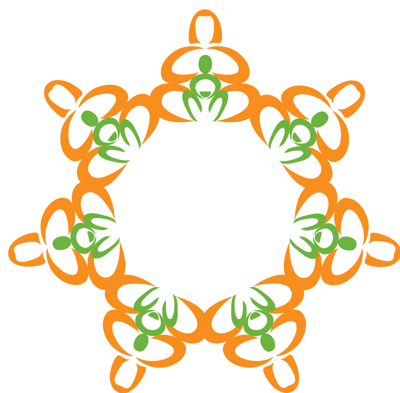
World Vision

Sustainable Health

FACILITATORS MANUAL



Training of Facilitators for **Positive Deviance/Hearth**

FIRST EDITION

Nutrition Centre of Expertise

Training of Facilitators for Positive Deviance/Hearth

FACILITATORS MANUAL

By Naomi Klaas,
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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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List of Acronyms

World Vision

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

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

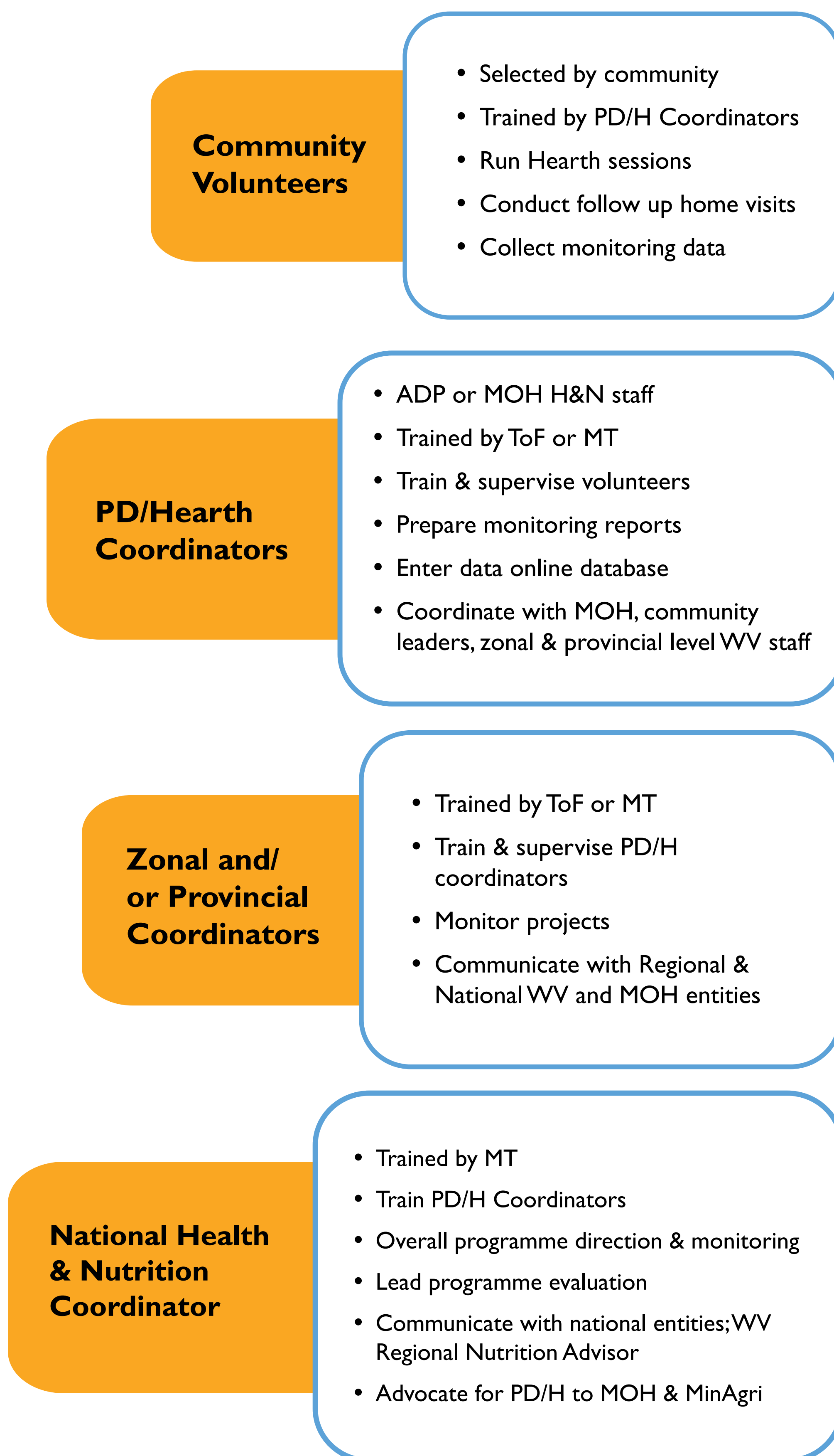
National Health and Nutrition Coordinator

	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



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

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.

