 'anticipated load' and budget. However, special emphasis should be placed on children 6–36 months of age because that is the period when the greatest impact can be made. Age determination can be identified using a growth chart, birth certificate or calendar of events.

Why are growth-monitoring data not sufficient? Growth-monitoring data does not capture all children, and those most likely to be missed are the poorest or those from the most at-risk families.

Where does growth monitoring fit into Hearth? Growth monitoring may help raise awareness of adequate growth and is an ongoing monitoring tool. The growth-monitoring programme serves to identify additional malnourished children over time and to support maintenance of rehabilitated children. *This very important element is often overlooked in PD/Hearth implementation.*

What about severely malnourished children and Hearth? Children who are severely malnourished with complications such as oedema, kwashiorkor or other health complications need more specialised medical treatment. These children should be referred to a health care provider. Refer to the WHO *Guidelines for Inpatient Treatment of Severely Malnourished Children* to clarify the protocol for the most severely malnourished children (not Hearth). If available, refer participants to the TALC publication *Caring for Severely Malnourished Children* (Ashworth and Burgess, 2003) , Training of PD/Hearth Volunteers Curriculum and its job aids for taking ANTHROs or provide the website for obtaining this useful reference: www.talcuk.org/a-z_booklist.hH.

5 Min

4. Weighing Techniques

Refer to the **PD/Hearth Volunteers Curriculum** and its job aids for taking anthros or the NCOE *Measuring and Promoting Child Growth Tool* (http://www.wvi.org/nutrition/publication/measuring-and-promoting-child-growth) for specifics on proper weighing techniques. Briefly discuss types of scales and weighing issues (calibration, disrobing children, alternatives to the sling), drawing on participants' experiences.

25 Min

5. Calculating Nutritional Status of Children

HANDOUT
15.1 – 75m/H 38

Distribute a copy of the 'Community Assessment Data' handout (Handout 15.1). Assign one child (from rows 1-16) to each participant. First plot the child's weight-for-age on the growth chart that was previously distributed in step 2 above. Next, fill in the child's nutritional status by colour in the colour column on Handout 15.1. Is the child growing well? Read out the nutritional status answers for each child on Handout 15.1, as participants check their results.

If computers are available, teach participants to use Excel-based PD/Hearth database to calculate Z-scores and obtain the nutritional status of children (Refer to Resource CD). Refer to Handout 36.10: 'User Guide for the PD/Hearth Excel Database'.

25 Min

6.

HANDOUT
15.2 – 77m/H 40

Distribute Handout 15.2 (WHO Anthro Tables). Explain that another way to calculate weight-for-age is by using the WHO weight-for-age reference tables (Handout 15.2), which are more precise than the community assessment form (Handout 15.1) because they also include the 'mild' status, while the WHO Growth Charts (handed out in step 2 above) only include normal, moderate and severe. Have the participants find the Z-score for the child they are assigned.

Compare the Z-score value to the colour in the 'Community Assessment Monitoring Sheet'. Are they the same? Which is easiest for caregivers to understand? Which would be used to monitor the programme?

25 Min

7.

Divide into pairs and practise counselling the caregiver about the growth of the child. Remember to be encouraging, to explain how the child is growing, to ask what the child has been like at home. Agree on one thing the caregiver could do at home to help the child's growth. Make sure each person has a chance to practise each role. Ask one or two pairs to role play their scenario for the whole group. Discuss the role plays together.

8.

HANDOUT
15.3 – 81m/H 44

Distribute Handout 15.3 and go through the indicators. Explain that this will be the handout we use when we go out to the field to collect the Nutrition Assessment Data of the community. **Point out that the community wealth ranking exercise must be completed before weighing of children begins so that the wealth ranking of the households could be completed while weighing the children.**

The last two columns of Handout 15.3 ("Classification of PD, NPD, and Non-PD" and "Nutritional Status") should be filled out back in the training room, after all the data is collected and not during the field work to save time.

Community Assessment Monitoring Sheet

World Vision

Community: Sunshine – ADP Light and Hope	**Date of Weighing:** March 11, 2011	
Total number of children under 36 months in community: **Total number of children under 36 months weighed:**		

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
1	M	6/3/2009	24	10.70	1	Non-Poor			
2	F	28/3/2010	11	6.8	4	Poor			
3	F	30/7/2009	19	7.1	6	Poor			
4	M	14/4/2008	35	10.1	1	Non-Poor			
5	F	3/8/2010	7	7.3	3	Poor			
6	M	3/10/2009	17	8.5	7 (twin)	Poor			
7	F	3/10/2009	17	10.7	7 (twin)	Poor			
8	M	20/5/2008	34	9.8	8	Poor			
9	F	21/111/2009	16	8.2	1	Poor			
10	F	8/2/2008	37	11.4	8	Non-Poor			
11	F	6/5/2010	10	8.6	3	Poor			
12	M	25/3/2010	12	7.4	6	Non-Poor			
13	F	25/9/2009	17	8.1	3	Poor			
14	F	25/9/2009	17	6.1	7	Poor			
15	F	23/7/2009	20	8.3	2	Poor			
16	M	9/12/2009	15	8.5	9	Poor			
17	F	28/8/2009	18	6.2	1	Poor		-4.20	
18	M	18/7/2009	20	8.4	1	Poor		-2.64	
19	M	15/5/2010	10	6.3	4	Poor		-3.33	

Community Assessment Monitoring Sheet

Day 2 Session 15

2 OF 2

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
20	M	15/5/2010	10	8.3	3	Non-Poor		-0.87	
21	F	3/3/2009	24	11.5	5	Poor		-0.02	
22	F	22/10/2008	29	8.9	2	Poor		-2.80	
23	F	6/6/2009	21	9.4	4	Poor		-1.21	
24	F	3/2/2008	37	10.8	3	Poor		-2.13	
25	M	9/9/2009	18	8.1	5	Non-Poor		-2.69	
26	M	3/6/2009	21	10.1	1	Poor		-1.22	
27	M	22/9/2009	18	9.5	4	Poor		-1.20	
28	F	24/9/2010	6	9.5	3	Non-Poor		2.35	
29	M	17/3/2010	12	8.2	5	Poor		-1.44	
30	M	6/6/2010	9	8.7	3	Non-Poor		-0.25	
31	F	4/4/2009	23	11.2	2	Non-Poor		-0.08	
32	M	28/1/2010	13	10.6	10	Poor		0.57	
33	M	7/12/2008	27	9	1	Non-Poor		-3.02	
34	F	4/12/2008	27	11.0	6	Poor		-0.80	
35	M	8/9/2009	18	10.0	8	Poor		-0.81	
36	F	30/11/2008	27	9.2	6	Poor		-2.34	
37	F	16/12/2008	27	9.4	4	Non-Poor		-2.07	
38	M	10/11/2010	4	10.2	7	Poor		3.47	
39	F	21/11/2009	16	9.8	4	Poor		0.06	
40	M	10/3/2010	12	7.0	4	Non-Poor		-2.91	
41	F	12/9/2008	30	8.4	3	Poor		-3.44	

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)*											
BOYS						**GIRLS**					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	0	3.3	2.9	2.5	2.1	F	0	3.2	2.8	2.4	2.0
M	1	4.5	3.9	3.4	2.9	F	1	4.2	3.6	3.2	2.7
M	2	5.6	4.9	4.3	3.8	F	2	5.1	4.5	3.9	3.4
M	3	6.4	5.7	5.0	4.4	F	3	5.8	5.2	4.5	4.0
M	4	7.0	6.2	5.6	4.9	F	4	6.4	5.7	5.0	4.4
M	5	7.5	6.7	6.0	5.3	F	5	6.9	6.1	5.4	4.8
M	6	7.9	7.1	6.4	5.7	F	6	7.3	6.5	5.7	5.1
M	7	8.3	7.4	6.7	5.9	F	7	7.6	6.8	6.0	5.3
M	8	8.6	7.7	6.9	6.2	F	8	7.9	7.0	6.3	5.6
M	9	8.9	8.0	7.1	6.4	F	9	8.2	7.3	6.5	5.8
M	10	9.2	8.2	7.4	6.6	F	10	8.5	7.5	6.7	5.9
M	11	9.4	8.4	7.6	6.8	F	11	8.7	7.7	6.9	6.1
M	12	9.6	8.6	7.7	6.9	F	12	8.9	7.9	7.0	6.3
M	13	9.9	8.8	7.9	7.1	F	13	9.2	8.1	7.2	6.4
M	14	10.1	9.0	8.1	7.2	F	14	9.4	8.3	7.4	6.6
M	15	10.3	9.2	8.3	7.4	F	15	9.6	8.5	7.6	6.7
M	16	10.5	9.4	8.4	7.5	F	16	9.8	8.7	7.7	6.9
M	17	10.7	9.6	8.6	7.7	F	17	10.0	8.9	7.9	7.0
M	18	10.9	9.8	8.8	7.8	F	18	10.2	9.1	8.1	7.2
M	19	11.1	10.0	8.9	8.0	F	19	10.4	9.2	8.2	7.3
M	20	11.3	10.1	9.1	8.1	F	20	10.6	9.4	8.4	7.5
M	21	11.5	10.3	9.2	8.2	F	21	10.9	9.6	8.6	7.6
M	22	11.8	10.5	9.4	8.4	F	22	11.1	9.8	8.7	7.8
M	23	12.0	10.7	9.5	8.5	F	23	11.3	10.0	8.9	7.9
M	24	12.2	10.8	9.7	8.6	F	24	11.5	10.2	9.0	8.1
M	25	12.4	11.0	9.8	8.8	F	25	11.7	10.3	9.2	8.2
M	26	12.5	11.2	10.0	8.9	F	26	11.9	10.5	9.4	8.4
M	27	12.7	11.3	10.1	9.0	F	27	12.1	10.7	9.5	8.5
M	28	12.9	11.5	10.2	9.1	F	28	12.3	10.9	9.7	8.6

* NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)

BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.9
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	9.0
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.1
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.3
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.4
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.5
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.6
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.7
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.8
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.9
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	10.1
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)*									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	0	2.9	2.5	2.1	F	0	2.8	2.4	2.0
M	1	3.9	3.4	2.9	F	1	3.6	3.2	2.7
M	2	4.9	4.3	3.8	F	2	4.5	3.9	3.4
M	3	5.7	5.0	4.4	F	3	5.2	4.5	4.0
M	4	6.2	5.6	4.9	F	4	5.7	5.0	4.4
M	5	6.7	6.0	5.3	F	5	6.1	5.4	4.8
M	6	7.1	6.4	5.7	F	6	6.5	5.7	5.1
M	7	7.4	6.7	5.9	F	7	6.8	6.0	5.3
M	8	7.7	6.9	6.2	F	8	7.0	6.3	5.6
M	9	8.0	7.1	6.4	F	9	7.3	6.5	5.8
M	10	8.2	7.4	6.6	F	10	7.5	6.7	5.9
M	11	8.4	7.6	6.8	F	11	7.7	6.9	6.1
M	12	8.6	7.7	6.9	F	12	7.9	7.0	6.3
M	13	8.8	7.9	7.1	F	13	8.1	7.2	6.4
M	14	9.0	8.1	7.2	F	14	8.3	7.4	6.6
M	15	9.2	8.3	7.4	F	15	8.5	7.6	6.7
M	16	9.4	8.4	7.5	F	16	8.7	7.7	6.9
M	17	9.6	8.6	7.7	F	17	8.9	7.9	7.0
M	18	9.8	8.8	7.8	F	18	9.1	8.1	7.2
M	19	10.0	8.9	8.0	F	19	9.2	8.2	7.3
M	20	10.1	9.1	8.1	F	20	9.4	8.4	7.5
M	21	10.3	9.2	8.2	F	21	9.6	8.6	7.6
M	22	10.5	9.4	8.4	F	22	9.8	8.7	7.8
M	23	10.7	9.5	8.5	F	23	10.0	8.9	7.9
M	24	10.8	9.7	8.6	F	24	10.2	9.0	8.1
M	25	11.0	9.8	8.8	F	25	10.3	9.2	8.2
M	26	11.2	10.0	8.9	F	26	10.5	9.4	8.4
M	27	11.3	10.1	9.0	F	27	10.7	9.5	8.5
M	28	11.5	10.2	9.1	F	28	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	29	11.7	10.4	9.2	F	29	11.1	9.8	8.8
M	30	11.8	10.5	9.4	F	30	11.2	10.0	8.9
M	31	12.0	10.7	9.5	F	31	11.4	10.1	9.0
M	32	12.1	10.8	9.6	F	32	11.6	10.3	9.1
M	33	12.3	10.9	9.7	F	33	11.7	10.4	9.3
M	34	12.4	11.0	9.8	F	34	11.9	10.5	9.4
M	35	12.6	11.2	9.9	F	35	12.0	10.7	9.5
M	36	12.7	11.3	10.0	F	36	12.2	10.8	9.6
M	37	12.9	11.4	10.1	F	37	12.4	10.9	9.7
M	38	13.0	11.5	10.2	F	38	12.5	11.1	9.8
M	39	13.1	11.6	10.3	F	39	12.7	11.2	9.9
M	40	13.3	11.8	10.4	F	40	12.8	11.3	10.1
M	41	13.4	11.9	10.5	F	41	13.0	11.5	10.2
M	42	13.6	12.0	10.6	F	42	13.1	11.6	10.3
M	43	13.7	12.1	10.7	F	43	13.3	11.7	10.4
M	44	13.8	12.2	10.8	F	44	13.4	11.8	10.5
M	45	14.0	12.4	10.9	F	45	13.6	12.0	10.6
M	46	14.1	12.5	11.0	F	46	13.7	12.1	10.7
M	47	14.3	12.6	11.1	F	47	13.9	12.2	10.8
M	48	14.4	12.7	11.2	F	48	14.0	12.3	10.9
M	49	14.5	12.8	11.3	F	49	14.2	12.4	11.0
M	50	14.7	12.9	11.4	F	50	14.3	12.6	11.1
M	51	14.8	13.1	11.5	F	51	14.5	12.7	11.2
M	52	15.0	13.2	11.6	F	52	14.6	12.8	11.3
M	53	15.1	13.3	11.7	F	53	14.8	12.9	11.4
M	54	15.2	13.4	11.8	F	54	14.9	13.0	11.5
M	55	15.4	13.5	11.9	F	55	15.1	13.2	11.6
M	56	15.5	13.6	12.0	F	56	15.2	13.3	11.7
M	57	15.6	13.7	12.1	F	57	15.3	13.4	11.8
M	58	15.8	13.8	12.2	F	58	15.5	13.5	11.9
M	59	15.9	14.0	12.3	F	59	15.6	13.6	12.0
M	60	16.0	14.1	12.4	F	60	15.8	13.7	12.1

Initial Assessment Worksheet

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

No.	Date of Survey	Child's Name	Sex (M/F)	Caregiver's Name	DOB (dd/mm/yyyy)	Age (Months)	Birth Order	Odema (Y or N)	Weight (kg)	Nutritional Status (Indicate Colour)	MUAC (<115mm) (Green, Yellow, Red)	Wealth Rank (Poor, Non-Poor)	Classification (PD, ND, NPD)	PDI HHs
1														
2														
3														
4														
5														
6														
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SESSION 16

Situational Analysis – Focus-Group Discussions (FGDs), Transect Walk, Community Mapping, Market Survey (STEP 3)

World Vision

95 MIN | DAY 2

By the end of this session, participants will be able to

1. Describe a situational analysis, identify potential sources of information, and know how to collect information through FGDs, transect walks, community mapping, and market surveys
2. Identify the standards for and challenges of conducting a wealth-ranking exercise.

Reference in *CORE PD/Hearth Guide*: pp. 62–75

Preparation

- Prepare a flip chart with a matrix to record FGD on feeding practices
- Print Handout 16.1 16.2A, 16.2B and 16.3.
- Soft copy of Situational Analysis Excel template (refer to Resource CD)

Materials

- Handout 16.1: Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years
- Handout 16.2A: Market Survey for PD/Hearth Cost Variance
- Handout 16.2B: Market Survey for PD/Hearth Quantity Variance
- Handout 16.3: Seasonal Calendar for PD/Hearth
- Blank flip charts and coloured markers
- 60 stones or leaves or other common material to use as markers
- Soft copy of Situational Analysis Excel template

STEPS

10 Min

1.

The situation analysis activities are generally used to understand the context of the community such as existing resources, the functionality of resources, the seasonality foods available, existing common diseases and sicknesses, the common practices within the households, food taboos, and other myths associated with child feeding and caring practices, etc. It is important to involve the community through this process of discovery to mobilize the community and to create community ownership for the program and it is an effective tool to help the community discover the resources that already exist so that they are empowered and motivated to overcome the problem of malnutrition as a community.

Wealth Ranking/Nutritional Assessment

Wealth ranking and initial nutritional assessment are used to identify the PD, non-PD, and ND households, it is important to identify these households in order to conduct PDIs. During the PDI, it is strongly recommended to visit 4 PD households, 2 ND households and 2-4 non-PD households.

Focus Group Discussions

Focus group discussions help implementers understand the existing practices and beliefs of caregivers, fathers, and elderly women around child feeding, caring, hygiene, and health seeking practices. The information given during the focus group discussion may not be 100% true and many times correct answers are given and not necessarily the true behaviors that are being practiced. For example, mothers may say they exclusive breastfeed their children up to 6 months, but in reality when you conduct household interviews during the PDIs or transect walks, majority of women may still feed water, porridge, and other foods starting at 3 months of age. Thus, it is important to grasp what statements are questionable and verify those facts during the PDIs and household interviews on the transect walks. Three separate FGDs are recommended with mothers' group, fathers' group, and elderly women's group. There should be approximately 7-10 participants in each group. It is advisable to include 2-3 mothers with children from each target age group: 0-6 months, 6-12 months, 12-24 months, and 24 -59 months.

Community/Social Mapping

Community/social mapping is used to mobilize the community and create community ownership of the program, as is wealth ranking. Community/social mapping is also used to help the community identify the existing resources within their surroundings such as the water sources, major roads where the market, farms, schools, and health centres are. It also helps the PD/Hearth implementers to understand the environment and the community existing resources and needs. The community map can be used to guide the Transect Walk.

Transect Walks

The transect walks are used to verify the information in the community mapping and also to get additional information about the existing resources. For example, if the community map shows 3 bore holes, the transect walk would help verify whether 3 bore holes are functioning well or if 2 are functioning and 1 requires repair. Thus the transect walk helps implementers to understand the current contexts of the community. It is also useful to visit 1 or 2 households on the transect walk and to get a glimpse of what the 'norm' is in the community such as seeing what the community grows in the gardens, whether it is common for fathers to work in the city, mothers to work in the garden, and mother-in-laws to primarily take care of children at home, etc.

Seasonal Calendar

The seasonal calendar is also useful for mobilizing the community and creating ownership of the program by involving the community in the program design. The seasonal calendar helps implementers understand what types of foods are available during various seasons and what sicknesses and diseases are common in certain seasons. By understanding what foods are available during certain seasons this information can be taken into account when conducting market survey and in the menu design. The sickness and disease information could be used to ask questions during the PDI especially to the PD households and how they seek health care services or how they treat children for these sicknesses or illnesses at home.

Market Survey

The market survey is used to identify the approximate cost and variability in cost or quantity of certain foods during different seasons. This information can be used to design a low cost and affordable Hearth menu. It can also help in the menu design so foods that are easily accessible and available included in the Hearth meal. The market survey is recommended to be conducted during different seasons. For example, if there is a rainy season and a dry season, a market survey should be conducted once during the rainy season and once during the dry season. The nutrient-dense, low cost foods available during the dry season could be used for Hearth menu A and the nutrient dense, low cost foods available during the rainy season could be used for Hearth menu B.

2.

Use the following questions to generate a discussion of situational analysis:

What kinds of information do we need in order to know what is normal in the community?

Programmers need general information on health, including immunisation coverage; incidence and case management of major childhood illnesses; micronutrient situation/supplementation; care-seeking; levels and causes of under-five mortality; current beliefs and behaviours.

Who are sources for this information?

In addition to volunteers and health staff, consult grandmothers, mothers and other caregivers, community leaders, fathers, grandfathers, vendors. Volunteers and health staff may have misinformation or lack information. They may be of slightly higher socioeconomic status than caregivers, so be cautious about 'information' that may be based on stereotypes. *Community members themselves have the best information about the local situation.*

How can we gather information?

Look for quantitative information, e.g. health-system documents, KPC and other surveys, as well as qualitative information such as interviews with key informants, group discussions, and PLA/PRA. (Participatory Learning for Action and Participatory Rapid Appraisal – PLA/PRA – are the two names commonly applied to participatory assessment methodology.) See *CORE PD/Hearth Guide* (p. 62) and the specific list of methodologies (p. 64).

How can we and the community learn the common feeding and health practices of families with malnourished children?

We can either conduct household interviews and observations using the same tools we will use for the PDI, or we can conduct guided group discussions with many poor non-PD caregivers and/or families to learn what are the existing practices, what are the existing beliefs (e.g. food taboos). Such discussions allow us to get a sense of the 'norm' within the community. This will later help to identify the PD practices.

10 Min

3. Focus Group Discussions

Gather the participants in a group. C*hoose one person to act as your recorder.* Explain that the remainder of the participants are 'community members', 'caregivers' and 'grandmothers'. Role play a **Focus Group Discussion** (FGD), using the following questions to guide the discussion to learn what are the existing practices, what are the existing beliefs (e.g. food taboos). Such discussions aloow us to get a sense of the 'norm' within the community. This will help later to identify the PD practices.

My name is _____. I am so glad you all came today to talk with us. We would like you to help us understand how families in this village feed their children. We would like to discuss this together. Everyone is welcome to say something. We'll go around the group so each of you can tell me your name and how many children you have. Would you mind if _____ takes some notes?

Point to a newborn child. What do people in this community feed newborn children? How often? How much? What else?

Point to a child that is 0–5 months of age. What do people in this community feed a baby of this age? How often? What else do they eat? Who feeds them?

Point to a child 6–8 months of age. What do people in this community feed a baby of this age? How often? What else do they eat? Who feeds them?

Point to a child 9–11 months of age. What do people feed a child this age? How much? Show me the amount with a fist or pile of rocks. How often?

Do the same for a child 12–24 months and then a child older than 24 months.

Are there any foods that you don't give children?

What do you feed a sick child?

Use probing questions to encourage group members to give more details. The goal is a flow of information that will allow us to capture the 'norm' within the community in feeding practices so we can easily identify PD practices during the PDIs. Conclude by thanking the participants for taking part. Point out that they have helped us understand how they feed children in this village.

Note: *In this practice FGD it will not be possible to discuss all the questions. The purpose is to give the participants an idea of how to ask questions and then probe further.*

10 Min

4. Discuss the Role Play

FGDs are not simply question-and-answer sessions. The facilitator needs to present a set of carefully chosen key issues. Remember to:

- Introduce yourself and have the participants introduce themselves.
- Create a comfortable atmosphere with a joke or casual talk.
- State the topic of the conversation or use a visual aid to begin the conversation.
- Request permission to use a cassette recorder or to take notes during the discussion.
- Do not ask simple 'yes/no' question, but ask open-ended questions instead.

The facilitator can use pictures, storytelling and other techniques in addition to asking questions to promote a lively discussion. The goal is for the group to discuss the issues rather than simply answering questions. Encourage all the participants to voice their ideas and opinions.

HANDOUT
16.1 – 91m/H 45

Review the questions used to guide the discussion. (List them on a flip chart.)

The recorder might use a chart like the one in Handout 16.1 to list the points made in the discussion.

Discuss the following questions with the group:

- What other information might you discover through a focus-group discussion? *(common childhood illnesses, levels of malnutrition, immunisation, health services available, attendance at GMP)*
- With whom might you have a FGD to discover that information? *(health practitioners, traditional birth attendants, caregivers, leaders, VHC)*

5 Min

5. Transect Walk

Ask if anyone has done a transect walk. Ask one person to describe how it is done. (If no one has done this, explain it yourself.) What is the purpose of a transect walk? *(to work with some community members to orient us to the community; to observe what resources are in the community , to understand what some of the challenges might be, to note especially those factors that might affect nutrition and health of children for good or bad)*

It is also good to conduct 1 household visit while on the transect walk to observe what is being planted in the gardens' of the households and to observe general hygiene and child caring practices. Please refer to the table below for positive feeding, caring, hygiene and health seeking practices.

Review the main reasons a child might not be growing well, as discussed on Day 1. Ask participants to name the ones they can remember.

(not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, unclean water, worms, no shoes, grandmother tries to help but doesn't always give good advice on practices)

Show the pictures of the two children. Which child looks healthy? unhealthy?

Post the picture of the healthy child on the wall.

Ask what feeding/food, caring, hygiene and health practices would have helped this child be healthy. Probe to help participants come up with as many positive behaviours as possible.

Feeding/Food	Caring	Hygiene	Health
Continued, frequent breastfeeding of infants up to 24 months	Positive interaction between child and others	Use of latrine and latrine cover	Complete immunisations (preventive)
Introduce other foods at six months	Supervision at all times	Hand washing with soap or ash after toilet, before eating, before food preparation	Mosquito nets used in malaria endemic areas
Feed 3–5 times / day	Father providing attention / affection	Safe water (boiled, covered)	Regular deworming , wearing of shoes
Variety in food; giving snacks between meals	Grandmother supports caregiver with good advice and practical care	Use of drying rack	Home treatment of sick child for minor illnesses
Active feeding	Father provides money to buy good foods for children	Keeping kitchen clean	Use of oral rehydration solution during diarrhoea
Continued breastfeeding along with appropriate liquids and foods during and after diarrhoea		Using windows and doors to air out the rooms during the day	Child is promptly taken to the health post for illnesses not responding to home treatment

20 Min

6. Community Mapping

Ask if anyone has done community mapping. If so, ask one person to describe the process. What information can be depicted on a community map?

Break into four groups. Each member of the group is from the same imaginary village. Work with them to develop a community map. Mark main landmarks, water points, fields, houses. Show which parts of the community have malnourished children. Remember to develop a key.

Discuss how these maps might be used for PD/Hearth. *Mark where malnourished children live; locate where PD families live; locate where volunteers live; select children for Hearth sessions by how close they live to the volunteer; change the colour of the house when the child becomes well nourished, and so on.*

Ensure the following landmarks and resources are mapped:

- water sources (such as ponds, rivers, lakes, swamps, boreholes/boleholes, wells, and springs)
- gardens or farms
- school
- health centres
- latrines
- markets and shops
- church or other religious buildings
- mountains or other geological barriers
- houses of children under 59 months of age
- houses of volunteers
- roads (major roads and smaller paths)

30 Min

7. Seasonal Calendar

HANDOUT
16.3 – 94m/H 48

Demonstrate how to make a seasonal calendar to show what foods are available to families throughout the year. Ask the participants if they know the food groups (for example, cereals, proteins, fruits, vegetables, fats). For each food group list the foods that the community grows. Do one food group at a time. Mark a grid of 12 months on the ground. Down the left side pile a sample of each of these foods (cereals: maize, sorghum, millet). Give the group a pile of 60 stones. Ask the group to distribute the stones to show the proportion of households with access to the different food items during the year. For example, if no families have a crop in certain months, there are no stones in those squares; if a food is available to families at all times of year in the same quantity, then each month would have an equal number of stones. Do this for all cereal crops and then for each of the other food groups. Create the seasonal calendar with the food groups the country uses. Make sure the results are recorded on a piece of paper after drawing on the ground.

Distribute Handout 16.3 and advise to use it to record the results. Write out the food items commonly used in the country and the common diseases that exist. Indicate with an 'x' as to when they are in high season for the various months.

5 Min

8. Market Survey

HANDOUT
16.2A – 92m/H 46
16.2B – 93m/H 47

A market survey provides information on the availability and price of foods in the community. It is carried out by visiting the market where the community buys its food and recording information in Handouts 16.2A and 16.2B.

Situational Analysis – Focus-Group Discussions (FGDs), Transect Walk, Community Mapping, Market Survey (STEP 3)

DAY 2

5 Min

9.

Discuss together the expected outcomes for situational analysis:

- Community involvement and commitment
- All activities done with community members
- Learn the common illnesses, health services and practices
- Learn the normal feeding practices and be able to highlight existing good/best practices
- Learn what harmful practices affect child health and nutrition
- Learn about the community's understanding of causes of malnutrition in its children
- Learn about food availability and affordability.

Tell participants that the next step in community mobilisation is to feed back all this information to the community. This will be discussed later in the course.

Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Child's Age	**Foods given,** including breastmilk and other liquids (name or pictures)	**Amounts** (bowl, cup, can, fist, spoonful)	**Frequency** (daily, weekly, rarely)	**Food taboos** (forbidden foods)	**Comments** Why?
Newborn					
0–5 months					
6–8 months					
9–11 months					
12–23 months					
≥24 months					
When child is sick					
When recovering					

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW						
	Units of Smallest Quantity Purchased	High Season (Months)	Cost during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Cost during Low Seasons ( )	Cost per 100 gram*

* NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Market Survey for PD/Hearth (Quantity Variance)

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

FOOD	RAW						
	Cost of Smallest Quantity Purchased	High Season (Months)	Quantity during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Quantity during Low Seasons ( )	Cost per 100 gram*

NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Seasonal Calendar for PD/Hearth

World Vision

Day 2 Session 16

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

Items (e.g. foods available, diseases, etc.)	MONTHS												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	

Identifying Positive Deviants (STEP 4)

SESSION 17

30 MIN | DAY 2

By the end of this session, participants will be able to

1. Explain the criteria and process for selecting PD families
2. Practise selecting PD families utilising nutrition-baseline and wealth-ranking-exercise data.

Reference in *CORE PD/Hearth Guide:* p. 68

Preparation

- If using data from a local village, be sure it is correct and that there are positive deviants.
- Write the definition of positive deviants on flip chart (see definition below).
- Make several large copies of the optical illusion pictures below.
- Print Handout 15.1

Materials

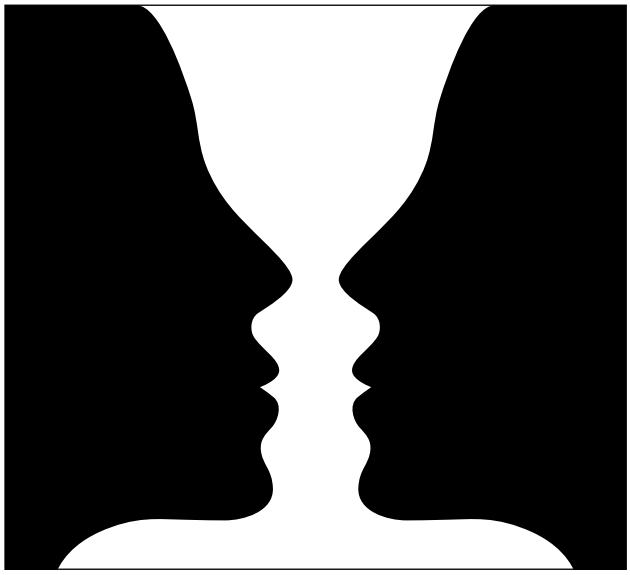
- Flip chart with definition of positive deviants:

  Positive deviants are individuals or groups (families, clans) whose special or uncommon practices and behaviours enable them to find better ways to prevent malnutrition than neighbours who share the same resources and face the same risks.

- Handout 15.1: Community Assessment Monitoring Sheet (this is from Session 15)
- Copies of Step 1 pictures

STEPS

1. 5 Min



Pass copies of these pictures around the group and ask participants what they see. There are two ways of looking at each photo. Make sure the participants see both ways. Point out how this is like PD, that is, there are different ways to look at reality, at problems. Solutions are sometimes 'hidden' in plain sight.

Discuss: Where should we look for solutions to malnutrition? (*caregivers, families who have children who are well nourished)*

5 Min

2.

Review the definition of positive deviants on the flip chart. In terms of nutrition,

Who are positive deviants? *Positive deviants are well-nourished children from poor families.*

Who cannot be positive deviants? *Only children, first-born children, a well-nourished child with malnourished siblings, children with atypical social or health problems, food-aid families, a child younger than seven months (the child's nutritional status is most likely due to breastfeeding), and/or children from non-poor families. See the list in the CORE PD/Hearth Guide (p. 68).*

Who identifies the positive deviants? *Supervisors and volunteers identify positive deviants.*

5 Min

3.

HANDOUT
15.1 – 75m/H 38

Review the criteria for identifying PD families, that is, good nutritional status *and* low wealth ranking. Divide the participants into pairs. Using Handout 15.1: 'Community Assessment Monitoring Sheet,' each pair decides which children are positive deviants by considering their weight, wealth ranking and birth order.

4.

This will provide a list of the potential PD children. However, the information needs to be confirmed by looking at the children's growth cards. Children who are truly PD will have been well nourished throughout their lives. If a child's growth card shows that he or she has only recently become well nourished or is not consistently growing well, do not accept that child as a PD.

An alternative way to teach this is to use data from the community to be visited during the course. If the ADP has done the nutritional assessment before the course, use the data collected on nutritional status and wealth ranking. Enter the data in the same format as Handout 15.1 and use the information to identify the PDs.

15 Min

5.

Discuss the list of potential PD children as a group. Be sure to cover the following:

- **Who knows which families are PD? Who has access to this information?** Only the staff should have this information, and staff members should not share it because there is a risk that PD families will be socially rejected.
- **What if there are no PD families in the community?** At least one PD family is needed. If none is identified, it will be necessary to conduct the PDI in an adjacent, very similar community using the team from the target community. If there are many PD families, choose a few that are most appropriate for conducting the PDI.

SESSION 18

Preparing for the Positive Deviance Inquiry (PDI) (STEP 4)

World Vision

75 MIN | DAY 2

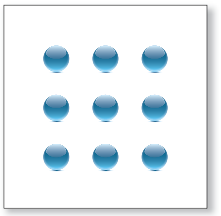
By the end of this session, participants will be able to

1. Describe the process, tools and methods for conducting the PDI
2. Identify resource tools for semi-structured interviews and observations during visits to PD households
3. Discuss the behaviours that influence the nutritional status of children
4. Develop a logistical plan for training and conducting the PDI.

Reference in *CORE PD/Hearth Guide*: pp. 85–89, 94–103

Preparation

- Print copies of Handout 18.1, 18.2, and 18.3.
- Adapt and practise telling the story of Nasirudin.
- Identify and orient trainers who will conduct the structured role play.
- Have three or four participants prepare the skit on visiting skills.
- Prepare a flip chart with nine large dots in three rows.



- Print and cut apart two sets of 24 behaviour cards (see sample in step 3 below).

Materials

- Print copies of Handout 18.1, 18.2, and 18.3.

STEPS

5 Min

1. Tell the story of Nasirudin

Nasirudin lived in a town. Often he would take a couple of donkeys laden with grass and cross the border of the town to enter the neighbouring territory. The customs officers at the border had a strong suspicion that Nasirudin was smuggling out some goods, but they could not find any. Nasirudin had only heaps of grass, which they examined very, very closely. They thought there might be small rings of gold or tiny diamonds. They even burned the grass, but in vain. Nasirudin's several crossings of the border did not reveal any smuggled goods, and he entered the neighbouring territory several times after giving a

big respectful salute to the officers. But there was always a cunning smile on his face. Their police instinct told them he was smuggling *something*, but they couldn't figure out what.

Many years later, long after Nasirudin had stopped his comings and goings from that town and lived in another town, one of the customs officers, who had by then retired, suddenly met him.

'Tell me, Nasirudin', the ex-customs officer asked, 'what were you were smuggling in those days?'

Nasirudin looked up and with the same cunning smile said, '*Donkeys,* of course'.

Discuss: What do you think is the message behind the story? *(the solution to something is often right in front of us but we don't see it; look for unexpected things; don't be misled by obvious things – the grass – and miss other things – the donkeys; be open minded)*

Brief the participants on the PDI process: 'We will be visiting families in our community to learn from them how they feed and care for their children who are under three years old. We will visit during the time that the caregivers feed their children. That way we can observe how they feed them, the care they give them and the relationship between the caregiver and other members of the family. We want to talk to the caregivers and observe what they do. But we will not make any comments. We need to have open minds and look for unexpected practices or ways of doing things. The positive deviance inquiry is intended to help discover that which is right in front of us. We expect to find something positive; we are like detectives looking for clues, and we need to get rid of any preconceived notions.' (**Note:** Volunteers may not be able to lead the PDI visit but will be valuable observers on the team.)

5 Min

2.

Discuss the kinds of information that will help us learn about feeding and caring practices. We will discover with community members foods which poor families use to keep their children healthy and strong. These foods are 'good foods'. We will discover the 'good care' these families give to their children. In the same way we will discover 'good health care' and 'good hygiene'.

By learning about these 'good' things from poor families with healthy children, we will be helping address the community's nutrition problems with solutions from its own people. These solutions will help other families in the community learn and understand how to help their children to be healthy and strong.

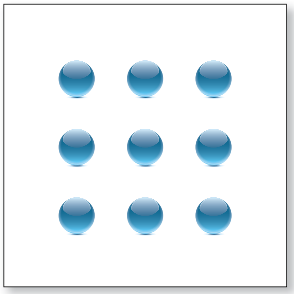
- **What categories of home-based behaviours are we looking at?** (*feeding practices; caring practices; hygiene practices; and health-care practices).* Ask

participants for an example of a positive practice for each category. (Refer to pp. 90–91 in the *CORE PD/Hearth Guide*.)

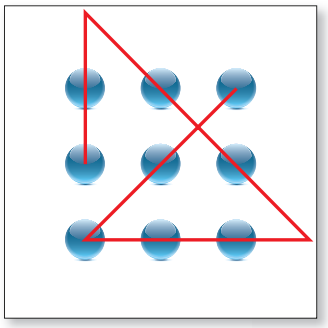
- **What are we trying to discover through the PDI?** The PDI seeks to identify unusual, successful and culturally acceptable behaviours and strategies practised by very poor families which can be more widely practised by others in the community who have similar resources. How does the PD family overcome the challenges and constraint that it shares with other families? For example, saving for health expenses is a positive but uncommon practice. The PDI should answer the question: How is *this* family able to save money?
- **The content for each category can be different according to cultural context. What are some examples of issues in feeding, caring, hygiene and health-seeking practices that are culturally specific?** Issues identified during the PDI can be explored for cultural appropriateness during the later process of sharing with the community (see Session 20, 'PDI Interpretation and Feedback').
- **Who should explore these?** The PD team and local partners.
- **Who is required on the PDI team?** The volunteers and supervisors must be on the team. Additional participants might include VHC members or Ministry of Health staff. It is very important that volunteers be part of the PDI team because they are most familiar with the community. Some of them may not be comfortable or have the skills to lead the interviews. With good training, however, they will become valuable team members who help us understand important community information. When selecting personnel, look for the following characteristics: belief in the approach, openness to learning from one less educated, and willingness to be led instead of leading. Note that PDI requires a change in attitude for Hearth managers and trainer; they are going to the community as learners, not as experts.
- **The PDI has an interviewer and observers.** Both roles are important. The interviewer may be a community member, a PD/Hearth volunteer, or a trainer/supervisor.
- **Training the PDI team.** Training should emphasise communication skills, listening skills and observation skills. It is particularly important to be able to probe into the issues in a culturally acceptable manner. Use role plays to practise skills and also to practise a home visit in the neighbourhood with a feedback session. The role of observer is awkward. Training is important to increase the comfort level.
- **What are some cultural filters that influence behaviours and how we view them?** In searching for behaviours that are positive and those that are problematic, the PDI team needs to look through the lens of local culture. Team members should look at family structure; socio-cultural norms; food taboos; patterns of decision making; traditional practices or customs; religion; beliefs; gender; and presence of informal or traditional health systems.

The role of grandmother may be particularly relevant to understanding the behaviours practised within the home. It is important to observe and engage the grandmother in the visit.

Ask each participant to draw nine dots on a piece of paper in the following pattern.



The goal of the puzzle is to connect all nine dots, using four or fewer straight lines, without lifting the pencil from the paper. Allow some time and then ask if anyone was able to do it. Have the person illustrate the solution on the flip chart. If no one solves the puzzle, draw this solution on the flip chart.



How is this like PD? PD is about *thinking outside the box!* It is finding solutions that are in the community but might not be obvious or easily seen.

The following exercise helps participants understand behaviours and skills that are important to the nutritional status of children.

5 Min

3.

Divide participants into two teams. Each team gets one set of 24 behaviour cards. Have the team members separate the cards into two piles: those with behaviours that *directly* affect the nutritional status of children, and those that do not. Tell them to be prepared to justify their choices.

Preparing for the Positive Deviance Inquiry (PDI) (STEP 4)

DAY 2

10 Min

4.

Bring the teams together. Call out each behaviour and have the team members put both hands in the air if the behaviour directly influences the nutritional status of children or put their hands behind their back if it does not. Have team members explain their choices, especially when there is disagreement about the behaviours.

Behaviour cards sample

Make two sets of cards. Write one behaviour on each card.

Thanks given for food	Nails are clipped	Use of home remedies for illness	Child is bathed every day	Boils water for children under six months old	Child eats five times a day
Mother tells stories and sings to child	Use of soap to wash hands	Child is given fruit for snack	Child breastfeeds during the day	Grandmother cares for child	Adds oil to porridge
Child is dewormed	Seeks medical help when ill	Eggs, snails, watercress, groundnuts are included in meal	Parent hits the child for not obeying	Kitchen pots are washed and left to dry on rack	Child feeds often during illness
Brushes child's teeth	Someone helps the child eat	Sleeps with window open	Child eats from own bowl	Washes hands after using latrine	Child wears sandals

5 Min

5.

What tools can be used to gather information about child-care behaviours (feeding, health-seeking, caring and hygiene)? Refer the participants to the 'Observation Checklist for PDI' and the sample 'Semi-structured Interview' in *the CORE PD/Hearth Guide* (pp. 99–103). Allow a few minutes for them to look these over.

Observation Exercise. Have the participants stand in pairs, facing each other. Each person carefully observes his or her partner for 30 seconds. Then tell the partners to turn and stand back to back. Each partner is to change one thing about his or her appearance (take off an earring, put on glasses, button a cuff, etc.). Then ask the partners to face each other again. Each is to tell the partner what has changed. Ask how many were able to identify the change. Emphasise the importance of *good observation* in order to explore behaviours through the cultural lens of the community.

10 Min

6. A simplified 24-hour recall exercise

The purpose of this exercise is to find out from the caregiver everything the child ate in the last 24 hours.

Demonstrate this method with a participant who acts as the caregiver of a young child. Ask the 'caregiver' what the child ate when he or she got up the previous day. Probe for more information, asking about amounts the child ate (ask to see the bowl), how the caregiver prepared the food, whether she added anything else, whether the child ate or drank anything else. Then ask about the next thing the child ate. Did the child eat anything between the first meal and the second? Continue with these probing questions until the full day has been covered. Be sure the observer is taking notes on the foods, quantities and frequencies.

HANDOUT
18.1 – 107m/H 49

Distribute Handout 18.1 and divide the participants into pairs. Have them practise doing a 24-hour recall with one acting as 'caregiver' and the other as 'interviewer'.

10 Min

7.

Use the following role play to demonstrate and practise the skills necessary for conducting a PDI. Begin with three facilitators for scenario 1 (interviewer with questionnaire; mother of child; older sibling; may use doll or additional facilitator as PD child).

Scenario 1: This role play portrays part of a PDI; during the part shown, the interviewer is focusing on feeding practises. The PD child is a well-nourished, 30-month-old girl. Her mother says the child eats only during the two daily meals. However, a sibling in the room is sharing a snack with the child (who is fed constantly by older siblings, her grandmother and neighbours). The mother talks very little. While the mother is being interviewed, the sibling washes the child's hands, scolds the child when she drops something and tries to pick it up to eat it, plays with the child, gives the child a drink, etc. (The interviewer and mother don't interact with the child or sibling during this time.)

After the role play, lead participants in discussing what is necessary for a successful PDI:

- The quality of the interviewer's probing skills. Note that probing was needed when information from the caregiver was not consistent with observation. It is all right to ask what the family does for a healthy child. But there should be no leading questions and no pre-formed ideas about what is 'right'. Listen to what family members say.
- The importance of knowing local languages and customs.
- Conducting the inquiry without a questionnaire in hand. Small talk can be employed to create a comfort level (this role play was brief, but an actual PDI is more often a two-hour visit in the village). Encourage caregivers to continue with whatever tasks they need to do. The interviewer may even help (getting water, stirring pot, playing with the child, etc.).
- Role of the observer. The second person/observer (a supervisor, volunteer or other community leader) may recognise positive behaviours that the interviewer from the community does not see or recognise.
- Seeking strategies, not just behaviours. Carefully probe to learn how the family manages to practise a behaviour that their peers seem unable to practise. For example, if the family is feeding the child an egg frequently, how do they afford this? If the house and children are very clean in spite of lack of water, how does the caregiver accomplish this good hygiene?

10 Min

8. Role play

Ask three or four participants to prepare a skit using all the wrong approaches to a visit. There should be two interviewers and a mother. The interviewer uses comments like 'We know you are poor and want to find out why'. The mother is busy and asks the interviewers to return at another time. They invite themselves in anyway. The interviewers are eating candy and talking on their cell phones. They use big words and ask offensive questions. They are not respectful. The mother is obviously annoyed, upset and then angry.

Ask participants how the interviewers could improve their visiting skills. Summarise the skills that are important for conducting a PDI home visit: probing in a culturally acceptable manner; mixing observation with conversation; good interaction to put the caregiver at ease.

10 Min

9.

HANDOUT
18.1 – 107m/H 49
18.2 – 109m/H 51

Give out Handout 18.2. Divide into groups of four or five people. Using Handouts 18.1 (interviewer) and 18.2 (observer), tell participants to role play a home visit with two participants acting as 'interviewer' and 'observer', and the others being 'family members'. Practise until the participants feel comfortable talking about the four 'goods' – feeding practices; caring practices; hygiene practices; and health-care practices – without referring to a list on a sheet of paper. Try to get the conversation to flow. Observe what the family members are doing as well as what they are saying.

10.

HANDOUT
18.3 – 110m/H 52

Ask participants to develop a logistical plan for the PDI in their country context, as a homework exercise. Distribute Handout 18.3 and instruct the participants to use Handout 18.3 to summarise the PDI findings of all households from the upcoming PDI field visit.

Purpose of a PDI

Through the situational analysis (FGDs, market survey, seasonal calendar, transect walk and community mapping), we now know what resources are available in the community and understand the common feeding, hygiene, caring, and health seeking practices. Overall, the findings provide us with a better knowledge of what the 'norm' is in the community.

By conducting a PDI in non-PD households, we can further identify:

- common practices, both good and poor behaviours,
- what are the barriers and challenges households face in practicing positive behaviours,
- what is the reasoning for some of their behavioural or food choices.

Once the reasoning, challenges and barriers are identified and understood, the PDI in PD households is used to observe and identify how the PD households overcome those very challenges and barriers that everyone else in their community cannot overcome. It is also an opportunity to understand the PD caregivers' thinking and reasoning behind the practices. Sometimes the PD caregivers will be practicing positive practices without any knowledge of it being a positive behaviour; it may just be a decision made because of family circumstances. Thus, PDI in PD households is used to find the local solutions.

The 24-hour recall during the PDI is also used to identify the PD foods. PD foods are the foods that only PD households feed their children and non-PD households do not feed their children. It is important to understand why non-PD households do not feed their children the PD foods and why the PD households do. This understanding could be used to explain why it is important to feed the children the PD foods during the Hearth session. PD foods are nutrient-dense, locally available, low in cost, and easily accessible in various seasons or even all year round.

(Participants are to create their own questions and guidelines for use in the field visit.)

House Visits

1. Be wise; respect the family.
2. Don't ask why they are poor.
3. Point out that you are here to learn, not to criticise.
4. Introduce yourself, congratulate the family on its good work, and ask permission to observe.
5. Make sure the information collected regarding child information (e.g. age, birth order, wealth ranking, etc.) is correct to ensure the child is a PD child.
6. Spend two to three hours in each PD house. It is good to go during a meal time to observe the child's feeding practices, but ensure you do not disturb the family.
7. Try to engage both the caregiver and grandmother (if present) while conducting the visit.
8. Conduct a 24-hour diet recall on the food the child ate yesterday. Fill out form.

24-Hour Dietary Recall Question Guide

1. What is the first thing the child ate yesterday after waking up?
2. How much did you give (of each feed)? How much of it did the child eat? Can you show me the bowl the child used?
3. How did you prepare the food? Fried? Boiled? Steamed?
4. What did you add? Any oil? Vegetables?
5. Did the child eat anything else?
6. Did the child drink anything?
7. What is the next time the child ate? What? How much? How prepared? What else did the child eat?
8. Did the child get anything else between first and second meal? And between second and last meal? (Note: food quantity, frequency and consistency).

Good Food/Feeding

1. Is the child breastfeeding? If not, at what age did the mother wean the child?
2. What foods is the child being fed today?
3. Who decides what the child will eat? What role do other family members play in child feeding decisions?
4. How many times did you see the child eat or drink?
5. Where does the family buy food? Who buys the food? How much money is spent on food each day?
6. How many meals and snacks does the child eat a day?
7. Are there any foods the caregiver does *not* give the child?

Sample Guiding Questions for Conducting a PDI

Good Child Care (try to observe without asking)

1. Who is the primary caregiver of the child?
2. What roles do other family members play in caring for the child?
3. Who is in the house during the day?
4. Does the caregiver take the child to the vaccination post? How often? Is the child on schedule?
5. Does the caregiver or others play with the child? How? How often?
6. How is the child disciplined? By whom?
7. What does the caregiver do to encourage the child to eat if he or she doesn't want to?

Good Health Care (ask for health card, ask caregiver questions)

1. How do you know when your child is sick?
2. Was the child sick in the past six months? If so, how many times?
3. What illnesses has the child had?
4. When the child was sick, what did you do? Did you feed the child anything differently?
5. What steps do you take to prevent illnesses?

Good Hygiene (observe body, food and environment)

1. Is the house clean? Is the kitchen clean?
2. Are the people clean?
3. If there is a latrine, how does it look?
4. Make observations about the water source.
5. Do pigs, mules, dogs or other animals go in and out of the house?

Questions	Remarks
Personal Hygiene	
Wash hands before/after?	
Plates washed?	
Nails	
Shoes	
Clothes	
Food preparation	
Handwashing (Check for soap and running water)	
Washing the food before cutting or cooking	
Food/water covered (before and after cooking)	
Household measures used (e.g. size of cup, spoon sizes, do they use fist sizes?)	
Home Environment	
Food availability (gardens)	
Animals present (cage, play with children?)	
Storage facilities (for water, food)	
Household waste management	
Toilets (cleanliness, distance, type)	
Water (boiled/filtered, distance, source)	
Interaction between caregiver and child	
Loving and caring behaviour	
Playing with the child	
Feeding Practices	
Does child pick up food from ground and eat it?	
Do you help the child to eat and watch child eating?	
Amount of food the child is eating?	
How many times do you feed per day?	
Feeding Practices **Health Seeking Practices**	
Do you see any ORS packets?	
Do you see an ITN? Is it in good condition?	
Do you feed the child differently when the child is sick (e.g. more or less food; more or less liquid; feed more frequently)?	

Results and Observations from the PDI

DATE ..... ADP ..... DISTRICT ..... COMMUNITY NAME .....

PD Food/Feeding		PD Caring		PD Hygiene		PD Health Seeking	
Non-PD Food/Feeding		**Non-PD Caring**		**Non-PD Hygiene**		**Non-PD Health Seeking**	

Preparing to Conduct a Situational Analysis and PDI (STEP 4) (Preparing for the field visit)

SESSION 19

60 MIN | DAY 2

By the end of this session, participants will have

1. Prepared questionnaires and tools for collecting data in the community in various ways.

Reference in CORE PD/Hearth Guide: pp 62–112

Preparation

- The host country staff will need to prepare communities for this activity. Ideally, these will be new ADP communities which will begin PD/Hearth for the first time. Select one community for every five workshop participants. In each community conduct a nutrition baseline of weights of at least 20 children, selected randomly, between the ages of 6 and 36 months. With existing community health volunteers and community leaders, conduct a wealth-ranking exercise. Using this information, classify the children who were weighed according to their family's wealth ranking. This information must be ready by the start of the training. Host country staff need to arrange with the community for a field visit on the third day of the training. They need to organise a focus group of caregivers, invite community leaders to a brief meeting during the visit, and ask if participants can visit selected families.

Materials

- Local growth chart for plotting weights, or WHO ANTHRO software to calculate nutritional status
- Flip chart with blank paper

STEPS

5 Min

1.

Explain to the workshop participants that we are going to conduct a situational analysis in actual communities the next day of the course. Explain that the National Office and cooperating ADP have already weighed children and conducted a wealth ranking. Based on their work, we can identify PD families to visit. We need to prepare the questionnaires and tools we will use for the activities we will conduct. Write the activities on a flip chart:

- **PDI** – We will conduct a PDI with several families.
- **Focus group** – We will investigate existing social norms and practices related to feeding and care of small children in a focus group with caregivers and family members, particularly grandmothers, from poor households who have children under three years of age.
- **Market survey** – We will take a market survey to assess food costs and what foods are available in markets and shops.

- **Social mapping and transect walk** – Social mapping and a transect walk with a few community leaders will help us identify local resources related to health and nutrition (availability of piped water and latrines, wild foods, health services etc.). The map should include health risk factors such as standing water where mosquitoes breed, garbage dumps etc., as well as the services available and their locations relative to the houses of the poor.
- **Seasonal calendar** – A seasonal calendar created with a few community members will identify the availability of food sources for families at different times of year.

2.

Divide the participants into five groups. Each group will develop questionnaires, observation forms and tools to conduct one of five different activities in the community. If they type these and a printer is available, they may print out the materials. If a printer is not available, ensure that each small group has at least one copy of each of the questionnaires, forms and tools. The facilitators circulate among the groups to provide guidance and support.

3.

Divide the participants into groups of no more than three people. These are the groups in which they will conduct the household visits tomorrow. Two small groups may join together for the other activities, such as the focus group discussions, the market survey, seasonal calendar and transect walk.

Personalise the Curriculum
Daily Summary and Evaluation

SESSION 20

30 MIN | DAY 2

By the end of this session, participants will be able to

1. Adapt the content of the day to their own cultures
2. Evaluate personal learning for the day

Preparation

- Make a flip chart with the daily evaluation sentence starters listed below.

Materials

- Half sheet of paper for each participant
- Each participant's curriculum

STEPS

20 Min

1.

Each participant reflects on the day's sessions and writes down ideas to improve or adapt the various presentations so they are more appropriate for the participant's specific culture. This is done by adapting case studies, games and hands-on exercises, developing role plays and including local stories. Ask the participants to be ready to share some of their good ideas.

5 Min

2.

Daily evaluation. Distribute a half sheet of paper to each participant. Ask the participants to respond to the three phrases written on the flip chart:

- Something I learned today that I will apply in our PD/Hearth programme is

_____

- Something new that I learned about PD/Hearth today is

_____

- Something I'm still confused about is

_____

Facilitators will review these evaluations at the end of the day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.

3.

Explain the departure time and transportation arrangements for the next day and quickly outline the agenda for the afternoon session following the field trip.

Remind participants the order of the exercises that will take place tomorrow during the field visit. 1 group will conduct the FGD with the caregivers, 1 group will conduct the FGD with the grandmothers, and 1 group will conduct the FGD with the father group. Simultaneously 1-2 groups will be conducting the wealth ranking exercise with a diverse group of community members. Once the FGD and wealth ranking is complete, the wealth ranking criteria should be shared with the rest of the participants so everyone knows the wealth ranking criteria prior to weighing the children (if weighing of children is needed). Transect walk and seasonal calendar could be completed at any time, and all participants should get an opportunity to conduct a market survey after the weighing of children.

2 Min

4. Thank participants for good work today. Mention any highlights of the day. Remind them of the meeting time for the morning.

Field Visit to Conduct Situational Analysis and PDI

SESSION 21

6.5 HOURS | DAY 3

Total field visit time of 4.5 hours includes transportation time.

By the end of this session, participants will be able to

1. Confidently conduct a FGD, wealth ranking transect walk, market survey, household visits, and PDIs.
2. Identify PD and Non-PD Behaviours during a PDI.

Materials

- Questionnaires and tools created by each group the previous day plus 120 mins for compiling results or Print out Handouts 14.3, 15.3, 16.1, 16.2A, 16.2B, and 16.3.
- Flip charts and markers

STEPS

4.5 Hours

1. Field Visit

HANDOUT
14.3 – 68m/H 37
15.3 – 81m/H 44
16.2A – 92m8/H 46
16.2B – 93m/H 47
16.3 – 94m/H 48

Distribute copies of Handouts 14.3, 15.3, 16.1, 16.2A, 16.2B, and 16.3 to each participant and remind them in how to fill-out the Handouts. Also, remind participants to refer children with 'red' coloured MUAC (severe acute malnutrition/wasting) to Health Centres or OTPs.

2 Hours

2. Compiling Feedback

HANDOUT
18.3 – 110m/H52

At the end of the visit each group will record the information it gathered on flip charts for all participants to see. The information will come from the FGD, PDI, transect walk, market survey and seasonal calendar. Create a summary of the information. Have the group reflect on the three questions again:

1. What are the different practices between PD and NPD/ND? (record findings in format shown in Handout 18.3)
2. What are some of the challenges faced in the community? (e.g. don't like feeding Sprinkles, breastfeeding but only up to 3 months, only feed rice porridge)?
3. What is the PD household doing to address these challenges at home? Identify the local solution for these challenges.

Use Question 1 to fill out the entire table on Handout 18.3 and use Question 2 to add important findings into the non-PD practices section of the table on Handout18.3. Use Question 3 to add important findings into the PD practices section. Put a star beside the PD foods listed under 'PD Food/Feeding' on Handout 18.3.

PDI Field Exercise: Identifying PD and Non-PD Behaviours

PD Food/Feeding	PD Caring	PD Hygiene	PD Health Seeking
Non-PD Food/Feeding	**Non-PD Caring**	**Non-PD Hygiene**	**Non-PD Health Seeking**

Review of Day 3 Field Visit and Agenda for Day 4

SESSION 22

15 MIN | DAY 4

STEPS

15 Min

1.

Engage participants in a discussion based on questions such as

- How did you feel about the visit yesterday?
- What did you find easy?
- What did you find difficult?

2.

Address any issues that may arise.

3.

Review the agenda for today, explaining that we will analyse the information gathered and decide how to use it for Hearth planning

SESSION 23

PDI Interpretation and Feedback: Determining Positive Deviance (STEP 4)

World Vision

80 MIN | DAY 4

By the end of this session, participants will be able to

1. Describe the categories of behaviours identified during the PDI analysis
2. Describe the participatory processes for analysing PDI data and selecting PD feeding, caring, hygiene and health-seeking behaviours to be used in PD/Hearth sessions
3. Demonstrate skills for sharing the PDI findings with the community.

Reference in CORE PD/Hearth Guide: *pp 89–98, 104–12.*

Materials

- Flip chart
- Matrix for each small group to record PD and non-PD behaviours

PD Food/Feeding	PD Caring	PD Hygiene	PD Health Seeking
Non-PD Food/Feeding	**Non-PD Caring**	**Non-PD Hygiene**	**Non-PD Health Seeking**

STEPS

15 Min

1.

Each group posts its field-visit summary sheet on the wall. The groups circulate around the room to read the behaviours/practices discovered by each group. In small groups the participants discuss each behaviour and place it in the matrix under the appropriate column for the PD families and then for the non-PD families for contrast. If a behaviour is repeated by more than one family, the group should highlight it and indicate how many times that behaviour was observed. This serves to illustrate common threads among the PD families and non-PD families.

Do not include positive practices that non-PD households practise and common practices that everyone practises. The key is to identify the unique positive practices that only PD households are practising that allow their children to be healthy. Especially point out local solutions that the PD households are practising.

30 Min

2.

Ask each group to explain the findings of its PD data in the large group. Show what behaviours were found in the PD families' homes and what behaviours were found in the non-PD homes. Answer the following questions:

1. What are the different practices between PD and NPD/ND? (record findings in format shown in Handout 18.3)
2. What are some of the challenges faced in the community? (e.g. don't like feeding Sprinkles, breastfeeding but only up to 3 months, only feed rice porridge)?
3. What is the PD household doing to address these challenges at home? Identify the local solution for these challenges.

For those behaviours that are considered positive, lead the group to select whether the behaviour could be practised by a poor family or only by a non-poor family. Is it feasible, easily replicable, affordable? Point out to participants how this exercise mirrors the process used in the community to analyse information from the PDI. Together, develop a summary chart of PD behaviours/skills/practices/messages that will need to be emphasised in Hearth sessions. Ensure the PD foods are used in the menu design in session 26.

25 Min

3.

Have each small group role play how to give this information back to the community. This will help to develop community ownership and enable community members to identify immediately accessible solutions to childhood malnutrition. Have at least one group present its role play and discuss it afterward with the large group. What was positive? What was difficult? What other ways could have the information been communicated?

Point out that by leading a group of villagers to identify uncommon good behaviours, you have facilitated community validation of choices ('buy-in').

Note: *Village volunteers may need help in analysing which behaviours are beneficial and which are harmful.*

10 Min

4.

Briefly summarise the steps in the PDI. Use this opportunity to repeat and clarify important points and answer any questions. The steps in the PDI are the following:

- Select the PDI team.
- Train the team (include lots of role play).
- Select sample PD households and conduct a practice PDI. These households are informed in advance, and the PDI team has the opportunity to practise and share notes.
- Conduct the PDI (may also conduct the PDI in non-PD and negative-deviant households for comparison purposes).
- Compile the findings.
- Share the findings with the community
- Plan the Hearth sessions using the information discovered about food (Hearth menu), active feeding, hygiene around eating/food, child development games, role of men (perhaps invite fathers to one Hearth day), role of grandmothers and other family members.
- Document other community initiatives resulting from the sharing with the community.

Promoting Behavioural Change

SESSION 24

40 MIN | DAY 4

By the end of this session, participants will be able to

1. Describe the stages of change
2. Relate to behavioural change from the perspective of an adopter and of a change agent
3. Give examples of motivating factors and barriers to change
4. List the key principles for behavioural change.

Reference in CORE PD/Hearth Guide: pp. 141, 143–45.

Detailed reference on behaviour change: http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

Preparation

- Write the following on a flip chart:

  'We behave our way into a new way of thinking.
  We do not think our way into a new way of behaving!'

- Prepare a flip chart with the questions asked in step 2 below.

Materials

- Blank flip charts

STEPS

5 Min

1.

Ask participants to think individually of one thing they have tried to change in their life. Ask them to try to remember what they did to make that change. What motivated them to try to change? How easy or hard was it? What things made it easier to adopt the new practice? What made it hard to adopt the new practice? How does a person adopt a new behaviour? (alone, with friends or a support group, with family). Ask if anyone is willing to tell the group whether he or she was successful in making the change. Why or why not? The facilitator should also talk about a change he or she made or failed to make.

5 Min

2.

Behaviour is embedded in culture and social context. Individual behaviours are motivated and influenced by the group, tribe, caste, beliefs, etc. Divide into groups of about five people. In the small groups think of a time when a community tried to change and then answer these questions: What motivated the community to

try to change? How easy or hard was it? What made it easier to adopt the new practice? What made it hard to adopt the new practice? Was the community successful in making the change? Why or why not? Have each group records its answers on a flip chart.

10 Min

3. Each group presents its flip chart with its example.

5 Min

4. As a group, look at all the charts. Can we identify stages in the change process? (The following are possible answers):

- We don't know what we want.
- We think we know what we want, but we can't do it.
- We are motivated to try something.
- We try/fail/reflect/try again, and so on.
- The new behaviour becomes a habit.
- We teach others about the new practice.

How fast do you think people progress through the stages to adopting a new behaviour? *(depends on the behaviour; depends on how desirable it is; depends on how complex it is to learn; depends on the cost in money, time, or energy; depends on whether other people approve or disapprove of the behaviour; depends on what obstacles get in the way)*

5 Min

5. Does knowledge or awareness equal behaviour change? Post the flip chart:

We behave our way into a new way of thinking.
We do not think our way into a new way of behaving!

Discuss together the meaning of this saying. Brainstorm about possible factors that enable or inhibit the behavioural change. Note these on a flip chart.

Factors That Enable Behavioural Change	Barriers That Inhibit Behavioural Change

5 Min

6.

Can you think of an example in PD/Hearth when a barrier might need to be removed before caregivers can feed their children different types of foods? What barriers might exist in the minds of caregivers? Note that we can only guess; to know for sure we have to ask the caregivers.

People take action when they believe it will benefit them; barriers keep people from taking action. A programme's activities should maximise the most important benefits and help overcome the most significant barriers.

What activities in PD/Hearth promote behavioural change?

Examples:

- From the PDI, we can learn what some families have done to overcome barriers and share that information through the Hearth sessions with the participants.
- It is important (from a behavioural change point of view) to stress that it is the community that needs to discover what works (the PD behaviours and strategies), not the PD facilitator.
- The PDI findings can be examined with the community at a community meeting, setting the stage for better adoption of sometimes controversial (unconventional) behaviours.
- Caregivers build skills and self-confidence as they practise feeding and cooking every day.
- The volunteers and community leaders give approval to caregivers for participation and for their children recovering.
- Caregivers get support from grandmothers, the other caregivers and the volunteers in trying the new practices.

5 Min

7.

Summarise the key points the participants have discovered about behavioural change and how it might influence how they implement PD/Hearth.

SESSION 25

Designing Hearth Sessions (STEP 5)

World Vision

115 MIN | DAY 4

By the end of this session, participants will be able to

1. Describe what happens in a Hearth session
2. List the activities that occur during Hearth sessions
3. Describe lessons caregivers will learn during different Hearth activities.

Reference in the CORE PD/Hearth Guide: Hearth Session Protocols, pp. 132, 135–40

Preparation

- Review Handout 25.1.
- Prepare one flip chart for each of the activities of a Hearth session.
- Review the equipment list on page 136 in the CORE PD/Hearth Guide. Ask several participants to develop a role play of what happens in a Hearth session.
- Ask participants to prepare a skit demonstrating what a Hearth session is like. Ask a person who has experience with Hearth sessions to act as the 'volunteer' (or a facilitator can be the 'volunteer'). Be sure to include greeting caregivers and their children, collecting the food contributions and mentioning how these can help children to grow well, handwashing and snack, food preparation, games with children, handwashing and feeding children, discussion of what each caregiver or caregiver-grandmother pair will bring the next day, and cleanup.

Materials

- Flip-chart paper
- A marker for each participant
- Handout 25.1: Examples of Learning Opportunities Through PD/Hearth Activities

STEPS

5 Min

1.

What are some strengths of the PD/Hearth approach?

Remind the participants to keep these two goals in mind:

Goal 1: The malnourished child will recuperate.

Goal 2: The child's caregiver(s) will learn new behaviours (so that rehabilitation is sustained at home).

Discovers existing strengths: The approach helps identify positive behaviours and strengths that exist in the community and builds upon them. Each community's practices are different, so the health-education messages built around those practices will likewise be different for each village.

The PD/Hearth approach follows a three-step process for behavioural change:

1. Discovery (PDI)
2. Demonstration (Hearth sessions)
3. Doing (in Hearth sessions and at home, with follow-up visits to reinforce learning).

Promotes role modelling: If the Hearth volunteer is a PD caregiver (e.g. mother, grandmother, father, grandfather), he or she becomes an excellent role model.

Is experiential: Hearth sessions avoid lecture-style teaching; instead, caregivers are involved in all steps (hands-on style of learning).

Is based on cultural/social norms: Norms are reinforced with community support. Interventions are culturally appropriate and often use songs and/or stories that are part of the culture. In Haiti, a contest was held during training to develop songs for Hearth. This was very successful; it animated the training process and enhanced Hearth education.

15 Min

2.

Present the role play that illustrates the different activities of a Hearth session. Discuss the role play, covering the following topics:

What activities take place during a Hearth session?
(Caregivers and volunteers work together to prepare food, feed and entertain the children. Children – and perhaps siblings – receive a small snack and have supervised play while the meal is being prepared.)

Where should the Hearth session be held?
(The session requires a central, adequate space, preferably a house. While the 'hearth' should be large enough to accommodate the group, it should not be very different from the homes of the participating families.)

Time required
(A session takes two to three hours each day. Caregivers participating in PD/Hearth programme should decide a time that is convenient for all of them.)

Are there basic requirements at the site?
(The site should have a latrine; water for drinking, cooking, and washing hands; and shade.)

What equipment needs to be at the site?
(See the list on page 137 in the CORE PD/Hearth Guide.)

5 Min

3.

Ask one participant to describe the order of activities during a Hearth session.

Briefly review the activities of Hearth. Have each of the following activities listed on flip chart paper, one activity per sheet, and post the sheets around the room.

- Arrival of caregivers and children; take attendance and track contributions for the day (e.g. menu and cooking materials)
- Weigh children on first and last days of the programme. Collect child growth cards to obtain immunisation, supplementation and deworming information for each child; if child has not been fully immunised, dewormed or received vitamin A supplementation, refer the child to the nearest health facility for proper treatment before joining the Hearth session.
- Collect food contribution
- Hand washing/hygiene
- Snack
- Cook
- Play games with children
- Feed children
- Decide on menu and cooking material contributions and assign roles for next day
- Clean up.

10 Min

4.

Hearth presents many informal learning opportunities for caregivers such as modelling, conversation and learning by doing. The topics in the examples below do not need to be taught through talks; rather, the volunteer reinforces these practices each day through conversations with the caregivers during the activities. Give each participant a marker and have them walk around the room where the Hearth activities are posted on flip chart paper. Ask them to list on the papers what caregivers can learn during each of these activities.

30 Min

5.

HANDOUT
25.1 – 129m/H 53

As a group, review each activity and add other learning opportunities. (See Handout 25.1.) Discuss other lessons caregivers might need to learn and grandmothers can support. Consider especially practices and messages from the PDI. How will caregivers and grandmothers have an opportunity to learn these? During which activities? What activities can contribute to early childhood stimulation? Emphasise that lectures or other formal teaching methods are not used during Hearth; instead, all the messages are conveyed through conversation and learning while doing.

35 Min

6.

Have participants refer to their PDI raw data. Give participants two to three minutes to study them and identify which PD behaviours they might select as the 'key messages' for Hearth sessions. List these on a flip chart. Have the group reach consensus on the most important six messages and the order they will be shared with the caregivers (For example, take into consideration the definition of the 'norm', which was found through the FGDs and PDIs in Non-PD and ND households. Select messages that are essential to address the most commonly practised poor behaviours, which directly affect the nutritional status of a child.). What would be three or four points that could be shared under each key message? How might other points be promoted? (This should lead back to the activity in Step 5.)

Example (refer to CORE PD/Hearth Guide, p. 132):

Key Message: BREASTFEEDING AND COMPLEMENTARY FEEDING

Sub-level Messages:

- Breastmilk is the best food for infants (good for protection, energy, and body building)
- Exclusive breastfeeding for six months, but complementary feeding with continued breastfeeding beginning at the age of six months and continuing up to two years
- Why introduce new food in addition to breastmilk
- Frequency, consistency and quantity of food
- Method of feeding.

Divide participants into six groups. Assign each group a key message. Ask each group to develop a simple song to teach its key message to caregivers and children. A good song will be repetitive, have a catchy tune, and include actions. The groups will present these songs during the remaining sessions as energisers.

10 Min

7.

Ask the first group to finish its song to prepare a 5–10 minute role play on how a first day of Hearth unfolds (refer to CORE PD/Hearth Guide, p. 138).

5 Min

8.

Clarify any questions about Hearth sessions, for example, variations from programme experience

- Food contributions – An extremely poor caregiver may be asked to bring firewood or water, an extra pot, or another item. Or staff may make a contract with families before Hearth, detailing expectations and including a pre-Hearth work up and list of contributions. Or, in a peri-urban area, in order to reduce the caregiver's time commitment, all the caregivers (or caregiver-grandmother pairs) bring food, two people stay to cook, and the others return with the children at meal time.
- Obtaining equipment for the Hearth sessions – If the volunteer does not have pots or dishes, each caregiver can bring the equipment for her own child(ren). Or the community might provide a sitting mat, a large pot, and so on.
- Finding an appropriate Hearth setting – If one volunteer cannot host all 12 days, the sessions may rotate among several homes.
- Prior visit to health centre – The volunteer can accompany each caregiver and child to the health centre in order to establish comfort and ensure compliance.
- Assuring fuel for Hearth – Fuel scarcity can influence the types of food cooked. Fuel can be the community's contribution to lessen the burden on individual caregivers or the volunteer.

Arrival of caregivers and children/attendance

- Volunteer gives positive reinforcement for good hygiene.
- Volunteer asks how things are going at home – troubleshoot and share observations.

Collect food contribution

Discuss:

- Cost and sources of nutritious food
- Food variety, healthy choices
- Safety of food, proper storage
- Where foods can be found, gathered
- Food production/home gardens

Hand washing/hygiene

Discuss:

- Modelling proper hand-washing technique
- Use of soap
- Times when hand-washing is important
- Reason to wash hands: bacteria/germs contribute to illness/diarrhoea
- Treatment of diarrhoea/illness, when to seek health care
- Immunisation, deworming
- Nail cutting
- Orientation to personal hygiene
- Latrine use
- Use of shoes

Snack

Discuss:

- Frequency of snacks and meals
- Why to feed children four to five times a day
- Healthy snacks that require little or no preparation
- Consistency of food
- Food groups and nutritional value of food
- Including a variety of food in a day
- Breastfeeding
- Food storage

Cooking the menu

Discuss:

- Nutritional value of food
- Sources of affordable food: food production/home gardens, barter, collecting wild fruits
- Variety of food
- Good cooking techniques
- Food hygiene and safety, storage
- Promoting thick consistency of food
- Palatability and appetising appearance
- Importance of feeding children four to five times a day
- Hearth is an extra meal

Child stimulation/play

Discuss:

- Modelling play and care of children
- Motor-skill development
- Cognitive development
- New ways to stimulate children – singing, dancing, clapping games, etc.
- Social skills/sharing/cooperation
- Appropriate touching/affection

Feeding children

Discuss:

- Active, responsive feeding
- Content of foods (colours, nutrients)
- PD foods and why they are good
- Importance of meal frequency (four to five times a day)
- Breastfeeding
- Portion sizes
- Troubleshooting feeding problems
- Food taboos
- Stimulating a child's appetite

Planning for the next day

Discuss:

- Local and affordable foods, including the PD foods.
- Quantity of food
- Food combinations – variety, colour
- Nutrient value of food – importance of variety
- Where to find foods
- Planning menus and budgets

Cleaning up

Discuss:

- Hygiene – clean surfaces and utensils
- Use of leftovers
- Food safety
- Food storage
- Reuse water, compost
- Latrine use and cleanliness

Menu Planning: Designing Hearth Sessions (STEP 5)

SESSION 26

245 MIN OR 4 HRS 5 MIN | DAY 14

By the end of this session, participants will be able to

1. Describe important elements of planning nutritionally and culturally appropriate menus for Hearth sessions
2. Calculate calorie and nutrient requirements to determine optimal Hearth menu recipes/meals.

Reference in *CORE PD/Hearth Guide*: pp. 114–19

Preparation

- Purchase a 'market basket' of local foods from the market and set out these foods *(Note:* foods normally eaten cooked must already be cooked).
- Purchase food scales that measure amounts as small as 1 gram.
- Review the PD food or dishes/meals identified during the PDI.
- Use actual prices to calculate the cost per gram of each food item and post this next to the food.
- Obtain copies of and familiarise yourself with the national/regional 'Food Composition Table'.
- Provide copies of the Excel spreadsheet 'Menu Calculation Tool' for participants to install on their computers (if available). Know how to use this programme.
- Print copies of 26.1, 26.2, 26.3, 26.4 and 26.5

Materials

- Flip chart 26 (below): Nutrients Required in the Meal
- Blank flip-chart paper
- Market-survey findings
- Local, national, or regional food composition (if available)
- Handout 26.1: Flip Chart 26 – Nutrients Required in the Meal
- Handout 26.2: Directions for the Menu-Planning Exercise
- Handout 26.3: PD/Hearth Menu Exercise – Food Composition Table
- Handout 26.4: Sample Menu-Planning Form
- Handout 26.5: User Guide for the PD/Hearth Menu Calculation Tool
- Plates, spoons for dividing bulk foods, a sharp knife, and small containers (little plastic cups)
- Scales to weigh food (in grams)

STEPS

10 Min

1.

Hearth is held for 12 days (six days a week), followed by two weeks of follow-up visits. The first goal of the two-week Hearth session is to rehabilitate the malnourished child. The hands-on nature of the session sets the stage for sustained behaviour change which will be reinforced during the follow-up home visits (and later by the community). Keep the goal in mind while reviewing the following points.

Importance of the extra meal

At each session, ask the caregiver what she fed the child at regular meals in order to be sure the Hearth meal is 'extra'. After the child's recuperation the caregiver, supported by the grandmother, should enrich regular meals on a permanent basis, for example, with PD foods.

Importance of a snack during the Hearth session

A snack provides nourishment for children while they play and the caregivers cook, reinforces the idea that children need to eat small amounts frequently, and supplements the nutrients provided by the main menu.

When to weigh children and why

Children should be weighed on Day 1, Day 12 and Day 30. It is also important to ensure that a community growth-monitoring programme (GMP) continues; weighing helps to confirm nutritional rehabilitation and to reinforce the new behaviours.

5 Min

2. Menu Preparation

HANDOUT
26.1 –139m/H 55

Based on the PDI findings and the market survey, menus will be designed which enable children to be rehabilitated quickly from malnutrition. Emphasise that the menu must be 'extra', must include a snack, and must include sufficient intake of protein and calories.

Show Handout 26.1: Flip chart 26 – Nutrients Required in the Meal. Emphasise the importance of Hearth menus meeting these requirements. Explain the motivational effect when caregivers see dramatic improvements in the child's health and behaviour. The child's appetite will return and overall mood and energy improve within 10 to 12 days. Families begin to see that food and caring are making a difference. This encourages them to continue the new practices.

Explain that the first step in menu planning is for the volunteer or supervisor to do a market survey. The purpose of this is twofold: (1) to reinforce the idea that the PD and other nutritious foods are affordable; and (2) to ensure that the menus planned will be affordable for caregivers to prepare at home. The market survey results will be used to create menus. Food composition tables (preferably country-specific ones) are also needed for menu preparation. *These may be available through the local UNICEF office or the Ministry of Health; for a fairly comprehensive table, see* http://ndb.nal.usda.gov/ndb/foods/list

25 Min

3.

HANDOUT
26.3 –141m/H 57

Distribute a sample page from the national/regional food composition table or if this is not available, refer to Handout 263: PD/Hearth Menu Exercise - Food Composition Table. Explore together how the table is set up (based on 100g of the foods listed; the table tells whether the food is fresh or cooked; if not specified, it means 100g of raw food; EP stands for edible portion (for example, we don't eat the shells of eggs, so they aren't part of the edible portion) divided by food groups or alphabetically; foods are listed down the left-hand column and the nutrients across the top (some tables have macronutrients like kcal and proteins divided from micronutrients such as iron, zinc, vitamin A and vitamin C).

Using a flip chart based on Handout 26.3, ask the participants to locate a specific food/ingredient (for example, fresh fig leaves). Guide them through filling out the chart for 100g of this food. Fill in the chart together. For now, don't worry about the columns named 'home measure' and 'cost/amount'.

Pick another ingredient and this time complete the chart for 140g of the food. Help the participants decide how to fill in the table for the nutrients. For example, 140g of whole grain millet:

100g = 361kcal

(level of nutrient in food = amount of nutrient in 100 g * number of grams used)

$$\frac{140g = 361kcal * 140g}{100g}$$

$$= 505.4kcal$$

Fill in the rest of the values, making sure that the participants understand how to do the calculations.

