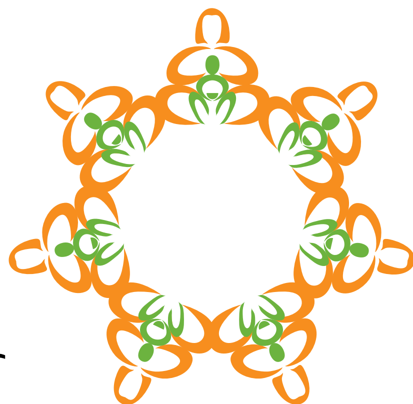
World Vision

Sustainable Health

MASTER TRAINERS
MANUAL



Training of Master Trainers for **Positive Deviance/Hearth**

FIRST EDITION

Nutrition Centre of Expertise

Training of Master Trainers for Positive Deviance/Hearth

MASTER TRAINERS MANUAL

By Naomi Klaas,
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WVI Nutrition Centre of Expertise

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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

Welcome to the Facilitation Manual for Master Trainers for

Positive Deviance (PD)/Hearth

INTRODUCTION

Through increasing experience, World Vision (WV) has recognised the need to develop competent Master Trainers of Trainers (TOTs) for Positive Deviance/Hearth (PD/Hearth) nutrition programmes implemented within the Area Development Programme (ADP) framework. This manual presents curriculum and exercises based on field experience in many countries representing all regions of the world. Adult learning methodologies – with practical examples, exercises, role plays and field visits – reinforce the principles of strong PD/Hearth programmes.

We trust this manual will enable Master Trainers to increase the understanding, skill and competency of WV staff and partners in order to rehabilitate malnourished children and prevent future malnutrition through the PD/Hearth programme.

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).

By the end of the course participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level
6. Complete a training curriculum adapted to their country context (National ToF Curriculum and Volunteer Training Curriculum.

PD/Hearth Short Overview

PD/Hearth is an internationally proven community-based model for rehabilitating malnourished children in their own homes. It targets moderately and severely underweight children aged between 6 and 36 months.[1]

From birth to three years of age, children experience very rapid growth and development. Children who are malnourished during this stage of life will not develop to their full potential. Early malnutrition affects a child's physical, mental, and emotional capacity throughout their entire life. Malnourished children are one of the most vulnerable groups in any community.

'Positive deviance', means 'different in a positive way from what is usual practice'. 'Hearth' refers to the place within a house where food is cooked and served. Despite limited resources, some parents find ways to raise well-nourished children. Identifying and understanding what these 'positive deviant families' are doing differently in their feeding, hygiene, caring, and/or health-seeking practices from the parents of malnourished children in the same community is the foundation for this project. Then volunteers share this knowledge and teach these positive practices to caregivers with malnourished children in practical lessons called 'Hearth sessions'. In addition, two menus are designed for the Hearth session. Each menu is composed of locally available, accessible, and affordable foods that are nutrient dense. All the ingredients are brought to the Hearth session by the participant caregivers who practise cooking the foods at the Hearth session. Hearth lasts for 12 days, followed by a 2 week follow-up conducted by the volunteers through home visits. The purpose of these home visits is to encourage caregivers to continue the positive practices at home, but also to help overcome barriers caregivers may face trying to practise the positive behaviours at home.

1. Some projects expand this range to include children age 6-59 months, that is, all "children under-5", and include mildly underweight children as well.

PD/Hearth empowers communities to take responsibility for addressing the causes of malnutrition by helping to identify local solutions to overcome malnutrition. The PD/Hearth standard model has three main goals:

1. Quickly rehabilitate malnourished children
2. Enable families to sustain the rehabilitation of these children
3. Prevent future malnutrition among all children in the community.

PD/Hearth aligns with World Vision's strategic priorities of ensuring health and nutrition for children in areas in which WV works, as well as WV's commitment to empowerment and sustainability. As of 2013, PD/Hearth has been successfully implemented within WV contexts since 1999, in more than 40 countries, and in all four operational regions of WV.

PD/Hearth Master Training

The PD/Hearth Master Training is aimed at building the cadre of staff within World Vision who are qualified and certified as Project Model Trainers.

The level of staff targeted is not limited to Support Office (SO), Regional Office (RO), National Office (NO) or ADP, but is instead targeted to staff whose job description requires them to train others in this model. It is intended that this process will help to raise the standard of quality in PD/Hearth training and implementation, and so will contribute to alleviating the burden of undernutrition in WV ADPs.

The Master Training does not teach PD/Hearth Methodology, but teaches how to teach it using appropriate adult learning methodology. Participants are required to complete assignments before the training and are expected to facilitate sessions during the event that will be graded both by peers and the expert trainers in order to provide feedback on how to improve on facilitation skills[1].

Because of the approach being taken, there are certain qualifications that need to be met before a participant is approved to begin the Master Trainer process. These qualifications include:

1. Facilitating learning in PD/Hearth is included as part of the participant's job description.
2. Sending office has plans and budget to support PD/Hearth training, and roll out of PD/Hearth implementation

1. For countries planning to introduce PD/Hearth, a National level Training of Facilitators for PD/Hearth should take place with facilitation by qualified Master Trainers, preferably from within the region (a list of recommended trainers can be provided upon request to the NCOE). Once training has occurred and experience in PD/Hearth is established then further training and facilitator needs can be planned and budgeted for. This may mean further training of staff, or use of the GTRN network to access qualified Master Trainers.

3. The participant has experience in implementing PD/Hearth:
    a. They have successfully completed a PD/Hearth training and
    b. They can demonstrate clear understanding of PD/Hearth methodology and key principles.
4. Sending office has implementation of PD/Hearth as part of national level nutrition and health strategy, or support of PD/Hearth implementation for a RO/SO level staff.
5. Sending office is committed to support building capacity of their own staff, as demonstrated by ensuring adequate time is available for staff members to complete the Master Trainer process, and budget allocated for supporting this process.

    Note:

    In some cases, the participant will proceed to fulfill the requirements to become a GTRN Level 2 Subject Matter Expert (SME).

A letter, signed by the participant's supervisor, must be sent ahead of time to the training organisers endorsing the proposed participant and ensuring that the above qualifications have been met. Supervisors will also be required to submit the participant's Job Description, and a strategy document that includes plans for implementation of PD/Hearth.

The number of participants in the Master Trainer course will be limited to 20 in order to maximise the learning potential of the initial face-to-face training.

At the end of the face-to-face event, each participant will have a one-on-one discussion with the expert facilitator to receive feedback on their performance, and to discuss follow up and requirements in order to complete the certification process. This feedback, Master Trainer Level and final grade will be provided via email to the participant, the participant's supervisor, and regional technical advisor.

Full Certification as a Master Trainer in PD/Hearth will be earned upon:

1. Satisfactory completion of recommendations made by expert consultants at the end of the Master Training face-to-face session
2. Satisfactory co-facilitation of a PD/Hearth training event, evaluated by a Level 3 Master Trainer
3. Recommendation by supervisor

Flow of Training (Refer to summary flow chart on pp. 14, Handout 3.2):

Please note: it is recommended that all PD/Hearth trainings are facilitated by at least 2 Master Trainers.

Master Trainer Level 3

The 'go-to' person for PD/Hearth trainings in the region

Can train in PD/Hearth cross-regionally with another facilitator

Master Trainer Level 2

Can train in PD/Hearth within their region with a Level 3 Master Trainer

Master Trainer Level 1

Can train in PD/Hearth within their country with a Level 3 Master Trainer

PD/Hearth Master Training Workshop (Regional Level):

Purpose: To build up a cadre of Master Trainers to improve PD/Hearth programme quality

Facilitator: International expert/Master Trainer Level 3

Participants: Master Training Candidates from within the region

Duration: 6 days at a regional location

Curriculum: WV PD/Hearth Master Training Curriculum

Outcome: Master Trainer Candidates – each participant will receive a grade and level of certification (Level 1, 2 or 3). They will also receive recommendations regarding areas of strength, and areas to work on.

National PD/Hearth Training of Facilitators Workshop (National and Sub – National Level):

Purpose: To train the national and sub-national level staff in PD/Hearth Methodology and implementation of the model[2]

Facilitator: Co-facilitated by a Master Trainer Level 3 and at least one other Master Trainer

Participants: National and Sub-national level staff responsible for implementing PD/Hearth in ADPs and training local level staff (See Handout 3.2 for more details). Participants must

2. The first 2-3 days may be set up as an orientation to PD/Hearth, and include national level staff who are responsible for sectors that are integrated with PD/Hearth (examples: Agriculture, Food Security, Economic Development, M&E, Quality Programming, Gender, WASH, Education, Health & HIV/AIDS Coordinators)

complete pre-workshop readings and pass two quizzes to qualify for PD/Hearth ToF Workshop.

Duration: 10–12 days of training close to a community/ADP planning to implement PD/Hearth or a community/ADP with PD/Hearth programming. There must be fieldwork incorporated into the training.

Curriculum: Adapted MT Curriculum with CORE PD/Hearth manual and orientation of PD/Hearth Volunteer Training manual

Outcome: PD/Hearth ToFs – each participant will be evaluated as either a PD/Hearth Facilitator (able to independently lead PD/Hearth implementation trainings) or Co-facilitator (able to co-lead implementation trainings with a Facilitator).

Volunteer Trainings (Community level):

Purpose: To train community volunteers to fulfill their role in implementation of the PD/Hearth model

Facilitator: Facilitated by at least one PD/Hearth ToF (Facilitator) or co-facilitated by a PD/Hearth ToF (Facilitator) and a PD/Hearth ToF (Co-facilitator)

Participants: Volunteers responsible for implementing PD/Hearth

Duration: 8–10 days at ADP level

Curriculum: PD/H Volunteer Training Manual

Outcome: PD/Hearth Volunteers ready to implement PD/Hearth with all key essential elements

PD/Hearth Competencies

Four levels of PD/Hearth implementers are included:

- Volunteer
- ADP/District-level staff (e.g. Development facilitators, Health and Nutrition Officers)

- Regional or Provincial Health and Nutrition Coordinator
- National Health and Nutrition Coordinator

The competencies at each subsequent level are progressive. Each level requires competence in the previous level as well as the skills listed for the level.

PD/Hearth Volunteer

Skill	Volunteer	Knowledge required
Community mobilisation	• Motivational skills • Identify key stakeholders in community • Identify key locations to promote PD/Hearth (e.g. church setting, community meeting, communal gardens) • Mobilise a PD/Hearth Committee (consists of leaders, fathers, grandmothers of community)	• Understand Theory of PD/Hearth and importance of PD/Hearth • Various roles important to success of PD/Hearth in community • Who the decision-makers are at household level
Measuring growth	• Weigh children	• Importance of proper weighing technique • Ability to weigh properly
	• Plot weights on growth chart	• Plot and interpret growth lines
	• Counsel caregivers	• IYCF practices • Communicate effectively with caregivers
Active participation in PDI	• Observation skills	• Factors that contribute to good child growth
	• Semi-structured interview skills	• Asking questions
	• Guided identification of good/bad behaviours	• Reflection of information gathered and how it contributes to child growth
Menu Preparation	• Making menus for Hearth	• Basic food groups • 'Special' (PD) foods • Prep of recipes • Calculating portion size for children

Conduct Hearth sessions	• Motivate/organise children/caregivers to attend Hearth	• Goals of programme • What is a Hearth • How to set up a Hearth • Role of each person
	• Supervise caregivers in cooking meals / feeding children	• Active feeding • IYCF practices
	• Teach simple nutrition/health/hygiene/caring • messages through example and talking	• Identify good/bad practices (IYCF, illness, care, hygiene) • How to give positive support
	• Monitor attendance, progress, food contributions	• Understand how to complete basic forms • Reflect on the information and what can be done to improve session
Conduct follow up home visits	• Household visits to support caregivers with new behaviours	• Purpose of home visit • Use of Home visit Observation Checklist form • Problem solving with caregiver
Communication	• Communicate concepts and methods with caregivers and community members in simple terms	
	• Report regularly to VHC	• Ability to communicate programme progress and results orally

ADP/District-level Staff

Skill	Supervisor	Knowledge required
Measuring growth	• Participate in identifying nutrition status of children to select participant children for PD/Hearth programme (screening should be done monthly to identify new participants to be included in next round of Hearth)	• Motivation/mobilisation of village leaders
	• Teach volunteers to interpret growth charts and counsel caregivers	• GMP technical ability
		• Communication of IYCF practices in simple terms

Situational Analysis	• Nutrition situation • Health services • Market survey	• Participatory Rapid Appraisal (PRA) • UNICEF framework of Causes of Malnutrition
	• Communicate with MoH, village leaders, health providers, volunteers	• Community mobilisation skills
PDI	• Identify PD/NDP/ malnourished children • Assist in PDI	• Principles of PD/H • Concept of PD
	• Train volunteers in PDI	• Adult education principles • Facilitation skills • Participatory assessment skills
	• Lead participants in analysis of PDI information • Develop appropriate key messages and behaviours to promote in each Hearth session.	• Breastfeeding • Complementary Feeding • Hygiene • Illness Prevention and treatment • Early child stimulation • Meal preparation for families • Nutrition and HIV/AIDS
	• Train volunteers in 6 key Hearth messages	
Menu Preparation	• Development of nutrient dense menus-based on PDI • Train volunteers in menu preparation using household measures	• Use of food tables and menu calculation software • Calorie, protein and MN requirements • Basic nutrition principles to be able to substitute recipes
Hearth sessions	• Supervise Hearth sessions	• Assist volunteers in organising set-up of Hearth • Assist in mobilisation of caregivers to attend • Essential Elements of PD/Hearth • Use of 'Supervision Checklist form'
	• Train volunteers in helping caregivers prep meals, actively feed, etc.	
	• Train volunteers in development and presentation of key messages	• Awareness of alternate teaching methods (song, picture, hands-on, example)
	• Supervise and motivate volunteers who run Hearth sessions and PD/Hearth committee	

Monitoring	• Assure implementation of Hearth protocol (hygiene, snack, cooking, feeding, training)	• Use of monitoring sheets to analyse effectiveness of process
	• Create monthly plan for implementing Hearth in geographic area	• Budget development • Logframe development • DIP
	• Ensure Hearth sessions take place monthly	Use of Hearth monitoring form
	• Ensure Day 12, 30, 6 months, 12 month, and 24 month follow-up conducted	• Use of Hearth monitoring form and PD/ Hearth database software
	• Ensure 2 week follow-up home visits are being conducted by volunteers after Hearth sessions	• Use of Home-visit Observation Checklist forms and track the submission of these forms by volunteers
	• Motivate village to take responsibility in monitoring growth of children (important for on-going screening of future PD/Hearth participant children)	• Community mobilisation skills • Communication skills • Community-based M+E techniques
	• Aggregate information from all Hearths in area	• Reflection and analysis
	• Competent in using PD/Hearth database software	• Familiar with MS Excel and internet
	• Analyse information and make appropriate programming decisions	• Decision making/problem solving skills
Communication	• Provide feedback to volunteers on their Hearth sessions, graduation rates, home visits, etc.	• Simplify technical findings and present in lay language
	• Report progress to supervisor/ADP manager/ community leaders	• Written and verbal communication skills
	• Communicate to volunteers the next group of identified participant children for PD/ Hearth - should identify from monthly GMP results	• List of underweight children from most recent monthly GMP results (monthly screening required)