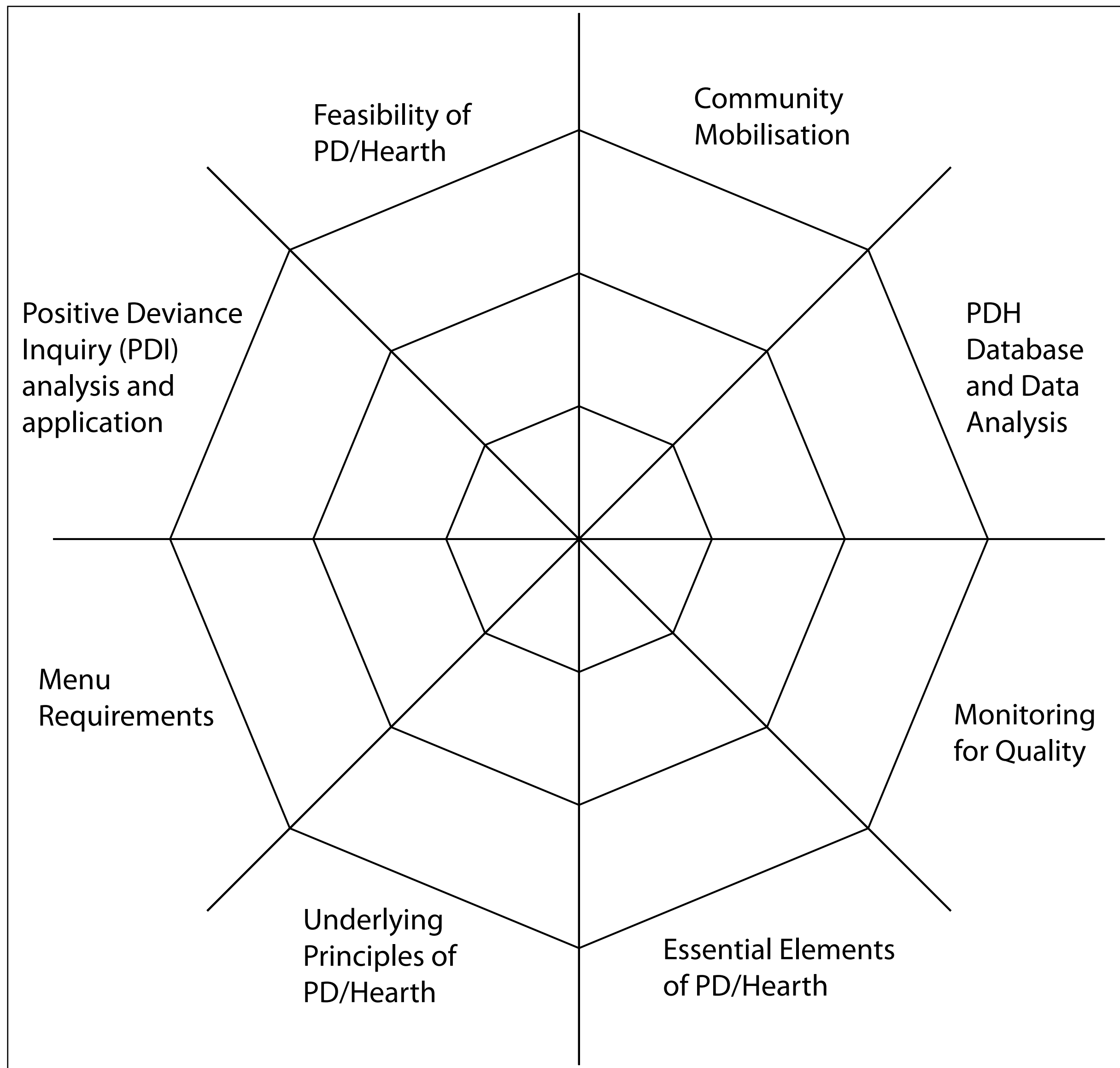
Review the group's expectations from step 3 and ask if anyone has questions on plans for the workshop.

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

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

Agenda for PD/Hearth Training of Facilitators

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 stakeholdersThe 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

Agenda for PD/Hearth Training of Facilitators

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

Agenda for PD/Hearth Training of Facilitators

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

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?

World Vision

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 <u>a long period of time</u>, 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:

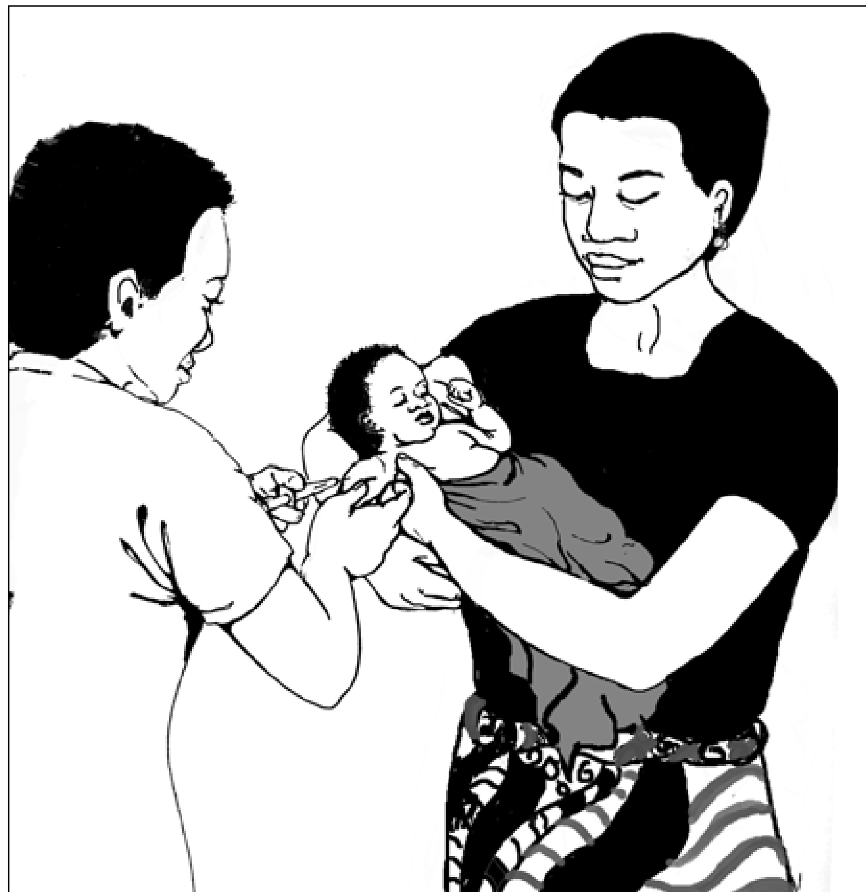
1. food
2. care
3. hygiene
4. health seeking behaviours