Choose one more ingredient and show the same calculation using a quantity less than 100g. For example, 40g of fresh camel meat:

100g = 188kcal

$$\frac{40g = 188kcal * 40g}{100g} = 75.2kcal$$

Fill in the remaining values for camel meat. Make sure that the participants understand how to do the calculations.

Add the total values for each of the nutrients. Compare the totals with the requirements for the optimal Hearth menu. What is missing in this sample menu? What foods might supply those nutrients? Look on the food tables under Vitamin A for foods high in that vitamin. Are any of those foods available and affordable in the community?

A child's stomach has the capacity of about 200–250g (the size of a child's fist). The total quantity of the menu cannot exceed that amount. Remember that the menu must also include a snack as well as the meal. What could be added to this meal?

What follows is not a sample menu to be copied for PD/H menu designs, it is only to be used as an example for menu calculation.

Food	Home Measure	Quantity g	Calories Kcal	Protein g	Vit. A µg RAE	Vit. C mg	Iron mg	Zinc mg	Cost/ amount
Fig leaf, fresh, EP*		100	22	1	13	20	0.2	0.1	
Millet, whole grain		140	505.4	16.24	28	0	11.2	4.34	
Camel meat, fresh		40	75.2	6.96	0	0	.48	1.16	
TOTAL		280	602.6	24.2	41	20	11.88	5.51	
Hearth Requirements		200–250	600–800	25–27	300	15–25	10	3–5	

* Edible Portion

In addition to selecting high calorie, protein, vitamin, or mineral-rich foods, various cooking methods could be promoted to improve the nutrient value of certain foods (e.g. boiling vs. drying/roasting).

Examples:

Germination:

1. Sort and clean cereal grains.
2. Soak for 1 day.
3. Drain and place in a sack or covered container.
4. Store in dark, warm place for 2-3 days until grain sprouts.
5. Dry sprouted grains in sun.
6. Grind and sieve the flour.

Fermentation:

1. Grind cereal grain into flour.
2. Soak flour in water (3 cups of flour to 7 cups of water).
3. Leave to ferment for 2-3 days.
4. Cook into porridge.

3 Hours

4.

HANDOUT
26.2 – 140m/H 56
26.3 – 141m/H 57
26.4 – 147m/H 63

Small-group menu-preparation activity. Divide the participants into groups of three or four.

Provide each small group with Handout 26.2: Directions for Menu Preparation and Handout 26.4: Sample Menu-planning form. The national/regional food composition table or Handout 26.3: PD/Hearth Menu Exercise – Food Composition Table may be shared among the groups.

- Each group goes to the 'market area' (the place where the food is spread out along with the containers and utensils) and takes foods for the menu it created based on the PDI findings and the market survey. The menu includes one snack and the meal.
- Groups use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the *CORE PD/Hearth Guide*, page 116, on how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Each group takes the amount they think a small child would eat. (Remember that a child's stomach is no larger than the child's fist.)
- Have a group member note the cost per gram of the food the group takes. Multiple the cost per gram of each food item by the number of grams used. Calculate the cost of the menu.
- After weighing the group's choices, place them on a plate.
- Using common household measures, such as bowls, cups, tins, and spoons, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.

Note: *If participants have computers and work in Excel, they can do the menu calculation using the spreadsheet provided. However, all participants must be able to use the 'Food Composition Table' and do the calculations manually, because they will be training others who will not have computer access. Ensure that local foods are entered into the spreadsheet before it is distributed to participants to load onto their computers.*

HANDOUT
26.5 – 148m/H 64

Excel instructions: Use a LCD projector to introduce the Menu Calculation Tool (Excel document) and to orient participants in how to use the tool. Copy ingredients and their nutrient values (columns A to G) from the master sheet and paste them into the list of ingredients on the worksheet Input Day 01. Ensure that the cost of ingredients (per 100 grams) in the master sheet is updated based on the local market survey. Click on the worksheet Menu Day 01. Enter the quantity of each ingredient to be used (column C). The levels of nutrients will be calculated. Compare the total amounts for each nutrient with the requirements of Hearth menus noted in red. Make adjustments to the menu as needed to adjust the levels of nutrients.

Allow groups to develop their menus before explaining the next steps.

- *Convert the cooked amount of food to a raw amount.* Demonstrate how to do this. When cooked, some foods either increase or decrease greatly in volume. For example, cooked rice has a volume about two times greater than raw rice; cooked beans, lentils and pulses about two times greater than raw. To convert cooked food in grams to raw food in grams, divide or multiply by the difference factor; for example,

  100g of cooked rice ÷ 2 = 50g of uncooked rice

Each group should convert all the ingredients in their menu to raw amounts.

- *Calculate the cost of the ingredients using the cost per gram of each food, then add up the total cost for the entire menu.* If the cost seems too high for a household, look for less expensive sources of food. For example, replace chicken, which might be too costly, with groundnuts or another source of protein commonly available in the community.
- *Change the weights of the ingredients to household measures.* When cooking at home, people do not usually talk about grams or weigh foods. So, the grams must be changed to household measures. Measure the quantity of each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.). Demonstrate how to do this with one ingredient, such as rice. Weigh 50g of raw rice and put it into a household measure. Write the household measure on the calculation sheet. Do the same for each ingredient.

This is the amount of the raw ingredients required for each child at each Hearth session. To calculate the total amount of ingredients required for *all* the children, multiply the measure of each ingredient by the number of children in the Hearth session.

Example: There are six children in one Hearth session. The menu uses 50 g uncooked rice per child – one large handful of uncooked rice. The whole recipe would require six large handfuls of uncooked rice (1 handful of rice x 6 children).

When all group members are satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form (Handout 26.4) to display with the plate.

Facilitators should work actively with the groups to guide the development of a menu and calculate nutritional composition (micronutrients, calories and protein) for each menu. Verify that each proposed menu meets nutrient requirements for recuperative feeding. (If laptops are available, each group may have one person calculate the menus with the Excel programme while others do the manual calculation.)

25 Min

5.

Gather in a large group. Have each small group show their final plate and menu-planning form, explain their menu, and point out the difficulties they encountered and the possible solutions they identified. Guide discussion on each proposal.

- Does the menu contain the correct protein, calorie and micronutrient composition?
- Is the quantity (volume) of food in the proposed menu a realistic amount for a child to eat? *(This has to be visualised, recalling that a child's stomach is the size of the child's fist.)*
- Does the menu include PD foods?
- Does the menu include locally available and accessible foods?
- Does the menu include a snack?
- Is the cost per serving realistic for a very poor family? *(While caregivers are not necessarily expected to replicate the exact menu at home, they should be able to afford all the ingredients in order to serve them regularly to the child.)*
- If a child finishes all the food served, should he or she be offered more? *(Yes, but not another whole portion. Also, the volunteer should visit the home and talk to the caregiver to assure that the child is receiving three other meals and another snack at home each day while attending Hearth. When not attending Hearth, a child 6–8 months of age should be receiving two meals and two snacks plus breastfeeding each day, and a child 9–24 months of age should receive three meals and two snacks daily plus breastfeeding. The Hearth meal is an extra meal.)*

- Considering that some children may need an extra small serving when they finish their first portion, how much extra food should be cooked? *(Cook an extra amount equivalent to two full portions.)*

***Note**: Although time does not allow in this training of Master Trainers, during training of facilitators (TOF) sessions the menus should be cooked and tested. This practice ensures that those being trained understand what will take place in the Hearth session. They can taste the menus and select the two best menus. They can measure out the amounts using local measures that the caregivers will use to serve each child. This is invaluable practice. Caregivers and grandmothers from the community can also be asked to join the tasting as a way of introducing them to what they will learn in the Hearth sessions.*

6.

A good Hearth menu should:

1. Include PD foods (based on PDI findings)
2. Be low in cost (affordable based on PDI)
3. Meet nutrient, calorie and protein requirements
4. Be small enough in volume that child could eat another meal at home soon after (250g–300g)
5. Include a snack (to increase child's appetite)
6. Based on local context and culturally acceptable (use locally available and accessible foods)
7. Have good consistency (doesn't run off of spoon like water, but is thicker)
8. Not consist of foods that are too chunky or bulky, as that makes it difficult for children to consume.

Calories: **600–800 (500–600*)**

Protein: **25–27g (18–20g*)**

Vitamin A: **300 µg RAE (RAE=retinol activity equivalent)**

Iron: **8–10mg**

Zinc: **3–5mg**

Vitamin C: **15–25mg**

*Amounts in parentheses are the minimum for a region with food insufficiency; recuperation will take longer with these amounts (see CORE PD/Hearth Guide, p. 114).

Note: *The vitamin A requirement has been updated since the publication of the CORE PD/Hearth Guide and PD/Hearth Addendum to use the currently accepted measure of Retinol Activity Equivalents (RAE). Make sure that the food composition tables you use lists vitamin content as µg RAE, not RE or IU (conversion rate: 1 µg RAE = 3.3 IU).*

Each group can go to the 'market area' (where the food and utensils are laid out) and take different foods for its menu. The menu includes one snack as well as the meal:

- Take the amount you think a small child would eat. Remember that a child's stomach is no larger than the child's fist.
- Note the cost per gram of the food you take.
- After weighing your group's choices, put the foods on a plate.
- Use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the CORE PD/Hearth Guide, page 116, which discusses how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Calculate the cost per gram used of each ingredient. Then add up the total cost of the menu for one child.
- Using common household measures, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.
- Convert the cooked amount of food to a raw amount. For rice, divide the cooked volume by 2 to get the uncooked measure. For example, 60g of cooked rice divided by 2 equals 30g of uncooked rice.

Conversion of cooked food in grams to raw food in grams:

Cooked rice, divide by 2

Cooked beans, lentils, pulses, divide by 2

Cooked porridge, divide by 2.5

Cooked green leaves, multiply by 1.4

- Change the gram amounts to household measures by measuring the quantity of each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.).
- For example, weigh out 30g of uncooked rice and put it into a cup that would be found in households or measure it by the handful, if that is more common.
- Write the household measure for each food on the calculation sheet.
- Each caregiver or caregiver-grandmother pair will contribute this amount of raw ingredients for their child(ren) at each Hearth session.
- When satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form to display with the plate.

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
1. Grains, Roots, and Tubers								
Cassava, boiled	165	1.2	1	13	1.4	0.2		1
Cassava, dried, raw	351	2.1	2	68	3.8	0.8		1
Cassava, raw	157	1.1	1	31	1.7	0.2		1
Maize flour, whole grain, yellow	361	6.93	11	0	2.4	1.7		5
Maize or Sorghum Ugali	110.3	3	2.1	0	1.3	0.5		7
Maize, white, whole, boiled	139	3.5	1	2	1.2	0.5		1
Maize, white, whole, dried, raw	363	9.2	3	8	3.2	1.4		1
Maize, yellow, boiled	136	3.6	35	1	1.6	0.6		1
Maize, yellow, dried, raw	354	9.4	101	4	4.2	1.7		1
Millet flour	373	10.75	0	0	3.9	2.6		5
Millet, whole grain, boiled	144	4.1	0	0	6.4	0.6		1
Potato, boiled	74	1.8	2	11	0.8	0.3		1
Rice Flake, water soaked	356	1.1	0	0	2.0	0.4		9
Rice noodle (mee suah)	320	9.10	0	0	1.6	0.7		10
Rice noodle, fermented	106	1.40	0	0	0.1	0.2		10
Rice steamed, white	131	2.20	0	0	0.4	0.6		10
Rice, brown, boiled	135	3	0	0	0.7	0.7		1
Rice, white, boiled	133	2.8	0	0	1.0	0.4		1
Rice, white, fried	370	6.81	0	0	1.6	1.2		10
Rice, white, raw	355	6.80	0	0	1.2	0.5		10
Rice, white, soaked	370	6.81	0	0	1.6	1.2		10
Sorghum flour	361	7.87	0	0	3.0	1.4		5
Sorghum, whole grain, boiled	153	4.6	2	0	3.6	0.6		1
Steamed sticky rice (white), grilled	229	4.60	0	0	0.1	0.2		10
sticky rice (white), steamed	229	4.60	0	0	0.3	1.0		10
Sweet Potato, boiled	101	1.7	789	15	1.7	0.3		1
Taro, boiled	100	1.9	4	3	0.9	0.2		1
Wheat flour, white	347	10.7	0	0	2.0	4.0		1
Wheat noodle (waiwai), instant	456	10.5	0	0	1.6	1.8		10
Yam, boiled	101	1.7	2	5	1.0	0.2		1
2. Legumes and Nuts								
Beans, kidney, boiled without salt	127	8.67	0	1	2.2	1.0		5
Beans, raw	32	2.4	54	18	1.0	0.3		1
Beans, yellow, cooked, boiled without salt	144	9.16	0	2	2.5	1.1		5
Cashewnut, raw	589	20	0	0	6.4	4.6		7
Chickpea, boiled without salt	164	8.86	1	1	2.9	1.5		5
Chickpea, dry	364	19.3	3	3	6.2	3.4		5
Coconut water	22	0.3	0	2	0.1	0.1		1
Coconut, mature, fresh, raw	387	3.2	0	2	2.5	0.9		1
Cowpea, Leafy tips, boiled and drained	22	4.67	29	18	1.1	0.2		5
Cowpea, seeds, black, dried, boiled	116	7.73	2	0	2.5	1.3		10
Groundnut, dried, raw	578	24.1	2	1	4.3	1.9		1
Groundnut, dried, roasted (also gnut flour)	567	25.8	0	0	4.6	1.7		6
Groundnut, fresh, boiled	236	10.8	0	0	1.9	1.0		6
Groundnut, fresh, roasted	374	17	0	0	3.0	1.1		6
Groundnut, seeds, dried, raw	577	24.8	0	1	2.3	2.8		1

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
2. Legumes and Nuts (continued)								
Lentils, boiled without salt	116	9.02	0	2	3.3	1.3		5
Lentils, raw	353	25.8	0	0	7.5	4.8		5
Mongogo Nut, Bok Nut	659	26.00	0	0	3.7	4.0		
Mung Bean, boiled without salt	105	7.02	1	1	1.4	0.8		5
Mung Bean, dried	324	22	19	0	8.0	0.8		2
Soya bean, boiled without salt	173	16.64	0	2	5.1	1.2		5
Soya bean, dried, raw	397	33.2	9	0	8.3	4.7		1
Soya bean, dry roasted	451	39.58	0	5	5.0	4.8		5
Soya bean, roasted without salt	471	35.22	0	2	3.9	3.1		5
3. Dairy Products (milk, yoghurt, cheese)								
Breastmilk, human, mature, raw	69	1.1	62	1	0.2	0.3		1
Milk UHT, Thaidenmark brand (non-fortified)	67	3.30	41	0	0.1	0.3		10
Milk, cow, powder, whole	492	25.3	295	12	0.7	4.0		1
Milk, cow, whole, raw	75	3.7	39	2	0.1	0.4		1
Milk, goat, whole, raw	69	3.4	35	2	0.1	4.0		1
Milk, instant, Anmum brand (fortified)	77	3.20	93	22	2.6	2.2		10
Yoghurt, drinking, foremost brand	84	1.50	14	3	0.1	0.3		10
Yoghurt, wholemilk, natural	75	3.5	33	1	0.1	4.0		1
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats)								
Anchovy (small fish), fillet, raw	123	18.4	15	0	3.3	1.7		1
Anchovy, fillet, grilled	668	27.6	20	2	3.8	2.5		1
Anchovy, fillet, steamed	542	22.4	16	2	2.9	2.1		1
Beef ball, blanched	84	16.5	7	1	5.0	0.0		10
Beef internal organ barbecue	94	14.0	2357	9	5.0	2.0		10
Beef intestine, raw	109	16.4	10	0	3.1	2.0		10
Beef liver, grilled	133	20.3	3841	18	10.1	3.9		10
Beef liver, pan-fried	175	26.52	7744	1	6.2	5.2		5
Beef liver, raw	135	20.36	4968	1	4.9	4.0		5
Beef lung, raw	84	16.0	95	6	6.1	1.7		10
Beef spleen, raw	95	18.2	103	29	0.7	2.1		10
Beef stomach, raw	102	11.0	0	0	1.9	1.3		10
Beef, blanched	150	20.0	2	0	3.0	5.0		10
Beef, dried, grilled	479	38.3	3	0	11.8	3.9		10
Beef, dry, fried	479	38.3	3	0	11.8	3.9		10
Beef, grilled	190	38.5	3	0	4.9	7.6		10
Beef, ground, 20% fat, pan-broiled	246	24.04	0	0	3.6	6.1		5
Beef, ground, 20% fat, raw	254	17.17	0	1	1.9	4.2		5
Beef, raw	273	17.2	3	0	2.3	5.3		10
Chicken, roasted	210	23.8	0	0	0.8	1.5		10
chicken gizzard, raw	102	20.2	34	3	3.1	3.2		10
Chicken heart	112	15.8	75	6	4.0	5.5		10
Chicken Liver	114	16.9	3296	18	9.0	2.5		9
Chicken liver, boiled	121	18.6	3178	14	7.3	3.2		10
Chicken liver, grilled	121	18.6	3273	14	7.3	3.1		10
Chicken liver, raw	121	18.6	3710	14	7.3	3.0		10
Chicken, boiled	193	28.6	5	1	0.6	1.0		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats) (continued)								
Chicken, cooked	285	26.9	39	0	1.4	1.8		6
Chicken, flesh only, raw	136	20.6	10	0	1.2	1.0		1
Chicken, raw	186	17.3	3	0	0.5	1.0		10
Cricket	127	12.90	0	0	9.5	0.0		11
Dried small fish *(usipa)*, cooked with salt	125	17	0	0	3.3	9.1		6
Duck, roasted	373	18.5	115	0	1.3	2.1		10
Fermented fish with bone	103	13.3	3	0	5.5	3.6		10
Fermented fish, sour, fried	108	19.5	1	0	2.1	2.4		10
Frog legs, raw	73	16.40	15	0	1.5	1.0		5
Lamb, composite of retail cuts, cooked	256	24.54	0	0	1.9	4.7		5
Lamb, meat, raw	217	17.2	10	0	2.3	3.1		1
Mackerel, Pacific and jack, cooked dry heat	201	25.73	23	2	1.5	0.9		5
Mackerel, raw	133	21.1	16	2	1.8	0.5		1
Mussels, boiled	33	3.1	208	0	2.9	1.9		2
Mutton/Lamb Liver	150	19.3	8250	20	6.3	4.0		9
Nile tilapia fish, raw	96	20.1	0	0	0.6	0.3		10
Nile tilapia, roasted	128	26.2	0	0	0.7	0.4		10
Pork blood, boiled	32	7.90	26	0	25.9	0.1		10
Pork liver, grilled	125	19.2	4242	19	15.5	5.3		10
Pork liver, raw	125	19.2	6291	25	15.5	5.6		10
Pork sausage, grilled	369	19.6	14	2	1.2	2.5		10
Pork skin, raw	320	19.8	6	0	2.1	0.3		10
Pork spleen, raw	87	16.1	241	26	1.0	2.3		10
Pork, boiled	204	33.0	0	0	1.5	1.3		10
Pork, fresh, cooked	201	27.51	1	0	1.0	0.1		5
Pork, grilled	249	26.2	0	0	2.5	1.8		10
Pork, meat, approx. 24% fat, raw	289	14.5	0	0	2.0	3.2		1
Pork, meat, approx. 40% fat, raw	405	12.6	0	0	1.9	3.2		1
Pork, raw	116	21.8	0	0	1.0	1.0		10
Pork, shreded, chinese style	357	43.1	0	0	17.8	1.3		10
Prawns or shrimps, cooked in moist heat	119	22.78	0	0	0.3	1.6		5
Rabbit, meat, raw	142	20.7	10	0	0.9	1.7		1
Rabbit, stewed	206	30.38	0	0	2.4	2.4		5
Short bodied mackerel fried	236	25.7	26	2	2.4	1.0		10
Short bodied mackerel, roasted	122	21.4	27	5	1.4	0.6		10
Siamese mud carp, grilled	124	21.1	9	1	0.6	1.5		10
Snail, pond, river	74	12.10	0	0	8.7	0.0		11
Tilapia, cooked dry heat	128	26.15	0	0	0.7	0.4		5
5. Eggs								
Egg, duck, whole, boiled	150	11.8	169	0	3.4	1.2		10
Egg, hardboiled	155	12.58	149	0	1.2	1.1		5
Egg, hen, whole	159	13.2	160	0	2.8	1.1		10
Egg, hen, whole, boiled	170	13.9	164	0	3.5	1.2		10
Egg, raw	139	12.1	207	0	2.4	1.3		1
Hen egg, fried	196	13.6	219	0	1.9	1.4		10
Omelet duck egg	183	12.6	365	0	3.2	1.0		10
Omelet hen egg	259	7.00	255	0	2.2	1.6		10

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
6. Vitamin-A Rich Fruits and Vegetables								
Amaranth, boiled	21	2.11	139	41	2.3	0.9		5
Bean leaves, fresh, cooked with salt	14	1.4	192	12	1.1	0.1		6
Carrot, boiled	33	0.9	1137	3	0.7	0.6		1
Carrot, raw	35	1	1201	7	0.9	0.8		1
Cassava, fresh leaves, cooked with salt	20	2	261	12	1.6	0.6		6
Cassava, fresh leaves, raw	98	0.9	1733	370	5.6	5.0		1
Chinese cabbage blanched	21	1.70	244	33	1.6	0.2		10
Dark Green Leaves, fresh	48	5	950	100	4.0	0.8		2
Dark Green Leaves, fresh, cooked with salt	18	1.1	401	17	0.5	0.1		6
Green amaranth, small, blanched	21	2.11	278	41	2.3	0.9		10
Green amaranth, small, fresh	35	3.60	510	49	3.1	1.2		10
Horse tamarind, young leaves	85	9.20	255	7	3.4	0.6		10
Mango, ripe, fruit, raw	62	0.6	427	35	1.0	0.6		1
Moringa leaves, boiled	91	8.8	699	0	4.8	0.7		1
Moringa leaves, raw	86	8.3	738	0	6.1	0.9		1
Morning glory/Swamp cabbage, blanched	20	2.08	520	16	1.3	0.2		10
Morning glory/Swamp cabbage, fresh	31	2.90	457	28	3.3	0.5		10
Mustard green blanched	19	2.27	708	14	1.1	0.2		10
Mustard green, fermented, sour	21	1.50	161	20	1.3	0.2		10
Mustard green, stem and leaves, boiled	22	1.70	249	43	1.5	0.1		10
Mustard leaves, fresh, cooked with salt	16	1.1	213	0	1.0	0.4		6
Mustard, fresh	28	2.20	317	57	2.5	0.2		10
Okra, leaves, cooked with salt	12	0.7	260	11	0.3	0.7		6
Papaya (paw paw), fruit, ripe, raw	38	0.5	355	59	0.7	1.4		1
Pumpkin, boiled	20	0.5	201	5	0.2	0.2		6
Pumpkin, fresh leaves, boiled	11	0.6	298	11	0.5	0.4		6
Pumpkin, mature, fresh	49	1.30	170	15	0.7	0.9		10
Pumpkin, raw	36	1	250	15	0.8	0.2		2
Squash, raw	47	0.4	240	1	0.3	0.2		2
Squash, winter, all varieties, cooked without salt	37	0.89	261	10	0.4	0.2		5
Tamarind, young leaf, fresh	68	3.80	381	32	1.5	0.5		10
Taro, leaves, cooked without salt	24	2.72	212	36	1.2	0.2		5
Taro, young leaves, raw	30	2.4	389	52	2.0	0.4		1
Wildbetal Leafbush	60	4.20	258	17	4.2	1.0		10
7. Other Fruits and Vegetables								
Apple, prink, fresh	63	0.50	14	2	0.2	0.0		10
Avocado, raw	149	1.6	20	16	1.1	0.6		1
Bamboo shoots, cooked, boiled, with salt	11	1.53	0	0	0.2	0.5		5
Bamboo shoots, cooked, boiled, without salt	12	1.53	0	0	0.2	0.5		5
Banana, flowers, fresh	38	1.60	34	10	1.1	0.3		10
Banana, ripe, raw	100	1.3	19	10	1.0	1.1		1
Banana, ripe, yellow	105	1.00	15	12	0.4	0.1		10
Banana, ripe, yellow, boiled	105	1.00	13	10	0.4	0.1		10
Bean sprouts, fresh	46	4.30	5	23	1.4	0.5		10
Cabbage, blanched	29	1.50	8	32	1.0	0.3		10
Cabbage, boiled	19.8	1.3	11	21	0.4	0.2		1
Cabbage, common, fresh	29	1.50	8	32	1.0	0.3		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Cabbage, raw	26	1.6	10	54	0.6	0.2		1
Cauliflower, boiled	28	2.7	1	47	0.8	0.4		9
Chayote, boiled	21	0.60	6	10	0.4	0.3		10
Chayote, fruit, fresh	21	0.60	6	10	0.4	0.7		10
Chilli pepper, hot, red, fresh	75	3.00	156	142	1.2	0.4		10
Cilantro	23	2.13	337	27	1.8	0.5		2
Coriander, fresh	33	2.50	431	34	2.6	0.2		10
Cucumber, fresh	23	0.80	9	12	0.4	0.2		10
Cumcumber	95.5	0.7	3	0	0.5	0.2		1
Dill, fresh	34	3.10	201	40	2.3	0.7		10
Eggplant, boiled without salt	35	0.83	2	1	0.3	0.1		5
Eggplant, raw	28	1.1	12	6	0.9	1.6		1
Eggplant/brinjal, green, fresh	37	1.50	10	8	0.9	0.2		10
Fennel common leaves, fresh	42	2.50	867	23	2.3	0.2		10
Fig, raw	78	1.4	79	15	6.0	1.5		1
Garlic, fresh	51	2.10	0	10	0.7	0.4		10
Garlic, raw	136	6.1	0	18	1.5	0.6		1
Ginger, raw	72	1.9	0	5	1.1	0.4		9
Guava, fruit, raw	58	1	95	281	1.4	1.8		1
Hairy basil, fresh	39	2.80	279	18	2.1	0.6		10
Jackfruit, raw	94	1.7	18	9	0.6	0.1		2
Lemon grass, fresh	78	0.80	3	1	2.0	0.5		10
Lemon, fruit, raw	36	0.7	2	46	0.6	0.1		1
Lemon, juice	29	1.1	3	53	0.6	0.1		4
Light/Pale Green Leaves, fresh	23	1.5	47	40	0.5	0.8		2
Mango, unripened, fruit, raw	55	0.5	10	86	1.4	0.6		1
Mint, leaf	42	2.90	467	84	4.1	0.8		10
Mushrooms, portabella, grilled	29	3.28	0	0	0.4	0.7		5
Okra, fresh, boiled	21	1.1	38	5	0.8	0.4		6
Okra, fresh, raw	31	1.7	72	29	0.9	3.0		1
Onion	50	1.60	0	8	0.7	0.2		10
onion, cooked	44	1.36	0	5	0.2	0.2		5
Onion, raw	32	1.1	1	7	0.5	0.2		1
Orange, raw	45	0.8	17	47	0.1	0.1		1
Orange, sweet, fresh	52	0.50	6	65	0.4	0.7		10
Pak kha yeng, raw	32	1.50	18	5	5.2	1.0		10
Passion Fruit	94	2.4	64	17	1.2	0.0		3
Pineapple, raw	56	0.4	15	31	0.5	2.2		1
Pomelo (grapefruit), raw	34	0.8	40	44	0.6	0.1		4
Radish, boiled	24	1.2	0	9	0.5	0.4		9
Radish, raw	18	0.9	0	17	0.4	0.4		9
Rumbutam, fresh	69	0.90	0	43	0.7	0.1		10
Shallot, bulb	67	1.70	1	9	0.9	0.3		10
Spring onion, fresh	44	2.20	475	42	2.3	0.4		10
Star fruit	32	0.60	10	29	0.7	0.0		11
Tamarind, fruit, raw	60	2.2	2	10	0.7	0.0		1
Tiliacora triandra diels	95	5.60	329	141	7.0	0.6		10

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Tomato, fresh	25	1.00	88	29	0.9	0.2		10
Tomato, raw	21	1	127	29	0.9	12.0		1
Tomato, red, ripe, cooked	18	0.95	24	23	0.7	0.1		5
Watermelon, fruit, raw	30	0.5	62	7	0.2	0.1		1
Yard long bean, green, fresh	40	2.60	41	20	0.8	0.5		10
8. Fats and Oils								
Butter, cow's milk	700	1	1060	0	0.2	0.1		1
Coconut oil	900	0	0	0	1.5	0.0		1
Ghee, cow	898	0	0	0	0.2	0.0		9
Groundnut oil	903	0	0	0	0.0	0.0		1
Mustard oil	900	0	0	0	0.0	0.0		9
Palm oil	895	0	0	0	0.4	0.0		1
Vegetable oil	884	0	0	0	0.0	0.0		4
9. Miscellaneous								
Fermented fish, liquid	13	1.20	3	0	2.9	0.1		10
Fish souce	48	5.40	5	1	2.4	0.2		10
Honey	322	0.3	0	2	0.6	2.0		1
Horse tamarind, seeds	152	11.8	34	2	4.3	1.4		10
Jaggery	383	0.4	160	0	11.1	0.0		8
Lemon, juice, fresh	24	0.50	1	25	0.1	0.1		10
Oyster sauce	73	2.90	6	7	1.1	0.1		10
Pumpkin seeds, without shell, roasted	594	25.6	0	0	6.0	8.0		11
Salt	0	0	0	0	0.3	0.1		5
Sesame seeds, white, roasted	682	26.1	0	0	13.0	7.2		10
Shrimp paste	85	4.60	21	0	2.2	1.1		10
Sprinkles (per sachet)	0	0	300	30	12.5	5.0		8
Sugar (white), not fortified	369	0	0	0	0.2	0.1		1
Tumeric, dried	335	6.9	1	0	33.2	3.8		9
Vinegar	27	0.2	0	0	0.5	0.0		1
10. Additional Foods								
Banana Porridge	105.3	0.6	65.6	9	0.4	0.1		7
Cassava Stiff Porridge	140	2.7	1.4	7	1.2	0.6		7
Coconut juice, fresh	37	0.10	0	5	0.1	0.2		10
Coconut milk	185	1.90	0	2	0.6	0.5		10
Deep fried banana with powder	373	2.00	11	8	0.4	0.1		10
Maize Porridge (with oil)	414.4	16.9	0.6	1	5.6	2.6		7
Porridge, white rice, boiled	59	4.10	0	0	0.1	0.2		10
Soy milk, Lactasoy brand	82	2.50	40	0	0.4	0.1		10

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Sample Menu-Planning Form

Menu A:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

Menu B:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

The PD/Hearth Menu Calculation Tool is developed to aid in designing low cost and nutrient-dense menus for Hearth sessions using local foods/ingredients that are easily accessible and available to community members. Based on the PDI findings and the market survey, 2-4 Hearth menus with a snack and a meal for each menu will be developed for each community using PD food(s) and locally sourced ingredients. To quickly rehabilitate children from malnutrition, Hearth menus need to meet optimal calorie and nutrient requirements[1]. Particularly, this Tool is useful in checking whether the meal and snack meet the requirements. Also it simplifies other calculations such as the total cost and quantity of ingredients required for all the children attending Hearth as these can be generated automatically.

The PD/Hearth Menu Calculation Tool has six tabs/worksheets: Introduction; Instructions; Master; Menu Day 1; Menu Day 2; Menu Day 3.

Tab 1 – Introduction: Contains a background information on the rationale for the Tool including who should be using this Tool and how it should be used.

Tab 2 – Instructions: Contains a step-by-step detailed guide on how to use the Master and Menu worksheets. Please refer to this worksheet as you design the Hearth menus.

Tab 3 – Master: Contains a Food Composition Table with the nutritional breakdown of 100 grams of edible portions of foods in terms of energy (Kcal), protein (g), Vitamin A RAE (mcg), Iron (mg) and Zinc (mg). The foods are categorised in 10 food groups: 1. Grains, roots, and Tubers; 2. Legumes and nuts; 3. Dairy products; 4. Flesh foods; 5. Eggs; 6. Vitamin A rich fruits and vegetables; 7. Other fruits and vegetables; 8. Fats and oils; 9. Miscellaneous; and 10. Additional foods (In cases where local food items are missing from this Master list, missing foods can be added to 'Additional foods' group by copying the energy and nutrient values from another food composition table).

Tab 4 – Menu Day 1: Contains a Menu Planning Form (calculates the menu requirements for ONE CHILD) and a table that allows automatic calculation of the cost and quantity of each ingredient required in the menu to feed 'X' number of children, depending on the number of participating children in Hearth sessions. The total cost of the menu for all children is also given.

Tabs 5 and 6 – Menu Day 2 and Day 3: Contains additional worksheets (same format as Menu Day 1) to create different menus. Most Hearth sessions should have at least 2 Hearth menus. You should consider changes in food availability or affordability at different seasons (e.g. dry vs. rainy season) when designing Hearth menus. For example, you may want to create a menu for each season. Also, you could inform caregivers of foods you could replace certain ingredients with so that they will be able to continuously use the Hearth menu to feed their children during various seasons.

Step-by-Step Instructions:

Based on the PDI findings and the market survey results, create Hearth menus.

1. (Master worksheet) Enter cost of each food in Cost for Raw Foods column identified from the market survey. Please note that cost should be entered per 100g of edible portion of the raw food (See Step 1 of the Instructions sheet for an example).

2. (Menu Day 1 worksheet) In the Menu Planning Form, use the drop down option to select the food group of choice and then use the drop down option to select the ingredient/food under the Food column, placing each ingredient under appropriate headings (i.e. Meal or Snack).

3. (Menu Day 1 worksheet) Enter quantity in grams for each ingredient under the Quantity (grams) column. Please note that this amount is 'cooked' values in grams that will be used in the menu for ONE child. See Step 3 of the Instructions sheet for how to estimate the amount of ingredient keeping in mind the cook/raw conversions.

4. (Menu Day worksheet) Repeat Step 2 and 3 for each food you will use. You can also enter the household measure for the ingredients for the raw amounts indicated in the Raw Quantity (grams) column.

5. (Menu Day worksheet) Once you finish entering all the ingredients/foods for the menu, you can check at the bottom of the Menu Planning Form to see whether you have met or exceeded the Hearth menu requirements.

    a. The total values for each nutrient, cost, and 'cooked' quantity of ingredients in the menu for one child are calculated automatically in the row number 36. Depending on the values displayed under each column, you may need to adjust quantity of each ingredient or select different ingredient to develop optimal Hearth menus.

    b. You can check by comparing the total values for each column against what is displayed in each column heading. Or, in the subsequent row, any discrepancies or differences between the total value of each nutrient in the menu and the amount of the same nutrient required in Hearth menu are available. If the menu meets all the nutrient requirements, then all the numbers in red/bracket will be "0". Try to adjust the quantities and/or types of foods included in the menu until you reach something very close to the required amount of nutrient.

    c. The values in red/bracket indicate that these nutrients need to be increased by adding foods/ ingredients that are high in these nutrients. For example, if the cell under the Iron column has "(3.50)", then you would need to increase amount of iron by 3.50 mg, by increasing quantity or adding iron rich foods like chicken or fish, still being mindful of the cost.

    d. Also the total quantity of 'cooked' foods should not be too much considering that a child has a small stomach (the size of a child's fist) and will not be able to eat a large volume of food at one sitting. Thus, depending on the total quantity (grams), you may need to select more nutrient dense food. For example, instead of selecting rice you may opt to select groundnut which will have more calories and proteins per gram basis.

6. (Menu Day worksheet) To calculate the total cost and quantity of ingredients required for the total number of children participating in Hearth sessions, enter the number of children who will be eating in a designated cell in the table below the Menu Planning Form chart. Also, determine a household measure for raw food amounts required for each ingredient from the Raw Quantity in grams column so that volunteers will know how much of uncooked ingredients will be needed for the Hearth menu. See Step 5 of the Instructions sheet for additional details.

SESSION 27

Review of Day 4 and Agenda for Day 5

World Vision

35 MIN | DAY 5

By the end of this session, participants will be able to

1. Review and demonstrate understanding of menu calculation process
2. Outline what will be covered today.

Preparation

- Print menu calculation test (provided in PD/Hearth Master Trainer TOT materials) for each participant

STEPS

30 Min

1. Hand out menu calculation tests for participants to complete. Collect the completed tests which will be marked by the facilitatiors and returned to the participants on the final day of the training.

5 Min

2. Review agenda for today.

By the end of the session, participants will be able to

1. Identify times to give information back to the community
2. Practise creative ways of presenting information to the community.

Materials

- A flip chart
- A brightly-coloured marker
- Maize or other plant leaves (several healthy green ones and several unhealthy yellow ones)
- Thirty or so stones (Step 2)
- A large 'Road to Health' card and coloured markers

STEPS

10 Min

1.

As discussed in the community mobilisation session on the second day, it is important to give information back to the community. When should information be given to the community? Develop a flip chart with the group (see sample below). Use a brightly-coloured marker to highlight the different times information is given back to the community.

SAMPLE STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP

Step 1: Ask for the community's permission and **invitation** to use the PD approach (finding existing solutions to malnutrition problems within the community).

Discuss a way to describe the PD concept in local language, using proverbs or stories.

Step 2: Engage the community in defining the problem. Weigh *all* the children in the target group.

Step 3: Share the results of the weighing with the whole community.

Step 4: Discuss childhood malnutrition with community members: its causes, and common challenges and constraints. Ask for their ideas or suggestions for solutions.

Step 5: Have a community meeting to share the baseline information (results of weighing) again and to give feedback on the findings from the group discussions (community analysis). Explore together with the

community members the links between the information discovered in the focus group discussion and the number of malnourished or well nourished children.

Step 6: Invite community members to participate in the PDI.

Step 7: Share the PDI findings with the whole community, examine the PD behaviours and strategies identified, and invite them to develop a plan of action that will include Hearth sessions.

At different times different information needs to be shared. This is extremely important in building community ownership and commitment. What are some ways to communicate with the community? *(Engage their attention, build on their ideas, and communicate in ways they can understand. Object lessons, skits, dance and song can be effective.)*

20 Min

2.

Divide into four groups. Assign each group one step (steps 3, 4, 5, 7). Each group must come up with a creative presentation of the information gathered from the community. Circulate and help the groups. Some examples follow.

Steps for presenting data on levels of malnutrition in the community and discussing possible causes

Step 1

Use green and yellow maize leaves to show healthy and unhealthy plants. Discuss why the yellow leaves are unhealthy and ways to make the plants healthy. *(use manure, weed them, space them properly, fertilise them)*

Link the maize leaves with children. Some children are growing well, and some are not. Why? (*not fed enough, not fed often enough, births not well spaced, sickly, not enough variety of food, parents absent)*

Use stones to show proportion of children who are like yellow leaves (malnourished) and those who are like green leaves (well nourished). What makes the difference between these groups of children? How have caregivers in the community tried to help their children grow better? What do some families do to keep their children well nourished?

Step 2

Make a very large 'Road to Health' card. Plot every child that was weighed in the community on the chart. Use the colours green, yellow and red to show the difference in levels of malnutrition. Talk to the community about how

healthy children's growth follows the curve. Ask how many children there are. How many are not growing well? How can they tell? Why do they think they are not growing well? What have they tried before to help children grow better?

Are any children growing well? Why do they think that is? Are there things these families do that we could learn from? What have they tried? What has worked? Introduce PD/Hearth – discovering together what these families do so all can have well-nourished children.

Presenting information comparing community norms with the PDI information

Step 3

Present two skits. The first shows a family with children who are sick. The family demonstrates poor behaviours *(caregiver goes to the field in the morning without feeding the children, eat only maize without washing hands, poor overall hygiene, grandmother tells mother not to feed the child when s/he has diarrhoea).* Include behaviours that are seen in the community. Exaggerate to make the skit funny.

The second skit shows a family with happy, healthy children demonstrating good practices (*feeding a variety of foods, washing hands, helping child eat, giving snacks, talking to children, grandmother supports caregiver's active feeding of children, gives separate bowl for young child to eat).* Include any practices that have been discovered in the PDI.

Talk with the community about how poor families with good practices have been able to keep their children healthy. Talk about the practices discovered in the PDI. Do they contribute to children being healthy? Could every family in the community do them?

Step 4

Hold a discussion with the community to create an action plan, including a discussion to identify mothers who will volunteer for the first PD/Hearth session in the community (among families with either underweight or healthy children).

30 Min

3.

Have the groups present the skits to the others. Discuss the presentations and encourage the participants to offer as many ideas as possible.

SESSION 29

Conducting the Hearth Session (Panel Discussion) (STEP 6)

World Vision

40 MIN | DAY 5

By the end of the session, participants will be able to

1. Identify key factors that have contributed to the success of Hearth sessions
2. Discuss adaptations to meet contextual needs in successful Hearth programmes.

Reference in *CORE PD/Hearth Guide*: pp. 135–39 and 143–45

Preparation

- Ask participants with PD/Hearth experience to take part in a panel discussion.
- Have the flip chart with the PD/Hearth objectives at the front of the room.

STEPS

10 Min

1.

Review together what takes place in a typical Hearth session. Ask participants to list the activities that take place. Mention that there are several days when other activities happen. The day before the Hearth sessions begin the volunteer must gather the caregivers in his or her session together. They will discuss what PD/Hearth is about, what each caregiver or caregiver-grandmother pair needs to bring, time and place to meet, and so on. Sometimes caregivers are invited to come after the volunteers have practised making the menu. The caregivers taste the food and discuss how they will learn to make these foods to help their children grow well.

On Day 1 and Day 12 all the children in the session will be weighed before they eat the food. The weights are recorded on the monitoring sheets. This will enable volunteers, supervisors, and caregivers to see whether each child is gaining sufficient weight.

5 Min

2.

Introduce the session, explaining the need to adapt the programme and to remain flexible while still focusing on the purpose of Hearth. Refer to the flip chart with the PD/Hearth objectives, and briefly go over the importance of adequate food intake, of local feasible interventions, and of the caregivers' participation. Introduce the panellists.

15–20 Min

3.

Ask each panellist to describe briefly his or her experience with PD/Hearth. If any adaptations were made, explain why. Did the adapted programme remain true to the principles of Hearth? Was the programme successful? Why?

5–10 Min

4.

Questions from participants.

Which elements of the programme might need to be tailored? What considerations might prompt adaptations? Ideas? (See the situations detailed in the *CORE PD/Hearth Guide*, pp. 143–45. The discussion should include examples of ways to follow up defaulters; how to avoid the stigma of participation; and methods to incorporate working mothers, grandmothers and/or multiple caregivers.)

Discuss the following adaptations, as well as any mentioned in earlier sessions that merit further discussion:

- The Haiti programme placed a volunteer in a local hospital to create a better link between the community and the hospital (for referrals and for other health services).
- In many urban settings the homes do not have sufficient space to hold a Hearth session. In India, plastic sheets were used to create a 'roof' over a dead-end alleyway between houses, thus creating a space to hold the sessions.
- Some NGOs are experimenting with ways to use Hearth along with food-distribution programmes. In Indonesia, volunteers are paid 'food for work' and the rice and oil are used in the sessions. These are staples all families have, so the emphasis is still on the caregivers contributing the PD foods. The sessions show families how they can feed their children well without donated rations.
- In Mali, one programme has each participating caregiver lead the Hearth session one day. On the previous afternoon the staff person visits the home to help the caregiver prepare the session. There is no volunteer.

SESSION 30

Supporting New Behaviours through Reflection and Home Visits (STEP 7)

World Vision

60 MIN | DAY 5

By the end of the session, participants will be able to

1. Help caregivers reflect on changes in their child to motivate on-going practice
2. Summarise the objectives, activities and frequency of home visits
3. Explain the objective and activities for providing community feedback.

Reference in *CORE PD/Hearth Guide*: pp. 141, 143–45

Further training on counselling for behaviour change is covered in the World Vision CHW/TTC training materials (available by contacting nutrition@wvi.org).

Preparation

- Ask six participants to act as 'caregivers' in the reflection skit.

STEPS

5 Min

1. Learning new habits takes time

Caregivers get a good start during the Hearth sessions, but need help to recognise the changes they see in their children and relate those changes to the extra food and care they are giving them. This can be done this having a reflection time together on the last day of Hearth. They also need to be encouraged to continue the new practices, so volunteers will visit caregivers in their homes during the two weeks after the Hearth sessions. These visits are intended to help caregivers overcome any problems they might be having in following the new practices.

10 Min

2. Role play a reflection time

Gather all the 'caregivers' in a circle on a mat. Point out that this is the last day of Hearth. Ask the 'caregivers' what they think, allowing time for them to answer. 'What did you like about Hearth?' 'What was your child like before the Hearth sessions started?' 'What is your child like now?' 'What do you think has made the difference?' 'Do you think you will be able to continue these same practices at home?' 'What obstacles do you think you might have?' Congratulate them on their great work.

5 Min

3. Discuss the role play together

Brainstorm for ways to solve the problems that caregivers might have. What do we want caregivers to learn from the reflection time? Why?

5 Min

4.

Explain the importance of practicing a new behaviour over a sufficient length of time for the behaviour to become a habit. The Hearth approach includes two weeks of Hearth followed by home visits during the two weeks after the Hearth session to reinforce the behaviours learned during the sessions. Each caregiver or caregiver-grandmother pair is briefly visited every two or three days by the volunteer to be sure the child continues to receive the 'extra' food and that the other PD behaviours are being practised. Reiterate the importance of the follow-up home visits.

10 Min

5.

Present the following scenario to demonstrate a home visit:

The volunteer 'drops in', chats with the mother and grandmother about neighbourhood news, and inquires about the child. (The child is playing at a neighbour's house.) The volunteer points out to the mother and grandmother that the child's newfound energy and interest in playing are signs of recovery. The mother mentions that the child had a bout of diarrhoea. When the volunteer asks how she treated it, she says she had oral rehydration solution but gave tea instead because she couldn't remember how to prepare the solution and the grandmother couldn't either and so suggested tea. The volunteer explains how to prepare ORS both to the mother and grandmother and asks them to repeat the directions. The volunteer asks whether the child's appetite is good, and the mother says yes and that she is giving the child extra food. The volunteer says she will check in the day after tomorrow, reminds the mother and grandmother of the final weigh-in on the following Friday, and congratulates them for their efforts to make their child healthy.

10 Min

6.

After the role play, ask participants:

- What was the purpose of the home visit? (*encourage caregivers to continue feeding and caring practices; encourage grandmother to support and advise caregivers of the practices; see that the child is continuing well; help caregiver and grandmother think of solutions to challenges)*
- What examples of positive reinforcement did you see?
- How did the volunteer help the mother and grandmother see the change in their child?
- How long was this home visit? *(brief, 10–15 minutes)* How often are caregivers visited by the volunteer? *(every two or three days)* How many visits can a volunteer could do in one day? *(two or three)*

Repeat yet again the importance of the follow-up visits in behaviour change and helping families find solutions.

15 Min

7.

Ask participants what challenges caregivers might have in practicing Hearth behaviours at home. Brainstorm possible solutions to each situation. Possible problems include:

- Forgetting what was taught
- Not having the ingredients for the menu
- Not knowing where to get affordable fish or vegetables
- Having a husband or mother-in-law who is resistant
- Having a child who is sick
- Having a child who refuses to eat.

By the end of the session, participants will be able to

1. Discuss considerations for children graduating from or repeating the Hearth sessions (Hearth protocols)
2. Discuss ways to work with the community to design an exit strategy and/or to link Hearth with other programmes.

Reference in *CORE PD/Hearth Guide*: pp. 124–28, 142

Preparation

- Print Handout 31.1
- Refer to Handout 15.2
- Blank flip chart

Materials

- Handout 15.2: WHO Weight-for-Age Reference Table
- Handout 31.1: Follow-up Cases

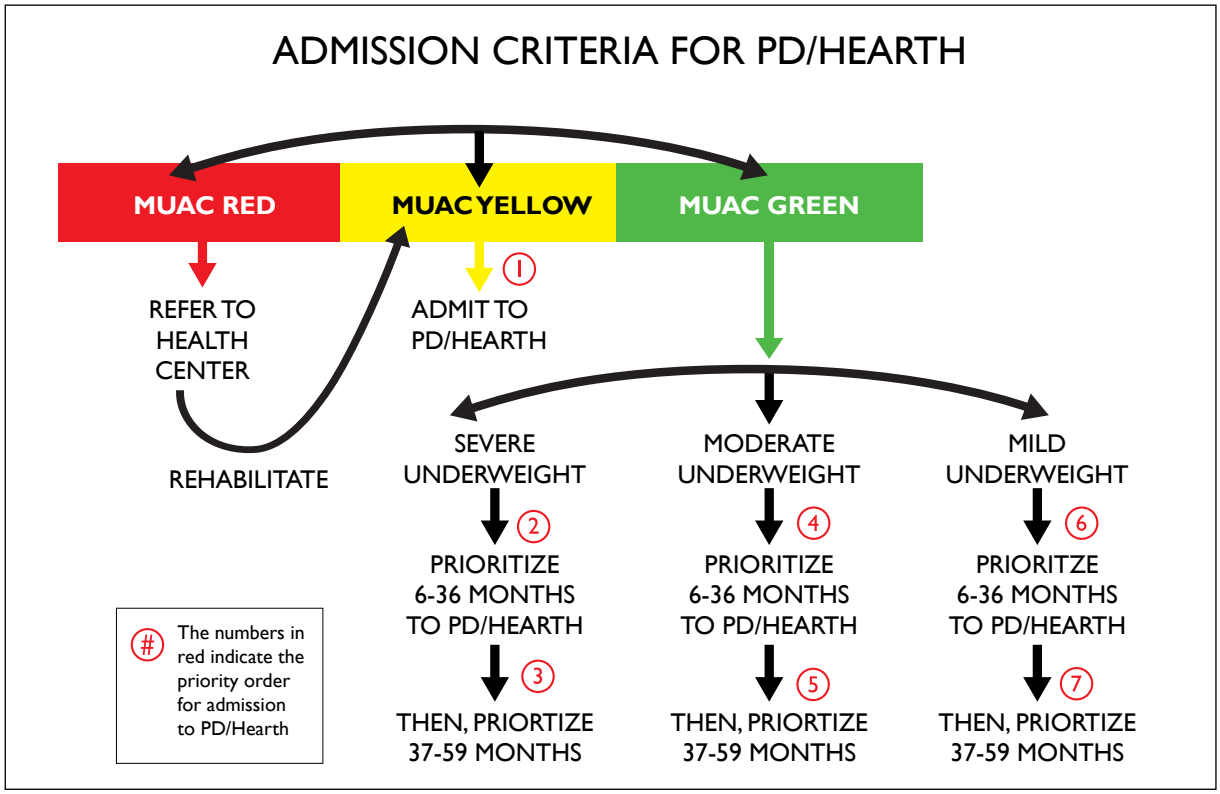
STEPS

10 Min

1. Please explain PD/Hearth Admission Criteria to the participants. If a child's MUAC is red, refer him/her to a health centre, otherwise follow this table for the order of admission.

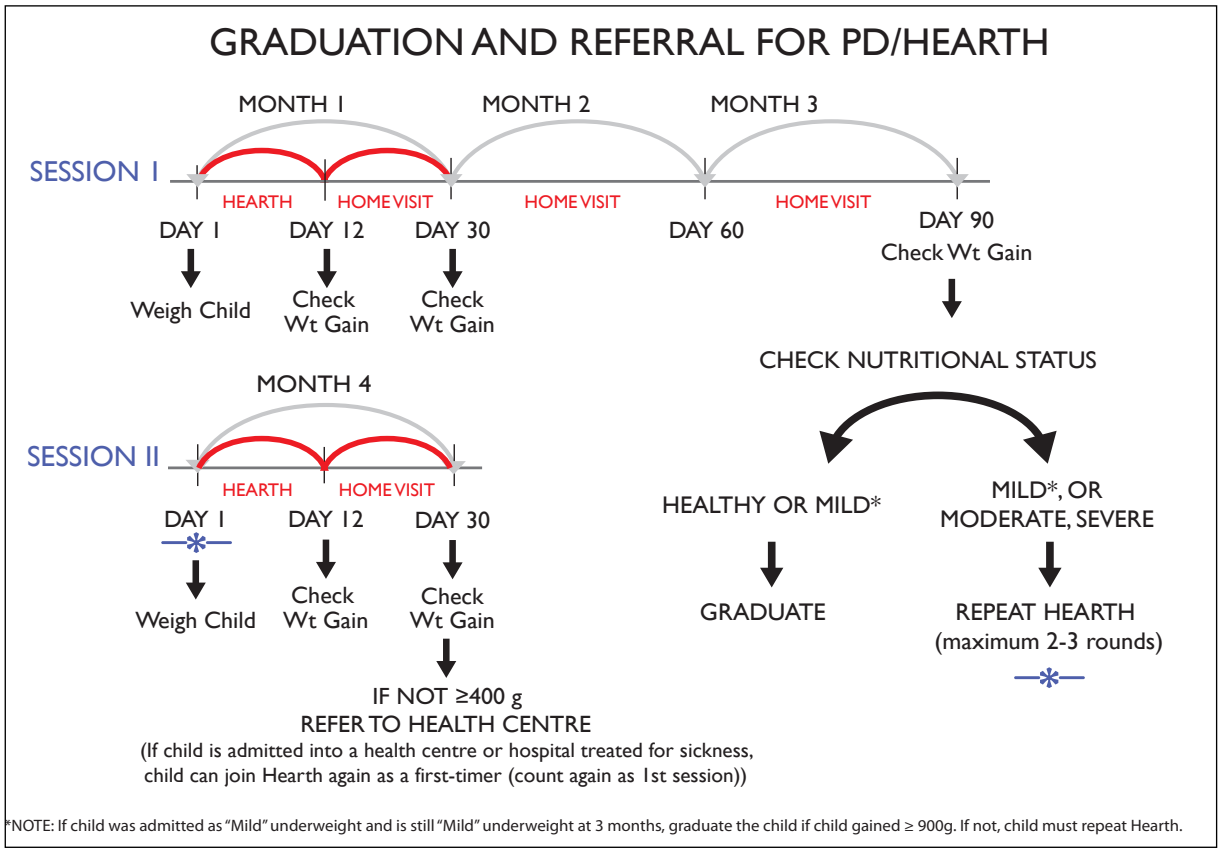
PD/Hearth Admission Criteria

Priority	MUAC	Underweight	Age
1	Yellow (Moderate)	Severe	6-59 months
2	Green (Healthy)	Severe	6-36 months
3	Green (Healthy)	Severe	37-59 months
4	Green (Healthy)	Moderate	6-36 months
5	Green (Healthy)	Moderate	37-59 months
6	Green (Healthy)	Mild	6-36 months
7	Green (Healthy)	Mild	37-59 months



Please explain PD/Hearth graduation criteria to the participants.

PD/Hearth Graduation Criteria



1. Graduation Criteria (Graduation declared at 3 months follow-up)

- **Nutritional Status Graduation Criteria**
  - **3 months**: Must be **"Healthy or Mild"** for underweight nutritional status for children to graduate, regardless of weight gain. If child is still "Moderate" or "Severe" underweight, repeat Hearth after 3 months (can be part of Hearth session, maximum 3 times – depends on the country; we recommend 2)
  - **3 months:** If child was admitted as "Mild" underweight, but child is "Healthy" nutritional status, graduate the child. If child was admitted as "Mild" underweight and is still "Mild" underweight at 3 months, graduate the child if child gained ≥ 900g. If not, child must repeat Hearth.
- **Weight gain requirements (encourage mothers are doing a good job if they meet these requirements, but it is not used for graduation criteria):**
  - **12 Days:** ≥ 200g
  - **30 Days:** ≥ 400g (If child did not gain close to 400g at 30 days, ensure mother is practicing the positive practices encouraged during Hearth session. If child seems to be sick, refer child to health centre)
  - **3 months:** ≥ 900g

2. For Home Follow-up Visits (Frequency during 2 weeks after Hearth; 2 years after Hearth; Monitoring of weights with GMP – also what to do with children who don't attend)

- Conduct home visits for 2 weeks after 12-days of Hearth session (2-3 times a week)
- Visit HH of PD/Hearth participants every month after 30 days for up to 1 year (if possible)
- Conduct "Health meeting" led by community every 1-3 months for community monitoring of PD Children's growth, share Health/Nutrition messages and meet with PDH participant caregivers after meeting
- Pay a special visit to HH to check weight of child and provide counseling as needed for children who have MUAC 'yellow' and for children severely underweight

3. When to Refer child for medical attention?

- During Initial Assessment or 1st Day of Hearth, if child is found to be "RED" for MUAC, refer to health centre and do not admit into PD/Hearth (follow-up with child and admit into PD/Hearth after child returns from Health Centre is and "YELLOW" or "GREEN" for MUAC

- If before Hearth, child has not received full immunization, Vitamin A supplementation and was not dewormed 6 months ago (need to make sure child is given all 3 before being admitted into Hearth)
- During **Hearth session**, child becomes ill (if child is referred to health centre, once child is back, reset the number of times child was in Hearth session)
- During **Follow-up visits**, child becomes ill (if child is referred to health centre, once child is back, reset the number of times child was in Hearth session)
- **Child doesn't gain at least 400g of weight after 2 consecutive Hearth sessions in 30 days, refer child to Health Centre for medical check-up**

4. Age limits for Participation in Hearth (how to deal with siblings not identified for Hearth)

- 6-59 months (Prioritize children 6-36 months of age first)


HANDOUT
15.2 – 77m/H 40

It is important to monitor not only the child's weight gain, but also to calculate the child's nutritional status using either the 'Road to Growth' charts or the WHO Anthro Table (Handout 15.2). A malnourished child is expected to gain 400 grams in one month with one Hearth session. If a child's nutritional status advances to green (normal) in one session, the child must continue to grow at the average expected rate (approximately 200–250 grams a month, depending on the child's age). Thus after 3 months the child should have gained 900 grams.

A 400 gram gain in Hearth will usually not move a child from one level of malnutrition to another, especially if the child is moderately or severely malnourished. The average gain needed to change from moderately malnourished to mildly malnourished is about 1.2 kilograms. This can be demonstrated with the WHO Weight-for-Age Reference (refer to Handout 15.2, 18 months for girls or boys). Look at the weight in the moderately malnourished column and subtract the weight in the mildly malnourished column. This is the amount of weight a child needs to gain to move from moderately malnourished to mildly malnourished. Notice that as the child gets older, more weight is needed to 'cross' from one level of nutrition to another.

A PD/Hearth programme needs to ensure that children are not only gaining the initial 400 grams in one month but are continuing to gain weight in a pattern consistent with the growth charts. This means that the programme does not expect the nutritional status of the child to improve (e.g. continuous catch-up growth) at home, but only to maintain healthy growth after the initial catch-up growth with the Hearth session. However, if catch-up growth is seen at home, that is a commendable achievement and the household's strategy to do this could be shared with others in the community. In many programmes children who gain 400 grams but are still malnourished enter another Hearth session in order to continue their catch-up growth.

When a child is not gaining adequate weight, this should be assessed together with the caregiver and family members. There may be understandable causes (for example, child may have had diarrhoea which prevented adequate weight gain of 400g in one month or 900g in three months). Continue to monitor the child at home. In some cases there may seem to be no clear reasons why the child has not gained adequate weight. In this situation, it may be decided together with the caregiver and family that it would be best to repeat the Hearth sessions in order to reinforce new skills and practices and allow the child to have another period of accelerated growth. If the child does not gain the graduation weight in the second round of Hearth (i.e. 400 g or more by the end of the month), the child should be referred to the local health facility to assess for underlying diseases.

Each child's situation is unique and graduation should be assessed individually.

What other elements might the community include in its Hearth protocol?

Be sure the important points from the *PD/Hearth Guide* (pp. 124–27) are highlighted. Include:

- A limit to the number of times a child may repeat Hearth
- When to refer the child for medical intervention
- What to do if attendance is poor
- Micronutrient and other supplemental activities
- Expectations for participation in growth monitoring programmes
- Age limits.

15 Min

2.

HANDOUT
31.1 – 165m/H 66

Break participants into small groups and assign each group one of the case studies (Handout 31.1). Participants should discuss the conditions for enrolling a child in Hearth and for graduating a child or having the child repeat Hearth. What action is indicated in the case of a chronic underachiever?

During the final five minutes, have each group briefly explain its case and recommendations.

10 Min

3.

Discuss the importance of a growth monitoring programme in the community, and note that a Hearth project may be developed in response to observations from the growth monitoring programme or vice-versa. Ask participants to suggest other community programmes that might lead to the development of a PD/

Hearth project. List these on a flip chart, and discuss issues that might arise with the addition of PD/Hearth to existing programmes. Continue with a discussion of integrating PD/Hearth with other programmes, either existing ones or new ones added as a result of the community mobilisation for PD/Hearth. *(Examples could include a water system, as a result of promotion of hand washing and overall hygiene; small business support or agricultural projects to supplement income and/or food supply; breastfeeding support groups, etc.)*

10 Min

4. At what time should PD/Hearth be replicated? Where and how? *(It is important that PD/Hearth implementers learn in a small pilot project. Once one project is successful, consider replicating it in other communities or other ADPs. One very successful project could become a learning centre to train other communities and staff. Do not proceed too quickly or replicate weak or unsuccessful projects.)*

1st case: Aisha is three years old, and an only child. After two Hearth sessions, she has gained 800 grams but is still moderately malnourished. Her mother, who is pregnant, appears to be following the new PD behaviours and working hard to rehabilitate Aisha, but she is becoming discouraged. The grandmother is taking care of Aisha during her pregnancy and advising her to continue feeding Aisha with what they learned at Hearth. The grandmother is confused that her daughter-in-law is discouraged and that the volunteers say that Aisha is still malnourished when she is looking very healthy, active and growing well.

2nd case: Tobir Village has many malnourished children, and Hearth sessions are proceeding well. However, some segments of the population are semi-nomadic, moving with the seasons to find work. Though these caregivers have been enthusiastic participants, it is difficult to follow their children during the dry season. Many return during the rainy season having lost weight again.

3rd case: Daniel is 23 months old. He and his mother (who also has two older children) just completed one Hearth session. His weight has not improved. The supervisor suspects, from her home visits, that the mother is preparing some extra food but sharing it with the whole family. The grandmother may support sharing the extra food with the entire family too.

4th case: During the sessions Budi gained 500 grams. By the end of the follow-up period he had lost the 500 grams.

By the end of the session, participants will be able to

1. Identify several key quality indicators for monitoring PD/Hearth activities
2. Describe supervision tools that are available to ensure the quality of PD/Hearth activities.

Reference in *CORE PD/Hearth Guide*: pp 140, 146–48, 157–84

Preparation

- Write each of the 3 Hearth goals on separate pieces of flip chart paper.
- Prepare a flip chart to show the Triple 'A' Cycle (**A**ction-**A**ssessment-**A**nalysis) – see page 168 of the *CORE PD/Hearth Guide*.
- Print copies of 32.1, 32.2, 32.3A, 32.3B, 32.4, 32.5, 32.6, 32.7, 32.8, 32.9 and 32.10

Materials

- Handout 32.1: Checklist of Materials Needed for PD/Hearth Sessions
- Handout 32.2: PD/Hearth Menu and Cooking Materials Tracking Sheet
- Handout 32.3A: Child Registration and Attendance Form
- Handout 32.3B: Child Registration and Attendance Form' (including Grandmothers)
- Handout 32.4: PD/Hearth Register and Monitoring Form
- Handout 32.5: Volunteer Home Visit Form
- Handout 32.6: Supervision of Hearth Session
- Handout 32.7: PD/Hearth Annual Report
- Handout 32.8: Monitoring Case Study Data Sheet
- Handout 32.9: PD/Hearth Monitoring Case Study Questions
- Handout 32.10: User Guide for the PD/Hearth Excel Database
- Blank flip chart
- LCD Projector
- Soft copy of Excel-based PD/Hearth database (found in Resource CD)

STEPS

20 Min

1.

Remind the participants of the three goals of PD/Hearth and ask them to discuss together some indicators that can be used to monitor and evaluate progress toward each of the three goals. Write each suggested indicator on the flip

chart for the goal to which it applies and indicate whether it is a qualitative or quantitative indicator.

Goal One: Malnourished Children Are Rehabilitated

Observe during the household visit if the child is eating PD foods. Caregivers may report a change (qualitative); measure weight gain (quantitative).

Note that PD/Hearth is a time-limited activity compared to other types of child-survival programmes. Therefore, monitoring and evaluation can lead to direct, immediate and simple modifications to the programme. For example, in Haiti the percentage of those attending was low. Therefore, after the first cycle, the staff interviewed both women who didn't attend and those who participated fully. The programme was modified for the second cycle to correct issues identified in the interviews.

Goal Two: Families Are Able to Sustain Rehabilitation at Home

Are PD behaviours maintained after six months (for example, if five key behaviours were discovered in the PDI, are caregivers still practising at least three of them) with the PD child and with siblings (qualitative)? Measure for sustained weight gain at three months, six months, 12 months etc. (quantitative). Identify the percentage of children who regularly attend the growth-monitoring programme and/or immunisation programmes (quantitative).

Goal Three: Future Malnutrition Is Prevented (Community Level)

Gather information through informal interviews with neighbours and friends (qualitative); gather data through a review of community weights or other nutritional assessment (quantitative). PD families that have graduated from the Hearth programme may formally mentor incoming participants (this, too, can be monitored/measured).

What External Factors Might be Monitored?

The quality of the existing health-care system can be evaluated for impact from the PD/Hearth programme: increased attendance; increased immunisation coverage; improved/more accurate weighing in the growth monitoring programme; referrals, etc. Indicators of community mobilisation and social change can be evaluated as well (new leadership, involvement of disadvantaged population, conflict resolutions, impact beyond nutrition, etc.).

Note: *The local hospital may need to budget for recuperation of severely malnourished children, because they will be more readily detected and referred early in the programme. Keep apprised of Ministry of Health policies for rehabilitation that may include community-based management of acute malnutrition (CMAM) which might be coordinated with PD/Hearth. After severely*

malnourished (wasted) children have completed the CMAM programme, they should participate in a PD/Hearth session so that their caregivers will learn new behaviours necessary to sustain the recuperation.

Who Monitors? The ADP/NGO monitors PD/Hearth activity; the community monitors the volunteer; and the volunteer monitors the caregivers and children.

Why Monitor?

- Supervision helps to ensure quality and consistency in the programme; is useful for troubleshooting; and provides an opportunity to reinforce training and strengthen skills.
- Supervision is an ongoing process. It helps motivate people, reinforces good performance, creates a sense of achievement, and serves as a way to share good ideas.
- Supervision provides an opportunity for adapting to situations as they occur. For example, participant attendance was found to be a problem in Haiti. In response, the supervisor determined that for the next session, the participant contribution would be dropped off early in the morning of the session. This allowed time for the supervisor to locate anyone who did not show up and encourage them to attend the session.

What to Monitor?

Monitor volunteer skills, communication skills, and adherence to Hearth protocols; menus (taste, consistency, nutritionally adequate, affordable, use of PD foods); food safety; caregivers' attendance all 12 days; recording of weights and other appropriate activities. Assessments are made through observation, conversations with volunteers, caregivers and grandmothers, and verification of records. The protocol for a supervisory visit includes:

- Observation
- Sharing in conversation
- Applying information – provide feedback

Analysis should be shared during a feedback session with the volunteer and with the Village Health Committee. Stress the positive first. Dwell on the outcome – How many children graduated? Look at key quality indicators together. *Remember: positive feedback, analysis of problems, identification of solutions and follow up.*

5 Min

2.

Ask participants to list potential indicators of behavioural change in Hearth. Write these on a blank flip chart.

- Observe practices during the visit (see the PDI questions/checklist in Session 18).
- Talk with the caregiver and grandmother for information on practices and if child is receiving extra food.
- Check for better health-seeking behaviours (what does the caregiver do and/or grandmother advise when the child is sick: attendance at health post, extra feeding, etc.).
- Verify weight gain (at one month, three months, six months, and twelve months following the Hearth session).
- Observe the health status of any new siblings.

Ask which of the indicators can be observed during home visits. Put an asterisk (*) next to these. Ask whether the supervisor or the volunteer would be more likely to observe and document these indicators.

20 Min

3.

HANDOUT
32.1 – 171m/H 67
32.2 – 172m/H 68
32.3A – 174m/H 70
32.3B – 175m/H 71
32.4 – 176m/H 72
32.5 – 177m/H 73
32.6 – 179m/H 75
32.7 – 180m/H 76

Distribute the sample checklists and monitoring forms (Handouts 32.1 to 32.7). Review these together. Volunteers will use the following forms:

- Handout 32.1 as a checklist of the materials needed for the PD/Hearth sessions
- Handout 32.2 to track caregivers' menus and cooking materials
- Handouts 32.3A/B and 32.5 to keep track of Hearth attendance and home visits, respectively.

Discuss options if literacy is a challenge for volunteers. (*older child could help with forms, develop pictorial forms, pair volunteers with at least one person who is literate)*

The supervisor of the volunteers (usually the trainer) will use the following monitoring forms:

- Handouts 32.4, 32.6, and 32.7 to track PD/Hearth programmes.

5 Min

4.

Refer to the Triple 'A' Cycle (on the flip chart) to demonstrate the continuous monitoring process. Emphasise the importance of feedback to volunteers and supervisors as well as to the community. Sharing results with the community increases ownership, encourages discussion and problem solving, and celebrates achievement.

How Can This Information be Used to Improve Programme Quality?

Seek mutual solutions, monitor the community taking charge, and provide refresher training.

Frequency of Supervision?

Supervise a new site frequently at first; try to be present on the last day of Hearth.

Implication for Budgeting (transport and time spent in the field)?

Supervision is time consuming. It is important to budget sufficient staff time.

10 Min

5.

Reiterate the importance of community involvement and community-wide change for success with sustaining the achievements of Hearth. Ask the participants to suggest ways to incorporate feedback to the community as part of the process of reinforcing the long-term practice of PD/Hearth behaviours. Note that attention to community-level indicators reflects the Hearth goal of affecting non-participants. Add examples of these indicators to the flip chart.

Community level

- Talk with neighbours (ask whether the PD/Hearth caregiver has talked about Hearth).
- Review the weights of the children in the community over time (from the GMP). Invite the community health committee to share the results of the GMP with the entire community on a regular basis. Help the committee develop posters to show progress (to promote social change).
- Meet with community leaders to share Hearth outcomes.
- Document success stories and share them within the village and beyond.

60 Min

6. Monitoring Case Study

HANDOUT
32.8 – 181m/H 77
32.9 – 185m/H 81

Distribute Handout 32.8: Monitoring Case Study Data Sheet and Handout 32.9: PD/Hearth Monitoring Case Study Questions. Ask the participants to work on and discuss each section before moving on to the next section. Work through all the sections.

30 MIN

7.

HANDOUT
32.10 – 187m/H 83

Please briefly go over the PD/Hearth Excel Database with the participants. Refer to Handout 32.10: User Guide for the PD/Hearth Excel Database.

Checklist of Materials Needed for PD/Hearth Sessions

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice,fufu, yams)			
Oil			
Other ingredients			

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 3	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 5	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

No.	DAY 7	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
No.	**DAY 9**	INGREDIENTS	COOKING MATERIALS	ROLE	**DAY 10**	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
No.	**DAY 11**	INGREDIENTS	COOKING MATERIALS	ROLE	**DAY 12**	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Child Registration and Attendance Form

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates (dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....
.....

#	Name of Child	Caregiver's Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Hearth Participant Child AND Primary Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Child Registration and Attendance Form (including Grandmothers)

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name/Grandmother Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Child and Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

#	**Attendance for Grandmother**											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

HANDOUT 32.4

Hearth Register and Monitoring Form

World Vision

Day 5 Session 32

1 OF 2

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

CHILD		1	2	3	4	5	6	7	8	9	10
Child's Name											
Caregiver's Name											
Child's Sex (M/F)											
Date of Birth (dd/mm/yyyy)											
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')											
At Day 1 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Green, yellow, red < 115mm)										
At Day 12 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight Gain (Day 12 - Day 1) in grams										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Hearth Register and Monitoring Form

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

	CHILD	1	2	3	4	5	6	7	8	9	10
At Day 30 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight gain (Month 1 - Day 1 weight) in grams										
	Gained 400g+ (Y/N)										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 3 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	Change in Status (Y/N)										
	MUAC (Optional)										
At 6 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 12 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
	CHILD	1	2	3	4	5	6	7	8	9	10
	COMMENTS (Explain reason for default if child has defaulted due to death (D), migration (M), referred to hospital (H), etc.)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Volunteer Home Visit Form

ADP Name ..... Village Name .....Caregiver's Name .....

Child's Name ..... Dates of Sessions.....Name of Hearth .....Volunteer .....

OBSERVATION LIST	Day #	Day #	Day #	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.							
Drinking water from safe source (borehole or protected well)							
Water is treated (Boiled/ chlorine)							
Water is covered with fitted cover or lid							
Clean separate cup is used for pouring drinking water from the pot							
Handwashing station exists (e.g. tippy tap)							
Jerry cans or water storage containers are clean							
Toilet/latrine is available and used or hole is dug and covered for defecation							
House and/or kitchen is clean							
Food utensils are clean							
Handwashing with running water and soap is practised by: Caregivers							
Children							
Other family members							
Food prepared is nutrient dense as learned in Hearth (includes all 3 food groups: protective, body building and energy foods)							
Size of portion served is age appropriate							
Caregiver actively feeds the child							
Child is offered more food after finishing first portion							
Caregiver says child is fed 4 - 5 times / day (including snacks)							
Child uses separate (own) plate, bowl, or cup							
Caregiver is motivated by changes in the child							
Yesterday night, mosquito net was used by the primary caregiver and all children U5 in the household							
Caregiver can say what to do when child is sick (example: feeds more liquid when child has diarrhea and feeds more frequently)							
Caregiver expresses being able to continue practising what was learned in Hearth at home							
Problems and questions about child feeding and care is discussed with the volunteer							

Supervision of PD/Hearth Session

Day 5 Session 32

Village Name ..... Hearth Name .....

Volunteer's Name(s) .....Today's Date.....