Regional/Provincial Health and Nutrition Coordinator

Skill	Regional/Provincial Health and Nutrition Coordinators	Knowledge required
Planning	• Analyse nutrition data • Identify geographic priority areas for PD/H • Communicate results to national partners/ WV leadership/communities/ADP staff	• Causes and consequences of malnutrition measure, calculate and classify malnutrition
	• Network with NGOs, government ministries, universities, international organisations (UNICEF etc)	• PD/H concepts, principles and practices • Role of diverse entities in PD/H implementation
	• Motivate participation of cross sectors specialists to contribute to PD/H • Lead multi-sector team in collaborative planning to integrate into PD/H programming	• Identification of gaps/key contributing factors and ways to address those.
	• Develop/adapt logframe for PD/H	
	• Develop DIP for PD/H	
	• Develop budget and workplan	
Monitoring	• Ensure all data is collected (no missing data) and entered into PD/H database • Analysis of aggregated data/Interpret findings • Make appropriate decisions based on data to strengthen programme	• Principles of monitoring systems for PD/H • Using tracking forms • Competent in PD/H Database • # of Hearth sites implemented per village
	• Support and supervision visits to Hearth projects • Mentor ADP/District staff	• PD/H menu requirements (meets nutrient requirements, low cost, use locally available foods, seasonal calendar considered)
	• Develop and implement evaluation plan for PD/H	
	• National level reporting (aggregated data) • Communication with partners	
Training	• Develop training materials • Train PD/Hearth Supervisors • Supervise and support PD/Hearth Supervisors and support Supervisors in training of volunteers	• Adult learning methodology • Ability to teach technical material in actively and in simple language • Facilitation skills

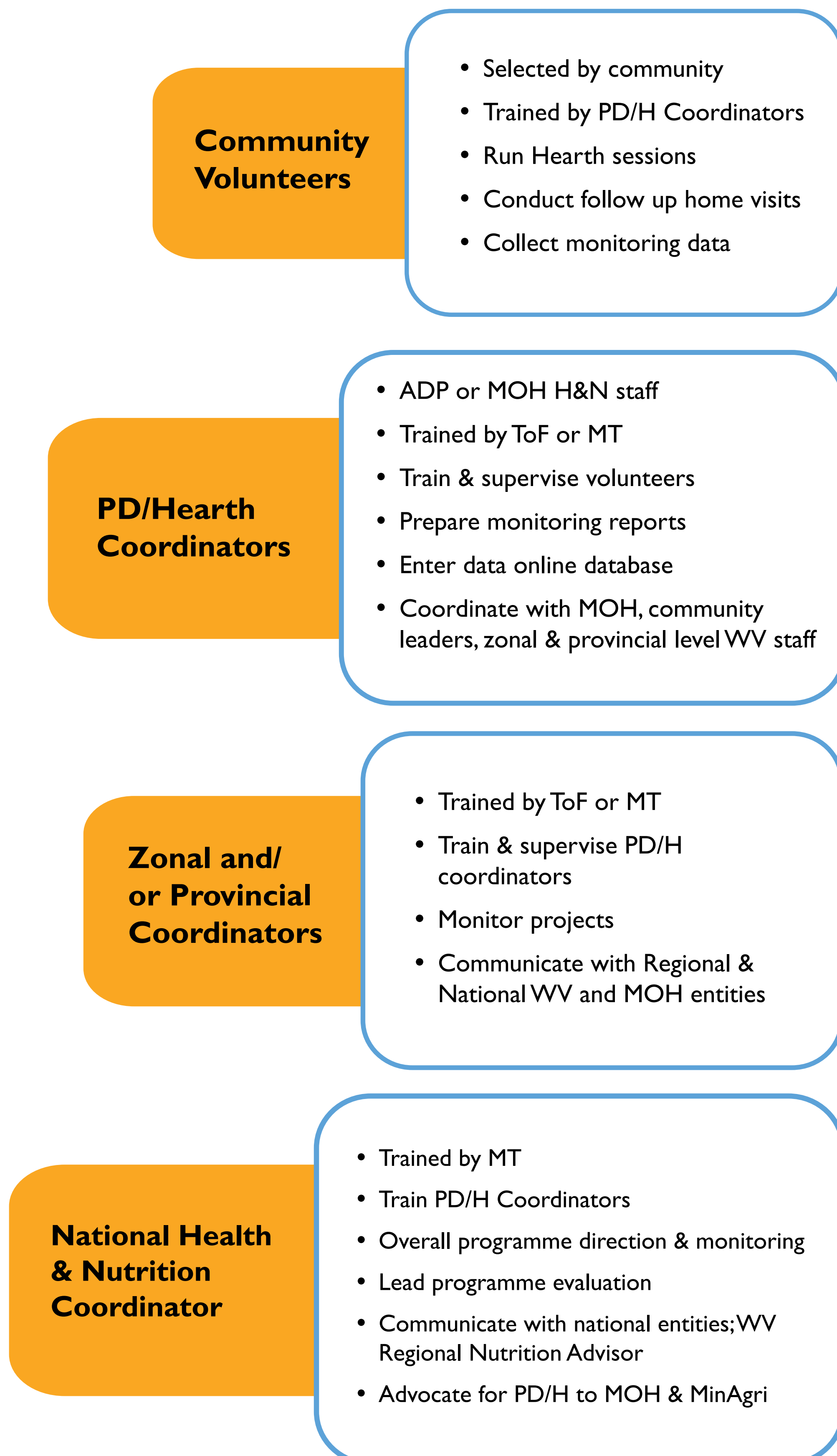
National Health and Nutrition Coordinator

	National Health and Nutrition Coordinator	**Knowledge/ skills required**
Skills	• Adult learning methodology • PD/H theory and methodology • Demonstrated ability in training others in PD/H, Hearth menu calculation tool/software and PD/H Database • Is deployable	• In the various areas listed below is able to lead others in the processes and/or train others in practical, hands-on ways • Computer processing skills (Competent in MS Excel and Internet use)
Area of Expertise		
Basic Public Health Science	• Population health, disease prevalence, prevention, health determinants, promotion, improving health outcomes • Applies epidemiological knowledge, approaches, methodologies • Understands and uses research methodologies and scientific evidence for health problems	• Use of secondary and primary data to identify gaps in nutrition and recommend appropriate interventions • Ability to advise on other relevant health interventions that would support improvement in community nutritional status
Analytical/ Assessment	• Defines gaps and top priorities for health in country aligned with WV strategic direction	• Identify situations where PD/H methodology would be feasible and beneficial • Advise when PD/H would have limited applicability and not be recommended
	• Use of quantitative /qualitative data	• Identify areas where nutrition is a problem and PD/H could be relevant • Identify contributing factors to low nutritional status that would need to be addressed • Use of data to 'advocate' for PD/H programmes • Ability to advise on PD/H field research or evaluation
	• Selects and defines relevant variables	
	• Applies ethical principles to data collection, storage, use and reporting	• Ability to set up monitoring systems following WV and PD/H standards
	• Knowledge of standardised data collection and management process and computer systems.	
	• Knowledgeable of risks and benefits to communities through assessment and planning	

National Health and Nutrition Coordinator – continued

Programme Planning and Policy Development	• Translates assessment information and data into programmes • Able to assess feasibility, applicability, risk management for WV ADPs • Uses standard techniques in decision making and planning • Develops PD/H programme plans, goals, objectives, expected outcomes, implementation process • Knowledgeable of assumptions that affect PD/H	• Uses data to mentor staff in improved programming
Leadership	• Creates shared vision and team learning • Manages team information, contracts, external agreements • Manages staff; motivates, conflict resolution, performance monitoring • Identifies factors that may impact programme delivery • Facilitates collaboration with internal and external stakeholders • Represents PD/H at internal and external forums • Monitors and maintains ethical and organisational performance standards	• Able to build and lead multi-cultural team around common goals • Able to advocate and collaborate with relevant nutrition and PD/H networks
Communication at multi-country/ regional level	• Written and verbal communication of health issues Facilitates and participates in diverse cultural, educational and professional groups • Solicits input from relevant team members • Advocates for top priority health issues aligned with 7-11 programming • Presents demographic, statistical. scientific and programme information for lay and professional audience	• Able to communicate technical PD/H information simply and clearly to non-technical audiences • Ability to communicate with other technical experts in health/nutrition or other relevant disciplines. • A learner's attitude

Flow Chart of World Vision PD/Hearth Reporting Lines



Wealth Ranking:
5 or 7 community members (diverse group)

Initial Nutrition Assessment:
First, please ensure the Ministry of Health allows NGOs and non-government approved personnel to weigh children. If the government has strict protocols, please mobilize government approved personnel (e.g. health centre staff, CHWs, etc.) to help weigh children on the day of assessment.

Weigh all children 6-36 months of age in the community (you could mobilize the caregivers to one site/location or to several decentralized sites/locations in the community to increase coverage and ask caregivers to bring their children 6-36 months of age on a specific day and time). Weighing children house to house is most accurate, but may require more time and resources.

Community/Social Mapping:
4-5 community leaders (men and women) and 1-2 CHWs

Focus Group Discussions:
Three separate FGDs are recommended with mothers group, fathers group, and elderly women's group. There should be approximately 7-10 participants in the mothers group. It is advisable to include 2-3 mothers with children from each target age group: 0-6 months, 6-12 months, 12-24 months, and 1 mother from the age group 24 -59 months. A smaller group of 4-5 participants could be mobilized for fathers and elderly women (grandmothers). Ensure there are 2 facilitators in the FGD who are good with speaking the local language (for interviewing and recording). If different groups are leading different FGDs, you may require more facilitators who speak the local language.

Seasonal Calendar/Transect Walk:
Good to have 1-2 CHWs or volunteers who could help navigate in the village/community

Market Survey:
Done by the team
Good to find out when the big market day is and keep in mind when planning the agenda

Positive Deviance Inquiry:
From the initial nutrition assessment, select at least 4 PD households (at least 1 household from each target age group: 0-6 months, 6-12 months; 12-24 months), 2 negative deviant households, and 2-4 non-PD households. These will be the households that will be visited during the PDI. You could always select more PD and non-PD households if necessary, depending on the number of participants in the training. Divide participants into groups of 3 people. Arrange for each group to be supported by a volunteer or someone who is familiar with the village so that the groups could find the households easily. Ensure the volunteer or the person from the village is not in the way of getting honest answers from the caregivers. If translators are needed, make sure at least one person in the group could speak the local language.

Welcome, TOT Objectives, Agenda, Introductions

SESSION 1

60 MIN | DAY 1

By the end of the session participants will

1. Have reviewed the training goals and desired outcomes
2. Have been introduced to the hosting agency and facilitation team
3. Be able to summarise participant expectations and workshop norms
4. Be able to evaluate their learning needs as individuals and as a group in key objectives of PD/Hearth.

Preparation

- Prepare a flip chart with overall training goal and objectives as shown on Handout 1.1.
- Prepare two copies of Flip Chart 1, the 'Target Evaluation' diagram. One copy is used now, and one at the end of the course.

Materials

- Objectives (Handout 1.1)
- Agenda (Handout 1.2)
- Blank sheets of flip-chart paper
- 8 dot stickers for each participant

STEPS

5 Min

1. The organisation hosting the event welcomes participants and introduces the lead facilitator as well as special guests attending the opening session.

10 Min

2. Cover basic information such as the locations of bathrooms, timing of breaks, etc. With the group, develop ground rules (promptness, cell-phone etiquette, computer use, etc.). Use a flip chart that will be posted during the workshop. Encourage full participation in all discussions and small-group work.

5 Min

3. Read the overall goal of the training and the training objectives. Based on these, ask what the participants expect. List responses on a separate sheet of flip-chart paper.

HANDOUT
1.1 – 4m/H 9

5 Min

4.

HANDOUT
1.2 – 5m/H 10

Distribute the training agenda and briefly review the planned content. Note that the activities have been planned to encourage maximum discussion and 'hands-on' work by participants. Participants will spend time revising a training curriculum to make it suitable for their own context.

10 Min

5.

Introduce all facilitators and describe their involvement with PD/Hearth to date. Have all the participants briefly introduce themselves.

10 Min

6.

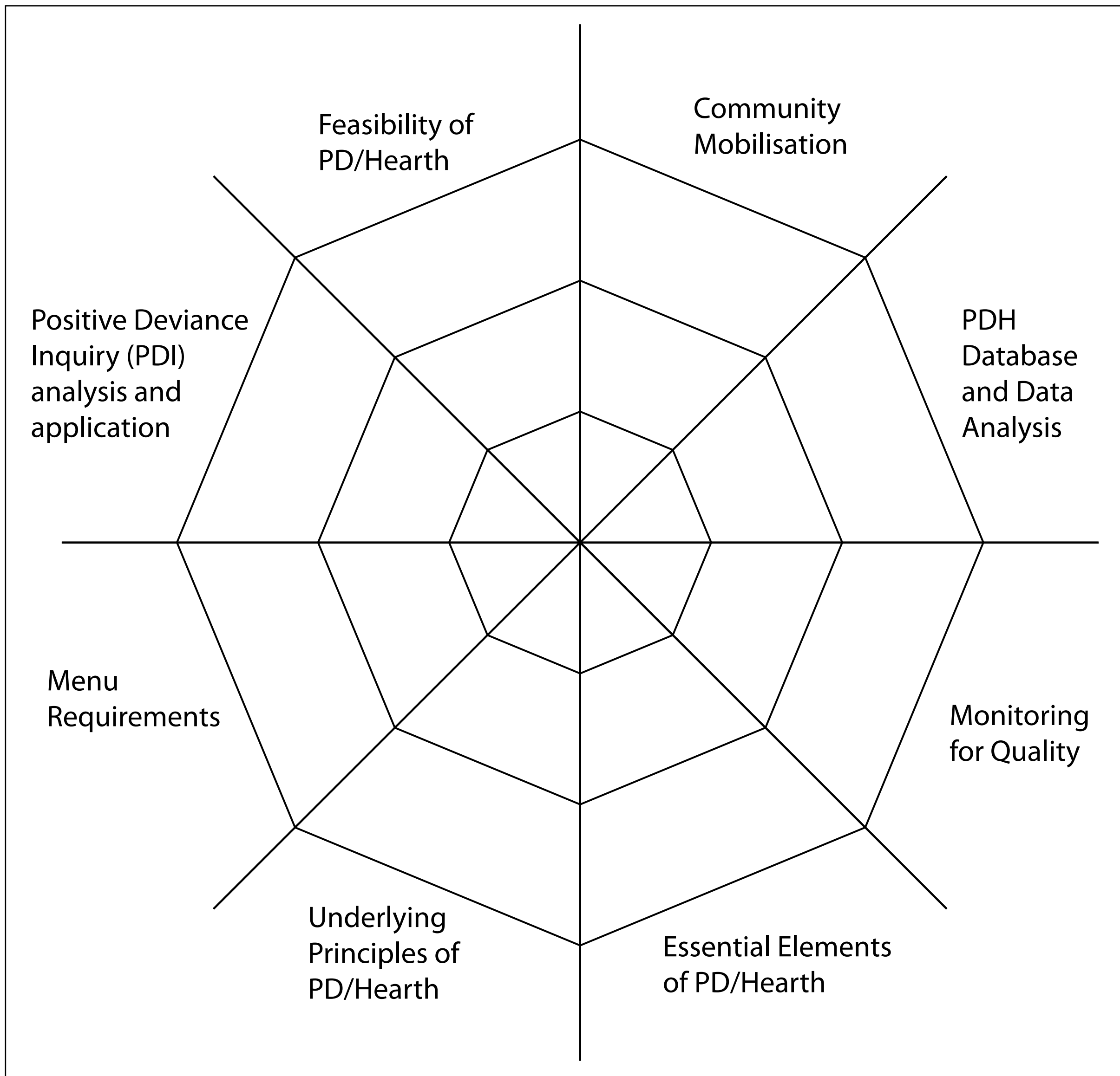
Review the group's expectations from step 3 and ask if anyone has questions on plans for the workshop.