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 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:

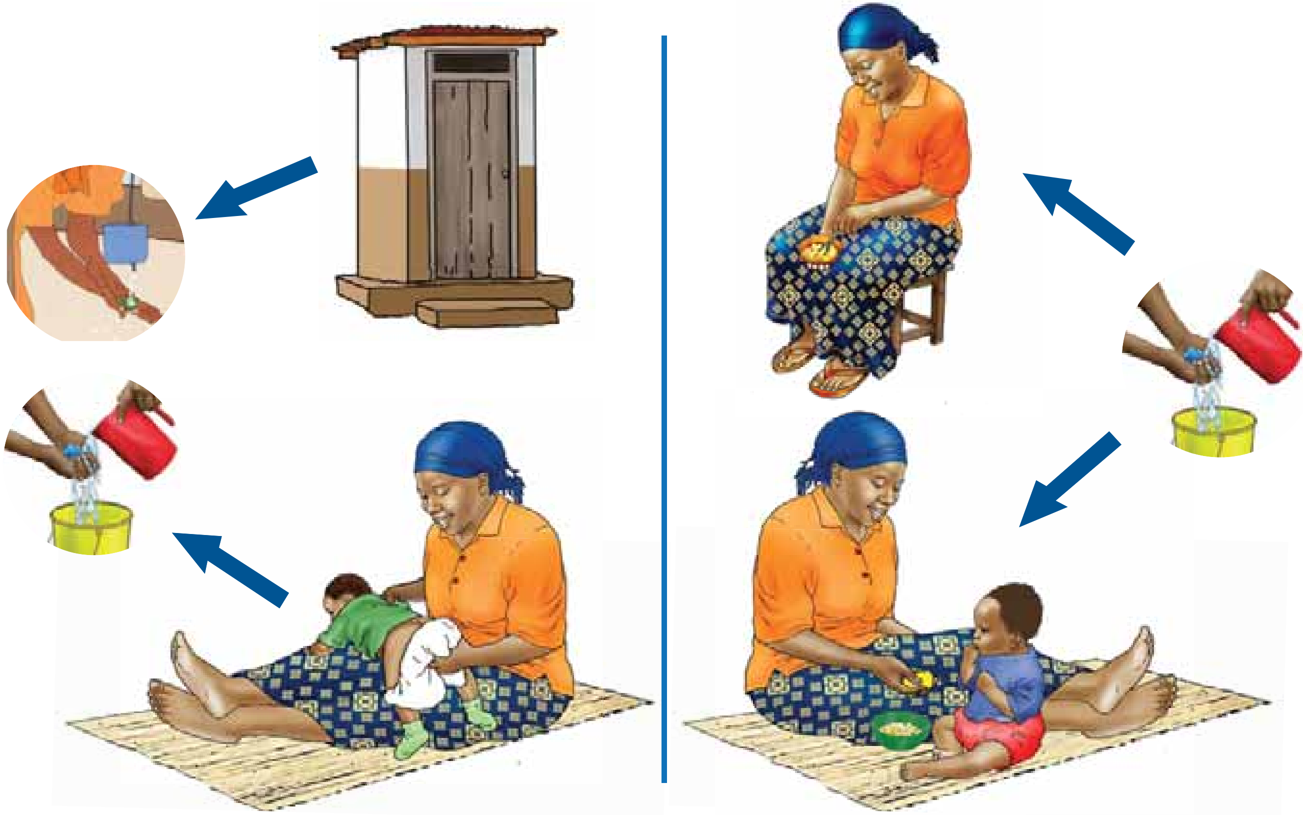
Why are snacks important for children?

(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.)

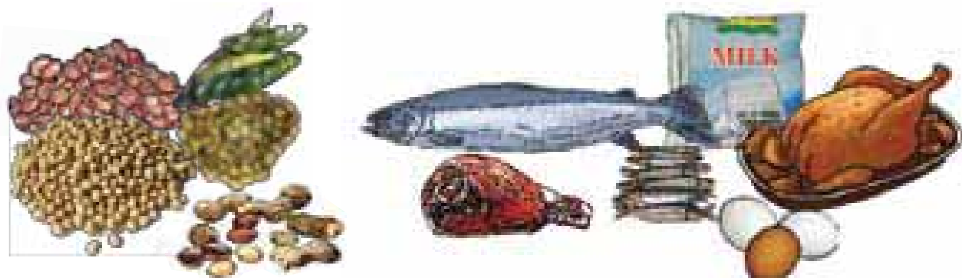
What foods give us GO, that is, energy to work and walk and play? (maize, rice, millet, wheat, cassava, oil, ghee, sugars, coconut, olives). Note that both staple foods and high-fat foods are part of the Energy Giving or GO group.