OBSERVATION LIST	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.				
Location of Session:				
Water is from safe source (borehole or protected well or protected spring)				
Water is treated (Boiled/ chlorine)				
Toilet/latrine available				
Handwashing station with soap exists (e. g. tippy tap)				
House is clean				
Food utensils are clean				
Session Is conducted by volunteers and/or lead mother				
Primary caregivers are assigned roles during Hearth				
Primary caregivers are the ones cooking the meal				
Primary caregivers can tell you how to cook Hearth menu for one child (using household measures)				
Number of caregivers attending				
Number of children attending				
Evidence of community participation/support				
Hand Washing is practised: by caregivers				
by children				
Number of caregivers who bring contribution to meal				
Menu used based on local and affordable food				
Menu is nutrient dense				
Food is prepared according to menu				
Consistency of Hearth meal is thick enough to slowly run on a spoon (not runny like water)				
Snack is given to children as the caregivers cook the Hearth meal				
Caregivers can recite different types of protective, body building and energy-giving foods				
Number of caregivers present and actively participating:				
in food preparation				
in child care				
in discussion of key messages				
Size of portion served is age appropriate				
Number of caregivers who actively feed their child				
Number of children who eat entire portion				
Number of children who are offered more food				
Key message discussed during PD/Hearth supervision visit				
Caregivers express being motivated by changes in child				
Caregivers can say what to do when child is sick				

PD/Hearth Annual Report

World Vision

Day 5 Session 32

PD/Hearth ADP Facilitator _____	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Total
In PD/Hearth Session (12 days) Weight gain (in grams) # of children	# of children												
Catch up (graduation): ≥ 200g													
Inadequate: < 200g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
In Rotation at 1 month (12 days + 2 weeks follow up) Weight gain (in grams)	# of children												
Catch up (graduation): ≥ 400g													
Inadequate: <400g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 3 months post hearth	# of children												
Adequate weight gain ≥ 900g													
Inadequate weight gain < 900g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 6 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Follow up at 12 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Total number of Re-admissions													
Round/Session #2													
Round/Session #3													

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth			At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
1	Shadin	1	m	26/03/2005	24	12/03/2007	7.5		24/3/2007	8.3	0.8		12/4/2007	8.3				
2	Jenia	1	f	01/02/2006	13	12/03/2007	7.0		24/3/2007	7.6	0.6		12/4/2007	7.6				
3	Helena	1	f	27/08/2005	19	12/03/2007	9.8		24/3/2007	10.1	0.3		12/4/2007	9.9				
4	Kalpana	1	f	05/10/2005	17	12/03/2007	7.5		24/3/2007	7.5	0.0		12/4/2007	7.5				
5	Saidur	1	m	21/10/2005	17	12/03/2007	6.6		24/3/2007	7.2	0.6		12/4/2007	7.3				
6	Sumana	1	f	06/06/2006	9	12/03/2007	6.0		24/3/2007	6.2	0.2		12/4/2007	6.5	0.5			
7	Swourav	1	m	19/02/2005	25	12/03/2007	9.0		24/3/2007	9.3	0.3		12/4/2007	9.5	0.5			
8	Simul	1	m	17/02/2005	25	12/03/2007	7.6		24/3/2007	7.9	0.3		12/4/2007	7.5	-0.1			
9	Tanvir	1	m	15/08/2005	19	12/03/2007	8.5		24/3/2007	8.7	0.2		12/4/2007	9.0	0.5			
10	Ruman	1	m	28/04/2005	22	12/03/2007	8.9		24/3/2007	8.5	-0.4		12/4/2007	9.4	0.5			
11	Ritu	1	f	11/05/2004	34	12/03/2007	9.7	O	24/3/2007	9.9	0.2	Y	12/4/2007	10.2	0.5	Y	O	N
12	Zashim	1	m	29/01/2005	25	12/03/2007	8.7	R	24/3/2007	9.0	0.3	Y	12/4/2007	9.3	0.6	Y	O	Y
13	Bashakhi	1	f	29/04/2005	22	12/03/2007	8.8	Y	24/3/2007	9.0	0.2	Y	12/4/2007	9.2	0.4	Y	Y	N
14	Sritimoni	1	f	25/10/2005	17	12/03/2007	7.5	O	24/3/2007	7.8	0.3	Y	12/4/2007	7.8	0.3	N	O	N
15	Farjana	1	f	25/03/2006	12	12/03/2007	6.0	R	24/3/2007	6.5	0.5	Y	12/4/2007	7.1	1.1	Y	O	N
16	Riyon	1	m	25/01/2005	26	12/03/2007	7.9	R	24/3/2007	8.1	0.2	Y	12/4/2007	8.4	0.5	Y	R	N
17	Sharmin	1	m	23/10/2004	29	12/03/2007	9.5	O	24/3/2007	9.7	0.2	Y	12/4/2007	10.2	0.7	Y	O	N
18	Rabbi	1	f	03/09/2004	30	12/03/2007	10.0	Y	24/3/2007	10.3	0.3	N	12/4/2007	11.0	1.0	Y	Y	N
19	Kurban Ali	1	m	20/01/2006	14	12/03/2007	6.8	R	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	R	N
20	Himel	1	m	11/11/2005	16	12/03/2007	7.2	R	24/3/2007	7.2	0.0	N	12/4/2007	7	-0.2	N	R	N
21	Anika	1	f	29/03/2004	35	12/03/2007	9.8	O	24/3/2007	10.0	0.2	Y	12/4/2007	10.5	0.7	Y	O	N
22	Afra Abiyat	1	f	29/03/2004	35	12/03/2007	10.5	O	24/3/2007	10.8	0.3	Y	12/4/2007	10.9	0.4	Y	Y	Y
23	Laboni	1	f	25/11/2005	16	12/03/2007	7.3	O	24/3/2007	7.5	0.2	Y	12/4/2007	7.2	-0.1	N	O	N

Monitoring Case Study Data Sheet

Day 5 Session 32

#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth				At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)		Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
24	Maruf	1	m	01/07/2006	8	12/03/2007	10.5	G		24/3/2007	10.3	-0.2	N	12/4/2007	10.9	0.4	S	G	N
25	Shanta	1	f	04/02/2006	13	12/03/2007	6.6	R		24/3/2007	6.7	0.1	N	12/4/2007	7.0	0.4	S	O	Y
26	Jesmin	1	f	27/09/2006	6	12/03/2007	6.8	G		24/3/2007	6.6	-0.2	N	12/4/2007	6.6	-0.2	N	Y	Y
27	Shakib	1	m	01/02/2006	13	12/03/2007	6.8	O		24/3/2007	6.9	0.1	N	12/4/2007	7.1	0.3	N	R	N
28	Shati	1	f	01/02/2006	13	12/03/2007	6.8	O		24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	S	O	N
29	Nurjahan	1	m	01/04/2005	23	12/03/2007	7.4	R		24/3/2007	7.7	0.3	Y	12/4/2007	7.9	0.5	S	R	N
30	Beauti	1	f	03/04/2005	23	12/03/2007	7.6	R		24/3/2007	7.7	0.1	N	12/4/2007	7.8	0.2	N	R	N
31	Salina	1	f	07/04/2005	23	12/03/2007	9	Y		24/3/2007	9.2	0.2	Y	12/4/2007	9.5	0.5	S	Y	Y
32	Marjina	1	f	07/09/2004	30	12/03/2007	9.1	O		24/3/2007	6.0	-3.1	N	12/4/2007	9.1	0.0	N	R	Y
33	Alam	1	m	10/07/2004	32	12/03/2007	10.1	O		24/3/2007	10.3	0.2	Y	12/4/2007	10.6	0.5	S	O	N
34	Shaila	1	f	18/10/2005	17	12/03/2007	7.3	O		24/3/2007	7.9	0.6	Y	12/4/2007	7.9	0.6	S	O	N
35	Abir	1	m	14/01/2005	26	12/03/2007	9.1	O		24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	S	O	N
36	Mim	1	f	05/04/2006	11	12/03/2007	6.1	R		24/3/2007	6	-0.1	N	12/4/2007	6.4	0.3	N	O	Y
37	Mamin	1	f	13/02/2006	13	12/03/2007	6.2	R		24/3/2007	6.5	0.3	Y	12/4/2007	6.7	0.5	S	O	Y
38	Alika	1	f	27/12/2004	27	12/03/2007	8.5	R		24/3/2007	8.8	0.3	Y	12/4/2007	8.9	0.4	S	O	N
39	Sumia	1	f	05/03/2006	12	12/03/2007	6.1	R		24/3/2007	6	-0.1	N	12/4/2007	6.0	-0.1	N	R	N
40	Nadia	1	f	03/04/2006	11	12/03/2007	10.3	G		24/3/2007	10.6	0.3	Y	12/4/2007	10.8	0.5	S	G	N
41	Aklima	1	f	01/04/2004	35	12/03/2007	9.1	R		24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	S	R	N
42	Lipa	1	f	20/04/2004	35	12/03/2007	9.6	R		24/3/2007	9.9	0.3	Y	12/4/2007	10.1	0.5	S	O	N
43	Mahamuda	1	m	23/05/2004	34	12/03/2007	9.6	R		24/3/2007	9.8	0.2	Y	12/4/2007	9.9	0.3	N	O	Y
44	Shapna	1	f	21/03/2005	24	12/03/2007	9	O		24/3/2007	9.1	0.1	N	12/4/2007	9.5	0.5	S	Y	N
45	Laboni	1	f	11/12/2004	27	12/03/2007	10	Y		24/3/2007	10.2	0.2	Y	12/4/2007	10.9	0.9	S	Y	N
46	Maria mim	1	f	02/02/2004	37	12/03/2007	10.2	O		24/3/2007	10.5	0.3	Y	12/4/2007	10.9	0.7	S	O	N
47	Arif	1	m	25/02/2005	25	12/03/2007	6.9	R		24/3/2007	7	0.1	N	12/4/2007	7.1	0.2	N	R	N
48	Rakkib	1	m	10/03/2004	36	12/03/2007	10	R		24/3/2007	11.2	1.2	Y	12/4/2007	11.1	1.1	S	Y	Y
49	Sabekun	1	m	25/03/2005	24	12/03/2007	9	O		24/3/2007	10	1.0	Y	12/4/2007	9.6	0.6	S	Y	Y

#	Name of Child	Child's Sex (M/F)	At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)				
			Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
1	Shadin	m	27	12/06/2007	8.9				12/09/2007	9.5		
2	Jenia	f	16	12/06/2007	8.2				12/09/2007	9.1		
3	Helena	f	22	12/06/2007	10.9				12/09/2007	11.7		
4	Kalpana	f	20	12/06/2007	8.8				12/09/2007	9.6		
5	Saidur	m	20	12/06/2007	6.7				12/09/2007	8.5		
6	Sumana	f	12	12/06/2007	6.9	0.90			12/09/2007	7.8		
7	Swourav	m	28	12/06/2007	10.3	1.30			12/09/2007	10.5		
8	Simul	m	28	12/06/2007	9.3	1.70			12/09/2007	9.8		
9	Tanvir	m	22	12/06/2007	9.6	1.10			12/09/2007	10.4		
10	Ruman	m	25	12/06/2007	9.6	0.70			12/09/2007	10.7		
11	Ritu	f	37	12/06/2007	11.2	1.50	Y	Y	12/09/2007	11.6	Y	N
12	Zashim	m	28	12/06/2007	10.4	1.70	Y	Y	12/09/2007	10.8	Y	N
13	Bashakhi	f	25	12/06/2007	9.7	0.90	Y	Y	12/09/2007	10.7	Y	N
14	Sritimoni	f	20	12/06/2007	8.5	1.00	Y	Y	12/09/2007	9.1	Y	N
15	Farjana	f	15	12/06/2007	7.2	1.20	Y	O	12/09/2007	7.8	O	N
16	Riyon	m	29	12/06/2007	8.9	1.00	Y	R	12/09/2007	10.4	O	N
17	Sharmin	m	32	12/06/2007	10.2	0.70	N	O	12/09/2007	10.8	O	N
18	Rabbi	f	33	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.6	Y	N
19	Kurban Ali	m	17	12/06/2007	8.3	1.50	Y	O	12/09/2007	9.5	Y	N
20	Himel	m	19	12/06/2007	7.8	0.60	N	R	12/09/2007	8.8	O	N
21	Anika	f	38	12/06/2007	11.1	1.30	Y	O	12/09/2007	12.0	Y	N
22	Afra Abiyat	f	38	12/06/2007	11.3	0.80	N	Y	12/09/2007	11.9	Y	N
23	Laboni	f	19	12/06/2007	7.7	0.40	N	O	12/09/2007	8.6	O	N

Monitoring Case Study Data Sheet

#	Name of Child	Child's Sex (M/F)	At 3 months (since 1st day of Hearth)						At 6 months (since 1st day of Hearth)			
			Age (month)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 3 - Day 1 weight) in kg	Gained 900g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Adequate weight for age? (Y/N)
24	Maruf	m	11	12/06/2007	10.6	0.10	N	G	12/09/2007	11.2	G	Y
25	Shanta	f	16	12/06/2007	8.3	1.70	Y	Y	12/09/2007	9.9	G	Y
26	Jesmin	f	9	12/06/2007	7.2	0.40	N	G	12/09/2007	8.3	G	Y
27	Shakib	m	16	12/06/2007	7.6	0.80	N	O	12/09/2007	8.3	O	N
28	Shati	f	16	12/06/2007	6.9	0.10	N	R	12/09/2007	7.9	O	N
29	Nurjahan	m	26	12/06/2007	9.9	2.50	Y	O	12/09/2007	11.0	Y	N
30	Beauti	f	26	12/06/2007	8.7	1.10	Y	O	12/09/2007	10.4	Y	N
31	Salina	f	26	12/06/2007	9.8	0.80	N	Y	12/09/2007	10.6	Y	N
32	Marjina	f	33	12/06/2007	9.5	0.40	N	O	12/09/2007	10.3	O	N
33	Alam	m	35	12/06/2007	11.2	1.10	Y	Y	12/09/2007	12.1	Y	N
34	Shaila	f	20	12/06/2007	8.5	1.20	Y	Y	12/09/2007	9.3	Y	N
35	Abir	m	29	12/06/2007	10.3	1.20	Y	O	12/09/2007	11.1	Y	N
36	Mim	f	14	12/06/2007	7.4	1.30	Y	O	12/09/2007	8.3	Y	N
37	Mamin	f	16	12/06/2007	7.9	1.70	Y	Y	12/09/2007	8.8	Y	N
38	Alika	f	30	12/06/2007	9.5	1.00	Y	O	12/09/2007	10.4	Y	N
39	Sumia	f	15	12/06/2007	6.8	0.70	N	O	12/09/2007	7.5	O	N
40	Nadia	f	14	12/06/2007	10.8	0.50	N	G	12/09/2007	11.6	G	Y
41	Aklima	f	38	12/06/2007	10.4	1.30	Y	O	12/09/2007	11.4	O	N
42	Lipa	f	38	12/06/2007	11.1	1.50	Y	Y	12/09/2007	12.3	Y	N
43	Mahamuda	m	37	12/06/2007	9.7	0.10	N	R	12/09/2007	11.2	O	N
44	Shapna	f	27	12/06/2007	10.4	1.40	Y	Y	12/09/2007	11.5	G	Y
45	Laboni	f	30	12/06/2007	11.0	1.00	Y	Y	12/09/2007	11.8	G	Y
46	Maria mim	f	40	12/06/2007	11.5	1.30	Y	Y	12/09/2007	11.9	Y	N
47	Arif	m	28	12/06/2007	8.4	1.50	Y	R	12/09/2007	9.7	O	N
48	Rakkib	m	39	12/06/2007	11.5	1.50	Y	O	12/09/2007	12.6	Y	N
49	Sabekun	m	27	12/06/2007	9.9	0.90	Y	O	12/09/2007	10.6	Y	N

1. Look carefully at the data sheet from the PD/Hearth sessions at Sunshine Village of Happiness & Light ADP. Children are measured at the beginning of the Hearth sessions. Complete the 'Nutrition Status' column for all children on Day 1.
    a. What questions do you have about this information?
    b. The children are weighed on Day 12, at the end of the sessions. Complete the 'Gained 200g+' column for each child.
    c. Calculate the number and percentage of children who have gained adequately during the Hearth sessions.
    d. What can you say about the Hearth sessions? What is going well? What needs improvement?
    e. Based on this data, what action would you take?

2. The children are measured again one month after the beginning of the Hearth sessions. Complete the 'Weight Gain' and the 'Catch-up' and the 'Nutrition Status' items in the one-month columns.
    a. Calculate the number and percentage of children who have gained adequately during the month.
    b. Calculate the number and percentage of children who have changed their nutrition status.
    c. What does the data tell you about the children?
    d. How many children would you recommend repeat the Hearth sessions?
    e. Choose two children and answer the following questions for each:
        - How has the child progressed? Is this satisfactory?
        - What changes (if any) would you recommend for the child over the next month?
        - How would you explain the child's progress to the caregiver?
    f. What does the data tell you about the Hearth programme?
    g. What action do you need to take?

3. The measurements are repeated three months after the Hearth session. Look at the results and complete the 'Nutrition Status' column using the WAZ (weight for age Z-scores).

    a. Calculate the number and percentage of children who have gained adequately.

    b. Do you see any trends that concern you? What does the data tell you about the programme?

    c. What action do you need to take?

4. The children are measured again six months after the hearth sessions. Calculate their nutritional status using WAZ.

    a. Choose two children and answer the following questions for each, using all the data provided in this case study:

        - Describe the child's progress throughout the monitoring period. What could be some reasons for the child's growth pattern?
        - Was the child successfully rehabilitated? How can you tell?
        - How would you follow up with this child?
        - How would you communicate the child's progress and current status to his or her caregiver?

    b. What is your opinion of the overall growth of the children involved in the programme?

    c. How many children were successfully rehabilitated? How can you tell?

    d. What might be some reasons for the growth pattern between three and six months?

    e. How would you follow up with this programme?

The PDH Excel Database is used to compile all the data collected during the initial assessment (situation analysis), PDH registration, and for monitoring and follow up of children in the PDH programme. This allows easier access and utilisation of data by staff. For example, clear summary tables are generated and available under different tabs. From the data collection forms (e.g. Child Registration, Hearth Register and Monitoring Form), staff can transfer recorded information into appropriate cells/columns in the PDH database. Some of the cells/columns contain a drop-down menu or a formula. This formatting is convenient and helps to reduce data entry or calculation errors. For example, child's age (months), underweight nutritional status, WAZ scores, and weight change (g) are calculated automatically.

In the PDH Excel Database, there are eight tabs or worksheets: Initial Assessment; Assessment Report; Monitoring Form; Table; Annual Report; Graph Follow-up; Graph Graduation & Weight Gain; and Graph Default. However, you only need to enter data under two tabs: Initial Assessment and Monitoring Form. All other tabs contain summary charts (e.g. tables, graphs) automatically generated from the compilation of inputted data. ***Please note, when entering the dates, follow the format provided i.e. DD/MM/YYYY.*** Make sure the default date on your computer is set as DD/MM/YYYY for smooth operation of the database. To change the default date format on your computer, see ***Note** below.

Tab 1 – Initial Assessment: Enter the registration, initial nutrition assessment and wealth-ranking data for PDH participant children under this tab. From this data, the PD, non-PD, and negative deviant households are identified and displayed under the "Classification" column.

- First, select an appropriate option for the Wealth Ranking Category (i.e. Very Poor, Poor, Rich or Poor, Non-Poor) and the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu for each at the top of the worksheet.
- Enter values under each column according to the headings. Enter values only in the "WHITE" cells as the values in grey-coloured cells (e.g. Current Age, Underweight Nutritional Status, Classification columns) are calculated automatically by the computer. For the Sex, Oedema, MUAC, Wealth Rank and PDI HHs columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 2 – Assessment Report: This tab contains a table and a pie chart which categorizes the total number of children from the initial assessment based on their underweight nutritional status (i.e. % of children who are normal weight or mildly, moderately or severely underweight). This gives a clear picture of the initial level of childhood malnutrition in the community.

Tab 3 – Monitoring Form: This tab contains a monitoring form to track changes in child's weight, weight-for-age Z score, and underweight nutritional status in the hearth sessions and the follow-ups, including reasons for default. Additional registration information, such as deworming, vitamin A supplementation, presence of oedema, and full immunisation status is also entered under this tab. Based on the child's nutritional status at 3 months, next course of action is identified for each child (i.e. not graduate and repeat hearth, or graduate and continue monitor).

- First, select an appropriate option for the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu at the top of the worksheet.
- Enter values under each column according to the heading. Enter values only in "WHITE" cells as the values in grey-coloured cells (i.e. Current Age, WAZ, Nutritional Status, Weight Change, Adequate Weight Gain columns) are calculated automatically by the computer. For the Oedema, Deworming, Vitamin A Supplementation, Full Immunisation, Sex, Round/Session # and Default Reason columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 4 – Table: This tab contains nine summary tables based on the monitoring data. The tables show the number of children (and %) based on underweight nutritional status at different time points (e.g. baseline, Day 12, Day 30, 3 months, 6 months and 1 year), number of children (and %) with adequate or inadequate weight gain and amount of average weight gain (at Day 12, 30 and 3 months), and number of children (and %) with improvement or no improvement in their nutritional status to mild/healthy status (at Day 12, 30 and 3 months), as well as the breakdown of the reasons for child default from PDH.

Tab 5 – Annual Report: This tab contains a PDH summary report for the selected fiscal year. The table contains information about number of children who gained adequate or inadequate weight in PDH session (Day 12) and at follow ups (1 and 3 months), as well as number of children in different underweight nutritional status categories (i.e. green, yellow, orange, red) at 6 and 12 months post-Hearth. Also, information about the total numbers of children weighed and those who defaulted is provided along with the breakdown of children based on their enrollment (i.e. 1st, 2nd or 3rd round/session).

- To generate a report, enter ADP name and use the drop-down menu to select or enter a fiscal year.

Tab 6 – GRAPH Follow-up: This tab contains a bar graph showing overall changes in underweight nutritional status of PDH participant children (%) at different time points (e.g. baseline/Day 1, 12, 30 of PDH, and 3, 6, 12 months of post-PDH).

Tab 7 – GRAPH Graduation & Weight Gain: This tab contains six pie charts. The first three charts show the percentage of children whose nutritional status improved (i.e. mild/healthy vs. still moderate/severe) at Day 12, Day 30 and 3 months. The last three charts show the percentage of children who gained adequate weight (i.e. ≥ 200g at Day 12; ≥ 400g at Day 30; ≥ 900g at 3 months).

Tab 8 – GRAPH Default: This tab contains a bar graph on child default rate. The breakdown of number of children based on reasons for default at different time points (at Day 12, 30, and 3, 6, 12 months) is given.

NOTE:

To change the default date format on your computer:

1. *Go to Control Panel, click Regional and Language Options.*
2. *Under the Formats tab, click Additional settings (or Customize this format) button.*
3. *Click the Date tab.*
4. *Use the drop-down menu to select "DD/MM/YYYY" as the default Short date format.*
5. *Click Apply and close.*

SESSION 33

Personalise the Curriculum
Daily Summary and Evaluation

World Vision

30 MIN | DAY 5

By the end of this session, participants will be able to

1. Adapt the content of day to their own culture
2. Evaluate personal learning for the day.

Preparation

- Write the daily evaluation questions on a flip chart.

Materials

- Curriculum for each person
- Half sheet of paper for each person

STEPS

20 Min

1.

Ask each participant to reflect on the day's sessions. They will write in their curriculum ideas to improve or adapt the various presentations methodologies so they are more appropriate for their own contexts. Participants should be ready to share any good ideas they might have.

8 Min

2. Daily Evaluation

Distribute a half sheet of paper to each participant. Ask the participants to complete the three phrases written on the flip chart.

1. Something I learned today that I will apply in our PD/Hearth programme is

   _____.

2. Something new that I learned about PD/Hearth today is

   _____.

3. Something I'm still confused about is

   _____.

The facilitators will review these evaluations at the end of each day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.

2 Min

3.

Thank the participants for their good work during the day. Mention any highlights of the day. Remind them of the meeting time for the next session.

Review of Day 5 and the Agenda for Day 6

SESSION 34

30 MIN | DAY 6

By the end of this session, participants will have

1. Reviewed the content of Day 5
2. Anticipated what will be covered today.

Materials

- Coloured cards/post-its
- Markers
- Prizes for winning team
- Blank flip chart

STEPS

25 Min

1.

Place three cards of different colours and some markers on each table. Working in small groups (one group at each table)

- Ask each group to develop three questions about the key concepts they have learned during the workshop.
- Ask the participants to write each question on one side of a coloured card and then turn the card so the written side is down.
- Ask the participants at each table to select a name for their team and to decide who will select a card from one of the other tables for the first turn.
- Have one facilitator keep score on the flip chart.
- Ask the representative from one table to select a card from another table. The team members may discuss the question but will have only one minute to give their answer to the question.
- For each correct response, the team wins 1 point. The team that wrote the question judges whether or not the response is correct.
- Select another table to draw a card. Continue until each table has had a chance to respond to a card. Give a prize to the winning team.

5 Min

2.

Review the agenda for today.

SESSION 35

Factors for the Success of PD/Hearth

45 MIN | DAY 6

By the end of this session, participants will be able to

1. Identify success factors for PD/Hearth
2. Receive solutions to their challenges from other participants
3. Develop an 'elevator speech' to promote key issues with National Office staff

Preparation

- A flip chart with the questions for the 'elevator speech'

STEPS

10 Min

1.

Ask participants what they believe the factors for the success of PD/Hearth might be. Make sure the following points are discussed:

- Commitment and support from the Regional Office, National Office, Support Office and ADPs.
- A small start. Initiate just one PD/Hearth in one community to learn from that experience before starting others in other communities.
- Frequent supportive supervision of volunteers – perhaps daily during their first rotation and then weekly.
- Quality training at each level.
- Integration of PD/Hearth with other sectors in the ADP to work together to address some of the underlying issues affecting the nutrition status of children; collaboration and support from other sector specialists; a team of people working collaboratively.
- Networks with government and non-governmental organisations that will work together to address nutrition issues for children.
- Change in community social norms through nutrition activities that involve all caregivers of young children, regardless of the children's nutritional status, and also the older women who influence them. This can include growth monitoring with good counselling, cooking and feeding demonstrations, breastfeeding support groups, grandmother groups, nutrition messages targeted to fathers and community leaders, health fairs, etc. PD/Hearth changes to behaviour will not 'last' if the community social norms with regard to child feeding do not also change.

5 Min

2.

Ask participants to think about their own programmes in light of the factors of success and the course so far. Each participant should write one main activity that would enable their programme to be more successful. Example: 'The menus for the Hearth sessions need to be improved to meet the nutrient requirements' or 'The community needs to be better informed of PD practices'.

15 Min

3.

Divide into pairs. One person in each pair will read his or her objective to the partner. In one minute the partner offers one or two ideas for actions it might be possible to try. The first person quickly jots the ideas down. Neither person makes any judgment, asks questions, or develops the ideas. Now the second person reads his or her objective, the partner offers one or two ideas, and the person writes them down. This step will take less than four minutes.

At the end of the four minutes, find new partners and repeat the process.

Repeat the process again. By this time each participant will have a list of creative ideas to consider in his or her own programme.

15 Min

4.

Develop an 'elevator speech'.

Present this activity to the participants:

You are returning home from your course with many ideas to try. You have approximately two minutes to explain to the National Director or Operations Director what you learned and what you want to do now. This is the amount of time it takes to ride the elevator from the ground floor to the third floor, so this is your 'elevator speech'. Think about what you will say. Fill in these statements (written on the flip chart) using only ***one*** line. Practise your 'elevator speech' with a partner.

Flip Chart 35

DAY 6

1. The most important or striking or insightful or valuable thing I learned was

_____

2. I am going to capitalise on this learning by

_____

3. The benefit to the organisation will be

_____

4. I need the following help to make this happen

_____

Post-test

SESSION 36

30 MIN | DAY 6

Materials

- PD/Hearth Post-test (provided in MT Trainers' Package)

STEPS

30 Min

1. Distribute Post-test provided in the MS Word document called "MT Trainers' Package".

2. Have the participants complete it and hand it in.

3. Facilitators mark the tests while the participants complete their PD/Hearth training plan (Session 37) and personalise their training curriculum (Session 38). The marked post-tests will be returned with the pre-test results.

SESSION 37

PD/Hearth Training Plan

World Vision

45 MIN | DAY 6

By the end of the session, participants will be able to

1. Draft a country PD/Hearth training plan
2. Receive feedback on their plans from regional adviser and facilitators.

Preparation

- Print Handout 37.1

Materials

- Handout 37.1: PD/Hearth Training Plan

STEPS

15 Min

1.

HANDOUT
37.1 –197m/H 86

Participants from each country work together to develop a country plan based on the questions on Handout 37.1: PD/Hearth Training Plan.

30 Min

2.

Each country group briefly presents its plan. Participants and facilitators give feedback on the plan.

Trainer's name:

Who will be trained?

Projected timetable of trainings:

Where trainings will take place? (number and names of ADPs currently implementing in this fiscal year):

Support required to fulfil plan?

SESSION 38

Personalise the Training Curriculum

World Vision

90 MIN | DAY 6

By the end of the session, participants will have

1. Adapted their training curriculum for PD/Hearth
2. Received feedback from the facilitator on their curriculum.

Preparation

- Print Handout 38.1

Materials

- Handout 38.1: Training Agenda and Methodology

STEPS

90 Min

1.

HANDOUT
38.1 – 199m/H 87

Distribute Handout 38.1. Ask the participants to fill in the methodology they will use during their trainings. Participants from one country may choose to work together to finalise their training curriculum. Some activities on the agenda might not be included in their TOF. Some other sessions might be added in. Encourage them to use creative methods – stories, songs, games, role plays, case studies, etc.

2.

The facilitators rotate among the participants to review the curriculum and offer feedback.

3.

The curriculum needs to be submitted to the regional adviser for review before they conduct their TOF.

PD/Hearth Agenda and Methodologies		
Day	**Topics**	**Methodology**
Day 1		
	Devotion	
	Welcome Ice breaker Workshop rules (parking lot) Introductions and expectations Overview of workshop purpose, objectives and agenda Target evaluation	
	Pre-test	
	Defining the role of a PD/Hearth Master Trainer	
	Learning styles and facilitation	
	Overview of PD/Hearth	
	Essential elements and key principles	
	How PD/Hearth addresses malnutrition	
	Step 1 – Determining the Feasibility of PD/Hearth	
	Integration and PD/Hearth	
	Personalise the training curriculum	
	Daily Summary and Evaluation	
Day 2		
	Devotion	
	Review of Day 1 and present Day 2 agenda	
	Step 2 – Community Mobilisation	
	Step 2 – Staffing Needs; selecting and training volunteers	
	Step 3 – Situational Analysis – wealth ranking	
	Step 3 – Situational Analysis – nutritional assessment	
	Step 3 – Situational Analysis – transect walk, household visits, focus-group discussions, market survey	
	Step 4 – Identifying Positive Deviants	
	Step 4 – Preparing for the PDI: home visits, 24-hour recall, observation	
	Step 4 – Conducting the PDI	
	Personalise the training curriculum	
	Daily Summary and Evaluation	

Day	Topics	Methodology
Day 3	Field Visit	
	Review of Day 2 and explain logistics for field visit	
	Field Visit – PDI, FGD, transect walk, market survey, household visits	
	Compile results of PDI on flip charts	
Day 4		
	Devotion	
	Review of Day 3 field visit and present day 4 agenda	
	Step 4 – PDI interpretation and feedback	
	Promoting behavioural change	
	Step 5 – Designing Hearth Sessions (Incorporating PD behaviours)	
	Step 5 – Menu planning	
Day 5		
	Devotion	
	Review of Day 4 and present Day 5 agenda	
	Community feedback meetings	
	Step 6 – Conducting Hearth sessions	
	Step 7 – Supporting new behaviours through reflection and home visits	
	Step 8 – Admission and graduation criteria and repeating Hearth sessions Exit strategy and reaching the rest of the community	
	Step 9 – Expanding PD/Hearth	
	Monitoring and evaluation	
	Personalise the training curriculum	
	Daily Summary and Evaluation	
Day 6		
	Devotion	
	Review of Day 5 and present Day 6 agenda	
	Factors for the success of PD/Hearth	
	Post-test	
	Training plan	
	Personalise the TOT training curriculum – review by facilitators	
	Target evaluation, final evaluation	
	Workshop Closing	

Final Evaluation and Closing

SESSION 39

30 MIN | DAY 6

By the end of the session, participants will have

1. Identified key areas of learning
2. Provide feedback on the training
3. Received a certificate of participation.

Preparation

- Flip chart with 'Target Evaluation Dart Board'
- Print Handout 39.1
- Certificates for all participants

Materials

- 'Target Evaluation' flip chart from Day 1 for comparison
- Eight small stickers for each participant
- Handout 39.1: Workshop Evaluation

STEPS

10 Min

1.

Repeat the 'Target Evaluation' exercise from Day 1.

- Give each participant eight stickers. Ask the participants to consider their understanding and skill in each of the eight areas on the 'Target Evaluation Dart Board' (Flip Chart 39). The more competent they feel in an area, the closer to the centre of that area they place a sticker. For areas in which they feel less confident or knowledgeable, the closer to the outer edge they place a sticker.
- Compare the first day's chart with the final day's chart. Discuss where participants feel they have grown in knowledge and skill. Congratulate them on their great work.

10 Min

2.

HANDOUT
39.1 – 203m/H 89

Have participants fill out Handout 39.1: Evaluation Form (an evaluation form for the course).

Flip Chart 39
Target Evaluation Dart Board

DAY 6

10 Min

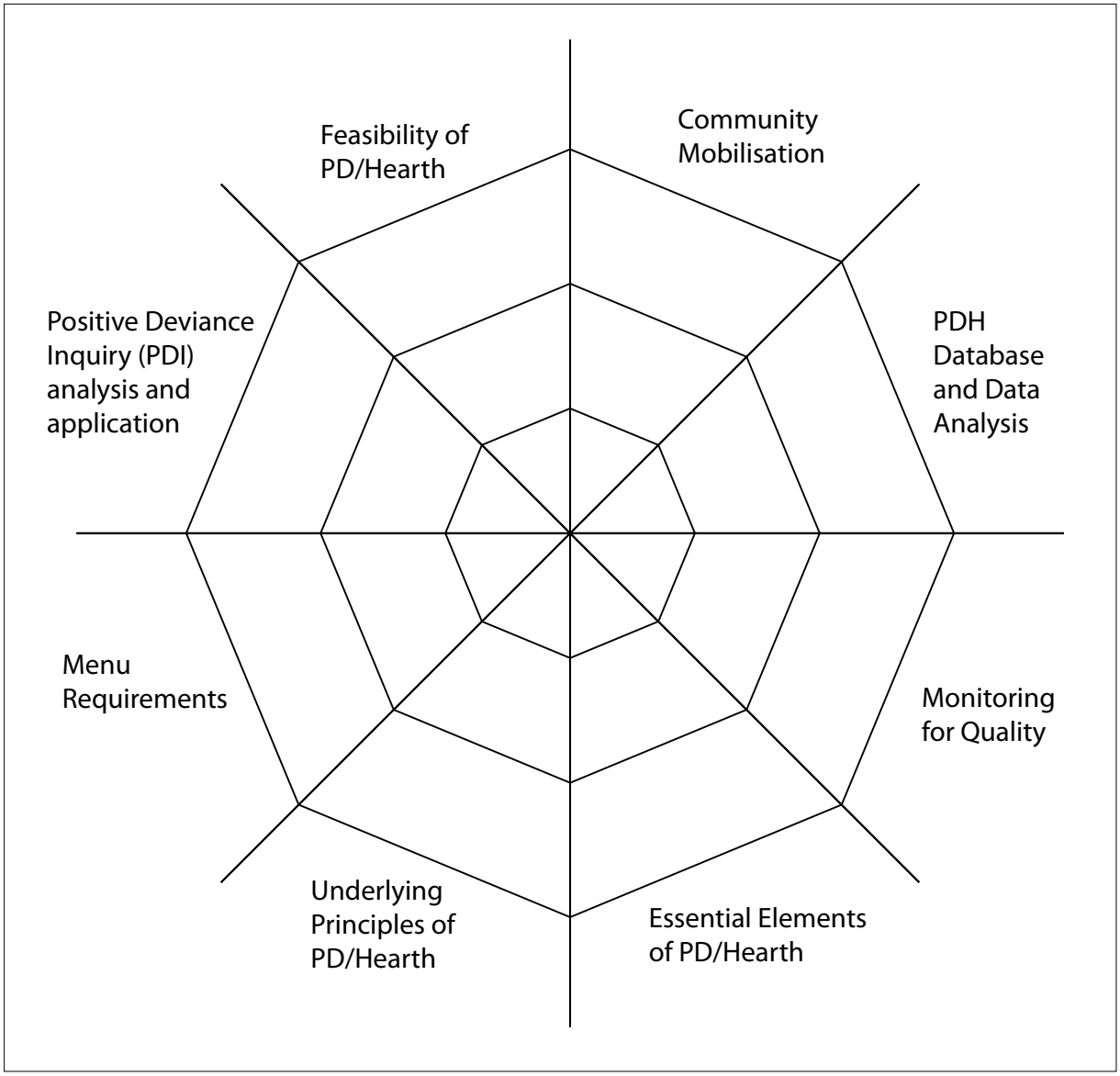
3.

Explain the next steps in master training:

- Each participant will submit to the regional adviser his or her country training plan and agenda and methodology forms.
- Each participant will receive his or her final marks and next steps from the regional office.

4.

Thank the host country, planners and logistics people. Thank participants for their great work.



Workshop Evaluation: World Vision PD/Hearth Master Training of Trainers Workshop

EVALUATION

Thank you for attending this year's PD/Hearth Master Training of Trainers Workshop. We hope you enjoyed your time, and that the workshop was a meaningful experience for you. Please take a few minutes to complete this evaluation. Your feedback is valuable and provides helpful information that will be used to plan the next workshop.

4. What did you expect from the workshop?

   _____
   _____
   _____

5. What do you feel was the most helpful part of the workshop? (for example, a particular session, a working group, a contact you made, certain resource material you obtained)

   _____
   _____
   _____

6. Please share some specific ways that you and/or your programme will apply the helpful information you noted in question #2.

   _____
   _____
   _____

7. What do you feel was the least helpful part of the workshop?

   _____
   _____
   _____

8. What would you do to improve this?

   _____
   _____
   _____

9. What would recommend for the next workshop?

   _____
   _____
   _____

10. What themes or topics would you suggest that we focus on or go into in more detail?

    _____
    _____
    _____

11. Should more background information be provided at the beginning of the workshop/training? What information?

    _____
    _____
    _____

Workshop Evaluation: World Vision PD/Hearth Master Training of Trainers Workshop

12. Other:

_____
_____
_____

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

For you, what was the highlight of this workshop?

_____
_____
_____

_____
_____
_____

Please share any other comments or suggestions to improve the next World Vision PD/Hearth Master TOT Workshop.

_____
_____
_____

_____
_____
_____

Thank you for your feedback!

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Sustainable Health

VOLUNTEERS
HANDOUTS

Training of Volunteers for **Positive Deviance/Hearth**

SECOND EDITION

Nutrition Centre of Expertise

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Positive Deviance/Hearth Volunteers

VOLUNTEERS
HANDOUTS

By Naomi Klaas,
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WVI Nutrition Centre of Expertise

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Copyediting: Joan Weber Laflamme.

Table of Contents

PLEASE NOTE: There can be more than one page for a handout. Page counts appear in the item lines for any handouts having more than one page. Multiple page handouts are designated on their respective pages as "page # of # pages".

The (page #m) refers to where each handout appears in the PD/Hearth Volunteer Manual. You can reference the "#m" at the bottom of the handout page here as well.

DAY 5

DAY 6

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)*											
BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	0	3.3	2.9	2.5	2.1	F	0	3.2	2.8	2.4	2.0
M	1	4.5	3.9	3.4	2.9	F	1	4.2	3.6	3.2	2.7
M	2	5.6	4.9	4.3	3.8	F	2	5.1	4.5	3.9	3.4
M	3	6.4	5.7	5.0	4.4	F	3	5.8	5.2	4.5	4.0
M	4	7.0	6.2	5.6	4.9	F	4	6.4	5.7	5.0	4.4
M	5	7.5	6.7	6.0	5.3	F	5	6.9	6.1	5.4	4.8
M	6	7.9	7.1	6.4	5.7	F	6	7.3	6.5	5.7	5.1
M	7	8.3	7.4	6.7	5.9	F	7	7.6	6.8	6.0	5.3
M	8	8.6	7.7	6.9	6.2	F	8	7.9	7.0	6.3	5.6
M	9	8.9	8.0	7.1	6.4	F	9	8.2	7.3	6.5	5.8
M	10	9.2	8.2	7.4	6.6	F	10	8.5	7.5	6.7	5.9
M	11	9.4	8.4	7.6	6.8	F	11	8.7	7.7	6.9	6.1
M	12	9.6	8.6	7.7	6.9	F	12	8.9	7.9	7.0	6.3
M	13	9.9	8.8	7.9	7.1	F	13	9.2	8.1	7.2	6.4
M	14	10.1	9.0	8.1	7.2	F	14	9.4	8.3	7.4	6.6
M	15	10.3	9.2	8.3	7.4	F	15	9.6	8.5	7.6	6.7
M	16	10.5	9.4	8.4	7.5	F	16	9.8	8.7	7.7	6.9
M	17	10.7	9.6	8.6	7.7	F	17	10.0	8.9	7.9	7.0
M	18	10.9	9.8	8.8	7.8	F	18	10.2	9.1	8.1	7.2
M	19	11.1	10.0	8.9	8.0	F	19	10.4	9.2	8.2	7.3
M	20	11.3	10.1	9.1	8.1	F	20	10.6	9.4	8.4	7.5
M	21	11.5	10.3	9.2	8.2	F	21	10.9	9.6	8.6	7.6
M	22	11.8	10.5	9.4	8.4	F	22	11.1	9.8	8.7	7.8
M	23	12.0	10.7	9.5	8.5	F	23	11.3	10.0	8.9	7.9
M	24	12.2	10.8	9.7	8.6	F	24	11.5	10.2	9.0	8.1
M	25	12.4	11.0	9.8	8.8	F	25	11.7	10.3	9.2	8.2
M	26	12.5	11.2	10.0	8.9	F	26	11.9	10.5	9.4	8.4
M	27	12.7	11.3	10.1	9.0	F	27	12.1	10.7	9.5	8.5
M	28	12.9	11.5	10.2	9.1	F	28	12.3	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)

BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.9
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	9.0
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.1
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.3
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.4
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.5
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.6
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.7
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.8
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.9
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	10.1
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)*									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	0	2.9	2.5	2.1	F	0	2.8	2.4	2.0
M	1	3.9	3.4	2.9	F	1	3.6	3.2	2.7
M	2	4.9	4.3	3.8	F	2	4.5	3.9	3.4
M	3	5.7	5.0	4.4	F	3	5.2	4.5	4.0
M	4	6.2	5.6	4.9	F	4	5.7	5.0	4.4
M	5	6.7	6.0	5.3	F	5	6.1	5.4	4.8
M	6	7.1	6.4	5.7	F	6	6.5	5.7	5.1
M	7	7.4	6.7	5.9	F	7	6.8	6.0	5.3
M	8	7.7	6.9	6.2	F	8	7.0	6.3	5.6
M	9	8.0	7.1	6.4	F	9	7.3	6.5	5.8
M	10	8.2	7.4	6.6	F	10	7.5	6.7	5.9
M	11	8.4	7.6	6.8	F	11	7.7	6.9	6.1
M	12	8.6	7.7	6.9	F	12	7.9	7.0	6.3
M	13	8.8	7.9	7.1	F	13	8.1	7.2	6.4
M	14	9.0	8.1	7.2	F	14	8.3	7.4	6.6
M	15	9.2	8.3	7.4	F	15	8.5	7.6	6.7
M	16	9.4	8.4	7.5	F	16	8.7	7.7	6.9
M	17	9.6	8.6	7.7	F	17	8.9	7.9	7.0
M	18	9.8	8.8	7.8	F	18	9.1	8.1	7.2
M	19	10.0	8.9	8.0	F	19	9.2	8.2	7.3
M	20	10.1	9.1	8.1	F	20	9.4	8.4	7.5
M	21	10.3	9.2	8.2	F	21	9.6	8.6	7.6
M	22	10.5	9.4	8.4	F	22	9.8	8.7	7.8
M	23	10.7	9.5	8.5	F	23	10.0	8.9	7.9
M	24	10.8	9.7	8.6	F	24	10.2	9.0	8.1
M	25	11.0	9.8	8.8	F	25	10.3	9.2	8.2
M	26	11.2	10.0	8.9	F	26	10.5	9.4	8.4
M	27	11.3	10.1	9.0	F	27	10.7	9.5	8.5
M	28	11.5	10.2	9.1	F	28	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	29	11.7	10.4	9.2	F	29	11.1	9.8	8.8
M	30	11.8	10.5	9.4	F	30	11.2	10.0	8.9
M	31	12.0	10.7	9.5	F	31	11.4	10.1	9.0
M	32	12.1	10.8	9.6	F	32	11.6	10.3	9.1
M	33	12.3	10.9	9.7	F	33	11.7	10.4	9.3
M	34	12.4	11.0	9.8	F	34	11.9	10.5	9.4
M	35	12.6	11.2	9.9	F	35	12.0	10.7	9.5
M	36	12.7	11.3	10.0	F	36	12.2	10.8	9.6
M	37	12.9	11.4	10.1	F	37	12.4	10.9	9.7
M	38	13.0	11.5	10.2	F	38	12.5	11.1	9.8
M	39	13.1	11.6	10.3	F	39	12.7	11.2	9.9
M	40	13.3	11.8	10.4	F	40	12.8	11.3	10.1
M	41	13.4	11.9	10.5	F	41	13.0	11.5	10.2
M	42	13.6	12.0	10.6	F	42	13.1	11.6	10.3
M	43	13.7	12.1	10.7	F	43	13.3	11.7	10.4
M	44	13.8	12.2	10.8	F	44	13.4	11.8	10.5
M	45	14.0	12.4	10.9	F	45	13.6	12.0	10.6
M	46	14.1	12.5	11.0	F	46	13.7	12.1	10.7
M	47	14.3	12.6	11.1	F	47	13.9	12.2	10.8
M	48	14.4	12.7	11.2	F	48	14.0	12.3	10.9
M	49	14.5	12.8	11.3	F	49	14.2	12.4	11.0
M	50	14.7	12.9	11.4	F	50	14.3	12.6	11.1
M	51	14.8	13.1	11.5	F	51	14.5	12.7	11.2
M	52	15.0	13.2	11.6	F	52	14.6	12.8	11.3
M	53	15.1	13.3	11.7	F	53	14.8	12.9	11.4
M	54	15.2	13.4	11.8	F	54	14.9	13.0	11.5
M	55	15.4	13.5	11.9	F	55	15.1	13.2	11.6
M	56	15.5	13.6	12.0	F	56	15.2	13.3	11.7
M	57	15.6	13.7	12.1	F	57	15.3	13.4	11.8
M	58	15.8	13.8	12.2	F	58	15.5	13.5	11.9
M	59	15.9	14.0	12.3	F	59	15.6	13.6	12.0
M	60	16.0	14.1	12.4	F	60	15.8	13.7	12.1

Monitoring Form 1
Materials Checklist Needed for PD/Hearth Sessions

Day 4 Session 8

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice,fufu, yams)			
Oil			
Other ingredients			

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 3	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 5	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Monitoring Form 2 – PD/Hearth Menu and Cooking Materials Tracking Sheet - Continued

Day 4 Session 8

No.	DAY 7	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 9	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 10	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 11	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 12	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Monitoring Form 3
Child Registration Form and Attendance

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Hearth Participant Child AND Primary Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Monitor Form 3 Child Registration Form and Attendance (Including Grandmother)

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name/Grandmother Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Child and Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

#	**Attendance for Grandmother**											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Hearth Register and Monitoring Form 4

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

		CHILD	1	2	3	4	5	6	7	8	9	10
Child's Name												
Caregiver's Name												
Child's Sex (M/F)												
Date of Birth (dd/mm/yyyy)												
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')												
At Day 1 of Hearth	Date (dd/mm/yyyy)											
	Weight (Kg)*											
	Underweight Nutritional Status (Indicate colour)											
	MUAC (Green, yellow, red < 115mm)											
At Day 12 of Hearth	Date (dd/mm/yyyy)											
	Weight (Kg)*											
	Weight Gain (Day 12 - Day 1) in grams											
	Underweight Nutritional Status (Indicate colour)											
	MUAC (Optional)											

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Hearth Register and Monitoring Form 4 - Continued

Day 6 Session 10

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

	CHILD	1	2	3	4	5	6	7	8	9	10
At Day 30 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight gain (Month 1 - Day 1 weight) in grams										
	Gained 400g+ (Y/N)										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 3 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	Change in Status (Y/N)										
	MUAC (Optional)										
At 6 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 12 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
	CHILD	1	2	3	4	5	6	7	8	9	10
	COMMENTS (Explain reason for default if child has defaulted due to death (D), migration (M), referred to hospital (H), etc.)										

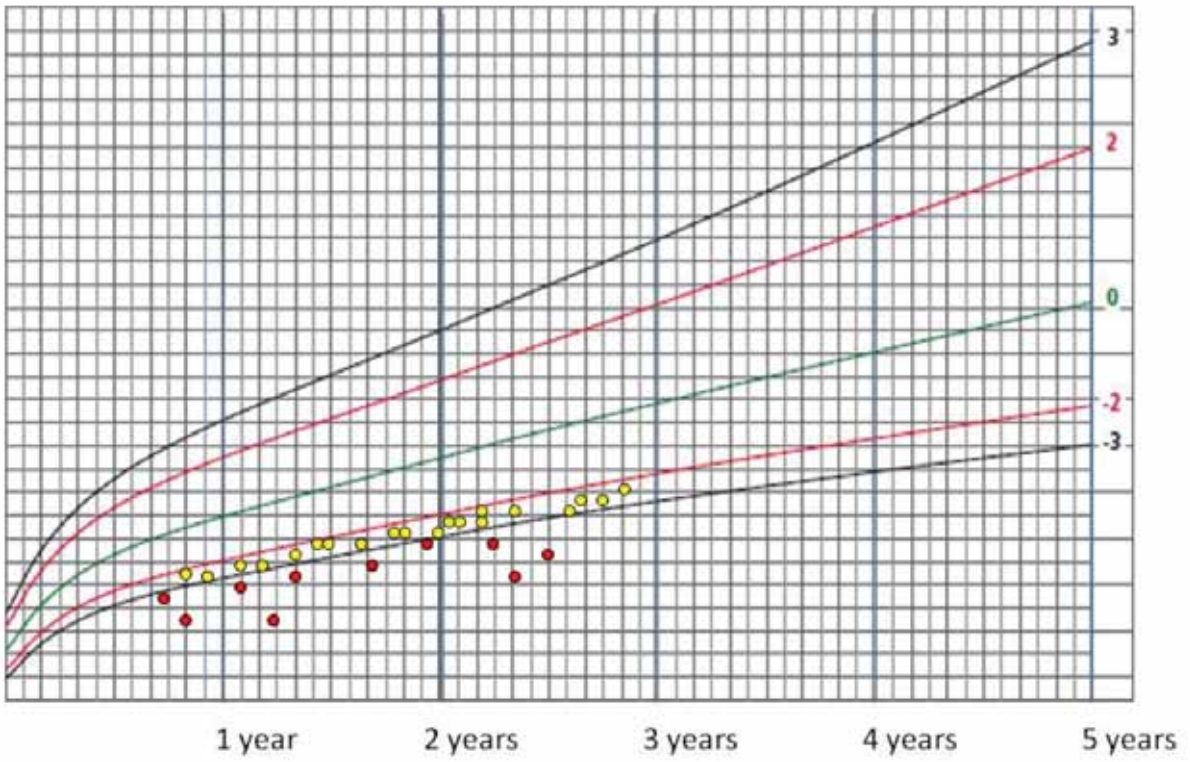
*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Monitoring Form 5
Volunteer Home Visit Form

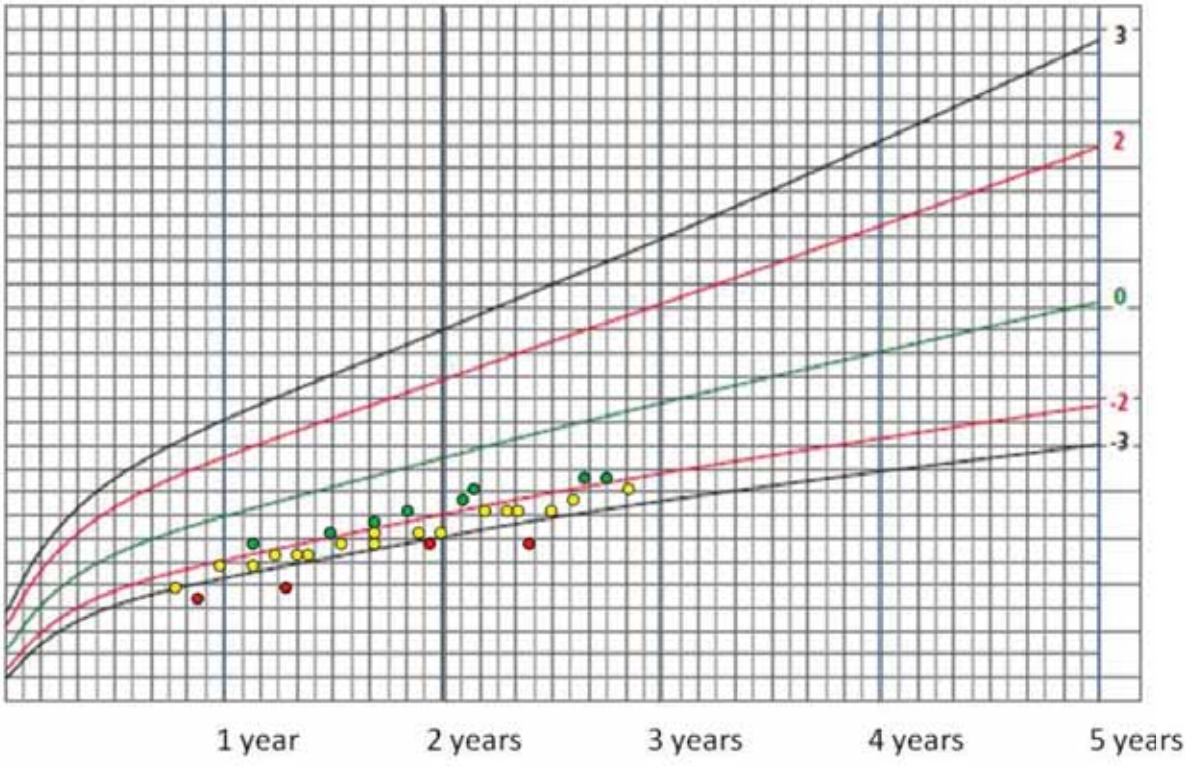
ADP Name ..... Village Name .....Caregiver's Name .....

Child's Name ..... Dates of Sessions.....Name of Hearth .....Volunteer .....

OBSERVATION LIST	Day #	Day #	Day #	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.							
Drinking water from safe source (borehole or protected well)							
Water is treated (Boiled/ chlorine)							
Water is covered with fitted cover or lid							
Clean separate cup is used for pouring drinking water from the pot							
Handwashing station exists (e.g. tippy tap)							
Jerry cans or water storage containers are clean							
Toilet/latrine is available and used or hole is dug and covered for defecation							
House and/or kitchen is clean							
Food utensils are clean							
Handwashing with running water and soap is practised by: Caregivers							
Children							
Other family members							
Food prepared is nutrient dense as learned in Hearth (includes all 3 food groups: protective, body building and energy foods)							
Size of portion served is age appropriate							
Caregiver actively feeds the child							
Child is offered more food after finishing first portion							
Caregiver says child is fed 4 - 5 times / day (including snacks)							
Child uses separate (own) plate, bowl, or cup							
Caregiver is motivated by changes in the child							
Yesterday night, mosquito net was used by the primary caregiver and all children U5 in the household							
Caregiver can say what to do when child is sick (example: feeds more liquid when child has diarrhea and feeds more frequently)							
Caregiver expresses being able to continue practising what was learned in Hearth at home							
Problems and questions about child feeding and care is discussed with the volunteer							



Before Hearth



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World Vision

Sustainable Health

VOLUNTEERS
JOB AIDS

Training of Volunteers for **Positive Deviance/Hearth**

SECOND EDITION

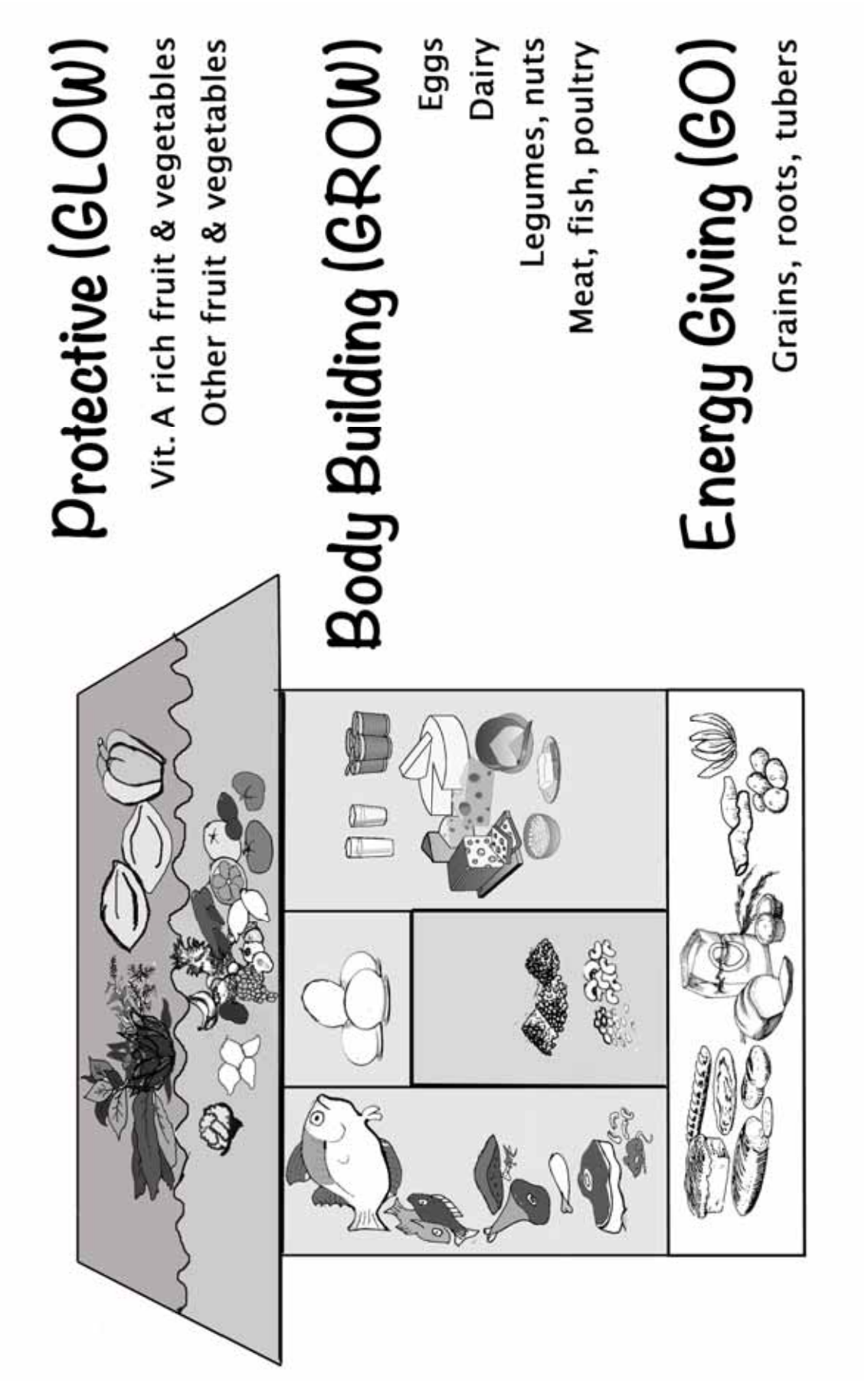
Nutrition Centre of Expertise

Energy Giving Foods (GO)

Body Building Foods (GROW)

For TM Page 8

Protective Foods (GLOW)

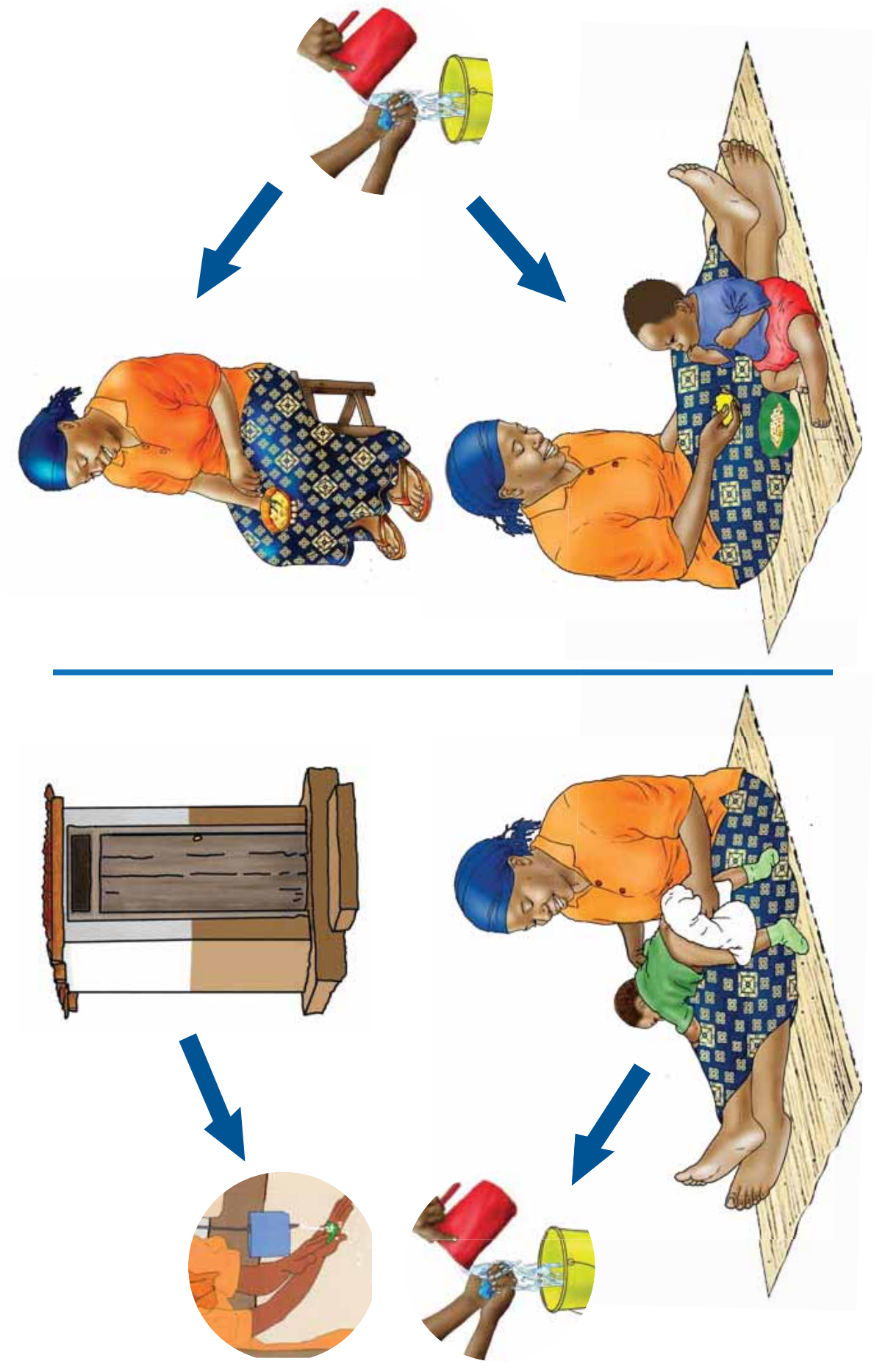

Protective (GLOW)
Vit. A rich fruit & vegetables
Other fruit & vegetables
Body Building (GROW)
Eggs
Dairy
Legumes, nuts
Meat, fish, poultry
Energy Giving (GO)
Grains, roots, tubers

Healthy Meals and Snacks

For TM Page 15

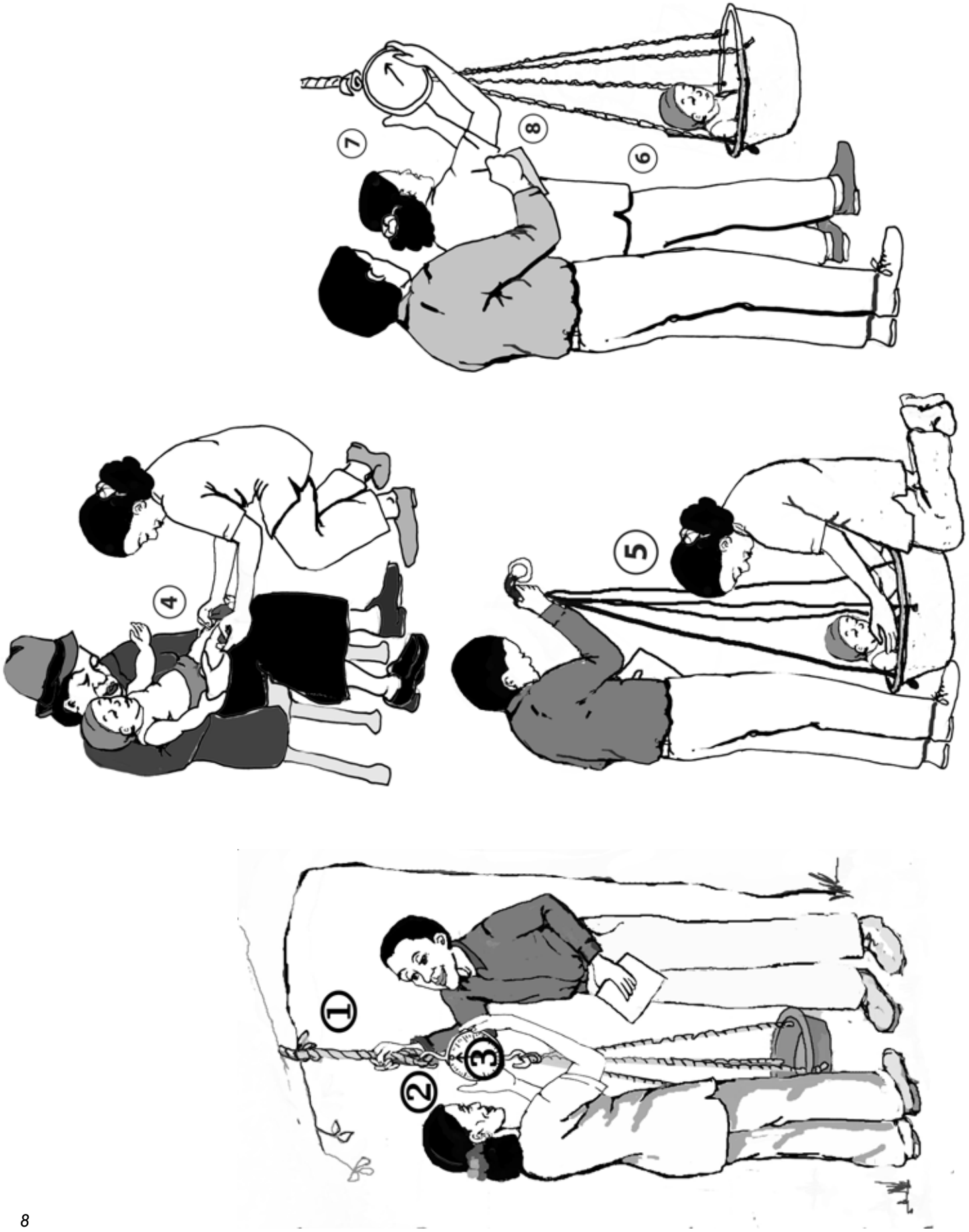
Hand Washing

For TM Page 16



Weighing and Measuring Children

For TM Page 20-21

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Weighing and Measuring Children

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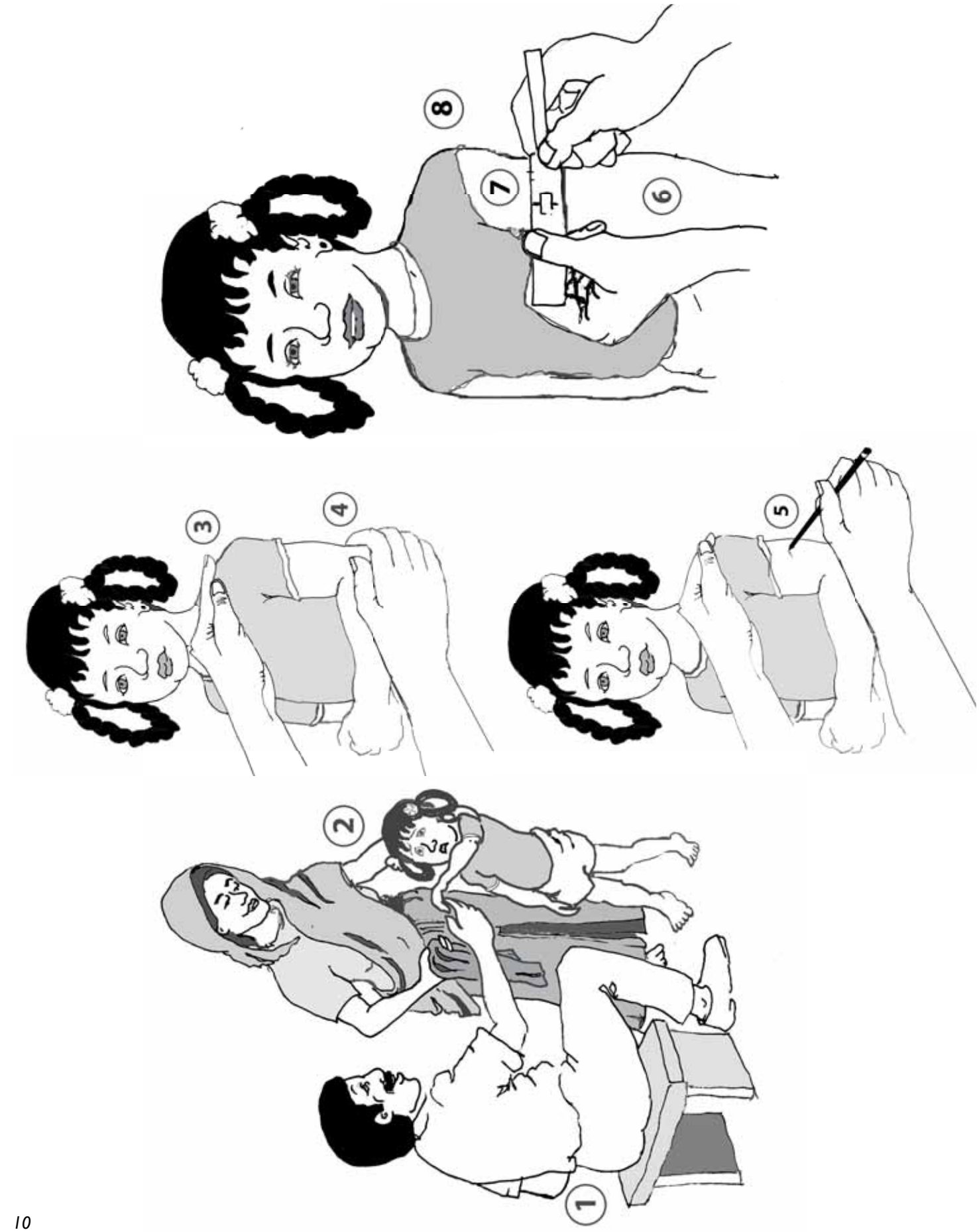
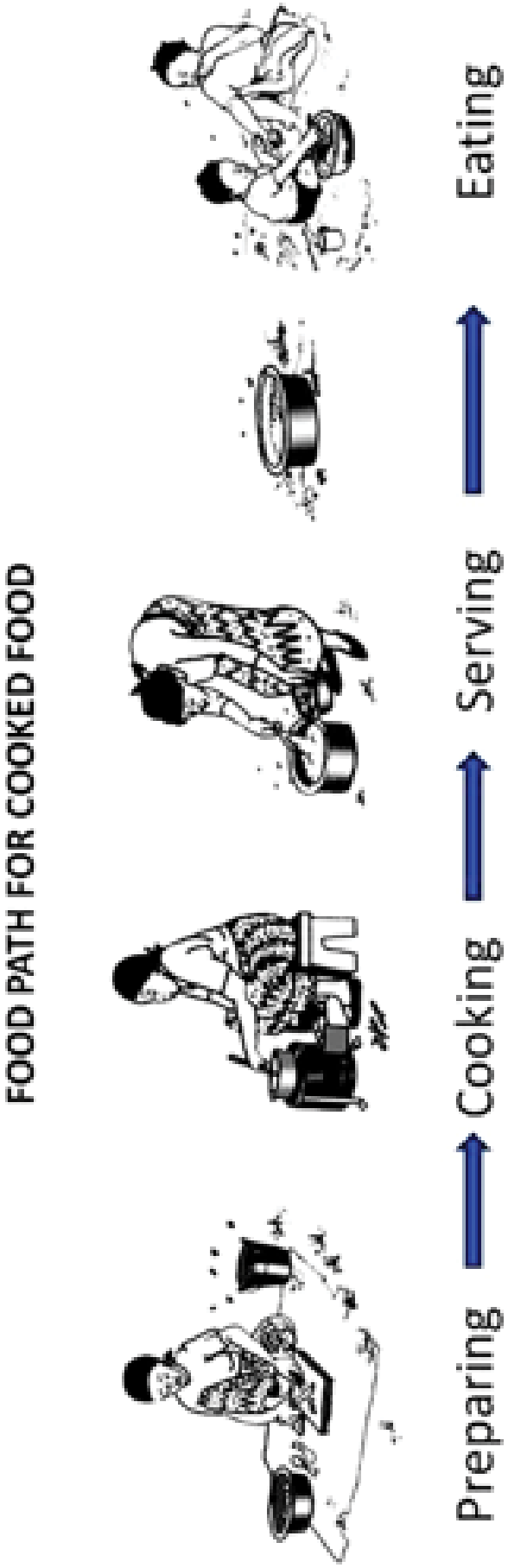
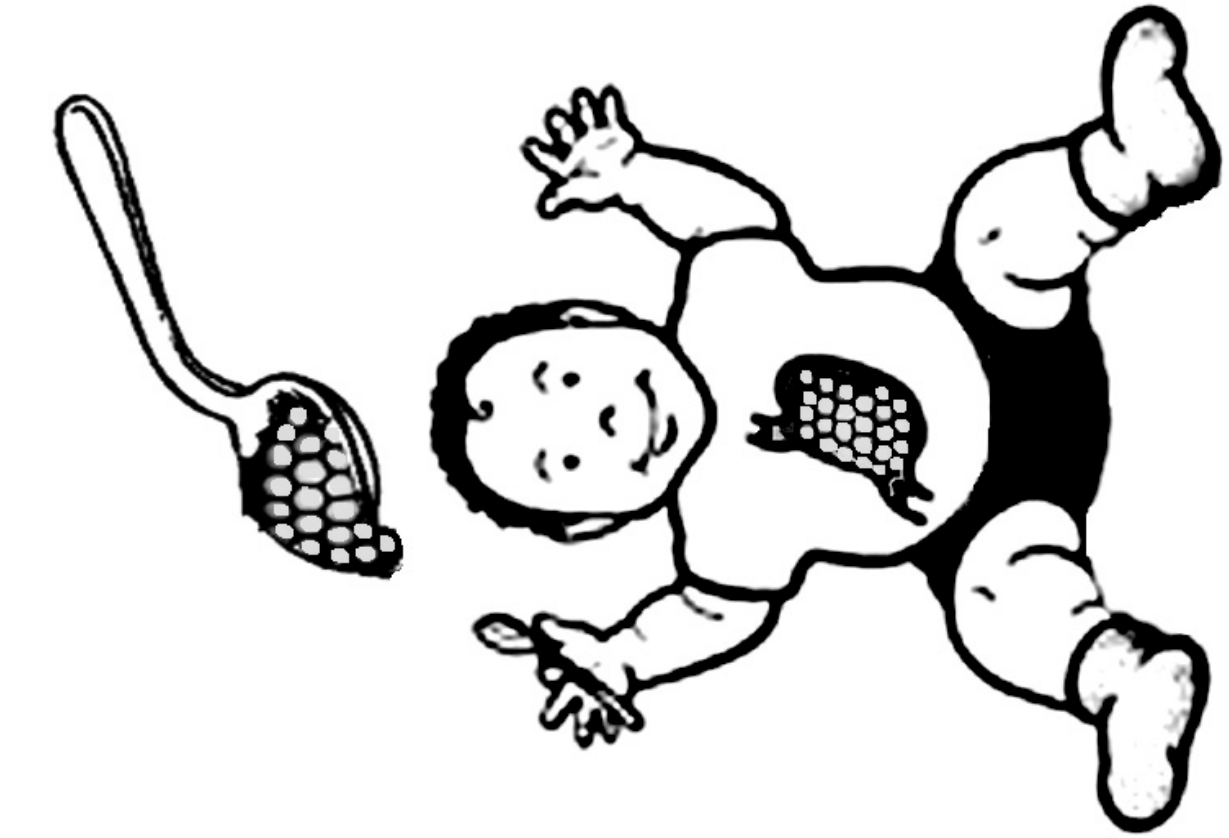
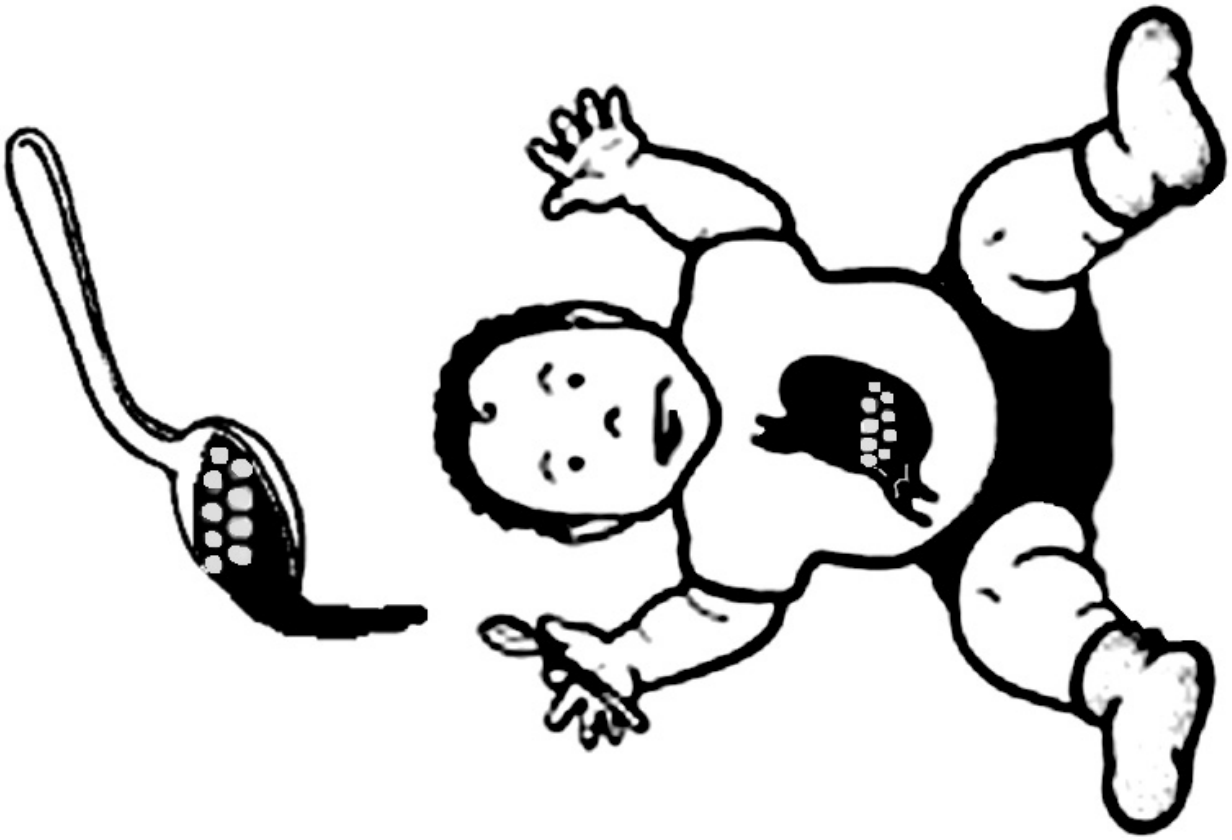



FOOD PATH FOR COOKED FOOD
Preparing
Cooking
Serving
Eating

Food Consistency

For TM Page 59





World Vision

Sustainable Health

VOLUNTEERS MANUAL

Training of Volunteers for **Positive Deviance/Hearth**

SECOND EDITION

Nutrition Centre of Expertise

World Vision

Positive Deviance/Hearth Volunteers

VOLUNTEERS
MANUAL

By Naomi Klaas,
Diane Baik and
Judiann McNulty

WVI Nutrition Centre of Expertise

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PLEASE NOTE: There can be more than one page for a handout. Page counts appear in the item lines for any handouts having more than one page. Multiple page handouts are designated on their respective pages as "page # of # pages".

The (page H#) refers to where each handout appears in the PD/Hearth Volunteer Handouts. You can reference the "#m" at the bottom of the handout page as well.

DAY 4

DAY 5

DAY 6

ADP	Area Development Programme
ANC	Ante-Natal Care
AOP	Annual Operating Plan
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
DHS	Demographic & Health Survey
DIP	Detailed Implementation Plan
DME	Design, Monitoring & Evaluation
ECCD	Early Childhood Care & Development
EP	Edible Portion
FGD	Focus Group Discussion
GMP	Growth Monitoring Programme
GTRN	Global Technical Resource Network
HAZ	Height for Age Z-score
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
ITN	Insecticide-Treated Bednet
IU	International Units
IYCF	Infant & Young Child Feeding
KPC	Knowledge, Practice & Coverage
MOH	Ministry of Health
MN	Micronutrient
MT	Master Trainer
MUAC	Mid-Upper Arm Circumference

NCOE	Nutrition Centre of Expertise
NHC	Nutrition & Health Coordinator
NGO	Non-Governmental Organisation
OD	Operations Director
ORS	Oral Rehydration Solution
PD	Positive Deviance/Positive Deviant
PDI	Positive Deviant Inquiry
PLA	Participatory Learning for Action
PRA	Participatory Rapid Appraisal
RAE	Retinol Activity Equivalent
RE	Retinol Equivalent
TOF	Trainer of Facilitators/Training of Facilitators
TOT	Trainer of Trainers/Training of Trainers
UNICEF	United Nations Children's Fund
VARK	Visual, Aural, Read/write, Kinesthetic
VHC	Village Health Committee
VHSC	Village Health & Sanitation Committee
WASH	Water, Sanitation & Hygiene
WAZ	Weight-for Age Z-score
WHO	World Health Organization
WHZ	Weight-for Height Z-score
WV	World Vision

Welcome to the Facilitation Manual for Training Volunteers for Positive Deviance (PD)/Hearth

INTRODUCTION

This training manual contains the information needed to conduct a five-day face-to-face training programme to equip PD/Hearth volunteers prior to starting the programme, with a sixth day of training to be held after the first week of Hearth implementation. The goal is to train PD/Hearth volunteers who will be competent and confident to guide and support caregivers to rehabilitate their malnourished children and prevent future malnutrition. Most sessions involve hands-on practice of the skills and knowledge volunteers will need to help caregivers learn.

The curriculum and exercises have been developed based on field experience from many countries in all regions of the world. Adult learning methodologies with practical examples, exercises, role plays and field visits reinforce the principles of strong PD/Hearth programmes. Facilitators should have experience applying adult learning methodologies as well as a thorough understanding of PD/Hearth principles, and preferably, implementation experience.

Participants should be selected in collaboration with community leaders, be motivated to help other caregivers learn to care for and feed their malnourished children, and be able to spend time in the programme activities. Grandmothers in the community could be well-suited to be volunteers, depending on the context. Fifteen is recommended as the maximum number of participants per trainer per training, to allow for interaction and hands-on learning. Thus, if there are two trainers, 30 is recommended as the maximum number of participants.

Arrangements need to be made for Day 2, during the practice sessions for weighing and taking MUAC measurements of children. For each group of 15 participants, 3 children between the ages of 6-36 months will be required for the practical session on weighing and taking MUAC measurements.