15 Min

7.

Complete the first stage of the 'Target Evaluation Dart Board' described below.

Flip Chart 1
Target Evaluation Dart Board



- Give each participant eight stickers.
- Ask participants to think about their understanding and skill in each of the eight areas listed on the 'dartboard'. The more competent they feel in each area, the closer to the centre of the target they should place a sticker. If they feel less confident or knowledgeable about an area, they place their sticker closer to the outer edge.
- When all participants have placed their stickers, discuss together areas where the group has strengths and areas that group members hope to strengthen in this course.
- Save this sheet for comparison at the end of the course.

Objectives for PD/Hearth Master Training

World Vision

Goal

WV staff and partners develop knowledge, skill and competencies in PD/Hearth to

- train others
- provide technical support
- monitor implementation.

Training objectives

By the end of the workshop, participants will be able to

1. Distinguish where PD/Hearth is an appropriate intervention
2. Articulate how PD/Hearth can and should be integrated with other ADP programmes/sectors
3. Practise the steps in implementing PD/Hearth
4. Use essential elements and principles of PD/Hearth to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level
6. Complete a training curriculum adapted to their country context.

Agenda for PD/Hearth Training of Trainers

Day and Date	Session	Topics	Time
		DAY 1	
1		Devotion	15 min
	1	Welcome Ice breaker Workshop rules (parking lot) Introductions and expectations Overview of workshop purpose, objectives and agenda Target Evaluation TOT methodology and curriculum adaptation	60 min
	2	Pre-test	30 min
	3	Defining the roles of a PD/Hearth Master Trainer	30 min
	4	Learning styles and facilitation	45 min
	5	Overview of PD/Hearth	45 min
	6	Essential elements and key principles	60 min
	7	How PD/Hearth addresses malnutrition	45 min
	8	Step 1 – Determining the feasibility of PD/Hearth	45 min
	9	Integration and PD/Hearth	60 min
	10	Personalise the training curriculum, daily summary, evaluation	45 min
		DAY 2	
2		Devotion	30 min
	11	Review Day 1 and present the Day 2 agenda	15 min
	12	Step 2 – Community mobilisation	60 min
	13	Step 2 – Staffing needs; selecting and training volunteers	45 min
	14	Step 3 – Situational analysis – Wealth ranking	95 min
	15	Step 3 – Situational analysis – Nutritional Assessment	95 min
	16	Step 3 – Situational analysis – transect walk, household visits, focus-group discussions (FGDs), market survey	30 min
	17	Step 4 – Identifying positive deviants	30 min
	18	Step 4 – Preparing for the positive deviant inquiry (PDI)	75 min
	19	Step 4 – Preparing for the field visit to conduct the situational analysis and PDI	60 min
	20	Personalise the training curriculum, daily summary, evaluation	30 min

Agenda for PD/Hearth Training of Trainers

Day and Date	Session	Topics	Time
		DAY 3 – FIELD VISIT	
3		Review Day 2 and explain details for field visit	15 min
	21	Field visit (PDI, FGD, transect walk, market survey, household visits)	4.5 hours incl. travel time
		Compile results of PDI on flip charts	120 min
		DAY 4	
4		Devotion	30 min
	22	Review Day 3 field visit and present Day 4 agenda	15 min
	23	Step 4 – PDI interpretation and feedback	80 min
	24	Promoting behavioural change	40 min
	25	Step 5 – Designing Hearth sessions (Incorporating positive deviance behaviours)	120 min
	26	Step 5 – Menu planning	245 min
		DAY 5	
5		Devotion	30 min
	27	Review Day 4 and present the Day 5 agenda	35 min
	28	Community feedback meetings	60 min
	29	Step 6 – Conducting Hearth sessions	40 min
	30	Step 7 – Supporting new behaviours through reflection and home visits	60 min
	31	Step 8 – Admission and graduation criteria and repeating Hearth sessions Exit strategy and reaching the rest of the community	45 min
		Step 9 – Expanding PD/Hearth	
	32	Monitoring and evaluation	120 min
	33	Personalise the training curriculum , daily summary, evaluation	30 min
		DAY 6	
6		Devotion	30 min
	34	Review Day 5 and present the Day 6 agenda	30 min
	35	Factors for the success of PD/Hearth	45 min
	36	Post-test	30 min
	37	Training plan	45 min
	38	Personalising the TOT curriculum – review by facilitators	90 min
	39	Final evaluation and workshop closing	30 min

Pre-test

Materials

- PD/Hearth Pre-test (Provided in the MS Word document called "MT Trainers' Package"

STEPS

1. Distribute Handout 2.1: Pre-test

File Named "MT Trainers' Package"

2. Have the participants complete it and hand it in.

3. Facilitators mark the tests while the participants complete their Learning Styles Questionnaire (Session 3) and personalise their training curriculum (Session 9). The marked pre-tests will be returned with the post-test results on the last day.

SESSION 3

30 MIN

Defining the Roles of a PD/Hearth Master Trainer

DAY 1

By the end of this session, participants will be able to

1. Describe their roles as a Master Trainer for PD/Hearth.

Preparation

- Print Handout 3.1 and 3.2

Materials

- Blank sheets of flip-chart paper
- Handout 3.1: PD/Hearth Competencies
- Handout 3.2: Flow Chart of WV PD/Hearth Reporting Lines

STEPS

5 Min

1.

Ask participants what qualities a Master Trainer should have. List these on a flip chart. *(understand context, communicate clearly, be able to mobilise the community, be creative in working together, prepare well, apply adult learning methodologies, listen to participants' responses)*

10 Min

2.

Divide the participants into small groups of four to five people. Ask them to discuss and come to agreement on what PD/Hearth trainers should be able to do. They should designate one person in the group to report back.

10 Min

3.

Ask each group's representative, in turn, to state one of the roles his or her group discussed. Write these on a flip chart. Go around more than once if the representatives have more to offer. Make sure that all of the points shown below are listed by asking for additional suggestions.

- Place PD/Hearth in context
- Develop a curriculum and training materials
- Develop a training plan
- Review participants' pre-work
- Conduct training
- Monitor and evaluate progress after training
- Provide technical support for training and quality implementation
- Evaluate and reflect

- Promote PD/Hearth with leadership
- Plan and coordinate with partners
- Work with other sectors to address underlying issues that affect malnutrition
- Be involved in programme design
- Be consistent about the PD/Hearth concept
- Develop methodology
- Conduct training needs assessment
- Develop in-country training of trainers
- Apply adult education principles and skills
- Resolve barriers and challenges that affect improvement in nutrition status

5 Min

4.

HANDOUT
3.1 – 10m/H 12
3.2 – 12m/H 14

In order to fulfil these various roles, PD/Hearth trainers need to develop certain skills and competencies. Refer the participants to the completed list of competencies in Handout 3.1. Ask participants to briefly consider which of these competencies they feel comfortable with and to put a check mark beside those skills or areas of knowledge they need to develop more. These competencies will be developed throughout the course.

Distribute Handout 3.2 as a reference for participants to understand the roles of different personnel in PD/Hearth implementation.

PD/Hearth Competencies

World Vision

Day 1 Session3

Principles of PD/Hearth

- Goals of PD/Hearth
- Adult learning principles
- Behaviour-change theory
- Community mobilisation and ownership in PD/Hearth

Training skills

- Criteria for selecting Hearth volunteers and staff
- Training PD/Hearth volunteers
- Training PD/Hearth supervisors
- Facilitation based on learning styles

Community mobilisation skills

- Tools for PD/Hearth community assessment
- Nutrition baselines in PD/Hearth
- Wealth-ranking exercises
- Identifying positive deviant households
- Market surveys
- Community mapping in PD/Hearth
- Conducting positive deviant inquiries
- Tools used in community feedback meetings
- Engaging grandmothers and others with influence on child care and feeding

Critical thinking skills

- How to determine if PD/Hearth is appropriate in a community
- Analysis of positive deviance inquiry
- Designing Hearth sessions
- How to develop PD/Hearth messages

Technical skills

- Use of food composition tables to calculate Hearth menus
- Converting metric measures into home measures
- Conducting Hearth sessions
- Characteristics of complementary feeding for a child of 6–36 months
- Graduation criteria for PD/Hearth
- Integration with other sectors, e.g. Agriculture, WASH (water, sanitation, hygiene)

Communication skills

- Supporting new behaviours and confidence-building skills
- Counselling skills in PD/Hearth

Project management skills

- Monitoring and evaluating PD/Hearth activities
- Analysis and reporting

Flow Chart of World Vision PD/Hearth Reporting Lines

World Vision

Community Volunteers

- Selected by community
- Trained by PD/H Coordinators
- Run Hearth sessions
- Conduct follow up home visits
- Collect monitoring data

PD/Hearth Coordinators

- ADP or MOH H&N staff
- Trained by ToF or MT
- Train & supervise volunteers
- Prepare monitoring reports
- Enter data online database
- Coordinate with MOH, community leaders, zonal & provincial level WV staff

Zonal and/ or Provincial Coordinators

- Trained by ToF or MT
- Train & supervise PD/H coordinators
- Monitor projects
- Communicate with Regional & National WV and MOH entities

National Health & Nutrition Coordinator

- Trained by MT
- Train PD/H Coordinators
- Overall programme direction & monitoring
- Lead programme evaluation
- Communicate with national entities; WV Regional Nutrition Advisor
- Advocate for PD/H to MOH & MinAgri

Learning Styles and Facilitation

By the end of this session, participants will be able to

1. Describe their learning style preference
2. Explain how their teaching style can be adapted to include other learning styles.

Reference in *CORE PD/Hearth Guide*: pp. 1–14

Preparation

- Print Handout 4.1 and 4.2

Materials

- Handout 4.1: VARK questionnaire.
- Handout 4.2: VARK answer key.

STEPS

10Min

1.

HANDOUT
4.1 – 15m/H 15
4.2 – 17m18/H 17

Explain the four learning styles: **V**isual, **A**ural, **R**ead/write, **K**inesthetic (movement). Everyone has preferred ways to learn. Some people learn best using all four styles equally. They are called multi-modal learners and will be in the fifth group. Distribute the VARK questionnaire and ask each participant to complete it. Distribute the VARK answer key and allow each person to mark his or her questionnaire and total the scores in each section. Ask each to determine his or her overall learning style.

25 Min

2.

Group the participants by their preferred learning styles. There will be five groups. Ask each group to discuss these questions:

- How do you learn best? Be prepared to share with the large group two examples of how you learn best.
- How do you adapt when the teaching style does not match your preferred learning style? Be prepared to share with the large group two ways to compensate.

- How can you adapt your teaching to accommodate the different learning styles of your students? Be prepared to share one way you can do this. In the large-group discussion you will discuss with the other groups if this way of adapting would help them learn.
- Share and discuss the examples in the large group.

5 Min

3.

Good facilitation requires adapting one's preferred learning style to include methods that will help people with different learning styles to learn.

List together on a flip chart different methods that can be used. Be sure to include a wide variety of creative teaching styles *(role play, case studies, song, drama, reading, writing, games, stories, drawing, etc.).*

5 Min

4.

Summarise the discussion. Emphasise the need to be creative and to use a wide variety of methodologies in facilitation of PD/Hearth courses.

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.

VARK Learning Styles Questionnaire

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ describe the activities you will be doing in the programme.
   - ☐ start practicing the activities you will be doing in the programme.
   - ☐ show them the list of activities in the programme.
   - ☐ show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ things you can click on and do.
   - ☐ interesting design and visual effects.
   - ☐ audio channels for music, chat and discussion.
   - ☐ interesting information and articles in print.

9. You have to present your ideas to your colleagues. You would:
   - ☐ write out your speech and learn it by reading it again and again.
   - ☐ write a few key words and practise what to say again and again.
   - ☐ gather examples and stories to make it real and practical.
   - ☐ make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
    - ☐ that used a written description or table of your results.
    - ☐ that used examples of what you have done.
    - ☐ from somebody who discussed it with you.
    - ☐ that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
    - ☐ trying it.
    - ☐ the salesperson telling you about it.
    - ☐ it is the latest design and looks good.
    - ☐ reading the details about its features.

12. You are going to make something special for your family. You would:
    - ☐ make something you have made before.
    - ☐ find written instructions to make it.
    - ☐ look for ideas and plans in books and magazines.
    - ☐ talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
    - ☐ clues from the diagrams in the instructions.
    - ☐ listening to somebody explaining it and asking questions.
    - ☐ watching others do it first.
    - ☐ reading the instructions.

(http://www.vark-learn.com, used with permission)

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

1. You are learning to take photos with your new digital camera or mobile phone. You would like to have:
   - ☐ **A** a chance to ask questions and talk about the camera's features.
   - ☐ **V** examples of good and poor photos and how to improve them.
   - ☐ **R** clear written instructions with lists and bullet points.
   - ☐ **K** diagrams showing the camera and how to use it.

2. You want to plan a surprise party for a friend. You would:
   - ☐ **R** make lists of what to do and what to buy for the party.
   - ☐ **K** invite friends and just let it happen.
   - ☐ **A** talk about it on the phone or text others.
   - ☐ **V** imagine the party happening.

3. You need to give someone directions to go to a house nearby. You would:
   - ☐ **K** walk with them.
   - ☐ **R** write down the directions as a list.
   - ☐ **A** tell them the directions.
   - ☐ **V** draw a map on a piece of paper or get a map online.

4. Do you prefer a teacher who likes to use:
   - ☐ **A** class discussions, online discussion, online chat and guest speakers.
   - ☐ **K** field trips, case studies, videos, labs and hands-on practical sessions.
   - ☐ **R** a textbook and plenty of handouts.
   - ☐ **V** an overview diagram, charts, labelled diagrams and maps.

5. You have a problem with your knee. Would you prefer that the doctor:
   - ☐ **V** showed you a diagram of what was wrong.
   - ☐ **A** described to you what was wrong
   - ☐ **K** demonstrated what was wrong using a model of a knee.
   - ☐ **R** gave you an article or brochure that explained knee injuries.

6. After reading a play you need to do a project. Would you prefer to:
   - ☐ **K** act out a scene from the play.
   - ☐ **A** read a speech from the play.
   - ☐ **V** draw or sketch something that happened in the play.
   - ☐ **R** write about the play.