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)*

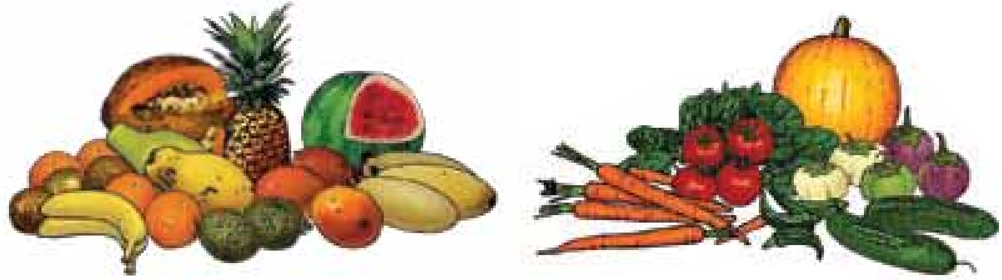


These foods often come from animals.

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.

Protective (GLOW)

Vit. A rich fruit & vegetables
Other fruit & vegetables

Body Building (GROW)

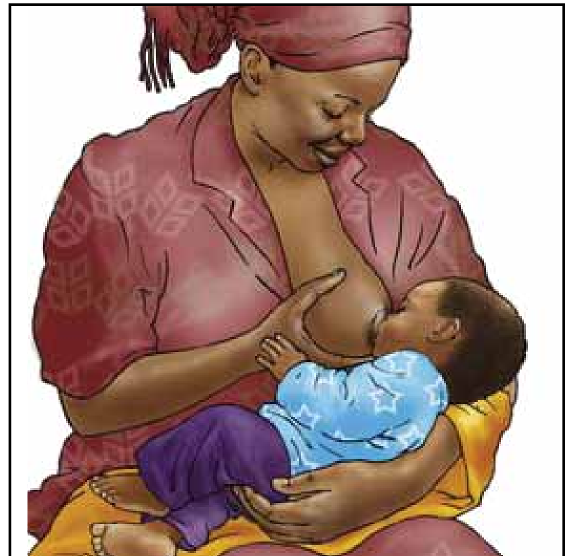
Eggs
Dairy
Legumes, nuts
Meat, fish, poultry

Energy Giving (GO)

Grains, roots, tubers

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

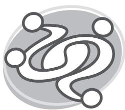
Ask participants what they know about PD/Hearth. Ask them to state the three goals of PD/Hearth. Show them the prepared flip chart.

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).

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).