By the end of the course participants will be able to

- Assist in measuring growth of children using weight and MUAC
- Actively participate in a Positive Deviant Inquiry (PDI)
- Teach caregivers how to prepare Hearth menus
- Conduct Hearth sessions (share the Hearth messages)
- Conduct household visits to support caregivers in application of new behaviours
- Communicate progress and results of Hearth sessions to community leaders
- Follow-up on the growth of the PD/Hearth participant children and monitor the Hearth programme.

PD/Hearth Volunteer Training Agenda

For questions, comments or feedback, contact the Nutrition Centre of Expertise:

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Day and Date	Session	Topics	Time
		DAY 1	
	1	Welcome and Introduction	15 min
	2	What is PD/Hearth?	25 min
	3	What is good nutrition?	30 min
	4	What is malnutrition?	95 min+
		DAY 2	
	5	Weighing and measuring children	5.5 hours
		DAY 3	
	6	Positive Deviant Inquiry	115 min
	7	Conduct PDI and share results with community	3.5-4 hours
		DAY 4	
	8	Using the information gathered	210 min
		DAY 5	
	9	Prepare for the Hearth sessions	4 hours
		DAY 6 – After 1st week of Hearth	
	10	Reflection and follow up	150 min
	11	Keeping the community informed	90 min

SESSION 1

Welcome and Introduction

15 MIN | DAY 1

Purpose

- To begin to learn about one another

Materials

- small pictures of animals or food, cut in half (one picture for every two participants)
- a bag to put the picture pieces in

STEPS

5 Min

1. Welcome each person to the group.

   Introduce yourself and tell something about your interest in helping families with young children.

   Explain that this training involves a lot of participation to aid learning. Encourage volunteers to come on time each day.

   Explain practical details such as where the toilets are and where to get water to drink.

10 Min

2. Each volunteer picks one piece of a picture from the bag. Explain this is half of a picture. They are to find the person with the other half of their picture and ask their partner's name, number of children and favourite food.

   At the end of five minutes the partners introduce one another to the whole group.

What Is PD/Hearth?

SESSION 2

25 MIN | DAY 1

Purpose

- To learn what PD/Hearth is
- To learn the three goals of PD/Hearth
- To understand the role and involvement of volunteers in the programme

STEPS

5 Min

1. Ask the Volunteers

- Are there children in your community who are not growing well? *(yes)*
- How can you tell? *(small, sickly, too thin, do not walk, do not play, cry a lot)*
- Why do you think these children are not growing well? *(not enough food, father not present, unsafe water, mother works, too many children in family)*
- Are there children who are growing well? *(yes)*
- How can you tell? *(happy, active, play, growing taller, not thin)*
- Why do you think these children are growing well? *(eat well, mother cares, grandmother helps, not too many children, family has more land to grow things)*
- Are all the children from poorer families ill and not growing well? *(no)*
- Are all the children from non-poor families healthy? *(no)*

10 Min

2. Explain

'We see in our village it is possible to be poor and still have children who are healthy and grow well. We want to discover what those families do to make sure their children are healthy so that families with malnourished children can learn the same things and make their children healthier. For two weeks we will meet together with the malnourished children and their caregivers. A child's caregivers could include their mother, father, grandmother, grandfather and/or older sibling – anyone who does a lot of the work of taking care of the child. Grandmothers[1] often give advice on child care and feeding even if someone else is directly taking care of the child. The advisor role is very important too so we will involve grandmothers as much as possible.

Each day the caregivers will bring a small amount of food to cook. These foods will make their children grow better. We will learn to cook foods that will help the malnourished children gain weight. We will also help the caregivers learn good habits in cooking, feeding, hygiene, health and caring for their children. In the end we want the malnourished children to improve quickly. We want to help families know how to keep their children healthy and growing well, and we want to keep other children from becoming malnourished.'

1. A Grandmother refers to a senior woman (related or unrelated to the child) who lives in close proximity to the child and who has influence on child care.

Introduce the three goals of PD/Hearth:

- To rehabilitate malnourished children quickly
- To help families keep their children healthy
- To prevent malnutrition from happening in the future.

10 Min

3. Tell the story 'Stone Soup'

A kindly, old stranger was walking through the land when he came upon a village. As he entered, the villagers moved towards their homes locking doors and windows. The stranger smiled and asked, 'Why are you all so frightened. I am a simple traveller, looking for a soft place to stay for the night and a warm place for a meal.'

'There's not a bite to eat in the whole province,' he was told. 'We are weak and our children are starving. Better keep moving on.'

'Oh, I have everything I need,' he said. 'In fact, I was thinking of making some stone soup to share with all of you.' He pulled an iron cauldron from his cloak, filled it with water, and began to build a fire under it. Then, with great ceremony, he drew an ordinary-looking stone from a silken bag and dropped it into the water.

By now, hearing the rumour of food, most of the villagers had come out of their homes or watched from their windows. As the stranger sniffed the 'broth' and licked his lips in anticipation, hunger began to overcome their fear.

'Ahh,' the stranger said to himself rather loudly, 'I do like a tasty stone soup. Of course, stone soup with cabbage -- that's hard to beat.' Soon a villager approached hesitantly, holding a small cabbage he'd retrieved from its hiding place, and added it to the pot.

'Wonderful!' cried the stranger. 'You know, I once had stone soup with cabbage and a bit of dried fish as well, and it was fit for a king.'

Another villager managed to find some dried fish . . . and so it went, through potatoes, onions, carrots, mushrooms, and so on, until there was indeed a delicious meal for everyone in the village to share.

The village elder offered the stranger a great deal of money for the 'magic' stone, but he refused to sell it and travelled on the next day. As he left, the stranger came upon a group of village children standing near the road. He gave the silken

bag containing the stone to the youngest child, whispering to a group, 'It was not the stone, but the villagers that had performed the magic.'

Like this story, we will all work together with families contributing what they can, to help improve the growth of our children.

4.

Discuss a way to describe the PD/Hearth Concepts in the local language

5. Explain the role of the volunteer in PD/Hearth

As a volunteer you will discover how poorer families feed and care for their children. You will learn how to help caregivers whose children are not growing well. You will guide them and teach to feed and care for their children. For two weeks you will spend about two hours with the caregivers and their children cooking together and feeding their children. This session is called "Hearth". Then, for an additional two weeks, you need about half an hour each day to visit the caregivers in their homes to see if they are continuing the practices they learned during Hearth. You would visit each home every two to three days. If caregivers are facing challenges at home that are preventing them from continuing the practices they learned at Hearth, it is part of your responsibility to together find solutions with the caregiver and family members, particularly the grandmother.

You will be provided with forms to use to track and monitor the children during the 2 weeks of home visits and then again at 3 months, 6 months, and 1 year after the first day of Hearth for the Hearth participant children. We will go through the monitoring forms later on in the training. Hearth will repeat once a month (or as frequently as the country office has decided).

You will learn many new things that you will be able to apply with your own families. At the same time you will help other families in the community.'

SESSION 3

What Is Good Nutrition?

30 MIN | DAY 1

Purpose

- To learn about a variety of foods needed to help children grow well

Materials

- A variety of food available in the community set on a table. Make sure there are eggs, protein sources, fruit, vegetables, nuts, oil and staple foods. If food is unavailable, use pictures. Use examples of foods that were found to be locally available and affordable in the community.
- a cooking pot
- three large stones, each with a large label: GO GROW GLOW
- a large cooking pot
- a variety of healthy and unhealthy snacks
- hand-washing facilities (basin, water, soap or ash)

STEPS

5 Min

1. Explain

'To grow well children need to have good food and to be free from illness. Children need enough food and a variety of different types of food. We will look at what types of food to eat and how to treat illness.'

10 Min

2.

Have participants call out what types of food they eat in their community.

1. What is the main food they eat? (rice, maize, millet)
2. What are other foods they eat? (any foods they list)
3. Why do we need to eat different types of food? (they taste good, some help us not get sick, some help us not to get hungry, they help children grow)

10 Min

3.

Set up a cooking pot that rests on three large stones, with the names on the stones turned to the inside. Discuss this cooking method.

Use the cooking pot and stones to explain the three food groups:

'Is the pot balanced? (yes)

What happens if we have fewer than three stones? (Take out a stone to demonstrate.)

To make sure our cooking pot does not spill we need to place it on three stones. If we take away one stone, the pot will fall over. For us to be healthy and not 'fall', we need different types of food. We are going to call each stone a different name to remind us of the types of food we need: Energy Giving, Body Building, and Protective (GO, GROW and GLOW). (Turn the stones so they can see the names.)

What foods give us GO, that is, energy to work and walk and play? (maize, rice, millet, wheat, cassava, oil, ghee, sugars, coconut, olives). Note that both staple foods and high-fat foods are part of the Energy Giving or GO group.

Can our pot balance on one stone? *(no)*

What happens to it? *(falls over, puts out the fire, spills the food)*

We need all three stones to keep the pot balanced. Another stone is called Body Building (GROW). What do you think Body Building or GROW foods do? *(help our bodies build muscles and nerves and grow strong)*

These foods often come from animals.

Which foods on the table are Body Building (GROW) foods? *(eggs, milk, fish, fowl, meat, groundnuts, beans, peas, nuts, seeds)*

Can our pot stand on two stones? *(no)*

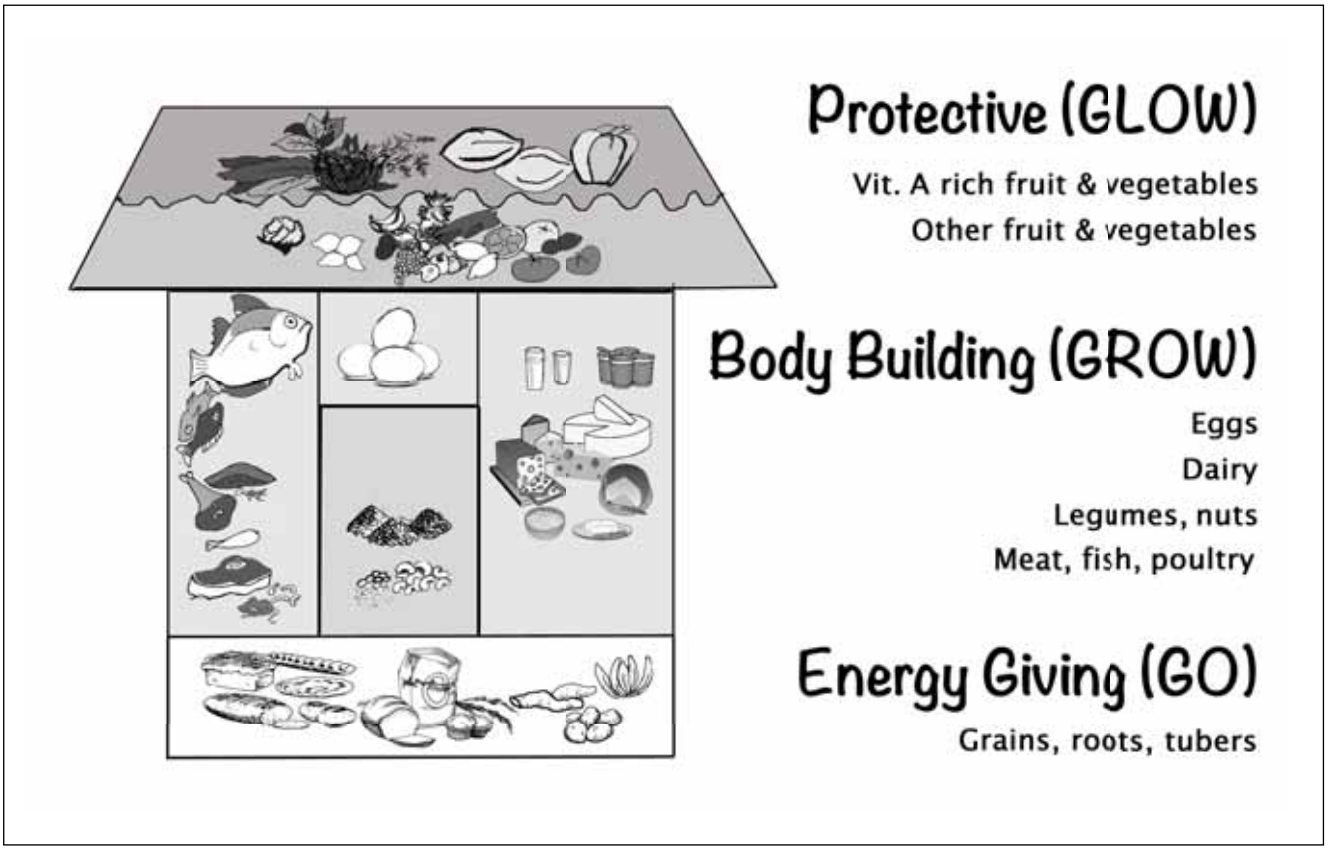
We need another stone. This one is called Protective (GLOW). What do you think Protective or GLOW foods do? *(protect our bodies from illness, make our hair, eyes and skin glow).*

They are often fruits and vegetables.

Which foods on the table are Protective (GLOW) foods?' *(carrots, pumpkin, tomatoes, dark-green leafy vegetables, papayas, mangos, oranges)*

Have each participant pick different types of food from the table. Make sure all the foods are taken. Now have the participants place the foods they picked by the proper stone.

When all the foods are placed, ask if all the foods are in the right places. Gently make any corrections.



What Is Good Nutrition?

Discuss how most people eat a low-cost staple food that forms the main part of the meal and provides energy. In many homes not much else is eaten. But to be healthy more than just this main food must be eaten. It is very important to also eat other foods in the Energy Giving (GO), Body Building (GROW), and Protective (GLOW) groups.

Discuss one food not included yet which is very important for babies and small children:

What is it? *(breast milk)*

Why is breast milk important?

(It contains exactly what a baby needs to be healthy and grow. For six months a baby does not need any other food or water.)

Why not give a baby other food or water before six months?

(baby is more likely to get diarrhoea, will take less breast milk and that will cause the supply of breast milk to decrease)

When do babies need to start to eat other foods? *(at six months)*

How long do babies need breast milk? *(up to 24 months)*

Why do babies need food at six months?

(they are more active, they need more energy and nutrients than they can get in breast milk, their gut has developed more and they can digest other food)

What happens if a baby does not get other foods at six months?

(will stop gaining weight and growing well, may not be interested in other foods later)

SESSION 4

What Is Malnutrition?

95 MIN* | DAY 1

*** plus time to mobilise the community for weighing on Day 2**

Purpose

- To learn what malnutrition looks like in children
- To learn some causes of malnutrition
- To learn the results of being malnourished

Materials

- two table-tennis balls, one perfectly round and the other crushed (or find a healthy branch of leaves and a dying branch of leaves)
- flip-chart paper and markers
- one litre boiled water
- a clean large bottle to mix oral rehydration solution
- a teaspoon
- salt
- sugar
- a small glass for each participant
- samples of healthy snack foods and 'junk foods' on a table

STEPS

15 Min

1. What does a malnourished child look like?

Ask the participants to think of a young child who is not growing well. What shows that the child is not well? Ask several participants to describe the child they are thinking of. *(listless, sad, irritable, sickly, no interest in playing, hesitant, thin arms and legs, may appear normal but be much older than the child looks)*

The girl on the right is stunted. She is 52 months old (about 4 years), while the girl on the left is twenty-six months old (about 2 years). Child stunting is very common but often goes unrecognised. It is more common than other forms of malnutrition, such as being underweight (low weight for age) or wasting (low weight for height).

Explain: 'While these signs help, we can't always tell that a child is not growing well, so we need to measure. Tomorrow, we will learn how to measure weight and mid-upper arm circumference (MUAC) to tell if a child is growing well.'

15 Min

2. Why is malnutrition a problem?

If you have table tennis balls:

Use the two table-tennis balls to demonstrate how a well-nourished child has a healthy growing pattern compared to a malnourished child.

Ask two participants to take turns bouncing the balls on the floor. Other participants should observe which ball bounces higher.

Ask two other participants to draw on a flip chart the height and pattern of the bounce of each table-tennis ball. Why does the perfect ball bounce higher?

Discuss the exercise:

How does the perfect table-tennis ball compare to a healthy child? The healthy child has more regular and more 'well rounded' growth and shows more energy. A malnourished child is like the crushed ball. This child's growth is not regular and he or she has very little energy.

Why do we care if a child grows well? *(Answers will vary, but ensure that the points below are made)*

If you have a healthy and unhealthy branch of leaves:

Use the healthy and unhealthy branch of leaves to demonstrate how a well-nourished child has a healthy growing pattern compared to a malnourished child.

Ask one participant to draw a tree that has access to a lot of rain and sunlight. Ask another participant to draw a tree that does not receive rain and only receives sunlight.

Discuss the exercise:

How does the tree with access to a lot of rain and sunlight compare to a healthy child? The healthy child has more regular growth and is "greener". A malnourished child is like the unhealthy branch. The leaves have no strength and little energy, like a malnourished child.

Why do we care if a child grows well? *(Answers will vary, but ensure that the points below are made)*

Review the consequences of malnutrition:

The results of malnutrition are very great. Malnourished children do not have much energy, are not very active, may cry often or seem very sleepy. They are much more likely to be ill with infections such as diarrhoea, pneumonia, tuberculosis and malaria. They also have an increased risk of becoming infected with HIV. When a child is malnourished, infection or illness is more likely to become serious or even cause death.

Small and sickly children are more likely to be enrolled in school late – or never – and they tend to stay in school less time. These children struggle to learn and often do not do well at school. This lack of healthy growing, both physically and mentally, will affect them throughout their lives.

As these malnourished children become adolescents, they may not have the knowledge and skill they need to become independent adults. Over their lifetime they will not be able to do as much work and will earn less than their friends who were well nourished as children. They will be less able to support their own children when they become parents. Girls will have difficulty with pregnancy or have small babies.

While all stages of a child's growth are important, the most critical time is earliest years of life. Thus children between 6–36 months who are malnourished come to the Hearth. Babies younger than six months need exclusive breastfeeding for healthy growth so are not included in Hearth.

15 Min

3. What causes a child to not grow well?

Tell the following story about Tomi. (Adapt the story to the community culture.)

Tomi is 15 months old. He is very small and very thin. Tomi has an older brother, Mo, who is 5 years old, and a sister, Sara, who is 3. Sara was born with low birth weight. Another sister was born very small and died soon after birth. Tomi's mother, Lila, is 27 years old. She is pregnant again. She breastfed all her babies, and –as the grandmother told her to - she also gives them tea and thin porridge. Lila works hard on a farm three miles from her home for a small wage. She finds the work very tiring, especially when she is pregnant. On the way back to the house she stops at the river to get a bucket of water. Once back at her house, she is too tired to do anything but cook the family's meal. Mo takes care of all the children while Lila is in the field. He tries hard to keep them clean and happy, but often Tomi has diarrhoea and a runny nose. They usually have tea for breakfast. At midday they eat whatever might be left over from the day before, but often there is nothing. In the evening the family eats maize or cassava and some green vegetables. They cannot afford meat or even beans.

Lead a discussion using the following questions:

- Who were the people in the story? What happened in the story? What was the problem? Why is Tomi too thin?

  Some of the reasons will not be clear in the story, but volunteers should think of possible causes for the problem. Have them call out reasons. You might need to ask them 'why?' to help them think more deeply. *(Tomi doesn't eat enough, not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, unclean water, worms, no shoes, grandmother tries to help but the tea and thin porridge are not good foods for babies)*

- Which is the biggest problem? Why? Does it happen in your community?

Summarise the discussion by saying there are many reasons children might not grow well. These can include practices related to:

1. food
2. care
3. hygiene
4. health seeking behaviours

15 Min

4. Nutritional status is also affected by illness

Explain that the body needs food to fight infection, but illness makes the child not want to eat. When the child eats less, the illness lasts longer or gets worse and can even lead to death. Children who are sick also will not grow well. It is important to help children not to become sick or to help children get better quickly.

Lead a discussion on childhood illnesses in the local community:

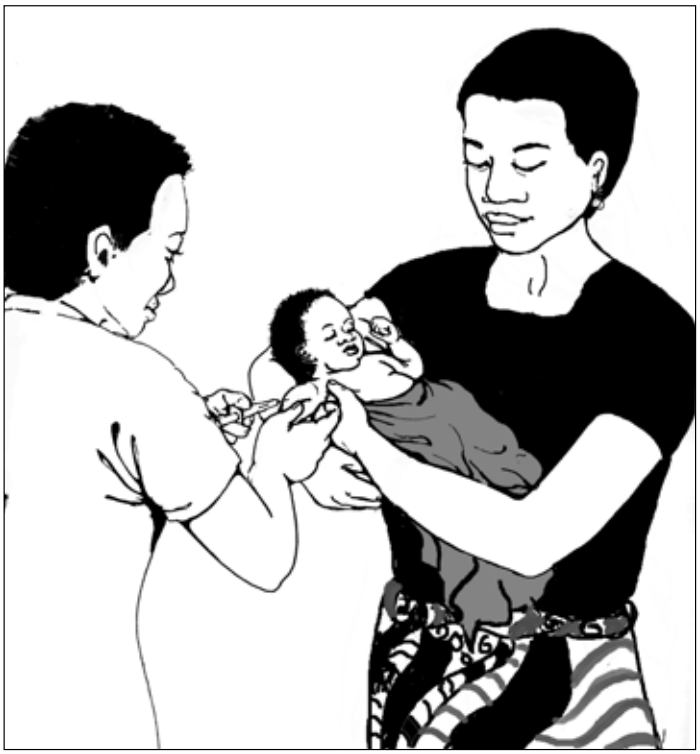
What illnesses do children in our community get?

(diarrhoea, colds, cough, fever, malaria, tuberculosis, pneumonia)

How can we help children not get sick?

Immunisation – When do children need to be immunised?

(refer to the Ministry of Health immunisation schedule)



Deworming – Why is deworming important?

(child may not feel like eating, body will not be able to use the food the child does eat, more loss of nutrients from the gut)

When do they need to be dewormed?

(refer to the Ministry of Health national protocol)

Vitamin A supplement – Why is this important?

(helps child see better, prevents blindness, helps fight infection and disease)

When do children need a vitamin A supplement?

(every six months, usually given at Health Post)

How do we treat children who are sick?

(continue to feed breast milk and give food and liquids during illness, go to the health post if the child is not getting better)

What do we do for a child with diarrhoea?

(give extra breastfeedings and other foods and liquids; give oral rehydration solution)

Review the method for mixing oral rehydration solution.

Before children enter the Hearth sessions, they should have completed their immunisations, received vitamin A supplements and been dewormed. This will give each child the best chance to recuperate from malnutrition. Volunteers will need to talk with the caregivers about this, and either send them or go with them to the health post to make sure each child has received all of these interventions.

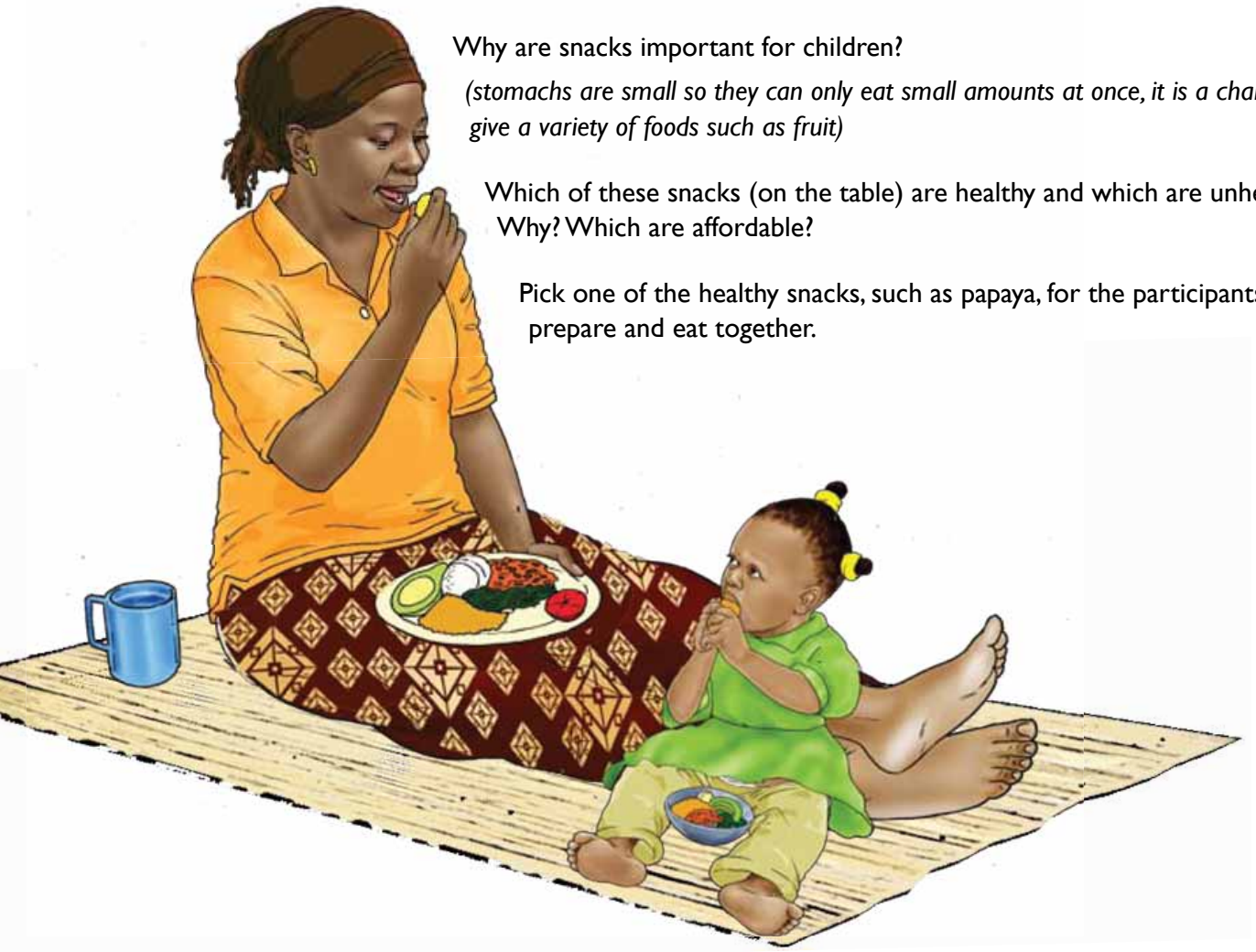
30 Min

5. Prepare and eat snack together

Discuss the importance of hand washing and the importance of snacks. Make a display of common snack foods. Include both healthy snacks (banana, papaya, mango, cooked milk, coconut, egg, groundnut, corn, yam, tortilla) and unhealthy snacks (soda, sweets, candy, crisps, junk food).

What Is Malnutrition?

One way to help children grow is to make sure they eat at least three to five times during the day. This includes meals and snacks. Lead a discussion using the following questions:



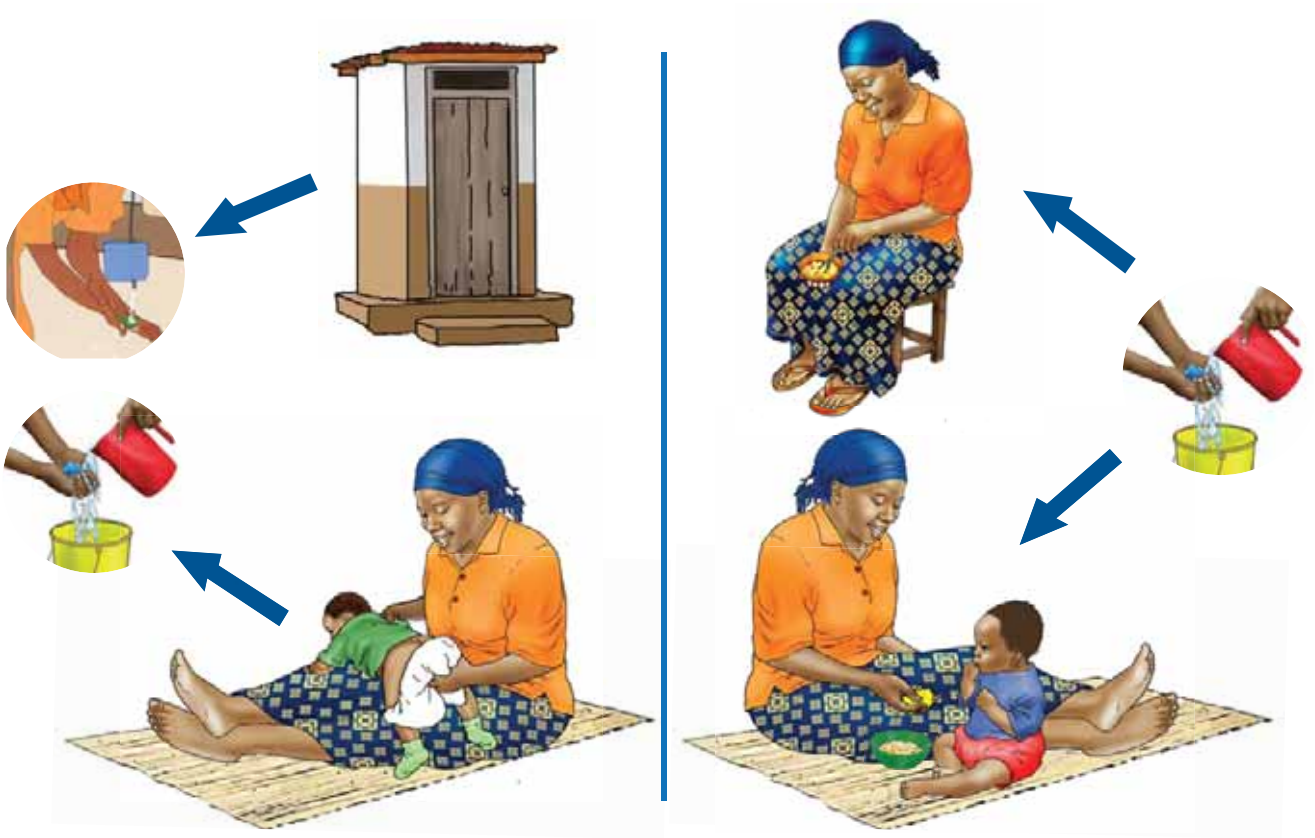
Why are snacks important for children?

(stomachs are small so they can only eat small amounts at once, it is a chance to give a variety of foods such as fruit)

Which of these snacks (on the table) are healthy and which are unhealthy? Why? Which are affordable?

Pick one of the healthy snacks, such as papaya, for the participants to prepare and eat together.

Have them wash their hands before preparing the snack. Discuss the reasons for hand washing together.



How do we wash hands? *(soap/ash and water, rub well, rinse)*

Why is it important to wash hands? *(to keep germs from spreading, getting into our food, mouths, making us sick)*

When do we need to wash our hands? *(before preparing food, before eating, after using latrine, after changing a diaper, after helping a child use the toilet, after helping a sick child)*

Prepare and eat the snack together. Wash fruit even if you are going to peel it so germs and dirt are not transferred to the flesh of the fruit, and cut with a clean knife

5 Min

6.

Ask participants to think of one new thing they learned today.

Ask them to name the three goals of PD/Hearth. *(to rehabilitate malnourished children quickly, to help families keep their children healthy and to prevent malnutrition from happening in the future)*

Ask them to name the four main reasons why children may not grow well. *(inadequate food, care, hygiene, health-seeking behaviours)*

Ask the volunteers to define their responsibility and role in PD/Hearth.

- Lead Hearth sessions *(sharing key messages with caregivers)*
- Visit households of PD/Hearth participant children for 2 weeks after the last day of Hearth
- Follow-up with the PD/Hearth participant caregivers at 3 months, 6 months, 1 year since first day of Hearth

7. Preparation for Day 2 (Field Work)

Ask volunteers to begin mobilising the community to have all households with children 6 months to 3 years old ready to bring their children to one site that is easy to access to be weighed tomorrow. The volunteers should remind caregivers to bring their children's growth or health cards if possible.

If growth monitoring (GMP) already exists in the community, organise the training so that the GMP day falls on the second day of the PD/Hearth Volunteer training day.

Tell the volunteers that tomorrow we will learn how to weigh and measure young children to know if they are growing well. Remind them of the time and place to meet. Thank them for participating.

Children are weighed the first and last days of the Hearth sessions. Volunteers will learn to weigh children using the World Vision Nutrition Centre of Expertise (NCOE) **Measuring and Promoting Child Growth** tool. Correct technique is very important and will not be mastered in just one session. For this reason, volunteers will assist those who have more experience and training in weighing children. The supervisor or health staff should attend the Hearth session on the days children are weighed in order to ensure that the weighing is done accurately. For more information on how to accurately plot child's weight on Growth chart and correctly interpret information from the growth curve, refer to Lesson 9 of the NCOE Measuring Child and Promoting Growth tool.

Purpose

- To weigh and take MUAC of children properly
- To consider factors of feeding, care, hygiene and health which are important to good nutrition
- To practise visiting skills for the Positive Deviant Inquiry (PDI)

Preparation

- Depending on the number of participants, arrange for at least 3 children between the ages of 6-36 months to be part of the practise sessions for taking weight and MUAC measurements. If there are more than 15 volunteers, additional children will be needed.
- For weighing scales, calibration and zeroing should be done prior to taking weight measurements to ensure accuracy. Zeroing should be done before every child. Recalibration should be done after every 10 children to make sure the scale is still reading properly.
    - To calibrate means to use known weights to see if the scale is reading correctly
        - Within a day before the growth monitoring session, weigh at least one or two known weight to make sure the scale is accurate, e.g 5 kg and10 kg weights.
        - If it is inaccurate, adjust the scale until it yields a correct weight measurement. This is the new 'zero'.
        - Note: If you cannot correct the scale, you may need to subtract or add the difference from the children's weight. This will increase chances for error in the children's weight. It is best to calibrate your scale BEFORE bringing it to the growth monitoring site and finding one that accurately measures a known weight.

- Zeroing: a process of adjusting the scale to 'zero'
  - Before weighing each child, check to ensure the needle on the scale points to 'zero', as determined by calibration.
  - For the hanging scale, zeroing should be done with the weighing basket or sling or pants.

Materials

- hanging scales and weighing pants (and standing scales if used in the community)
- MUAC tapes
- pencils
- recording chart
- a copy of the NCOE Measuring and Promoting Child Growth tool (available from nutrition@wvi.org or www.wvi.org/nutrition under Tools)
- weight monitoring charts, Anthro tables, and attendance charts (these will be used in the Hearth sessions)
- a picture of a healthy child and a picture of a malnourished child
- sheets of flip-chart paper, cut or torn in half, one for each group of three or four volunteers
- paper cut into a circle, one for each volunteer

STEPS

60 Min

1. Procedure to weigh a child using hanging scales

It is easiest to weigh children with two people: one person to assist the mother in placing child in the scales and read the measurement, and one person to record the weight. Use the Hearth weight monitoring charts to record the weights of children.

Prepare the scales

1. Hang scales from a strong support, such as a tree.
2. Scales must be at eye level.
3. With weighing basket or sling attached, adjust the scales to zero.

Prepare the child

The learning facilitator acts as the health worker or measurer. Ask one participant to volunteer to be the mother and a second participant to volunteer to be the recorder.

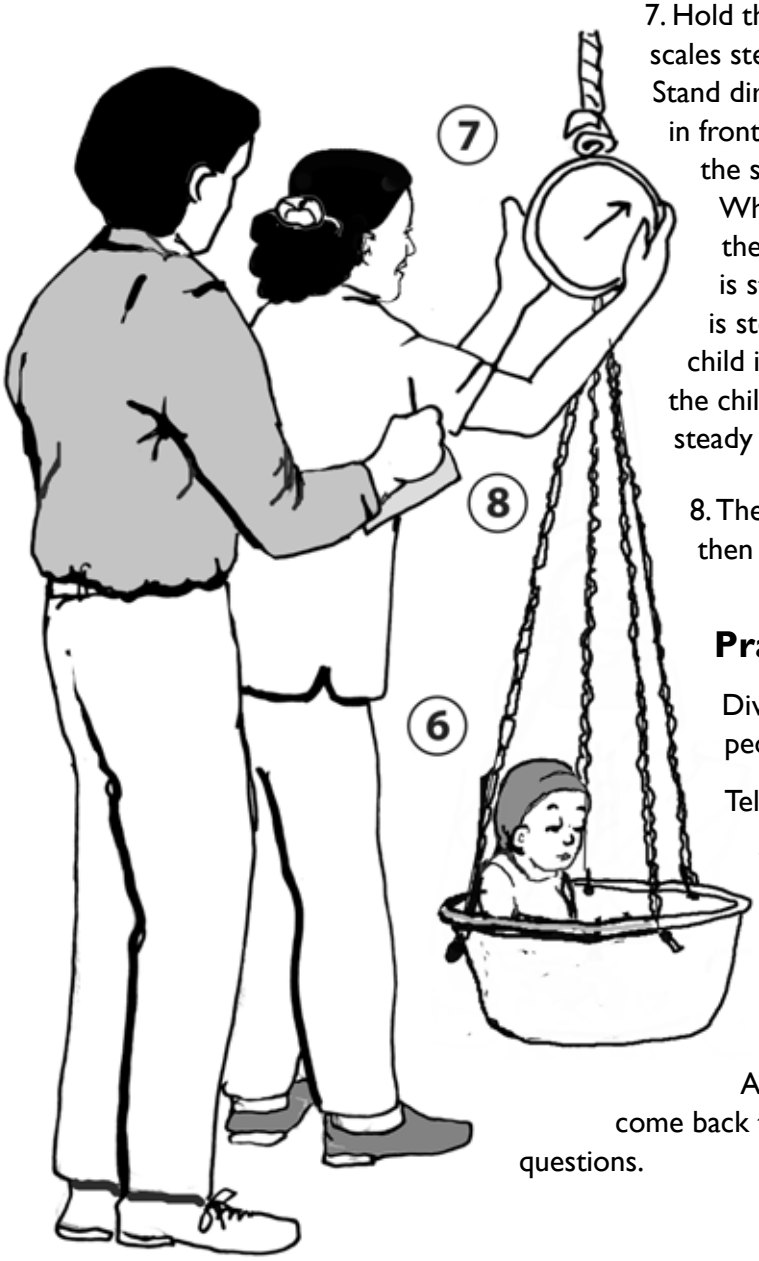
You can use a doll or a sack of grain to take the place of a child for this demonstration.

4. Ask the mother to hold the child, while removing the child's outer clothing. Do not remove the child's underpants. If the mother does not want the child to be without a covering, give her a lightweight cloth to cover the child.

Measure the child's weight

5. Place the child in the basket or sling and ensure that it is secure.

6. Carefully lift the child up by holding the straps of the basket or sling. Hook the straps onto the scales. Gently let go of the child and allow the child to swing freely. Check the position of the child to make sure the child is not touching or holding anything.



7. Hold the scales steady. Stand directly in front of the scales. When the child is still and the needle is steady, read aloud the measurement to 0.1 kg. If the child is moving about, ask the mother to talk gently to the child to calm him or her, and wait until the needle is steady before reading the measurement.

8. The assistant repeats the measurement aloud and then records the weight immediately.

Practice

Divide the participants into working groups of three people.

Tell each group to practise the series of steps you just demonstrated. They should take turns acting the part of the mother, the reader, and the recorder.

When you give these instructions, say clearly the list of steps one more time.

After they have practised one or two times, come back together as a group to discuss any challenges or questions.

60 Min

2. Procedure to weigh a child older than 24 months using standing scales

Ask a participant to volunteer to act as the child to be weighed.

The learning facilitator will take the role of the reader.

Ask another participant to take the role of the recorder/ assistant. Use the Hearth weight monitoring charts to record the weights of children.

Then demonstrate in the following order:

1. Set scales on smooth, hard surface, in good light. Scales should be out of direct sunlight because heat may affect the readings.

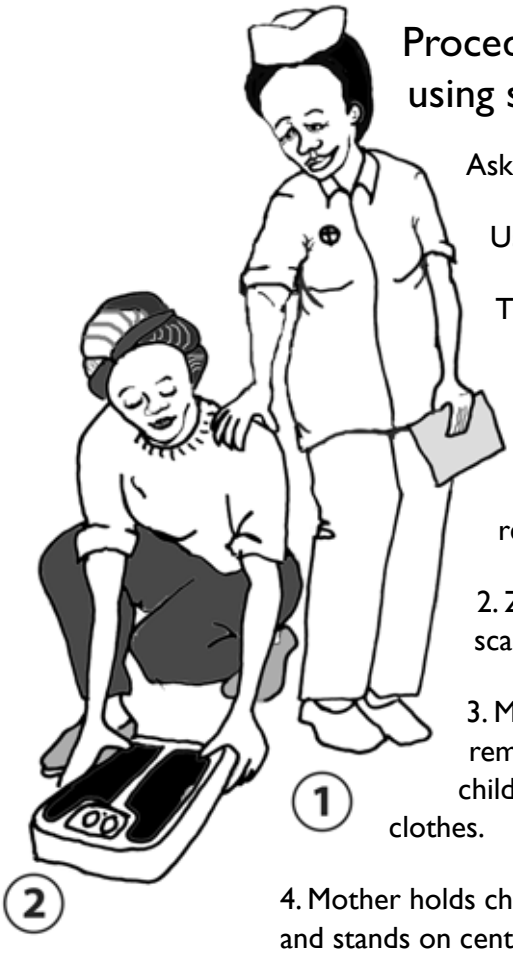
2. Reader zeroes the scales.

3. Ask volunteer playing role of the child to remove his or her shoes and any sweaters or jackets, with assistance if necessary.

4. Child stands with feet at centre of scales.

5. Reader kneels by the scales and, when the needle or digital display is no longer moving, reads aloud the weight of the child to the nearest 0.1 kg.

6. Recorder stands behind the reader and repeats the weight aloud before writing it on the form. Reader checks the accuracy of the information on the form.



Procedure to weigh a child younger than 24 months using standing scales

Ask a participant to volunteer to act as the mother.

Use a doll (or sack of grain or a rock) to represent a child.

The learning facilitator will take the role of the reader.

Then demonstrate in the following order:

1. Set scales on smooth hard surface in good light. Scales should be out of direct sunlight because the heat may affect the readings.

2. Zero the scales.

3. Mother removes child's outer clothes.

4. Mother holds child and stands on centre of the scales.

5. Reader kneels by scales and, when the reading is steady, reads aloud the weight of mother + child, to the nearest 0.1 kg.

6. Recorder stands behind reader and repeats the weight aloud before writing it on the form.

7. Mother steps off scales, gives the child to another person to hold, and then stands on the scales alone.

8. The reader reads aloud the weight of the mother alone.

9. Recorder repeats the weight aloud and records the mother's weight on the form. Recorder does the calculation on the sheet. Reader checks the accuracy of the information and calculation.

Note: *The mother's weight is recorded only to be able to calculate the weight of the child by subtracting the mother's weight from the weight of the mother + child together.*

For example:

Weight of mother + child = 59.6 kg

Weight of mother only (without the child) = 52.1 kg

Weight of child (59.6 – 52.1) = 7.5 kg

Now ask the participants to calculate the actual weight of the 'child' that was just weighed.

Discuss their answers. Are participants correct in their calculations? If not, why not? Answer any questions.

Practice

Divide the participants into working groups of three people.

Tell each group to practise the series of steps you just demonstrated. They should take turns acting the part of the mother, the reader, and the recorder.

When you give these instructions, say clearly the list of steps one more time.

After they have practised one or two times, come back together as a group to discuss any challenges or questions.

30 Min

3. Mid-Upper Arm Circumference (MUAC)

PD/Hearth Admission Criteria: Discuss the target age group (e.g. 6 months to 3 years old) and the nutritional status of children that will be included in the PD/Hearth programme (e.g. mild and/or moderate and severely underweight children). Children who are wasted (MUAC <11.5cm or 115mm) should not be included, but should be referred to the nearest health centre or hospital for proper treatment.

Ask for a volunteer to take the role of the child in your demonstration of how to take the MUAC measurement.

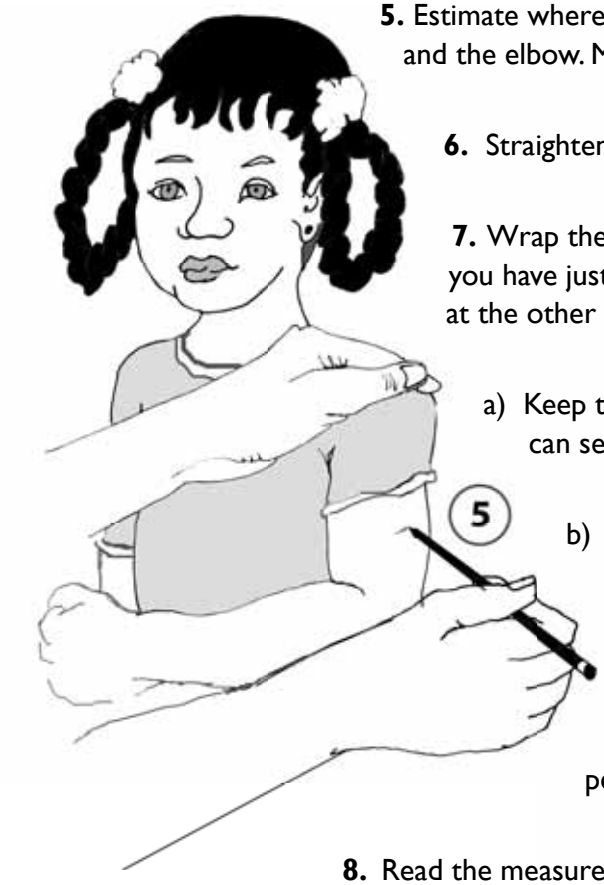
1. Work at eye level. Sit down when that is possible.

2. Ask the mother to remove any clothing that covers the child's arm.

Then we find the mid-point of the child's upper arm by doing the following steps.

3. Locate the tip of the child's shoulder with your fingertips.

4. Bend the child's elbow so the arm makes a right angle.



5. Estimate where the middle of the upper arm is between the shoulder tip and the elbow. Mark this as the mid-point.

6. Straighten the child's arm.

7. Wrap the MUAC band around the child's arm at the mid-point mark you have just made. Insert the end of the band through the thin opening at the other end of the band.

a) Keep the colours or numbers on the band right side up so that you can see them, and be sure that the band is flat against the skin.

b) Make sure the band is not too tight (if the band is too tight, this bunches up the skin and we do not get an accurate reading).

c) Make sure the band is not too loose (the band is too loose if you can fit a pencil under it)

8. Read the measurement aloud (either the colour or number which shows most completely in the wide window on the band). Ask the assistant to repeat the measurement and to record it on the form.

Check that the measurement is recorded correctly.

Gently remove the tape from the child's arm. Thank the mother and the child for their cooperation.

30 Min

4. Feeding, care, hygiene and health behaviours

Review the main reasons a child might not be growing well, as discussed on Day 1. Ask participants to name the ones they can remember.

(not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, unclean water, worms, no shoes, grandmother tries to help but doesn't always give good advice on practices)

Show the pictures of the two children. Which child looks healthy? unhealthy?

Post the picture of the healthy child on the wall.

Ask what feeding/food, caring, hygiene and health practices would have helped this child be healthy. Probe to help participants come up with as many positive behaviours as possible.

Feeding/Food	Caring	Hygiene	Health
Continued, frequent breastfeeding of infants up to 24 months	Positive interaction between child and others	Use of latrine and latrine cover	Complete immunisations (preventive)
Introduce other foods at six months	Supervision at all times	Hand washing with soap or ash after toilet, before eating, before food preparation	Mosquito nets used in malaria endemic areas
Feed 3–5 times / day	Father providing attention / affection	Safe water (boiled, covered)	Regular deworming , wearing of shoes
Variety in food; giving snacks between meals	Grandmother supports caregiver with good advice and practical care	Use of drying rack	Home treatment of sick child for minor illnesses
Active feeding	Father provides money to buy good foods for children	Keeping kitchen clean	Use of oral rehydration solution during diarrhoea
Continued breastfeeding along with appropriate liquids and foods during and after diarrhoea		Using windows and doors to air out the rooms during the day	Child is promptly taken to the health post for illnesses not responding to home treatment

60 Min

5. Wealth Ranking Exercise

(10 min) Explain to the volunteers that 'we want to identify positive deviant children in our target age group. Remember, positive deviant children are children from poor families who are healthy. To do this, we must first identify the different socioeconomic classes within our community. This exercise is called, "Wealth ranking". We and the community must believe that the PD families are truly among the poorest!'

Why do we need to do this to prepare for implementing Hearth in a given community?

Explain that it is important to do this exercise with community members because only they know how to define poorest in their community. They must agree with the final assignment of families in order to believe later that there are PD families.

The objective of the wealth-ranking exercise is to understand the way the community classifies its economic differences and to determine criteria for classifying extended families or households. If people share food, resources and income in nuclear units, then wealth ranking is done by household. If the food, resources and other income are shared across multiple, related households, then wealth ranking must consider the extended family instead.

(50 min) Choose two different versions of an object, for example, two stones of different colours. Lay the stones out on the ground with some distance between them. Explain that one stone represents the non-poor families and the second represents the poorest people. Have everyone look at the non-poor stone and reflect silently on which families in their community would go with this stone. Ask participants how they know these families are not poor. What do these families have that families in the poor category (stone) don't have? List all the characteristics. Prompt them to think about housing, farm implements, livestock, clothing, transport, occupations, amount of land owned, and so on. Does everyone agree that families in the poor category don't have these characteristics?

Now focus attention on the second stone. Remind participants that these are the poorest people. What don't they have that the non-poor families have? What income do they have? What about their houses? jobs? clothing? Do they own any livestock? What kind and how many? It may be necessary to add a third stone if the participants say there is another group which is even poorer. If so, ask for characteristics of those people. To validate the criteria, ask the participants to think silently about the poorest family they know. Do these families meet the criteria for poorest that were just agreed upon?

Agree with the volunteers on 4-5 main criteria that classify households as poor and non-poor (Refer to the Case Example on page 25 if needed). Let the volunteers know that we will be asking caregivers questions to identify their wealth status as we measure and record the children's weights and MUAC in the field.

Case Example for Wealth-Ranking Session

To be classified as poor in one sample community, a family must meet at least three of the following criteria:

- lives in one-room house (Sample Question: How many rooms do you have in your home?)
- house made of bamboo (Sample Question: What is your house made of?)
- house has dirt or cement floor (Sample Question: What is the floor of your house made from?)
- no regular salary (Sample Question: What is the job of the head of the household?)
- no more than one person in the family working (Sample Question: Who works in the family?)

Child's name and family name	Child's age in months	Wealth ranking for family	Wealth ranking (P = poor; Non-P = Non-poor)
Risa (F) Heni/Sali	31	Both parents work as vendors, rent one-room house, bamboo, dirt floor	P
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	P
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	Non-P
Agus (M)S riali/Wiarso	18	Father works part time, mother works part time, rent block house	Non-P
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	P
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	Non-P

120 Min

6. Going to the community to conduct the situational analysis: Weigh and collect the MUAC measurements of the children.

Ask the volunteers to begin mobilising the community. Once families with children less than 3 years of age have gathered, introduce the team and explain that we are here to fight off malnutrition together. The volunteers should encourage community members to define the problem of having unhealthy children in the community. Engage the community in a discussion about the issue of childhood malnutrition: discuss its causes, common challenges and constraints and ask for their ideas or suggestions for solutions.

Emphasise that we can overcome malnutrition together because good health is not only available for the rich. Good health is available for all of us, we just need to know the right foods, caring practices, health-seeking practices, and hygiene practices to follow. Introduce the concept of PD/Hearth in the local language as practised in Day 1; e.g. *Even within our own community, there are children that are very healthy and we will be learning from these households about what practices they are doing to keep their children healthy. We will then practise these learnings during our PD/Hearth programme. A healthy future for our children is available for all of us! We are going to be weighing children 6 months old to 3 years old today, so please begin to line up your children to be weighed.*

Have the volunteers organise the children and then assist the ADP staff and/or health centre staff to weigh them and take the MUAC measurements. Volunteers should assist in the classification of wealth ranking for each household by asking questions determined previously during the wealth ranking session. Wealth ranking should be conducted simultaneously as children's weights and MUAC are being measured. ADP staff will provide forms for recording weight and socioeconomic classification of each child.

After the visit, ADP staff will collect the forms with all the weights, MUAC and wealth ranking recorded. Using the data, ADP staff will identify the nutritional status of each child using the ANTHRO tables. Taking the nutritional status, wealth ranking, and MUAC data, ADP staff will be able to identify the Positive Deviant families (PDs), that is, poor families that have well-nourished children, for tomorrow's exercise. The purpose is to learn what good practices the families have that enable them to have well-nourished children. Seeing is believing. Volunteers have to be convinced of the value of PD practices in order to persuade other families to adopt them.

Organise the volunteers with the appropriate ADP project staff and health centre staff to conduct the PDIs and assign them to the households to visit tomorrow.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)*											
BOYS						**GIRLS**					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	0	3.3	2.9	2.5	2.1	F	0	3.2	2.8	2.4	2.0
M	1	4.5	3.9	3.4	2.9	F	1	4.2	3.6	3.2	2.7
M	2	5.6	4.9	4.3	3.8	F	2	5.1	4.5	3.9	3.4
M	3	6.4	5.7	5.0	4.4	F	3	5.8	5.2	4.5	4.0
M	4	7.0	6.2	5.6	4.9	F	4	6.4	5.7	5.0	4.4
M	5	7.5	6.7	6.0	5.3	F	5	6.9	6.1	5.4	4.8
M	6	7.9	7.1	6.4	5.7	F	6	7.3	6.5	5.7	5.1
M	7	8.3	7.4	6.7	5.9	F	7	7.6	6.8	6.0	5.3
M	8	8.6	7.7	6.9	6.2	F	8	7.9	7.0	6.3	5.6
M	9	8.9	8.0	7.1	6.4	F	9	8.2	7.3	6.5	5.8
M	10	9.2	8.2	7.4	6.6	F	10	8.5	7.5	6.7	5.9
M	11	9.4	8.4	7.6	6.8	F	11	8.7	7.7	6.9	6.1
M	12	9.6	8.6	7.7	6.9	F	12	8.9	7.9	7.0	6.3
M	13	9.9	8.8	7.9	7.1	F	13	9.2	8.1	7.2	6.4
M	14	10.1	9.0	8.1	7.2	F	14	9.4	8.3	7.4	6.6
M	15	10.3	9.2	8.3	7.4	F	15	9.6	8.5	7.6	6.7
M	16	10.5	9.4	8.4	7.5	F	16	9.8	8.7	7.7	6.9
M	17	10.7	9.6	8.6	7.7	F	17	10.0	8.9	7.9	7.0
M	18	10.9	9.8	8.8	7.8	F	18	10.2	9.1	8.1	7.2
M	19	11.1	10.0	8.9	8.0	F	19	10.4	9.2	8.2	7.3
M	20	11.3	10.1	9.1	8.1	F	20	10.6	9.4	8.4	7.5
M	21	11.5	10.3	9.2	8.2	F	21	10.9	9.6	8.6	7.6
M	22	11.8	10.5	9.4	8.4	F	22	11.1	9.8	8.7	7.8
M	23	12.0	10.7	9.5	8.5	F	23	11.3	10.0	8.9	7.9
M	24	12.2	10.8	9.7	8.6	F	24	11.5	10.2	9.0	8.1
M	25	12.4	11.0	9.8	8.8	F	25	11.7	10.3	9.2	8.2
M	26	12.5	11.2	10.0	8.9	F	26	11.9	10.5	9.4	8.4
M	27	12.7	11.3	10.1	9.0	F	27	12.1	10.7	9.5	8.5
M	28	12.9	11.5	10.2	9.1	F	28	12.3	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)											
BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.9
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	9.0
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.1
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.3
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.4
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.5
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.6
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.7
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.8
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.9
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	10.1
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)*									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	0	2.9	2.5	2.1	F	0	2.8	2.4	2.0
M	1	3.9	3.4	2.9	F	1	3.6	3.2	2.7
M	2	4.9	4.3	3.8	F	2	4.5	3.9	3.4
M	3	5.7	5.0	4.4	F	3	5.2	4.5	4.0
M	4	6.2	5.6	4.9	F	4	5.7	5.0	4.4
M	5	6.7	6.0	5.3	F	5	6.1	5.4	4.8
M	6	7.1	6.4	5.7	F	6	6.5	5.7	5.1
M	7	7.4	6.7	5.9	F	7	6.8	6.0	5.3
M	8	7.7	6.9	6.2	F	8	7.0	6.3	5.6
M	9	8.0	7.1	6.4	F	9	7.3	6.5	5.8
M	10	8.2	7.4	6.6	F	10	7.5	6.7	5.9
M	11	8.4	7.6	6.8	F	11	7.7	6.9	6.1
M	12	8.6	7.7	6.9	F	12	7.9	7.0	6.3
M	13	8.8	7.9	7.1	F	13	8.1	7.2	6.4
M	14	9.0	8.1	7.2	F	14	8.3	7.4	6.6
M	15	9.2	8.3	7.4	F	15	8.5	7.6	6.7
M	16	9.4	8.4	7.5	F	16	8.7	7.7	6.9
M	17	9.6	8.6	7.7	F	17	8.9	7.9	7.0
M	18	9.8	8.8	7.8	F	18	9.1	8.1	7.2
M	19	10.0	8.9	8.0	F	19	9.2	8.2	7.3
M	20	10.1	9.1	8.1	F	20	9.4	8.4	7.5
M	21	10.3	9.2	8.2	F	21	9.6	8.6	7.6
M	22	10.5	9.4	8.4	F	22	9.8	8.7	7.8
M	23	10.7	9.5	8.5	F	23	10.0	8.9	7.9
M	24	10.8	9.7	8.6	F	24	10.2	9.0	8.1
M	25	11.0	9.8	8.8	F	25	10.3	9.2	8.2
M	26	11.2	10.0	8.9	F	26	10.5	9.4	8.4
M	27	11.3	10.1	9.0	F	27	10.7	9.5	8.5
M	28	11.5	10.2	9.1	F	28	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	29	11.7	10.4	9.2	F	29	11.1	9.8	8.8
M	30	11.8	10.5	9.4	F	30	11.2	10.0	8.9
M	31	12.0	10.7	9.5	F	31	11.4	10.1	9.0
M	32	12.1	10.8	9.6	F	32	11.6	10.3	9.1
M	33	12.3	10.9	9.7	F	33	11.7	10.4	9.3
M	34	12.4	11.0	9.8	F	34	11.9	10.5	9.4
M	35	12.6	11.2	9.9	F	35	12.0	10.7	9.5
M	36	12.7	11.3	10.0	F	36	12.2	10.8	9.6
M	37	12.9	11.4	10.1	F	37	12.4	10.9	9.7
M	38	13.0	11.5	10.2	F	38	12.5	11.1	9.8
M	39	13.1	11.6	10.3	F	39	12.7	11.2	9.9
M	40	13.3	11.8	10.4	F	40	12.8	11.3	10.1
M	41	13.4	11.9	10.5	F	41	13.0	11.5	10.2
M	42	13.6	12.0	10.6	F	42	13.1	11.6	10.3
M	43	13.7	12.1	10.7	F	43	13.3	11.7	10.4
M	44	13.8	12.2	10.8	F	44	13.4	11.8	10.5
M	45	14.0	12.4	10.9	F	45	13.6	12.0	10.6
M	46	14.1	12.5	11.0	F	46	13.7	12.1	10.7
M	47	14.3	12.6	11.1	F	47	13.9	12.2	10.8
M	48	14.4	12.7	11.2	F	48	14.0	12.3	10.9
M	49	14.5	12.8	11.3	F	49	14.2	12.4	11.0
M	50	14.7	12.9	11.4	F	50	14.3	12.6	11.1
M	51	14.8	13.1	11.5	F	51	14.5	12.7	11.2
M	52	15.0	13.2	11.6	F	52	14.6	12.8	11.3
M	53	15.1	13.3	11.7	F	53	14.8	12.9	11.4
M	54	15.2	13.4	11.8	F	54	14.9	13.0	11.5
M	55	15.4	13.5	11.9	F	55	15.1	13.2	11.6
M	56	15.5	13.6	12.0	F	56	15.2	13.3	11.7
M	57	15.6	13.7	12.1	F	57	15.3	13.4	11.8
M	58	15.8	13.8	12.2	F	58	15.5	13.5	11.9
M	59	15.9	14.0	12.3	F	59	15.6	13.6	12.0
M	60	16.0	14.1	12.4	F	60	15.8	13.7	12.1

Positive Deviant Inquiry (PDI)

Note: Volunteers do not need to cover this section in full (can skip to summary)

ADP staff, community leaders, health care providers and others will be involved in the PDI. Volunteers and Health centre staff do not lead the PDI, but they can be valuable team members. ADP project staff lead the PDI session.

Preparation

- To learn how to visit families in order to learn about their feeding, caring, health, and hygiene practices.
- Print and cut apart two sets of 24 behaviour cards (see sample in Step 5).

Materials

- *Adapt and practise the story of Nasirudin (below)*

STEPS

5 Min

1. Tell the following story about Nasirudin

Nasirudin lived in a town. Often he would take a couple of donkeys laden with grass and cross the border of the town to enter the neighbouring territory. The customs officers at the border had a strong suspicion that Nasirudin was smuggling out some goods, but they could not find any. Nasirudin had only heaps of grass, which they examined very, very closely. They thought there might be small rings of gold or tiny diamonds. They even burned the grass, but in vain. Nasirudin's several crossings of the border did not reveal any smuggled goods, and he entered the neighbouring territory several times after giving a big respectful salute to the officers. But there was always a cunning smile on his face. Their police instinct told them he was smuggling something, but they couldn't figure out what.

Many years later, long after Nasirudin had stopped his comings and goings from that town and lived in another town, one of the customs officers, who had by then retired, suddenly met him.

'Tell me, Nasirudin', the ex-customs officer asked, 'what were you were smuggling in those days?'

Nasirudin looked up and with the same cunning smile said, 'Donkeys, of course'.

10 Min

2. What is the message behind the story?

(the solution to something is often right in front of us but we don't see it, look for unexpected things, don't be misled by obvious things (the grass) and miss other things (the donkeys), be open minded)

Explain the PDI:

'We want to discover what the poor families who have healthy children do in each of the areas of food/feeding, caring, hygiene and health. To learn about our community we are going to talk to caregivers and grandmothers in a group about how they feed and care for children, and we will visit some families at home to see what they do. We will also find out what foods are available in the community that poor families can afford.

We will visit during the time that caregivers are feeding their children. That way we can observe how they feed them, the care they give them and the relationship between the caregiver and other influential members of the family, such as the grandmother. We want to talk to the caregivers, including grandmothers, and ***observe*** what they do ***but not make any comments***. We need to have open minds and look for unexpected practices or ways of doing things.'

Note: Although volunteers will not lead the PDI visit, they will be valuable observers on the team. Volunteers will also help caregivers feel comfortable to answer questions honestly during home visits.

15 Min

3. What information will help us learn about feeding and caring practices?

Explain the categories of positive deviant practices:

- 'We will identify the foods which poor families use to feed their children to keep them healthy and strong. These foods are called good foods.
- We will identify the care that poor families give to their children to keep them healthy and strong. This care is called good care.
- We will identify the hygiene that poor families use to keep their children healthy and strong. This hygiene is called good hygiene.
- We will identify the health care that poor families use to keep their children healthy and strong. This health care is called good health care.

These four things, good food/feeding, good caring, good hygiene and good health care, are important in making a child healthy and strong. By learning about them from poor families with healthy children, we solve our community's nutrition problems with our own solutions. Our solutions will help families in our community learn and understand how to keep their children healthy and strong.'

Help the volunteers identify the types of information they will need. Samples are included here.

Sample Guidelines for Conducting a PDI

Good food:

- Is the child breastfeeding? If not, at what age did the mother wean the child?
- What foods is the caregiver giving the child today? Identify all the foods and how she prepares them.
- Who decides what the child will eat? What role do other family members play in child feeding decisions?
- How many times did the child eat or drink while you observed?
- Does someone help the child eat?
- Where does the family buy food? Who buys it? How much money is spent on food each day?
- How many 'meals' does the child eat a day? How much does the child eat?
- Are there any foods the caregiver does not give the child?

Good care (observe rather than asking the family, if possible):

- Who is the primary caregiver of the child?
- What roles do other family members play in the care of the child?
- Who is in the house during the day?
- Does the caregiver take the child to the vaccination post? How often? Is the child on schedule?
- Does the caregiver or others play with the child? How? How often?
- How is the child disciplined? By whom?
- How does the caregiver encourage the child to eat when he or she doesn't want to?

Good health care (ask for the health card and/or ask the caregiver these questions):

- How do you know when your child is sick?
- Was the child sick in the past 6 months? If so, how many times?
- What illnessses has the child had?
- When the child was sick, what did you do? Did you feed the child anything differently?
- What steps do you take to prevent illnesses?

Good hygiene:

- Is the house clean? Is the kitchen clean?
- Are the people clean and bathed?
- Is there a latrine? How does it look?
- Make observations on the water source.
- Do pigs, mules, dogs or other animals go in and out of the house?

The following exercise helps participants to understand behaviours and skills that are important to the nutritional status of children.

5 Min

4. Divide participants into two teams. Each team gets one set of 24 behaviour cards. Have the team members separate the cards into two piles: those with behaviours that *directly* affect the nutritional status of children, and those that do not. Tell them to be prepared to justify their choices.

10 Min

5. 

Bring the teams together. Call out each behaviour and have the team members put both hands in the air if the behaviour directly influences the nutritional status of children or put their hands behind their back if it does not. Have team members explain their choices, especially when there is disagreement about the behaviours.

Behaviour cards sample

Make two sets of cards. Write one behaviour on each card.

Thanks given for food	Nails are clipped	Use of home remedies for illness	Child is bathed every day
Boils water for children under six months old	Child eats five times a day	Mother tells stories and sings to child	Use of soap to wash hands

Child is given fruit for snack	Child breastfeeds during the day	Grandmother cares for child	Adds oil to porridge
Child is dewormed	Seeks medical help when ill	Eggs, snails, watercress, groundnuts are included in meal	Parent hits the child for not obeying
Kitchen pots are washed and left to dry on rack	Child feeds often during illness	Brushes child's teeth	Someone helps the child eat
Sleeps with window open	Child eats from own bowl	Washes hands after using latrine	Child wears sandals

15 Min

6. What do children eat in one day?

Explain the 24 hour recall:

'We want to find out what families feed their children. Think about what you ate yesterday. Can you remember everything you ate? Is it easy to remember? *(no)* We want the caregiver to tell us each food she gave the child yesterday. To help her remember, we will start with breakfast and work through the day. Ask questions to help her remember but be careful not to give her suggestions.'

Role play: Facilitator with one participant. Ask for a volunteer to act the part of the caregiver (e.g. mother or grandmother). The facilitator plays the part of the volunteer visitor. Start with breakfast and work through all the foods the 'caregiver' gave her child yesterday till bedtime. Use questions like these: What did you give Mari first? Anything else? How did you make that? Did you add anything else? Did Mari have anything else with that? What did she eat next? At what time? Thank the volunteer 'caregiver'.

Answer any questions from the participants. Divide into pairs. Practise this method to find out what each partner ate yesterday.

Emphasise that the way questions are asked is important. For example, ask, 'What did Mari eat when she got up yesterday?' *(rice)* 'Did she have anything with the rice?' *(beans)* 'Anything else?' Do not suggest answers by asking, 'Didn't she have beans with her rice?' Caregivers will often answer with what they think the interviewer wants to hear. It is important that caregivers feel free to answer accurately.

5 Min

7. Observation exercise

Have participants stand in pairs facing each other and carefully observe each other for 30 seconds. Then ask them to stand back-to-back and change one thing about their appearance (take off an earring, put on glasses, button a cuff, for example). Partners then face each other again and see if they know what changed. Ask how many observed correctly. Emphasise the importance of **good observation** in order to explore behaviours through the cultural lens of the community and of **probing communication** to glean information without bias.

15 Min

8 Role play visiting families

Divide participants into groups of five. Each group will have an 'interviewer', 'observer', a 'mother' and two 'children'. Group members will practise either scenario 1 or scenario 2 for a family visit. The 'interviewer' will talk with the 'mother' about feeding, care, health and hygiene. The 'observer' will listen and look to see what other information he or she can learn that will be valuable.

Scenario 1: This role play portrays part of a PDI. During the part shown, the interviewer focuses on feeding practices. The PD child is a well-nourished 30-month-old girl. Her mother says the child eats only during the two daily meals. However, a sibling in the room is sharing a snack with the child (who is fed constantly by older siblings, grandmother and neighbours). In this culture 'meals/feeding' means a meal with rice. The mother talks very little. While she is being interviewed, the sibling washes the child's hands, scolds the child when she drops something and tries to pick it up to eat it, plays with the child, gives the child a drink, and so on. (The interviewer and mother don't interact with the child or sibling during this time.)

Scenario 2: This PDI visit is being made to a family with five children. The 3-month-old baby is breastfeeding, and there is also a 2-year-old present. The older brother and sisters are in school. The mother is talking about the help she gets from her mother-in-law who instructs her on breastfeeding, preparing meals for the 2-year-old child, and general child care. They have a small garden and use the vegetables in the porridge and sauce she makes. The child is outside putting a dirty stick in her mouth. The mother-in-law stops her, washes the child's hands and then feeds her a banana as a snack. The interviewer then switches the discussion to snacks and foods at different times of the day and does a simple 24-hour recall of food eaten. She also engages the mother-in-law who has just entered the house.

15 Min

9. Discuss the role play

- What did they like?
- What did they learn?
- What surprised them?
- What did they find hard?
- What would they do differently?

Be sure to emphasise that the PDI team is not to give answers or make comments. The team is there to learn from the caregivers.

10 Min

10. Scenario 3: Introduce the do's and don'ts of doing interviews

Have four people perform the following skit, deliberately exaggerating to draw out bad technique in a funny way:

The PDI team arrives at the house. The members do not introduce the team properly. They say they want to visit the mother because she is poor and they want to find out how she manages to feed so many children. The interviewer's cell phone goes off. As she answers it, the other members of the PDI team start talking, laughing and eating candies, not offering any to the mother. The mother says she has six children and the interviewer makes a disapproving face. The interviewer has a long list of questions in a big book and reads one after the other, not listening to the answers the mother gives. When the mother says the youngest child has diarrhoea, the interviewer starts to lecture her. The team seems bored and disrespectful. The mother says she is busy and would like them to leave. The interviewer keeps insisting on asking 'a few more questions'.

After the role play discuss with the group what was good about the interview team's approach. Discuss what was not done correctly. Talk about the do's and don'ts of doing interviews. Emphasise important skills to remember:

- Be wise and respect the family. Be friendly and polite.
- Introduce yourself, congratulate the family members on their good work and ask permission to observe and talk to them.
- Include all influential family members in the discussion.
- Don't ask them why they are poor.
- Remember that the team is there to learn, not to criticise or lecture.

10 Min

11. Logistics

Explain that today the volunteers will be visiting families to discover the good feeding, caring, hygiene and health behaviours they practise. Explain where to meet, how the visits will be organised and what they will do with the information they gather.

Organise groups to conduct home visit PDIs (4 groups); Market Survey (1 group), Transect Walk (1-2 groups), and Focus Group Discussions (1-2 groups). Give each PDI team the names of the families it is to visit. **The volunteers will not lead these activities but will participate in them.**

Feeding Back to the Community and Visiting Families

Purpose

- To share results of the nutrition assessment with the community
- To conduct a Positive Deviant Inquiry in the community

STEPS

20 Min

1.

Review with the volunteers the initial assessment information (results of weighing and findings from group discussions) and discuss how this could be communicated to the community. Divide the volunteers into groups to practise creative ways of sharing the assessment findings with the community. Two examples are provided as a guide.

Example 1

Use green and yellow maize leaves to show healthy and unhealthy plants. Discuss why the yellow leaves are unhealthy and ways to make the plants healthy. *(use manure, weed them, space them properly, fertilise them)*

Link the maize leaves with children. Some children are growing well, and some are not. Why? *(not fed enough, not fed often enough, not well spaced, sickly, not enough variety of food, parents absent)*

Use stones to show proportion of children who are like yellow leaves (malnourished) and those who are like green leaves (well nourished). What makes the difference between these groups of children? How have caregivers in the community tried to help their children grow better? What do some families do to keep their children well nourished?

Example 2

Make a very large 'Road to Health' card. Plot every child that was weighed in the community on the chart. Use the colours green, yellow and red to show the difference in levels of malnutrition. Talk to the community about how healthy children's growth follows the curve. Ask how many children there are. How many are not growing well? How can they tell? Why do they think they are not growing well? What have they tried before to help children grow better?

Are any children growing well? Why do they think that is? Are there things these families do that we could learn from? What have they tried? What has worked? Introduce PD/Hearth – discovering together what these families do so all can have well-nourished children.

60 Min

2.

Mobilise the community again. The volunteers will then share the nutrition assessment results and the findings from the group discussions with the community and community leaders.

150 Min

3.

After feeding back to the community, break off into the respective groups.

- Each PDI visit will take two to three hours and should cover a time when the caregiver is making food and feeding the child, if possible (4 or more groups).
- The Market Survey team will visit the market and shops to determine food availability and what is affordable for families (1 group).
- The Transect Walk group will conduct a community mapping exercise to observe the good things and not so good things in the community that might affect the children's health. (1-2 groups).
- Focus-group discussions (FGD) will be held with caregivers and grandmothers to determine the normal feeding and caring practices in the community (1-2 groups).

NOTE: *Use formats provided by ADP Project Staff for each activity*

Using the Information Gathered

SESSION 8

210 MIN | DAY 4

Purpose

- To find positive common practices from the information gathered from each PDI group

Materials

- Flip charts and markers
- Props to illustrate Hearth activities (e.g. soap and towel; cooking pot and utensils)

STEPS

30 Min

1. Present the PDI Findings

ADP staff, with the help of volunteers, will gather the information from the FGD, PDI, transect walk and market survey. Present a summary of the information in a field-visit summary sheet (see format below). Use an asterisk (*) to indicate which practices are from the family visit. Points without an asterisk indicate common practices in the community.

PD Food/Feeding	PD Caring	PD Hygiene	PD Health Seeking
Non-PD Food/ Feeding	**Non-PD Caring**	**Non-PD Hygiene**	**Non-PD Health Seeking**

45 Min

2. Identify Key Hearth Messages from the PDI Data

In the large group ask each small group to explain the findings of its PDI data. Show what behaviours were found in the PD families' homes and what behaviours were found in the non-PD homes or learned through FGDs, transect walk, or market survey.

For behaviours considered positive, ask the group whether the behaviour could be practised by a poor family or only by a non-poor family. In other words, is it feasible, easy to do, and affordable?

Ask each group to identify behaviours that are practised by more than one family. The group should highlight these practices and indicate how many times that behaviour was observed. This serves to illustrate common threads among the PD families.

Work together to develop a summary chart of special foods, behaviours, skills, practices, and messages that should be emphasised in Hearth sessions. Tell volunteers that we will learn how to use this information to help families with malnourished children.

Choose 6 key messages to be shared with caregivers during the Hearth sessions, and ensure the volunteers are very familiar with these.

10 Min

3. Preparing for the Hearth sessions

Volunteers play a key role in the preparations for the Hearth sessions. Introduce the steps involved, explaining that these activities should be done with the help of the supervisor/trainer and the support of the community.

i. Identify the volunteers that will lead the Hearth Sessions (responsible for sharing key messages)

ii. Become familiar with 2 Hearth menus and how to cook them

iii. Conduct a short home visit to each family who will participate in the Hearth session. Meet with the caregiver and grandmother and identify if child is truly from a poor family and is malnourished. Invite them to an orientation meeting.

iv. Conduct an orientation meeting for PD/Hearth participant caregivers. Volunteers need to be sure the following topics are discussed:

- **Importance of immunisation, vitamin A supplements and deworming**

  Check that each child's immunisations are complete, that the child has had the vitamin A supplement and that he or she has been dewormed. If not, encourage the caregiver to go to the health post to have these completed before the sessions begin.

- Explain **where to meet the first day,** what the programme will be and what the caregivers need to bring (e.g. ingredients, firewood, plates/bowls/cups, spoons).
- Agree on **a suitable location** for the Hearth sessions. The location should have:
  - Adequate space for caregivers to cook and children to play in the shade
  - A source of water
  - A latrine close by

Note that the home visits (step iii) and orientation meeting (step iv) will be carried out on Day 5 of this training. Encourage the volunteers to notify caregivers that they will be visited in their homes tomorrow by ADP/Health Centre staff and PD/Hearth volunteers.

60 Min

4. What happens in a Hearth session?

Introduce the activities include in Hearth sessions:

- arrival of caregivers and children; taking attendance
- weighing children (on the first day and last day only)
- •collecting food contribution
- hand washing and preparing/serving a snack
- playing with children
- food preparation
- hand washing and feeding children
- planning for the next day – contributions, tasks
- clean up

Remind the volunteers that each of these activities provides an opportunity to help caregivers learn behaviours and skills that will help their children grow well. Caregivers will learn best through informal conversation and hands-on activities, not lectures.

Set up each of the activities of the Hearth session as a 'station' around the room. Use props (for example, soap and water at the hand-washing area; a pot, a spoon and some food at the cooking area). Go to each station as a group and discuss what caregivers can learn there. Demonstrate the conversation or activity at each station. Ask participants to role play interacting with the caregivers. Emphasise learning while doing and using conversation based on the activities to discuss reasons for each of the practices being promoted. Use the list below as a guide.

Key roles and messages appropriate to different activities of the Hearth sessions:

Arrival of caregivers and children; attendance

- Welcome the caregivers and children with respect.
- Make a positive observation on the appearance of both child and caregiver.
- State the importance of coming every day to see change and learn new practices.
- Ask how things are going at home; troubleshoot and share observations.
- Encourage commitment of both families and community.

Weighing children

- Importance of child growing well
- Growing well enables the child to learn better
- Growing well makes the child stronger
- Growing well results in better health.

Collect food contribution

- Cost and sources of nutritious food
- Food variety
- Safety of food
- Positive reinforcement of healthy choices
- Nutritious accessible foods
- Proper storage
- Where foods can be found and gathered
- Food production/home gardens

Handwashing/ hygiene

- Demonstrate proper hand-washing technique
- Use of soap
- Times when hand washing is important
- Why we wash hands: bacteria and germs contribute to illness/diarrhoea
- Treatment of diarrhoea and illness, and when to seek health care
- Immunisation, de-worming
- Nail cutting
- Personal hygiene
- Latrine use
- Use of shoes

Key roles and messages appropriate to different activities of the Hearth sessions continued:

Snack

- Frequency of snacks and meals
- Why it is important to feed children 4–5 times a day
- Healthy snacks that require little or no preparation
- Consistency of food
- Food groups
- Nutritional value of food
- Importance of including a variety of food each day
- Breastfeeding
- Food storage

Cooking

- Nutritional value of food
- Sources of affordable food: food production/home gardens, barter, gathering
- Variety of food
- Good cooking techniques
- Food hygiene and safety
- Food storage
- Palatable food
- Importance of feeding children 4–5 times a day
- Hearth is an extra meal

Child stimulation/playing games with children

- Modelling play and care of children
- Motor skills and cognitive development
- New ways to stimulate children
- Singing, dancing, clapping games, and so forth
- Social skills, sharing and cooperation
- Appropriate touching/affection

Key roles and messages appropriate to different activities of the Hearth sessions continued:

Feeding children

- Active, responsive feeding
- Food content (colours, nutrients)
- PD foods
- Importance of meal frequency (4–5) times a day
- Breastfeeding
- Portion sizes
- Troubleshooting feeding problems
- Food taboos
- Active healthy children related to well-fed and well-nourished children

Planning for the next day

- PD foods
- Local and affordable foods
- Quantity of food
- Food combinations – variety, colour
- Ownership/empowerment
- Nutrient value of food – importance of variety
- Where to find foods
- Planning menus and budgets
- Importance of returning the next day

Clean up

- Hygiene – clean surfaces and utensils
- Use of leftovers
- Food safety
- Food storage
- Reuse water, compost
- Latrine use and cleanliness
- Respect for others

30 Min

5. Monitoring Forms

Introduce the 2 monitoring forms that volunteers will use (see monitoring forms at the end of the session). Explain each carefully. Practise filling the forms out correctly. Note: it is not mandatory to use these forms, but they are designed as Job Aids to support the work of the volunteers.