VARK Learning Styles Questionnaire ANSWER KEY

World Vision

Day 1 Session 2

7. You have been selected as a tutor or a leader for a nutrition programme. This is interesting for your colleagues. You would:
   - ☐ **A** describe the activities you will be doing in the programme.
   - ☐ **K** start practicing the activities you will be doing in the programme.
   - ☐ **R** show them the list of activities in the programme.
   - ☐ **V** show them the map of where it will be held and photos about it.

8. You like websites that have:
   - ☐ **K** things you can click on and do.
   - ☐ **V** interesting design and visual effects.
   - ☐ **A** audio channels for music, chat and discussion.
   - ☐ **R** interesting information and articles in print.

9. You have to present your ideas to your colleagues. You would:
   - ☐ **R** write out your speech and learn it by reading it again and again.
   - ☐ **A** write a few key words and practise what to say again and again.
   - ☐ **K** gather examples and stories to make it real and practical.
   - ☐ **V** make diagrams or get graphs to help explain your ideas.

10. You want some feedback about an event, competition or test. You would like to have feedback:
    - ☐ **R** that used a written description or table of your results.
    - ☐ **K** that used examples of what you have done.
    - ☐ **A** from somebody who discussed it with you.
    - ☐ **V** that used graphs showing what you achieved.

11. You are about to buy a new digital camera or mobile phone. Other than price, what would most influence your decision?
    - ☐ **K** trying it.
    - ☐ **A** the salesperson telling you about it.
    - ☐ **V** it is the latest design and looks good.
    - ☐ **R** reading the details about its features.

12. You are going to make something special for your family. You would:
    - ☐ **K** make something you have made before.
    - ☐ **R** find written instructions to make it.
    - ☐ **V** look for ideas and plans in books and magazines.
    - ☐ **A** talk it over with your friends.

13. Remember when you learned how to play a game. You learned best by:
    - ☐ **V** clues from the diagrams in the instructions.
    - ☐ **A** listening to somebody explaining it and asking questions.
    - ☐ **K** watching others do it first.
    - ☐ **R** reading the instructions.

Total Personal Score: Visual =____ Aural =____ Read/Write =_____ Kinaesthetic =____

Overview of Positive Deviance/Hearth

SESSION 5

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe the PD/Hearth approach in simple English
2. Explain how PD/Hearth is different from traditional nutrition education
3. List the three goals of PD/Hearth.

Reference in *CORE PD/Hearth Guide*: *pp. 1–14*

Preparation

- Prepare a flip chart with the three goals of PD/Hearth
- Print Handout 5.1

Materials

- Handout 5.1: Observation of a PD/Hearth Session
- Flip-chart paper
- Fresh foods (e.g. vegetables, eggs), plates, cooking pot, etc. for role play
- Glass half filled with water

STEPS

10 Min

1.

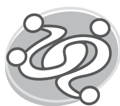
Ask participants what they know about PD/Hearth. Ask them to state the three goals of PD/Hearth. Show them the prepared flip chart.

2.

Ask how each of the three goals is accomplished through PD/Hearth.

1. ***Quickly rehabilitate malnourished children:*** *Hearth sessions feed a nutrient-dense menu for 12 days plus provide two weeks of follow up; caregivers learn and practise new skills, knowledge*
2. ***Sustain rehabilitation:*** *Follow-up visits ensure continuation of new habits learned; use of local, affordable foods; and involvement in production projects or other interventions that help address underlying causes of malnutrition*
3. ***Prevent future malnutrition:*** *A growth-monitoring programme ensures that the child continues growing well and identifies those who become malnourished; community involvement, including key influencers like grandmothers, builds understanding of causes and solutions to malnutrition and promotes adoption of new behaviours to change norms*

3.



Ask how PD/Hearth differs from more traditional nutrition-education efforts:

(Solutions come from within the community; bottom-up, not top-down programme; uses local, available and affordable resources; learning by doing; community 'owns' the problem and is involved in the solution, recognises the role of grandmothers as household advisors to child care and feeding).

The following table outlines some of the differences that you may wish to discuss.

Traditional Approach	Positive Deviance Approach
Needs-based: 'What is "wrong" here?' Based on **missing** resources	***Asset***-based: 'What is right here?' Based on **existing** resources
Assessment surveys can take up to ***six months***	Positive deviance inquiry (PDI) can take up to ***two weeks***
Depends on supply from outside	Generated by participants and community
Teaching what is ***not*** currently known	***Discovery*** of what ***is*** already known and practised by some individuals (positive deviance)
Solutions from ***outside*** the community	Solutions from ***within*** the community
Outside culture intervention; not always culturally appropriate	Culturally acceptable; based on ***indigenous knowledge***
Dependency, non-participatory; participants are **beneficiaries**	Empowering, participatory; participants are **actors** in their own development
Top down, vertical directives	***Bottom up,*** horizontal integration, variety of stakeholders
Design by ***donors, institutions and NGO***	Equal partnership, in which ***community, caregivers and NGO*** partner to manage and implement project
External inputs not sustained after programme completion; impact diminishes	***Inputs from community*** sustained; impact sustained as well
Centre-based rehabilitation of malnutrition	***Home-based*** rehabilitation and practice; community-based
Expensive, in context of duration of benefits	***Low cost,*** in context of sustained rehabilitation, malnutrition and deaths averted
Run by outside ***experts*** and programme staff	Run by ***community*** and community volunteers and caregivers themselves with training and support from programme staff
NGO or health-agency owned	***Community-owned***

Traditional Approach	Positive Deviance Approach
Teachers/nutritionist from ***outside***; health providers	***Local*** peer educators; volunteer providers
Passive recipients: caregivers of malnourished children	***Active participants:*** caregivers of malnourished children and family/community decision makers
Individual-focussed: considers caregiver isolated from cultural context and enjoys full decision-making power over his/her child	***Family-focussed:*** considers caregiver in the context of the family and cultural system and recognises grandmother's influential role as household advisors related to child care and feeding
KAP: Knowledge, Attitude, Practice Knowledge change approach	***PAK:*** Practice, Attitude, Knowledge Behavioural change approach
Short-term impact	Sustained impact

Pass around a glass that is half filled with water. Ask participants to say how they view the glass (half full or half empty). One can choose to look at a problem in terms of what is lacking or in terms of what is present.

10 Min

4.

Ask the participants to prepare a role play to illustrate a PD/Hearth session using the food and other materials provided. They must come to agreement on what to illustrate, and each participant must have a speaking role.

10 Min

5.

Participants present the role play.

15 Min

6.

Review the role play. Ask participants to name the key elements they agreed to illustrate. Why is each of these elements important? Were there other elements that might (or should) have been included in the role play?

2 – 4 Hours

7.

Alternative Approach to Steps 4–6 above

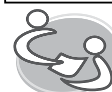
HANDOUT
5.1 – 23m/H 19

This overview session can be accomplished effectively by visiting a Hearth session that is in progress. If a community close to the training location is presently implementing PD/Hearth, plan a visit to observe a Hearth session. Distribute Handout 5.1: Observation of a PD/Hearth Session. Observe each of these elements in the visit. The grey boxes indicate elements that you will not be able to

observe. Talk to the Hearth Volunteer or the Hearth Supervisor, if possible, to decide if these elements were completed.

Upon return to the training location, discuss key elements, why they are important, and if any components were missing. Reflect on the observations. Include questions such as 'Why do you believe the PD/Hearth approach is appropriate?' or 'Do you ever feel that communities don't have local solutions?' Discuss how the PD/Hearth approach to rehabilitating malnourished children differs from more traditional approaches.

Observation of a PD/Hearth Session



Observe the strengths and challenges of PD/Hearth sessions. You will not be able to observe the essential components shaded in grey. Ask the Hearth volunteer or supervisor to determine if these elements were included.

Identify variations or innovations that have been implemented and how that may have affected results.

Essential PD/Hearth Project Components	Check for yes	Strengths	Challenges
1. Actively involve the community, including grandmothers, throughout the process (including integration with other sectors).			
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated.			
3. Conduct a PDI in every community. Incorporate findings into the Hearth (menu, message and tips, storytelling about what already works).			
4. Prior to sessions, deworm all children and provide immunisations and micronutrients.			
5. Use community volunteers to conduct sessions/follow-up home visits.			
6. Design Hearth-session menus based on locally available and affordable foods.			
7. The Hearth-session menus are nutrient-dense enough to ensure rapid recuperation.			
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth.			
9. Have caregivers present and actively involved every day of the Hearth session.			
10. Conduct the Hearth session for 10–12 days within a two-week period.			
11. Include follow-up home visits for two weeks after the session (every 1–2 days).			
12. If a child does not gain weight after two sessions, refer the child to a health centre.			
13. Limit the number of participant caregivers in each Hearth session to ten or fewer. (If working with caregiver-grandmother pairs, five pairs or fewer is preferred.)			
14. Monitor and evaluate progress.			

Essential Elements

By the end of this session, participants will be able to

1. List the 14 essential elements for PD/Hearth implementation
2. Explain the importance of and reasons these elements are essential.

Reference: *Positive Deviance/Hearth Essential Elements, A Resource Guide for Sustainably Rehabilitating Malnourished Children (Addendum),* June 2005 http://www.coregroup.org/storage/documents/Diffusion_of_Innovation/PD_Hearth_Addendum_Jun_2009.pdf

Preparation

- Review Handout 6.1 and 6.2

Materials

- Handout 6.1: Positive Deviance/Hearth Essential Elements
- Handout 6.2: PD/Hearth Essential Elements – Detailed Observations and Key Questions
- Flip-chart paper, cut or torn in half
- A paper circle for each participant (four circles should fit easily on the half sheet of flip-chart paper without overlapping)

STEPS

5 Min

1. Shrinking Paper Exercise

Divide the participants into groups of three or four, and give each group half a sheet of flip-chart paper and one circle for each team member. Each team member places his or her circle on the half sheet of flip-chart paper without overlapping another member's circle.

Then, ask them to remove their circles, fold the flip-chart paper in half, and repeat the exercise. Keep doing this until the papers grow so small that there is room for only one team member's paper circle.

Ask participants to explain how this game might relate to PD/Hearth. How do people manage when resources are few? What coping skills do some individuals or groups develop? What are the characteristics of a PD behaviour? (*PD – positive deviance – solutions are behaviours and strategies that are local, simple, cheap, easy to replicate or adopt, and sustainable because they already exist before the intervention starts.)*

5 Min

2.

Explain that certain features of the PD/Hearth approach are essential for success. Because children quickly recover, their families are motivated to continue the new behaviours. Ask participants to name any of these essential elements.

10 Min

3.

HANDOUT
6.1 – 26m/H 20

Distribute Handout 6.1 and ensure that all 14 essential elements have been named. Divide into pairs. Assign two essential elements to each pair. Each pair is to list the reasons its two elements are essential. Those who finish early can look at the other essential elements and discuss the reasoning behind them.

20 Min

4.

Each pair explains to the group its two elements and the reasons they are essential.

10 Min

5.

HANDOUT
6.2 – m30/H 24

Discuss who is responsible for assuring that PD/Hearth in each community adheres to the essential elements. *(ADP staff that supervises, community Hearth committee, or volunteers, depending on the element).* Ask for examples. Present Handout 6.2: PD/Hearth Essential Elements – Detailed Observations and Key Questions, which can be used as a tool to monitor essential elements in a Hearth project.

10 Min

6.

Based on the essential elements, have the participants respond to the following challenges:

- The ADP wants to provide the food for PD/Hearth sessions.
- Caregivers are busy, so they want to send their children but not attend the Hearth sessions themselves.
- Volunteers, caregivers, or grandmothers change the menu based on what they have at home and would like to cook.
- Children 5–7 years old are included in PD/Hearth.

PD/Hearth Essential Elements

Several elements are essential to the implementation of an effective PD/Hearth project. Experience has shown that these elements cannot be adapted, modified, or omitted without seriously diminishing the effectiveness of the programme.

1. **Actively involve the community throughout the process.** Community leaders and a village health committee can provide support in organising the weighing of all children in the target age group; recruiting volunteers; conducting the PDI; contributing materials, utensils, and food for the sessions; assuring that eligible caregivers[1] attend the Hearth session regularly; and encouraging other community members, including key influencers like grandmothers, to support the families with malnourished children as they adopt new practices. Grandmothers[2] often play a major role in child care and feeding and act as advisors in this area to younger women who seek their advice and expertise. Engaging grandmothers from the start of the PD/Hearth implementation will facilitate the community's involvement and learning as grandmothers are key influencers in addressing child malnutrition. In the different steps of the PD/Hearth process, grandmothers can participate as mobilisers, hearth committee members and/or volunteers, participants in focus group discussions on child care and feeding, those being talked to and observed during the PDI, participants in Hearth sessions with the caregivers and children, key audience members in community feedback sessions, and supporters and advisors at home for the caregivers. The community can participate in monitoring project implementation and results. The higher the visibility of Hearth in the community, the greater the nutritional impact will be. Hearth sessions provide "living proof" that good nutrition practices help malnourished children. This raises the consciousness of community members and empowers them to prevent malnutrition within their community.

2. **Use growth monitoring to identify malnourished children and monitor the nutritional status of participants who have graduated from Hearth**. If a growth-monitoring and counselling programme does not exist in the community when PD/Hearth is initiated, it should be started in time to monitor the children who complete the Hearth session. The growth-monitoring programme must include good nutrition counselling and explanations of the child's growth for the caregivers. It is also an important tool for monitoring the progress of *all* the children in the target group over time, and it allows the integration of newly malnourished children into the second or third Hearth session.

3. **Use community members and staff in each and every community to conduct a Positive Deviance Inquiry.** The PDI is not simply a fact-finding exercise for the project staff. It is an opportunity for community members (e.g. Hearth volunteers, health staff, community leaders, grandmothers) to 'discover' that very poor families have certain good practices which enable them to prevent malnutrition and that these practices can be used by any family with similarly scarce resources. In order for a community to take ownership, the discovery process must take place in *that* community. Each community or communities within 40km radius with similar cultural practices, belief, and food availability need its own PDI to discover its positive deviance (PD) practices. Many programmes have tried to save time by using the PDI results from one community in another; doing

1. The term caregiver refers to anyone who has significant responsibility for the care and feeding of a young child. This may be a parent, grandparent and/or older sibling, depending on the cultural context and family situation. In some cases two caregivers, such as a mother-grandmother pair, may attend the Hearth sessions.
2. A grandmother refers to a senior woman (related or unrelated to the child) who lives in close proximity to the child and who has influence on child care.

so means that the second community loses the process of the discovery that results from the PDI. If there are no poor families with well-nourished children in a particular community, the PDI may need to look at families with only mildly malnourished children. Alternatively, if the community can identify a nearby community with the same culture, socioeconomic conditions and, perhaps, blood relationships, the volunteers can be taken there to identify PD families with whom to conduct the PDI. Since family coping may change with the seasons, it may be necessary to repeat the PDI during different seasons of the year.

The PDI consists both of questioning the family members, including caregivers and grandmothers, and of making careful observations of the situation. The list of questions that has been developed is best used as a discussion guide rather than as interview questions. With sufficient practice the PDI team should be able to visit the families without relying on the list of questions. A second or third person from the PDI team can concentrate on observing practices related to child care, hygiene, sanitation and food preparation, noting the roles of influential family members as well as what foods and materials are available in the home. Projects need to allow sufficient time to prepare for and conduct PDI visits to obtain the most useful information.