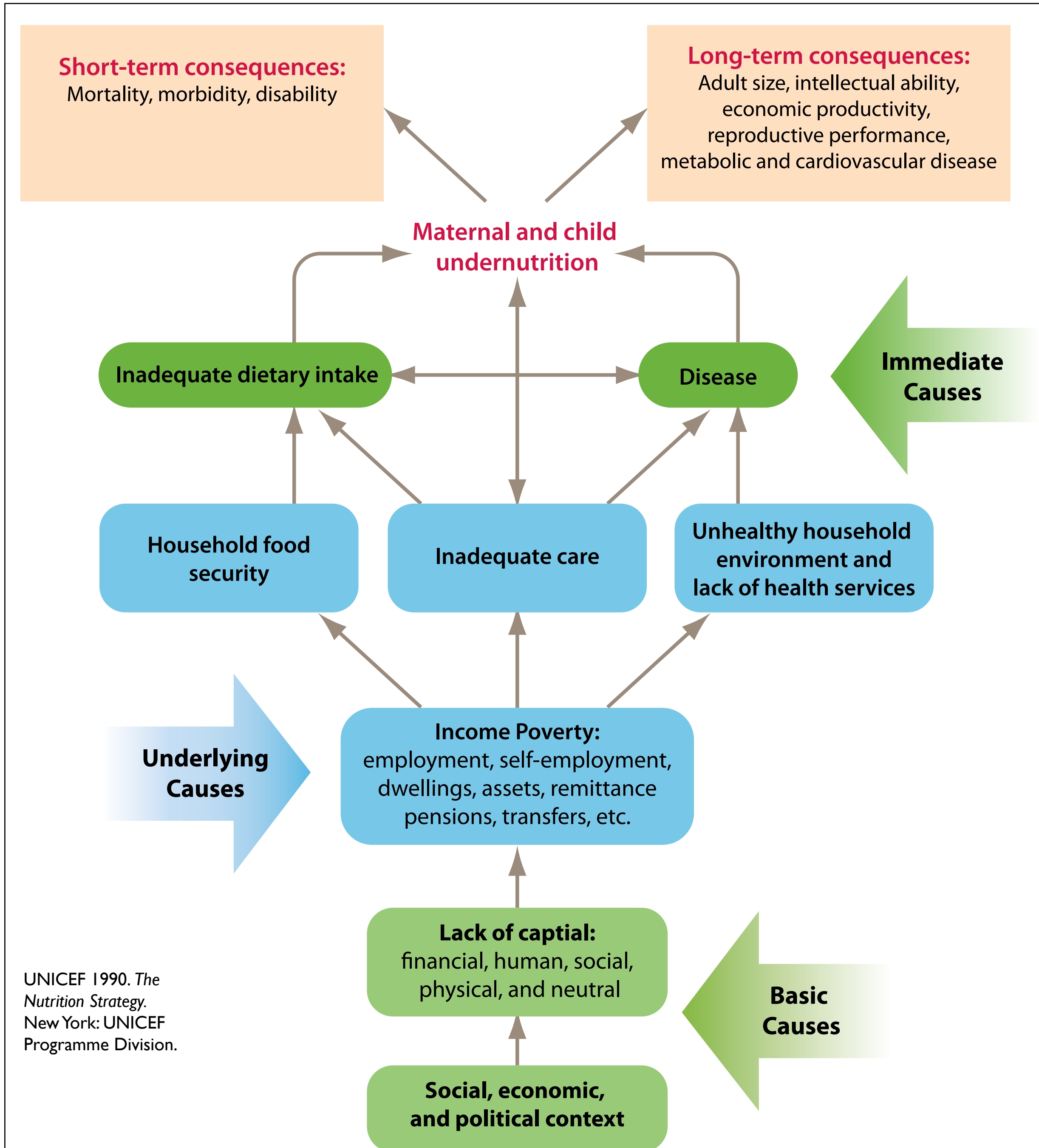


Figure 1: The UNICEF Conceptual Framework Depicting the Causes of Child Malnutrition.

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).*

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.*

<table>
<tr><th></th><th>STEPS</th><th>APPROXIMATE TIME REQUIRED</th><th></th></tr>
<tr><td>Step 1</td><td>Decide whether the PD/Hearth approach is feasible in the target community.</td><td></td><td rowspan="9">Monitor

and

Evaluate</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>

Determining the Feasibility of the PD/Hearth Approach for the Target Community (STEP 1)

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 *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.

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.

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

30 MIN

Review of Day 1 and Agenda for Day 2

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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.

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?

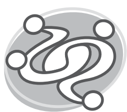
Materials

- 10.1 Handout: Community Mobilsation (STEP 2)

STEPS

30 Min

1. Introduce PD/Hearth Step 2

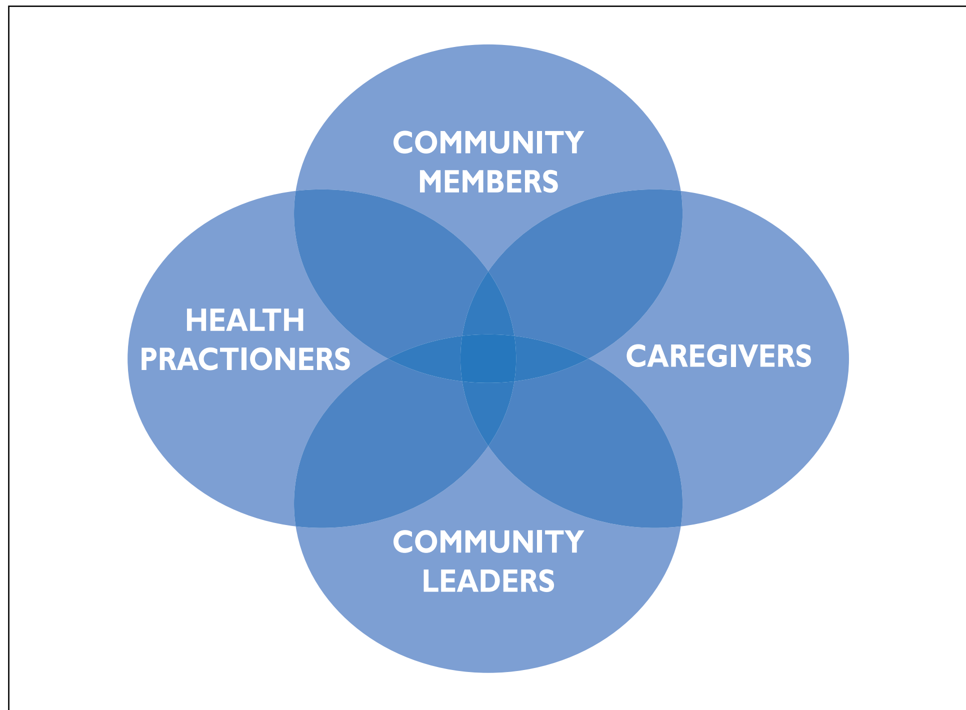


Stress the importance of community mobilisation. PD/Hearth needs involvement by the community in order to succeed. This is a very important component that is often overlooked but necessary to deliver sustainable impact and prevent malnutrition in younger siblings. PD/Hearth Facilitators should have a 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.

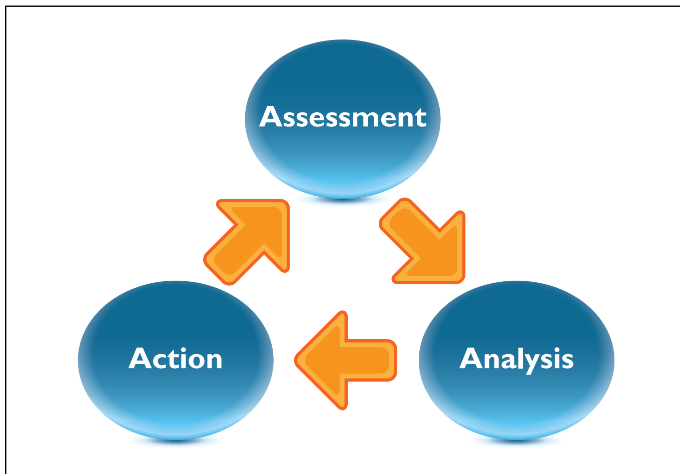
How do you keep this involvement throughout the project?