Monitoring Form 1 (Job Aid): The Checklist of Materials Needed for Hearth Sessions is designed to help in preparing all the items for the Hearth sessions. Discuss who might provide each of these items and how to fill in the form.

Monitoring Form 2 (Job Aid): The Menu and Cooking Materials form keeps track of the ingredients and cooking materials for the menu, and the contributions each caregiver brings to the Hearth sessions. Work with the volunteers to fill out the form.

20 Min

6. Song preparation

Have participants work in small groups to create a song about one of the key behaviours emphasised in the Hearth sessions. *(For example, how to prepare and use an oral rehydration solution, feeding children 3–5 times a day, or hand washing after*

toileting and before eating.) They should use simple language, perhaps rhyming, a well-known tune, repetition and actions. Have each group perform its song. Have the whole group learn one or two of the songs.

15 Min

7. Review the day

Ask participants: What is one new thing that you learned today?

Explain to the volunteers that the next day they will be going through each step of the Hearth session just as they will do in their sessions with caregivers and children. They may all work on one menu or, if there are a large number of volunteers, divide them into two groups with each group cooking a different menu. Explain the menu(s) you will be making. These menus are based on what we learned from the caregivers with well-nourished children whom we visited. Explain that just as caregivers will bring a food contribution to the Hearth sessions each day, each volunteer will bring a food contribution to make the menu the next day. Decide together who will bring each food item needed to prepare the menu the next day.

Thank the volunteers for their great work and remind them of the time and place to meet tomorrow.

NOTE: *ADP project staff should use the data collected from the PDI, FGDs, and Market Survey to develop 2 menus suitable for the community's context, using locally accessible, affordable ingredients). Try cooking the menus in preparation for tomorrow's session.*

Monitoring Form 1
Materials Checklist Needed for PD/Hearth Sessions

Day 4 Session 8

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice,fufu, yams)			
Oil			
Other ingredients			

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 3	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 5	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Monitoring Form 2 – PD/Hearth Menu and Cooking Materials Tracking Sheet - Continued

Day 4 Session 8

No.	DAY 7	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 9	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 10	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 11	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 12	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

3 hours training session
1 hour field work

Preparation

- To practise menu preparation
- To learn what happens in a Hearth session
- To prepare participating caregivers for the Hearth sessions

Materials

- cooking pots and utensils
- food for recipes
- spoons, cups, plates
- household measures

Note: *If possible, arrange for a few children from the community to participate in the practice Hearth session.*

STEPS

5 Min

1. Introduction to Practice Hearth Session

Explain that today's lesson will be a practice Hearth session, including preparation of the menu and snacks, just as the volunteers will do for the actual Hearth sessions. Volunteers will act as the caregivers of malnourished children for the role play.

The Hearth menu is based on the information gathered in the PDI. The menu will be developed and evaluated by staff to ensure that it meets programme requirements. For example, menus must have enough nutrients (nutrient density) to enable children to recover quickly from malnutrition. Volunteers are not expected to do these menu calculations.

Tell the volunteers that each menu will include a main dish and a snack. Each menu has the exact type and amount of food that children need to have energy (to GO), build their bodies (to GROW) and not become sick (to GLOW). Explain that this is a special meal, like a medicine, to help malnourished children gain weight quickly. It is an **extra** meal, not a replacement for other meals eaten at home.

Remind the volunteers that their job is to guide and support caregivers while they develop new habits to care for their children. Caregivers learn by doing the activities. Caregivers will take turns doing different jobs. The jobs include:

- Helping to prepare the location and start the fire (caregivers need to come 15 minutes early)
- Cooking
- Playing with children
- Cleaning up

105 Min

2. Practise and discuss together the steps of the Hearth session

The facilitator will act as the volunteer and the participants will act as the caregivers coming to the Hearth session. Ideally a few children from the community will be involved as well.

(10 min) As each 'caregiver' arrives, thank them for attending and for their contribution of food.

Gather around the table or mat with the foods on it. Ask volunteers what three types of food we need to have to make sure we are healthy *(GO, GROW, GLOW foods)*. Review the three types of stones that hold up the cooking pot. Ask them to rearrange the food on the table in the three groups. Explain any corrections that are needed. Congratulate them on their great work. If PD foods or recipes were identified in the PDI, ask the volunteers to point out which foods these were or explain the combination used.

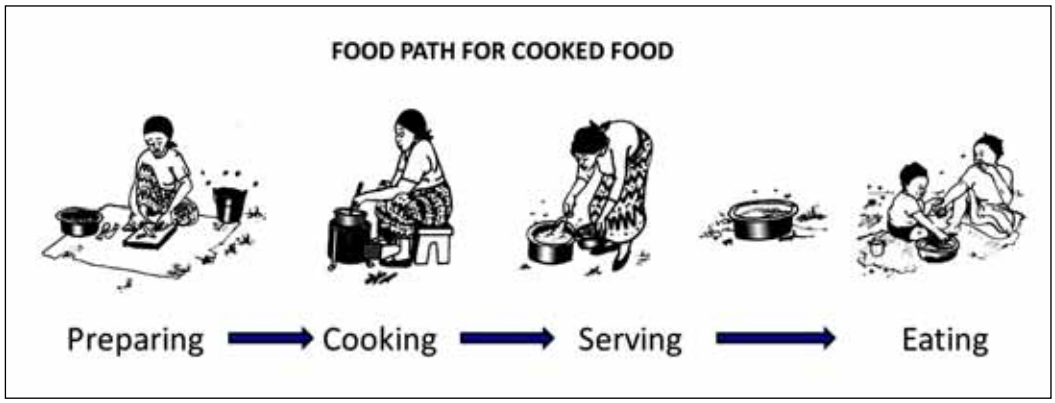
(10 min) Explain to the volunteers that we are going to learn how to prepare the menus they will use in the sessions. Wash hands. Check for short nails. Explain how to wash *(with soap or ash),* when *(before cooking, eating, feeding children, after using latrine) and why (to get rid of germs that can make us sick)*. Emphasise the importance of good hygiene.

(10 min) Prepare the snack. Wash the hands of the children before giving them the snack. Show them good hand-washing technique. During hand washing, talk to the children about why, when and how to wash their hands.

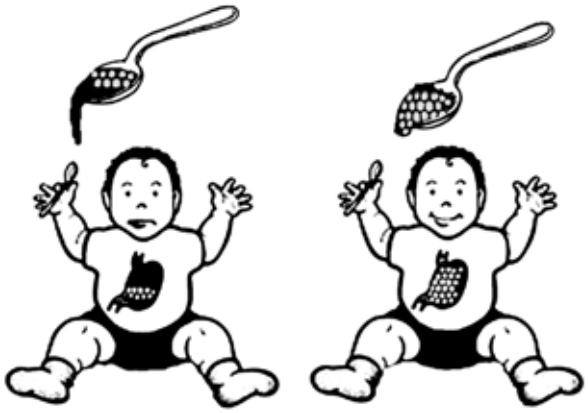
Point out to the volunteers that a snack provides nourishment for children while they play and the caregivers cook. Explain that children need to eat small amounts frequently, and the snack provides nutrients in addition to those in the main meals.

If no children are present for this session, the volunteers can eat the snack. Explain as they do that during a Hearth session some caregivers would play with the children and others would be cooking. These jobs would alternate on different

days. Sing a child's action song together. Review together some games they can play with the children: singing games, clapping games, telling stories, playing peek-a-boo, action songs, stacking blocks, rolling a ball.



(45 min) Divide the volunteers into groups. Have each group cook the Hearth menu food. Guide them. Demonstrate techniques. Talk about food safety *(heating leftovers, cooking foods well, washing food before preparation, washing hands).*



Emphasise the importance of good consistency in the food; if there is too much liquid the child's stomach gets full without an adequate amount of the food he or she needs to keep healthy and to grow. The food should fall off the spoon in globs, not pour off. Let them know that this is what they will do with the caregivers during the Hearth sessions.

If grandmothers will be participating in the Hearth sessions as additional caregivers (e.g. caregiver-grandmother pairs), explain that their role during the cooking session is to support the caregivers in the preparation of the meal, through conducting small tasks or providing advice.

(15 min) When the meal is prepared, gather the participants and explain the menu. Discuss the consistency of the food, whether it includes GO, GROW and GLOW foods, and the amount each child will need to eat. Divide participants into pairs or groups of three. One person will act as the caregiver, one as the child, and if there are three people, the third will act as the grandmother. Give each 'caregiver' or 'caregiver-grandmother pair' a child's portion. They will feed the 'child'. The 'child' will pretend not to eat, or to need help.

Discuss the role play:
Explain about active feeding, and why it is important.
Show how caregivers and grandmothers can encourage children to eat.
Explain that children should be offered more if they finish their whole portion.
Some children will not be able to eat all the food during the first few days.
Sometimes a malnourished child vomits the meal or has diarrhoea. If this happens, volunteers should encourage the caregiver to clean the child up and offer the child more food. As the child improves over a couple of days, he or she will be able to eat more and more.

Repeat the exercise two more times to give every person an opportunity to play all the roles.

(15 min) Clean up the cooking area. Talk about the menu for the next day, the contribution that each caregiver will bring, and who will do which jobs.

5 Min

3. Observing changes in children

The goal of the Hearth sessions is to help children quickly gain weight and become healthier. By using the special menus as extra food, or 'medicine', and by practicing good food/feeding, care, hygiene and health behaviours, caregivers will begin to see changes in their children. Ask the participants what changes they think they might see. *(child more active, less crying, eats more, more alert, smiles more, gains weight, less frequently sick)*

15 Min

4.

Discuss the session together with the volunteers. Answer any questions they may have. How did they feel about the session?

10 Min

5. Monitoring

Note: The level of literacy of the volunteers will affect how much detail they need on monitoring and how these monitoring forms can be used. In some programmes, pictorial monitoring forms have been developed for volunteers to use.

Discuss the importance of being able to follow the progress of each child and of the Hearth sessions overall. This is called monitoring. Ask the volunteers what they think is important information to keep track of *(how many children attend Hearth, how many caregivers attend, what caregivers contribute, do children gain weight)*. Explain that this information will help show if any changes should be made to the way the Hearth sessions are being conducted. It will also help the volunteers to talk to community leaders and health care providers about the changes they see in the children and why those changes are taking place.

The monitoring forms should be shared with the supervisor or trainer of PD/ Hearth every time they visit. The supervisor or trainer will also provide support in talking with community members about the information volunteers have collected on the Hearth sessions.

40 Min

6.

Introduce the monitoring form "Child Registration and Attendance" that volunteers will use (see monitoring forms at end of the Session). Explain it carefully and practise filling the form out correctly.

Monitoring Form 3: The Child Registration and Attendance form is to help keep track of the children, caregivers and grandmothers (if applicable) who attend the Hearth session, and to see how often they come. Carefully go through this form together, filling in the information at the top of the page and then the information for one child. Show the volunteers how they will keep track of the attendance by putting a check mark (√) or 'x' beside the child's name each day they and their caregiver attend. This form **must** be used to monitor the Hearth sessions. Use the version which includes grandmother attendance if applicable.

60 Min

7. Field Work

Conduct home visits for participant caregivers (or caregiver-grandmother pairs) and conduct orientation meeting to prepare for the first day of Hearth.

Note: *The field work could be done before the day's training session if more appropriate.*

Note: Following this session, the Hearth sessions will be conducted and Day 6 of this training will continue after the first week of the Hearth session, before the second week begins.

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Hearth Participant Child AND Primary Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Monitor Form 3 Child Registration Form and Attendance (Including Grandmother)

ADP Name ..... Village Name .....Name of Hearth .....

Hearth Session Dates(dd/mm/yyyy): From .....To ..... Number of Children Participating ..... Name of Volunteer .....

#	Name of Child	Caregiver's Name/Grandmother Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	**Attendance for Child and Caregiver***											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

#	**Attendance for Grandmother**											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

SESSION 10

Reflection and Follow-up to Hearth Session; Graduation Criteria and Follow-up Growth Monitoring

World Vision

150 MIN | DAY 6

This day of training should take place after the first week of Hearth sessions but before the second week begins.

Preparation

- To practise conducting a reflection time with caregivers
- To understand the reasons for follow-up visits and how to conduct them

Materials

- None

STEPS

1.

Explain that new habits take time to learn. Caregivers have a good start during the Hearth sessions but they need help to recognise the changes they see in their children. This can be done by having a reflection time together. Caregivers also need encouragement to continue the new practices in the weeks after the Hearth session. Volunteers will visit caregivers and grandmothers in their homes during the two weeks after the Hearth sessions to help caregivers overcome any problems they might have in maintaining the new practices and to encourage grandmothers in supporting the new practices.

25 Min

2. Role play a reflection time

To help caregivers recognise changes in their children and relate those changes to the extra food and care they are giving, it is important to spend time reflecting with them on the last day of Hearth. The facilitator plays the part of the volunteer and each volunteer represents one caregiver or grandmother during the role play.

Gather all the 'caregivers' in a circle on a mat. Say, 'We are on the last day of Hearth. What do you think? Did you like it? What was your child like before the Hearth sessions started?' Allow time for each 'caregiver' to answer. Then ask, 'What is your child like now? What do you think has made the difference? Do you think you will be able to continue these practices at home? What problems do you think you might have?'

Brainstorm together on ways to overcome obstacles that caregivers might face. Congratulate them on their great work.

After the role play answer any questions the volunteers have. Ask:

- What new behaviours do we want caregivers to learn during Hearth sessions?
- Do you think caregivers will be able to do these things at home? Do you think the grandmothers can support the caregivers in doing these things at home?

10 Min

3. Role play a home visit

To encourage caregivers to continue implementing the new practices from Hearth, a volunteer will visit each one in her home every two or three days for two weeks following the Hearth sessions. These are not just social visits. Emphasise the importance of the follow-up home visits in ensuring behaviour change and helping families find solutions. Perform the following role play of a home visit with different facilitators acting as the 'volunteer', 'mother' and 'grandmother'.

The volunteer 'drops in', chats with the mother and the grandmother about neighbourhood news, and inquires about the child. (The child is off playing at the neighbour's.) The volunteer points out to the mother and the grandmother that the child's new-found energy and interest in playing are good signs of recovery. The mother mentions that the child had a bout of diarrhoea. When the volunteer asks how she treated it, she says she had ORS but gave tea instead because she couldn't remember how to prepare ORS and the grandmother couldn't either and so suggested tea. The volunteer explains how to prepare ORS to both the mother and grandmother and asks them to repeat the directions. She asks whether the child's appetite is good and the mother says yes and that she is giving extra food. The volunteer says she will check in the day after tomorrow, reminds the mother and grandmother of the final weigh-in next Friday and congratulates them for their efforts to make their child healthy.

After the role play, ask participants:

- What examples of encouraging the caregivers did you see?
- What good behaviours did the volunteer emphasise?
- How did the volunteer help the mother and grandmother see the change in the child?
- What behaviours and feeding practices did the volunteer reinforce?
- How long was this home visit? How many visits could a volunteer do in one day?

Emphasise once again the importance of the follow-up home visits in ensuring behaviour change and helping families find solutions.

5 Min

4. Indicators of behavioural change

Ask participants to list some indicators of behavioural change they might observe on the home visits. Write these on a flip chart. Examples include:

- The child is receiving extra food.
- There is evidence of better health-seeking behaviours (what the caregiver does when the child is sick, attendance at health post, extra feeding).

See the sample PDI questions/checklist (Session 6, Number 3) for other indicators.

10 Min

5. Challenges

Ask participants what challenges caregivers might have in practicing the new 'good' behaviours at home. Brainstorm to discover some possible solutions to each of the following problems.

The caregiver

- forgot what was taught
- is instructed by the grandmother who is resistant to the new practices
- doesn't have the ingredients for the menu
- doesn't know where to get affordable fish or vegetables
- is encountering resistance from her husband
- has a sick child
- has a child who refuses to eat

60 Min

6. Monitoring

Introduce Monitoring Form 4: "Hearth Register and Monitoring Form" and Monitoring Form 5: "Home Visit" that volunteers will use (see monitoring forms at end of the session).

Monitoring Form 4: The Hearth Register and Monitoring form helps keep track of the growth of the PD/Hearth participant children during follow-up visits at 1 month, 3 months, 6 months, and 1 year from their first day of Hearth. It is helpful to keep these monitoring forms in a binder at a volunteer leader's home, community leader's home or the health centre (if it is in close proximity to the community). This form **MUST** be used to follow-up the PD/Hearth participant children.

Monitoring Form 5 (Job Aid): The Home Visit form helps keep track of information that is observed during the home visits. Work through a sample home

visit scenario and help the volunteers fill out this form properly. This form is not mandatory to use, but can be helpful.

NOTE: *ADP staff should ensure volunteers have sufficient forms and should supply the volunteers with binders and office supplies to monitor the programme.*

20 Min

7. Role play follow-up visits

Remind the volunteers that during home visits it is important to be as encouraging as possible. The purpose is to help the caregivers solve any problems with child feeding and care they might have. Before leaving the home, the volunteer should have the caregiver (and grandmother if present) repeat the action steps they will take before the next visit.

Divide participants into groups of two or three. Give them the following (or adapted) scenarios to practise related to the home visit. Discuss together each scenario and agree on one thing the caregiver could try.

Scenario 1: You are visiting Sarina, who has a 22-month-old boy. He does not want to eat at all. He appears to be sick and cries a lot. The child has diarrhoea and the mother-in-law does not want Sarina to give him food or breastfeed him. Sarina cannot remember how to make an oral rehydration solution. What will you do?

Scenario 2: You are visiting Bertha, who has a 13-month-old girl. Before Hearth the baby breastfed but did not eat much else. She was very thin and lacked energy. She put on some weight during Hearth. The mother is very happy. She is breastfeeding more now, and the baby loves the porridge that she learned to make in Hearth. She makes the porridge with milk, groundnuts, maize and small dried fish. Her husband says she cannot continue to make special food for the child because it is too expensive and that she is paying too much attention to the child. What will you do?

Scenario 3: You are visiting Mari, who has 18-month-old twins. She is very happy because both twins like the food she makes. But she is concerned that she will not always be able to get the same ingredients that she learned to use in the Hearth sessions. She is afraid the twins will stop growing if she does not use the same menu. What will you do?

Have several groups perform their role play for the whole group. Discuss each one. What was good about the visit? What was good about what the volunteer said? Was any information left out? What could be improved? How did the 'volunteer' feel about the visit?

Emphasise the importance of encouraging both caregivers and grandmothers, being positive and trying to get the caregiver(s) to agree to try one thing before the next visit.

20 Min

8. Hearth Graduation Criteria

Ask the volunteers: How will we know if children have successfully completed Hearth?

Explain that on the last day of Hearth sessions, ADP or Health centre staff will weigh the children with the assistance of the volunteers. If they have gained at least 200 grams that is satisfactory. However, children need to keep gaining weight at home, so they should be weighed again two weeks after the end of the session (i.e. one month after starting Hearth). If they have gained at least 400 grams from the start of Hearth, that is satisfactory.

Children need to continue to gain about 200–250 grams each month. They need to be weighed regularly to ensure that they continue to gain weight and are growing well for their age. They should be weighed at 3, 6 and 12 months after starting Hearth, at least. When children continue to gain weight, they are growing well. Their families and the Hearth volunteers can be proud.

Those who have gained less than 400 grams by the end of the month of their Hearth session should go to another session as soon as it is scheduled. If a child is still not gaining enough weight after two complete 10-12 day Hearth sessions, he or she should be referred to the health post or doctor to make sure there is no underlying reason.

Note: *Children who gain 400 grams may repeat the Hearth session as determined by criteria set by the National Office or Ministry of Health partners (e.g. the graduation criteria is not only gaining 400 grams, but also that the child's nutritional status has improved).*

Discuss together the following situations. Decide if the child will graduate and what is best next step for the child:

Case 1: Aisha is 3 years old and an only child. After two Hearth sessions she has gained 90 grams but is still malnourished. Her mother, who is pregnant, appears to be following the new PD behaviours and working hard to rehabilitate Aisha, but she is becoming discouraged.

Case 2: During the sessions Budi gained 500 grams. By the end of the follow-up period he had lost the 500 grams. His mother does not know what the problem is, but she is concerned.

Case 3: Tobir Village has many malnourished children, and Hearth sessions are proceeding well, but some segments of the population are semi-nomadic, moving with the seasons to find work. Though these mothers have been enthusiastic participants, it is difficult to follow their children during the dry season. Many return during the rainy season having lost weight again.

Case 4: Chandar was very thin and sickly. During the Hearth sessions he gained 300 grams and was starting to be more active. His mother noticed a great difference. In the next two weeks Chandar gained another 100 grams.

Case 5: Oumou was very thin and could not walk at 22 months of age. Her parents were very concerned and wanted to do everything they could to help Oumou. During the Hearth sessions she gained 400 grams. In the next two weeks she gained another 300 grams. By the end of another month, Oumou had gained an additional 400 grams. Her parents are very happy that she is gaining weight so well.

Hearth Register and Monitoring Form 4

World Vision

1 OF 2

Day 6 Session 10

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

Child's Name										
Caregiver's Name										
CHILD		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Child's Sex (M/F)										
Date of Birth (dd/mm/yyyy)										
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')										
At Day 1 of Hearth	Date (dd/mm/yyyy)									
	Weight (Kg)*									
	Underweight Nutritional Status (Indicate colour)									
	MUAC (Green, yellow, red < 115mm)									
At Day 12 of Hearth	Date (dd/mm/yyyy)									
	Weight (Kg)*									
	Weight Gain (Day 12 - Day 1) in grams									
	Underweight Nutritional Status (Indicate colour)									
	MUAC (Optional)									

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

Hearth Register and Monitoring Form 4 -Continued

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

	CHILD	1	2	3	4	5	6	7	8	9	10
At Day 30 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight gain (Month 1 - Day 1 weight) in grams										
	Gained 400g+ (Y/N)										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 3 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	Change in Status (Y/N)										
	MUAC (Optional)										
At 6 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 12 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
	CHILD	1	2	3	4	5	6	7	8	9	10
	COMMENTS (Explain reason for default if child has defaulted due to death (D), migration (M), referred to hospital (H), etc.)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

ADP Name ..... Village Name .....Caregiver's Name .....

Child's Name ..... Dates of Sessions.....Name of Hearth .....Volunteer .....

OBSERVATION LIST	Day #	Day #	Day #	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.							
Drinking water from safe source (borehole or protected well)							
Water is treated (Boiled/ chlorine)							
Water is covered with fitted cover or lid							
Clean separate cup is used for pouring drinking water from the pot							
Handwashing station exists (e.g. tippy tap)							
Jerry cans or water storage containers are clean							
Toilet/latrine is available and used or hole is dug and covered for defecation							
House and/or kitchen is clean							
Food utensils are clean							
Handwashing with running water and soap is practised by: Caregivers							
Children							
Other family members							
Food prepared is nutrient dense as learned in Hearth (includes all 3 food groups: protective, body building and energy foods)							
Size of portion served is age appropriate							
Caregiver actively feeds the child							
Child is offered more food after finishing first portion							
Caregiver says child is fed 4 - 5 times / day (including snacks)							
Child uses separate (own) plate, bowl, or cup							
Caregiver is motivated by changes in the child							
Yesterday night, mosquito net was used by the primary caregiver and all children U5 in the household							
Caregiver can say what to do when child is sick (example: feeds more liquid when child has diarrhea and feeds more frequently)							
Caregiver expresses being able to continue practising what was learned in Hearth at home							
Problems and questions about child feeding and care is discussed with the volunteer							

Keeping the Community Informed

Purpose

- To learn ways to show how many children have graduated
- To practise sharing the information

Materials

- A number of fist-sized stones
- Several green and yellow maize (or other plant) leaves

STEPS

10 Min

1. Introduction

Alt is important to communicate the programme's progress with community members. Discuss the following questions:

- Who do you think might like to know about the progress of the PD/Hearth programme? *(caregivers and families of participant children, community leaders, village health committee and volunteers, community leaders)*
- What information do you think they need to know? *(how many children were involved, what were they like before, what they are like now, how many have graduated, what support the community could give to help improve or maintain results)*
- Why do they need to know this information? (*to see that what they are doing makes a difference, to recognise improvements in children, to help them learn about child malnutrition, to help them realise that there are solutions in their own community)*

Brainstorm: How do participants think they could communicate this information to the various groups of people in the community? Several suggestions follow within the examples listed below.

45 Min

2. Role play a meeting with caregivers

Example 1

(Ask each volunteer to represent a family in the Hearth sessions.)

Welcome each person to the meeting. Talk about how hard they have been working to improve the health of their children and how well the children are doing as a result. The children were weighed the first day and last day of Hearth. Ask caregivers to pick up a fist-size stone to represent each child in their family. Ask them to put each stone in one of three piles – one for a child who was healthy and had good weight before the Hearth sessions; another for a child

who was not growing well or was underweight; and a third for a child was very underweight. Compare the size of the three piles. Which is biggest? We want to see all the children in the 'good' weight pile.

Again ask caregivers to pick up a fist-size stone for each child in their family. Repeat the process for the children's weights **now.** Make the piles close enough to the 'before Hearth' piles so that you can compare them.

Compare the 'now' piles. Which pile is biggest? What does this tell us? Now compare the 'before Hearth' piles with the 'now' piles. Which are bigger? What does this tell us? (Note – if there are many stones in the underweight piles still, there should be another Hearth session to help these children improve.)

Ask several of those who have a child who has improved to tell the group what differences they have seen in their child. What made the difference? Draw out the positive behaviours they practised. Can these behaviours be practised by everyone in the community or only by a non-poor family? Are these practices doable? affordable?

Encourage them to continue the feeding and caring practices they learned in Hearth in the home to make sure the 'good' weight pile gets bigger and no stones remain in the 'underweight' piles.

Example 2

Use green and yellow maize leaves to show healthy and unhealthy plants. Discuss why the yellow leaves are unhealthy and ways to make the plants healthy. (use manure, weed them, water them, space them properly, fertilise them). Can we make yellow maize grow better? How? (the same answers as above.) Make a connection between the maize leaves and children. Some children are growing well, and some are not. Why? (not fed enough, not fed often enough, not well spaced, sickly, not enough variety of food, parents absent)

Use stones to show the proportion of children who were like yellow leaves (malnourished) and those who were like green leaves (well-nourished) at the start of the Hearth programme. Pile a stone beside the yellow leaves for every malnourished child and beside the green leaves for every well-nourished child. Ask: Can these children move from the yellow pile to the green pile? How? (feeding more, giving variety of food, washing hands, taking care of child when sick). What makes the difference between these groups of children? How have caregivers in the community tried to help their children grow better? What do some families do to keep their children well-nourished?

Discuss with the community whether children's growth has improved with the Hearth programme. Take a stone from the yellow pile and move to the green pile for each child who has improved in growth. Help them see the children are

growing better. Talk about how to make sure these children stay like the green maize leaves. There are still children in the yellow pile. How do we help these children become like the green maize leaves?

Example 3

Post two large growth charts on the wall (see samples at end of this session). One chart will show the beginning weights of the children. These can be colour-coded with green, yellow and red. Let the group see how many children are in each category, emphasising which children were growing well and which were not. The second large growth chart shows the weights of children at the end of Hearth. Plot every child on the growth charts. Explain the green, yellow and red categories (normal weight, underweight, very underweight). Help them see the number of children in each category before Hearth and now. Discuss together whether there are fewer children in the yellow and red categories. Are there more children in the green area? Is this an improvement? What has caused these changes? Are some children still not growing well enough? Are they happy with the current situation? What should they do now?

Example 4: Presenting information comparing community norms with the PDI information

Present two skits. The first shows a family (including the grandmother) with children who are sick. The family demonstrates poor behaviours *(caregiver goes to the field in the morning without feeding the children, eat only maize without washing hands, poor overall hygiene).* Include behaviours that are seen in the community. Exaggerate to make the skit funny.

The second skit shows a family (including the grandmother) with happy, healthy children demonstrating good practices *(feeding a variety of foods, washing hands, helping child eat, giving snacks, talking to children).* Include any practices that have been discovered in the PDI.

Talk with the community about how poor families with good practices have been able to keep their children healthy. Talk about the practices discovered in the PDI. Do they contribute to children being healthy? Could every family in the community do them?

30 Min

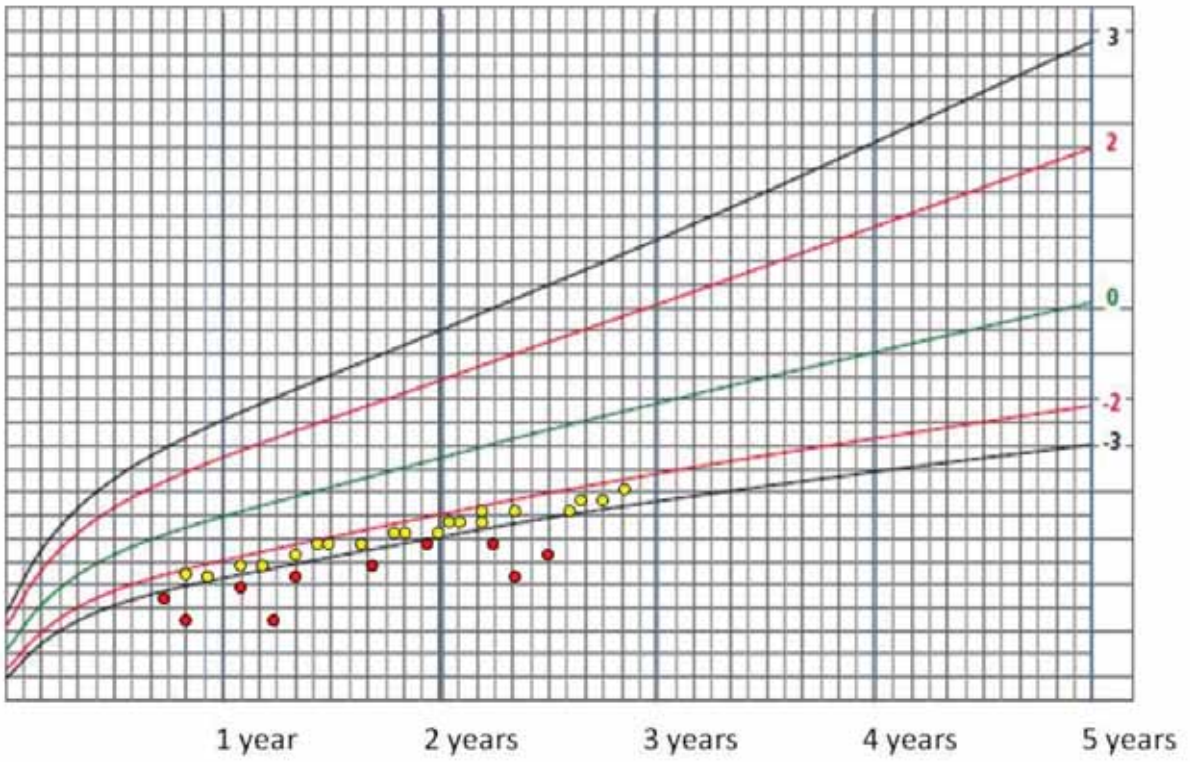
3. Role play

Divide participants into two groups. Each group decides what group in the community it will have an information meeting with and how it will share information. Develop a role play of the community meeting. Each group will act its role play for the whole group, who will be the 'community'. Discuss each role play. What was good? What was the reaction of the community? What could be improved? Was this hard?

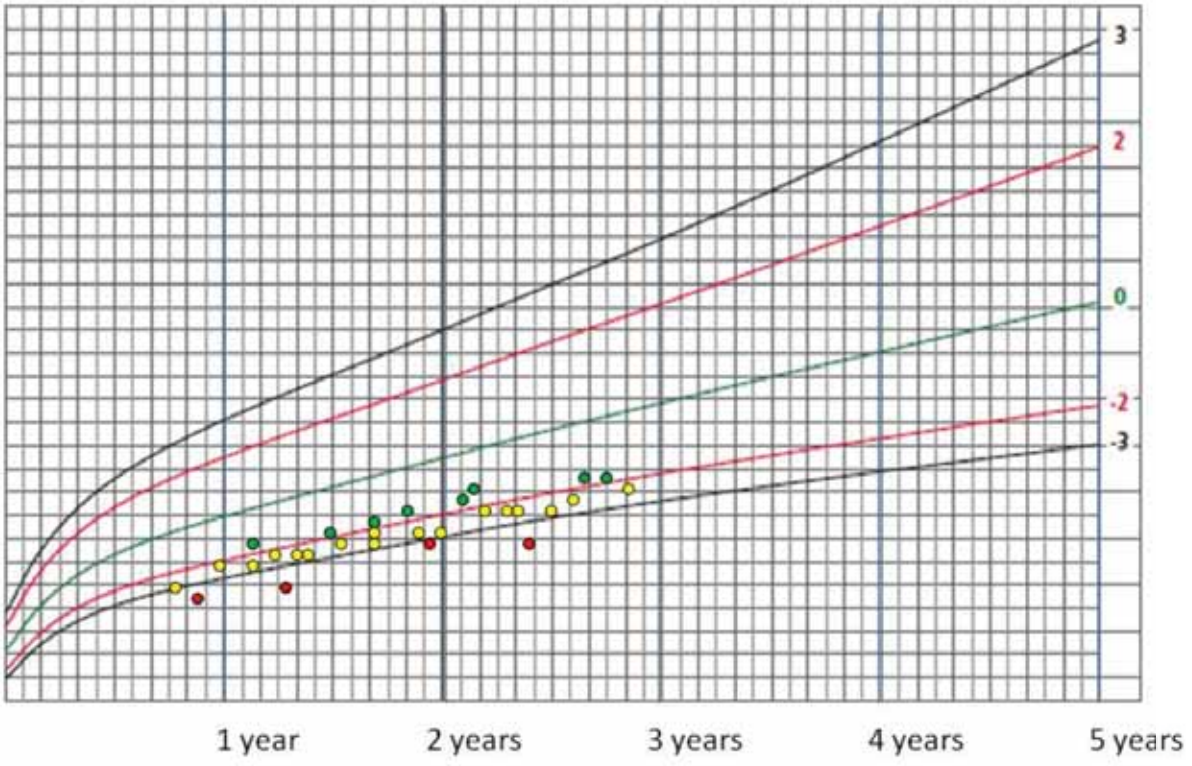
5 Min

4. Closing

Explain that the volunteers have come to the end of the training. Thank them for coming. Congratulate them on their hard work and all that they have learned. Encourage them to use what they have learned with their own families and also to help many children in their community to become healthier.



Before Hearth



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ASTUTE: ADDRESSING STUNTING IN TANZANIA EARLY *"MTOTO MWEREVU"*

WORKSHOP TOOLKIT

LEARNING EXCHANGE WORKSHOP
TO PROMOTE MULTI-SECTORAL NUTRITION CAPACITY IN COUNCILS

7– 8 February, 2018
Adden Palace Hotel, Ilemela MC, Mwanza

Workshop participants (Regional Nutrition Officers from ATUTE Regions: Mwanza, Geita, Shinyanga, Kagera and Kigoma; Officers from PANITA and IMA World Health; Facilitators from Tanzania Food and Nutrition Centre, Sokoine University of Agriculture, Nelson Mandela Institution of Science and Technology, and Cornell University)

with the financial support of:

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TABLE OF CONTENTS

TOOLKIT PURPOSE

This toolkit provides helpful tips and templates as well as considerations for starting project activities for the ASTUTE Initiative titled *"Strengthening Multi-sectoral Nutrition (MSN) Capacities among Council Officers"*. These tips and templates are meant to support approaches to building MSN in councils as discussed at the workshop held the 7-8 of February 2018. These tools are being shared in order to help guide Regional Nutrition Officers (RNuOs) to use mentoring and provide support to a council MSN action team who will work together to learn best practices in strengthening MSN collaboration and action in districts. By providing tailored support, expertise, and advice to this team, RNuOs will help build on existing knowledge of the best practices for promoting multi-sectoral collaboration for nutrition.

USING A MENTORING APPROACH

There are many tips and tools on mentoring available in the TFNC manual titled *Building a strong nutrition systems across sectors: A manual for strengthening district capacity to improve MSN planning and action*. The manual outlines the approaches used in the Building Strong Nutrition Systems project, examples of which were discussed during the workshop. TFNC will share this manual with ASTUTE RNuOs at the end of March 2018. Part Two of the manual includes details on how to develop district MSN capacity through mentoring.

Good mentoring develops over time but the following guidelines may help you begin the mentoring process.

Make Introductions

- Introduce yourself – get to know the mentee.
- Explore interests – ask questions, promote discussion, and encourage conversations by sharing your own story and experiences.
- Develop rapport – have informal conversations with your mentee. Give yourself and the mentee ample time and room to get to know each other.
- Stay active – respond to the mentee promptly as well as reach out to the mentee with new information and resources they may appreciate as well as opportunities to network with others.
- Establish best channels of communication – choose what works well for both of you early and formalize expectations around meeting times.
- Seek out mentors – newer mentors can benefit from having additional guidance from those with more experience.

Build Respect and Trust

- Take mentee seriously – A question or problem that seems trivial may be more serious for your mentee.
- Listen patiently and look for the real problem – Give your mentee time to get to issues that they may find sensitive or embarrassing. Give important issues time to emerge.
- Be frank and direct – Let the mentee know what you can or cannot offer in the mentoring relationship. Explain concerns directly and offer recommendations.
- Help mentee develop self-esteem – Provide praise as well as suggestions for improvement.
- Invite other mentors – Acknowledge that not a single person can fulfill the needs of the mentee.

- Hold face to face meetings – Suggest meeting in the mentee's office or suggested space so that you are working within his or her space.
- Be a wise and trusted counselor – It is important to be a mentor who cares and is there when needed.
- For example being on time for meetings, making notes during meetings and referring to those notes in follow up meetings.
- Don't over-direct – Suggest various "road maps" but allow your mentee to make their choices and avoid dictating choices or controlling the mentees' behavior.
- Be constructive -- Critical feedback is essential to spur growth and improvement.
- Encourage feedback – Ensure you know the needs of the mentee so you are better able to help. Ask whether you are sufficiently or too involved.
- Talk at a good time – If the mentee reaches out to you at an inconvenient time suggest an alternative time instead of listening impatiently.
- Remember the goal – The goal is not to overtake the mentee but to provide guidance and help them be more equipped for their work. Encourage confidence, independent thinking, and self-sufficiency.

Mentoring is a different approach than supportive supervision. Supportive supervision often means administrative oversight, provided periodically to oversee and monitor officers, services, records, supplies, or finances. It revolves around planned supervisory visits or review of quarterly reports. Mentoring however involves a flexible, relationship-based approach that promotes goal setting, dialogue, and actions to reach common aims. It is a mutual learning experience across a range of individuals working in multiple sectors within a district. Below are tips for what a successful mentor aims for and what pitfalls they avoid.

What a Mentor DOES	What a Mentor DOES NOT Do
Listen and learn to ask questions: Be open to the mentee's problems and ideas and understand that many challenges are caused by larger complex factors. **Support and facilitate:** Help mentee develop a supportive network and provide access to new people and experiences. Invite higher authorities to be involved (e.g., DMO, DAICO). **Review:** Discuss country-level guidelines, terms of references, and the challenges and opportunities in actualizing them. **Expand information and resources:** Provide up-to-date knowledge and equip mentee with the ability to access resources to meet goals and make thoughtful decisions. **Encourage and motivate:** Develop mentee's self-esteem, help mentees move beyond their comfort zone, and provide opportunities to learn by experience and broaden thinking.	**Problem solve:** Do not assume the role of problem solver for the mentee. **Take over:** Do not do what the mentees can do themselves. **Create goals:** Do not give goals to the mentee. Allow the mentee to shape and create his or her own goals. **Force:** Do not force mentees into one direction or determine choices. **Condemn:** Do not tell the mentee that he or she is wrong or focus on the negative. Do not underestimate mentees' capabilities.

Mentees also play an important role in the mentor-mentee relationship. The table below highlights the actions that mentees can focus on to increase their success, encourage a positive mentoring relationship, and which pitfalls to avoid.

What a Mentee DOES	What a Mentee DOES NOT Do
Take initiative: Recognize the need for mentoring, seek advice when needed, clarify goals, and give feedback.	**Avoid challenges:** Do not expect mentors to solve your problems for you. Welcome activities that help you learn by doing.
Welcome experience: Be enthusiastic about pursuing a wide range of professional experiences.	**Stay in your comfort zone:** Do not shy away from new learning experiences, even if they are challenging.
Accept challenges: Realize there are challenges in any work—try to learn from them.	**Remain closed:** Recognize that everyone (supervisors, colleagues, community leaders) has something to teach you.
Be approachable and advocate: Network and build key relationships through hospital and community visits and public forums.	**Be non-transparent:** Do not hesitate to ask for advice on how to access opportunities and resources you need.
Be proactive and collaborate: Seek opportunities to link with other officers and share learning from mentorship.	

Everyone in this project is learning together so please share questions and successes with the Whatsapp group of RNuOs, ASTUTE officers, and facilitators. Also, the research team including Luitfrid Nnally (Tanzania Food and Nutrition Centre) and Kate Dickin (Cornell University) can provide support as needed.

In the ASTUTE MSN Initiative, documenting the mentoring visits is an important part of understanding team goals and progress towards planned activities. A mentoring visit template to help RNuOs guide discussions, decisions, and progress is available in **Annex 1**. RNuOs and teams can jointly fill out the template at each meeting. RNuOs can then share completed meeting notes with interviewers during interviews to discuss progress and what activities and discussions have occurred among team members.

POSSIBLE STEPS IN THE MSN INITIATIVE

You can provide support to selected DNuO and MSN teams by working within the existing government system to strengthen local capacity, motivate collaboration, and encourage relationship building.

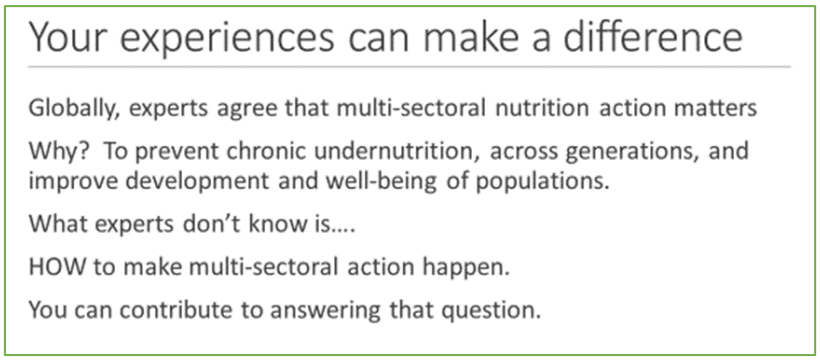
The steps below are to guide RNuOs in supporting MSN action teams. While these steps can be used to guide the team, team members may also find other successful paths to follow. Each team can adapt capacity building activities to their own context and needs. The below steps are for action teams to lead and complete. Your role as RNuO is to provide mentorship and support.

STEP ONE: What does MSN look like in Tanzania?
- Create action teams
- Share knowledge and understand policies

STEP TWO: What is the district situation and how can we learn from each other?
- Reach out to stakeholders
- Create district profiles

STEP THREE: How can we work together to improve nutrition?
- Hold an engagement workshop
- Create networks and maintain communication
- Develop MSN priorities
- Use workshop results to advocate for MSN

The ASTUTE MSN Initiative is primarily a way for RNuOs to take an active role in learning, documenting, and sharing what works and what's needed for MSN to work better.



CREATE A MSN ACTION TEAM

There are different ways a council MSN action team can be developed. Work with the DNuO to understand their ideas for how to create a team based on their knowledge and experiences.

Consider asking the following questions to DNuOs to support them in developing a small action team of 2-3 additional members to participate in the ASTUTE MSN Initiative.

Example questions to ask DNuOs to help support creation of a council MSN action team:

1. What departments should be included? Why?
2. Who do you work well with in the district? What have you worked on together?
3. Who would be a valuable asset as a team member? Why?
4. Who currently does nutrition-sensitive work in this district?
5. Who has the time and motivation to commit to working on MSN actions?
6. Who could you consult to help you make this decision on who should be involved in the ASTUTE MSN Initiative?

It is helpful to establish expectations around meeting and communication early in the process. Ask your team how best to contact them, when and where you will meet, and how often you will communicate. Tell team members they should contact you if they have questions between meetings.

Structure the first 1-2 mentoring visits to discuss key MSN topics with team members. This will help you understand the team members' experiences and how MSN might be strengthened. Workshop participants role-played what to discuss with council MSN action teams. You can discuss a range of topics and questions with team members, a few examples are below.

Suggested topics and questions to discuss with teams:

- Stunting and hidden hunger, even if not visibly malnourished
- Many activities influence nutrition—how can a team comprised of members from different sectors improve nutrition?
- Better nutrition also benefits other sectors—children learn better, workers are smarter and stronger, mothers and babies survive, and local food is valued

Examples of questions for action teams to work on together:

- What are the current district MSN challenges? What MSN opportunities exist?
- How could the action team strengthen MSN action?
- What outcomes do they hope to see after 6 months? After 1 year?

- What support does the team need to accomplish their goals?
- How will the team measure their success?
- How can the team strengthen:
  - collaboration between departments and key stakeholders?
  - knowledge on what nutrition-relevant activities are happening?
  - impacts on the MSN Steering Committee?
  - partnerships with CHWs, CSOs, and community-based groups?

As noted in the workshop repot, the *National Multi-sectoral Nutrition Action Plan (NMNAP)* and the *Guideline for Councils for the Preparation of Plan and Budget for Nutrition* are two leading MSN documents that provide guidance and can be helpful to discuss with teams.

INVOLVE STAKEHOLDERS

Support action teams to identify and reach out to key stakeholders in the district. Mentoring could help action teams connect with CSOs, understand implementation challenges for CHWs, and help link CHWs with other sectors at the community level. Before teams reach out to stakeholders, discuss questions that will help them target who to identify and what topics to discuss, for example:

- What do you want to know?
- What information currently exists?
- How can you start new stakeholder relationships or strengthen ongoing partnerships?

When you discuss reaching out to stakeholders with your team, consider the following questions:

Example Questions for Team Members to Discuss:

- ☐ Which nutrition-specific and nutrition-sensitive actions are happening in the district (and where)? Which individuals, organizations, and sectors are implementing these actions?
- ☐ What delivery channels are being used to implement these activities?
- ☐ What gaps in actions or coverage exist?
- ☐ What are the MSN success stories in the district?
- ☐ What are the challenges for MSN stakeholders in implementing actions and connecting with others?
- ☐ How could nutrition actions be strengthened in other sectors?

Example Sources of Information on Stakeholders and Activities:

- ☐ What district-level data exist?
- ☐ Who might have relevant district-level data?
- ☐ Do other officers/departments know of nutrition-related problems and actions in the district?
- ☐ Does the action team connect with the people or organisations they need to? Who is missing?
- ☐ What information is at the Development Office registry, at PANITA, with HODs, at the community-level?
- ☐ How are current data and resources used?
- ☐ What additional data and resources could help you improve multi-sectoral nutrition actions?
- ☐ How could you collect additional information?
- ☐ How could the team compile information into a district data profile?

Example Approaches to Build Relationships:

- ☐ Find common ground. Identify an interest, topic, or opinion that you both share. Stakeholders are more likely to relax, trust you, and share their opinion if they feel you have common points of view.
- ☐ Listen attentively and with interest; understand the stakeholder's perspective and situation.
- ☐ Respond with genuine sincerity, concern, and interest.
- ☐ Ask open-ended questions. Give stakeholders opportunity to talk about their interests, values, needs, wants, challenges, and successes as they relate to providing nutrition-related activities.
- ☐ Follow-up to provide useful information/contacts or send a message to thank them for their time.
- ☐ Find ways to stay in touch and to connect stakeholders with each other.
- ☐ Invite stakeholders to take part in an engagement workshop to further discuss courses of action.

Your action team should collect information from stakeholders they feel is useful to fill their gaps in knowledge and to help them build professional relationships. A template for recording stakeholder information can be found in **Annex 2**. This template can be adapted to fit what types of information teams identify as important.

Workshop participants discussed how to prioritize which stakeholders to contact and build relationships with. For tips on how to prioritize stakeholders, see below.

Tips for Prioritizing Which Stakeholders to Map

1. Identify influential and dynamic stakeholders. Look for people who can bring about rapid change.
2. Look for high-visibility individual champions and advocates. Committed and passionate individuals and groups in a sector are as important as the sector itself.
3. Locate organizations serving the most vulnerable in terms of limited human resources and the negative impact malnutrition already has on the economy and communities.

DEVELOP A DISTRICT DATA PROFILE

Participants each received sample data profiles of their regions and discussed the possibility of working with teams to develop district-level profiles.

A data profiling tool can give you lots of information and insights into where problems exist. For example, district-level data can highlight variability in the distribution of nutrition-related problems and the importance of multi-sectoral action to address the problems. When you talk with actions teams about district profiles consider the following questions:

- Who will you target? To make the profile meaningful, consider how the profiles will be used and who the profiles will target.
- What does the target audience care about? What data and evidence do you focus on? Once you know who the profile is for, decide what information the target audience is most interested in. What information is important that they lack? What decisions do they make where your information might be useful in the decision-making process?
- What are the challenges, but also where is there progress? Positive trends are motivating. Balance the district's successes with the challenges to show that success is possible and work to build upon that success. You can even show how other districts or countries have had successes to advocate for trying particular methods or activities.
- What if sophisticated local data don't exist? Action teams can use profiles to provide insights from information they learn and gather throughout connecting with stakeholders and other project activities. Strengthening relationships with stakeholders in government and communities is a great way to learn about existing data sources and information that otherwise might be unknown. Profiles are a way to communicate your own experiences and learning, but also key insights from others.

HOLD A STAKEHOLDER ENGAGEMENT WORKSHOP

Workshops are a great way to engage important stakeholders, get their input, share knowledge, make joint decisions, and plan for future actions. An engagement workshop involves stakeholders working actively towards common objectives. Have action teams adapt the engagement workshop approach to their own district needs.

Adults learn best when they are actively involved in the learning process. Encourage action teams to use participatory approaches to bring several people together to exchange knowledge, test assumptions, and solve problems. The learning in a workshop is linked to real life experiences where workshop participants can use and test new skills and receive feedback.

Your team can develop specific workshop goals and objectives which meet their needs. Some example goals include:

- Increase understanding and consensus of district MSN issues, priorities, and solutions.
- Build broader support for MSN programs and initiatives.
- Improve communication and collaboration through the sharing of information and experiences.
- Develop potential approaches to deliver programs more effectively and efficiently.
- Leverage resources and avoid duplication of MSN efforts.
- Ensure decisions are based on knowledge that otherwise might be overlooked, including local perspectives, or information typically shared among one department only.
- Reflect a wider range of concerns and values in decision-making.
- Strengthen capacity of district and community leaders.

Furthermore, your team should identify workshop activities which fit their needs. In the Building Strong Nutrition Systems project, DNuOs identified the following workshop activities which they made as participatory as possible to keep the stakeholders interested and engaged:

- Review the National Multi-sectoral Nutrition Action Plan (NMNAP) and guidance on nutrition-sensitive actions.
- Identify common goals, objectives, and interests across the individuals from different sectors.
- Examine stakeholder examples that highlights ‘’what works’’ when trying to integrate nutrition into other sectors.
- Discuss challenges and opportunities in working across sectors.
- Develop joint multi-sectoral priorities relevant to the district context.
- Test the feasibility of possible future actions by discussing what information, resources, skills, commitment, and support is needed.
- Discuss the way forward and identify follow-up actions.

There are many different facilitation techniques to consider when planning workshop activities. By using several types of facilitation techniques, participants can have the opportunity to think, communicate, and share ideas in different ways. Particular facilitation techniques, when combined, help to maximize sharing and learning among stakeholders in a workshop. See below for a few examples.

Facilitation Techniques

Record Ideas	Ask participants to record their ideas on flip charts, posters, or post-it notes placed on the walls. This helps everyone see the thinking process throughout the workshop. It also makes it easy to review or build upon earlier ideas. At the end of the workshop, facilitators can also collect the posters to capture what has been shared.
Work in Different sized Groups	Enhance interaction and learning by using small group work. Include participants from different disciplines in each group. Groups of five or fewer people allow for a variety of ideas to be explored. However, if the activity requires participants to describe experiences in detail, then working in pairs allows both participants to talk and listen. Change the small groups throughout the day to ensure individuals get the opportunity to work with different people.
Report out	Bring the best ideas forward by asking small groups to report back their ideas to the larger group. Placing a time (or length) limit on the report out can help manage time. Alternatively, ask a few individuals or groups to report out and then individuals from other teams can add anything that is missing.
Use Reflective Writing	Use reflective writing to have participants think about topics discussed during the workshop. Reflection is an exploration of the topics discussed, not just a description of them. This activity can reveal gaps in the topics discussed as well as strengths and successes. Reflective writing can also help participants organize their thoughts before sharing them with the larger group.
Introduce Case Studies	Have participants examine a case study about a particular aspect or experience related to multi-sectoral nutrition planning and action. Case studies describe an individual, organization, event, or action in a specific time or place. They can help generate ideas and discussion. Choose a case that offers an interesting, unusual, or particularly revealing set of circumstances.

SHARE WORKSHOP RESULTS TO ADVOCATE FOR MSN

During the workshop a lot of information is shared and learned. After the workshop, summarize key findings and decisions made and report back to the stakeholders, to your supervisors and key district decision makers, and if appropriate, to the District Council Steering Committee on Nutrition. Results, including workshop goals, MSN challenges, and priority action areas identified, can be shared in a 1-2 page brief, in a district profile, in a presentation, or in a more formal report. Talk to your team to see what formats they are most familiar with or different ways to share information that they are most excited about. If there is interest, help your team learn new approaches to sharing information and advocating for MSN action.

ANNEX 1. VISIT TEMPLATE TO GUIDE DISCUSSIONS AND DECISIONS

Review previous visit worksheet filled during the last meeting which can serve as a starting point for the next visit.

General Information

Who is present: _____

Date: _____

Location _____

Activities and Accomplishments since Last Meeting

Activities Pursued since Last Meeting	Major Accomplishments
▪ ▪ ▪	▪ ▪ ▪

Meeting Agenda and Goals

The goals for this meeting to further develop activities and progress are:

1. _____
2. _____
3. _____

Topics of Discussion

Key topics discussed include:

1. _____
2. _____
3. _____

Perceived Challenges and Strategies to Address Them

State the key challenges encountered, actions taken to overcome them, and any pending matters to resolve.

Key Challenges	Actions Taken	Matters to Resolve
▪ ▪ ▪	▪ ▪ ▪	▪ ▪ ▪

Activities to Pursue and Next Steps

List the major activities, tasks, or events the team is planning to undertake in the next few weeks and the steps for how to get there:

Next Steps: Specific tasks for the Council Officers	Next Steps: Specific tasks for the Regional Nutrition Officer
▪	▪
▪	▪
▪	▪
▪	▪

Other Upcoming Responsibilities

List any other upcoming events, trainings, initiatives, or responsibilities that team members will be engaged in that the team should know about and plan around:

1. _____
2. _____
3. _____
4. _____

Next Conversation

Date: _____ Hour: _____ Location: _____

RNuO's Meeting Notes

Document what went well. Did team members seem to be at ease? Motivated and engaged? What does the team most need to work on? Describe in detail your observations on this team and how this meeting went:

ANNEX 2. STAKEHOLDER INFORMATION WORKSHEET

This worksheet can help council officers conduct outreach to stakeholders to gather information on current nutrition-specific and nutrition-sensitive activities in the district. Talking to stakeholders to ask these questions encourages dialogue and builds relationships. The information gathered can be put together in a summary of district nutrition activities. This is an adaption based on the Initiative: http://www.reachpartnership.org/reach-countries/tanzania and pilot tested in Tanzania as part of the Building Strong Nutrition Systems project: http://blogs.cornell.edu/centirgroup/research-projects/strengthening-nutrition-systems/

A. STAKEHOLDER PERSONAL DATA:

1. District Registration Number	
2. Date of interview *(dd/mm/yyyy)*	
3. Organization/group name	
4. Organization type *(circle one)*	a. Civil society (CSO) b. Faith based (FBO) c. Government d. Non-government (NGO) e. Private sector f. Other, specify: _____
5. Organization main office location *(address)*	
6. Interviewee name	
7. Interviewee position title	
8. Interviewee phone	
9. Interviewee email	

B. STAKEHOLDER SIZE:

1. How many paid staff are a part of this organization?	*(write response):*
2. How many volunteers are a part of this organization?	*(write response):*

C. STAKEHOLDER ACTIVITIES:

1. I would like to learn generally what your organization does. Does your organization currently have activities related to…? *(Read the list out loud and circle yes or no based on their response. More than one answer is possible.)*	a. **Agriculture and farming**	0. No	1. Yes
	b. **Disease prevention and management**	0. No	1. Yes
	c. **Economic activities**	0. No	1. Yes
	d. **Educational development**	0. No	1. Yes
	e. **Environmental conservation/Climate change**	0. No	1. Yes
	f. **Family planning and reproductive health**	0. No	1. Yes
	g. **Maternal and child health**	0. No	1. Yes
	h. **Social welfare and protection**	0. No	1. Yes
	i. **Water, sanitation, and hygiene** (WASH)	0. No	1. Yes
	j. **Other topic area** (specify): _____	0. No	1. Yes

2. What specific <u>activities</u> is this organization currently involved in that affect the general health and growth of mothers, young children, or other vulnerable groups in this district? *(list responses)*	a. Activity 1:
	b. Activity 2:
	c. Activity 3:

D. ACTIVITY SHEET Activity Sheet #_____

Ask about and make notes on each activity mentioned that is relevant to the health and growth of mothers and young children. If there are many relevant activities and time allows, you can fill out extra sheets. Use the bullet point questions to help make sure you learn the key points about each activity.

1. I would like to learn about these activities in more detail. Starting with _____ (activity 1 above), please tell me more about this activity.

- What are the goals? What are the activities?
- Who are the target groups?
- How do you reach these groups? (eg. CHWs, agricultural agents, community meetings, media, schools, etc.)
- Where is it being implemented? (how many and which communities, wards, districts, etc.)

2. Now please tell me more about _____ (activity 2 above).

- What are the goals? What are the activities?
- Who are the target groups?
- How do you reach these groups? (eg. CHWs, agricultural agents, community meetings, media, schools, etc.)
- Where is it being implemented? (how many and which communities, wards, districts, etc.)

3. Now please tell me more about _____ (activity 3 above).

- What are the goals? What are the activities?
- Who are the target groups?
- How do you reach these groups? (eg. CHWs, agricultural agents, community meetings, media, schools, etc.)
- Where is it being implemented? (how many and which communities, wards, districts, etc.)

E. SUCCESSES, CHALLENGES AND COLLABORATIONS

1. What successes have you and this organization experienced in delivering these activities you've just described. *(Probe):* What has worked well?	*(write response):*
2. What kinds of challenges do you and your organization face when planning for and delivering these activities?	*(write response):*

3. Which government departments, if any, does this organization directly work with on the activities you have described?			
a. Agriculture and Food Security	0. No 1. Yes	i. Police and legal department	0. No 1. Yes
b. Communication & Information	0. No 1. Yes	j. Policy and Planning	0. No 1. Yes
c. Community development	0. No 1. Yes	k. Social Welfare	0. No 1. Yes
d. Education	0. No 1. Yes	l. Trade	0. No 1. Yes
e. Finance	0. No 1. Yes	m. Water and Irrigation	0. No 1. Yes
f. Health and Social Welfare	0. No 1. Yes	n. Other *(specify)*	0. No 1. Yes
g. Livestock and Fisheries	0. No 1. Yes		

4a. Do you work with any other organizations or partners on the activities you have told me about? *(circle one)*	0. No 1. Yes
4b. *(If yes)* Which organizations do you directly work with? *(List each organization's name on a separate row)*	1. _____ 2. _____ 3. _____
4d. Are there any other organizations or stakeholders you know of who work in this district on similar types of activities that I could talk to? *(If yes, list each organization's name on a separate row)*	1. _____ 2. _____ 3. _____

5. In your experience, in this district how is there collaboration among different groups or stakeholders to improve nutrition? What could be improved?	*(write response):*

This concludes the questions I have for you today. I really am grateful for your willingness to share your time and experiences with me. I have learned a lot. Is there anything else you would like to share or discuss before we conclude our meeting?

Thank you!

F. STAKEHOLDER EVALUATION CHECKLIST

1. Does this organization reach groups that are particularly vulnerable to malnutrition?	0. No 1. Yes
2. Are the goals of this organization nutrition-sensitive?	0. No 1. Yes
3. Are the goals of this organization nutrition-specific?	0. No 1. Yes
4. Is this organization engaged in activities that could add or strengthen a nutrition component?	0. No 1. Yes
5. Do you think this organization is useful to partner with?	0. No 1. Yes

G. INTERVIEWER OBSERVATIONS

1. What are your observations and impressions about this stakeholder?	*(write response):*
2. In what ways would multi-sectoral nutrition collaboration with this stakeholder make sense? Why or why not? What could be the next action steps? Do you think it would be useful to include them in a stakeholder engagement workshop?	*(write response):*

CHECKLIST FOR PLANNING, IMPLEMENTING, AND EVALUATING POSITIVE DEVIANCE/HEARTH (PDH

Use the checklist below to ensure that you incorporate key elements of PDH into PDH activities. The grid below should be used:

1. Before deciding whether to implement PDH (specifically, are the requirements listed under "Planning" being met?);
2. Before implementing each stage of PDH (Planning, Training, Community Mobilisation, and so on);
3. While implementing each stage so that you can make adjustments to PDH activities; and
4. After PDH implementation to identify what went well, challenges, and how PDH can be improved in the future

1. PLANNING

Preparation:

- Are the criteria for PDH programmes met (homes are located a short distance from one another, 30% prevalence of moderate and severe malnutrition or 30 children 6-36 months of age who are malnourished, community commitment, availability of nutritious foods, availability of health facilities, and community commitment)?
- Have RNuOs, DNuOs, their counterparts from other government sectors (if involved), and IMA staff read, understood, and reviewed the PDH facilitator's manual?

Involvement:

- Do ward development committees and village leaders play a lead role in planning and overseeing all PDH activities, including:
  - Support in organising the weighing of all children in the target age?
  - Conducting the PDI?
  - Contributing materials, utensils, and food for the sessions?
  - Assuring that eligible caregivers attend Hearth session regularly?
  - Encouraging other community members, including grandmothers, to support families with malnourished children as they adopt new practises?
- Is there capacity building of local leaders to ensure that they can manage all aspects of PDH?
- Does village leadership suggest solutions to potential challenges with PDH implementation (e.g., ensuring that only eligible children are included in Hearth sessions and making certain that caregivers bring PD foods to every Hearth session)?
- Do grandmothers participate in the different steps of PDH, including serving as:
  - Community mobilisers?
  - Village committees?
  - Members of focus group discussions?
  - Those being talked to and observed during the PDI?
  - Participants in Hearth sessions?
  - Key audience members in community feedback sessions?
- Are relevant government sectors represented (i.e., not just health but agriculture, education, community development, and WASH)?
- Is a monthly plan developed to make sure Hearth sessions occur each month and follow-up home visits are made? The plan should be developed in conjunction with village leaders.

2. TRAINING

Does the CHW supervisor take a major responsibility for training, or do IMA staff assume primary leadership for training? It should be a mix.

Are manuals used appropriately and effectively?

3. COMMUNITY MOBILISATION

- Is there high commitment to PDH among community leaders and community members themselves?
- Does the community identify a few good measures of wealth that can be used easily for selecting PDs?
- See also "Planning" above.

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4. MEASURING GROWTH

- Does weighing take place at the ward level? (It should.) Please liaise with health facilities within the ward to get a sense of which villages have the highest level of MAM and SAM, based on the health facilities' routine nutrition assessments during growth monitoring activities. Then focus on those villages if weighing all children at the ward level is too burdensome.
- Are the Seca scales ASTUTE purchased used? If not, there is a high risk of misclassification of positive, negative, and non-positive deviants.
- Are government staff (including health facility workers) involved in weighing children and recording their weights?
- Are children of the right age (6-36 months old) weighed? If not, there is a risk of overwhelming the health system and diverting resources away from PDH programmes. See ideas under "Hearth sessions" for additional thoughts about including children of the right age.

5. SITUATIONAL ANALYSIS

- Are all activities for the situational analysis conducted (focus group discussions, market survey, seasonal calendar, transect walk, community mapping, PDIs)?
- Are all relevant food, care, and health topics considered during the situational analysis (diet plus WASH plus ECD plus gender)?

6. PDIS

How are the following handouts used?

- Observation Checklist for Positive Deviance Inquiries (Handout 18.2)
- Sample Guiding Questions for Conducting a PDI (Handout 22.1)

Meaning of PDIs:

- Is the PDI a fact-finding exercise for ASTUTE, or an opportunity for CHWs, health facility workers, community leaders, and other influences including grandmothers to discover that very poor families have positive, uncommon practises which enable them to prevent malnutrition? It should be the latter.
- Do those conducting PDIs understand that PD families are the experts and those who conduct PDIs are the learners?

Implementing PDIs:

- Is the correct number of PDIs being conducted? PDIs should be conducted in at least two villages that meet PDH criteria.
- Is the right number of PDIs being conducted within each village? There should be 4-6 PDIs with positive deviants and two PDIs with negative deviants. There is no need to conduct PDIs among non-positive deviants.
- Do PDIs last a minimum of two hours? Do PDIs generally include a meal time?
- Do those conducting PDIs carry out a natural conversation with PDs, rather than asking closed-ended questions from a checklist?
- Do those conducting PDIs observe potential behaviours, not just ask about them? In particular, the following should be asked about and observed:
  - Is environmental sanitation (latrines, animal faeces, disposal of infant faeces, etc.) observed to identify PD behaviours?
  - How are the diets of sick children managed? Do parents give as much or more foods and liquids during and after diarrhoea?
  - How are children stimulated?

Participants:

- Are fathers included in PDIs?
- What is done to make sure health facility workers promote the very behaviours identified during PDIs?
- Are ward development committees and village leaders made aware of PDI results and PD behaviours?

7. MENU PREPARATION

- Is a range of PD foods considered? (See all of session 30, including the use of a market basket of nutritious, affordable foods.)
- Are nutrient requirements calculated using the Excel spreadsheet?
- Are portion sizes adequate?
- Is breast milk included in the menu? (It should be.)
- Are animal source foods included in the menu? Are fruits and vegetables included in the menu? They should always be included, even if they aren't mentioned in PDIs.
- If there is seasonal scarcity of fruits and vegetables, use results from market surveys and seasonal calendars to identify what is available now. During PDIs, be sure to ask about food preservation strategies such as solar drying.
- Will each meal include a variety of colours (e.g., green, leafy vegetables; orange-fleshed foods; etc.)?
- Is each meal energy dense, as specified

in the PD facilitator's manual?

8. HEARTH SESSIONS

Supporting materials:

- How are the following documents used?
  - Supervision of PD/Hearth Session (Handout 36.6)
  - Observation of a PD/Hearth Session (Handout 5.1)
  - Handout 6.1: PD/Hearth Essential Elements
  - Checklist of Materials Needed for PD/Hearth Sessions (Job Aid) – (Handout 36.1)
  - Child Registration and Attendance Form (Handout 36.3A)

Logistics:

- If caregivers cannot make the time to attend Hearth sessions, are Hearth sessions moved to a more convenient time?
- Are Hearth sessions limited to 10-15 children? More than this number makes it difficult to conduct effective Hearth sessions.
- Are Hearth sessions conducted away from clinics and other "official" sites?

Participants:

- What is done to ensure that the community understands who Hearth sessions are for? Possible approaches include 1) announcements ahead of time from ward development committees and community leaders about who should be included in Hearth sessions, 2) reminders that children older than 36 months have already survived a vulnerable time period and that now children younger than 36 months need special attention, and 3) reminders that mothers can practise the new behaviours learnt in Hearth sessions with older children as well.
- Are children of the right age included in Hearth sessions? Children who attend should be 6-36 months of age except in rare cases when other children need to be with their caregivers (for example, infants less than 6 months of age).
- In rare cases when an older sibling is brought along, is s/he given the opportunity to participate in some way such as helping with handwashing? (If caregivers bring several children too old for Hearth, but who still need attention, one of the oldest children present may be tasked with taking them to an area some distance away to play so that mothers are not distracted and the noise level during food preparation and feeding is kept down.)
- If other children are present, are they allowed to eat only if there is leftover or surplus food and the Hearth participant children have already eaten?
- Are extra ingredients added to the PD foods, or is the quantity of food increased so that hungry mothers can eat?
- Are well-nourished children included in Hearth sessions? (They shouldn't be.) Hearth sessions are not to be community feeding events.
- How are men involved in Hearth sessions (or how do they support mothers and grandmothers who attend)? How—in addition to Hearth sessions—can fathers contribute to improving their children's nutritional status?

Responsibilities:

- Are all caregivers asked to perform a role each day (e.g., two caregivers to prepare the meal, two caregivers to help others practise ECD, two caregivers responsible for hygiene and sanitation, etc.)?
- Are responsibilities for each of these tasks rotated from day to day?
- Does every caregiver bring a positive deviant food (or in cases where families are extremely poor, a cooking pan, utensil, firewood, water, etc.) to every Hearth session?
- Are caregivers who do not bring a food (or other) contribution allowed to attend Hearth? (They shouldn't be.) This is a hard and fast rule.
- Do caregivers "teach back" what they've learned at each Hearth session so that the CHW is certain each caregiver understands the behaviour he or she must practise at home?
- Does every caregiver have the opportunity to practise PD behaviours in each of the 12 Hearth sessions? Practise is critical to establishing healthy habits.

Prior to Hearth sessions:

- Are children who participate in Hearth not currently sick (including no malaria)?
- Are children who will participate in Hearth de-wormed and given Vitamin A before Hearth sessions?
- What is being done to reduce any community stigma caregivers might experience by attending Hearth sessions?
- What is done to inform the rest of the community about Hearth sessions, including who should participate, why, and the purpose of Hearth sessions overall?

During hearth sessions:

- Are Hearth participants reminded that money alone cannot solve the issues of poor health and nutrition (as evidenced by PDIs among negative deviants)?
- Are caregivers able to identify the consequences of having malnourished children—and the advantages of

having well-nourished children? (Caregivers themselves should identify consequences, if possible.)

- Are caregivers who attend Hearth sessions actively involved in carrying out Hearth and not simply passive recipients of information?
- Are all relevant food, care, and health topics addressed at some point during the 12 days of Hearth? Pay particular attention to ECD and responsive feeding.

Diet:

- Does the menu of foods offered change from day to day, or are leftovers served? (Foods offered should change on a daily basis.)
- Are PD foods purchased? (They shouldn't be.)
- Are PD snacks given early in each Hearth session so that children aren't hungry?
- Is the quantity of food the child eats what was planned during menu preparation?

ECD, including responsive feeding:

- Are children stimulated through the use of locally-made toys and through other activities?
- Do some children refuse to eat? If so, do caregivers practise responsive feeding (or are they helped to do so)? Responsive feeding includes encouraging the child to eat through:
  - Eye contact;
  - Feeding patiently;
  - Avoiding force feeding;
  - (Caregivers) demonstrating how the child should eat;
  - Verbal encouragement;
  - "Games" to make eating more fun
  - Allowing the child to occasionally feed him or herself if the child wants and is able to; and
  - Responding to the child's hunger cues.
- Do children have their own plates? (To see what the child eats, the mother and child shouldn't share a plate.)

WASH:

- Is a mat available so that children aren't in the dirt?
- Are children kept away from animals and faeces, including infant faeces?
- Are caregivers' and children's hands washed before preparing food and before and after eating?

Between Hearth sessions:

- After the 6th day of Hearth (i.e., the seventh day), do caregivers stay home and practise the new behaviours they've learnt on days 1-6?
- On day 8, are caregivers asked about their experiences on day 7 (i.e., whether the behaviour was practised at home, why or why not, and what can be done to help the caregiver develop a strategy for addressing the challenges; this should include identifying any obstacles encountered)?
- On the 8th day of Hearth, do caregivers offer each other solutions to any problems they faced on day 7?

Subsequent rounds of Hearth sessions:

- Is a second round of Hearth sessions conducted the very next month (i.e., two weeks after the first round of Hearth sessions are over)?
- Are children who did not graduate from the first Hearth session as well as other children found to be malnourished during weight monitoring (as part of the situational analysis) included in the second round of Hearth sessions?
- Are children who do not gain weight after two 12-day sessions referred to a health facility to check for any underlying causes of illness such as malaria, tuberculosis, HIV/AIDS, or other infection?
- Is a third round of Hearth conducted, if needed? (Caregivers should not attend more than two rounds of Hearth to avoid dependency.)
- What is attendance like? Every child must be present for days 1 and 12 and ideally, every day in-between.

9. FOLLOW-UP VISITS

- Are initial home visits occurring every 2–3 days for two weeks after the Hearth session? It takes an average of 21 days of practise for a new behaviour to become a habit. Follow-up home visits are an excellent opportunity to ensure the positive practises promoted during Hearth sessions are also being practised at home.
- Are home visits occurring at 12 and 30 days, then 6 months, 12 months, and 24 months after Hearth sessions?
- Are children gaining weight as they should at each follow-up visit? If not, why not?
- Do CHWs use negotiation to conduct follow-up visits with families that participated in Hearth? In particular, Asking; Listening; and Recommending several small, do-able actions the caregiver can try, then allowing him or her to

choose one of the actions, are especially important steps that are often ignored.

10. MONITORING

- Are levels of malnutrition, measured as part of the situational analysis, about what you'd expect? If not, why not?
- Are data for identifying PDs entered into spreadsheets correctly?
- Are data complete?
- Are numbers (e.g., weights of children) plausible, or are they exceptionally high or low? If exceptionally high or low, why?
- Are all children who participate in Hearth sessions weighed on days 1 and 12?
- What percent of children graduate after the first Hearth (12 sessions)? What percent don't?
- Are some children losing weight? Why?
- If only a few children graduate, what explains the lack of progress?
- If you were an independent (neutral) outside evaluator, what would you say about the progress of PDH? What's working well? What isn't?

11. COMMUNICATION

- Are results from situational analyses, weighings, and Hearth sessions available to community leaders for their input?
- Do CHWs receive constructive feedback on Hearth sessions, graduation rates, and home visits?
- Are DNuOs, RNuOs, and other government officials made aware of PDH programmes and impact?

COMMUNITY HEALTH WORKER (CHW) ROLES AND RESPONSIBILITIES

MAIN RESPONSIBILITY:

Serve as link to health facilities, connecting community members to services. Advocate for nutrition in existing community groups and establish new support groups. Serve as change agent in families.

MAIN DUTIES:

1. Identifies community groups that are eager to learn about and promote good nutrition, WASH, ECD, and agriculture. Visits unions, credit associations, TASAF meetings, religious groups at mosques and churches, self-help groups, other groups for men and women, Ward Development Committees, and so on.
2. Determines which community groups demonstrate commitment to health. Prioritises groups that want to improve health and also have members who can influence practices related to nutrition, WASH, ECD, and agriculture, for example, fathers, grandmothers, and mothers.
3. Identifies 1000 day households (households with pregnant women and children less than 2 years of age).
4. Lobbies for space in meetings to:
    a. Discuss the importance of good nutrition for ensuring smart children
    b. Talk about specific practices people can adopt to improve children's health and development
    c. Identify things group members can do to improve children's growth and development
    d. Commit group members to take a specific action to improve health
    e. Commit group members to talk to others about what they've learned
5. Revitalise existing support groups that target 1000 day mothers and those who influence them, including fathers and grandmothers. If it doesn't make sense to revitalise existing groups, form new ones.
6. Conducts home visits.
7. With support from CHW supervisors, introduces himself or herself to health facilities. Shares his or her name and mobile number with health facility staff so that they can refer patients to CHWs for community-based support.
8. Refers community members to health facilities for ANC, malnutrition, and other health and developmental challenges. Follows up to make sure mother (or other family member) visited the health facility.
9. Collects community level data as specified in training. Returns completed forms to supervisor.
10. Coordinates with supervisor on a regular basis.

Fixed remuneration: TSH 15,000 per month.

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COMMUNITY HEALTH WORKER (CHW) SUPERVISOR JOB DESCRIPTION AND RECRUITMENT POSTING TEMPLATE

MAIN RESPONSIBILITY:

Supervise the activities of community health workers (CHWs) and provide them with adequate coaching and support to ensure the quality of their work and the accuracy of their monthly reports.

MAIN DUTIES:

1. Provides overall supervision of Mtoto Mwerevu's community-based activities in his/her catchment area.
2. Ensures high quality and timely implementation of community-based activities by the CHWs in his/her catchment area.
3. Builds and maintains strong cooperation with WDCs to keep them informed and actively involved in community health activities.
4. Builds and ensures strong partnership with health facilities in his/her catchment area.
5. Ensures safe and accurate use/storage of working kits/tools provided.

PRINCIPAL TASKS:

1. Maps the location of all CHWs in catchment area and maintains a register to track those who have received training.
2. Establishes a monthly work plan and calendar of supervision activities and shares it with health facilities and the CHWs in his/her catchment area.
3. With CHW supervisor, introduces self to health facilities. Makes sure that health facilities have the name and mobile phone number for CHWs and supervisors to improve referral of patients for community-based support.
4. Conducts at least one supervision visit every day to observe a support group, a visit to a community group, a home visit, or some other behaviour change activity.
5. Ensures supervision of each CHW under his/her responsibility every month.
6. During supervisory visits, supports CHWs to plan their monthly activities. This includes helping the CHW be a *connector*, an *advocate*, and a *change agent* by:
    a. Identifying 1000 day households.
    b. Identifying and working with community groups eager to promote good nutrition, WASH, ECD, and agriculture.
    c. Revitalising existing support groups and forming new ones.
    d. Conducting home visits and follow up.
7. During supervisory visits, evaluates CHWs' performance, provides feedback, and agrees on recommendations to solve problems and improve CHW performance.
8. Attends WDC and health facility meetings in her/his catchment area whenever they happen.
9. Compiles monthly supervision forms at each supervision visit.
10. Collects monthly activity reports from each CHW under his/her responsibility every month.
11. Ensures quality review of the reports provided by CHWs.
12. Submits monthly reports to DNuOs, consolidating information from the monthly activity report compiled by all CHWs under his/her supervision.

WORKING RULES:

- The supervisor will work 5 days out of 7 in the week.
- The supervisor shall maintain all working tools provided by the programme in good condition.
- The supervisor must adapt his or her schedule to the work plan of each CHW so that the supervisor can attend support groups, home visits, etc.
- Supervisors' absences must be approved by the WEO/DNuO.
- In case of illness, the supervisor must produce a medical certificate.
- In case of noncompliance with these rules, the WEO/DNuO will ask the supervisor to give reasons in writing and warn her/him and if the problem persists, the WEO/DNuO may propose termination of the contract.