4. **Prior to the Hearth sessions, deworm all children, update immunisations and provide needed micronutrients.** Children are more likely to show quick recuperation when these important health interventions are taken care of before the Hearth session. Families should be referred for these services to the local health facility with whom the project is collaborating. These activities are kept separate from the Hearth session so that families do not attribute the child's improvement in nutritional status to these activities rather than to the food and feeding practices. During the Hearth session and follow-up home visits families will be encouraged to continue to access these and other preventive health services including growth monitoring and the use of insecticide-treated bed nets (ITNs), where needed. In areas of high malaria prevalence, children may need diagnosis and treatment before attending the Hearth sessions. If it becomes evident during the PDI that very poor families are using ITNs, it will be useful to discuss how they afford them in order to share that information with the Hearth participants. All children may be checked for underlying illness and/or anaemia before entering Hearth to screen for treatable conditions.

5. **Utilise community men and women as volunteers to conduct the Hearth sessions and the follow-up home visits.** Caregivers will learn best from those who normally provide child care advice and support within their culture and community, and who understand local customs and conditions. The volunteers can be any community members, including grandmothers, with a good reputation, credibility, healthy children and a willingness to take on the necessary responsibilities.

   Note: *PD caregivers are not necessarily Hearth volunteers. The PDI results in a collection of PD practices from multiple PD families; it is extremely rare that one family models all the PD practices. We are not looking for PD persons but PD practices. In many cultures identifying individuals or families as models (or somehow 'better') results in social rejection by their peers.*

6. **Design optimal Hearth menus based on locally available and affordable foods.** Participating families must be able to replicate meals in their own homes with limited resources. This is the only way they will be able to sustain the improved nutritional status of their children and prevent future malnutrition in the family. The affordability of foods is verified through the PDI, which discovers the foods used by the poor families with well-nourished children, and the market survey, which explores the costs and nutritional content of foods available for purchase.

7. **Provide a special, nutrient-dense meal capable of ensuring the rapid recuperation of the child.** The daily Hearth menu includes an extra meal and snack, an addition to what the child normally eats at home in one day. This menu must contain the following nutrient levels for each child:

Calories:	600–800 kcal
Protein:	25–27 g
Vitamin A:	400–500 µg RE (retinol equivalent) or 300 µg RAE (retinol activity equivalent)
Iron:	8–10 mg (may need iron supplementation or a fortified product to meet this requirement)
Zinc:	3–5 mg
Vitamin C:	15–25 mg

These figures show the range of supplementary nutrient levels necessary to rehabilitate malnourished children. Specific levels for children of different ages are listed in the *CORE PD/Hearth Guide*. Consider the Hearth meal as 'medicine'; this is the dosage prescribed. If the Hearth supplemental meal does not meet this minimum standard, then weight gains are compromised. The meal is a supplement, not a meal substitute. The additional calories and protein are needed for 'catch-up' growth of the child. When the child is no longer underweight, this 'extra' energy and protein-rich meal is no longer necessary. However, to sustain the rehabilitation gains, regular family meals need to be more balanced and nutritious. Caregivers learn how to do this during the Hearth sessions.

8. **Ensure that caregivers bring a daily contribution of food and/or materials to the Hearth sessions.** One of the fundamentals of PD/Hearth is that families learn that they really can afford to feed their children nutritious food. The PDI revealed what poor families feed their well-nourished children. Obtaining and bringing the foods reinforces the use of these affordable foods. The community also realises it is able to rehabilitate its malnourished children without outside material support.

9. **Have caregivers present and actively involved every day of the Hearth sessions.** Involvement promotes ownership and active learning and builds self-confidence. Repetition of new skills and practices enables caregivers to learn and adopt new behaviours. Attendance and active involvement of caregivers each day of the Hearth sessions is necessary for children to achieve adequate weight gain.

10. **Conduct the Hearth session for 10–12 days within a two-week period.** Within 8–12 days of starting the Hearth sessions caregivers will see notable improvement in their children. They may need some guidance to recognise the changes in their child, such as improved appetite, increased

activity, less irritability, higher level of alertness. Recognising these changes motivates the caregivers to adopt new feeding, caring and health practices. If a child is not fed the special extra meal over sequential days, recovery will be so slow that the caregiver will not have the satisfaction and motivation to continue the programme. There may be breaks of one or two days during the Hearth sessions to allow for weekends, holidays, or market days *(e.g. 4 days + market day + 4 days + market day + 4 days)*. The family must be encouraged to prepare the special meal at home on the days off. This Hearth session may be repeated the next month as some children will not experience 'catch-up' growth within a month.

11. **Include follow-up visits at home every 2–3 days for two weeks after the Hearth session.** It takes an average of 21 days of practice for a new behaviour to become a habit. The caregivers will need continued support to implement the new practices in their own homes. During home visits the volunteers or staff can help caregivers think of solutions to any difficulties they are encountering or respond to concerns about the child's progress, and can support grandmothers in their role as household advisors to facilitate positive changes in child care and feeding. By continuing to practise these new behaviours, the improved nutritional status of the participating child will be sustained at home and malnutrition will be prevented among future children.

12. **Refer a child who doesn't gain weight after two 10–12 day sessions to a health facility to check for any underlying causes of illness such as tuberculosis, HIV/ AIDS, or other infection**. If the child does not have an illness, direct families to other social services or to income-generation projects. The average number of sessions it takes to graduate a child varies among programmes, but the number of sessions a caregiver can attend is normally limited to two; otherwise, caregivers may become dependent on Hearth and not internalise new behaviours. A sense of urgency to rehabilitate a malnourished child should be instilled and encouraged in the caregiver and family. However, some children may need more time to gain weight. (Some projects opt to have all children checked for underlying illness before entering Hearth to screen for treatable diseases.)

13. **Limit the number of participants in each Hearth session.** Having a limited number of participants provides a 'safe' environment in which rapport can be built, and it gives all caregivers an equal opportunity to participate in all activities. Experience has shown that Hearth sessions are most successful when limited to no more than ten caregivers or five caregiver-grandmother pairs.

14. **Monitor and evaluate progress.** At a minimum, projects should monitor Hearth attendance, admission and one-month weights, and the percent of children who graduate after one session or after two sessions. Depending on community goals and national protocols, graduation may be determined as 400g weight gain in one month; an upward growth trend on the growth curve during two months; moving up one level (e.g. from moderate to mild malnutrition); or achieving normal weight for age. Projects monitor the longer-term impact by measuring the weight gains of participants two months, six months and one year after graduation, and by tracking growth of younger siblings and the target age group over time. Projects may develop other indicators to monitor the quality of implementation, community support, and so forth. Many examples of such indicators are given in the *CORE PD/Hearth Guide*.

Essential PD/Hearth Elements
Detailed Observations and Key Questions

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 persons.	• How were the families to visit identified? • How was the PDI conducted? By whom? • How was information analysed? • Were PD foods/practices identified? • How were grandmothers involved? • How was the information utilised? Menus/ messages? • Was there sufficient technical skill to complete the PDI well?
4. Prior to sessions, deworm all children and provide immunisations and micronutrients. The purpose is to support rapid recuperation. Refer families to the local health centre before Hearth sessions so recuperation is not attributed to these activities. In endemic areas, malaria may need treatment before Hearth sessions.	• Was a situation analysis completed (nutritional assessment, feeding practices, expanded programme of immunisation coverage, vitamin A)? • Were all children under three years of age weighed? • Were children dewormed, immunised, vitamin A supplementation completed? • Were pre-existing underlying illnesses treated?

Essential PD/Hearth project elements	Key questions to consider
5. Use community volunteers to conduct sessions and follow-up home visits. Caregivers will be more comfortable and learn best from peers. A volunteer can be any community member, either male or female, who has a good reputation, is credible, has children in good health, and is willing to take on responsibilities.	• How were Hearth volunteers selected? • How were Hearth volunteers trained? • Were there gaps in the key competencies needed to implement the programme effectively?
6. Design Hearth session menus based on locally available and affordable foods. This is necessary to promote replication in home with limited resources in order to sustain improved nutritional status. Use foods confirmed through the PDI and verify the cost/ nutritional content through a market survey.	• Was a market survey completed? • Were PD foods identified? • Were the foods local, available and affordable?
7. Hearth session menus are nutrient dense to ensure rapid recuperation. Menu plus snack must contain required protein, calories and micronutrients to provide 'catch-up' growth The Hearth meal is 'medicine'. The extra meal is a supplement, not a meal substitute. To sustain the rehabilitation, families learn that meals need to be balanced and nutritious.	• Who decided on the menus? When? • Were menus nutrient dense (by programme standards)? • Who analysed the menus? • Were the menus followed in sessions? • Were the menu followed at home?
8. Ensure that caregivers bring a daily contribution of food or materials to Hearth. This reinforces the fact that families can afford to feed nutritious food. The contributions make implementation possible without outside material support. Families providing resources ensures that the programme is non-paternalistic	• Were PD foods identified? • Did caregivers contribute PD foods? Other foods?
9. Have caregivers present and actively involved every day of the Hearth session. This promotes ownership, active learning and confidence. Repetition of practices builds habits that sustain rehabilitation and prevent malnutrition. Daily attendance is necessary to achieve weight gain.	• Was a caregiver involved with each child? Did caregiver-grandmother pairs work together where appropriate? • Did all caregivers participate in all the activities every day of the programme?

Essential PD/Hearth Elements Detailed Observations and Key Questions

Essential PD/Hearth project elements	Key questions to consider
10. Conduct the Hearth session for 10–12 days within a two-week period. Eight to twelve days are needed to see changes in the child. Caregivers may need help to identify improvement in appetite, energy, alertness, less irritability, and so forth. Changes in the child motivate caregivers to adopt and continue the new practices. If the child is not fed an extra meal over sequential days, changes are too slow for the caregiver to notice.	• Were PD/Hearth sessions conducted for 10-12 days? • What were attendance rates? • Was time spent reflecting with caregivers about changes in child?
11. Include follow-up home visits (every 2–3 days) for two weeks after the session. Caregivers need continued support. It takes 21 days to change a behaviour into a habit. Home visits help find solutions to obstacles to adopting new practices that are being faced at home. Home visits provide opportunities to address questions families may have about the child's growth.	• What did follow-up visits include? How often did they occur? By whom? • Did volunteers have the information and skills to support families in overcoming obstacles to child feeding/growth?
12. If a child doesn't gain after two sessions, refer the child to the health centre. A child with no underlying health issues who is not gaining may need referral to other social-services or income-generation projects. A sense of urgency to rehabilitate the child is needed by caregivers, families and volunteers.	• What happened if a child became sick during the session(s)? • Under what circumstances was a child referred to the health centre?
13. Limit the number of participants in each Hearth session to ten or fewer. A limited number of participants provides a 'safe' environment where rapport can be built. Caregivers have an equal opportunity to participate in all activities.	• How many children attended the sessions? • How many caregivers or caregiver-grandmother pairs attended the sessions? • Did caregivers participate in all aspects of the sessions?
14. Monitor and evaluate progress. Record attendance, entering and one-month weight, the percent of children who graduate. Check the long-term impact by measuring weight gain at two or six months, one year, and monitor the weight of younger children.	• Were graduation criteria established? • Was monitoring information used to improve implementation? When? How? • Was there adequate technical support for managers? For volunteers? • Was supervision frequent enough? Was it adequate?

How PD/Hearth Addresses Malnutrition

By the end of this session, participants will be able to

1. Name the steps in the PD/Hearth approach
2. Explain how PD/Hearth addresses different causes of malnutrition
3. List the components of child care.

Reference in *CORE PD/Hearth Guide*: pp. 1–14

Preparation

- Adapt the story of Tomi to the community context
- Make title cards for the wall labelled IMMEDIATE, ROOT and BASIC
- Write 'Key Steps in the PD/Hearth Approach' on a flip chart or use Handout 7.1: Flip Chart 7 – Ten Key Steps in the PD/Hearth Approach

Materials

- Two table tennis balls: one round, one crushed
- UNICEF model of malnutrition (refer to *CORE PD/Hearth Guide*, pp. 11–12, or print as a handout)
- Flip chart and markers
- Handout 7.1: Flip Chart 7 – Ten Key Steps in the PD/Hearth Approach
- Sticky notes and markers for participants

STEPS

5 Min

1.

Ask participants to think of a young child who is not growing well. Ask several participants to describe the child to the group. What things tell you that the child is not well? *(listless, sad, irritable, often sleepy, may cry a lot, sickly, no interest in playing, hesitant, thin arms and legs, much older than he or she looks)*

5 Min

2.

Demonstrate the healthy growing pattern of a well-nourished child compared to a malnourished child by using two table tennis balls. One ball is perfect, and the other is crushed. Ask two participants to bounce the balls on the floor, one at a time. Other participants should observe which ball bounces higher. Discuss this. Ask two other participants to draw on a flip chart the height and pattern of the bounce of each table tennis ball. Discuss reasons why the perfect ball bounces higher. Point out that a healthy child is like the perfect table-tennis ball. The healthy child has more regular and more 'well rounded' growth and shows more energy. A malnourished child is like the crushed ball. His or her growth is not regular and s/he has very little energy.

5 Min

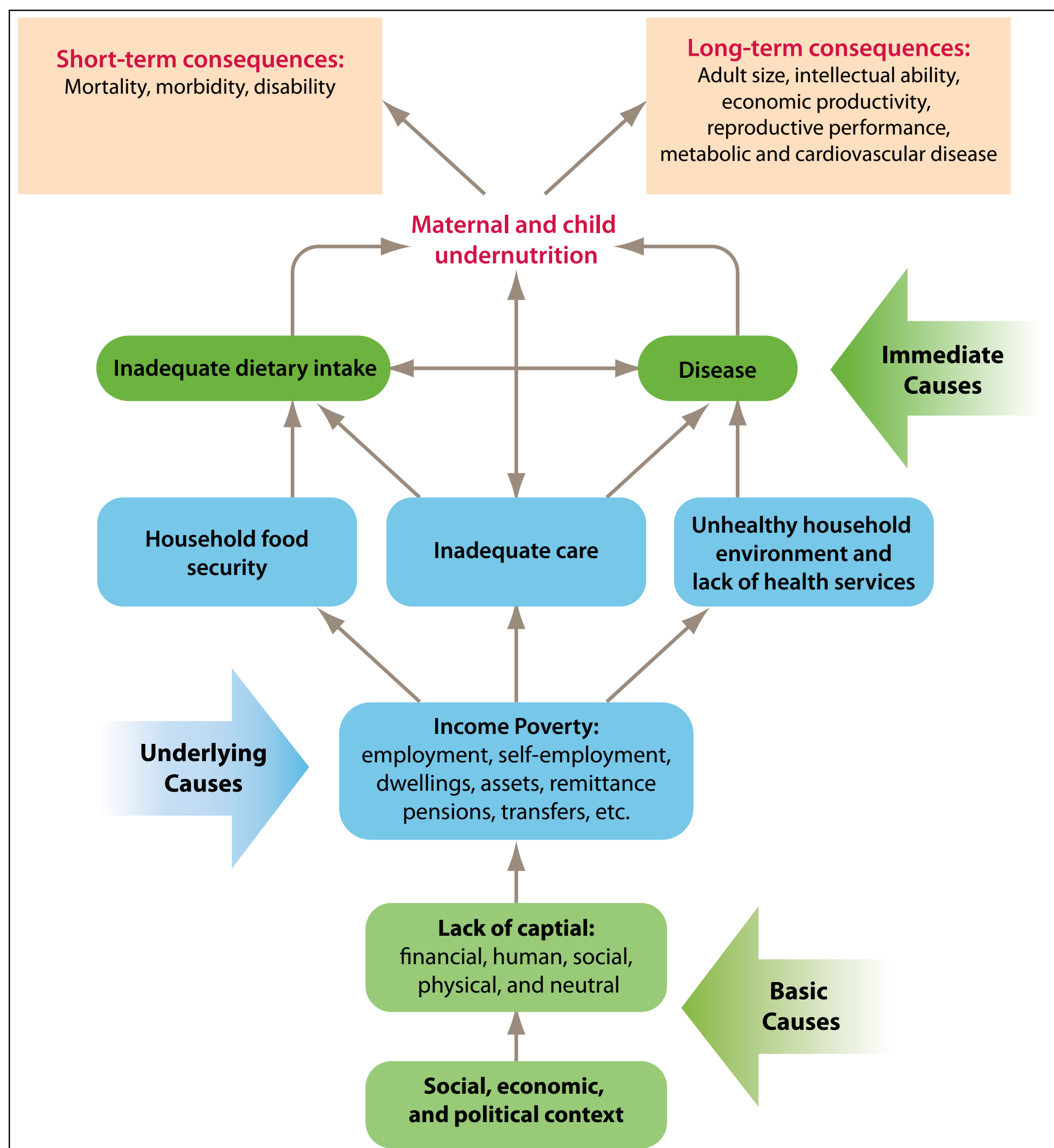
3.