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)

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.

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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.

VARK Learning Styles Questionnaire ANSWER KEY

World Vision

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Check all that apply. Then, using the answer key, add up the scores for V, A, R, and K.

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   - ☐ **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.

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   - ☐ **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.

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   - ☐ **K** demonstrated what was wrong using a model of a knee.
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   - ☐ **V** draw or sketch something that happened in the play.
   - ☐ **R** write about 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.
   - ☐ **V** show them the map of where it will be held and photos about it.

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   - ☐ **K** things you can click on and do.
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   - ☐ **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.

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    - ☐ **R** that used a written description or table of your results.
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    - ☐ **A** from somebody who discussed it with you.
    - ☐ **V** that used graphs showing what you achieved.

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    - ☐ **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 =____

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 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)

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	

SESSION 14

95 MIN

Situational Analysis – Nutritional Assessment (Weighing All the Children in the Target Community) (STEP 3)

World Vision

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/chts_wfa_girls_z/en/index.hHl

  WHO Growth Charts for Boys: http://www.who.int/childgrowth/standards/chts_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.

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

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

World Vision

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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	

World Vision

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

World Vision

Day 2 Session 14

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

Initial Assessment Worksheet

HANDOUT 14.3

Day 2 Session 14

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														

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)

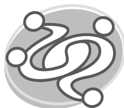
Materials

- 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.

HANDOUT 15.1

Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years

World Vision

Day 2 Session 15

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)

World Vision

HANDOUT 15.2A

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

HANDOUT 15.2B

Market Survey for PD/Hearth (Quantity Variance)

Day 2 Session 15

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

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)

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.

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).

Identifying Positive Deviants (Step 4)

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.*

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)

105 MIN | DAY 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

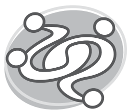
5 Min

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.

Sample Guiding Questions for Conducting a PDI

(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?

HANDOUT 22.2

Observation Checklist

World Vision

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	PD Caring	PD Hygiene	PD Health Seeking
Non-PD Food/Feeding	**Non-PD Caring**	**Non-PD Hygiene**	**Non-PD Health Seeking**

SESSION 23

Field Visit to Conduct PDI

World Vision

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.

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)

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.

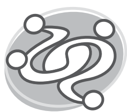
Materials

- 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.

HANDOUT
28.1 – 125m/H 46

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.

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

Examples of Learning Opportunities through PD/Hearth Activities

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.

Flip Chart 30
Nutrients Required in the Meal

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: 1µg 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)

World Vision

Day 7 Session 30

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

PD/Hearth Menu Exercise
Food Composition Table (per 100g of edible portion)

World Vision

Day 7 Session 30

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)

World Vision

Day 7 Session 30

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)

World Vision

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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HANDOUT 30.4

Sample Menu-Planning Form

World Vision

Day 7 Session 30

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.

User Guide for the PD/Hearth Menu Calculation Tool

World Vision

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

World Vision

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.

Essential Elements of PD/Hearth

World Vision

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

World Vision

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

World Vision

Day 8 Session 32

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)

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.

Admission, Graduation, Repeating Hearth Sessions as Needed (STEP 8) Expanding PD/Hearth (STEP 9)