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TEMPLATE OF CHW SUPERVISOR RECRUITMENT POSTING

POST: Supervisor

LOCATION: Kagera, Mwanza, Kigoma, Shinyanga and Geita (at least 10 villages in his/her catchment area)

DURATION: One year (can be renewed based on performance)

PROBATORY PERIOD: 3 months

MONTHLY ALLOWANCE: 100,000 TZS / month, upon delivery of monthly report and supervision forms plus transport allowance of 80,000 TZS / month

RESPONSIBLE FOR: Supervising the work of 20 Community Health Workers (CHWs)

RESPONSIBLE TO: WEO/DNuO

COORDINATING WITH: Ward Development Councils (WDC), Health facilities, District Nutrition Officers

DESIRED QUALIFICATIONS:

- Age: 18 or above.
- Education: Completed at least secondary school education, preferably completed form four (or at the very least, form two level of schooling).
- Working experience: At least 5 years of experience working as CHW and / or similar role working for community development, preferably in health and nutrition projects.
- Skills: Solid literacy and math; good sense of planning / organisation; good communication skills.
- Other: Availability and willingness to move / travel frequently in the catchment area.

IMPORTANT NOTES:

- In those areas where no candidates match the requirements, DNuOs and regional staff from Mtoto Mwerevu, in collaboration with local government, will establish procedures for recruitment (such as written / oral tests, interviews, etc.).
- Working as Supervisor is a full time job. Candidates must be made aware of this, and agree to commit accordingly.
- Supervisors should be based at village / ward level.
- Supervisors cannot be selected amongst government employees, nor amongst health facility staff.
- In the village where he/she resides, the supervisor will not act as CHW. Therefore, in a given village, there will be 2 CHWs + the supervisor.
- Supervisors will be under the direct responsibility of WEOs / DNuOs; however, the government (health facilities and WDC in catchment areas) can provide feedback and support CHW supervisors.
- In case of low performance of the supervisor, the WEO, in communication with Mtoto Mwerevu regional staff, can remove him / her and work with the local government to select a new supervisor while keeping the government (health facilities, WDCs) informed.
- The DNuO / WEO should officially introduce selected supervisors to health facilities and WDCs.

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COMMUNITY HEALTH WORKER (CHW) SUPERVISORS' GUIDE TO MONTHLY MEETINGS WITH CHWS

WHAT IS SUPPORTIVE SUPERVISION?

It is a process of guiding, monitoring, and coaching workers to promote compliance with standards and assure delivery of quality activities. During supervisory visits, you work as a team to meet common goals and objectives.

WHO SHOULD USE THIS GUIDE?

Mtoto Mwerevu CHW supervisors as you build the capacity of CHWs. See below:

A separate guide will help CHW supervisors help CHWs.

WHY IS SUPPORTIVE SUPERVISION IMPORTANT?

Mtoto Mwerevu can't succeed without it. When you hold regular, effective meetings with CHWs, you can:

- Give them the emotional and other support they need to face challenges on their own;
- Help CHWs to better understand their roles;
- Give CHWs the knowledge and skills they need to do their jobs effectively; and
- Motivate them.

HOW OFTEN SHOULD YOU MEET WITH CHWS? Monthly.

MATERIALS TO TAKE WITH YOU TO MONTHLY MEETINGS WITH CHWS:

- This guide;
- The list of CHWs' roles and responsibilities;
- Job aids and checklists for home visits and support groups distributed in IYCF/ECD/WASH training;
- M&E reports on programme coverage; and
- Anything else you think would be appropriate.

WHAT SHOULD HAPPEN WHEN YOU MEET WITH CHWS?

EVERY MONTH

1. If they know *how many* households they should visit every week (6 visits every week);
2. If they know *which* households should be visited. The following households should be visited:
   a. With at least one child < 5 years of age who is *mildly* or *moderately* malnourished;
   b. Participating in TASAF or who are very poor but not participating in TASAF;
   c. With mothers in their first pregnancy;
   d. With children 3-9 months old; and
   e. Experiencing challenges with breastfeeding, complementary feeding, WASH or ECD.

   Note: Most of these households will need to be visited two times (sometimes more). This is how negotiation is used in home visits;

   Other questions:

   f. Ask if CHWs are visiting other households (note: *no other households other than the ones listed above should be visited*);

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g. Find out where CHWs have worked (geographic area); and

h. If CHWs are unclear on who should be visited and how often, provide them guidance. Please take advantage of the very next opportunity you meet with CHWs (for example, when you pay them);

3. *What* CHWs discuss during home visits. *For each age of the child:* MIYCAN, WASH, ECD (and women's workload); the focus should not only be on MIYCAN but also other topics, especially WASH and ECD);

Conduct role plays, depending on the age of the child:

1. Get volunteers from the group for the role play to act the part of CHW, mother or father, and child;
2. Select one age group (pregnant or breastfeeding mother, child < 6 months old, children 6-11 months, children 12-24 months old) for the role play (the role play should include age-appropriate complementary feeding, WASH, and ECD practices);
3. Ask the volunteer to act as if he or she is conducting a home visit;
4. At the end of the role play, ask for comments, first from the CHW conducting the role play, then from the mother or father, then from the CHWs observing the role play:
   a. What went well? What needs improvement?
5. Review all steps of negotiation and give concrete examples of how the CHW performed each step;
6. Provide any final input on the role play;

Ask:

1. Whether CHWs are using negotiation and if so, how?
   a. Use checklist distributed in Mtoto Mwerevu's training for IYCF, ECD, WASH, and maternal health to check the quality of the role play; and
2. Ask supervisors to identify challenges and successes with home visits (for example, do CHWs avoid giving messages?).

For monitoring and evaluation, you should:

1. Collect M&E forms, including household visit forms; and
2. Ask about challenges CHWs face when completing necessary forms.

For other issues, you should:

1. Help the CHW prepare what he or she needs to do that day;
   a. Home visits. CHWs should:
      i. Know the age of the child;
      ii. Revise the 8 steps for negotiation;
      iii. Understand which job aids will be used that day;
      iv. Identify which counseling will be used that day;
      v. Have form #3 (home visit form);
   b. Community meetings. CHWs should be able to:
      i. Determine the best meetings to visit;
      ii. Know how to get permission to present during the meeting;
      iii. Choose the most relevant topic for the group visited/type of meeting;
      iv. Understand talking points for CHWs during community meetings;
      v. Commit the group to an action (telling their neighbours about nutrition, WASH, and ECD; trying a new practice they've learned about today; etc.);
2. Ensure that CHWs have all of the supplies they need:
   a. Counseling cards;
   b. Bags;
   c. Fliers (if copies are available): Maternal nutrition, infant and young child feeding, breast and complementary feeding, early childhood development 0-3 and 3-8 years old;
   d. Job aids:
      i. One page sheet on the 8 steps of negotiation;
      ii. Job aids for mothers and children 0-5, 6-11, and 12-23 months of age;
      iii. Job aids for conducting support groups and home visits;
   e. Talking points for CHWs during community meetings;
   f. Data collection forms and counter books;
3. Review how CHWs can use data that have been collected to improve performance.
   a. Household level
      i. Number of households visited and which groups are being visited (are priority households targeted?; see home visit form #3);

ii. Topics discussed during household visits, according to the needs of the household and community (are some topics like WASH and ECD not covered?; see home visit form #3);

iii. Households that might need special attention (e.g., households with more than one child less than two years old);

iv. Households that need second visits as part of negotiation;

v. Whether families that need referrals to health facilities get them and whether families actually go to the health facilities; and

vi. Whether CHWs use job aids for home visits to improve upon quality.

b. Support groups

i. Number of support groups and whether the right people are attending support groups (e.g., mothers with children less than 5 years of age, pregnant mothers, husbands, etc.; see support group form #2);

ii. Topics discussed during support groups, according to the needs of the community (are some topics like WASH and ECD not covered?; see support group form #2);

iii. Groups that might need special attention;

iv. Whether families that need referrals to health facilities get them and whether families actually go to the health facilities; and

v. Whether CHWs use job aids for support groups to improve upon quality.

4. Ask about any other challenges CHWs face (e.g., lack of transport, challenges paying CHWs including unknown payment schedule and late payment, low morale, etc.); ask for their proposed solutions to those challenges and help CHWs problem-solve.

5. Make sure CHWs get paid.

OFTEN BUT NOT EVERY MONTH:

For health facilities, you should ask:

1. If CHWs are able to connect to health facilities and how that is going;

2. If CHWs understand their roles in connecting community members to health facilities;

3. What support CHWs need; and

4. Review roles and responsibilities for CHWs.

If CHWs facilitate support groups, ask:

1. How many support groups CHWs have conducted;

2. Who has attended support groups (Mothers? Fathers? Grandparents?);

3. How the CHW engages support group members;

4. What CHWs discuss during support groups (MIYCAN, WASH, ECD, women's workload) (the focus should not only be on MIYCAN but also other topics, especially WASH and ECD); and

5. What challenges and successes CHWs have had with support groups (Are the right people attending? Is the group meeting interesting? Do mothers get the chance to practice new behaviours? etc.).

Revise the following questions to help build the capacity of CHWs when they conduct support groups. Does the CHW:

1. Choose a topic of discussion relevant to those attending (for example, a support group on disposing of infant faeces includes families with infants)

2. Introduce herself/himself to the group

3. Have everyone sit in a circle

4. Ask whether those who attended last month's meeting shared their experiences with others in the community

5. Ask questions that generate participation from all support group members

6. Ask group members to share their own experience

7. Identify a few practices related to today's theme that group members can try

8. Commit support group participants to trying a small, do-able action (actions might be different for different people in the group)

9. Resolve barriers families face as they try the new practice

10. (Where possible), give group members an opportunity to practice the new behaviour(s)

11. Request that group members speak to others in the community to encourage them to practice the behaviours discussed in today's meeting

12. Tell group members the place, date, and theme of the next meeting

General:

1. Go over *Mtoto Mwerevu's* checklist "Talking points for CHWs during community meetings" to make sure that CHWs meet with community groups and discuss appropriate topics; Groups CHWs should consider approaching about nutrition, ECD, and WASH include TASAF, religious groups, unions, credit associations, self-help groups for women and men, Ward Development Committees, etc.;

2. Hear about the health and well-being of the catchment area overall; and

3. Assign new tasks, when needed.

COMMUNITY HEALTH WORKER (CHW) TRAINING DIALOGUES FOR COUNSELLING ON COMPLEMENTARY FEEDING

INTRODUCTION

HOW TO USE THESE TRAINING DIALOGUES

This is a guide for CHW supervisors to help you use findings from Mtoto Mwerevu's research to support effective counselling. The steps in this guide will help you as help CHWs as they discuss (step 5 of negotiation) and recommend (step 6) practices people can try to improve the nutrition of their children. These new, detailed messages on complementary feeding are based on research in communities like theirs. Through using these guides, you will assist CHWs as they help families overcome challenges they may face when feeding their young children foods such as eggs, meat, fish, poultry, legumes, beans, nuts, vegetables, and fruits. It is important for you to review the details of these messages in advance so that you can explain them to CHWs.

During your monthly meetings with CHWs, they will:

- Discuss their own experiences;
- Hear more detailed messages about complementary feeding;
- Listen to success stories from families in communities like theirs; and
- Role play home visits using negotiation.

You should devote two hours of your monthly meetings with CHWs to these activities. You can use these guides to help families:

- Give children a variety of foods to eat (session 3);
- Encourage children to eat (session 4); and
- Give healthy snacks (session 5).

A separate guide includes the following modules:

- Breastfeed exclusively (session 1);
- Know what to do when babies cry (session 2).

During role plays, *one* CHW will play his or her own role as CHW. One or two CHWs will play the role of mother, father, and\or grandparent. The remaining CHWs will observe the role play. At the end, CHWs can ask questions about the role play and provide helpful feedback. During role plays, as CHW supervisors, please do not demonstrate how to conduct negotiation using these more detailed messages. Rather, let CHWs demonstrate and practise this on their own, as specified below. While this is happening, you can observe then provide feedback that is not judgmental.

Now have two CHWs demonstrate in front of the entire group role play #1, below (Baby Joseph). One CHW plays his or her own role as the CHW and the other CHW is the mother or father. After the role-play, you can use the discussion questions listed or others you think may be helpful to generate a discussion amongst CHWs.

Small groups of three will now role play simultaneously to give more opportunity for each CHW to play each of the three roles. Once 2-3 CHWs have completed the first role play and all CHWs have had the opportunity to discuss it, give every CHW the chance to role play. In smaller groups of three CHWs:

- One CHW plays the role of CHW;
- One CHW plays the role of mother, father (or other family member); and
- One CHW is the observer.

For this part of role playing, use the same case (#3, Baby Joseph). In your role plays, every CHW gets an opportunity to practise, in groups of three (CHW, mother or father, and observer). This way, every CHW learns together how to support families. As you role play in small groups of three, think about the demonstration you just saw with one CHW and one mother or father. What went well? What can be improved? Try to incorporate what you learnt into your own role play in groups of three.

As with the role play in plenary, after the role-play, you can use the discussion questions listed or others you think may be helpful to generate a discussion amongst CHWs.

Once you have finished role-playing one time in your small group of three, conduct a second role play with the CHW becoming the mother or father, the mother or father becoming the observer, and the observer becoming the CHW. Then discuss what went well and what could be improved. During the third role play, switch roles once again so that everyone has the opportunity to practise being a CHW.

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Note: Some CHWs may struggle with the basic steps of negotiation. If this is the case, discuss each step that is a challenge to them. Have the CHWs demonstrate a home visit, and give CHWs feedback, based on what you observe. Steps that may be particularly challenging for CHWs may include:

- Spending enough time asking about the caregiver's situation (step 2: Ask) before identifying recommendations the caregiver might try (step 4: Identify);
- Identifying then giving several recommendations the caregiver can try (step 4: Identify and step 6: Recommend), not just one;
- As part of step 6 (Recommend), asking caregivers what they understand each recommendation to be to make sure that they fully understand the actions presented to them (step 7: Agree);
- Recommending things caregivers can try (step 6: Recommend) before asking about, listening, and discussing the caregiver's situation;
- Making sure the caregiver agrees to a practice (step 7: Agree) before setting up the next home visit; and
- Using the job aid that corresponds to the age of the child. This is particularly important!

WHAT DID WE LEARN FROM THE HOUSEHOLD TRIALS RESEARCH?

Tell CHWs: Children were not being fed a diverse diet. Most children were fed grains and tubers.

- Almost half of children were fed *dagaa*, but it was very uncommon for children to be fed other animal-source foods like fish, eggs, meat, poultry, or animal milk.
- More than half of children were fed fruits and vegetables, but feeding yellow or orange fruits and vegetables, beans, and nuts was uncommon.
- It is difficult for many families to access a variety of foods because of the high cost and seasonal availability.
- The idea of a "balanced diet" was not well understood. Several parents thought giving a variety of grains made a porridge balanced. A balanced diet has a variety of different types of foods, like eggs, meat, fish, poultry, legumes, beans, nuts, vegetables and fruits.

SESSION 3: HELPING FAMILIES TO GIVE CHILDREN A VARIETY OF FOODS TO EAT. A GUIDE FOR CHW SUPERVISORS DURING MONTHLY MEETINGS WITH CHWS.

STRATEGIES TO SUPPORT FAMILIES TO INCREASE DIETARY DIVERSITY.

1. What have CHWs experienced?

CHW supervisors, begin by asking what CHWs have heard from families:

We know that after six months it is important for babies to start eating other foods in addition to breastmilk. It is recommended that babies eat a variety of different types of foods. Most babies eat grains and tubers. What do families tell you about the types of foods they are feeding their children from 6 – 12 months and from 12 – 24 months? What challenges do they face feeding their young children other foods such as eggs, meat, fish, poultry, legumes, beans, nuts, vegetables and fruits?

Be sure to give CHWs enough time to discuss the topic.

2. What do families need to know?

Tell CHWs:

- It is good for babies to eat a variety of foods to grow well and be healthy and smart. Examples of a variety of foods includes dagaa, fish, meat, egg, beans, nuts, and orange/yellow fleshed fruits and vegetables, in addition to grains and tubers and other fruits and vegetables.
- Babies only eat a small amount of food so it is important that those foods will help them grow well and be healthy and smart.

Together with all CHWs, read through and discuss the messages and other information on giving children a variety of foods to eat (see table 3). Keeping in mind the 8 steps of negotiation, make sure the CHWs understand and are able to discuss (step 5) the messages and why they are important, and recommend actions (step 6) for mothers and fathers. This information will be used in the role-plays discussed below.

3. Real experiences from families participating in household trials on complementary feeding

Supervisors, share the following success stories from caregivers with your CHWs:

Families were willing to try feeding new foods, this included adding foods like eggs, nuts, beans and animal milk to porridge or giving children small pieces of meat or fish that were cut very small. Families reported that children liked eating the foods and their children looked healthier. Fathers were involved in feeding their children in different ways. Some fathers purchased foods specifically for their children, others fed their children directly, and a few shared food from their plates with their child.

Here are some success stories from mothers:

A mother said: "I make nutritional porridge with maize, dagaa, ground nuts, beans, several things. The porridge is thick, because if you make it light, it is like nothing. A mother should make a thick porridge, fill the cup, and feed the child with a spoon."

Another mother said: "I gave my child smashed cooked bananas and dagaa. I just prepared it and gave it to him but when I saw he liked it I continued trying. Then, I mixed the cooked bananas with fish and again with beef. The results are great! He liked it and got used to it quickly. I see him having good health; he has a good body. Now he has grown plump."

Here are some success stories from fathers:

A father said: "When I got money, I thought I have a son that I should buy fish for, at least to boost his appetite. So, I bought fish and gave it to his mother to prepare for him and turns out he liked fish most."

Another father said: "I prepared maize, searched for soya, I searched for millet. We went to grind. It is me who went and prepared and ground and bought those foods that had to be bought. At the time of cooking for him we added egg and small fish. I added some groundnuts because I had a little."

A father said: "When they prepare the food for me, I invite my son. He comes and we eat from the same plate together. I have been doing this almost every day since it was recommended to me. It makes me happy. At first, my son was not used to it. When I used to invite him, he used to refuse until when he got used to it. Others in my family are happy seeing me eating with my child. Some fathers may not want to try this because small children have a tendency to get food on you and smothering you with food; but when they come to my house and see how I eat with my child, then they will learn from there on. The child sees that he is not segregated and he also likes it. I will continue because the child will learn how to feed himself and he will feel loved by each parent."

TABLE 3: RECOMMENDATIONS TO HELP FAMILIES FEED A VARIETY OF FOODS, USING THE 8 STEPS OF NEGOTIATION

During negotiation, *discuss* the following messages, *recommend* 2-3, and help the mother or other family member pick 1-2 and *agree* to try them.

NEGOTIATION STEP 5: DISCUSS		NEGOTIATION STEP 6: RECOMMEND	
MESSAGE	**WHY THIS IS IMPORTANT**	**FOR MOTHERS**	**FOR FATHERS**
The child needs to eat eggs, fish, dagaa, or other meat as often as possible.	• From 6 months of age, young children can eat well-cooked and finely-chopped eggs and mashed meat and fish, even if they don't have teeth. • Eggs, meat, fish and *dagaa* are very important to help children grow well and be healthy. • Your baby's stomach is ready to digest foods like eggs or meat. You can ensure that your baby can safely swallow those foods by mashing them, chopping them finely, or making powder of dried meat.	• Give your child fish, *dagaa*, or other types of meat, which can be minced using a mortar *(kinu)* or chopped finely with a knife. • Give your child cooked eggs to eat. • Give your child fish, *dagaa*, or other types of meat as early and as often as possible. • Save some of the food you raise that you would normally sell (like eggs, milk, fish, chicken) and keep it for your baby.	• Give your wife money to buy eggs, fish, *dagaa*, or other meat for your baby. • Buy eggs, fish, *dagaa*, or other meat to give to your baby. • Save some of the food you raise that you would normally sell (like eggs, milk, fish, chicken) and keep it for your baby. • Reassure your wife (and other family members) that the child can eat meat, fish, and other family foods that are mashed well. • Share food from your plate, including meat, fish, eggs, etc. with your child.
The child needs to be fed a variety of foods.	• After 6 months and as the child grows older, he/she can eat well-cooked and finely-chopped eggs, meat and fish even if s/he does not have teeth. • At this age, your baby is old enough to eat all family foods that are mashed and well-cooked. • When your baby eats a variety of foods, it is good for your baby to grow well and be healthy and smart. • Your baby will enjoy new tastes. • Your baby will feel satisfied longer, will cry less, and allow the mother and father to do their work. • In addition to breast milk and specially prepared foods (like porridge), family foods (like fish, meat, egg, and beans) help children to grow well and be healthy.	• Offer family foods, including eggs, meat, fish, *dagaa*, vegetables, beans. These foods can be chopped and mashed so they are easy for the child to swallow. • When feeding family foods, do not only give the broth/sauce. Be sure to give the thick parts (meat, fish, *dagaa*, vegetables, beans, peas). • Give potatoes, yams, bananas, plantains, cassava and rice mixed with sauce and meat, fish, *dagaa*, beans, chicken, or peas. • Vegetables can be pounded or mashed after cooking and given to your child. • Fruits that are cut in small pieces or mashed/pounded can be a good snack. • Save some of the food you raise that you would normally sell (like eggs, milk, fish, chicken) and keep it for your baby. • Share food from your plate, including meat, fish, eggs, etc. with your child.	• Give your wife money to buy different kinds of foods for your baby (such as eggs, fish, *dagaa*, vegetables, nuts, beans, milk, meat). • Buy different kinds of foods for your baby (such as eggs, fish, *dagaa*, vegetables, nuts, beans, milk, meat). • Save some of the food you grow or raise that you would normally sell (eggs, milk, fish, chicken, vegetables) and keep it for your baby. • Reassure your wife (and other family members) that the child can eat meat, fish, vegetables, beans, nuts, and other family foods that are mashed well. • Help your wife with her other chores so that she has time to prepare meals with a variety of foods for your child. • Share food from your plate, including meat, fish, eggs, etc. with your child.

4. Role play: Practise counselling families on giving a variety of food

For the role play session, please remember to have CHWs learn by acting out roles of CHWs and family members, observing each other, and sharing ideas to improve negotiation with families on giving a variety of food. Encourage those acting as family members to raise challenges and not be too agreeable! Role plays should be as realistic as possible.

ROLE PLAY #1: BABY JOSEPH

The **CHW** should follow the 8 steps of negotiation:

1. Greet the mother and father with respect;
2. Ask them about current caregiving practices;
3. Listen to their problems or concerns;
4. Identify a *few* messages to share with the mother and father, based on their situation (see table 3);
5. Discuss each of the practices (table 3);
6. Recommend 2 or 3 of the practices parents can try (table 3);
7. Ask the parents to agree to practise 1-2 of these behaviours; Ask what might make it easy or difficult to try them;
8. Set up an appointment for a return visit at which time you can ask the mother and father how things have gone.

CHWs:

Do not read the scenario for mothers and fathers in advance; In your first few practices, please consult table 3. When you feel comfortable with the recommendations in table 3, you don't need to refer to it in subsequent role plays; and remember to have the mother or father tell you what you have learnt. When family members "teach back" what they have learnt about new practices, you can be sure that they understand the practices that they have agreed to try.

The **mother** and **father** read the scenario below and act their parts, per the scenario.

Baby Joseph is 11 months old. His mother is breastfeeding and also feeds him porridge, vegetables, and beans. Papa Tumaini is a fisherman, and the family often eats fish, but they do not think Joseph can eat fish at such a young age, so they often just give him the broth that the fish is cooked in. The family does not usually have eggs or meat. They sometimes have peanuts.

Observers: Watch how the CHW identifies problems, concerns, and negotiates a solution.

CHW supervisors: after the role-play, it is very important to discuss what the group learnt. Do this in a supportive way, not blaming anyone for mistakes. Remind CHWs that role-playing is just a way to practise and learn from each other!

CHW supervisors: first ask for comments from the group. Some ideas for possible questions after the role play are as follows:

For the CHW, how did it feel to deliver the new messages? What worked well? What was difficult? What needs more practice? Did the family ask questions that you did not know how to answer?

For the mother or father, what did the CHW do well? Were the messages clear? Did the CHW address your concerns? Did you feel comfortable asking the CHW questions?

For observers, how did the CHW try to build rapport with family members and was it successful? How did the CHW try to understand the family situation and help them with challenges? For example, did the CHW find out about the foods that the family had access to? What suggestions do you have for CHWs? Has this situation ever come up for you during your home visits? What did you do?

SESSION 4: HELPING FAMILIES TO ENCOURAGE CHILDREN TO EAT. A GUIDE FOR CHW SUPERVISORS DURING MONTHLY MEETINGS WITH CHWS.

Strategies to support families to practise responsive feeding

1.What have CHWs experienced?

CHW supervisors, begin by asking CHWs: what have you heard from families about how they feed their children or encourage them to eat? What are some of the challenges families face?

2. What did we learn from the household trials research?

Tell CHWs:

- Many parents had challenges getting their young children to eat the food that was offered.
- Some mothers reported that children refused to eat certain foods or that children would spit out foods that were offered.
- Although this was a common challenge, very few families tried encouraging their children to eat more. But amongst those who did, they reported that encouraging their children to eat resulted in their children eating more.

3. What do families need to know?

Tell CHWs: Feeding times are periods of learning and love. It is recommended that caregivers talk to babies and young children during feeding, are patient, feed slowly, and encourage him/her to eat, but without force. Read through and discuss the messages and other information on encouraging the child to eat. Keeping in mind the 8 steps of negotiation, make sure the CHWs understand and are able to *discuss* the messages (step 5) and why they are important, and *recommend* actions (step 6) for mothers and fathers. This information will be used in the role-plays discussed below.

4. Real experiences from families participating in household trials on encouraging the child to eat

CHW supervisors, share the following success stories from mothers who tried these recommendations:

A mother said: "The thing that I liked was that the child ate food that she didn't usually eat. I felt so happy and amazed because even when I don't have money, I know that if I prepare this food and sing to the child when I'm giving it to her, she will eat and like it. I have seen that when I feed her and praise and clap and show her that I am happy, it has helped her to eat all of the food that she is given.

A father said: "I tried being at home during meal times so that I could eat together with my child and encourage him. I made it seem like a game and that he should like whatever he is eating. Even when I am not around, others in my family can do it."

Another father said: "I enjoyed sitting and playing with my child when I'm home from work. If she's here at home, I play with her. I tell her sweet stories. My wife says that I should continue playing with my child after I come home from work, so that my child can eat happily."

TABLE 4: RECOMMENDATIONS TO HELP FAMILIES ENCOURAGE THEIR BABIES TO EAT

During negotiation, *discuss* the following messages, *recommend* 2-3, and help the mother or other family member pick 1-2 and *agree* to try them.

NEGOTIATION STEP 5: DISCUSS		NEGOTIATION STEP 6: RECOMMEND	
MESSAGE	**WHY THIS IS IMPORTANT**	**FOR MOTHERS**	**FOR FATHERS**
Be patient and actively encourage the child to eat	• Feeding times are a chance for the child to learn. Talk with the child about the names of foods and utensils, how things are bigger or smaller, how the food tastes, and colors or numbers. • The child may need time to get used to eating foods other than breast milk. • Infants and young children may need help to ensure that they eat enough. Feeding the child new foods may require active care and encouragement. • Pay attention to the child's signs for hunger and to encourage the child to eat new foods. • Allowing children to touch and pick up their food and feed themselves helps develop coordination and improve movement.	• Be patient and encourage your child to eat by sitting with your child and smiling, laughing, and talking to them • Don't force your child to eat. Feed slowly, and talk to the child during feeding, with eye-to-eye contact. • Praise the child for trying new foods or eating all that is offered. • If the child refuses a food, keep trying. It can take time to get used to new foods (7-8 times of trying a new food). • If the child is distracted, feed in a calm place, and try to limit distractions during meals. • Offer foods that your child can pick up with her/his fingers and feed herself/himself (sweet potato, bananas, slices of fruits, beans, and other foods cut into small pieces) • Make feeding time a fun time with games, songs, and stories that encourage your child to eat.	• Encourage your child to eat more. Offer soft/mashed foods off of your own plate. • Talk with your children about their food and praise them for eating well. • Help your wife with her other chores so that she has time to encourage your child to eat more at each meal. • Help your wife with feeding your baby when she has too many tasks to do. • Encourage your child to eat more by making it into a game. You can pretend the food is a truck or other vehicle that has to make a delivery into the child's mouth. • Help your wife by feeding your baby. You can make feeding fun by playing games and telling stories that encourage your baby to eat.

5. Role play: Practise counselling families on responsive feeding

For the role play session, please remember to have CHWs learn by acting out roles of CHWs and family members, observing each other, and sharing ideas to improve negotiation with families on responsive feeding. Encourage those acting as family members to raise challenges and not be too agreeable! Role plays should be as realistic as possible.

ROLE PLAY #2: BABY NINA

The **CHW** should follow the 8 steps of negotiation:

1. Greet the mother and father with respect;
2. Ask them about current caregiving practices;
3. Listen to their problems or concerns;
4. Identify a few messages to share with the mother and father, based on their situation (see table 4);
5. Discuss each of the practices (table 4);
6. Recommend 2 or 3 of the practices parents can try (table 4);
7. Ask the parents to agree to practise 1-2 of these behaviours; Ask what might make it easy or difficult to try them;
8. Set up an appointment for a return visit at which time you can ask the mother and father how things have gone.

CHWs:

Do *not* read the scenario for mothers and fathers in advance;

In your first few practices, please consult table 4. When you feel comfortable with the recommendations in table 4, you don't need to refer to it in subsequent role plays; and

Remember to have the mother or father tell you what you have learnt. When family members "teach back" what they have learnt about new practices, you can be sure that they understand the practices that they have agreed to try.

The **mother** and **father** read the scenario below and act their parts, per the scenario.

Baby Nina is 10 months old. Nina's mama is breastfeeding and feeding the baby porridge. Mama tried giving the baby egg, but the baby would spit it out and refuse to eat it. She tried a second time, but it seemed like the baby was throwing up. Her mother-in-law and husband suggested waiting until the baby is older. If asked, the family would be willing to try talking, singing, and other ways to encourage the child to eat. The father is often home in the evenings when the mother is feeding the baby.

Observers: Watch how the CHW identifies problems, concerns, and negotiates a solution.

CHW supervisors: after the role-play, it is very important to discuss what the group learnt. Do this in a supportive way, not blaming anyone for mistakes. Remind CHWs that role-playing is just a way to practise and learn from each other!

CHW supervisors: first ask for comments from the group. Some ideas for possible questions after the role play are as follows:

For the CHW, how did it feel to deliver the new messages? What worked well? What was difficult? What needs more practice? Did the family ask questions that you did not know how to answer?

For the mother or father, what did the CHW do well? Were the messages clear? Did the CHW address your concerns? Did you feel comfortable asking the CHW questions?

For observers, how did the CHW try to build rapport with family members and was it successful? How did the CHW try to understand the family situation and help them with challenges? For example, did the CHW find out about the foods that the family had access to? What suggestions do you have for CHWs? Has this situation ever come up for you during your home visits? What did you do?

SESSION 5: HELPING FAMILIES TO GIVE HEALTHY SNACKS. A GUIDE FOR CHW SUPERVISORS DURING MONTHLY MEETINGS WITH CHWS.

Strategies to ensure children receive healthy foods and snacks.

1. What have CHWs experienced?

CHW supervisors, tell CHWs: After 6 months, babies and young children should be fed a variety of healthy foods. But it is becoming more common for babies to also receive sugary snacks and drinks, like biscuits, sweets, and drinks with sugar. CHW supervisors, ask CHWs: What do families tell you about giving biscuits, sweets, and sugary drinks? What are some of the challenges families face?

Be sure to give CHWs enough time to discuss the topic.

2. What did we learn from the household trials research?

Tell CHWs:

- More than half of babies had been fed sugary snacks in the week before our first visit with them.
- Many babies were given coffee or tea with sugar, juices with sugar added, or soda.
- All parents who agreed to try replacing sugary snacks with healthy snacks reported making this change.

3. What do families need to know?

Tell CHWs:

Parents should avoid giving their child sugary snacks (like biscuits and sweets) and sugary drinks (such as tea, coffee and soda) because these drinks have low nutrient value and decrease the child's appetite for more nutritious foods. Read through and discuss the messages and other information on giving children healthy snacks. Keeping in mind the 8 steps of negotiation, make sure the CHWs understand and are able to *discuss* the messages (step 5) and why they are important, and *recommend* actions (step 6) for mothers and fathers. This information will be used in the role-plays discussed below.

4. Real experiences from families participating in household trials on giving children healthy snacks

CHW supervisors, tell CHWs: Parents were happy to replace sugary snacks with healthy snacks because they understood that sugary snacks did not benefit their child's health.

CHW supervisors, share the following success stories from mothers:

One mother said: "I liked that recommendation to stop giving sweets and biscuits because those things are harmful. Sweets and biscuits have too much sugar which is not good for the baby. They can cause decaying of teeth. My family members agreed and said it is not good to give the baby sweets and biscuits."

Another mother said: "I tried not giving the biscuits or sweets, and instead I gave her fruits. I gave her bananas. Sweets have nothing. I didn't encounter any difficulty."

Here are some success stories from fathers:

One father said: "I educated the family members not to give the baby biscuits. I educated them that the foods that we give the baby, for instance tinned juice, soda, and biscuits are not healthy for the child."

Another father said: "As soon as I was informed and realised that biscuits are not healthy for children, I stood up and started educating my family that this food is bad for children and we made changes. They asked me what the child can eat. I advised them on fruits like papaws, watermelon, cucumber, mangoes and oranges, but things with much sugar like biscuits are not good."

TABLE 5: RECOMMENDATIONS TO HELP FAMILIES FEED HEALTHY SNACKS AND DRINKS

During negotiation, *discuss* the following messages, *recommend* 2-3, and help the mother or other family member pick 1-2 and *agree* to try them.

NEGOTIATION STEP 5: DISCUSS		NEGOTIATION STEP 6: RECOMMEND	
MESSAGE	**WHY THIS IS IMPORTANT**	**FOR MOTHERS**	**FOR FATHERS**
Replace sweet snacks and sugary drinks with healthy snacks and drinks	• Sweet snacks and sugary drinks do not give your child important nutrients. Fruits and other snacks will help the child feel satisfied longer, cry less, and allow the mother and father to do other work. • If the child eats too many sweet snacks, he/she may not feel hungry at meal time.	• Avoid giving a baby tea, coffee, soda and sugary or colored drinks. Offer milk or breastfeed instead. • Avoid giving sugary biscuits and other snacks; give fruits (such as pieces of ripe mango, papaya, banana), avocado, vegetables, boiled Irish potatoes, sweet potatoes.	• Only buy nutritious foods for your baby, do not buy sugary snacks, biscuits, or sweetened drinks and ask others not to feed these foods to your child.

5. Role play: Practise counselling families on healthy snacks and drinks

For the role play session, please remember to have CHWs learn by acting out roles of CHWs and family members, observing each other, and sharing ideas to improve negotiation with families on giving healthy snacks and drinks. Encourage those acting as family members to raise challenges and not be too agreeable! Role plays should be as realistic as possible.

ROLE PLAY #1: BABY STANLEY

The **CHW** should follow the 8 steps of negotiation:

1. Greet the mother and father with respect;
2. Ask them about current caregiving practices;
3. Listen to their problems or concerns;
4. Identify a *few* messages to share with the mother and father, based on their situation (see table 5);
5. Discuss each of the practices (table 5);
6. Recommend 2 or 3 of the practices parents can try (table 5);
7. Ask the parents to agree to practise 1-2 of these behaviours; Ask what might make it easy or difficult to try them;
8. Set up an appointment for a return visit at which time you can ask the mother and father how things have gone.

CHWs:

Do not read the scenario for mothers and fathers in advance;

In your first few practices, please consult table 2. When you feel comfortable with the recommendations in table 2, you don't need to refer to it in subsequent role plays; and

Remember to have the mother or father tell you what you have learnt. When family members "teach back" what they have learnt about new practices, you can be sure that they understand the practices that they have agreed to try.

The **mother** and **father** read the scenario below and act their parts, per the scenario.

Baby Stanley is 14 months old, and is the youngest of three children. Stanley's mama is breastfeeding and Stanley eats family foods, though sometimes he does not seem to be very hungry for the evening meal. Papa will often bring home sweets and biscuits to the children when he arrives home in the evening after working. Name enjoys eating biscuits, and Papa likes to see Stanley eating them.

Observers: Watch how the CHW identifies problems, concerns, and negotiates a solution.

CHW supervisors: after the role-play, it is very important to discuss what the group learnt. Do this in a supportive way, not blaming anyone for mistakes. Remind CHWs that role-playing is just a way to practise and learn from each other!

CHW supervisors: first ask for comments from the group. Some ideas for possible questions after the role play are as follows:

For the CHW, how did it feel to deliver the new messages? What worked well? What was difficult? What needs more practice? Did the family ask questions that you did not know how to answer?

For the mother or father, what did the CHW do well? Were the messages clear? Did the CHW address your concerns? Did you feel comfortable asking the CHW questions?

For observers, how did the CHW try to build rapport with family members and was it successful? How did the CHW try to understand the family situation and help them with challenges? For example, did the CHW find out about the foods the child was eating? What suggestions do you have for CHWs? Has this situation ever come up for you during your home visits? What did you do

COMMUNITY HEALTH WORKER (CHW) TRAINING DIALOGUES FOR COUNSELLING ON EXCLUSIVE BREASTFEEDING

INTRODUCTION

HOW TO USE THESE TRAINING DIALOGUES

This is a guide for CHW supervisors to help you use findings from *Mtoto Mwerevu's* research to support effective counselling. Using the steps in this guide, you can help CHWs to discuss (step 5 of negotiation) and recommend (step 6) practices people can try to improve the nutrition of their children. These new, detailed messages on exclusive breastfeeding are based on research in communities like theirs and can. assist CHWs to help families overcome challenges such as babies crying a lot or mothers struggling to breastfeed exclusively. It is important for you to review the details of these messages in advance so that you can explain them to CHWs.

During your monthly meetings, CHWs will:

- Discuss their own experiences;
- Hear more detailed messages about exclusive breastfeeding;
- Listen to success stories from families in communities like theirs; and
- Role play home visits using negotiation with the mother or father.

You should devote two hours of your monthly meetings with CHWs to these activities. You can use these guides to help families:

- Breastfeed exclusively (session 1);
- Know what to do when babies cry (session 2);
- Give children a variety of foods to eat (session 3);
- Encourage children to eat (session 4); and
- Give healthy snacks (session 5).

During role plays, *one* CHW will play his or her own role as CHW. *One* or *two* CHWs will play the role of mother, father, and\or other family members. The remaining CHWs will observe the role play. At the end, CHWs can ask questions about the role play and provide helpful feedback. During role plays, as CHW supervisors, please do not demonstrate how to conduct negotiation using these more detailed messages. Rather, let CHWs demonstrate and practise this on their own, as specified below. While this is happening, you can observe then provide feedback that is supportive, not judgmental.

Now have two CHWs demonstrate in front of the entire group the role play in section 5, below (Baby Aadila). One CHW plays his or her own role as the CHW and the other CHW is the mother or father. After the role-play, you can use the discussion questions listed or others you think may be helpful to generate a discussion amongst CHWs.

Small groups of three will now role play simultaneously to give more opportunity for each CHW to play each of the three roles. Once 2-3 CHWs have completed the first role play and all CHWs have had the opportunity to discuss it, give every CHW the chance to role play. In smaller groups of three CHWs:

- One CHW plays the role of CHW;
- One CHW plays the role of mother, father (or other family member); and
- One CHW is the observer.

For this part of role playing, use the same case in section 5 (Baby Aadila). In your role plays, every CHW gets an opportunity to practise, in groups of three (CHW, mother or father, and observer). This way, every CHW learns together how to support families. As you role play in small groups of three, think about the demonstration you just saw with one CHW and one mother or father. What went well? What can be improved? Try to incorporate what you learnt into your own role play in groups of three.

As with the role play in plenary, after the role-play, you can use the discussion questions listed or others you think may be helpful to generate a discussion amongst CHWs.

Once you have finished role-playing one time in your small group of three, conduct a second role play with the CHW becoming the mother or father, the mother or father becoming the observer, and the observer becoming the CHW. Then discuss what went well and what could be improved. During the third role play, switch roles once again so that everyone has the opportunity to practise being a CHW.

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Note: Some CHWs may struggle with the basic steps of negotiation. If this is the case, discuss each step that is a challenge to them. Have the CHWs demonstrate a home visit, and give CHWs feedback, based on what you observe. Steps that may be particularly challenging for CHWs may include:

- Spending enough time asking about the caregiver's situation (step 2: Ask) before identifying recommendations the caregiver might try (step 4: Identify);
- Identifying then giving *several* recommendations the caregiver can try (step 4: Identify and step 6: Recommend), not just one;
- As part of step 6 (Recommend), asking caregivers what they understand each recommendation to be to make sure that they fully understand the actions presented to them (step 7: Agree);
- Recommending things caregivers can try (step 6: Recommend) before asking about, listening, and discussing the caregiver's situation;
- Making sure the caregiver agrees to a practise (step 7: Agree) before setting up the next home visit; and
- Using the job aid that corresponds to the age of the child. *This is particularly important!*

WHAT DID WE LEARN FROM THE HOUSEHOLD TRIALS RESEARCH?

In Tanzania, a lot of mothers (about 8 in 10) breastfeed their babies exclusively in the first two months of life, but as the child ages, fewer and fewer do so. By six months of age, less than 3 in 10 mothers breastfeed exclusively. To understand why, we consulted with mothers and fathers of babies 0-5 months old in two regions near Lake Victoria. Mothers and fathers were counselled then asked to choose and try new practices related to exclusive breastfeeding. Then fathers and mothers were interviewed about their experience trying the new practise, and their motivations and concerns so that we could identify barriers to improving exclusive breastfeeding.

Many parents know about exclusive breastfeeding but they need more details to understand that it means to *not give anything* other than breastmilk. For example, even if parents did not give any food other than breastmilk, some of them gave water, thinking infants were thirsty. Many parents gave gripe water as well as traditional herbal remedies and medicines from the pharmacy, usually to stop baby's crying or because they felt that the baby must be having stomach pain or other symptoms related to *mchango*.

Parents need practical strategies to address challenges, such as ways to soothe a crying baby without giving gripe water. Mtoto Mwerevu found that mothers did not have enough time and energy to breastfeed fully, due to having a lot of work to do inside and outside the home. Men did not usually help with household chores or child care.

Most mothers were willing to try the recommendations to breastfeed more frequently and not give gripe water and traditional medicines. Fathers were willing to provide food to breastfeeding mothers. Most fathers also encouraged mothers to breastfeed and some were willing to help with household chores or by encouraging others in the household to help.

Mtoto Mwerevu found that parents need more detailed counselling to help them overcome barriers to exclusive breastfeeding. For example:

- Mothers need support to breastfeed often enough and long enough. Fathers can help with this;
- Parents need help calming an infant who cries a lot and seems to have stomach pain or *mchango*, which they consider to be serious health problems; and
- Parents need to know why and how to avoid giving gripe water and traditional medicines that are not prescribed by a doctor

SESSION 1: HELPING FAMILIES TO BREASTFEED EXCLUSIVELY. A GUIDE FOR CHW SUPERVISORS DURING MONTHLY MEETINGS.

STRATEGIES TO ENSURE THERE IS ENOUGH BREAST MILK FOR THE BABY: FEEDING MORE OFTEN AND LONGER

1. What have CHWs experienced?

CHW supervisors, begin by asking what CHWs have heard from families:

We know that exclusive breastfeeding is recommended for babies from birth to 6 months. Ask: What do families tell you about challenges they face giving the baby only mother's milk?

2. What did we learn from the household trials research?

Tell CHWs: Many parents know about exclusive breastfeeding but mothers don't always manage to breastfeed exclusively. Practices can be improved:

- Mothers need time to breastfeed longer at each feed and breastfeed more often. This will help them make plenty of milk. The family can help by reducing mothers' workloads;
- Some parents believe that they are breastfeeding their child exclusively because they do not give other foods, but they give liquids such as water, gripe water, traditional medicine, or non-prescribed medicines; and
- Often, babies are given water because parents think their babies are thirsty.

3. What do families need to know?

Tell CHWs: Breastmilk has everything a baby needs to eat and drink to grow well. Breastmilk also helps protect the baby from many sicknesses.

Together with all CHWs, read then thoroughly discuss the messages and other information on exclusive breastfeeding in table 1. Keeping in mind the 8 steps of negotiation, make sure the CHWs understand and are able to *discuss* (step 5) the messages and why they are important, and *recommend* actions (step 6) for mothers and fathers. This information will be used in the role-plays discussed below.

4. Real experiences from families participating in household trials on exclusive breastfeeding

Supervisors, share the following success stories from mothers with your CHWs:

In its research, *Mtoto Mwerevu* found that some fathers and other family members were willing to help mothers with chores so that they had more time to breastfeed. Some parents reported they were more confident about the mothers' milk supply. Other families reported that their babies cried less and slept better when they breastfed fully.

A mother said: "I liked the recommendation to breastfeed longer each time the child breastfeeds. In the past, I used to breastfeed my son for a shorter time and the milk was not coming out. Now, I breastfeed him until he finishes all the milk and he is satisfied."

A young mother said: "My daughter wasn't getting any sleep before but now she sleeps just after being breastfed. This is a good outcome…you can even do other chores comfortably."

Here are some success stories from fathers:

A young father of a 2-month old said: "I decided to help my wife with household chores so that she gets enough time to breastfeed. I encouraged her to use all the time she needed to breastfeed the baby. She listened and worked on it. She now breastfeeds the baby more often. I did this because I want to fulfil my duties of ensuring that my baby has good health. I made sure that whenever I was at home, my wife should breastfeed the baby as often as possible. The results were excellent. My wife realised that if the baby is properly fed, the baby sleeps a lot and this improves the baby's health. This gives me enough time to work on other things."

A young father of a 3-month old daughter said: "My wife was happy when other family members started assisting with small chores like cleaning utensils and collecting vegetables from the market. Her breastmilk has increased and the baby is breastfed whenever needed. What I like is that since family members started assisting my wife, the baby cries less because she is breastfed frequently."

TABLE 1: RECOMMENDATIONS TO HELP MOTHERS BREASTFEED EXCLUSIVELY, USING THE 8 STEPS OF NEGOTIATION

During negotiation, *discuss* the following messages, *recommend* 2-3, and help the mother or their family member pick 1-2 and *agree* to try them.

NEGOTIATION STEP 5: DISCUSS		NEGOTIATION STEP 6: RECOMMEND	
MESSAGE	**WHY THIS IS IMPORTANT**	**FOR MOTHERS**	**FOR FATHERS**

Breastfeed often throughout the day and night.
 	
Ask the father, mother-in-law, and other family members to help with one of the tasks you normally carry out outside the home. What small task might a family member or friend help you with?
	• The more a baby suckles, the more milk is produced.
	• Breastfeeding frequently day and night:
	  ◦ Helps your baby grow;
	  ◦ Helps you make plenty of milk;
	  ◦ Gives the baby all the food and water she needs;
	  ◦ Because your baby has a small stomach, your baby needs to breastfeed often.
	• Breastfeeding often also prevents breast engorgement and pain.
		• Ask others to help with work outside the home so you can stay home more to breastfeed during the day.
		• Ask your husband to let you return home from the field early so that you have time to breastfeed longer.
		• Ask family members to help with household chores so you can rest and breastfeed the baby fully.
		• Take your baby with you when you leave home, or ask someone to bring your baby to you for feeding.
			• Help your wife with work such as farming, fetching water and getting firewood so she has time to breastfeed often and long enough. This helps your child to grow well and be happy and healthy.
			• Let your wife return home from the field early so that she has time to breastfeed longer.
			• Buy nutritious foods for your wife and encourage her to eat well to build confidence in her breastmilk supply.

Take time to breastfeed for as long as the baby wants at each feed. Let the baby finish all the milk in one breast and then offer the other breast.	• When a baby breastfeeds longer each time, the baby gets more nutrient-rich milk. • A baby needs both the “foremilk” (high in water for thirst and sugar for energy) and “hindmilk” (high in fat so baby feels full and grows strong).	See recommendations above. Also: • Eat a balanced diet and eat more frequently to ensure that you produce enough milk.	See recommendations above.
Do not give the baby any foods or liquids other than breast milk. Only give medicines when instructed by a doctor or a health worker.	• Breastmilk alone protects the baby’s health. • Breastfeeding fully (as described above) means no other food or drink is needed. • Babies who breastfeed exclusively are less likely to get diarrhoea and other illnesses because breast milk is clean and protects against infections. • Foods, water, or drinks other than breastmilk that are given to the baby before 6 months can take up space in the baby’s small stomach. Less room for breast milk can mean the baby will not grow as well. • Other medicines can hurt your baby. Most gripe water contains alcohol that can affect the baby’s brain and does not cure any sickness. • Giving any other liquids including plain water, gripe water and traditional medicines increases the risk that your baby will get sick.	• Talk to other family members about the importance of exclusive breastfeeding.	• Encourage your wife to breastfeed exclusively. • Ask your wife not to give porridge or other foods to the baby before 6 months. • Do not buy gripe water

5. Role play: Practise counselling families on exclusive breastfeeding

For the role play session, please remember to have CHWs learn by acting out roles of CHWs and family members, observing each other, and sharing ideas to improve negotiation with families on breastfeeding practices. Encourage those acting as family members to raise challenges and not be too agreeable! Role plays should be as realistic as possible.

ROLE PLAY #1: BABY AADILA

The **CHW** should follow the 8 steps of negotiation:

1. Greet the mother and father with respect;
2. Ask them about current caregiving practices—regardless of whether or not they breastfeed exclusively;
3. Listen to their problems or concerns;
4. Identify a *few* messages to share with the mother and father, based on their situation (see table 1);
5. Discuss each of the practices (table 1);
6. Recommend 2 or 3 of the practices parents can try (table 1);
7. Ask the parents to agree to practise 1-2 of these behaviours; Ask what might make it easy or difficult to try them;
8. Set up an appointment for a return visit at which time you can ask the mother and father how things have gone.

CHWs:

Do *not* read the scenario for mothers and fathers in advance;

In your first few practices, please consult table 1. When you feel comfortable with the recommendations in table 1, you don't need to refer to it in subsequent role plays; and

Remember to have the mother or father tell you what you have learnt. When family members "teach back" what they have learnt about new practices, you can be sure that they understand the practices that they have agreed to try.

The **mother** and **father** read the scenario below and act their parts, per the scenario.

Baby Aadila is 3 months old. Mama Aadila is exclusively breastfeeding the baby but she is worried about having enough milk for the baby. Baba Aadila and the baby's grandmother say it is time to give the baby some porridge because milk is not enough, and Mama Aadila has a lot of work to do. During the day, Mama Aadila goes to the fields and leaves the baby at home with the older children. Baba Aadila works to provide money for the family and normally spends days away at the island for fishing. When he comes home, he is always tired.

Observers: Watch how the CHW identifies problems, concerns, and negotiates a solution.

CHW supervisors: after the role-play, it is very important to discuss what the group learnt. Do this in a supportive way, not blaming anyone for mistakes. Remind CHWs that role-playing is just a way to practise and learn from each other!

CHW supervisors: first ask for comments from the group. Some ideas for possible questions after the role play are as follows:

For the CHW, how did it feel to deliver the new messages? What worked well? What was difficult? What needs more practise? Did the family ask questions that you did not know how to answer?

For the mother or father, what did the CHW do well? Were the messages clear? Did the CHW address your concerns? Did you feel comfortable asking the CHW questions?

For observers, how did the CHW try to build rapport with family members and was it successful? How did the CHW try to understand the family situation and help them with challenges? For example, did the CHW find out about mothers' concerns about whether she had enough breastmilk? Did the CHW ask about any challenges mothers and fathers have with heavy workloads? What suggestions do you have for CHWs? Has this situation ever come up for you during your home visits? What did you do?

SESSION 2: HELPING FAMILIES WHEN THEIR BABIES CRY. A GUIDE FOR CHW SUPERVISORS DURING MONTHLY MEETINGS WITH CHWS.

Supportive strategies to reduce parents' worry when a baby cries and help them to exclusively breastfeed

1.What have CHWs experienced?

CHW supervisors, begin by asking CHWs: what have you heard from families related to crying or *mchango*? What do family members tell you about crying and *mchango*? How do these affect breastfeeding practices?

2. What did we learn from the household trials research?

Tell CHWs:

- Some parents worried that breast milk was not sufficient for the baby and that crying was a sign of hunger. Parents said cues to breastfeed were when the baby was crying or urinated, particularly at night;
- Many parents said that when their babies continued to cry, they worried that the baby had stomach pain or an illness like mchango so they gave gripe water or traditional herbal medicines;
- Sometimes, health workers recommended gripe water (it is important that CHWs not do so!); and
- Many parents did not realise that gripe water contains alcohol and is not good for babies. After counselling, some parents were able to soothe the baby and stop giving gripe water. Some parents were motivated to stop using gripe water because they wanted to protect the baby's brain development.

3. What do families need to know?

Tell CHWs: Crying is normal for babies, especially during the first few months of life. Babies cry for many reasons. Breastmilk is the best thing to offer a baby when he or she cries. But sometimes crying is not due to hunger, pain, or anything parents can control. Some babies just cry a lot while others cry a little and it is not the mother's fault. Many babies will cry less once they are 3 or 4 months old.

Tell CHWs: Excessive crying by the baby can upset the relationship between the baby and the mother, and can cause tension with other members of the family. An important way to help a breastfeeding mother is to counsel her and her family about the baby's crying. CHWs and health professionals can support families who worry about a baby crying by reassuring parents and offering ways to respond to crying. No single approach works for everyone so it is important to support families to find what helps them to manage fussy or distressed babies and to respond appropriately.

Together with all CHWs, read then throughly discuss the messages and other information on calming the crying baby in table 2. Keeping in mind the 8 steps of negotiation, make sure the CHWs understand and are able to *discuss* the messages (step 5) and why they are important, and *recommend* actions (step 6) for mothers and fathers. This information will be used in the role-plays discussed below.

4. Real experiences from families participating in household trials on exclusive breastfeeding

CHW supervisors, share the following success stories from mothers who tried these recommendations:

An older mother said the following about her 1-month old daughter: "Whenever I calm the baby, she stops crying and the stomach pain ceases to the point that she sleeps."

Another mother said she was able to calm the baby by carrying the baby around in the morning while the mother continued her chores. The mother said "When the baby cried a lot, I carried her and played with her so that I had freedom to complete my other chores. When I soothed the baby, she stopped crying regularly, she had no problems with colic, and she ate nicely. My husband and other children helped me a lot by also calming my daughter."

Another mother said "When I stopped giving gripe water, I was able to put my child on my thighs and caress her back. Sometimes I would carry her and move her around with me. Now, I'm not facing any difficulty and there have been no problems for the baby or me."

Here is a success story from a father: "The advice to calm the child is good. I made a mistake. I encouraged my wife to give my child gripe water. But once I heard that giving gripe water was not good, I told my wife to stop giving it to the baby. At night, our baby continued to cry but we kept soothing the child and she fell asleep. At first, my family members told me to give gripe water but I was patient and kept soothing the child. My neighbours thought I was crazy. But now they see that soothing is better than giving gripe water."

TABLE 2: RECOMMENDATIONS TO HELP FAMILIES RESPOND TO BABIES CRYING, USING THE 8 STEPS OF NEGOTIATION

During negotiation, *discuss* the following messages, *recommend* 2-3, and help the mother or other family member pick 1-2 and *agree* to try them.

NEGOTIATION STEP 5: DISCUSS		NEGOTIATION STEP 6: RECOMMEND	
MESSAGE	**WHY THIS IS IMPORTANT**	**FOR MOTHERS**	**FOR FATHERS**
Do not give gripe water, traditional medicines (including traditional medicines applied to the breast), herbal treatments that are given by mouth, or any other liquids to the baby, even if a family member, friend, health worker, or anyone else recommends it.	• Giving only breast milk is the best way to protect the baby's health. Breastmilk protects babies from diseases such as diarrhoea, upper respiratory infections, and other illnesses; • Often, there is no way to keep babies from crying, and babies usually grow out of this phase when they are 3 or 4 months old; • Often, gripe water contains alcohol that can damage the baby's brain; • Sometimes, crying is not due to hunger, pain, or anything parents can control. It is common in babies and is not unique to your baby.	• When your baby is crying, try giving breastmilk or see if the baby is wet; • Ask other family members not to give gripe water, traditional medicines, herbal treatments, or any other liquids to the baby. Explain to them that breastmilk is the best way to protect the baby's health.	• Ask your wife and other family members to not give gripe water, traditional medicines, herbal treatments, or other liquids that have not been provided at the health facility. Explain to them that breastmilk is the best way to protect the baby's health.
When the baby is crying, try calming the baby by rocking the baby to sleep or holding the baby on his or her tummy on your lap and rubbing the baby's back.		• It may help to speak or sing softly to your baby while you rock or massage him or her. • Ask other family members to hold and soothe the baby.	• Be patient when the baby cries. Reassure the mother. • Assist the mother with soothing or distracting the baby (rock the baby to sleep; hold the baby on his or her tummy on your hand or lap and rub baby's back). • Ask other family members to hold and soothe the baby.
If you are worried the baby is crying due to sickness, the best thing to do is to see a health worker.		• Babies cry for many reasons. It is not your fault. • If crying seems unusual and severe, talk to a health worker.	• Babies cry for many reasons. It is not your wife's fault.

5. Role play: Practise counselling families on exclusive breastfeeding when babies cry

For the role play session, please remember to have CHWs learn by acting out roles of CHWs and family members, observing each other, and sharing ideas to improve negotiation with families on calming the crying baby. Encourage those acting as family members to raise challenges and not be too agreeable! Role plays should be as realistic as possible.

ROLE PLAY #2: BABY EMMANUEL

The **CHW** should follow the 8 steps of negotiation:

1. Greet the mother and father with respect;
2. Ask them about current caregiving practices—regardless of whether or not they breastfeed exclusively;
3. Listen to their problems or concerns;
4. Identify a *few* messages to share with the mother and father, based on their situation (see table 1);
5. Discuss each of the practices (table 1);
6. Recommend 2 or 3 of the practices parents can try (table 1);
7. Ask the parents to agree to practise 1-2 of these behaviours; Ask what might make it easy or difficult to try them;
8. Set up an appointment for a return visit at which time you can ask the mother and father how things have gone.

CHWs:

Do not read the scenario for mothers and fathers in advance;

In your first few practices, please consult table 2. When you feel comfortable with the recommendations in table 2, you don't need to refer to it in subsequent role plays; and

Remember to have the mother or father tell you what you have learnt. When family members "teach back" what they have learnt about new practices, you can be sure that they understand the practices that they have agreed to try.

The **mother** and **father** read the scenario below and act their parts, per the scenario.

Scenario: Baby Emmanuel is one month old. Mama Emmanuel says she is exclusively breastfeeding however she also gives gripe water to the baby. She gives gripe water to stop the baby from crying and because she believes he is suffering from stomach pain due to mchango. Baba Emmanuel says it is sad to see the baby cry, and gripe water is good because it helps the baby sleep. Both Mama Emmanuel and baba Emmanuel give gripe water so they can complete work without being distracted by Baby Emmanuel's cries.

Observers: Watch how the CHW identifies problems, concerns, and negotiates a solution.

CHW supervisors: after the role-play, it is very important to discuss what the group learnt. Do this in a supportive way, not blaming anyone for mistakes. Remind CHWs that role-playing is just a way to practise and learn from each other!

CHW supervisors: first ask for comments from the group. Some ideas for possible questions after the role play are as follows:

For the CHW, how did it feel to deliver the new messages? What worked well? What was difficult? What needs more practise? Did the family ask questions that you did not know how to answer?

For the mother or father, what did the CHW do well? Were the messages clear? Did the CHW address your concerns? Did you feel comfortable asking the CHW questions?

For observers, how did the CHW try to build rapport with family members and was it successful? How did the CHW try to understand the family situation and help them with challenges? For example, did the CHW find out about their concerns about the child crying? Has this situation ever come up for you during your home visits? What did you do?

CSO SUPERVISORS' GUIDE TO MONTHLY MEETINGS WITH CSO VOLUNTEERS

WHAT IS SUPPORTIVE SUPERVISION?

It is a process of guiding, monitoring, and coaching workers to promote compliance with standards and assure delivery of quality activities. During supervisory visits, you work as a team to meet common goals and objectives.

WHO SHOULD USE THIS GUIDE?

Mtoto Mwerevu CSO supervisors as you build the capacity of CSO volunteers.
See below:

WHY IS SUPPORTIVE SUPERVISION IMPORTANT?

Mtoto Mwerevu can't succeed without it. When you hold regular, effective meetings with volunteers, you can:

- Give them emotional and other support needed to face challenges on their own;
- Help volunteers understand their roles better;
- Give volunteers the knowledge and skills they need to do their jobs effectively; and
- Motivate them.

HOW OFTEN SHOULD YOU MEET WITH VOLUNTEERS?

Monthly.

REVIEW THE MATERIALS TO TAKE WITH YOU TO MONTHLY MEETINGS WITH VOLUNTEERS:

- This guide;
- The list of volunteers' roles and responsibilities;
- Job aids (2.2-2.5) and checklists (checklist 5.1 for all support groups and checklists 5.2-5.5 for IYCF, ECD, WASH, and maternal nutrition);
- M&E reports on programme coverage; and
- Anything else you think would be appropriate.

WHAT SHOULD HAPPEN WHEN YOU MEET WITH VOLUNTEERS?

EVERY MONTH

Review roles and responsibilities, including conducting support groups (and facilitation or behaviour change) and collecting programme data using form 2.

For support groups, praise volunteers for the good work they have done to date. Then ask volunteers:

1. If they know *how many* support groups they should hold every month (at least 1 support group per month);
2. If they know *which* individuals should be invited to support groups. The following households should be invited:
   a. Participating in TASAF or who are very poor but not participating in TASAF;
   b. With mothers in their first pregnancy;
   c. With children <2 years old;

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d. Experiencing challenges with breastfeeding, complementary feeding, WASH, or ECD;

e. Find out where volunteers have worked (geographic area); and

f. If volunteers are unclear on who should attend support groups and how often, provide them guidance. Please take advantage of the very next opportunity you meet with volunteers (for example, when you pay them). *Volunteers should actively encourage grandmothers and husbands to participate, provided they do not interrupt mothers' support groups.*

3. *What* volunteers discuss during support groups: ONE topic per support group, including Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN), Water, Sanitation, and Hygiene (WASH), Early Childhood Development (ECD), and women's workload. The focus should not only be on MIYCAN but also other topics, especially WASH and ECD.

Conduct role plays to practise support groups, depending on the topic of the support group:

1. Get volunteers from the group to role play in groups of three: CSO volunteer, mother, and observer who gives comments about how the volunteer did during role play. Alternatively, for support groups with fathers or grandmothers, volunteers should practise, acting as: 1. volunteer, father and observer, or 2. volunteer, grandmother, and observer;
2. Select one appropriate topic for the support group, depending on the needs of the community (one element of MIYCAN such as complementary feeding, WASH, or ECD practices);
3. Ask the volunteer to act as if he or she is conducting a support group;
4. At the end of the role play, ask for comments, first from the volunteer conducting the role play, then from the mother, father, or grandmother, then from the observer: What went well? What needs improvement?
5. Review all elements of quality support groups and give concrete examples of how the volunteer performed each step;
6. Provide any final input on the role play, including suggestions for how to improve them.

Ask:

1. The geographic coverage of support groups;
2. Use checklists 5.1-5.5 distributed in *Mtoto Mwerevu's* training for IYCF, ECD, WASH, and maternal health to check the quality of the role play; and
3. Ask CSO staff to identify challenges and successes with support groups (for example, do volunteers avoid giving messages?).

For monitoring and evaluation, you should:

1. Collect M&E forms, including support group form (form #2); and
2. Ask about challenges volunteers face when completing necessary forms.

For other issues, you should:

1. Help the volunteer prepare what he or she needs to do that day;

   a. Support groups. Volunteers should:

      i. Know the ages of the children;

      ii. Understand which job aids they will use that day;

      iii. Have form #2 (support group form);

   b. Community meetings. These include TASAF meetings as well as events such as World Breastfeeding Week. Volunteers should describe:

      i. How to know the best meetings to visit;

      ii. How to get permission to present during the meeting;

      iii. Choose the most relevant topic for the group visited/type of meeting;

      iv. Understand talking points for volunteers during community meetings;

      v. Commit the group to an action (telling their neighbours about nutrition, WASH, and ECD; trying a new practice they've learnt about today; etc.);

2. Ensure that volunteers have all of the supplies they need:
   a. Counseling cards;
   b. Bags;
   c. Fliers (if copies are available): Maternal nutrition, infant and young child feeding, breast and complementary feeding, early childhood development 0-3 and 3-8 years old;
   i. Job aids for conducting support groups (job aids 2.2-2.5);
   d. Talking points for volunteers during community meetings;
   e. Data collection forms.
3. Review how volunteers can use data that have been collected to improve performance.
   a. Coordinate with CHWs and their supervisors to determine what topics are being covered during household visits so that complementary topics can be discussed in support groups;
   b. Learn from CSO staff what radio spots are being aired so that the same topics can be addressed in support groups;
   c. Identify households that might need special attention (e.g., households with more than one child less than two years old) and therefore need to attend support groups;
   d. Whether volunteers use job aids (job aids 2.2-2.5) for support groups to improve upon quality;
   e. Number of support groups and whether the right people are attending support groups (e.g., mothers with children less than 5 years of age, pregnant mothers, husbands, etc.; see support group form #2);
   f. Topics discussed during support groups, according to the needs of the community (are some topics like WASH and ECD not covered?; see support group form #2);
4. Ask about any other challenges volunteers face (e.g., lack of transport, challenges paying volunteers including unknown payment schedule and late payment, low morale, etc.); ask for their proposed solutions to those challenges and help volunteers problem-solve.
5. Make sure volunteers get paid.

OFTEN BUT NOT EVERY MONTH:

Revise the following questions to help build the capacity of volunteers when they conduct support groups. Does the volunteer:

1. Choose a topic of discussion relevant to those attending (for example, a support group on disposing of infant faeces includes families with infants)
2. Introduce herself/himself to the group
3. Have everyone sit in a circle
4. Ask whether those who attended last month's meeting shared their experiences with others in the community
5. Ask questions that generate participation from all support group members
6. Ask group members to share their own experience
7. Identify a few practices related to today's theme that group members can try
8. Commit support group participants to trying a small, do-able action (actions might be different for different people in the group)
9. Resolve barriers families face as they try the new practice
10. (Where possible), give group members an opportunity to practise the new behaviour(s)
11. Request that group members speak to others in the community to encourage them to practise the behaviours discussed in today's meeting
12. Tell group members the place, date, and theme of the next meeting

GENERAL:

1. Go over *Mtoto Mwerevu's* checklist "Talking points for CHWs and CSO volunteer staff during community meetings" to make sure that volunteers meet with community groups and discuss appropriate topics; Groups volunteers should consider approaching about nutrition, ECD, and WASH include TASAF, religious groups, unions, credit associations, self-help groups for women and men, Ward Development Committees, etc.;
2. Hear about the health and well-being of the catchment area overall; and
3. Assign new tasks, when needed.

CIVIL SOCIETY ORGANISATION (CSO) VOLUNTEER ROLES AND RESPONSIBILITIES

MAIN RESPONSIBILITY:

Facilitate discussion for behaviour change to the support groups, connecting community members to services. Advocate for nutrition in existing community forums such as TASAF meetings, World Breastfeeding Week, etc.

MAIN DUTIES:

1. Identify existing community support groups that are eager to learn about and promote good nutrition, WASH, ECD, and agriculture. Visits unions, credit associations, TASAF meetings, religious groups at mosques and churches, self-help groups, other groups for men and women, Ward Development Committees, etc.

2. Determine which community groups demonstrate commitment to health. Prioritise groups that want to improve health and have members who can influence practices related to nutrition, WASH, ECD, and agriculture – i.e. fathers, grandmothers, and mothers.

3. Lobbies for space in meetings to:
    a. Discuss the importance of good nutrition for children
    b. Talk about specific practices people can adopt to improve children's health and development
    c. Identify things group members can do to improve children's growth and development
    d. Commit group members to take specific actions to improve health
    e. Commit group members to talk to others about what they've learned

4. Revitalise existing support groups that target 1000 day mothers and those who influence them, including fathers and grandmothers. If it doesn't make sense to revitalise existing groups, form new ones.

5. Collects data from the support group visits. Returns completed forms to CSO M&E staff.

6. Coordinates with CSO on a regular basis.

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DISTRICT NUTRITION OFFICER (DNUO) GUIDE TO MONTHLY MEETINGS WITH COMMUNITY HEALTH WORKER (CHW) SUPERVISORS

WHAT IS SUPPORTIVE SUPERVISION?

It is a process of guiding, monitoring, and coaching workers to promote compliance with standards and assure delivery of quality activities. During supervisory visits, you work as a team to meet common goals and objectives.

WHO SHOULD USE THIS GUIDE?

Mtoto Mwerevu regional staff and DNuOs as you build the capacity of CHW supervisors. In turn, supervisors will more effectively supervise CHWs.
See below:

A separate guide will help CHW supervisors help CHWs.

Mtoto Mwerevu's regional staff and DNuOs → **CHW supervisors** → **CHWs**

↑ **THIS GUIDE HELPS HERE** ↑

WHY IS SUPPORTIVE SUPERVISION IMPORTANT?

Mtoto Mwerevu can't succeed without it. When you hold regular, effective meetings with supervisors, you can:

- Give them the emotional and other support they need to face challenges on their own;
- Help supervisors understand their roles better;
- Share with supervisors the knowledge and skills they need to do their jobs effectively; and
- Motivate supervisors.

HOW OFTEN SHOULD YOU CONDUCT SUPERVISION OF CHW SUPERVISORS? Monthly.

REVIEW THE MATERIALS DNUOS SHOULD TAKE WITH THEM TO MONTHLY MEETINGS WITH CHW SUPERVISORS:

- This guide;
- The guide to help CHW supervisors help CHWs;
- CHW supervisor job description;
- CHW job descriptions;
- Checklists for home visits and support groups distributed in IYCF\ECD\WASH training;
- M&E reports on programme coverage; and
- Anything else you think would be appropriate.

WHAT SHOULD HAPPEN WHEN YOU MEET WITH SUPERVISORS?

EVERY MONTH, you should ask supervisors whether they are reviewing the following with CHWs about household visits:

1. If CHWs know *how many* households they should visit every week (6 visits/week);
2. If CHWs know *which* households should be visited. The following households should be visited:
   a. With at least one child < 5 years of age who is *mildly* or *moderately* malnourished;
   b. Participating in TASAF or who are very poor but not participating in TASAF;
   c. With mothers in their first pregnancy;
   d. With children 3-9 months old; and
   e. Experiencing challenges with breastfeeding, complementary feeding, WASH or ECD.

   Note: Most of these households will need to be visited two times (sometimes more). This is how negotiation is used in home visits.

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3. Ask if CHW supervisors know whether CHWs are visiting other households *(note: no other households other than the ones listed above should be visited)*;
4. Find out from CHW supervisors where CHWs have worked (geographic area);
5. If CHW supervisors are unclear on who CHWs should visit and how often, provide them guidance;
6. Ask supervisors what CHWs discuss during home visits. For each age of the child: MIYCAN, WASH, ECD (and women's workload; the focus should not only be on MIYCAN but also other topics, especially WASH and ECD);
7. Ask CHW supervisors how CHWs prepare for and conduct a home visit based on the age of the child;
8. Whether CHWs are using negotiation and if so, how?
    a. Use checklist distributed in *Mtoto Mwerevu's* IYCF\ECD\WASH training; and
    b. Ask supervisors to identify challenges and successes with home visits (for example, do CHWs avoid giving messages only?);
    c. To ensure that CHW supervisors know how to negotiate, consider having two CHW supervisors demonstrate how to negotiate and give them constructive feedback.
9. Check with supervisors to make sure they have a schedule for observing each CHW as s/he conducts home visits and support groups;
10. Ask supervisors to identify challenges and successes with home visits;
11. Together with CHW supervisors, problem-solve challenges;
12. Help supervisors ensure that CHWs have all of the supplies they need (for a full list, see the CHW supervisor monthly guide);
13. Ask supervisors whether CHWs are able to connect to health facilities and how that is going;
14. Ask CHW supervisors whether CHWs have been able to complete the M&E forms correctly and have been able to resolve any challenges with data collection and filling out forms;
15. Review how CHW supervisors can use data that have been collected to improve the performance of CHWs.
    a. Household level
        i. Number of households visited and which groups are being visited (are priority households targeted?; see home visit form #3);
        ii. Topics discussed during household visits, according to the needs of the household and community (are some topics like WASH and ECD not covered?; see home visit form #3);
        iii. Households that might need special attention (e.g., households with more than one child less than two years old);
        iv. Households that need second visits as part of negotiation;
        v. Whether families that need referrals to health facilities get them and whether families actually go to the health facilities; and
        vi. Whether CHW supervisors use checklists for home visits to improve upon quality;
    b. Support groups
        i. Number of support groups and whether the right people are attending support groups (e.g., mothers with children less than 5 years of age, pregnant mothers, husbands, etc.; see support group form #2);
        ii. Topics discussed during support groups, according to the needs of the community (are some topics like WASH and ECD not covered?; see support group form #2);
        iii. Groups that might need special attention;
        iv. Whether families that need referrals to health facilities get them and whether families actually go to the health facilities; and
        v. Whether CHW supervisors use checklists for support groups to improve upon quality.
16. Ask about any other challenges supervisors face (e.g., lack of transport, challenges getting CHWs paid, low morale, etc.); help them solve these challenges.

For support groups, ask:

1. How many support groups CHWs have conducted;
2. Who has attended support groups (Mothers? Fathers? Grandparents?);
3. How the CHW engages support group members (see checklist for support groups distributed in *Mtoto Mwerevu's* IYCF\ECD\WASH training);
4. What CHWs discuss during support groups (MIYCAN, WASH, ECD, women's workload) (the focus should not be on MIYCAN alone but also other topics, especially WASH and ECD); and
5. What challenges and successes CHWs have had with support groups (Are the right people attending? Is the group meeting interesting? Do mothers get the chance to practise new behaviours? etc.).

OFTEN BUT NOT EVERY MONTH, you should:

1. Go over *Mtoto Mwerevu's* checklist "Talking points for CHWs during community meetings" to make sure supervisors help CHWs meet with community groups and discuss appropriate topics; Groups CHWs should consider approaching about nutrition, ECD, and WASH include TASAF, religious groups, unions, credit associations, self-help groups for women and men, Ward Development Committees, etc.;
2. Ask if CHWs are able to connect to health facilities and how that is going;
3. Find out whether CHW supervisors understand their roles;
4. Identify what support CHW supervisors need;
5. Hear about the health and well-being of the catchment area overall; and
6. Assign new tasks, when needed.

FORM 4.1: HOME VISIT CHECKLIST FOR SUPERVISORS OF CHWS, CSOS AND OTHER VOLUNTEERS FOR MOTHERS AND FOR CHILDREN OF ALL AGES NEGOTIATING FOR BEHAVIOUR CHANGE

INSTRUCTIONS

1. Use the checklist immediately below for home visits (regardless of topic)
2. Also use the checklist that corresponds to the topic the CHW is discussing today (IYCF, ECD or WASH) to make sure the CHW is covering the correct topic areas and is using negotiation skills per the training they received

DOES THE CHW OR OTHER VOLUNTEER:

1. Introduce herself/himself and establish confidence
2. Introduce herself/himself and greet the household head (if present)
3. Ask about whether other family members are present who would benefit by participating in the discussion (influencing groups)
4. Keep his/her head level with the mother/parent/caregiver
5. Pay attention and maintain eye contact
6. Ask open-ended questions
7. Choose a topic that is appropriate to 1) the age of the child, 2) whether the mother is pregnant or breastfeeding, or 3) any other needs in the household
8. Follow the steps of Negotiating for Behaviour Change
    a. Spend enough time asking, listening and observing to really understand the situation of the mother, father or other individual in the household
    b. As appropriate, praise the person for doing recommended practices (especially if this is a return visit)
    c. Identify difficulties to changing practices
    d. Discuss and recommend options (small, do-able actions) individuals can try
    e. Get the individual/people to agree to try one or more of the solutions
    f. Resolve any questions/concerns about practising the behaviour
    g. Agree upon a date/time for a follow-up appointment
    h. Review key points of the last meeting

Ask the CHW or lead mother to name one or more things he/she did well. Note your observations here:
Name one important thing you recommend to the CHW or lead mother that she can work on to improve next time:
Other feedback:

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FORM 4.2: IYCF

If the home visit is about IYCF, for all children < 2 years of age, use this job aid:

ASK AND LISTEN

- Child's age
- How the child is doing, recent illness, apathy, etc.
- Current breastfeeding status
- If mother is experiencing any difficulties breastfeeding
- Whether the child is drinking other fluids
- Whether the child is eating other foods
- What the mother/caregiver does to encourage the child to eat

OBSERVE

- Mother breastfeeding (if possible)
- Hygiene related to feeding, including hand washing before preparing food and feeding the child

IDENTIFY

- Any feeding difficulties
- Priority difficulties (if more than one difficulty)

DISCUSS AND RECOMMEND

- Praise the mother/caregiver for doing recommended practices
- Address breastfeeding difficulties (for example, poor attachment, poor breastfeeding patterns) with practical help
- Discuss age-appropriate feeding recommendations
- Present 2 or 3 small, do-able actions (not commands) that are appropriate to the child's age and feeding behaviours
- Help mother/caregiver select agreed upon behaviour that she or he can try to address feeding challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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FORM 4.3: ECD

If the home visit is about ECD, for all children < 2 years of age, use this job aid:

ASK AND LISTEN

- Child's age
- How the child is doing, recent illness, apathy, fussiness, etc.
- Current breastfeeding status and what else the child eats/drinks (look for signs of hunger)
- How the child is developing (see child development milestones below)

OBSERVE

- What mother/caregiver does to encourage the child to eat
- Whether the mother/caregiver engages the child
  - Talks to child/imitates child's sounds
  - Sings to child
  - Plays with child
  - Shows child objects/encourages the child to pick up objects and/or organise them
  - Imitates child's physical actions (for example, waving bye-bye)
  - Smiles
- Whether the mother/caregiver praises the child for talking, playing, crawling, standing, etc.

IDENTIFY

- Any actions mothers can take to stimulate the child
- Priority action(s) (if more than one)

DISCUSS AND RECOMMEND

- Praise the mother/caregiver for doing recommended practices
- Address mother/caregiver lack of stimulation (for example, doesn't talk, sing, play, show, imitate, smile) with practical help
- If helpful, demonstrate 1-2 actions to stimulate child
- Discuss age-appropriate recommendations for stimulating the child
- Present 2 or 3 small, do-able actions (not commands) that are appropriate to the child's age and developmental stage
- Help mother/caregiver select agreed upon behaviour that she or he can try to address developmental challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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FORM 4.4: WASH

If the home visit is about WASH, for all children, use this job aid:

ASK AND LISTEN

- Who lives in the household
- Challenges families face with respect to latrine and water access/use, hand washing, and keeping the compound clean (see points under OBSERVE below)

OBSERVE

- Supportive environment (availability of a latrine, place for hand washing, water, soap that can be accessed with minimal effort/little decision-making)
    - Hand washing station with soap and water is nearby toilet (not out of the way)
- Presence of animals in the compound/whether animals are caged
- How close animals are to children
- Presence of animal or human waste in or near compound
- Hygiene related to feeding including hand washing before preparing food and feeding the child, after going to the bathroom, after handling child's faeces/cleaning the child's bottom, after handling livestock, etc.