Why do we care if children do not grow well? (Ensure that the following points come out: *more likely to be ill with infections such as diarrhoea, pneumonia, tuberculosis and malaria; increased risk of becoming infected with HIV; infection/illness more likely to become serious or even cause death; learn more slowly and do not achieve well at school; lack of growing, both physically and mentally, will affect them throughout their lives; over their lifetime they will not be able to do as much work and will earn much less than those who were well nourished as children; will be less able to support their own children when they become parents; girls will have difficulty with pregnancy when they are grown women or they will have small babies)*

10 Min

4.

Refer to the UNICEF model of malnutrition (Figure 1).



Tell the following story about Tomi and ask participants to think about why Tomi is not growing well. Some of the reasons will not be clear in the story, but they can think about what might be causes related to the three levels in the diagram. Adapt the story to the community culture.

> Tomi is 15 months old. He is very small and very thin. Tomi has an older brother, Mo, who is 5 years old, and a sister, Sara, who is 3. Sara was born with low birth weight. Another sister was born very small and died soon after birth. Tomi's mother, Lila, is 27 years old. She is pregnant again. She breastfed all her babies, and—as the grandmother told her to—she also gives them tea and thin porridge. Lila works hard on a farm three miles from her home for a small wage. She finds the work very tiring, especially when she is pregnant. On the way back to the house she stops at the river to get a bucket of water. Once back at her house, she is too tired to do anything but cook the family's meal. Mo takes care of all the children while Lila is in the field. He tries hard to keep them clean and happy, but often Tomi has diarrhoea and a runny nose. They usually have tea for breakfast. At midday they eat whatever might be left over from the day before, but often there is nothing. In the evening the family eats maize or cassava and some green vegetables. They cannot afford meat or even beans.

Lead a discussion using the following questions: What are some reasons Tomi is not growing well? As participants give reasons, ask them why each might be a problem. Dig deeper, asking 'And why is that? And why?' to help them think of underlying causes of malnutrition. Have them write each reason on a sticky note and post it under the appropriate label on the wall. Move this part along quickly.

Ask which of these reasons is the biggest problem. Why? Does this happen in the communities where participants have worked?

Summarise the discussion by saying that there are many reasons that children do not grow well. These can include behaviour related to food, care, hygiene and health.

5 Min

5.

In the small groups have the participants use the levels of malnutrition to discuss how PD/Hearth addresses the causes of malnutrition. *(PD/Hearth is a short-term/immediate intervention addressing immediate causes. It responds especially to the first level of the illustration: immediate causes – inadequate dietary intake and disease. At the second level – underlying causes – the impact of the PD/Hearth approach is more limited. Discuss the implications on PD/Hearth from (1) insufficient household food security; (2) insufficient health services (creates demand) and unhealthy environment; and (3) insufficient maternal care and child care. Some root causes may also need to be addressed to solve the problems leading to malnutrition. PD/Hearth does not directly work on these issues. It is important to integrate with other sectors to address some of these basic and underlying factors.)*

5 Min

6. Ask each group to explain to the whole group one level of the diagram. Ask for added input from others.

Ask participants what percentage of children under the age of 3 is malnourished in their district. How do they react to that? Choose to see the positive side of the situation. If 45 per cent of children are malnourished, with PD we look at the 55 per cent of children who are *not* malnourished to find solutions to the problem of malnutrition.

5 Min

7. Discuss 'inadequate care' and the topics related to it on the UNICEF chart. Note that the PD/Hearth approach emphasises four components of child care:

- Feeding practices
- Caring practices (affection/attention), including psycho-social and family-child interaction/stimulation)
- Hygiene practices
- Health-care practices (including preventive health practices, home management of illness and health seeking).

Others causes of malnutrition depend on the cultural and local context and may include cattle disease (Southern Sudan), low birth weight, gender bias, and limited access to water, among others.

5 Min

8. 3 Types of Malnutrition

1. Underweight (Weight-for-age less than - 2 SD from reference)

Identifies *children who are 'underweight', that is, they weigh less than a healthy, well-nourished child of the same age*. This may be because the child has not grown normally in height, weight, or both, or because he or she has lost weight. ***However, underweight children are not necessarily wasted (i.e. have lost a significant amount of weight in a short amount of time to the extent of apparent 'thinness') and their poor nutritional status may not be as visible as wasting because it is not as severe.***

Measuring the rate at which children increase in weight is a very good way to monitor individual children's growth. The advantage of underweight is that it *reflects both past and present undernutrition in a population;* the disadvantage is that it is unable to distinguish between the two. Therefore, if a population has a high rate of underweight, we do not know if the reason is a ***recent*** lack of food or illness in the population or ***long-term*** undernutrition. Underweight is also a good indicator for monitoring data. If underweight is used

to target children who need IYCF counselling, you could prevent further stunting in the population and also wasting.

2. Stunting (Height/length-for-age less than - 2 SD from reference)

Identifies *children who are 'stunted' or shorter than expected for a healthy, well-nourished child of the same age.* If children are undernourished, their growth in height slows down. Children who are undernourished for a long time are shorter than they should be. We refer to this as '*chronic' or long-term undernutrition.* ***However, the stunted children are not necessarily wasted because a child that has been undernourished for a long period of time, may not have lost significant weight in a short amount of time. Thus, the child can be stunted, but not necessarily wasted.*** Stunting may be less visible than wasting or 'thinness' especially when the whole community has been affected by long-term undernutrition. In such case, shortness in height in children may have become a new 'norm' (i.e. many children are shorter than they should be and have not achieved normal heights) and may not be readily perceived as a critical problem.

Measuring the rate at which children increase in height is not a good way to monitor individual children's growth. However stunting is useful when we want to:

- **Assess the nutritional status of a population,** for example, when we do a survey of a community. Children's heights are an indicator of chronic malnutrition in the community and tell us if that community has been undernourished in the past or continues to be undernourished. This helps us to find which areas are most undernourished.
- **Measure changes in the nutritional situation of a community.** Height-for-age measurement of the children tells us whether, over a period of time, the nutrition situation is improving or getting worse. This is useful for our programme managers and planners who have to decide how to use funds and other resources, and for people who evaluate the effects of development projects.

Therefore, stunting is most useful for assessing overall community nutrition status and measuring long-term changes. Also, stunting does not vary by seasons over the year.

3. Wasting (Weight-for-height/length less than - 2 SD from reference or 'yellow or red' MUAC)

Identifies *children who are 'wasted', that is, thinner than expected for a healthy, well-nourished child of the same height.* These children have lost a significant amount of weight in a short period of time due to poor food security and nutrition and/or illness. ***This means wasted children will also be underweight, that is, they weigh less than a healthy, well-nourished child of the same age.*** Wasting *reflects recent, short-term (acute) malnutrition or illness.* It is a sign that a child is extremely undernourished and will die within several days to several hours if not

addressed. A severely wasted (severe acute malnutrition) child must be referred to a health centre or hospital, but if the child is moderately wasted (moderate acute malnutrition) the parents can improve the child's nutrition at home and the child can recover from wasting.

Wasting is the most severe form of undernutrition out of the three nutrition indicators, including: wasting, stunting, and underweight. MUAC can also be used to enable health and nutrition workers to quickly identify a severe acutely malnourished child. It is useful for **screening or assessing nutritional status of individual children** as well as for **assessing the nutritional situation of a community in an emergency situation.** The proportion of wasted children in an area may vary by the season, due to annual periods of food insecurity or seasonal illness. Thus, wasting is appropriate for examining short-term effects such as seasonal changes in food supply or short-term nutritional stress brought on by illness. Wasting is addressed through treatment and preventive nutrition activities.

Triggers for Action for 3 Types of Malnutrition

% of children 0-59 months moderately and severely undernourished

	Acceptable	Attention Required	Critical
Underweight	< 10%	10-19%	≥ 20%
Stunting	< 20%	20-29%	≥ 30%
Wasting	< 5%	5-9%	≥ 10%

In sum, when children do not receive good nutrition (i.e. a variety of foods in adequate amount) and/or have an underlying illness, they will start to lose weight and can become underweight. If this continues for a longer period of time, children's growth in height will slow down and they will not be able to reach their normal heights. So these children will be shorter than their same-age peers, resulting in stunting. Children who lose a significant amount of weight in a short period of time may be identified as wasted. Wasting is the most severe form of undernutrition among the three indicators as severely acute malnourished (or severely wasted) children (identified by red MUAC or WHZ < -3) can die quickly if not treated soon.

5 Min

9.

HANDOUT
7.1 – 40m/H 27

Introduce the key steps to PD/Hearth using a prepared flip chart (see below). This chart will be referred to while working through each step of the programme. Each key step number is noted in the title of the relevant session in the curriculum.

10.

Summarise the session, emphasising that the PD/Hearth approach seeks sustainable behaviour change, at the individual and family level as well as at the community level, in order to achieve the three goals of PD/Hearth *(to rehabilitate malnourished children quickly, to sustain rehabilitation, and to prevent future malnutrition).*

HANDOUT 7.1

Flip Chart 7
Ten Key Steps in the PD/Hearth Approach

World Vision

Day 1 Session 7

Note to trainers: *The amount of time for each step will depend on the local context (with the exception of Steps 6 and 7). An example of the timing is included for Steps 2–7 to guide discussion with planners. Each key step number is noted in the title of the relevant session in the curriculum. Monitoring and evaluation occurs throughout the process, as illustrated by the right hand column.*

<table>
<tr><th></th><th>STEPS</th><th>APPROXIMATE TIME REQUIRED</th><th rowspan="10">Monitor

and

Evaluate</th></tr>
<tr><td>Step 1</td><td>Decide whether the PD/Hearth approach is feasible in the target community.</td><td></td></tr>
<tr><td>Step 2</td><td>Begin mobilising the community (mobilise or create Village Health/ Hearth Committee or working group within the community); select and train staff.</td><td rowspan="3">Mobilising the community can take several months and takes place throughout the entire project period.

Steps 2 to 4 can take approximately 2–3 weeks, including:

2 days of training

2 days for situational analysis

2 days for PDI

2 days for analysis and feedback to the community</td></tr>
<tr><td>Step 3</td><td>Prepare for a PDI (situational analysis).</td></tr>
<tr><td>Step 4</td><td>Conduct a PDI.</td></tr>
<tr><td>Step 5</td><td>Design Hearth sessions.</td><td>2 days</td></tr>
<tr><td>Step 6</td><td>Conduct Hearth sessions.</td><td>2 weeks</td></tr>
<tr><td>Step 7</td><td>Support new behaviours through follow-up visits.</td><td>Every 2-3 days in the 2 weeks immediately after the Hearth session, and continuing less frequently after that</td></tr>
<tr><td>Step 8</td><td>Repeat Hearth as needed.

Monitor progress of Hearth graduates and track growth of all young children.</td><td></td></tr>
<tr><td>Step 9</td><td>Expand the PD/Hearth programme to additional communities.</td><td></td></tr>
<tr><td>Step 10</td><td>Exit strategy for once underweight is eliminated or ADP phases out</td><td></td><td></td></tr>
</table>

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

SESSION 8

45 MIN | DAY 1

By the end of this session, participants will be able to

1. Describe the assessment process and essential considerations for determining if PD/Hearth is a possible approach in a target area
2. Evaluate if PD/Hearth is a good approach for a target community (case study)
3. Review alternative approaches to use when PD/Hearth is not feasible or appropriate.

Reference in *CORE PD/Hearth Guide*: pp. 17–25

Preparation

- Flip chart for step 1. Write on the top: 'Essential Considerations for PD/Hearth Programme'
- Flip chart (1 for each small group) with the questions for the exercise in step 2 written on it
- Print out Handout 8.1and 8.2

Materials

- Handout 8.1: Case Studies. Is PD/Hearth Appropriate for These Settings?
- Handout 8.2: Where to Implement PD/Hearth

STEPS

10 Min

1. Emphasise that PD/Hearth does not work everywhere. Quickly introduce the following criteria for determining when PD/Hearth is appropriate:

   a. **Malnutrition levels of approximately 30 per cent or higher (or > 30 children).** For the purposes of PD/Hearth, malnutrition is defined as low weight for age.

      How would you know the general level of malnutrition without doing your own assessment? *(Seek existing sources of information, such as an ongoing growth monitoring programme (GMP); national or local assessments; survey information – DHS data for the region, KPC baseline from a child survival programme; or even visual assessment in an acute situation.)*

      Experience shows that a rate of 30 per cent malnutrition does not apply to all situations. There may be a low overall malnutrition rate in a community, but a very high rate in one neighbourhood, for example, with 30 malnourished children under three years of age. (This situation also warrants starting a PD/Hearth programme.)

b. **Availability of affordable food.** Note that working in famine situations is difficult.

c. **Geographic proximity of homes.** It is easier for caregivers to attend Hearth and for volunteers to follow up with home visits when distances are not significant.

d. **Urban vs. Rural.** Cite some advantages and disadvantages of urban and rural programmes. Urban setting/slums require a rethinking of the Hearth approach because families often do not cook at home but resort to street vendors. The PD concept can be applied by looking at PD street vendors in addition to PD families.

e. **Community commitment.** Look for evidence of peer support, leadership, sense of community. (Note that transient populations—refugees, internally displaced persons (IDPs)—may lack a sense of community.) It may be necessary to form a village health committee (VHC) if there is no existing committee to work with.

f. **Complementary health services.** A functioning health centre, for example, can provide important inputs that are not available at the Hearth, such as deworming, immunisations, micronutrient supplementation (especially Vitamin A) and referrals.

g. **Systems for identifying and tracking malnourished children.** A growth monitoring programme (GMP) is not a precondition, but it may need to be added.

h. **Limited reliance on food aid.** Food aid can pose an issue for programme sustainability. PD/Hearth can be implemented if affordable, local foods are available and the food aid ignored. If food aid is provided for the entire community, PD/Hearth could be incorporated into the context, educating caregivers in how to use the resources received from food aid to enrich their meals. However, it is important to emphasise that in most months where food security exists, local foods could be used to overcome malnutrition.

i. **Organisational commitment of the implementing agency.** This will ensure access to financial, training and technical support as it is needed.