SESSION 35

85 MIN | DAY 8

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

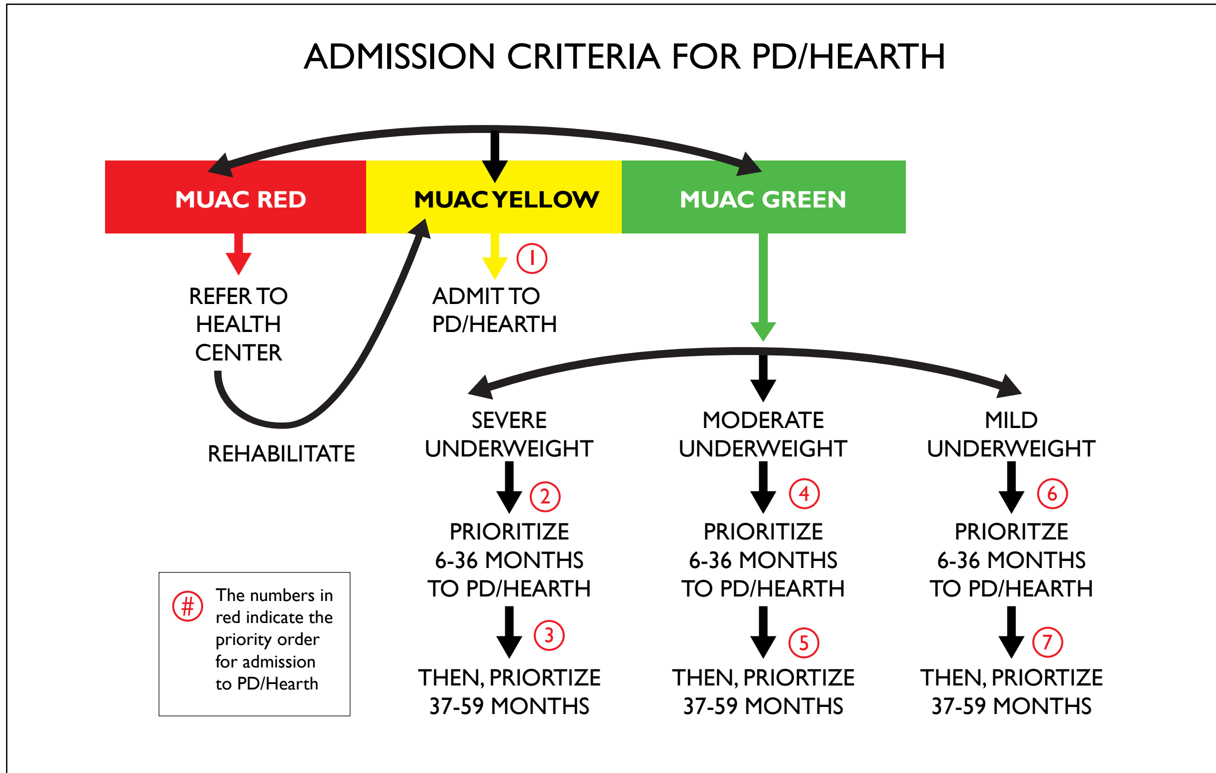
50 Min

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

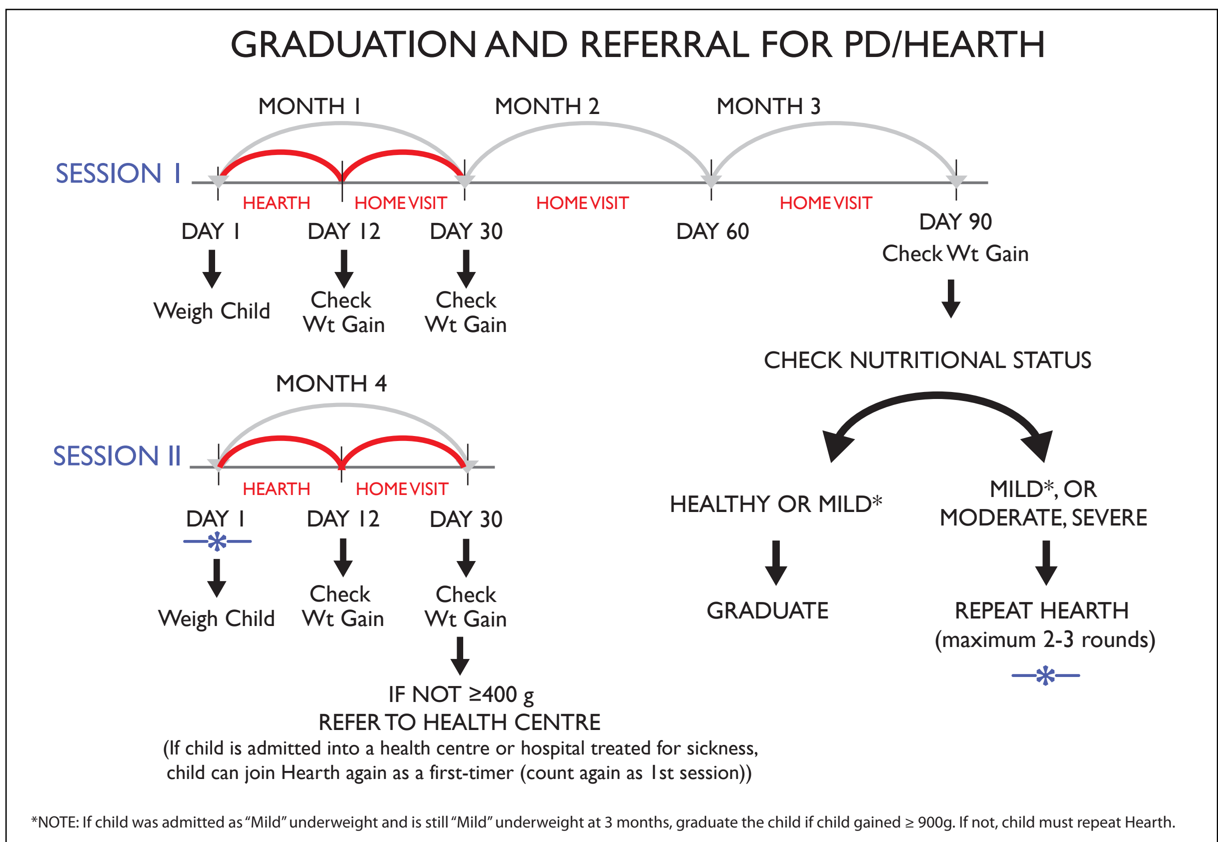
Priority	MUAC	Underweight	Age
1	Yellow (Moderate)	Severe	6-59 months
2	Green (Healthy)	Severe	6-36 months
3	Green (Healthy)	Severe	37-59 months
4	Green (Healthy)	Moderate	6-36 months
5	Green (Healthy)	Moderate	37-59 months
6	Green (Healthy)	Mild	6-36 months
7	Green (Healthy)	Mild	37-59 months

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**
     - o **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)
     - o **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):**
     - o **12 Days:** ≥ 200g
     - o **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)
     - o **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.