IDENTIFY

- Any difficulties with water, sanitation and hygiene
- Priority difficulties (if more than one difficulty)

DISCUSS AND RECOMMEND

- Praise the mother/caregiver for doing recommended practices
- Address WASH difficulties (for example, poor hand washing, child close to animal waste, etc.) with practical help
    - If helpful, demonstrate 1-2 actions (for example, correct hand washing)
- Discuss WASH recommendations
- Present 2 or 3 small, do-able actions (not commands) that are appropriate for the household
- Help mother/caregiver select agreed upon behaviour that she or he can try to address WASH challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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FORM 4.5: MATERNAL HEALTH

If the home visit is about maternal health, use this job aid:

ASK AND LISTEN

- How the mother is doing, recent illness, lack of energy, work load, etc.
- Whether the mother is currently pregnant and/or breastfeeding
- Type and amount of food mother currently eats
- Whether mother is seeking care for her own health
- Where she receives care
- When and how often she receives care

OBSERVE

- Work load, health of mother, energy level, foods the mother eats

IDENTIFY

- Any difficulties
- Priority difficulties (if more than one difficulty)

DISCUSS AND RECOMMEND

- Praise the mother for doing recommended practices
- Address difficulties (for example, heavy workload, lack of ANC) with practical help
- Discuss recommendations for mother
- Present 2 or 3 small, do-able actions (not commands) that are appropriate to the mother's behaviours
- Help mother select agreed upon behaviour that she or he can try to address challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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FORM 1.1: HOME VISIT JOB AID FOR CHWS FOR CHILDREN 0-5 MONTHS OF AGE NEGOTIATING FOR BEHAVIOUR CHANGE

Ask for name and age of child

HEALTH OF THE CHILD

- Ask the mother: how the child is doing? *(show interest in the child)*:
  - Sick or apathetic?
  - Restless or crying?

ASK, LISTEN, AND OBSERVE:

Child development

- Does the caregiver sometimes engage the child by:
  - Talking to child/imitating child's sounds?
  - Singing to child?
  - Playing with child?
  - Showing objects, encouraging child to pick up objects and organise them?
  - Imitating child's physical actions (for example, waving bye-bye)?
  - Smiling?
- Is the father sometimes engaged in any of the above activities?
- Toys or books present? (simple, homemade toys are okay)
- Does the caregiver praise child for talking, playing, crawling, standing, etc.?

ASK, LISTEN, AND OBSERVE:

WASH

- Are there animals in the compound? Are they caged? Are they close to children?
- Animal or human faeces in compound?
- Infant in dirt (including on a soil floor)—even if the compound has been swept?
- Infant seen eating dirt?

ASK, LISTEN, AND OBSERVE:

Food for the child

- Is child breastfed? (note challenges with positioning and attachment)
- How frequently is child breastfed?
- Does mother empty one breast before going to the other?
- Is mother having problems breastfeeding?
- What does mother/caregiver do to encourage the child to breastfeed?
- If not breastfeeding exclusively, does mother/caregiver feed baby using a clean cup and spoon?
- Does child appear to be hungry?
- Is child drinking other fluids like water?
  - What? How frequently? How much?
- Is child eating other foods? (for example, porridge)
  - What? How frequently? How much?

IDENTIFY

Most important difficulties with care of child

DISCUSS AND RECOMMEND

Small, doable caring action mother can try

PRACTISE

Mother is given the opportunity to try the new practice within the agreed time. The action is noted on the form for next visit reference.

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FORM 1.2: HOME VISIT JOB AID FOR CHWS FOR CHILDREN 6-11 MONTHS OF AGE NEGOTIATING FOR BEHAVIOUR CHANGE

Ask for name and age of child

HEALTH OF THE CHILD

- Ask the mother: how the child is doing? *(show interest in the child)*:
  - Sick or apathetic?
  - Restless or crying?

ASK, LISTEN, AND OBSERVE:

Child development

- Does the caregiver sometimes engage the child by:
  - Talking to child/imitating child's sounds?
  - Singing to child?
  - Playing with child?
  - Showing objects, encouraging child to pick up objects and organise them?
  - Imitating child's physical actions (for example, waving bye-bye)?
  - Smiling?
- Is the father sometimes engaged in any of the above activities?
- Toys or books present? (simple, homemade toys are okay)
- Does the caregiver praise child for talking, playing, crawling, standing, etc.?

ASK, LISTEN, AND OBSERVE:

WASH

- Are there animals in the compound? Are they caged? Are they close to children?
- Animal or human faeces in compound?
- Infant in dirt (including on a soil floor)—even if the compound has been swept?
- Infant seen eating dirt?

ASK, LISTEN, AND OBSERVE:

Food for the child

- Is child still breastfed?
- Is child drinking other fluids?
- Is child eating other foods? (see list below)
- Does child appear to be hungry?
- Does the child eat any of the following foods? How frequently? How much?
  - Meat: meat, fish (such as *dagaa*), poultry/eggs, organs, milk
  - Legumes: beans, chickpeas
  - Vegetables: maize, cassava, sweet potatoes, pumpkins, avocados; leaves from pumpkin and cassava
  - Fruits: mangoes, papaya, oranges, guava, bananas
  - Staples: (including *ugali*)

IDENTIFY

Most important difficulties with care of child

DISCUSS AND RECOMMEND

Small, doable caring action mother can try

PRACTISE

Mother is given the opportunity to try the new practice within the agreed time. The action is noted on the form for next visit reference.

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FORM 1.3: HOME VISIT JOB AID FOR CHWS FOR CHILDREN 12-23 MONTHS OF AGE NEGOTIATING FOR BEHAVIOUR CHANGE

Ask for name and age of child

HEALTH OF THE CHILD

- Ask the mother: how the child is doing? *(show interest in the child)*:
  - Sick or apathetic?
  - Restless or crying?

ASK, LISTEN, AND OBSERVE:

Child development

- Does the caregiver sometimes engage the child by:
  - Talking to child/imitating child's sounds?
  - Singing to child?
  - Playing with child?
  - Showing objects, encouraging child to pick up objects and organise them?
  - Imitating child's physical actions (for example, waving bye-bye)?
  - Smiling?
- Is the father sometimes engaged in any of the above activities?
- Toys or books present? (simple, homemade toys are okay)
- Does the caregiver praise child for talking, playing, crawling, standing, etc.?

ASK, LISTEN, AND OBSERVE:

WASH

- Are there animals in the compound? Are they caged? Are they close to children?
- Animal or human faeces in compound?
- Infant in dirt (including on a soil floor)—even if the compound has been swept?
- Infant seen eating dirt?

ASK, LISTEN, AND OBSERVE:

Food for the child

- Is child still breastfed?
- Is child drinking other fluids?
- Is child eating other foods? (see list below)
- Does child appear to be hungry?
- Does the child eat any of the following foods? How frequently? How much?
  - Meat: meat, fish (such as *dagaa*), poultry/eggs, organs, milk
  - Legumes: beans, chickpeas
  - Vegetables: maize, cassava, sweet potatoes, pumpkins, avocados; leaves from pumpkin and cassava
  - Fruits: mangoes, papaya, oranges, guava, bananas
  - Staples: (including *ugali*)

IDENTIFY

Most important difficulties with care of child

DISCUSS AND RECOMMEND

Small, doable caring action mother can try

PRACTISE

Mother is given the opportunity to try the new practice within the agreed time. The action is noted on the form for next visit reference.

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FORM 1.4: HOME VISIT JOB AID FOR CHWS FOR MATERNAL HEALTH NEGOTIATING FOR BEHAVIOUR CHANGE

Name and age of mother

HEALTH OF THE CHILD

- Ask the mother: how are you yourself doing? *(show genuine interest in mother)*

ASK, LISTEN, AND OBSERVE:

Care seeking

- Ask the mother: Are you pregnant or recently delivered?
- Do you go for antenatal/postnatal care?
  - Where?
  - How often?

ASK, LISTEN, AND OBSERVE:

Gender

- Who:
  - Farms?
  - Fetches water and wood?
  - Cooks?
  - Cleans?
  - Stimulates children? (Check for roles men play)
- Do you work outside the household?
- Who helps you with your workload?
- Who makes decisions about the food and health care you and your children receive?
- Which livestock and crops do you own/control?

ASK, LISTEN, AND OBSERVE:

WASH

Sanitation

- Does the household have a toilet or pit latrine?
- Do household members use it?

Water

- Challenges faced accessing and using drinking water
- Source of drinking water (Is it safe?)
- Do you boil drinking water for family use?

Hand washing

- Soap and water located where family members will use them? (near latrine, house, or inside kitchen?)
- Is the place for soap and water clean? Inviting?
- Observe where hands are washed

Hands washed with soap and safe water:

- Before preparing food?
- Before feeding child?
- After defaecation?
- After cleaning child's bottom?
- After handling human or animal faeces?

ASK, LISTEN, AND OBSERVE:

Food for the mother

- What foods do you eat? How frequently? How much?
  - Meat: meat, fish (such as dagaa), poultry/eggs, organs, milk
  - Legumes: groundnuts, beans, chickpeas
  - Vegetables: maize, cassava, sweet potatoes, pumpkins, avocados, leaves from pumpkin and cassava, amaranth, pumpkin
  - Fruits: mangoes, papaya, oranges, guava, bananas
  - Staples: (including ugali)
- How many meals does a mother eat in a day?
- Do you get extra meals or extra food?
- Do you take iron folate tablet obtained from health facility or bought?
- Have you received vitamin A capsule within 6 weeks of delivery?

IDENTIFY

Most important difficulties with mother's own well-being

DISCUSS AND RECOMMEND

Small, doable action mother agrees to improve her health

PRACTISE

Mother is given the opportunity to try the new practice for herself within the agreed time. The action is noted on the form for next visit reference.

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FORM 5.1: SUPPORT GROUP CHECKLIST FOR CSO SUPERVISORS AND CSO VOLUNTEERS FOR ALL TOPICS

INSTRUCTIONS

1. Use the checklist immediately below for support groups (regardless of topic)
2. Also use the same job aid that corresponds to the topic the CHW is discussing today (IYCF, ECD, or WASH) to make sure the CHW is covering the correct topic areas and is using behaviour change skills, per the training they received

DOES THE CHW:

1. Introduce herself/himself to the group?
2. Choose a topic of discussion relevant to those attending (for example, a support group on disposing of infant faeces includes families with infants)?
3. Ask volunteer lead mothers to share their experiences visiting others between the last meeting and this one?
4. Ask questions that generate participation from all support group members?
5. Ask group members to share their own experience?
6. Have everyone sit in a circle?
7. Identify a few practices related to today's theme that group members can try?
8. Commit support group participants to trying a small, do-able action?
9. Resolve barriers families face as they try the new practice?
10. (Where possible), give group members an opportunity to practise the new behaviour(s)?
11. Ask volunteer lead mothers to visit others in the community to encourage them to practise the behaviour discussed in today's meeting?
12. Tell group members the place, date, and theme of the next meeting?

Number of women/men attending the support group:	
Small, do-able action(s) support group participants will try this week:	
Barriers that came up in today's support group:	
How barriers were resolved:	
Ask support group facilitator to name one or more thing(s) he/she did well. Note your observations here:	
Name one important thing you recommend to the support group facilitator that he/she can work on to improve the next time:	
Other feedback:	

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FORM 5.2: IYCF

If the support group is about IYCF, for all children < 2 years of age, use this checklist:

ASK AND LISTEN

- Child's age
- How the child is doing, recent illness, apathy, etc.
- Current breastfeeding status
- If mother is experiencing any difficulties breastfeeding
- Whether child is drinking other fluids
- Whether child is eating other foods
- What mother/caregiver does to encourage the child to eat

OBSERVE

- Mother breastfeeding (if possible)
- Hygiene related to feeding including hand washing before preparing food and feeding the child

IDENTIFY

- Any feeding difficulties
- Priority difficulties (if more than one difficulty)

DISCUSS AND RECOMMEND

- Praise the mother/caregiver for doing recommended practices
- Address breastfeeding difficulties (for example, poor attachment, poor breastfeeding patterns) with practical help
- Discuss age-appropriate feeding recommendations
- Present 2 or 3 small, do-able actions (not commands) that are appropriate to the child's age and feeding behaviours
- Help mother/caregiver select agreed upon behaviour that she or he can try to address feeding challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/ concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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FORM 5.3: ECD

If the support group is about ECD, for all children < 2 years of age, use this checklist:

ASK AND LISTEN

- Child's age
- How the child is doing, recent illness, apathy, fussiness, etc.
- Current breastfeeding status and what else the child eats/drinks (look for signs of hunger)
- How the child is developing (see child development milestones, below)

OBSERVE

- What mother/caregiver does to encourage the child to eat
- Whether mother/caregiver engages the child
- Talks to child/imitates child's sounds
    - Sings to child
    - Plays with child
    - Shows child objects/encourages child to pick up objects and/or organise them
    - Imitates child's physical actions (for example, waving bye-bye)
    - Smiles
- Whether mother/caregiver praises child for talking, playing, crawling, standing, etc.

IDENTIFY

- Any actions mothers can take to stimulate the child
- Priority actions (if more than one)

DISCUSS AND RECOMMEND

- Praise the mother/caregiver for doing recommended practices
- Address mother/caregiver lack of stimulation (for example, doesn't talk, sing, play, show, imitate, smile) with practical help
- If helpful, demonstrate 1-2 actions to stimulate child
- Discuss age-appropriate recommendations for stimulating the child
- Present 2 or 3 small, do-able actions (not commands) that are appropriate to the child's age and developmental stage
- Help mother/caregiver select agreed upon behaviour that she or he can try to address developmental challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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FORM 5.4: WASH

If the support group is about WASH, for all children < 2 years of age, use this checklist:

ASK AND LISTEN

- Who lives in the household
- Challenges families face with respect to latrine and water access/use, hand washing, and keeping the compound clean (see points under OBSERVE, below)

OBSERVE

- Supportive environment (availability of a latrine, place for hand washing, water, soap that can be accessed with minimal effort/little decision-making)
    - Hand washing station with soap and water is near toilet (not out of the way)
- Presence of animals in the compound/whether animals are caged
- How close animals are to children
- Presence of animal or human waste in or near compound
- Hygiene related to feeding including hand washing before preparing food and feeding the child, after going to the bathroom, after handling child's faeces/cleaning the child's bottom, after handling livestock, etc.

IDENTIFY

- Any difficulties with water, sanitation, and hygiene
- Priority difficulties (if more than one difficulty)

DISCUSS AND RECOMMEND

- Praise the mother/caregiver for doing recommended practices
- Address WASH difficulties (for example, poor hand washing, child close to animal waste, etc.) with practical help
    - If helpful, demonstrate 1-2 actions (for example, correct hand washing)
- Discuss WASH recommendations
- Present 2 or 3 small, do-able actions (not commands) that are appropriate for the household
- Help mother/caregiver select agreed upon behaviour that she or he can try to address WASH challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/ concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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FORM 5.5: MATERNAL HEALTH

If the support group is about maternal health, use this checklist:

ASK AND LISTEN

- How the mother is doing, recent illness, lack of energy, work load, etc.
- Whether the mother is currently pregnant and/or breastfeeding
- Type and amount of food mother currently eats
- Whether mother is seeking care for her own health
- Where she receives care
- When and how often she receives care

OBSERVE

- Work load, health of mother/energy levels, foods mother eats

IDENTIFY

- Any difficulties
- Priority difficulties (if more than one difficulty)

DISCUSS AND RECOMMEND

- Praise the mother for doing recommended practices
- Address difficulties (for example, heavy work load, lack of ANC) with practical help
- Discuss recommendations for mother
- Present 2 or 3 small, do-able actions (not commands) that are appropriate to the mother's behaviours
- Help mother select agreed upon behaviour that she or he can try to address challenges
- Ask the mother/caregiver to repeat the agreed-upon new behaviour
- Ask the mother/caregiver about any questions/ concerns
- Suggest where the mother/caregiver can find additional support
- Agree upon a date/time for a follow-up appointment
- Thank the mother/caregiver for his/her time

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INSTRUCTION SHEET & DEFINITION OF TERMS

Name of Form	Home Visit Form
Symbol	Form Number 03
Purpose	Counselling during home visit on nutrition and other practices
Level/Location	Community Level
Implementer	Community Health Worker (CHW)
Data Source	Household
Time/Frequency	Monthly
Management/Archive	After being completed and verified, one copy should be kept by the CHW and one copy should be forwarded to the supervisor.
Steps to fill out the form	NOTE: USE CAPITAL LETTERS IN RECORDING INFORMATION IN THIS FORM
	This form will be used for more than one household, but the households must be in the same hamlet. In the case that blank space remains on the sheet, do not add information of other households from different hamlets. In such a case, start a new form to have clear demarcation of the hamlets.
	Each Row (H1...Hn): Represent information for one particular household in the hamlet that received a home visit.
	1. Ensure all information at the top of the form is filled in correctly, including: month/year of the report, region, district, ward, village, hamlet and the name/contact information of the CHW who conducted the home visit.
	2. Record the date of the visit in the following format: dd/mm/yyyy (dd-day, mm-month, yyyy-year).
	3. Columns (1, 2, 3, and 4): Record the number indicating the sex of each child 0-59 months old who live in the household. Put the numbers in the boxes that corresponds to children's ages.
	4. Column (5): Record the number indicating the sex of each child 5-9 years of age who live in the household.
	5. Column (6): Record the number indicating the sex of each adolescent 10-19 years of age who live in the household.
	6. Column (7): Record the number of pregnant women that live in the household.
	7. Column (8): Record the number of other women who are NOT pregnant who live in the household.
	8. Column (9): Record the number of fathers who live in the household.
	9. Column (10): Record the number indicating the sex of other persons who live in the household. This might include grandmothers, grandfathers, and/or others who reside in the household.
	10. Column (11): Put a ✓ if, on this visit, the CHW counselled the mother on early initiation of breastfeeding or exclusive breastfeeding.
	11. Put a ✓ if the CHW has counselled on variety of foods (column 12), thickness & frequency (column 13), responsive feeding (column 14), or feeding the sick child (column 15). If multiple topics were covered, put a check next to all topics the CHW and caregiver discussed.
	12. Put a ✓ if the CHW has counselled on improved water sources (column 16), keeping the child away from dirt and faeces (column 17), safe disposal of child faeces (column 19), or hand washing before preparing food and feeding the child (column 19). If multiple topics were covered, put a check next to all topics the CHW and caregiver discussed.
	13. Put a ✓ if the CHW has counselled on talking to the child (column 20) or toys (column 21). Put a check next to all topics the CHW and caregiver discussed.
	14. Put a ✓ if the CHW has counselled on IFAs (column 22), diet (column 23), or ANC/PNC (column 24). If multiple topics were covered, put a check next to all topics the CHW and caregiver discussed.
	15. Column (25): Record the mobile phone number of the head of the household if one exists.
	16. Total: In the last row, record a sum for each of the columns by adding the numbers (columns 1-10) or ✓ marks (columns 11-29) in each column.
Verification	Make sure you review the form before submitting to the supervisor

Form Number 03: HOME VISIT

Home visit report (month/year) _____

Region_____ District _____ Ward _____ Village/Street_____ Hamlet_____

CHW Name _____ Mobile phone _____

Topics Covered																	Breast feeding	Complementary feeding				Water, Sanitation & Hygiene (WASH)				Early Child Development (ECD)		Maternal Health			Contacts
Household ID	Date of Home visit	Children 0-5 months of age		Children 6-11 months of age		Children 12 -23 months of age		Children 24 -59 months of age		Children with 5-9 years of age		Adoles-cent girls with age 10-19 years	Pregnant women	Other mothers with age 20 years and above years	Husbands	Others		Early initiation/ exclusive breast-feeding	Variety, including ASFs	Thickness and frequency	Responsive feeding	Food for a sick child	Access to improved water source	Children away from animals/ dirt	Safe disposal of child feces	Hand washing at critical times	Talk to child	Household toys for children	IFAs	Varieties of foods	Reduce work load for breasting mother s	Contact of the Household Head
		(1)		(2)		(3)		(4)		(5)		(6)	(7)	(8)	(9)	(10)		(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)
		M	F	M	F	M	F	M	F	M	F	F	F	F	M	M	F														
Total																															

INSTRUCTION & DEFINITION SHEET – BENEFICIARIES REGISTRATION FORM

Name of Form	Beneficiaries Registration form
Symbol	Form Number 01
Purpose	Registration of household members/beneficiaries
Level/Location	Household
Implementer	Community Health Worker
Data Source	People living within the household
Time/Frequency	Once before implementation starts
Management/Archive	The form number is filled. One copy should be sent to the Supervisor and one copy should be kept by the CHW.
Steps to fill out the form	NOTE: USE CAPITAL LETTERS IN RECORDING INFORMATION IN THIS FORM
	1. Record all general information including the date, region, district, ward, village, and hamlet.
	2. Record the name of the Community Health Worker and his/her contact information.
	3. Record the names of both the head of the household and his/her spouse.
	4. Record the mobile phone numbers of both the head of the household and his/her spouse; if one of them does not have a contact number, just record one.
	5. Column (1): Record the names of all beneficiaries within the household. This includes males and females in the following age categories: 0-5 months, 6-11 months, 12-23 months, 24-59 months, 5-9 years, 10-19 years. It also includes pregnant women and all disabled beneficiaries (but not other disabled individuals in the household).
	6. Column (2): Put a ✓ to indicate the sex of the head of household and spouse.
	7. Columns (3, 4, 5, and 6): Put a ✓ to indicate the sex of each child 0-59 months of age. If there are no children in a given age category, leave the corresponding box blank.
	8. Columns (7 and 8): Put a ✓ to indicate the sex of each child 5-19 years of age. If there are no children in a given age category, leave the corresponding box blank.
	9. Columns (9): Put a ✓ to indicate the sex of each adult 20 years and above of age.
	10. Column (10): This column is for pregnant women. Put a ✓ if the beneficiary is pregnant.
	11. Column (11): Put a ✓ to indicate if the beneficiary is disabled. Put the check in the box corresponding to the sex of the disabled beneficiary.
	12. TOTAL: Add all of the ✓ and record the total at the bottom of each column.
Verification	Make sure you review the form before submitting to the supervisor

FORM NUMBER 01 : BENEFICIARIES REGISTRATION FORM

Date_____
(dd/mm/yyyy)

Region_____ District _____ Ward _____ Village/Street_____ Hamlet_____

Household ID _____

CHW Name _____ Mobile Phone Number _____

Name of the Household Head_____ Mobile Phone Number _____

Spouse of the Household Head _____ Mobile Phone Number _____

	Names of the Household members (Beneficiaries)	Sex of the Household Head and Spouse		Children with age from 0 to 5 months		Children with age from 6 to 11 months		Children with age from 12 to 23 months		Children with age from 24 to 59 months		Children with age from 5 to 9 years		Adolescent girls with age from 10 to 19 years	Adults with age from 20 years and above		Pregnant women	Disabilities	
	(1)	(2)		(3)		(4)		(5)		(6)		(7)		(8)	(9)		(10)	(11)	
No.	M	M	F	M	F	M	F	M	F	M	F	M	F	F	M	F	F	M	F
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			
	Total:																		

DISSEMINATION OF RESULTS AND OTHER OUTPUTS OF OPERATIONS RESEARCH FOR ASTUTESCALING UP GROWTH: ADDRESSING STUNTING IN TANZANIA EARLY (IN THE UNDER 5S)

Funded by UK Aid's Department for International Development (DFID).
Updated August 2019

PEER-REVIEWED PUBLICATIONS

Matare CR, Craig HC, Martin SL, Kayanda RA, Chapleau GM, Bezner Kerr R, Dearden KA, Nnally LP and Dickin KL. Barriers and Opportunities for Improved Exclusive Breastfeeding Practices in Tanzania: Household Trials with Mothers and Fathers. *Food and Nutrition Bulletin*, 2019 May.

ORAL SCIENTIFIC CONFERENCE PRESENTATIONS

Owoputi I, Kayanda RA, Bezner Kerr R, Dearden KA, Martin SL, Nnally LP, Dickin KL. He said, she said: Using pile sort methods to explore differences in decision-making and resource allocation for food, agriculture, and other costs among couples in Tanzania. Annual *Agriculture, Nutrition and Health (ANH) Academy Week*, Hyderabad, India, 2019 Jun 24-29.

Martin SL, Matare CR, Kayanda RA, Riggle KR, Owoputi I, Bezner Kerr R, Dearden KA, Nnally LP, Dickin KL. Increasing family support for recommended complementary feeding practices in Tanzania. *Annual Meeting of the Society for Applied Anthropology*, Philadelphia, PA, 2018 Apr 3-7.

Dearden KA, Mulokozi G, Mbaruku G, Mugyabuso J, Linehan M, Torres S, Remes P, Atugonza V, Kezakubi D (2018). How evidence transformed the design of an SBCC intervention to improve nutrition in Tanzania. Oral presentation at the International Social and Behavior Change Communication/ Entertainment Education Summit, Nusa Dua, Indonesia.

Dearden KA, Mulokozi G, Dobies KA (2019). Positive Deviance/Hearth: a sustainable, human centered approach to improving children's nutrition in Tanzania. Presented at the annual meeting of the Christian Connections for International Health Conference, Baltimore, MD.

Mulokozi G, Dobies KA, Dearden KA (2019). Ensuring people's empowerment in nutrition through home visits in Tanzania. Presented at the annual meeting of the Christian Connections for International Health Conference, Baltimore, MD.

POSTER PRESENTATIONS

Dickin KL, Chapleau GM, Kazoba A Kayanda RA, McCann J, Frommer M, Lambert V, Martin SL, Nnally LP. Policy vs. practice: Exploring a mentoring approach for building capacity to implement multisectoral nutrition policies in Tanzania. *Nutrition 2019 (American Society for Nutrition Annual Meeting)*, Baltimore, MD, 2019 Jun 8-11.

Matare CR, Craig H, Martin SL, Kayanda RA, Chapleau GM, Bezner Kerr R, Dearden KA, Nnally LP, Dickin KL. Overcoming perceptions of colic and increasing support to improve exclusive breastfeeding practices in Tanzania: Household trials with mothers and fathers. Nutrition 2018 (American Society for Nutrition Annual Meeting), Boston, MA, 2018 Jun 9-12.

Martin SL, Matare CR, Kayanda RA, Owoputi I, Bezner Kerr R, Dearden KA, Nnally LP, Kazoba A, Dickin KL. Recommendations to increase children's dietary diversity and decrease sugary snacks are acceptable and feasible for mothers and fathers in Tanzania. *Nutrition 2018 (American Society for Nutrition Annual Meeting)*, Boston, MA, 2018 Jun 9-12.

SYMPOSIA

Gryboski K, Matare CR, Mukuria A, Martin SL, Palmquist A, Yourkavitch J. Engaging fathers, grandmothers, and other family members in maternal and child nutrition: sharing lessons from development for humanitarian contexts. Symposium at *CORE Group Global Health Practitioner Conference*, Bethesda, MD, 2018 Jun 4-7.

SUBMITTED ABSTRACTS

Owoputi I, Kayanda RA, Bezner Kerr R, Dearden KA, Martin SL, Nnally LP, Dickin KL. Exploring CHW perspectives on successes and challenges of home visiting to promote health and nutrition messages in Tanzania: Gender and targeting. Accepted for *American Public Health Association Annual Meeting*, Philadelphia, PA, 2019 Nov 2-6.

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Matare CR, et al. Engaging men for improved breastfeeding and complementary feeding behaviors in Tanzanian households with children under the age of 2 years. *Interagency Gender Working Group (IGWG) Plenary: Gender in a Changing World: New Opportunities, New Challenges*, Washington D.C., 2019 May 29.

SUBMITTED ORAL AND POSTER PRESENTATIONS

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Dickin KL, Chapleau GM, Kazoba A Kayanda RA, McCann J, Frommer M, Lambert V, L. Martin SL, Nnally LP (2019). Policy vs. practice: exploring a mentoring approach for building capacity to implement multisectoral nutrition policies in Tanzania. Submitted to Nutrition 2019 (American Society for Nutrition Annual Meeting), Boston, MA.

Crookston BT, Hall PC, West JH, Torres S, Linehan M, Hoj TH, Smith R, Niedfeldt H, Sever T, Powell E, Mulokozi G. Role of men and women during pregnancy: the perceptions of Tanzanian males and females. Submitted to American Public Health Association Annual Meeting, Philadelphia, PA.

MANUSCRIPTS IN PROGRESS

Martin S, et al. Household Trials of Improved Practices (TIPs) on barriers and facilitators to improved complementary (CF) practices. (in progress)

Craig H, et al. "Because of the *mchango* problem, I give my baby gripe water so he sleeps and stops crying": Exclusive breastfeeding recommendations need to address parents' concerns of colic-like symptoms of *mchango* in infants 0-6 months in Lake Zone, Tanzania. (in progress)

Kayanda RA, et al. Recipe trials for complementary feeding for infants 6 to 24 months in Lake Zone, Tanzania. (in progress)

SUBMITTED MANUSCRIPTS

Hall PC, Alexander C, Shrestha S, Tounkara M, Cooper S, Hunt L, Hoj T, Dearden KA, West JH, Kezakubi D, Atugonza V, Crookston BT. Media access is associated with knowledge of optimal water, sanitation, and hygiene practices in Tanzania. International Journal of Environmental Research and Public Health.

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Verdeja M, Thomas K, Dorsan G, Hawks M, Dearden KA, Stroupe N, Hoj TH, West JH, Crookston BT, Kezakubi D, Atugonza V, PC Hall. Water, sanitation, and hygiene factors associated with child Illness in Tanzania.

Moxley V, Graul MF, Stoneking N, Hale C, Torres S, Linehan M, Dobies KA, Mulokozi G, Hoj TH, Crookston BT, Hall PC, West JH. Early Childhood Nutrition Knowledge of Caregivers in Tanzania

Manzione LC, Kriser H, Gamboa EG, Hanson CM, Linehan M, Mulokozi G, Mwaipape O, Hoj T, West JH, Hall PC, Crookston BT. Maternal Employment Status and Minimum Meal Frequency in Children 6-23 Months in Tanzania.

PROGRAMMATIC PRODUCTS
(for Government and Program Personnel)

CHW Dialogue Training Guides on Exclusive Breastfeeding and Complementary Feeding. Training Guides, Prepared for IMA World Health, 2018 Dec.

Cornell drafted these guides based on key findings from the Trials of Improved Practices (TIPs) studies on exclusive breastfeeding (EBF) and complementary feeding (CF). Guides target CHW supervisors to help use findings from ASTUTE's research to support effective counseling. The steps in the guide will help CHWs as they discuss and recommend home-based practices people can try to improved nutrition of their children.

Scaling Up Growth: Addressing Stunting in Tanzania Early (in the under 5s). Operations Research Update, Prepared for Department of International Development (DFID), 2018 June.

Cornell wrote this summary that was circulated during DFID's annual review meeting of IMA World Health's ASTUTE Programme activities. The summary included the objective, methods, and key findings to date for each phase of the Operations Research: TIPs on Exclusive Breastfeeding, TIPs on Complementary Feeding, Building MSN Capacity, and Implementation Research.

Operations Research Input on ASTUTE SBCC Messages. Report, Prepared for IMA World Health, 2018 May 17.

Report details messages that were developed based on the TIPs studies that asked parents to try new practices related to EBF and CF. We found parents appreciated more detailed information to understand what it really means for example to "give only mother's milk". This report provides suggested nuances to messages and draws on research findings to support current IMA messaging around key nutrition behaviors.

Learning Exchange Workshop to Promote Multisectoral Nutrition Capacity in Councils. Workshop Report, Adden Palace Hotel, Ilemela MC, Mwanza, 2018 Feb 7-8. Prepared for IMA World Health, ASTUTE Nutrition Officers, and RNuOs.

Report includes key discussion topics and learnings of the workshop. It draws on presentations and subsequent discussions, key points and individuals' notes from break out groups, information collected on flip charts, as well as participant responses to a workshop evaluation.

Learning Exchange Workshop to Promote Multisectoral Nutrition Capacity in Councils. Workshop Toolkit, Adden Palace Hotel, Ilemela MC, Mwanza, 2018 Feb 7-8. Prepared for IMA World Health, ASTUTE Nutrition Officers, and RNuOs.

Toolkit shared with RNuOs to help guide them to mentor Council MSN Action Teams. Toolkit provides helpful tips and templates as well as considerations for starting project activities and supporting approaches to building MSN in councils as discussed at the workshop. By providing tailored support, expertise, and advice to this team, RNuOs will help build on existing knowledge of the best practices for promoting multisectoral collaboration for nutrition.

Operations Research on Addressing Stunting in Tanzania Early (ASTUTE): Strengthening Multi-Sectoral Nutrition Capacities among Council Officers. Operations Research Brief, 2017 Dec.

Brief provides an overview of the MSN Capacity Building study. Researchers circulated to key stakeholders and partners in study sites to inform them of study objectives, upcoming activities, and key research contacts.

Scaling Up Growth: ASTUTE: Addressing Stunting in Tanzania Early. Operations Research Brief, 2015.

Brief provides an overview of the three phases of Operations Research: TIPs, MSN Capacity Building, and Implementation Assessment. Researchers circulated to key stakeholders and partners in study sites to inform them of OR objectives, an overview of each study phase, and key research contacts.

PROGRAMMATIC PRESENTATIONS
(for Government and Program Personnel)

Kayanda RA, Nnally LP. Mtoto Mwerevu Operations Research: Progress, Results, and Implications for Stunting Prevention. Presentation to *Tanzania Food and Nutrition Centre (TFNC)*, Dar es Salaam, Tanzania, 2018 Aug 8.

Presentation of OR findings delivered to TFNC at the NIMR Conference Hall in Dar es Salaam. There were sixteen attendees at the meeting including twelve individuals from TFNC and one from DFID.

Kayanda RA. District-level reports on research progress.

Reports drafted by Rosemary Kayanda with input from IMA and Cornell colleagues outlining the progress of the trials for improved practices (TIPs) and the recipe trials programs were circulated to RMOs in all study sites. Kayanda additionally shared slides for presenting TIPs findings at the request of the RMO Kagera who presented OR findings to the Regional Health Management Team and other key nutrition stakeholders.

TRAINING MANUALS AND CURRICULA

Tanzania Food and Nutrition Centre in collaboration with Cornell University and the Building Strong Nutrition Systems (BSNS) Project. Building A Strong Nutrition System Across Sectors: A manual for strengthening district capacity to improve multi-sectoral nutrition planning and action. Dar es Salaam, Tanzania, 2018 April.

Cornell developed this manual in collaboration with TFNC for the BSNS project. BSNS project findings informed the methods used in the OR Multisectoral Nutrition Capacity Building study. TFNC printed and mailed hard copy manuals to every RNuO in ASTUTE regions as guidance for mentoring council multisectoral nutrition action teams.

ADDITIONAL FUNDING OBTAINED

(to Support Research and Dissemination Activities)

Division of Nutritional Sciences (DNS) Travel Grant, Cornell University, (2018)

Einaudi Graduate Travel Grant, Cornell University, (2019)

Engaged Cornell, Cornell University, (2019-2020)

Scaling Up Growth: Addressing Stunting in Tanzania Early (in the under 5s)

UPDATE ON OPERATIONS RESEARCH

August 2019

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Tanzania Food and Nutrition Centre

IMA WorldHealth

Cornell University

OVERVIEW

Addressing Stunting in Tanzania Early (ASTUTE), led by IMA World Health and funded with UK aid from the UK government through the Department of International Development (DFID), aims to effectively operationalize Tanzania's national nutrition policies at scale. ASTUTE's goal is to reach three million mothers and prevent stunting in 50,000 children, collectively reducing stunting prevalence in children under five years by at least 7 percentage points in 5 target regions surrounding Lake Victoria in Tanzania.

Cornell University designed and conducted operations research, in collaboration with IMA World Health and the Tanzania Food and Nutrition Centre (TFNC), to strengthen ASTUTE intervention efforts through exploring attitudes and conditions around infant and young child feeding (IYCF) behaviours and local capacity to deliver quality and effective interventions. The research contained 4 phases, summarized below.

Data collection for operations research started in April 2017 and concluded in May 2019. Preliminary findings have been shared with key stakeholders in participating research sites. Ongoing analysis and dissemination will provide helpful information for continual selection, design and strengthening of community intervention activities that promote nutrition-focused behavioural change. Results will also highlight mechanisms for building capacity of frontline staff and developing an enabling environment to work across sectors on nutrition.

Phase 1. Trials of improved practices (TIPs) and Focus Group Discussions (FGDs) with women and men on exclusive breastfeeding (EBF) for infants 0 to 5 months to learn what feeding practices are acceptable, feasible and can be recommended at scale.

> **Study Sites** (Region-district): Mwanza-Sengerema and Geita-Chato.
> **Objective:** To ensure EBF messages are acceptable and feasible by exploring mothers' and fathers' willingness to try recommended strategies, and motivations, barriers and facilitators of practices.
> **Methods**: Trials of Improved Practices (TIPs) with 72 parents of babies aged 0-6 months and 4 focus group discussions (FGD) with men to explore roles to support EBF. TIPs involved 3 household visits: (1) to assess current feeding practices, (2) to provide tailored recommendations on doable actions to improve practices, and (3) interviews on acceptability and experiences with recommended practices.
> **Select Findings**: Common problems/barriers were giving water, using gripe water when concerned about babies crying, and mothers' lack of time to feed. After counseling, most mothers were able to EBF; fathers encouraged mothers and provided food for sufficient breast milk supply. A few fathers helped reduce wives' workloads; some couples said communication improved, supporting EBF.

Phase 2. Trials of improved practices (TIPs) and Focus Group Discussions (FGDs) with women and men on complementary feeding (CF) for infants 6 to 18 months to learn what feeding practices are acceptable, feasible and can be recommended at scale.

> **Study Sites** (Region-district): Mwanza-Sengerema, Geita-Chato and Kagera-Misenyi.
> **Objectives:** To ensure recommendations on CF are acceptable and feasible by testing with mothers and fathers, gaining feedback, and exploring men's willingness to support and participate in feeding.
> **Methods**: FGDs/recipe trials (60 parents); TIPs (50 mothers and 40 fathers of children 6-18 months).

Select Findings: Most frequently-needed recommendations were: thicken porridge, increase dietary diversity, replace sugary snacks, and feed responsively. After counseling, mothers tried practices to improve diet diversity and nutrient content. Fathers purchased healthier snacks and helped with chores; some fathers fed children, valued being counseled, and felt connected to their children.

Phase 3. Assessing mentoring and multisectoral action teams as vehicles to build capacity of district officers to coordinate and implement nutrition actions.

Study Sites (Region-district): Mwanza-Nyamagana, Kigoma-Kasulu, Kagera-Missenyi, Geita-Chato, Shinyanga-Kahama
Objective: To build MSN capacity and assess how mentoring by Regional Nutrition Officers (RNuOs) impacts the ability of district officers to form strategic multi-sectoral partnerships and support communities and frontline workers.
Methods: We trained 5 Regional Nutrition Officers to each mentor one District Nutrition Officer to form an action team with 2-3 officers from other sectors. Support calls and funding for basic expenses were provided. Team members were mentored to plan goals and activities aligned with MSN policy, and interviewed 3-4 times over 14 months to learn from their experiences. Transcribed interviews (n=66) with 27 regional and district officers were analyzed thematically.
Preliminary Findings: Most Nutrition Officers organized teams across health, agriculture, and education departments. Mentoring capacity varied across mentors but was instrumental for providing teams with official status and credibility. Officers outside the health sector felt their work aligned with nutrition but were initially unaware of policy to guide actions. With adaptation, local governments may benefit from an "action team" approach to prioritize MSN initiatives.

Phase 4. Implementation research on home visiting by Community Health Workers (CHWs) and household decision-making on recommended maternal, infant, and young child nutrition (MIYCN) practices.

Study Sites (Region-district): Kagera-Mabira, Kyaka, Gera; and Shinyanga-Mpunze, Samuye, Mwalukwa.
Objectives: To refine programme implementation by assessing how CHWs target home visiting and messages, challenges CHWs face, and community response; to support behaviour change by exploring household decision-making, gender roles and other influences on adopting recommended practices.
Methods: Interviews with CHWs; household surveys of families in selected districts; interviews and card sort activities to explore household decision-making on nutrition, WASH and ECD behaviours.
Preliminary Findings: Forthcoming in 2020.

BACKGROUND

In Tanzania, child mortality is decreasing and health and nutrition are improving. Although Tanzania surpassed the Millennium Development Goals for Children, Food Security and Nutrition, child stunting continues to pose a serious public health concern, affecting 32% of Tanzanian children under age five (TNNS 2018). Stunting is associated with poor cognitive development and educational outcomes, with long-term implications for individuals and communities.

To address this problem, UK Aid Direct/Department for International Development is supporting the Scaling up Growth: Addressing Stunting in Tanzania Early (ASTUTE) or *Mtoto Mwerevu* project which IMA World Health is implementing in 5 regions around Lake Victoria in collaboration with the Government of Tanzania and other partners.

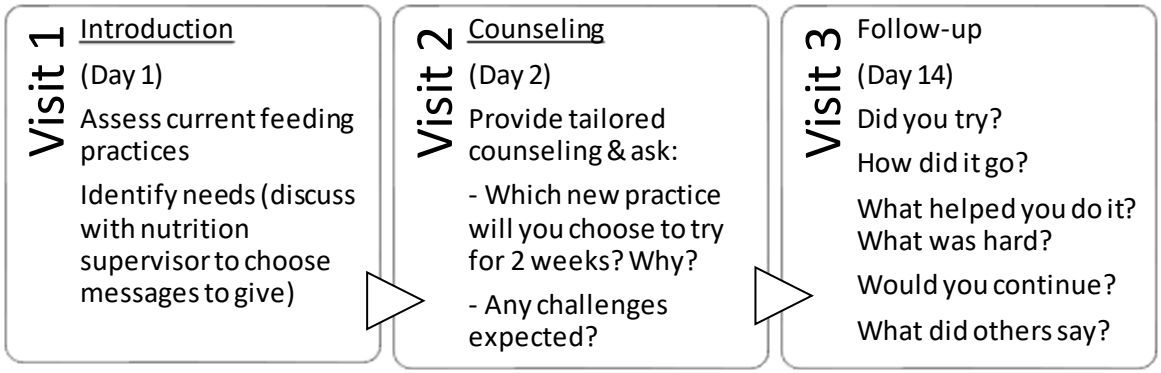
A team from the Division of Nutritional Sciences at Cornell University, in collaboration with the Tanzania Food and Nutrition Centre and IMA World Health, conducted innovative operations research designed to provide feedback to refine social and behavioural change messages, programme implementation and training, and to build capacity to deliver the multisectoral interventions needed to combat stunting in Tanzania. This applied research uses methods developed specifically for the Tanzanian context and focuses on questions directly relevant to the ASTUTE programme. The goal is to build on Tanzania's strong National Multisectoral Nutrition Action Plan (NMNAP) and cadres of trained personnel coordinating and implementing programmes to support the healthy growth and development of young children.

PHASE 1 AND 2 METHODS: What are Trials of Improved Practices (TIPs)?

Trials of Improved Practices (TIPs) is a well-tested and adaptable method to explore the acceptability of recommended behaviour changes with community members prior to scaling up delivery of messages. This innovative approach is called "consultative research" because we consult with community members on whether suggested behaviours are feasible in their family context, whether they are willing and able to try them, and whether they find them acceptable.

TIPs research involves several visits to a small sample of families so interviewers develop rapport and can gather detailed and realistic information. The process followed in Phase 1 and 2 of the operations research is shown in figure 1 below. During household visits with mothers, interviewers assessed current feeding in order to identify tailored messages to provide the next day. On Day 2, mothers were offered choices of these small doable steps to improve child feeding and asked to select what to try. After 2 weeks, interviewers returned to learn from mothers how they felt about the recommendations after trying them out. This dialogue with participants over time provides much more in-depth information than a survey because it is based on actual experience.

Figure 1: Steps in 3-visit Trials of Improved Practices on child feeding in ASTUTE OR



In the ASTUTE operations research, the TIPs approach focused on the infant and young child feeding behaviours most relevant to prevent stunting. We developed counseling guides that tested specific messages on exclusive breastfeeding and complementary feeding, conducting FGDs and recipe trials with mothers to identify local foods and recipes to diversify child diets.

Recognizing the importance of gender roles and support to reduce women's workloads, this study broke new ground by conducting TIPs with fathers as well as mothers. We held FGDs with groups of men to gather ideas on potential ways that men can support child feeding. Then, we visited men whose wives were in TIPs, provided counseling, and asked these fathers to choose specific behaviours to try and support improved child feeding.

For Phase 1 and 2 of the operations research, most of the data are qualitative, meaning that we analyze the responses of mothers and fathers during interviews by summarizing the range of views and experiences. We look for themes that are unexpected and highlight issues that may affect the success of a programme. Quotes from the parents are used to show the types of responses and their words help us to understand what motivates their behaviour, what concerns they have, and how they interpret the feeding recommendations.

PHASE 1: What have we learned from TIPs on Exclusive Breast Feeding (EBF)?

In Tanzania, EBF decreases from 84% in the first two months of a child's life to 27% by the 6th month. To combat this rapid decline and improve child survival rates, ASTUTE is providing messages promoting EBF. This phase of OR found that these messages are very important, but also that parents need more detailed counseling to overcome barriers to EBF. **Table 1** includes recommendations on what information to provide to parents to support improved breastfeeding practices and shows how the Phase 1 results led to these recommendations.

Research methods: TIPs were conducted with 72 parents of babies aged 0-6 months in 4 communities in Mwanza (Sengerema district) and Geita (Chato district) and 4 FGDs were held with men to explore roles to support EBF. TIPs involved 3 household visits during which fathers and mothers were interviewed individually to assess their willingness to adopt the recommended strategies and to identify barriers and facilitators to improving breastfeeding practices.

Status: This phase of the research is complete.

Key results: Most mothers began to practice EBF after being counseled on breastfeeding more frequently and providing their infant with only breast milk. Fathers most often chose to encourage their wives and to support them by providing food to help ensure sufficient supply of breast milk. Some fathers helped the mothers with their workloads and most provided emotional support. Some couples said because of participating in TIPs and discussing child feeding, their communication with each other improved and this supported improved breastfeeding practices.

Identified Barriers:

- Many parents had concerns about "*mchango*" (crying and other colic-like symptoms) in infants and often used gripe water, traditional medications, and non-prescribed medicines to treat symptoms of *mchango*, such as abdominal pain or crying.
- Some parents gave water, thinking infants might be thirsty.
- Women had heavy workloads leaving them limited time and energy to breastfeed.
- Some fathers reported social norms as barriers to involvement in chores and child care but others were willing to help.

Recommendations:

- To promote EBF and overcome barriers, counseling needs to address infant crying, *mchango* and related symptoms, which parents regard as serious health problems.

- Teach parents soothing techniques and ways to cope with prolonged crying, and encourage them to avoid giving gripe water and other non-prescribed medications.
- Engaging with men may help change social norms and improve support for breastfeeding.

Dissemination:

- Summary reports were shared with each district after fieldwork was completed.
- Findings were presented at "Nutrition 2018" in June 2018. (See EBF abstract & EBF poster)
- Manuscript, "Overcoming Perceptions of *Mchango* and Increasing Support to Improve Exclusive Breastfeeding in Tanzania" was published in *Food and Nutrition Bulletin,* 2019 May.
- We provided IMA World Health feedback on messages – See table 1 below. Parents wanted more detailed information to understand what it really means to "give only mother's milk," as well as the reasons for recommended practices and practical strategies to overcome barriers. Table 1 includes overall messages on EBF and child care, plus detailed messages on what to actually do. The second column highlights brief examples of research findings, including some quotes, to show why these messages are important to address parents' concerns and motivations, and to clarify more general messages.
- We developed a CHW Dialogue Training Guide on Exclusive Breastfeeding based on key findings from this research. The guide targets CHW supervisors to help use findings from ASTUTE's research to support effective counseling. The steps in the guide will help CHWs as they discuss and recommend home-based practices people can try to improved nutrition of their children.

Table 1: Input on social and behavioural change messages to support EBF based on results of TIPs

New messages to support EBF The following messages build on existing breastfeeding recommendations by explaining how and why to breastfeed exclusively and avoid other liquids.	**Results and illustrative quotes** From Trials of Improved Practices with mothers and fathers in "Mtoto Mwerevu" regions
Overall EBF message: Breastmilk has everything a baby needs to eat and drink to grow well, and also helps to protect the baby from many sicknesses. Do not give any other foods or liquids.	Many parents are aware of and report that they are exclusively breastfeeding but need to feed longer and more often, and avoid giving other liquids.
Breastfeeding "strategy" messages: a. Take time to breastfeed for as long as your baby wants at each feed. The longer you breastfeed at each feed, the more nutrient-rich milk your baby gets. Let the baby finish all the milk in one breast before offering the other breast. The baby needs both the "foremilk" (high in water for thirst) and "hind milk" (high in fat and sugar so baby feels full and grows strong) b. Breastfeed often throughout the day and night to help your baby grow and help you make plenty of milk. c. Fathers: Help your wife with activities so she has time to breastfeed long enough and often enough so your child will grow well and be healthy.	Quotes from parents: "I already encouraged my wife to breastfeed exclusively but I reminded her to breastfeed for a longer time so that the child gets all kinds of milk as we learnt that the first milk which comes out has lots of water and the second one has the nutrients." (father #38) "The first milk is for giving water to baby, the second is for glucose and the third is for fat, that's how the baby become healthy…" (father #40) "I was told that we should not give our babies water because mother's milk has enough, especially the first milk." (mother #43)
Overall "crying baby" message/background: Crying is normal for babies, especially during the first few months of life, and babies cry for many reasons.	Many parents reported that when their babies cried they worried that the baby had stomach pain

Breastmilk is the best thing to offer when a baby cries. Sometimes, crying is not due to hunger, pain, or anything parents can control. Some babies just cry a lot while others cry a little. Many babies will cry less once they are 3 or 4 months old.	or an illness and then gave gripe water or herbal medicine. Some parents worried that breast milk was not sufficient for the baby.
Crying baby "strategy" messages to support EBF: a. When your baby is crying, try giving breastmilk or see if the baby is wet. b. Try calming the baby in other ways, such as rocking the baby to sleep or holding the baby on their tummy on your lap, rocking the baby and rubbing the baby's back. c. Do <u>not</u> give gripe water or any other liquids. Many types of gripe water have alcohol that can affect the baby's brain. Giving only breast milk is the best way to protect the baby's health. d. If you are worried the baby is crying due to sickness, the best thing to do is to see a health worker.	Parents said cues to breastfeed were babies crying or urinating, particularly at night. "Even when I change her diapers, I breastfeed her before she cries." "…every time she woke up to urinate I breastfed her. So I woke up to change her urinated clothes then breastfeed." Some parents successfully soothed the baby and were able to stop giving gripe water. Many parents do not realize that gripe water contains alcohol. Some participants mentioned brain development as motivation for improved practices: "I don't want my baby to be mentally retarded" "I want my baby to grow, brain-wise"

PHASE 2: What have we learned from TIPs on complementary feeding?

High rates of stunting in Lake Zone, Tanzania are due in part to suboptimal complementary feeding practices of children under 2 years. The complementary feeding study covered 6 communities in 3 regions (Mwanza, Geita, and Kagera), to include maize and banana-staple areas. FGDs and recipe trials were held with 60 parents and TIPs included 50 mothers and 40 fathers of children 6-18 mos. The study also explored fathers' willingness to participate in complementary feeding as they were identified as key influencers of infant feeding practices.

Status. Data analysis is complete and a manuscript drafted. Select key findings are presented below.

Key results: Initially mothers reported that children were fed thin porridge, had limited dietary diversity of foods, rarely consumed animal source foods, and some were fed sweet snacks and drinks. After counseling, most mothers and fathers reported improved practices . Overall, thick porridge was very acceptable. Adding foods to porridge was also accepted, but depended on what family foods were available. Eggs were not available for some families. Practices that did not require additional money were most feasible for families.

Fathers were counseled on the importance of nutrient-dense foods and support for mothers. Fathers provided money to purchase nutritious foods and bought healthier snacks for children. Some men helped with chores or fed children; this message is acceptable for part of the population.

Emergent Themes:

- Dietary recommendations were accepted by parents
- Perceived improvements in child health, appearance and temperament motivated mothers to continue the improved practices
- Most fathers reported providing support for complementary feeding, which their wives confirmed
- Fathers valued being counseled, and feeling connected to their children
- Improved communication and increased cooperation between couples
- Responsive feeding was not selected or tried by most participants

Barriers:

- Cost of nutritious foods, especially animal-source foods
- Seasonal availability of some foods

Recommendations:

- Encourage parents to increase diet diversity by giving family foods and to purchase specific foods for infants
- Additional research is needed on responsive feeding and how best to encourage parents to feed their children responsively
- Engage fathers in complementary feeding by encouraging them to provide nutritious foods and feed their children.
- Promote replacing sugary snacks and beverages with fruits and other snacks.

Dissemination:

- Each district in the study received a report after field work was completed.
- Preliminary results were presented at the conference "Nutrition 2018" in June 2018. (see CF Abstract and CF Poster) as well as at the Annual Meeting of the Society for Applied Anthropology in April 2018 (see slides), and an abstract is under review for the Micronutrient Forum 5th Global Conference 2020.
- We developed a CHW Dialogue Training Guide on Complementary Feeding based on key findings from this research. The guide targets CHW supervisors to help use findings from ASTUTE's research to support effective counseling. The steps in the guide will help CHWs as they discuss and recommend home-based practices people can try to improved nutrition of their children.
- A research manuscript for publication is in preparation for submission in September 2019.

Table 2: Examples of messages included in the CHW Dialogue Training Guide to support complementary feeding based on TIPs results

Messages for mothers	Messages for fathers	Illustrative quotes
• Offer family foods, including eggs, meat, fish, *dagaa*, vegetables, beans. These foods can be chopped and mashed so they are easy for the child to swallow.	• Save some of the food you raise that you would normally sell (like eggs, milk, fish, chicken) and keep it for your baby. • Reassure your wife (and other family members) that the child can eat meat, fish, and other family foods that are mashed well.	"When they prepare the food for me, I invite my son. He comes and we eat from the same plate together. I have been doing this almost every day since it was recommended to me. It makes me happy. At first, my son was not used to it. When I used to invite him, he used to refuse until when he got used to it. Others in my

	• Share food from your plate, including meat, fish, eggs, etc. with your child.	family are happy seeing me eating with my child." –Father
• Avoid giving sugary biscuits and other snacks; give fruits (such as pieces of ripe mango, papaya, banana), avocado, vegetables, boiled Irish potatoes, sweet potatoes.	Only buy nutritious foods for your baby, do not buy sugary snacks, biscuits, or sweetened drinks and ask others not to feed these foods to your child.	"I tried not giving the biscuits or sweets, and instead I gave her fruits. I gave her bananas. Sweets have nothing. I didn't encounter any difficulty." -mother "I educated the family members not to give the baby biscuits. I educated them that the foods that we give the baby, for instance tinned juice, soda, and biscuits are not healthy for the child." –Father
• Be patient and encourage your child to eat by sitting with your child and smiling, laughing, and talking to them	Help your wife by feeding your baby. You can make feeding fun by playing games and telling stories that encourage your baby to eat.	"The thing that I liked was that the child ate food that she didn't usually eat. I felt so happy and amazed because even when I don't have money, I know that if I prepare this food and sing to the child when I'm giving it to her, she will eat and like it." – mother "I enjoyed sitting and playing with my child when I'm home from work. If she's here at home, I play with her. I tell her sweet stories. My wife says that I should continue playing with my child after I come home from work, so that my child can eat happily."-Father

PHASE 3: How can Tanzania strengthen capacity for multi-sectoral nutrition planning and action in communities?

Nutrition is usually seen as part of the health sector, but is greatly impacted by other sectors such as agriculture, education and community development. This is recognized in Tanzania's National Nutrition Action Plan (NMNAP). To combat stunting and promote good nutrition, there is great national support to bring the expertise of the different departments together. However, working across sectors is challenging and we have found in a previous project in Tanzania that having a mentor to support DNuOs was important as they learned to build strategic partnerships and advocate for nutrition. Learn more here: Building Strong Nutrition Systems.

What is mentoring? While there are numerous definitions of mentoring, we conceptualized mentoring as "having two or more individuals willingly form a mutually respectful, trusting

relationship focused on goals that foster the potential of the mentee, while considering the needs of the mentor and the context in which they must function" (Kochan, 2002).

Research methods: Based on a mentoring approach developed with the Tanzania Food and Nutrition Centre (TFNC) in a previous pilot project (mentioned above), we made adaptations to create a more sustainable strategy that supports Regional Nutrition Officers (RNuOs) to mentor and work closely with District Nutrition Officers (DNuOs). The goal was to support DNuOs to create an action team of field officers across different sectors in the council, and to work with them to develop goals and implement activities that align with the NMNAP and to engage with stakeholders such as ward and village implementers, Civil Society Organizations (CSOs) and community members.

Regional Nutrition Officers (*mentors*) were supported by a 3-day learning exchange workshop (see report & toolkit) in February 2018 to introduce the mentoring approach and garner local input and collaboration for approaches to MSN strengthening. The workshop covered specific themes such as study objectives, a mentor's role, and multisectoral nutrition policy and approaches. District Nutrition Officers and their mentors involved in the previous Building Strong Nutrition Systems study attended to share their challenges and accomplishments. This workshop was a great success and a wonderful opportunity for RNuOs to share experiences and become motivated to provide mentoring and support to district council team.

Participants shared the most useful parts of the workshop were:

- Discussions of mentoring, specifically differences between a mentor and roles of the supervisor, teacher and coach.
- Steps on creating council MSN teams.
- Hearing from experienced DNuOs and RNuOs.

We also created sample Regional data profiles on the nutrition situation in each region, to help to set goals and advocate for nutrition priorities. Mentors were asked to guide council teams to use available data to create similar materials using data and programme examples in the selected districts. We provided mentors with a suggested schema for mentoring MSN action teams but encouraged flexibility and shaping of the approach to local contexts (figure 2).

Figure 2. Suggested steps for Regional Nutrition Officers to support District Nutrition Officers and a team of 3-4 officers from key sectors.

The mentees participated voluntarily and mentors were provided per diem and transport costs for mentoring visits. Research staff conducted quarterly support calls in Kiswahili with mentors to evaluate fidelity and address implementation challenges mid-study. Outside of these inputs, we minimized interaction between research staff and mentors, relying on them to identify priority areas for improvement and mentor district teams with minimal input, a mechanism to ensure sustainability of the approach.

Active mentoring occurred in one district in each of the 5 ASTUTE regions, in districts selected by the regional government between March 2018 and April 2019. The operations research monitored and supported RNuO mentoring activities and the impacts and activities at the district level. Observations and interviews explored the mentoring process and experiences of RNuOs as well as skill and confidence development amongst council officers and their ability to collaborate and strengthen departmental connections and plan and create actions that support improved nutritional outcomes.

Status. Data has been collected and coded. Analysis and write-up of results is ongoing and thus select preliminary findings are provided below.

Preliminary Results:

Topic	Salient quote
• Most Nutrition Officers developed action teams comprised of officers from Health, Agriculture, and Education Departments. Education, Community Development, and Social Welfare officers stated their department was in a prime position to work on nutrition given their strong presence in communities, but their departments had not yet prioritized nutrition.	▶ *"Ever since the RNuO started coming, nutrition now is being seen as an activity in this department. Before it was not even known if there are nutrition activities to focus on. So now it has been known." (Community Development Officer, Site #2)*
• Action teams provided an opportunity for officers across sectors to "own" nutrition and propose ways to collaborate on nutrition action. It gave motivated officers an avenue for clarifying key challenges and strategies to address them.	▶ *"The exchange of knowledge and experience amongst team members helps us address challenges. We need to sit together and share experiences for a long period of time. Let every one of us bring forward what they are competent at, then come up with a common understanding." (District Nutrition Officer, Site #4)*
• Motivation, humility, social conscience and the desire to learn from others was critical for action team membership.	▶ *"It requires a lot of commitment to the community. You must think, 'I am a leader of a people who are malnourished, who need education to improve their knowledge and well-being' and you work with your heart." (Community Development Officer, #5)*

• Regional mentoring to establish action teams put key MSN players into contact who otherwise were not likely to collaborate. These new intersectoral connections increased access to information, data, and expertise relevant to each participant's work.	▶ *We learn from each other when we go for capacity building. You find that you don't know everything; when others speak there are things that you learn. Sincerely I have seen this team has made us to become friends…Even it is now easier to ask fellow colleagues feedback on something in their area…Now we work together. (Agriculture Officer, Site #3)*
• Council officers reported an ability to strengthen the link between district leaders and community members, acting as a conduit to share data, ideas, and feedback that improve community-centered interventions.	▶ *"The Heads of Department end up giving orders instead of discussing. Because of this action team now there is cooperation which involves members from multiple sectors who can actually go to the community. I think this team can advise Heads of Department, discuss what needs to be done, and bring them suggestions from those at the community-level." (District Nutrition Officers, Site #2)*
• Lack of funds, inconsistent access to transport and fuel, and heavy workloads were key challenges for coordination across sectors. Teams with strong mentors and highly motivated mentees found strategies to overcome these challenges and engage in joint nutrition actions in communities.	▶ When it comes to work accountability, lack of resources becomes an irrelevant excuse for not fulfilling your duties. There always has to be work you can be accounted for. (Agriculture Officer, Site #2)

Select examples of actions completed by MSN action teams:

Topic	Action
Strengthen school feeding programmes	▪ Conduct supportive supervision in primary and secondary schools, educate on diet diversity and the benefits of school feeding programmes, help set up school gardens (e.g. locate orange flesh sweet potato vines, clear land)
	▪ Facilitate 1 day sensitization and advocacy meeting to 3 Ward Development Committee (WDC) members across 3 wards on the importance of school feeding programmes
Cascade the multisectoral nutrition (MSN) approach to local levels	▪ Conduct 1 day training on MSN strategy to reduce stunting amongst Primary Health Teachers, Community Health Workers (CHWs), CHW Supervisors, and Extension Officers
	▪ Develop Multisectoral Nutrition (MSN) Committees in 5 wards comprised of ward-level officers from key sectors and community leaders; have members sign government "nutrition compact" to increase accountability and motivation

Leverage multisectoral partnerships to strengthen nutrition-specific interventions	▪ Develop promotional materials for Vitamin A supplementation campaign and have officers advertise in their respective sector using their existing community-based connections

Recommendations provided by participants and district leaders:

We disseminated preliminary findings and recommendations in the 4 research sites that completed study activities. Dissemination meetings included Regional Nutrition Officers, Action Team members, and key regional and district leaders. Attendees were very enthusiastic and generated ideas for how to sustain and scale-up study approaches. Select recommendations are provided below.

- Have Action Team members sign the "nutrition compact" to acknowledge their role and boost accountability and motivation. Signatures are currently only required for administrative leaders including Regional Administrative Secretaries and Regional Medical Officers.

- Create a vehicle share that spans across departments in order for the Action Team to implement several multi-sectoral actions per trip.

- Use current policy to fund Action Team activities (e.g. allocation of 1,000 TSH per child < 5 years in every district).

- Identify ways to share strategies across districts and regions—Teams were motivated to try new activities after learning what others did.

- Scale-up approaches using officers who have firsthand experience with developing strategies to overcome key challenges faced by implementation staff across the country. The initial Action Team members are in a strong position to serve as mentors for others interested in the approach.

Dissemination:

- This work was presented at the American Society for Nutrition (ASN) in June 2019 (see abstract & poster) and the Federation of African Nutrition Societies (FANUS) in August 2019 (see abstract & slides) and will be presented as a poster at the *Qualitative Evaluation (QE) Symposium* in Brasilia, Brazil in October 2019 (see abstract).
- Post-study, researchers reported on preliminary findings and recommendations during a 90 minute meeting with mentors, mentees, and district leaders in the 4 study sites who completed activities. Participants in turn shared their experiences and recommendations on future efforts for MSN strengthening. (see slides)
- Analysis is ongoing and manuscripts are forthcoming.

PHASE 4: Implementation research on CHW delivery of home visits and exploration of factors that affect families' practice of key recommendations

Despite the existence of effective interventions to address stunting, many children still suffer from poor health and development due to preventable and treatable health problems. Quality implementation at a large scale is challenging and there is a lack information on strategies to

improve success. This has led to global calls for more implementation research to understand how best to scale up effective interventions and ensure adequate reach and delivery.

ASTUTE is implementing an innovative home-visiting approach through Community Health Workers (CHWs) and CHW supervisors working with District Nutrition Officers (DNuOs). The programme has trained and provided detailed guidance to CHWs and supervisors on how to target priority families and deliver appropriate messages. ASTUTE can contribute greatly to the knowledge base on implementation of home visiting through community health workers (CHW).

The programme also provided an opportunity to delve into families' experiences with recommended practices and the household dynamics and characteristics associated with ability to adopt key nutrition, WASH, and ECD behaviours. This phase of operations research assessed 1) factors affecting implementation and quality of CHW delivery of interventions, including CHW success in reaching and targeting priority families and perceptions of the home visit messaging and 2) household dynamics such as decision-making, gender and social norms that may affect family attitudes and practice of recommended behaviours.

Sites and sampling: In close collaboration with Kagera and Shinyanga Regional Government Officers, we identify 4 districts (Kyerwa, Missenyi, Ushetu and Shinyanga Dc) for this study.

> **Phase A:** Within Kagera and Shinyanda regions, 12 wards, 35 villages, and 211 hamlets were identified. A total of 16,200 households were visited including 5,438 eligible pregnant women or young children under 2.5 years old. All CHWs working in ASTUTE sites were surveyed (n=66). Qualitative in-depth interviews were completed with 20 CHWs and 6 CHWs supervisors.
>
> **Phase B:** Within Kagera and Shinyanga regions, 6 wards, 14 villages and 44 hamlets were identified. A total of 58 couples (families) were recruited and agreed to participate, including pregnant women and/or mothers/caretakers of children under the age of 24 months and their male partners. A total of 58 men and 58 women completed the survey, in-depth interviews, and pile sorts.

Status. While data collection is complete, coding, analysis and write-up of results is ongoing and will continue into 2020.

Data collection: This research consisted of two phases (A and B). Phase A focused on how 66 CHWs targeted households and how they deliver the messages by (1) interviewing CHWs and CHW supervisors, and (2) surveying household in selected communities to assess success of targeting and outreach. CHWs and families will also be asked about their views on home visits and key messages,

Phase B used qualitative methods with families, including pile sorts and in-depth interviews with mothers and fathers that are eligible to receive home visits. Through using innovative pile sort methods that asked participants to reflect on how resources are allocated and how decisions are made, combined with interviews on current practices, gender roles, and socio-economic status, we learned about the conditions necessary for a family to put into practice the messages that ASTUTE interventions provide. Results from this research can be used to guide programmatic targeting and facilitation of behaviour change.

Overall, understanding facilitators and barriers during implementation of health interventions, and gender and household dynamics that affect intervention uptake will help to increase effectiveness and number of people reached by existing and future interventions.

Preliminary Findings for Implementation Study Phase B:

- Interviews with community members showed women often reported they had little say over decisions made around managing money and resources, and would often agree with their husbands to avoid conflict or violence (even though joint decision-making was often reported).

- Women frequently reported that they did not know what their husbands spent household money on but suspected that it was alcohol or other leisure activities.

- Almost all men and women reported, jointly or alone, that they would allocate money for business, savings, and/or for emergency use if children or other family members fell ill.

Dissemination:

- After the study, researchers officially reported on preliminary findings and recommendations during six Participatory Workshops to share preliminary findings and encourage discussion on results with local government and community partners. Researchers focused on findings and programme implications related to household, social, and gender dynamics around programming, health, and nutrition. Workshops strengthened relevance of the findings and involved community partners in building capacity to successfully implement local programming.
- Presented preliminary results, "He said, she said: Using pile sort methods to explore differences in decision-making and resource allocation for food, agriculture, and other costs amongst couples in Tanzania." at the Annual Agriculture, Nutrition and Health (ANH) Academy Week, Hyderabad, India, June 2019. (see abstract)
- Analysis is ongoing and manuscripts are forthcoming.

OPERATIONS RESEARCH PRODUCT LIST

Dissemination of Results and Other Outputs of Operations Research for ASTUTE Scaling Up Growth: Addressing Stunting in Tanzania Early (in the under 5s).

Funded by United Kingdom Department for International Development (DFID).

Updated August 22, 2019

Peer-reviewed Publications

CR Matare, HC Craig, SL Martin, RA Kayanda, GM Chapleau, R Bezner Kerr, KA Dearden, LP Nnally and KL Dickin. Barriers and Opportunities for Improved Exclusive Breastfeeding Practices in Tanzania: Household Trials with Mothers and Fathers. *Food and Nutrition Bulletin,* 2019 May.

Oral Scientific Conference Presentations

Kayanda RA, Klemm GC, Kazoba A, McCann J, Nnally LP, Dickin KL. Multi-sectoral "Action Teams" Help District Officers Implement Nutrition Policies and Strengthen Coordination Across Sectors for Nutrition in Tanzania. Accepted for *Federation of African Nutrition Societies (FANUS)*, Kigali, Rwanda, 2019 Aug 26-29.

Owoputi I, Kayanda RA, Bezner Kerr R, Dearden KA, Martin SL, Nnally LP, Dickin KL. He said, she said: Using pile sort methods to explore differences in decision-making and resource allocation for food,

agriculture, and other costs amongst couples in Tanzania. *Annual Agriculture, Nutrition and Health (ANH) Academy Week*, Hyderabad, India, 2019 Jun 24-29.

Martin SL, Matare CR, Kayanda RA, Riggle KR, Owoputi I, Bezner Kerr R, Dearden KA, Nnally LP, Dickin KL. Increasing family support for recommended complementary feeding practices in Tanzania. *Annual Meeting of the Society for Applied Anthropology*, Philadelphia, PA, 2018 Apr 3-7.

Poster Presentations

Locklear K, Khan M, Kayanda RA, Kazoba A, Matare CR, Owoputi I, Nnally L, Bezner Kerr R, Dearden KA, Dickin KL. Spousal Support and Cooperation within Complementary Feeding Practices in Tanzania. Accepted for presentation at *Society for Advancement of Chicanos/Hispanics and Native Americans in Science (SACNAS)*, Honolulu, HI, 2019 Oct 31-Nov 2.

Dickin KL, Klemm GC, Kazoba A, Kayanda RA, McCann J, Nnally LP. Exploring Mentoring as a Novel Strategy to Support implementation of National Nutrition Policies through Multi-sectoral Coordination in Tanzania. Submitted to *Qualitative Evaluation (QE) Symposium*, Brasilia, Brazil, 2019 Oct 9-11.

Kayanda RA, Matare CR, Craig HC, Rosenthal HE, Martin SL, Nnally LP, Dearden KA, Dickin KL. Recipe trials: A participatory approach to understanding accessibility, attitudes and norms towards foods to improve complementary feeding in Tanzania. Accepted for *Federation of African Nutrition Societies (FANUS)*, Kigali, Rwanda, 2019 Aug 26-29.

Dickin KL, Chapleau GM, Kazoba A Kayanda RA, McCann J, Frommer M, Lambert V, L. Martin SL, Nnally LP. Policy vs. practice: Exploring a mentoring approach for building capacity to implement multisectoral nutrition policies in Tanzania. *Nutrition 2019 (American Society for Nutrition Annual Meeting)*, Baltimore, MD, 2019 Jun 8-11.

Matare CR, Craig H, Martin SL, Kayanda RA, Chapleau GM, Bezner Kerr R, Dearden KA, Nnally LP, Dickin KL. Overcoming perceptions of colic and increasing support to improve exclusive breastfeeding practices in Tanzania: Household trials with mothers and fathers. Nutrition 2018 (American Society for Nutrition Annual Meeting), Boston, MA, 2018 Jun 9-12.

Martin SL, Matare CR, Kayanda RA, Owoputi I, Bezner Kerr R, Dearden KA, Nnally LP, Kazoba A, Dickin KL. Recommendations to increase children's dietary diversity and decrease sugary snacks are acceptable and feasible for mothers and fathers in Tanzania. *Nutrition 2018 (American Society for Nutrition Annual Meeting)*, Boston, MA, 2018 Jun 9-12.

Symposia

Gryboski K, Matare CR, Mukuria A, Martin SL, Palmquist A, Yourkavitch J. Engaging fathers, grandmothers, and other family members in maternal and child nutrition: sharing lessons from development for humanitarian contexts. Symposium at *CORE Group Global Health Practitioner Conference*, Bethesda, MD, 2018 Jun 4-7.

Manuscripts in Progress

Martin S, et al. Household Trials of Improved Practices (TIPs) on barriers and facilitators to improved complementary (CF) practices. (in progress)

Craig H, et al. "Because of the *mchango* problem, I give my baby gripe water so he sleeps and stops crying": Exclusive breastfeeding recommendations need to address parents' concerns of colic-like symptoms of *mchango* in infants 0-6 months in Lake Zone, Tanzania. (in progress)

Kayanda RA, et al. Recipe trials for complementary feeding for infants 6 to 24 months in Lake Zone, Tanzania. (in progress)

Programmatic Products (for Government and Programme Personnel)

Knowledge for Action Brief: Council Multi-sectoral "Action Teams" Enhance Coordination for Nutrition Activities. Prepared for Council-level debrief meetings, 2019 July.

Cornell drafted this brief based on preliminary findings of key themes from the first three (of four) rounds of data collection for the Multi-sectoral Nutrition Initiative Study. The brief focuses on Multi-sectoral Action team accomplishments, barriers, and strategies for increasing collaboration. Briefs were printed and shared with participants and council and regional leaders in the study sites.

CHW Dialogue Training Guides on Exclusive Breastfeeding and Complementary Feeding. Training Guides, Prepared for IMA World Health, 2018 Dec.

Cornell drafted these guides based on key findings from the Trials of Improved Practices (TIPs) studies on exclusive breastfeeding (EBF) and complementary feeding (CF). Guides target CHW supervisors to help use findings from ASTUTE's research to support effective counseling. The steps in the guide will help CHWs as they discuss and recommend home-based practices people can try to improved nutrition of their children.

Scaling Up Growth: Addressing Stunting in Tanzania Early (in the under 5s). Operations Research Update, Prepared for Department of International Development (DFID), 2018 June.

Cornell wrote this summary that was circulated during DFID's annual review meeting of IMA World Health's ASTUTE Programme activities. The summary included the objective, methods, and key findings to date for each phase of the Operations Research: TIPs on Exclusive Breastfeeding, TIPs on Complementary Feeding, Building MSN Capacity, and Implementation Research.

Operations Research Input on ASTUTE SBCC Messages. Report, Prepared for IMA World Health, 2018 May 17.

Report details messages that were developed based on the TIPs studies that asked parents to try new practices related to EBF and CF. We found parents appreciated more detailed information to understand what it really means for example to "give only mother's milk". This report provides suggested nuances to messages and draws on research findings to support current IMA messaging around key nutrition behaviours.

Learning Exchange Workshop to Promote Multisectoral Nutrition Capacity in Councils. Workshop Report, Adden Palace Hotel, Ilemela MC, Mwanza, 2018 Feb 7-8. Prepared for IMA World Health, ASTUTE Nutrition Officers, and RNuOs.

Report includes key discussion topics and learnings of the workshop. It draws on presentations and subsequent discussions, key points and individuals' notes from break out groups, information collected on flip charts, as well as participant responses to a workshop evaluation.

Learning Exchange Workshop to Promote Multisectoral Nutrition Capacity in Councils. Workshop Toolkit, Adden Palace Hotel, Ilemela MC, Mwanza, 2018 Feb 7-8. Prepared for IMA World Health, ASTUTE Nutrition Officers, and RNuOs.

Toolkit shared with RNuOs to help guide them to mentor Council MSN Action Teams. Toolkit provides helpful tips and templates as well as considerations for starting project activities and supporting approaches to building MSN in councils as discussed at the workshop. By providing tailored support, expertise, and advice to this team, RNuOs will help build on existing knowledge of the best practices for promoting multisectoral collaboration for nutrition.

Operations Research on Addressing Stunting in Tanzania Early (ASTUTE): Strengthening Multi-Sectoral Nutrition Capacities amongst Council Officers. Operations Research Brief, 2017 Dec.

Brief provides an overview of the MSN Capacity Building study. Researchers circulated to key stakeholders and partners in study sites to inform them of study objectives, upcoming activities, and key research contacts.

Scaling Up Growth: ASTUTE: Addressing Stunting in Tanzania Early. Operations Research Brief, 2015.

Brief provides an overview of the three phases of Operations Research: TIPs, MSN Capacity Building, and Implementation Assessment. Researchers circulated to key stakeholders and partners in study sites to inform them of OR objectives, an overview of each study phase, and key research contacts.

Programmatic Presentations (for Government and Programme Personnel)

Kayanda RA. Mtoto Mwerevu Operations Research: Progress, Results, and Implications for Stunting Prevention. Presentation to *Development Partners Group for Health (DPG) Nutrition*, Dar es Salaam, Tanzania, 2019 Aug 13.

Presentation of OR findings focusing on the select TIPs themes of the impact of availability, workload, economic barriers, and gender and relationships on infant and young child feeding. Select findings of the MSN study were the main focus of this meeting since these results had not yet been shared nationally. Twelve major non-government organizations who are involved in nutrition in Tanzania attended the meeting.

Kayanda RA, Kazoba A, Nnally LP. Dissemination in councils of the Multisectoral Nutrition (MSN) Study through 90 minute meetings. Four study sites in the lake zone, Tanzania, 2019 July 15-31.

Dissemination of select preliminary results was provided as courtesy to participants to share key themes and elicit feedback as a way to improve the accuracy and validity of the findings and implications for programmes. Discussions highlighted the successes of MSN action teams and facilitated sharing of experiences and recommendations for strengthening and scaling up capacity building approaches. Members from the Council Steering Committee on Nutrition were invited to promote continued efforts to boost MSN planning and implementation in councils.

Kayanda RA, Kazoba A, Owoputi I. Dissemination in wards of the Community-based Implementation Study through half day workshops. Six study sites in the lake zone, Tanzania, 2019 July 15-31.

Preliminary findings were shared to encourage discussion on results with local government and community partners. Discussions focused on findings and programme implications related to impact of household, social, and gender dynamics on health and nutrition. Participatory workshops helped to strengthen relevance of the findings and involved community partners in building capacity to successfully implement nutrition programming.

Kayanda RA, Nnally LP. Mtoto Mwerevu Operations Research: Progress, Results, and Implications for Stunting Prevention. Presentation to *Tanzania Food and Nutrition Centre (TFNC)*, Dar es Salaam, Tanzania, 2018 Aug 8.

Presentation of OR findings delivered to TFNC at the NIMR Conference Hall in Dar es Salaam. There were sixteen attendees at the meeting including twelve individuals from TFNC and one from DFID.

Kayanda RA. District-level reports on research progress.

Reports drafted by Rosemary Kayanda with input from IMA and Cornell colleagues outlining the progress of the trials for improved practices (TIPs) and the recipe trials programmes were circulated to RMOs in all study sites. Kayanda additionally shared slides for presenting TIPs findings at the request of the RMO Kagera who presented OR findings to the Regional Health Management Team and other key nutrition stakeholders.

Training Manuals and Curricula

Tanzania Food and Nutrition Centre in collaboration with Cornell University and the Building Strong Nutrition Systems (BSNS) Project. Building A Strong Nutrition System Across Sectors: A manual for strengthening district capacity to improve multi-sectoral nutrition planning and action. Dar es Salaam, Tanzania, 2018 April.