10 Min

2.

HANDOUT
8.1 – 44m/H 28
8.2 – 45m/H 29

Divide participants into small groups and pass out the case studies (Handout 8.1), the implementation criteria (Handout 8.2) and a flip chart with the following questions to each group. For each case the group should answer the following questions and summarise for the large-group discussion:

- Does this case meet the criteria for a PD/Hearth programme?
- What are the strengths that would help PD/Hearth succeed in this community? Advantages?

- What are the challenges of doing PD/Hearth in this community? Disadvantages?
- If PD/Hearth is not appropriate, what other approaches could address the nutrition problem?

20 Min

3.

Return to the large group. Allow each small group to discuss the case studies informally and to present its conclusions about the appropriateness of PD/Hearth. Ask for comments and discussion by the large group. Be sure to discuss alternative strategies if PD/Hearth is considered inappropriate.

Case study notes:

Coast village – level of malnutrition does not warrant the effort of PD/Hearth.

North interior – PD/Hearth is not appropriate; work is needed with the daycare, not the home.

Northeast mounds – Homes are too dispersed. Use creative approaches to promote appropriate breastfeeding and complementary feeding at clinics, markets, by radio, and so forth.

South Farming Community – PD/Hearth would be appropriate; grandmothers could be asked to run the Hearth sessions. Children will need to be screened for stunting.

Peri-urban slums – This situation has some potential for successful PD/Hearth; however, it may be more important to put together menus of street foods since women don't cook at home.

5 Min

4.

Recap the important criteria and take questions from the group on PD/Hearth Step 1 (determining the feasibility of PD/Hearth).

Case Studies:Is PD/Hearth Appropriate for These Settings?

Read and analyse the following cases. Decide whether PD/Hearth will work in each situation. If not, explain why not and think about an alternative approach. Suggest additional nutrition strategies and interventions needed from other sectors. If PD/Hearth is appropriate, but there are special challenges, please describe how to overcome them.

Case 1 – Coastal village – 12 per cent malnutrition but 35 children underweight

All the families make their living by fishing or selling fish. They live in a small village with houses very close together. The men are gone from before dawn until noon. When they return, they expect their big meal to be waiting. The women spend the afternoon cleaning fish and repairing the fishing nets. They work together on the beach and take their babies on their backs. Older children stay at the house with grandmothers or older siblings. There is plenty of fish to eat, but few fruits and vegetables most of the year. The health centre is in the next town, 15 minutes away by bus.

Case 2 – North interior – 35 per cent malnutrition

Families live in very small villages scattered through the tea estates. There are 10 to 20 families in each village. It can take between 30 minutes and one hour to walk over very hilly terrain to the main estate village. Nearly all the mothers work full time on the tea estates. The children from six months to three years spend nine hours a day in daycare with two paid employees. Food in the day care is provided by the estate. (After three years of age, children stay with grandparents during the day until they start school at age five.) The day care is located next to a good health clinic provided by the estate management. There is a joint management body made up of representatives of both workers and management.

Case 3 – Northeast – 32 per cent malnutrition

This good agricultural area produces grain, fruits and vegetables. The houses are dispersed, spread out over mounds. Grandmothers care for the small children when women go to the fields to work or the river to fish. There is a health centre in the nearest town, which is a four-hour walk for many families. When the rains come and water surrounds their mound, families cannot easily travel to other homes or villages. Some families have to move to higher ground for three or four months, which makes it difficult for them to raise poultry or livestock.

Case 4 – South farming community – 39 per cent malnutrition

Most of the children in this community are very short for their age. The families are engaged in farming, with most women at home except during harvest time. The village is very compact, and people work together on many community projects. Grandmothers decide when children should start getting water or food, often when they are one month old. There is a small Christian hospital, and government health workers bring vaccines and vitamin A.

Case 5 – Peri-urban – 20 per cent malnutrition

Families live in densely populated squatter settlements in simple houses with no sanitation. Water is fetched from central water taps some distance away. Families have easy access to health facilities. Because the houses are so small, most families do not cook at home. They buy cooked food from street vendors and snacks from the many small shops. Most women are at home during the day. Those who work leave their children in the care of older women. There are approximately 40 moderately and severely underweight children between the ages of 6-36 months.

PD/Hearth will not work everywhere. It is important to consider the following criteria when deciding if PD/Hearth is the right approach for a given community.

1. **Mild, moderate and severe malnutrition, based on weight for age, affects more than 30 per cent of children 6 to 36 months old or 30 underweight children between the ages of 6-36 months.** PD/Hearth is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include mild, moderate and severe malnutrition, but programmes concerned with cost efficiency may want to focus PD/Hearth activities on those who are moderately or severely malnourished and use less intensive methods to address the children with mild malnutrition. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely malnourished children in the 6–36 month age range.** Since it is unlikely that an implementing agency will have done a census-based nutritional assessment prior to deciding whether to implement the programme, the decision can be based on existing growth monitoring data, data from surveys of a representative sample of the population, or other existing data.

   Note: *PD/Hearth uses weight for age because that is the indicator most sensitive to change and does not require height measurements, which are difficult to collect. While mid-upper arm circumference (MUAC) is useful in screening for malnutrition in emergencies, it is not specific enough to identify all children who are also below weight for their age.*

2. ***Affordable food is available.*** A fundamental precept of PD/Hearth is that families can rehabilitate their children and prevent malnutrition with affordable, locally available food. If all poor families in the community are reliant on food aid or are eating only the staple food due to lack of anything else, other interventions to improve food security must come first.

3. ***Homes are located within a short distance of one another***. Because caregivers are expected to come with their children to the Hearth session every day and the volunteers must make frequent home visits, the homes must be within easy walking distance from a central point.

4. ***There is a community commitment to overcome malnutrition.*** A commitment will serve to mobilise resources and pave the way for organising Hearth sessions and providing peer support to participating families. If there is no governing or civic body to work with, it may be necessary to form a village health committee. PD/Hearth has not been successful where populations are transient and lack a sense of community.

5. ***There is access to basic complementary health services.*** Health services are necessary for the children to receive inputs not available at the Hearth, such as deworming, immunisations, malaria treatment, micronutrient supplementation and referrals. Children receive the needed services ***before*** entering the Hearth and may be referred for further evaluation and treatment if they do not show adequate weight gain after participating in the Hearth for two weeks with two more weeks of follow-up visits at home.

6. ***Systems for identifying and tracking malnourished children exist or can be developed.*** While such systems are not a prerequisite, they must be developed for the programme. The first step may be a door-to-door census and weighing of children, but then a routine monthly growth-monitoring system must be established not only to track the children who complete the Hearth sessions, but also to detect other children who may need to enter the programme. PD/Hearth is intended to be only one phase of a wider nutrition programme.

7. ***The presence of food aid in Hearth can be minimised with careful planning.*** Families need to learn to provide the nutrition their children need from local foods, rather than food aid, which is not a sustainable solution to malnutrition or food insecurity. Limited amounts of food aid, in the form of local staples (such as rice and oil) can be used in the Hearth menus, but the participating families must contribute the other foods in order to learn firsthand about their accessibility and affordability. The Hearth sessions emphasise using locally available foods.

8. ***Organisational commitment of the implementing agency is strong.*** This is essential. Because of the effort required to start a PD/Hearth programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PD/Hearth need to devote themselves full time to PD/Hearth, particularly in the start-up months. Projects should consider budgeting for additional staff and recruiting additional volunteers rather than expecting existing staff and volunteers to add the PD/Hearth to their existing responsibilities. Since PD/Hearth is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.

Integration and PD/Hearth

By the end of this session, participants will be able to

1. Describe how PD/Hearth can be integrated in the ADP
2. Plan how to advocate with managers for integration.

Preparation

- Ask several participants to prepare ahead of time a five-minute skit on advocating with their WV supervisors for PD/Hearth

Skit 1: Advocating with WV supervisors

The national health and nutrition coordinator (NHC) is meeting with the operational director (OD). The OD is resistant to spending the time or money to implement PD/Hearth, saying it is too expensive to train people, takes too much staff time to implement and is too technical. The NHC presents the OD with facts about the situation: 45 per cent malnutrition will mean that these children are often sick; it will take more resources to try and keep them in good health; they will not develop well mentally, and when they go to school they will not learn well; as adults they will not have the physical or mental capacity to be productive and to care for their own families. PD/Hearth helps the community be responsible for its children and to discover the knowledge and resources to keep its children healthy. Focusing on empowering families and communities to rehabilitate their malnourished children now solves a present problem and builds towards a productive future for the community.

Result: They agree to try a pilot PD/Hearth project in one community.

- Ask several participants to prepare ahead of time a five-minute skit on establishing networks for PD/Hearth with the local Ministry of Health

Skit 2: Establishing networks with the local Ministry of Health

The ADP manager and regional health advisor pay a visit to the local health officer. The health officer is constantly interrupted (the phone, someone bringing tea, someone bringing a paper to be signed) and is obviously very distracted. The ADP manager and regional health advisor tell the health officer about the high levels of malnutrition in the community and how the children are suffering (sick, don't grow), which will result in higher health costs, lower productivity and continued health costs in the future. They present the idea of PD/Hearth to address these issues *now* and ask for support from the local health officer, who agrees that these issues are important but very hard to address.

Result: They agree to meet again and discuss what they might do together.

- Make two large puzzles out of heavy paper. Use a different colour for each puzzle. Cut each puzzle apart so there is one puzzle piece for each participant plus a few extra pieces. Label each of the pieces for the participants with one sector name from the list in step 2 below (you might have to add or subtract sectors to have the right number). Leave several puzzle pieces blank.

STEPS

5 Min

1.

Discuss with the participants the following questions:

- What is an overall goal for your ADP?
- What projects does your ADP have to reach that goal?
- What special projects do you have within your ADP?
- How does each of these projects contribute to the overall goal?
- What happens when each of those projects is planned and implemented as a separate entity? (*there is less impact; the overall goal of the ADP may not be affected as greatly; there is competition among projects*)

15 Min

2.

Divide the group in half. Give each group the labelled pieces of one of the puzzles, one piece for each person. Do not give out any of the blank pieces. Possible sectors include:

Food security
Health
Economic development
Disability
DME (design, monitoring, evaluation)
Special projects
Gender
Peace and reconciliation
Education/ECCD (early child care and development)
Livelihoods

The participants work together to assemble the puzzle, but each group will find it is missing some pieces. Have each group discuss examples of how PD/Hearth can be integrated with the sectors in their puzzle. What other sectors might need to collaborate with PD/Hearth to make it more effective? (*Examples: Communications, Advocacy, Agriculture*).

Imagine the group is the ADP staff and each person is the specialist for the sector on his or her puzzle piece. Direct each group to come up with a plan for integrating the various sectors with PD/Hearth in order to achieve its ADP's overall goal. *(Examples:* ***Education****: support hand-washing behaviours from PDI – stimulate children as agent of change in their homes.* ***Economic development****: support to increase the amount of family income available to spend on food; use resources they have available; create income-generating projects.* ***Food security****: preserve food (drying, pickling, etc.).* ***Livelihoods:*** *caregivers who comply with key behaviours being monitored receive benefits (hens, seeds, etc.); for example, if a pregnant women attends all her ANC visits – or takes her iron/folate supplements, or displays other positive behaviours specified – she receives benefits from the ADP food security project)*

10 Min

3. Have the two groups share their plans.

10 Min

4. At what stages can we integrate PD/Hearth into the ADP?

- design
- redesign
- training
- selection of target families – have all sectors target the same community/ families to ensure they receive the support they need to change behaviour
- preparation of annual operating plan (AOP)
- implementation
- planning – develop joint plan of action
- completion of the PDI (the data gathered shows where we are) – meet with participants in working groups for DME (design, monitoring and evaluation), economic development, food security, health, special projects, etc.; present the findings and discuss together how each sector can address the underlying issues that affect nutrition.

20 Min

5. Have the groups present the skits on how to advocate with World Vision leadership and how to advocate with the Ministry of Health.

Discuss the following questions:

- With whom does PD/Hearth need to collaborate or network? *(local health authority, international non-governmental organisation [INGO], local NGO, local leaders, local networks [formal and informal], community-based organisations, non-government health services [mission hospitals])*
- What are the advantages of networking? *(sharing human resources, information, materials and facilitation; joint targeting – for example, if another group is doing WASH, orient the group to PD/Hearth and work in same area to increase impact; referral of cases)*
- How can you ensure learnings from the PDIs, and other key health and nutrition messages are shared with the entire community on an on-going basis?
    - Through community feedback sessions
    - Partner and involve the Ministry of Health and health facility staff during the community mobilisation and training of volunteers (even PD/Hearth TOTs is possible) to ensure key messages and unique findings from PDIs are incorporated into the existing system for sharing Health and Nutrition messages (selection of only six key messages for a 12-day PD/Hearth Session may be limiting so it would be good to scale-up the learnings from PD/Hearth)
    - Share with community during visits to the health facility, counselling sessions for caregivers, mother care groups, breastfeeding support groups, and/or regular monthly GMP sessions (if system is in place)
    - Advocate, educate and remind the community on an on-going basis through community/district radio messages
- How can you develop the commitment and support of leaders within WV?
    - Advocate – within WV with supervisors, ADP managers and Zonal/National Office leadership, as well as with community members and other entities such as the Ministry of Health.
    - Use real data – from your assessments, PDIs, and so forth to inform leaders about the extent of nutrition problems and the potential positive outcomes using resources already in the community.By the end of this session, participants will be able to

Personalise the Curriculum
Daily Summary and Evaluation

By the end of this session, participants will be able to

1. Adapt the content of this day's sessions to their own culture
2. Reflect on the concept of PD/Hearth
3. Evaluate their personal learning for the day.

Preparation

- Practise telling the 'Stone Soup' story
- Make a flip chart with the daily evaluation questions (listed below)

Materials

- Half sheet of paper for each person

STEPS

30 Min

1. Each participant will reflect on the day's sessions thus far and write in his or her curriculum ideas to improve or adapt the various methods of presenting the material so they are more appropriate for his or her culture. Ask the participants to be ready to share any good ideas they might have.

5 Min

2. Tell the 'Stone Soap' story

A kindly, old stranger was walking through the land when he came upon a village. As he entered, the villagers moved into their homes, locking doors and windows. The stranger smiled and asked, 'Why are you all so frightened? I am a simple traveller, looking for a warm place to stay for the night and a place for a meal.'

'There's not a bite to eat in the whole province,' he was told. 'We are weak, and our children are starving. Better keep moving on.'