135 MIN DAY 8

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)

World Vision

Day 8 Session 36

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)

World Vision

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						

HANDOUT 36.3A

Child Registration and Attendance Form

World Vision

Day 8 Session36

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)

HANDOUT 36.3B

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 8 Session 36

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)										
At Day 1 of Hearth – Weight (Kg)*										
At Day 1 of Hearth – Underweight Nutritional Status (Indicate colour)										
At Day 1 of Hearth – MUAC (Green, yellow, red < 115mm)										
At Day 12 of Hearth – Date (dd/mm/yyyy)										
At Day 12 of Hearth – Weight (Kg)*										
At Day 12 of Hearth – Weight Gain (Day 12 - Day 1) in grams										
At Day 12 of Hearth – Underweight Nutritional Status (Indicate colour)										
At Day 12 of Hearth – 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

World Vision

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.

HANDOUT 36.5

Volunteer Home Visit Form

World Vision

Day 8 Session 36

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				

HANDOUT 36.7

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/yyy)	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

World Vision

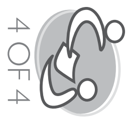
Day 8 Session 36

#	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

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)
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

PD/Hearth Monitoring Case Study Questions

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.*

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

World Vision

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

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

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'.

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.

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?

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

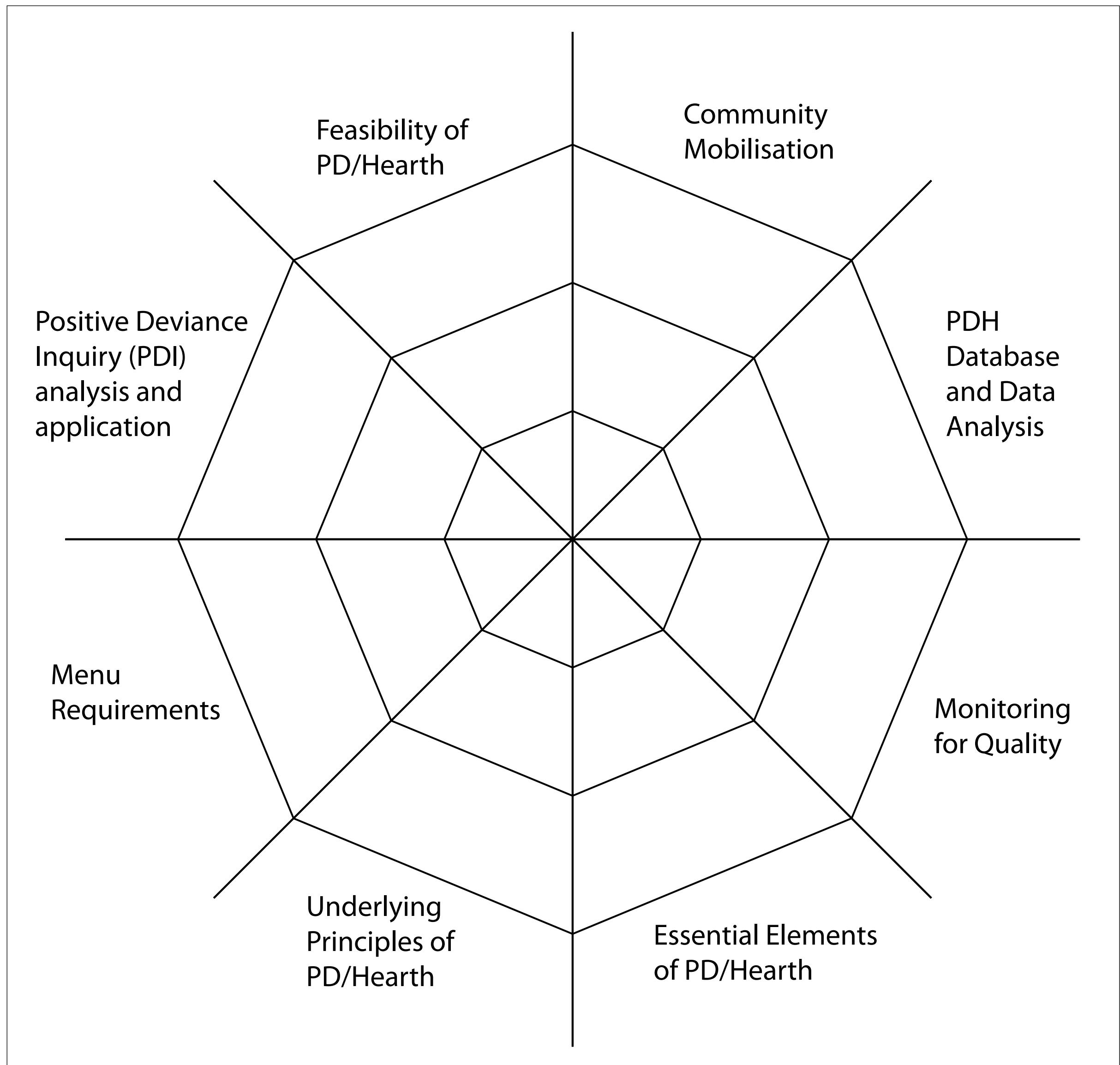
3.

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

World Vision

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.

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____
____

4. What do you feel was the least helpful part of the workshop?

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____
____

5. What would you do to improve this?

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____
____

6. What would recommend for the next workshop?

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____
____

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?

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Please share any other comments or suggestions to improve the next World Vision PD/Hearth TOF Workshop.

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Thank you for your feedback!

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