Cornell developed this manual in collaboration with TFNC for the BSNS project. BSNS project findings informed the methods used in the OR Multisectoral Nutrition Capacity Building study. TFNC printed and mailed hard copy manuals to every RNuO in ASTUTE regions as guidance for mentoring council multisectoral nutrition action teams.

Other Resources

https://blogs.cornell.edu/centirgroup/research-projects/the-astute-project/

Additional Funding Obtained (to Support Research and Dissemination Activities)

Division of Nutritional Sciences (DNS) Travel Grant, Cornell University, (2018)
Conference Travel Grant, Cornell University Graduate School, (2019)
Einaudi Graduate Travel Grant, Cornell University, (2019-2020)
Engaged Cornell, Cornell University, (2019-2020)

USING SIMPLIFIED FIXED OBLIGATION GRANTS (FOGS) TO INCREASE GOVERNMENT OWNERSHIP AND REDUCE STUNTING

OVERVIEW

Fixed obligation grants (FOGs) are grants used to support very specific development activities, where both the grant donor and recipient understand the costs required to meet certain deliverables and carry out specific activities.[1] FOGs—also known as Fixed Award Amounts (FAAs)—are different from other contractual mechanisms because grantees are paid an amount upon the achievement of a milestone/outcome, rather than on a line-by-line basis for individual expenses as they are incurred. Grantees are also not required to report on actual costs spent during activity implementation or provide receipts—just on their outcomes. That makes FOGs easier to administer and implement for both the donor and the recipient organisation, particularly for local organisations and governments.

IMA provided FOGs to regional and district government within the DFID ASTUTE stunting reduction programme as a tool for enabling the government to plan their nutrition activities and practise allocating these funds. Using FOGs, rather than implementing the activities through NGOs, promotes ownership and buy-in from the government at all levels and increases the likelihood that the government will own and sustain stunting reduction activities following the project's end.

WHY THIS IS AN IMPORTANT AREA FOR NUTRITION PROGRAMME IMPLEMENTERS IN TANZANIA

Nutrition has historically been excluded from the annual budgeting process at the regional and district-level in Tanzania due to competing priorities and limited funds, as well as the need for support from other sectors. Key decision makers (regional and district level government directors, councilors and departmental heads) used to feel that vitamin A supplementation, mass deworming events, and routine iron folate supplementation were sufficient programmes for the government to demonstrate their commitment to preventing and addressing nutrition issues. More recently, many districts have included nutrition priorities in the annual plans and budgets, but execution of related activities has been low due to not blocking off the committed budgets. NGOs simultaneously have worked to fill nutrition gaps created by the lack of government funding and support. The FOG mechanism marries these two approaches, creating a system in which donor-funded programmes work in partnership with government structures and processes. FOG benefits include fostering high levels of transparency around what is required for reimbursement; minimising paperwork and accounting, freeing up manpower amongst grantees; and promoting accountability and results since the funding is tied to activity completion rather than labour.

STRATEGIES USED IN TANZANIA

IMA sought to close the gap between government efforts and donor-funded nutrition programmes within the ASTUTE programme by creating a flexible funding system that is locally-rooted to foster country ownership. IMA drew from its successful work in Tanzania under USAID's ENVISION: A World Free of Neglected Tropical Diseases (NTD) programme, led by RTI International globally. Since 2010, IMA under ENVISION has used FOG/FAA mechanisms to implement NTD activities in close collaboration with regional and district authorities. Through this process, IMA has allocated nearly 40% of the annual project budget by direct transfer of funds to regional and district councils to implement NTD activities. Lead ENVISION partner RTI's implementation of NTD elimination programmes through IMA World Health and other partners in 19 countries globally[2] has found that FOGs successfully build capacity within the country, both in technical areas as well as in management, budgeting, and administration. FOGs have been used to implement disease-specific assessments, enable supportive supervision, promote social mobilisation, and other activities.

Today, IMA uses FOGs within the ASTUTE programme as the primary mechanism to administer local stunting reduction funding through both government (in 36 target districts and 5 regions in the Lakes region) and to 48 CSOs (working at community-level on SBC interventions). Funding through

1 www.ntdenvision.org/webinars https://www.ntdenvision.org/sites/default/files/docs/fog_webinar_final.pdf

2 www.NTDenvision.org

UKaid from the British people

IMA World Health

these FOGs helps to ensure that local government authorities (LGAs) and regional secretariats (RSs) include ASTUTEs priority nutrition activities in their annual work plans and budgets system for the Tanzanian government's medium-term expenditure framework (MTEF) every year.

ASTUTE uses FOGs as fixed-price instruments by providing a pre-agreed upon amount of funds for the achievement of a predetermined number of activities, organised into milestones. Under this mechanism, LGA and RS recipients must provide proof of performance by completing "Milestone of Activities" forms before subsequent payments are delivered. The first milestone payment is generally made upon the signing of the contract. Subsequent payments are made on receipt of a deliverable, such as the FOG recipient's activity work plan and budget, which can be done before actual activity implementation begins. This enables the recipient to be awarded starter funding to cover the first set of milestone activities. Payments are delivered through LGAs or sub-treasury general deposit accounts with provision for President's Office - Regional Administration and Local Governments (PO-RALG). The PO-RALG controls the amounts allocated to each LGA or RS and is recorded in cash books or expenditure accounts for all levels.

KEY APPROACHES USED AND LESSONS LEARNT

IMA's approach to FOGs has achieved programme success in numerous settings, including fragile states, through building on existing government structures instead of replacing them, and working within the limitations of each setting rather than creating a temporarily more ideal environment to achieve short-term, donor-driven results.

The model is rooted in a strong understanding of the local context and respect for national priorities and needs. It is based on the understanding that local ownership and commitment requires that governments and communities lead and monitor their programmes, but do not always have the full range of technical and management skills needed to be successful. IMA's approach is to provide the support, training, mentoring and guidance to build local capacity to design, implement and monitor the results of their programmes. IMA has developed standardised planning tools to facilitate the planning and budgeting processes but adjusts these to each setting and technical area as appropriate.

For ASTUTE, IMA provided local LGA and RS capacity strengthening to successfully develop and implement FOGs as a key local ownership strategy. This included orienting key stakeholders on the purpose and components of FOGs, as well as one-on-one mentorship through questions as they arose. Equally important was developing mutually agreed upon work plans between IMA and LGAs or RSs and funding them. The work plan is linked to and funded through the centrally-managed LGA spending account or the sub-treasury account. However, the FOG funding is clearly labeled within the government accounting system to specify the recipient (specific LGA or RS). This helps create a sense of ownership with the local, sub-national and central governments, with our support.

Lessons Learnt

FOGs were one of the primary components that led to the success of the ASTUTE nutrition programme managed by IMA in Tanzania. With 41 administrative entities (36 LGAs and 5 RSs) receiving funds through the FOG approach, all produced fundable work plans, executed agreed activities, and achieved their milestones with variations in timeliness in completion of their reports. We recommend that other implementers consider FOGs as a successful strategy for promoting local ownership of nutrition and other multi-sectoral development interventions. Lessons learnt regarding this process include:

- Sit down with each LGA/RS to identify budget gaps within their current government. This is important to develop the nutrition FOG budget and work plan, and fill gaps from existing resources.
- Simplify onerous reporting by eliminating detailed financial reporting. Instead, grantees submit narrative milestone reports with key supporting documents (such as signed minutes of coordination meetings, attendance lists, pay slips, etc.) The template is provided below.
- Develop and document clear and realistic milestones within the FOG work plan so that it is easy to administer payments.

Challenges and Recommendations

- The frequent changes of government leaders/ representatives at the LGA and RS levels can slow down decision making. It necessitates frequent orientation/ re-orientation by project staff on FOGs and their components.
- Bureaucracy within the LGA level creates slowdowns and excessive approvals to request funding from the donor and approval for implementation. Complicated government accounting systems can also delay access to funds at the district level.

To mitigate these issues, IMA recommends encouraging RS and LGA-level advocacy on managing nutrition-specific and nutrition-sensitive activities funded through the FOG system, as well as committing government resources for nutrition activities. In addition, programme implementers should plan and budget for frequent staff turnover and ensure they can provide on-the-job FOG training and supportive supervision when new key authority staff is hired or elected. Doing so will create constant communication with LGA, RS and central government authorities to push for timely approval of funds, or rectifying issues related to late access of funds from central deposit accounts to cash books of LGAs. This

supplements the original training of key LGA and RS-level finance and programme authorities who participate in FOG administration, including directors, accountants, and programme managers from departments hosting nutrition work. The ASTUTE team also identified a key contact and advocate working in PO-RALG, who can look into delays of payment or submission of documentation as it arises, moving paperwork forward as needed.

TOOLS AVAILABLE

IMA has included sample FOG templates within the ASTUTE Stunting Reduction Toolkit that can be adapted by Tanzanian implementers. These include:

- Sample **FOG Cover Sheet and Grant Agreement**, which includes terms and conditions and relevant information for creating a FOG between donor and recipient.
- Sample **FOG Performance Report Template**, which details the project by name, reporting period, milestones and numbers, and contact information for who completed the report. It also specifies the supporting documents required for each milestone report to ensure timely payment: key achievement, activity status, challenges experienced, recommendations, and success stories and photos.
- Sample **Success Story Template**, which provides suggestions and guidance on how to report on a success story related to the FOG and project.
- A **FOG Checklist**, which is attached as an annex to the milestone report. It includes space for programme/grant managers to mark the status for the completion of each activity, and whether it is complete or not.[3]
- **FOG budget template**, which demonstrates how to link incremental payments upon completion of each milestone. The first payment is made upon completion of the recipient's work plan.
- A **sample FOG Invoice** from the LGA or RS that will enable payment based upon the agreed milestone completion. It is addressed to the funder, and certified and signed by the grantee.

3 Partial certification is not permitted to receive payment, though in certain instances partial deductions may be made for incomplete milestones if there are mitigating circumstances or inter-linked activity issues.

In addition, donors and implementers may want to refer to:

- USAID ENVISION *Webinar on Fixed Obligation Grants: Sharing Best Practices.* Recorded webinar and PowerPoint slides available at: https://www.ntdenvision.org/resource/webinars/envision_webinar_on_fixed_obligation_grants_sharing_best_practices (May 2017).
- USAID guidance: *Fixed amount awards to NGOs: An Additional Help Document for ADS Chapter 303:* https://www.usaid.gov/sites/default/files/documents/1868/303saj.pdf (Dec. 2014).

REVIEW OF DELIVERABLES FOGS - CHECKLIST

DISTRICT:				
FOG #:				
No.	Description	Target	Yes/No/NA	Remark / Comment / Explanation
1	**Milestone 1 - District Specific Budget & Workplan**			
1.1	FOG Signed			
2	**Milistone 2 - Strategic Planning, NTD/ FLHWs Trainings & Social Mobilisation**	Target		
2.1	Organise quarterly multi-sectoral nutrition steering committee meetings	1 meeting		
2.2	Organise quarterly work plan review meetings	1 meeting		
2.3	Carry-out quarterly supervision visits	wards		
2.4	Hold orientation sessions with CHMT/CMT members on strategies to reduce stunting	2 session		
2.5	Conduct PD/H Piloting Training	1 training		
2.6	Conduct advocacy sessions	1 session		
2.7	Conduct refresher training to district level Master Trainers	1 training		
2.8	Train district health facility workers on strategies to reduce stunting	HF workers		
2.9	Train district community health workers and CSO participants on strategies to reduce stunting	CHWs/CSOs		
2.10	Identify households of pregnant women and children-under-two and existing support groups (mapping)	1 report		
2.11	Conduct home visits and provide incentives to CHWs	3 or 4 months		
2.12	Provide incentives to CHW Supervisors	3 or 4 months		
2.13	Conduct monthly meetings with CHW Supervisors	3 or 4 months		
2.14	Prepare report	1 report		
	Regional Focal Person Name & Signature:			
	Programme Manager (print):			
	Program Manager Signature:			
	Date:			
	Grants Manager (print):			
	Grants Manager Signature:			
	Date:			

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REVIEW OF DELIVERABLES
FOGS - CHECKLIST

REGION:				
FOG #:				
No.	Description	Target	Yes/No/NA	Remark / Comment /Explanation
1	**Milestone 1 - Region Secretariat Specific Budget & Workplan**			
1.1	FOG Signed	1 Fog		
2	**Milistone 2 - Strategic Planning, Bi-annual RMNSC & Social Mobilisation**	Target		
2.1	Organise annual Planning and Budgeting Workshop	1 Workshop		
2.2	Conduct Bi-annual Regional Multisectoral Nutrition Steering Committee Meeting	1 meeting		
2.3	Carry-our quarterly joint supportive supervision to district level activities planned	1 Supervision		
	Programme Manager (print):			
	Programme Manager Signature:			
	Date:			
	Grants Manager (print):			
	Grants Manager Signature:			
	Date:			

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PERFORMANCE REPORT TEMPLATE

Project Name:	
Reporting Period:	
Milestone Number:	
Reporting Date:	
Report Prepared By:	
RNuO / DNuO Email:	

Information below should be provided in bullet format. Please include 3-5 bullets per section below.
Reports should be a maximum of 2 pages not including photos or Annexes. Annexes should include:

1. *Signed Attendance registers for any activity by responsible participants*
2. *Signed participants payment list /sheet by responsible participants*
3. *Signed meeting minutes*
4. *Signed supportive supervision report*
5. *Photographs and success stories*

I. KEY ACHIEVEMENTS AND ACTIVITY STATUS (Include here updates on activities completed during this reporting period including any key dates and important data.)

Activity	Date

II. CHALLENGES (Clarify the challenges and how they were or will be addressed.)

Activity

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III. RECOMMENDATIONS (Identification of problems requiring intervention from IMA, DFID, government institutions, relevant development partners, or beneficiary associations.)

Activity

IV. PHOTOGRAPHS AND SUCCESS STORIES (Documentation should include photos and success stories resulting from programme activities. Photos should include captions describing activities, people, location, and dates. Success stories are optional but should highlight exceptional practices captured in the field. Quotes from individuals, high quality photos and data supporting successes add interest to the stories.)

SUCCESS STORY TEMPLATE

Time to read: 5 minutes

Time to complete: ~1 hour

INTRODUCTION

Completion of the Success Story package is an integral part of the communications process. We look forward to your submissions and are grateful for your time and support!

1. WHAT CONSTITUTES A COMPLETE SUCCESS STORY PACKAGE?

As part of the Success Story package, please complete the following three (3) items.

1. Complete **one (1) interview**, which begins on Page 5. The interview should highlight one (1) beneficiary who has received services in the last year.
2. Take **three to five (3-5) photos** of the child that is interviewed.
3. Complete **one (1) media release waiver** for the beneficiary who is featured in the photos that you send to IMA. You can download a waiver on the IMA intranet or by contacting a member of the IMA External Relations Team at info@imaworldhealth.org. We have forms in various local languages, so please let us know which you require.

2. WHO IS INVOLVED IN THE SUCCESS STORY?

Please note that completion of the Success Story requires interviews with the following people:

- the beneficiary
- parent/community leader/educator
- field staff member.

3. WHY DOES IMA COLLECT SUCCESS STORIES?

- Success Stories will be considered for use in marketing, including but not limited to: blog posts, campaigns, social media, e-newsletters, etc.
- The Success Story and accompanying photos confirm to donors that services are reaching beneficiaries.
- Hearing from beneficiaries, parents/community leaders/educators, and field staff helps donors understand the impact and effect they have.

SUGGESTIONS & GUIDELINES

4. THE INTERVIEW

- Answers should be detailed and when possible, at minimum 3-4 sentences.
- Ask teachers, parents and/or community members for **recommendations on children to profile**.
- If talking to children, choose a child ages 6 to 16.
- Use a conversational tone in your answers.

5. PHOTOS

SENDING PHOTOS:

- Please send **three to five (3-5) photos** of the beneficiary that is interviewed.
- Upload the photos to a Google Drive folder and share it with the IMA External Relations Team, OR
- **Attach the photos in an email** to the IMA External Relations Team at info@imaworldhealth.org.
- Do not embed/insert the photos into this or any document.

WHAT TYPE OF PHOTOS SHOULD WE TAKE?

- File Type: .jpeg
- Resolution: 300 dpi (high resolution)
- Minimum width: 800 pixels
- Shape: Horizontal photos are preferred

IDEAL PHOTOS

- Great photos have one focus — one face or action.
- Outdoor photos with natural light are preferred.
- Photos should be taken at the child's level or below.
- Check the scenery behind the child and what is featured in the background.
- Try to capture candid and natural moments.

THINGS TO AVOID

- Do not have the person in the photo make a sad or a serious face
- Do not photograph a child that is inappropriately exposed (i.e. naked or uncovered)

6. MEDIA RELEASE WAIVER

Complete one (1) Media Release waiver for the beneficiary.

FEATURED INTERVIEW

1. BACKGROUND INFORMATION

Donor/Partner Name	
Reporting Cycle	
Date of Featured Interview	
Beneficiary's First and Last Name	
Beneficiary's Age	
Beneficiary's Gender	
Is this the first time s/he has received these services?	
If no, how many times has s/he received services?	
Beneficiary's nearest city	
Short description of the community's environment / terrain, local economy, and primary challenges	

2. BENEFICIARY'S THOUGHTS ON SERVICES RECEIVED

Please use the beneficiary's own words.

- Tell us about the service you received. Did you have access to this type of service before? If so, where was it available? How much did a cost?
- Tell me the story of the day you received these services.
- How do these services make a difference in your life?
- What is your favourite class in school (for children) or activity/hobby (for adults)?
- What do you want to be when you grow up (child)/where do you see yourself in 5 years (adult)?

3. PARENT/COMMUNITY LEADER/EDUCATOR (IF INTERVIEWING A CHILD)

- Name, position within the community (if applicable):
- What is the child's personal story and family situation?
- What makes you proud of this child, and what do you hope this child will do in their future?
- How have you seen (or how will) the services provided help children/this child in your community?
- What is your hope or dream for the younger generation?

4. DONOR/PARTNER PERSPECTIVE

- Field staff name, position:
- What are the main interventions and support your organisation provides in the child's community?
- How will the services provided enhance the programme and goals that your organisation is trying to accomplish in this community?
- How long has this community been receiving these services?
- How do the beneficiaries directly benefit from those programmes?
- Why are these services needed in this community? (Please be specific)
- What was your favourite part of providing these services?
- What inspires you to do this work?
- What do you wish people knew about your organisation and the people you serve?

5. PARENT/COMMUNITY LEADER/EDUCATOR (IF INTERVIEWING A CHILD)

- Are there any additional anecdotal stories you'd like to share with us, about this beneficiary or any others?

Before submitting: Did you remember to take **three to five (3-5) photos** of the beneficiary? Did you complete **a separate Media Release waiver for each individual that was featured prominently in the photos?**

Thank you for your time and diligence in completing this Success Story interview, taking photos, and getting the waivers signed by all those featured in the photos. Your partnership and work on the ground is of the highest value, and we appreciate all you do!

Thank you!

PERMISSION FOR PHOTOGRAPHY AND VIDEO

I grant to IMA World Health the absolute and irrevocable right and unrestricted permission concerning any photographs and/or video taken of me or in which I may be included with others, to use, reuse, publish, and republish the material in whole or in part, individually or in connection with other material, in any and all media now or hereafter known, including the internet, and for any purpose whatsoever, specifically including illustration, promotion, art, editorial, advertising, and trade, without restriction as to alteration; and to use my name in connection with any use if desired.

I release and discharge IMA World Health from any and all claims and demands that may arise out of or in connection with the use of the photographs or video, including without limitation any and all claims for libel or violation of any right of publicity or privacy.

I am a legally competent adult and have the right to contract in my own name. I have read this document and fully understand its contents. This release shall be binding upon me and my heirs, legal representatives, and assigns.

SIGNATURE

NAME

ADDRESS (Line 1)

ADDRESS (Line 2)

DATE

WITNESS

ADDRESS (Line 1)

ADDRESS (Line 2)

FIXED OBLIGATION GRANT AGREEMENT (FOG)
No. EXAMPLE-DC-FOG-3

Recipient Data	
1. Name:	
2. Address:	
3. TIN/Registration No.	
4. Status:	

Grant Agreement Data	
5. Effective Date:	
6. End date:	
7. Total Grant Amount (TSH):	
8. Programme Name:	
9. Donor Prime Contract No.:	
10. Source of funding:	

11. Recipient Technical Lead:		**12. Donor Technical Lead:**	

Recipient agrees to furnish and deliver all items and perform all services set forth or otherwise identified above and on any continuation sheets for consideration stated herein. The rights and obligations of the parties to this Grant Agreement will be subject to and governed by the provisions and specifications attached or incorporated herein.

In witness of their agreement and their acceptance of the terms and conditions of this Grant Agreement, the parties intending to be legally bound hereby have caused this Grant Agreement to be properly executed by their duly authorised representatives.

Donor Authorised Representative:		**Recipient Authorised Representative:**	
_____	_____	_____	_____
Signature:	Date:	Signature:	Date:

Table of Contents

This Grant Agreement is entered into by and between_____, a _____ and existing under the laws of _____with a principal office located at _____ represented by its Country Office in _____hereinafter referred to as _____ or "Prime Contractor" and_____. _____and _____ __are each referred to herein as a "Party" and, collectively, as "the Parties".

1. Recitals

WHEREAS, _____ has entered into a contract with _____ ("**Prime Contract**") for the implementation of a Programme entitled: _____ ("**the Programme");**

WHEREAS, _____is the lead agency on the Programme and is authorised to make Grant Agreements to nongovernmental development organisations and other qualified entities;

WHEREAS, Recipient is specifically qualified and equipped to perform the work and/or services necessary to support _____ activities under the Prime Contract;

WHEREAS, Recipient has agreed to perform the specified work and/or services set forth in the Schedule below;

NOW THEREFORE, in consideration of the mutual covenants and agreements set forth herein, the Parties, intending to be legally bound, incorporate the Recitals as listed above in the Grant Agreement, and hereby agree as follows:

2. Privity of Grant Agreement

2.1 Although this Grant Agreement is funded with funds from the _____, neither _____ nor any of its departments, agencies, or employees is or will be a party to this Agreement or any lower-tier Subagreement or subcontract. No Agreement between _____ and Recipient is established by this Agreement. All communications regarding this Agreement must be directed to _____ and not to _____.

3. Purpose of the Agreement

3.1 The purpose of this Agreement is to define the relationship between _____ and Recipient with respect to the implementation of the Programme as funded by _____.

3.2 Recipient and _____ affirm that they are both autonomous organisations, and agree to work together to implement the objectives of the Programme through the performance of each organisation's responsibilities as outlined in this Grant Agreement. The Recipient is not the agent of _____ and has no authority to represent and shall not purport to represent or enter into any commitments on behalf of _____in any respect.

3.3 All applicable statutes and regulations in **Attachment G** (_____ Terms and Conditions) and **Attachment H** (_____Standard Terms and Conditions) are incorporated as integral parts of this Grant Agreement.

4. Responsibilities of the Recipient

4.1 The Recipient shall conduct the activities and provide the deliverables/tasks as set forth in the Programme Description in **Attachment A**, which is hereby incorporated and made a part of this Grant Agreement. Recipient agrees that all funding disbursed under this Grant Agreement shall be used exclusively towards the attainment of the proposed objectives.

5. Performance Period

5.1 The period of performance (the "**Term**") for completion of work described in **Attachment A** begins from the effective date as indicated under Block 5 and continues through the end date as indicated under Block 6 on the Cover Page, unless the period of performance is extended by written modification to this Grant Agreement.

6. Amount and type of Grant Agreement

6.1 This is a Fixed Amount Award with a total agreement value (the "**Total Grant Amount**") that shall not exceed the amount stated under Block 7 on the Cover Page, in accordance with **Attachment B**, Detailed Budget. _____ will not be liable for reimbursing the Recipient for any amount in excess of the Total Grant Amount, or outside of the Term.

7. Disbursement of Funds

7.1 Payment shall be made to the Recipient upon satisfactory completion, delivery, and acceptance by the _____ Technical Lead for this Grant Agreement of each milestone specified in the milestone payment schedule as provided in **Attachment C**. The _____ Technical Lead for this Grant Agreement is specified under Block 12 on the Cover Page, who may be changed by _____ at any time upon written notice.

7.2 The Recipient shall submit an original and two copies of a properly prepared invoice as provided in **Attachment D**, a copy of the deliverable, and the completed and signed Milestone Certification for the Milestone being billed as provided in **Attachment E**. Each invoice will be identified by the Award Number, specify the Milestone that is being billed, and the fixed amount associated with that Milestone. Payment shall be made within thirty (30) days after receipt of a proper invoice.

7.3 Recipient agrees to retain all receipts in the event that the receipts need to be audited by _____, _____, and any agents of _____ or the donor.

7.4 Unless notified otherwise, Payment to the Recipient will be made to the bank account specified in **Attachment F**. It is the Recipient's responsibility to provide _____ with the correct banking information.

7.5 Recipient agrees to refund to _____ any amount paid to Recipient if later the milestone is determined to be incomplete or whose quality was compromised. Recipient must make such refund within fifteen (15) days of receipt of written notice that such amounts will not be accepted. Costs accepted are directly associated with the milestone as described in **Attachment C**.

7.6 Milestone Certifications that do not strictly comply with the terms and conditions of the Grant Agreement will be returned to Recipient for correction and resubmission. Partial payment will not be made, unless _____determines in its absolute discretion on a case-by-case basis, that:

a) it can appropriately identify a discrete portion of a noncompliant milestone for separate payment; and
b) such an accommodation will not result in undue administrative burden or significantly hinder exercise of _____ Programme or fiscal monitoring responsibilities.

7.7 Upon submission of the claim for payment for the final milestone, the Recipient must certify in writing to the _____ Technical Lead that the Grant Agreement is completed and the Recipient will make no further claim against _____after final payment. If the Recipient cannot certify to the completion of milestones, it shall be expected to make appropriate reimbursements to _____.

8. Monitoring and Evaluation

8.1 Recipient is responsible for managing and monitoring those activities for which it has responsibility under **Attachment A**, Programme Description. Recipient shall immediately notify _____ of any misuse, loss, or theft of funds or property funded under this Grant Agreement. In addition, _____ shall be promptly informed of problems, delays, or adverse conditions that may materially impair the ability of Recipient to satisfactorily achieve the deliverables of this Grant Agreement. This notification shall include a statement of the action taken or contemplated, and any assistance needed to resolve the situation.

8.2 _____ shall have the right to monitor and evaluate Recipient activity under this Grant Agreement, including site visits as appropriate, and have reasonable access to records or other information in order to assess such performance and compliance with this Grant Agreement.

9. Taxes and Duties

9.1 Recipient is responsible for all taxes, duties, license fees, payroll withholding and remittance, and other financial obligations of whatever nature, as may be levied under the Applicable Law, arising out of or relating to Recipient, Recipient's representatives, the activities, or any payments or other benefits made to or received by Recipient pursuant to, or otherwise in connection with, the making or performance of the Grant Agreement. The amount of all such taxes is deemed to have been included in the Subgrant amount.

10. Notices

10.1 Except as otherwise specifically provided under this Grant Agreement, all notices and other communications required or permitted hereunder to be given in writing shall be addressed as and directed to the person provided in Section 9.2 and Section 9.3. All notices shall be effective upon receipt. Either party shall have the right to change its contact person or address for notice hereunder by giving not less than thirty (30) days of notice to the other party.

10.2 - Recipient:

Name:
Title:
Address:
Tel:
Email:

10.3 - _____ (Prime Contractor)

Programmematic/Finance Matters:

Agreement Administration Matters:

11. _____ Terms and Conditions

11.1 The General Terms and Conditions governing this Grant Agreement are set forth in **Attachment G** and are hereby incorporated into this Grant Agreement.

12. Funder Terms and Conditions

12.1 This Grant Agreement is subject to the Funder Terms and Conditions applicable to _____ Prime Contract. Those provisions are set forth in **Attachment H** and are hereby incorporated into this Grant Agreement.

13. Special Conditions

13.1 _____ Statement of Priorities and Expectations: In line with Statement of Priorities and Expectations (Attachment J), throughout the life of this Agreement the Recipient must be able to demonstrate how they are meeting these expectations.

13.2 Intellectual Property Rights: Clause 21 of DFD terms and conditions (as per Attachment H) shall be deleted and replaced by the following provisions:

13.2.1 Any Reports or documents prepared or information or inventions produced by or on behalf of the Recipient relating to this agreement and all intellectual property rights therein shall be the property of the _____. The Recipient hereby assigns to the _____ all intellectual property rights in the above mentioned material generated by the Recipient in the performance of this Agreement and waives all moral rights relating to such materials.

14. Order of Precedence

14.1 Conflict between any of the clauses and attachments of this agreement shall be resolved by applying the following descending order of precedence:

i. Terms of Agreement (including special conditions)
ii. Attachment H - _____ Terms and Conditions
iii. Attachment G - _____Terms and Conditions
iv. Attachment A - Programme Description
v. Attachment B/C - Detailed Budget & Milestone Payment Schedule.

15. Closeout

15.1 The parties release each other from any claims and liability, upon completion of the Agreement which entails a) submission and acceptance of Programme deliverable by _____, b) Disposition of Inventory/Equipment (if any), and c) by signing and accepting a closeout checklist as per Attachment I. Recipient agrees to complete Attachment I upon closeout or termination of this Agreement and submit it to _____Grants Manager, listed in the notice section of this Agreement. _____Grants Manager will then issue a final modification, closing this Agreement.

16. Signatures

16.1 This Agreement may be executed in counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument. The parties are entitled to rely on a counterpart executed and delivered by facsimile to the same extent as a counterpart with an original signature.

ATTACHMENT A – PROGRAMME DESCRIPTION

More than 250 million children under age 5 in lower- and middle-income countries are at risk for not attaining their maximum developmental potential because they are stunted. Long-term consequences of poor early child development, inadequate maternal infant and young child feeding and poor water sanitation and hygiene practices include reduced cognitive performance, educational attainment, adult productivity and inter-generational poverty. _____reduces chronic undernutrition (stunting) amongst children under age 5, and makes them smarter.

Funded by the _____, activities are being implemented in _____. _____people live in these regions - including _____stunted children.

_____ supports the Government of _____ and its National Multi-sectoral Nutrition Action Plan. We 1) strengthen multi-sectoral response to nutrition, 2) enhance optimal care practices for maternal, infant and young child nutrition; water, sanitation and hygiene; and early childhood development, and 3) increase the knowledge of pregnant women, caregivers, households, and community decision makers. _____ coordinates and strengthens multi-sectoral teams through technical working groups for nutrition, annual planning, quarterly support visits, training, and grants for multi-sectoral nutrition response. _____ also informs policy through lessons learned and operations research.

By _____, _____ will train 3,600 people including district nutritionists, community health workers, agricultural extension agents, community development officers and health facility workers. It will strengthen 50 civil society organisations in their ability to deliver integrated interventions that make a difference in the lives of women and children. Training will increase understanding of adolescent, maternal, and infant and young child nutrition; early childhood development; and WASH. Just as importantly, training will equip community health workers and other extension agents with the tools they need to change behaviors.

_____ project is implemented in _____ councils. However, phase one of project implementation took place in _____ councils. Phase 2 of project implementation is involving the remaining _____ councils and so far the project has supported all the _____ councils in planning and budgeting for nutrition for FY _____.

The responsibility of the sub-recipient during the period of this agreement shall be to:

1. To conduct quarterly District multi-sectoral Nutrition Steering Committee meetings by _____.
2. To conduct home visits and provide incentives to CHWs & CHW Supervisors.
3. To organise quarterly work plan review meetings by _____.
4. To conduct quarterly supportive supervision of community level activities planned to address reduction of stunting by _____.
5. To conduct quarterly supportive supervision to RCH health facilities by _____.
6. DNuO to conduct monthly meetings with CHW Supervisors by _____.
7. To conduct advocacy on appropriate child feeding practices through commemoration of the World Breastfeeding Week by _____.
8. To conduct community mobilisation to sensitise community in _____ wards on actions to reduce stunting and how to access support by _____.
9. Prepare quarterly and annual reports and invoices and submit to _____ and _____ by _____.
10. To conduct Positive Deviance/Hearth training

ATTACHMENT B – DETAILED BUDGET

_____-SUPPORTED NUTRITION ACTIVITIES FOR _____FOR FINANCIAL YEAR 2018/2019

ACTIVITY	*DESCRIPTION*	*ITEM*	*UNIT*	*QUANTITY*	*DAYS/TRIP*	*COST(Tshs)*	*TOTAL*
1	To conduct quarterly District multi-sectoral Nutrition Steering Committee meetings by _____.	Refreshments	person		4	10,000	1,000,000
		Office consumables (pens, notebooks, markers, flip chart, solatape)	set		4	100,000	400,000
		Extra duty allowance to participants	person		4	30,000	3,000,000
		Refreshments	person		4	10,000	1,000,000
		Venue	room		4	100,000	400,000
		Extra duty allowances for cashier	person		4	30,000	120,000
		Police escort	person		4	20,000	80,000
		Communication allowance for DNuO	package		4	10,000	40,000

		Sub-Total Activity 1					**6,040,000**
2	To conduct home visits in order to influence behaviour change in MIYCAN, WASH, ECD by _____.	Monthly allowance to CHWs	person		12	15,000	33,840,000
		Supervisors Monthly Allowance	person		12	100,000	10,800,000
		Supervisors transport allowance per month	person		12	80,000	8,640,000
		Extra duty allowances for cashier	person		4	30,000	120,000
		Police escort	person		4	20,000	160,000
		Sub-Total Activity 2					**53,560,000**
3	To organise Biannual work plan review meetings by _____	Refreshments	person		2	10,000	500,000
		Stationery	set		2	2,000	100,000
		Conference facilities	package		2	4,000	200,000
		Extra duty allowance	person		2	30,000	1,500,000
		Extra duty allowances for cashier	person		2	30,000	60,000
		Police escort	person		2	20,000	80,000

		Communication allowance for DNuO	package		2	10,000	20,000
		Sub-Total Activity 3					**2,460,000**
4	Conduct quarterly Multisectoral supportive supervision of community level activities planned to address reduction of stunting by _____	Extra duty to Multisectoral Team	person		32	30,000	5,760,000
		Extra duty to driver	person		32	20,000	640,000
		Diesel	liter		4	2,300	920,000
		Extra duty allowances for cashier	person		4	30,000	120,000
		Police escort	person		4	20,000	160,000
		Communication allowance for DNuO	package		4	10,000	40,000
		Sub-Total Activity 4					**7,640,000**
5	To conduct quarterly Multisectoral supportive supervision to RCH health facilities by _____	Extra duty —average of one person per health facility per quarter	person		41	30,000	4,920,000
		Diesel	litre		4	2,500	1,000,000
		Driver	person		22	20,000	1,760,000
		Extra duty allowances for cashier	person		4	30,000	120,000

		Police escort	person		4	20,000	160,000
		Communication allowance for DNuO	package		4	10,000	40,000
		Sub-Total Activity 5					**8,000,000**
6	DNuO to conduct monthly meetings with CHWs Supervisors by _____	Extra duty for CHW supervisors	person		12	30,000	3,240,000
		Refreshments	person		12	10,000	1,320,000
		Fare	person		12	10,000	1,080,000
		Extra duty CHW Coordinator & DNuO	person		12	30,000	720,000
		Extra duty allowances for cashier	person		4	30,000	120,000
		Police escort	person		4	20,000	160,000
		Communication allowance for DNuO	package		4	10,000	40,000
		Sub-Total Activity 6					**6,680,000**
7	To conduct advocacy on appropriate child feeding practices through commemoration of the World Breastfeeding Week by _____	Extra duty (DNuO and DRCHCo) & a member from DCDO's office	Person		10	30,000	900,000
		Extra duty driver	Person		10	20,000	200,000
		Diesel	litres		10		500,000

						2,500	
		Extra duty to cashier	person		1	30,000	30,000
		Police escort	person		1	20,000	40,000
		Sub-Total Activity 7					**1,670,000**
	BUDGET FOR PDH - _____	**SUB ACTIVITY 10**					
8	To conduct situation analysis and positive deviance inquiry	Extra duty to 1 WEO, 3 VEOs, and 6 hamlet leaders per village and 2 CHWs x 3 villages per Ward	person		1	20,000	560,000
		Per diem to Regional facilitator to closely supervise the situation Analysis and PDI	person		3	100,000	600,000
		Per diem to district level facilitator to closely supervise the situation Analysis and PDI	person		4	40,000	320,000
		Extra duty to 1 HFWs per village for supporting nutrition assessment	person		1	20,000	60,000
		Refreshments like big bottle of water & light snack	person		2	1,500	120,000

	Stationery including purchasing alkaline batteries for weighing scales	Lumpsum		1	300,000	300,000
	Per diem to driver	person		4	30,000	120,000
	Fuel for 1 government vehicle x 1 two-way trip per village	liter		3	2,500	375,000
	PDH Sub-Total Activity					**2,455,000**
To conduct PD/Hearth sessions to 2 villages by _____	Allowance to 6 CHWs, 2 CHW supervisors, 3 VEOs and 6 hamlet leaders per village to support Hearth sessions and home visits	person		4	20,000	2,320,000
	Per diem to 2 district facilitators to supervise the 12-day Hearth sessions x 4 sessions	person		3	40,000	5,760,000
	Extra duty to HFW to support weighing children during the 1st day, 12th day, 30th day and 90th day	person		3	20,000	240,000

	Stationery including purchasing alkaline batteries for weighing scales (TSH 50,000 per village per quarter)	Set		4	50,000	600,000
	Per diem to Regional Facilitator to closely supervise the re-weighing of children during 1st day, 12th day, 30th day and 90th day of the Hearth sessions	person		8	100,000	1,600,000
	Per diem to 2 district level facilitators to closely supervise the re-weighing of children during 1st day, 12th day, 30th day and 90th day of the hearth sessions	person		2	40,000	160,000
	Per diem to driver from district level	person		5	30,000	600,000
	Fuel (one two-way trip per quarter per village destination x 3 villages)	liter		12	2,500	1,500,000
	Police escort, one per quarter	person		4	20,000	160,000

		Cashier, one per quarter	person		4	30,000	120,000
		Sub-Total Activity 8					**13,060,000**
		PDH Training Total Budget					**15,515,000**
9	To conduct community mobilisation to sensitise community in 5 wards on actions to reduce stunting and how to access support (including support groups, health facilities, home visits, PDH, etc.) by _____	Extra duty (DNuO and a member from DCDO's office)	Person		2	30,000	120,000
		Extra duty (Community leaders-WEOs,VEOs)	Person		2	15,000	150,000
		Councilor	Person		2	30,000	60,000
		1 CHW supervisor + 16 CHWs + 2 CSO volunteers (maximum of 8 villages per ward	Person		2	10,000	380,000
		Hiring sound system for conducting public announcement to pull crowd to the event and performing in an open space	Person		2	150,000	300,000
		Hiring cultural group to perform at an open space	Person		2	100,000	200,000
		Driver extra duty	person		2	20,000	40,000
		Diesel	litres		2		150,000

						2,500	
		Sub-Total Activity 9					**1,400,000**
10	Prepare Quarterly and Annual Report and submit to _____& _____ by _____	Stationery	set		4	200,000	800,000
		Sub-Total Activity 10					**800,000**
	SUB GRAND TOTAL						
	GRAND TOTAL						**103,765,000**

ATTACHMENT C – MILESTONE PAYMENT SCHEDULE

MILESTONE PAYMENT SCHEDULE- _____					
Milestone 1	**Milestone 1 Activities**	**Budget Required**	**Target**	**Deadline**	**Payment for Success**
	FOG SIGNED	-	1 FOG		**,000**
	Milestone 1 Total	-			
Milestone 2	**Milestone 2 Activities**	**Budget Required**	**Target**	**Deadline**	**Payment for Success**
	To conduct quarterly district multisectoral nutritional steering committee meetings by _____				**43,590,000**
	To conduct home visits and provide incentives to CHWs & CHW Supervisors				
	To organise Biannual work plan review meetings by _____				
	To conduct quarterly multisectoral supportive supervision of community level activities planned to address reduction of stunting by _____				
	To conduct quarterly supportive multisectoral supervision to RCH health facilities by _____				
	DNuO to conduct monthly meetings with CHW Supervisors by _____				
	To conduct advocacy on appropriate child feeding practices through commemoration of the World Breastfeeding Week by _____				
	Pd healthy Training				
	Prepare quarterly and annual reports and invoices and submit to _____ and _____ by _____				
	Milestone 2 Total				
Milestone 3	**Milestone 3 Activities**	**Budget Required**	**Target**	**Deadline**	**Payment for Success**

	To conduct quarterly district multisectoral nutritional steering committee meetings by _____				
	To conduct home visits and provide incentives to CHWs & CHW Supervisors				
	To organise Biannual work plan review meetings by _____				
	To conduct quarterly supportive supervision of community level activities planned to address reduction of stunting by _____				
	To conduct quarterly supportive multisectoral supervision to RCH health facilities by _____				**400,000**
	DNuO to conduct monthly meetings with CHW Supervisors by _____				
	To conduct community mobilisation to sensitise community in 5 wards on actions to reduce stunting and how to access support by _____				
	Prepare quarterly and annual reports and invoices and submit to _____and _____ by _____				
	Milestone 3 Total				

ATTACHMENT D – INVOICE TEMPLATE

MILESTONE 1 INVOICE					
Name of LGA or RS:				Invoice #:	
Project Name:				Date:	
To:					

Milestone #	**Description of Milestone**	**Amount (TSH)**
1	FOG Signed	
TOTAL AMOUNT DUE FOR MILESTONE 1:		

The Certificate of Completion of Milestone must be included with this invoice.

The undersigned hereby certifies:
1) that the Programme funds have been used solely for the purposes of the Agreement in accordance with its terms and conditions
2) that all requirements called for in this Agreement as of the date of this invoice have been met
3) if this invoice is for the final milestone, the recipient certifies that the Agreement is completed and the recipient will make no further claim against _____ after final payment
4) amounts included in each invoice must represent the total cost of the milestone that has been achieved. No partial payments will be made for partially delivered milestones.

Signed: _____

Typed Name: _____

Title: _____

Date: _____

ATTACHMENT D – INVOICE TEMPLATE

MILESTONE 2 INVOICE					
Name of LGA or RS:				Invoice #:	
Project Name:				Date:	
To:					

Milestone #	Description of Milestone	Amount (TSH)
1	To conduct quarterly district multisectoral nutritional steering committee meetings by _____	
2	To conduct home visits and provide incentives to CHWs & CHW Supervisors	
3	To organise Biannual work plan review meetings by _____	
4	To conduct quarterly multisectoral supportive supervision of community level activities planned to address reduction of stunting by _____	
5	To conduct quarterly multisectoral supportive supervision to RCH health facilities by _____	
6	DNuO to conduct monthly meetings with CHW Supervisors by _____	
7	To conduct advocacy on appropriate child feeding practices through commemoration of the World Breastfeeding Week by _____	
8	Positive Deviance/Hearth Training	
9	Prepare quarterly and annual reports and invoices and submit to _____ and _____ by _____	
TOTAL AMOUNT DUE FOR MILESTONE 2:		

The Certificate of Completion of Milestone must be included with this invoice.
The undersigned hereby certifies:
1) that the Programme funds have been used solely for the purposes of the Agreement in accordance with its terms and conditions
2) that all requirements called for in this Agreement as of the date of this invoice have been met
3) if this invoice is for the final milestone, the recipient certifies that the Agreement is completed and the recipient will make no further claim against _____ after final payment
4) amounts included in each invoice must represent the total cost of the milestone that has been achieved. No partial payments will be made for partially delivered milestones.

Signed: _____

Typed Name: _____

Title: _____

Date: _____

ATTACHMENT D – INVOICE TEMPLATE

MILESTONE 3 INVOICE					
Name of LGA or RS:				Invoice #:	
Project Name:				Date:	
To:					

Milestone #	Description of Milestone	Amount (TSH)
1	To conduct quarterly district multisectoral nutritional steering committee meetings by _____	
2	To conduct home visits and provide incentives to CHWs & CHW Supervisors	
3	To organise Biannual work plan review meetings by _____	
4	To conduct quarterly supportive supervision of community level activities planned to address reduction of stunting by _____	
5	To conduct quarterly supportive multisectoral supervision to RCH health facilities by _____	
6	DNuO to conduct monthly meetings with CHW Supervisors by _____	
7	To conduct community mobilisation to sensitise community in _____ wards on actions to reduce stunting and how to access support by _____	
8	Prepare quarterly and annual reports and invoices and submit to _____ and _____ by _____	
TOTAL AMOUNT DUE FOR MILESTONE 3:		

The Certificate of Completion of Milestone must be included with this invoice.

The undersigned hereby certifies:
1) that the Programme funds have been used solely for the purposes of the Agreement in accordance with its terms and conditions
2) that all requirements called for in this Agreement as of the date of this invoice have been met
3) if this invoice is for the final milestone, the recipient certifies that the Agreement is completed and the recipient will make no further claim against _____ after final payment
4) amounts included in each invoice must represent the total cost of the milestone that has been achieved. No partial payments will be made for partially delivered milestones.

Signed: _____

Typed Name: _____

Title: _____

Date: _____

ATTACHMENT E – MILESTONE CERTIFICATION TEMPLATE

CERTIFICATE OF COMPLETION OF MILESTONE 1

Project Name:
Prime Contract No:
Funder:
Recipient:
Grant Agreement No.:

Deliverable #	Description of Deliverable(s)
1	FOG Signed

This document is to certify that the above described deliverable(s) under the _____ Project in _____ has/have been completed and delivered in accordance with Grant Agreement # _____and we seek your concurrence. If there are any outstanding issues or concerns that have not been addressed, please alert the Recipient Technical Lead of our organisation for this project as soon as possible.

Signed: _____

Typed Name: _____

Title: _____

Date: _____

**********Below this line for _____ use only**********

Date Received by _____:	
_____Acceptance of Certificate:	Yes / No. If "No", provide written explanation here and issue feedback to partner.
_____Authorised Signature:	
Name:	
Date of Signature	

ATTACHMENT E – MILESTONE CERTIFICATION TEMPLATE

CERTIFICATE OF COMPLETION OF MILESTONE 2

Project Name:
Prime Contract No:
Funder:
Recipient:
Grant Agreement No.:

Deliverable #	Description of Deliverable(s)
1	To conduct quarterly district multisectoral nutritional steering committee meetings by _____
2	To conduct home visits and provide incentives to CHWs & CHW Supervisors
3	To organise Biannual work plan review meetings by _____
4	To conduct quarterly multisectoral supportive supervision of community level activities planned to address reduction of stunting by _____
5	To conduct quarterly multisectoral supportive supervision to RCH health facilities by _____
6	DNuO to conduct monthly meetings with CHW Supervisors by _____
7	To conduct advocacy on appropriate child feeding practices through commemoration of the World Breastfeeding Week by _____
8	Positive Deviance/Hearth Training
9	Prepare quarterly and annual reports and invoices and submit to _____ and _____ by _____

This document is to certify that the above described deliverable(s) under the _____ in _____ has/have been completed and delivered in accordance with Grant Agreement # _____and we seek your concurrence. If there are any outstanding issues or concerns that have not been addressed, please alert the Recipient Technical Lead of our organisation for this project as soon as possible.

Signed: _____

Typed Name: _____

Title: _____

Date: _____

**********Below this line for _____use only**********

Date Received by_____:	
_____Acceptance of Certificate:	Yes / No. If "No", provide written explanation here and issue feedback to partner.
_____Authorised Signature:	
Name:	
Date of Signature	

ATTACHMENT E – MILESTONE CERTIFICATION TEMPLATE

CERTIFICATE OF COMPLETION OF MILESTONE 3

Project Name:
Prime Contract No:
Funder:
Recipient:
Grant Agreement No.:

Deliverable #	Description of Deliverable(s)
1	To conduct quarterly district multisectoral nutritional steering committee meetings by _____
2	To conduct home visits and provide incentives to CHWs & CHW Supervisors
3	To organise Biannual work plan review meetings by _____
4	To conduct quarterly supportive supervision of community level activities planned to address reduction of stunting by _____
5	To conduct quarterly supportive multisectoral supervision to RCH health facilities by _____
6	DNuO to conduct monthly meetings with CHW Supervisors by _____
7	To conduct community mobilisation to sensitise community in 5 wards on actions to reduce stunting and how to access support by _____
8	Prepare quarterly and annual reports and invoices and submit to _____and _____ by _____

This document is to certify that the above described deliverable(s) under the _____in _____ has/have been completed and delivered in accordance with Grant Agreement #_____and we seek your concurrence. If there are any outstanding issues or concerns that have not been addressed, please alert the Recipient Technical Lead of our organisation for this project as soon as possible.

Signed: _____

Typed Name: _____

Title: _____

Date: _____

**********Below this line for _____ use only**********

Date Received by _____:	
_____Acceptance of Certificate:	Yes / No. If "No", provide written explanation here and issue feedback to partner.
_____Authorised Signature:	
Name:	
Date of Signature	

ATTACHMENT F – RECIPIENT BANKING INFORMATION

Payments to the Recipient under this Grant Agreement will be made to the following bank account:

Bank Name:	
Branch Name:	
Branch Address:	
Account Name:	
Account Number:	
Swift Code:	

A. INDEPENDENT ENTITIES

The Parties recognise that this Grant Agreement does not create any actual or apparent agency, partnership, joint venture, franchise or relationship of employer and employee between the Parties. The Parties expressly disclaim any agency, partnership, joint venture, franchise or relationship of employer and employee between them, agree that they are acting solely as autonomous entities hereunder and agree that the Parties have no fiduciary duty to one another or any other special or implied duties that are not expressly stated herein. The Recipient is not authorised to enter into or commit _____ to any agreements of any kind, and the Recipient shall not represent itself as the agent or legal representative of _____.

B. PROHIBITION AGAINST CORRUPTION

The Recipient and its representatives shall not commit or appear to commit any corrupt (including offering, giving, receiving or soliciting anything of value to influence the actions of any public official) or fraudulent (including misrepresentation of facts to influence a procurement practice) action or practice.

C. GRATUITIES/KICKBACKS

No gratuities (in the form of entertainment, gifts, travel, or anything of value) or kickbacks shall be offered or given by Recipient or by any agent, representative, affiliate or Recipient of Recipient to any officer or employee of _____ customer or _____. This restriction specifically prohibits the direct or indirect inclusion of any kickback amounts in any invoices or billings submitted under this Agreement or any other agreement with _____. _____ may, by written notice to Recipient, immediately terminate the right of Recipient to proceed under this Agreement if it is found that gratuities (in the form of entertainment, gifts, travel or anything of value) or kickbacks were offered or given by Recipient, or by any agent or representative of Recipient, to any officer or employee of _____ customer or _____.

D. PROHIBITION AGAINST TERRORIST FINANCING

The Recipient must not engage in transactions with, or provide resources or support to, individuals and organisations associated with terrorism. In addition, the Recipient must verify that no support or resources are provided to individuals or entities identified in lists promulgated by the _____, the _____, and the _____. This provision must be included in all lower tier agreements issued under this Grant Agreement.

E. CODE OF CONDUCT FOR THE PROTECTION OF BENEFICIARIES OF ASSISTANCE FROM SEXUAL EXPLOITATION AND ABUSE

As a condition of this Grant Agreement, the Recipient agrees to adhere to a code of conduct for the protection of beneficiaries of assistance from sexual exploitation and abuse in humanitarian relief operations conducted hereunder consistent with the six core principles listed below set forth by the UN Interagency Standing Committee on Protection from Sexual Exploitation and Abuse in Humanitarian Crises:

a) Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
b) Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.
c) Exchange of money, employment, goods or services for sex, including sexual favors or other forms of humiliating, degrading or exploitative behavior is prohibited. This includes exchange of assistance that is due to beneficiaries.
d) Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
e) Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same humanitarian aid agency or not, he or she must report such concerns via established agency reporting mechanisms.
f) Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

F. PROHIBITION AGAINST TRAFFICKING IN PERSONS

_____ is authorised to terminate this Grant Agreement if the Recipient or its employees, or any of its respective lower tier grantees or their employees, engage in any of the following conduct:

1) Trafficking in persons (as defined in the Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children, supplementing the UN Convention against Transnational Organised Crime) during the period of the Award;
2) Procurement of a commercial sex act during the period of the Award; or
3) Use of forced labor in the performance of this Sub-Contract Agreement.

For purposes of this Clause, "***employee***" means an individual who is engaged in the performance of this Grant Agreement as a direct employee, consultant or volunteer of the Recipient or any of its respective Recipient s.

The Recipient must include in all agreements, including subawards and contracts, a provision prohibiting the conduct described in this Clause.

G. PROHIBITION ON ASSISTANCE TO DRUG TRAFFICKERS

_____ reserves the right to terminate this Grant Agreement, to request a refund or take measures if Recipient is found to have been convicted of a narcotic offence or engaged in drug trafficking activities.

H. CORRUPTION, COMMISSION, DISCOUNTS, AND FRAUD

The Recipient warrants and represents to _____ that neither the Recipient nor any of the Recipient's personnel:

- has given, offered or agreed to give or accepted, any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any act in relation to the obtaining or execution of any agreement or for showing or forbearing to show favor or disfavor to any person or entity in relation to any agreement; or
- has entered into any agreement in connection with which commission has been paid or agreed to be paid by or to the Recipient or Recipient's Personnel or on their behalf or to their knowledge unless, before such contract was made, particulars of any such commission and of the terms of any agreement for the payment of such commission were disclosed in writing to _____, whose written consent was subsequently given to such payment.

Neither the Recipient nor any of the Recipient's Personnel shall accept for or on their own benefit any trade commission, discount or similar payment or benefit in connection with this Grant Agreement.

The Recipient undertakes that neither the Recipient nor the Recipient's Personnel shall attempt or commit any fraud, deception, financial or procedural wrongdoing in relation to the performance by the Recipient of its obligations under the Grant Agreement and shall immediately notify _____ of any circumstances giving rise to a suspicion that such wrongful activity may occur or has occurred.

I. ORGANISATIONAL CONFLICT OF INTEREST

Neither the Recipient nor any of the Recipient's Personnel shall engage in any personal, business or professional activity which conflicts or could conflict with any of their obligations in relation to this Grant Agreement.

The Recipient and the Recipient's Personnel shall notify _____immediately of any actual or potential conflict together with recommendations as to how the conflict can be avoided.

The Recipient further agrees to insert provisions which will conform substantially to the language of this clause in any lower-tier grant or subgrant arising out of this Grant Agreement.

J. PUBLICITY AND MEDIA COMMUNICATION

All inquiries from media representatives to the Recipient or its personnel providing support under a _____ activity must be facilitated by _____. Recipient or its personnel may not refer to _____ or its funders or projects in any way without written authorisation. No one, other than the individuals designated in advance by _____, is authorised to represent _____ to the media.

K. CONFIDENTIAL INFORMATION

During the term of the Grant Agreement, the Recipient and its employees may receive or have access to information that is confidential and proprietary to _____. Confidential information may be used by Recipient or its employees to perform its obligations under the Grant Agreement. Recipient will take reasonable care to protect the confidential information and will notify _____ if its confidential information has been disclosed. This provision will survive termination of this Grant Agreement for a period of three (3) years at which time Recipient either will

return or destroy any copies of confidential information.

All work under this Grant Agreement shall be performed by Recipient employees, and none of the work shall be subcontracted.

L. CONFIDENTIALITY AND OWNERSHIP OF INTELLECTUAL PROPERTY.

Recipient is free to copyright any books, publications, or other materials developed in the course of or under this project. However, _____ shall have the exclusive and irrevocable right to reproduce, publish, or otherwise use the results of Recipient's intellectual activity free-of-charge and also allow third parties to use the results of Recipient's activity. Recipient shall provide _____ and _____ with copies of all published works and audio and video materials developed under the project.

M. LIABILITY AND INDEMNIFICATION

Recipient assumes liability for all loss, damage, cost and expense arising out of or in any way connected with Recipient 's breach of warranty or representation or actions in connection with the operation or performance of, or the failure to perform, any duty, obligation, or activity on the part of Recipient , its directors, contractor(s), Recipient (s), agent(s), or employee(s) in connection with its responsibilities as specified in this Agreement, the Attachments, and any amendments thereto.

Recipient further agrees to defend, indemnify and hold _____, and all of the directors, officers, agents and employees of _____ harmless from all loss, damage, cost and expense, including all reasonable attorneys' fees, incurred by _____ or arising from or in any way connected with Recipient 's breach of warranty or representation or actions in connection with the operation or performance of, or failure to perform, any duty, obligation, or activity on the part of Recipient , its Recipient (s), agent(s), or employee(s) in connection with this Grant Agreement.

Recipient shall comply with all applicable national, local, and international laws, including those of the U.S., and any country, state or locality where the activities under the Grant Agreement will be performed. Such laws include all statutes, decrees, ordinances, administrative orders, rules, regulations, and other directives, policies and instructions with binding legal effect that relate to or affect the Grant Agreement and/or the activities to be performed under this Grant Agreement. Recipient shall be solely responsible for payment of all costs of such compliance. In addition, Recipient shall obtain and maintain in a timely and effective manner all licenses, permits, registrations and/or governmental (whether national, local, U.S. or international) approvals necessary to successfully implement the activities.

N. FORCE MAJEURE

Where the performance by the Recipient of their obligations under this Grant Agreement is delayed, hindered or prevented by an event or events beyond the reasonable control of the Recipient and against which an experienced Recipient could not reasonably have been expected to take precautions, the Recipient shall promptly notify _____ in writing, specifying the nature of the force majeure event and stating the anticipated delay in the performance of this Grant Agreement.

Force majeure that could prevent Recipient from performing any its obligations hereunder could include, without limitation, strikes, lockouts, unavailability, shortages or delays in delivery of material or equipment, acts of God, or any statute, regulation or rule of the Federal, any state or local government, or any agency thereof, now or hereafter in force.

From the date of receipt of notice, _____ may, at its sole discretion, either suspend this Grant Agreement for up to a period of thirty (30) days ("the Suspension Period") or terminate this Grant Agreement forthwith. If by the end of the Suspension Period the parties have not agreed to a further period of suspension or reinstatement of the Grant Agreement, this Agreement shall terminate automatically.

O. DISPUTE RESOLUTION

The Parties shall attempt to resolve all claims, disputes and other matters in question between _____and Recipient arising out of or relating to this Grant Agreement or the breach, suspension, or termination thereof by good faith negotiations. Those that are not resolved through negotiations shall proceed to arbitration. Jurisdiction and venue for all disputes arising under or relating in any way to this Recipient shall lie in the State and Federal courts located in Washington, D.C. and any arbitration shall be conducted in the English language. Recipient expressly agrees to waive objection to jurisdiction in Washington, D.C. The arbitrator(s) shall have the discretion to hear and determine at any stage of the arbitration any issue asserted by any Party to be dispositive of any claim or counterclaim, in whole or part, in accordance with such procedure as the arbitrator(s) may deem

appropriate, and the arbitrator(s) may render an award on such issue. Judgment upon any award(s) rendered by the arbitrator may be entered in any court having jurisdiction thereof.

P. MODIFICATION

This Grant Agreement may only be modified by issuance of a formal written Agreement Modification Notice signed jointly by authorised agents representing _____ and the Recipient.

Q. TERMINATION AND SUSPENSION

a. Termination

_____ may terminate this Grant Agreement in whole or in part, at any time, and for any reason, by providing thirty (30) calendar days written notice of the effective date of the suspension or termination to the grantee. _____ shall reimburse Recipient for allowable costs incurred up to and including the effective date of termination. Except as otherwise provided in this paragraph, in the event of the termination of this Grant Agreement, _____ shall have no further liability of any kind to Recipient.

b. Allowability of Costs at Termination

Costs to Recipient resulting from obligations incurred by Recipient after notice of termination are not allowable unless _____ expressly authorises them. Costs to Recipient resulting from obligations incurred by Recipient after notice of termination which are necessary and not reasonably avoidable are allowable if (1) the costs result from obligations which were properly incurred by Recipient before the notice of termination, are not in anticipation of it, and in the case of a termination, are no cancellable; and (2) the costs would be allowable if the Grant Agreement were not terminated or if the Grant Agreement expired normally at the end of the Term.

c. Settlement of Funds

Upon termination of this Grant Agreement according to any paragraph in the Termination clause, within thirty (15) days after termination, Recipient shall return to _____any funds that have not been expensed or that are not otherwise obligated under a legally binding agreement.

d. Suspension

_____may suspend this Grant Agreement for any one of the following reasons:

- Suspected loss, damage and/or misuse of resources by Recipient or its agents;
- Conditions exist that cause unjustifiable risk(s) to persons, property or resources;
- Recipient 's failure to meet reporting requirements under this Grant Agreement;
- Breach by Recipient of any provision of this Grant Agreement;
- Recipient becomes insolvent or bankrupt; or
- Force Majeure

If _____ determines that suspension is necessary for any of the above reasons, it shall provide to Recipient written notice stating the effective date of the suspension with an explanation of the grounds for suspension. Upon receipt of such notice, Recipient shall immediately cease expending any funds under this Grant Agreement, and it shall safeguard and/or return Programme assets and funds in its possession during the period of suspension, in accordance with _____'s instructions. The Parties agree to meet as soon as possible to try to resolve the issue causing such suspension.

R. GOVERNING LAW

This Grant Agreement shall be governed by, and construed under, the laws of Washington DC, USA (without reference to the conflicts of laws rules thereof).

S. ASSIGNMENT AND LOWER TIER SUBGRANT

The Recipient shall not transfer, assign, subcontract or sub-award any or all of its interest in this Grant Agreement without the prior written consent of _____. Any transfer, assignment, sub-contracting or sub-agreement made by the Recipient in violation of this Grant Agreement shall be null and void.

All terms and conditions of this Grant Agreement shall be binding upon the Parties hereto, their personal representatives, and successors and approved assigns.

T. ENTIRETY OF AGREEMENT

This Sub-Contract Agreement contains the entire agreement of the Parties related to the subject matter hereof and no representations, inducements, promises or agreements, oral or otherwise, between the Parties not included herein shall be of any force or effect.

U. SEVERABILITY

If any one or more provisions of this Grant Agreement shall be invalid, illegal or unenforceable in any respect, the validity, legality, and enforceability of the remaining provisions contained herein shall not be in any way affected or impaired thereby.

V. HEADINGS

Any headings in this Sub-Contract Agreement are for convenience of reference only and are not to be taken into consideration in the interpretation hereof.

W. WAIVER

The failure by _____to invoke or enforce any provision of the Grant Agreement shall in no way be considered a waiver of such provisions or in any way affect the validity of the Grant Agreement.

X. RECORD RETENTION AND ACCESS

The grantee will maintain books, records, documents, Programme and individual service records and other evidence of its accounting and billing procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of this Grant Agreement. These records will be subject at all reasonable times to monitoring, inspection, review or audit by authorised employees or agents of _____ or its funding sponsor. The Recipient will retain all such records concerning this grant for a period of three (3) years after the submission of the final financial report, unless a longer period is specified in the specific terms and conditions of the Grant Agreement. If any litigation, claim or audit is started before the expiration date of this three-year period, the records will be retained until all litigation, claims or audit findings involving the records have been resolved.

ATTACHMENT H – _____ STANDARD TERMS AND CONDITIONS

_____ STANDARD TERMS AND CONDITIONS IS INCLUDED AS A SEPARATE ATTACHMENT

ATTACHMENT I – CLOSEOUT CHECKLIST

Fixed Obligation Grant Agreement

_____'S PRIME CONTRACT:

PRIME CONTRACT NO:

PRIME CONTRACT PERIOD OF PERFORMANCE:

RECIPIENT NAME: _____

GRANT AGREEMENT NO: _____

TYPE OF GRANT AGREEMENT: FIXED OBLIGATION GRANT

GRANT AGREEMENT PERIOD OF PERFORMANCE: _____

LAST GRANT AGREEMENT AMENDMENT NO.: _____

FILE REVIEW

☐**FULLY SIGNED AND COMPLETE CONTRACT ON FILE**

☐**ALL AMENDMENTS ARE FULLY EXECUTED AND ON FILE**

☐**ALL REQUIRED CERTIFICATIONS AND FUNDER CLEARANCES ON FILE**

☐**SUPPORTING DOCUMENTATION IN PLACE (INCLUDING CHECKLISTS, INTERNAL REVIEW NOTES, PRE-AWARD REVIEWS, AUDITS)**

TECHNICAL/PROGRAMME

☐**COMPLETED ALL REQUIREMENTS, TERMS AND CONDITIONS PER FOG AGREEMENT**

☐**COMPLETED AND ACCEPTED ALL REQUIREMENTS OF THE REPORTS PROVISION STATED IN THE FOG AGREEMENT**

☐**REQUIRED DELIVERABLES SUBMITTED (INDICATE WHAT)**

_____

EQUIPMENT

("EQUIPMENT" MEANS ANY EQUIPMENT, COMPUTER HARDWARE OR SOFTWARE, MATERIALS, GOODS AND VEHICLES AND ASSOCIATED SERVICES NECESSARILY REQUIRED FOR THE IMPLEMENTATION OF THE SERVICES, WHICH THE RECIPIENT CANNOT REASONABLY BE EXPECTED TO PROVIDE, WHICH ARE FINANCED OR PROVIDED BY _____ FOR USE BY THE RECIPIENT).

WAS THERE EQUIPMENT PURCHASED UNDER AGREEMENT?

☐ **YES** ☐ **NO**

ARE THE OWNERSHIP IN EQUIPMENT VESTED IN _____ AND ARE CLEARLY MARKED?

☐ **YES** ☐ **NO**

THE RECIPIENT SHALL HAVE AN UP-TO-DATE INVENTORY OF THE EQUIPMENT, ITS CONDITION AND LOCATION AND SUCH INVENTORY AVAILABLE TO _____ IMMEDIATELY ON REQUEST.

☐ **YES** ☐ **NO**

THE RECIPIENT NOTIFIED_____IMMEDIATELY WHEN RECIPIENT BECAME AWARE OF ANY LOSS OF OR DAMAGE TO EQUIPMENT.

☐ **YES** ☐ **NO**

☐ **EQUIPMENT DISPOSITION PLAN RECEIVED**

☐ **FUNDER APPROVAL OF EQUIPMENT DISPOSITION PLAN ON FILE**

DOES THE RECIPIENT INTEND TO USE THIS ON OTHER _____ FUNDED PROJECTS?

☐ **YES** ☐ **NO**

INTELLECTUAL PROPERTY RIGHT

(Any Reports or documents prepared or information or inventions produced by or on behalf of the Recipient relating to this agreement and all intellectual property rights therein shall be the property of _____.

☐ **REPORT, DOCUMENTS, INFORMATION, INVENTIONS PRODUCED UNDER THIS GRANT AGREEMENT ARE DISPOSITION PLAN RECEIVED**

CLOSEOUT AMENDMENT | FINAL PROJECT LETTER (AS NEEDED)

☐**FULLY EXECUTED BY BOTH PARTIES**

☐**RELEASE OF CLAIM AND RESPONSIBILITY SIGNED BY RECIPIENT**

ATTACHMENT J - _____ STATEMENT OF PRIORITIES AND EXPECTATIONS

Whenever the term "Supplier" is used in this section, "Recipient" shall be substituted.

This Statement sets out the expectations that _____ has of its suppliers. Standard elements of good business practice should also be applied. This Statement focuses on expectations that are particularly relevant to _____ and is intended to reach and be applied by all members of the supply chain.

DFI D expects its suppliers to:

1) **Improve Value for Money** - demonstrate and continually strive to improve value for money in all that they do.

This means:
a. Actively seeking to demonstrate and maximise results, and reduce costs through the life of the contract.
b. Pricing appropriately and honestly to reflect Programme requirements and risks.
c. Proactively pursuing continuous improvement to reduce waste and improve efficiency across their organisation and the wider supply chain.
d. Earning fair but not excessive rewards.

2) **Act with Professionalism and Integrity** - operate and behave responsibly in conducting business.

This means:
a. Being honest and realistic about capacity and capability when bidding.
b. Engaging sub-contractors in a way that is consistent with _____ treatment of its own suppliers not only when bidding but also in subsequent contract delivery, and demonstrating this to _____where required.
c. Applying a zero tolerance approach to corruption and fraud, with top-quality risk management.
d. Working collaboratively to build professional business relationships, including with _____ staff.
e. Acting in a manner which supports the development of a mature business relationship with _____.
f. Demonstrating clear, active commitment to Corporate Social Responsibility.

3) **Deliver Transparency** - implement an open book approach, allowing and using scrutiny to learn and drive improvement.

This means:
a. Being transparent about costs to enable better decision making on value for money choices.
b. Publishing information to show how and where _____ funding is being used and the results
achieved.

4) **Be Accountable** - take responsibility for ensuring the consistent delivery of high performance.

This means:
a. Applying pricing structures that align payments to results and reflect a more balanced sharing of performance risk.
b. Expecting to be held to account for delivery and accepting responsibility for their role, including being honest when things go wrong so that lessons can be learned. ·

5) Align with _____ - recognise _____ priorities and proactively reflect and support these in their work.

This means:
a. Applying a strong emphasis on building local capacity by proactively seeking ways to develop local markets and institutions and avoiding the use of restrictive exclusivity agreements.
b. Being able to operate widely across _____ priority countries, including in fragile and conflict affected states.
c. Openly sharing and transferring innovation and knowledge of what works to maximise overall development impact.
d. Accepting we work in challenging environments and acting to manage uncertainty and change in a way which protects value for money.
e. Reflecting _____ international development goals and tangibly demonstrating their commitment to
poverty reduction.
f. Proactively supporting and implementing wider HM Government policy initiatives e.g. SMEs, Apprenticeships, prompt payment, supporting economic growth.

DISABILITY-INCLUSIVE STUNTING PROGRAMMING

CONSIDERATIONS FOR TANZANIAN NUTRITION PROGRAMME IMPLEMENTERS

WHY IS IT IMPORTANT TO ADDRESS THE NEEDS OF THE DISABLED IN NUTRITION PROGRAMMING?

An estimated 2.5 million+ Tanzanians are living with a disability of some kind, with the prevalence of disability ranging from 6-13%.[1] People with disabilities have unique needs and vulnerabilities – particularly around nutrition and development - that impact their ability to survive and thrive mentally and/or physically. These include:

- Most nutrition programming focuses on preventing pre-natal disability and disability in children, but the ***nutrition needs of children and adults with disabilities are rarely addressed***.[2] Access to people with disabilities (PWD) is often limited, and healthcare workers and CHWs may face challenges in communicating with disabled children, their caretakers, or other disabled adults.[3] Outreach and behaviour change communication campaigns struggle to address the special needs of PWD. Yet disabled people have the same or greater nutritional needs as the general population.

- PWD experience the same delayed development and poor clinical outcomes from malnutrition as the general population. However, ***PWD are particularly vulnerable to undernutrition due to specific physical or medical factors***. For example, a child with a cleft palate may be unable to breastfeed. In addition, disabled children may take more time or skills to feed, resulting in insufficient feeding time or dietary diversity. They may also require greater nutrition. As a result, disabled children experience higher incidence of malnutrition, stunting, and wasting.[4]

- ***Stigma and discrimination against PWD contribute to undernutrition*** through several pathways. Often, disabled children are denied food or receive less than other family members, under the belief that a child will not survive to adulthood or that the lives of non-disabled children are a higher priority in an area of constrained resources.[5] Some communities practise traditional infanticide where breastmilk is withheld from visibly disabled infants.[6]

- ***Poor maternal nutrition – and lack of quality and timely pre-natal care – can contribute to disabilities.*** Pregnant women deficient in folic acid may deliver children with neural tube disorders, for example.[7] Maternal iodine deficiency contributes to preventable brain damage in infants. In Tanzania, 36% of women of child-bearing age are iodine deficient.[8]

- ***Malnourished children suffer from related long-term conditions and disabilities.*** Children lacking Vitamin A may go blind.[9] Or their impaired state can make them vulnerable to malaria or meningitis, which may contribute to neuro-disabilities. Stunted children overall have an increased risk of developing a disability.[10]

While there is no one definition of disability, the UN Convention on the Rights of Persons with Disabilities (UN CRPD) notes that disability is an evolving concept and that "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." The ASTUTE programme supports DFID's rights-based approach to disability inclusion; addressing the physical, communication, legal and attitudinal barriers that people with disabilities face.

1 CCBRT Disability in Tanzania. (n.d.). Retrieved from http://www.ccbrt.or.tz/programmes/disability/disability-in-tanzania/
2 WHO, World Bank. World report on disability. Geneva: World Health Organization, 2011
3 Groce, N. E., Farkas, A., Schultink, W., & Bieler, R. B. (2013, October 1). Inclusive nutrition for children and adults with disabilities. Retrieved from https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(13)70056-1/fulltext
4 Groce, N., Challenger, E., Berman-Bieler, R., Farkas, A., Yilmaz, N., Schultink, W. Kerac, M. (2014, April). Malnutrition and disability: Unexplored opportunities for collaboration. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232244/
5 Groce, N. E., Farkas, A., Schultink, W., & Bieler, R. B. (2013, October 1). Inclusive nutrition for children and adults with disabilities. Retrieved from https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(13)70056-1/fulltext
6 Ibid.
7 Blencowe H, Cousens S, Modell B, Lawn J. Folic acid to reduce neonatal mortality from neural tube disorders. Int J Epidemiol 2010; 39 (suppl 1): i110–21
8 Tanzania Malnutrition Fact Sheet 2016. (2016, October). Retrieved from https://www.fantaproject.org/sites/default/files/resources/Tanzania-Malnutrition-Factsheet-Oct2016.pdf
9 Courtright P, Hutchinson AK, Lewallen S. Visual impairment in children in middle- and lower-income countries. Arch Dis Child 2011; 96: 1129–34
10 Groce, N., Challenger, E., Berman-Bieler, R., Farkas, A., Yilmaz, N., Schultink, W. Kerac, M. (2014, April). Malnutrition and disability: Unexplored opportunities for collaboration. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232244/

UKaid from the British people

IMA World Health

WHAT DOES TANZANIAN POLICY AND LAW SAY ABOUT ADDRESSING PWD HEALTH NEEDS?

- The Government of Tanzania is committed to protecting and advancing the rights of the disabled and have signed a number of related international covenants, including the United Nations ***Convention on the Rights of Persons with Disabilities*** (CRPD) (2006) and the East African Policy on Persons with Disabilities (2012), as well as allied instruments like the UN Convention on the Rights of the Child.
- The GoT developed and adopted the ***National Disability Policy*** (2004), which expanded the country's definition of disability to include a medical to social approach acknowledging the attitudinal, environmental, and institutional factors that limit functional capacity of physical or mental impairments. The landmark ***Persons with Disabilities Act*** (2010) expanded the rights and services to be afforded for PWD and legal and social accountability mechanisms.
- The MOHSW ***Health Sector Strategic Plan*** (2015 – 2020) details the plans and objectives for providing community-based health and development services for PWD, calling for increased training on community-based rehabilitation for PWD for LGAs.
- The 2016 ***Tanzanian National Food and Nutrition Policy and Multi-Sectoral Nutrition Action Plan*** (2016-2021) call for strengthening food and nutrition services for people with disabilities as an over-arching objective, in line with National Food and Nutrition Policy (2016) objectives to improve the nutritional status of vulnerable groups.

RECOMMENDED GUIDANCE FOR NUTRITION PROGRAMME IMPLEMENTERS

When possible, experts recommend using a "twin track" approach: include PWD in mainstream nutrition programmes, as well as provide disability-specific actions for nutrition. Recommendations include:

Programme Planning and Design:

- Review national and donor nutrition and disability policies, strategies and standards to identify how disability has been addressed as resources to guide your programme, and what gaps remain for your programme. Examine any existing data on disabilities from surveys or assessments.
- Ensure any baseline research includes methods that accommodate persons with disabilities to help identify bottlenecks and barriers they experience in nutrition services. Collect primary data on nutrition-related needs for PWD. Use creative methods involving play or art to engage children to gather their inputs.
- Include people with experience in disability as part of the programme design team. If that's not possible, seek their feedback on your planned programme approaches.
- Review and observe nutrition access points (health facilities, agricultural projects/demonstration kitchen gardens, community group meeting points) to assess their friendliness to those with physical barriers. Work with PWD and community members to identify solutions.
- Allocate resources (human, financial) to ensure disability-inclusive programming is in your programme budget.
- Link to/liaise with national or regional/district community rehabilitation programmes and disabled schools in your target areas to better understand the landscape and needs of the disabled in the region. Partner with them when possible.
- Examine whether your nutrition intervention can include both disability mainstreaming and special disability services. If the latter is not possible, is it possible for a local CSO, nutrition partner in country, national-level entity, or another group familiar with the community to take this on in a way that is PWD friendly? Drawing attention to the matter in a positive, results-oriented way may be the best way to gain/delegate support through another mechanism.

Programme Implementation:

- At the prevention level work with health facilities and CHWs to address maternal iodine deficiency, Vitamin A and folic acid, and follow-up with clients to ensure they receive these services.
- At facility level, work with managers to engage people with different types of disabilities. E.g. in accessibility audits, someone who uses a wheelchair and someone who is blind will have different perspectives on the accessibility of a facility. Educate government and clinicians at all levels about the link between nutrition and disabilities.
- When possible, offer home-based outreach nutrition services for pregnant women and children, including messaging and service delivery (such as Vitamin A and deworming for disabled children, and IFAS for pregnant women). Provide intensive IYCF counseling related to disabled children to prevent stunting and reduce secondary illness, combating the cultural belief that disabled children will just stay small.[11]
- Orient CHWs on disability mainstreaming and data collection. Assist them with addressing discrimination and stigma when providing nutrition services, ensuring nutrition-related information is in formats that people with different types of disabilities can understand.
- Consider the accessibility of meeting and consultation venues (including the WASH facilities) and consider accessible transport or supplemental transport

11 Gross, N. et al. Inclusive nutrition for children and adults with disabilities. The Lancet: Global Health. Vol. 1, Issue 4: Oct. 2013.

allowances for disabled participants. Ensure disabled households receive fee waivers/user fee subsidisation – if eligible – to encourage health-seeking behaviour. Encourage PD/Hearth and other nutrition community groups to meet in accessible settings.

- Establish partnerships with organisations that have expertise in disability, including NGOs, disability service providers and Organisations of Persons with Disabilities (DPOs). Encourage participation of people with disabilities in community groups to ensure their voices are heard at the leadership level.

Monitoring and Evaluation:

- Disaggregate data by age, gender, and disability status and analyze results to ensure equity in service delivery and nutrition outcomes between PWD and non-disabled.
- Integrate disability measurement questions into baseline and end-line evaluations, if conducted. These can be drawn from the UN-led Washington Group on Disability Statistics.[12] Use the findings to improve your current programming and share with the GoT and other implementers.
- Consider informal feedback mechanisms to capture perspectives and challenges from community volunteers and clients in reaching the disabled with nutrition programming.
- Include PWD, when possible, in data collection and dissemination efforts. Use participatory evaluations and complaint and feedback mechanisms to gather the perspectives of PWD.
- Assist LGAs and nutrition programming in developing disability-sensitive statistics.

RESOURCES FOR DISABILITY INCLUSIVE PROGRAMMING:

Additional disability inclusion guidance may be found within the DFID Strategy for Disability Inclusive Development 2018-2023:

The following resources may be useful for nutrition programme implementers seeking to incorporate the needs of PWD and provide disability inclusive programming: https://www.gov.uk/government/publications/dfids-disability-inclusion-strategy-2018-to-2023

12 http://www.washingtongroup-disability.com/