'Oh, I have everything I need,' he said. 'In fact, I was thinking of making some stone soup to share with all of you.' He pulled an iron cauldron from his cloak, filled it with water, and built a fire under it. Then, with great ceremony, he drew an ordinary-looking stone from a silken bag and dropped it into the water.

By now, hearing the rumour of food, most of the villagers had come out of their homes or were watching from their windows. As the stranger sniffed the 'broth' and licked his lips in anticipation, hunger began to overcome their fear.

'Ah,' the stranger said to himself rather loudly, 'I do like a tasty stone soup. Of course, stone soup with cabbage – that's hard to beat.' Soon a villager

approached hesitantly, holding a small cabbage he'd retrieved from its hiding place, and added it to the pot.

'Wonderful!' cried the stranger. 'You know, I once had stone soup with cabbage and a bit of dried fish as well, and it was fit for a king.'

Another villager managed to find some dried fish . . . and so it went, through potatoes, onions, carrots, mushrooms, and so on, until there was indeed a delicious meal for everyone in the village to share.

The village elder offered the stranger a great deal of money for the 'magic' stone, but he refused to sell it and travelled on the next day. As he left, the stranger came upon a group of village children standing near the road. He gave the silken bag containing the stone to the youngest child, whispering to the group, 'It was not the stone, but the villagers who performed the magic.'

5 Min

3. Discuss with Participants

How do you think this story is like PD/Hearth? *(community works together; everybody contributes what he or she can; uses what is available in community; learn from one another; helps the growth of children)*

5 Min

4. Daily Evaluation

Distribute a half sheet of paper to each participant. Ask them to respond to the three phrases written on the flip chart.

1. Something I learned today that I will apply in our PD/Hearth programme is

   ____.

2. Something new that I learned about PD/Hearth today is

   ____.

3. Something I'm still confused about is

   ____.

Note: *The facilitators will review these evaluations at the end of each day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.*

2 Min

5.

Thank the participants for their good work. Mention any highlights of the day. Remind them of the time for the next meeting.

Review of Day 1 and Agenda for Day 2

By the end of this session, participants will be able to

1. Review Day 1 content
2. Outline what will be covered today.

Preparation

- Review questions for Day 1.

Materials

- Ball
- Prizes for winning team members

STEPS

10 Min

1.

Ask the participants to form two lines facing each other. Ask a question. Throw the ball to a person, who must then answer the question. If the answer is correct, ask another question. If it is incorrect, repeat the question. The person holding the ball throws it to a person on the other team, who must answer the question. The team that answers the most questions correctly wins.

Possible questions:

- What is one goal of PD/Hearth? (ask the question three times; people give different goals)
- What is one of the essential elements of PD/Hearth? (possibility of 14 answers)
- What is a criterion to determine if PD/Hearth is feasible?
- What is a responsibility of a Master Trainer?

5 Min

2.

Review agenda for today.

Community Mobilisation (STEP 2)

DAY 2

By the end of this session, participants will be able to

1. Describe successful community mobilisation methods for involving key stakeholders and community members
2. Identify key stakeholders.

Reference in *CORE PD/Hearth Guide*: pp. 27-–29, 43–59; see also p. 185.

Resources for Community Participation:

Lisa Howard-Grabman and G. Snetro, *How to Mobilise Communities for Health and Social Change (*Baltimore: Johns Hopkins University Center for Communication Programs, 2003).

Judiann McNulty, S. Mason, and Judi Aubel, *Participation for Empowerment (*Atlanta: CARE, 2001). Available: www.coregroup.org/imci/CoreItemDetail.asp?ID=18

Karen Schoonmaker-Freudenberger, *Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A Manual for CRS Field Workers and Partners (*Baltimore: Catholic Relief Services, 1999). Available: www.catholicrelief.org/what/overseas/rra_manual.cfm.

Preparation

- Print out Handout 12.1
- Prepare one flip chart titled 'Whom do you need to mobilise for PD/Hearth?' with a simple Venn diagram on it.
- Prepare one flip chart with the Triple A cycle (see below).
- Prepare a flip chart with the following discussion questions:
  - What is the role of the Ministry of Health?
  - What is the role of the Village Health Committee?
  - How do you get maximum buy-in and support? How do you keep this involvement?

Materials

- If possible, copies of the resources listed above for participants to examine
- A brick (or other 'base') for each group of four; these need to be identical
- 12.1 Handout: Community Mobilsation (STEP 2)

STEPS

10 Min

1. Building to the Sky Game

Divide participants into groups of four. Give each group an identical base (brick or book, for example) on which to build a tower. They will have two minutes to build a tower on the base using anything available in the room. At the end of two minutes, look at the towers. Congratulate those with the highest. Then lead a discussion on which is highest, strongest, most pleasing, and so on. After this brief discussion, remove the base of the winning tower. What happens? Ask participants how this illustrates PD/Hearth and working in the community *(base needs to be stable; base needs to be strong; use what is available; each tower is unique; without the base, the tower is unstable)*

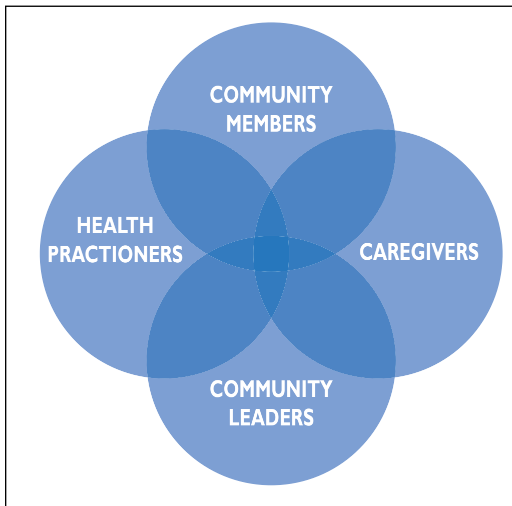
30 Min

2. Introduce PD/Hearth Step 2

Stress the importance of community mobilisation. PD/Hearth needs involvement by the community in order to succeed. This is a very important component that is often overlooked but necessary to deliver sustainable impact and prevent malnutrition in younger siblings. Master PD/Hearth Trainers should have a solid background in community mobilisation. Indicate that community mobilisation is a big topic, and many participants have a lot of experience with it. The discussions in this course will focus on the context of community mobilisation for PD/Hearth, but will also pull from the expertise of the group. Use key questions to brainstorm and guide discussion, writing group input on flip charts. (*Note:* uncover the previously written questions one at a time.)

HANDOUT
12.1 – 56m/H 31

Whom do you need to mobilise for PD/Hearth? Show the participants the diagram of overlapping circles (Venn diagram) below. Each large circle represents a group of people in the community who may need to be mobilised for PD/Hearth. Ask participants who in the community needs to be mobilised. As they call out answers write one group of people in each circle. Ask who are people within each of these groups who should be included? Add these groups to the smaller overlapping circles to show that there are many stakeholders who need to be mobilised for PD/Hearth *(community leaders; fathers, grandmothers, mothers and other caregivers; health staff, volunteers and their families [large time commitment]; traditional healers; traditional birth attendants; schoolteachers; and many others can contribute to the success of a PD/Hearth programme).*



What is the role of the Ministry of Health? *(How is it incorporated?)*

The Ministry of Health provides support services such as immunisation, deworming, vitamin A supplementation; training; monitoring; and scale-up of learnings from PD/Hearth into existing health and nutrition message sharing systems).

What is the role of the Village Health Committee? *(Does a VHC exist? Does it need to be revived?)*

The VHC manages and coordinates health activities at the local level; sets criteria for, selects and supervises community health volunteers; and collaborates with the implementing organisation and district health staff (contextual depending on the country's existing Ministry of Health structure).

Can PD/Hearth be implemented without a Village Health Committee?

In the absence of a VHC, it is important to identify management resources at the grassroots level; build on existing resources. If possible, work to re-establish a non-functioning committee or establish a VHC or Village Hearth Committee.

What is the role of grandmothers?

In many cultures grandmothers are highly influential in the home as advisors on child care and feeding, and thus are important figures to engage throughout PD/Hearth. The following activity will help to illustrate the importance grandmothers have, especially in maternal and child care, and the necessity to include them in PD/Hearth.

Ask participants to write down on small pieces of paper what areas a grandmother would have a role/influence within a family in their community. For example, a grandmother would give advice to young women about marriage and how to manage their household. Use the pieces of paper to form a tree of the multi-faceted roles of grandmothers in the family and community.

Ask participants to identify ways to involve grandmothers in PD/Hearth. Ensure the following points are included:

- Consider grandmothers for leadership roles, including VHC and Hearth volunteer positions
- Consult grandmothers during situational analysis
- Interview grandmothers during PDI and/or involve grandmothers in conducting the PDI
- Engage grandmothers as participants in Hearth, either as caregivers, volunteers or part of caregiver-grandmother pairs

- Include grandmothers in follow up home visits, including review of child's progress and discussion of challenges to implementing PD practices at home

15 Min

3.

Divide into four groups (or as many groups as circles on the Venn diagram). Each group represents one community group. Come up with as many strategies as possible for:

- Maximising commitment and support; and
- Maintaining involvement throughout the project.

After a few minutes, call on volunteers to state the ideas their groups have come up with. *Note:* Listen to the participants' knowledge. *The solutions are in the group.*

Discuss the following questions:

How do you get maximum commitment and support?

Engage the community as the primary partner, with a role in selection criteria of volunteers. Be sure to involve in the process people who might raise barriers.

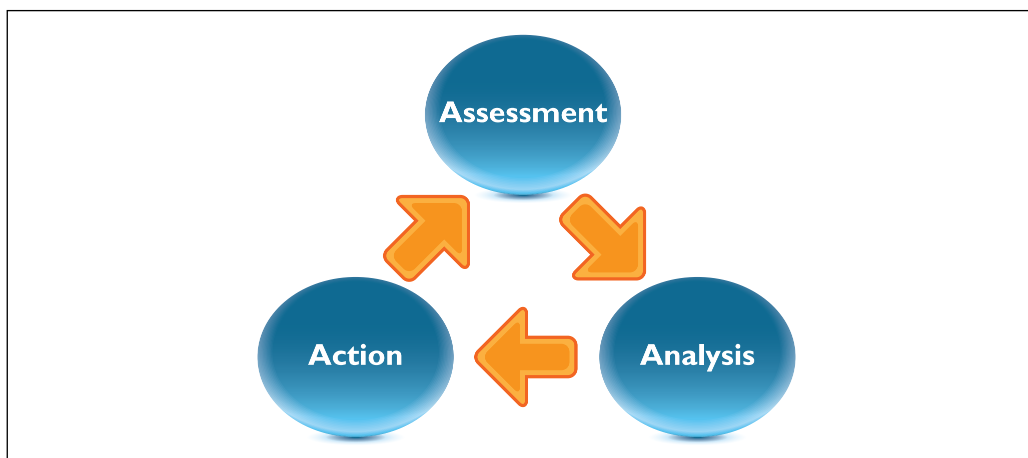
How do you keep this involvement throughout the project?

Establish a partnership with the community from the beginning and maintain it throughout.

See the **Triple A** cycle (assess, analyse, action) discussion on p. 29 of the *CORE PD/Hearth Guide*. Programme management is carried out in partnership with the community by assessing the problem, analysing its causes and taking action based on this analysis.

From the community mobilisation steps below, what activities might the community include in each circle (assessment, analysis, action)?

Discuss together key times when the community can be mobilised (based on the following steps).



STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP:

Step 1 Identify community leaders using existing community health volunteers and plan to meet with community leaders, religious leaders and women representatives.

Step 2A Ask community leaders for their permission and invitation to use the PD approach (finding existing solutions to malnutrition problems from within the community).

Step 2B Ask about the existing local health systems (e.g. Village Health and Sanitation Committee (VHSC), VHC (Village Health Commitee), etc.). Discuss a way to describe PD concepts in the local language (i.e. proverbs, stories). Discuss volunteer selection if a particular volunteer group does not already exist.

Step 3 Engage the community to define the problem (conduct wealth ranking); weigh all the children in the target group with community members, especially men (special GMP session). Involve community in focus group discussions, community mapping, seasonal calendar, transect walk, and market survey.

Step 4 Community Feedback Sessions: engage community members in discussion about the issue of childhood malnutrition; discuss its causes, common challenges and constraints, and ask for their ideas or suggestions for solutions. Involve men, grandmothers, mothers and all women who delivered the year before, include TBAs and traditional healers as well as religious leaders. Other very important activities to engage community members include: social mapping (include young men and women in this activity), seasonal calendar, market survey and wealth ranking.

Step 5 Second Community Feedback Session: Prepare and train leaders to carry out a meeting with the larger community to share the baseline information (results of the weighing) and the findings from group discussions as well as the PD concept from the visual poster to show nutritional assessment results. Also share the visuals of community created social mapping, seasonal calendar, market survey and wealth ranking. Discuss on the volunteer identification or if there are no volunteers yet, select volunteers.

Step 6 Plan and carry out PD inquiries with community members.

Step 7 Have community members (VHC) analyse and select key PD behaviours and have them share the PDI findings with the whole community, examining the PD behaviours and strategies with the community members; invite them to develop a plan of action that will include Hearth sessions.

Step 8 Involve or remain transparent to the community in selecting staff – such as a supervisor, village hearth committee members, and/or community health volunteers – to contribute to the staff's credibility and to promote the community's ownership of the programme.

Step 9 Involve the community in monitoring monthly progress in the nutritional status of all children in the target group. (In Bangladesh a consolidated community growth monitoring chart is used for all children participating in PD/Hearth so the entire community can see the effectiveness of the programme.)

Step 10 Appreciation Day/Graduation Day

Step 11 Program Monitoring and Review

4.

For the community mobilisation and ownership Step 2, conduct a role play where you are meeting with the community leaders for the first time to talk about the following:

- Ask community leaders for permission to help the community overcome malnutrition
- Explain the concept of PDH without using technical language
- Explain the program of PDH (12 day long education session)
- Emphasize that we are here to learn from the community because there are positive behaviours that are allowing their children to stay healthy whether they are practicing the behaviours knowingly or not. We are here to identify those positive practices, especially from those households who do not have a big house and many cattle, yet they still have very healthy children
- Ask if there would be any members from the community who would like to help volunteer to run the program as this program cannot be run without the community taking the leadership

5 Min

5.

Summarise some of the key challenges to community involvement and some of the solutions developed by the group. Refer participants to additional exercises for mobilising communities in the *CORE PD/Hearth Guide*, pp. 43–52. Answer any remaining questions. Note that we will be spending time throughout the remainder of the course working on each of these activities.

Note: *It is vitally important to understand fully the community players, conflicts, priorities, existing structures and resources.*

If hard copies of the resources for community participation listed above are available, suggest that participants look at these during breaks and/or list websites where participants can obtain them.

Staffing Needs
Selecting and Training Volunteers (STEP 2)

DAY 2

By the end of this session, participants will be able to

1. Describe the roles and responsibilities of staff and volunteers required for PD/Hearth, with an overview of the organisational structure.

References in *CORE PD/Hearth Guide*: pp. 20–24, 31–35, 39–42, 50–56

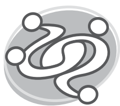
Materials

- Organisation chart (See p. 24 in the *CORE PD/Hearth Guide*)
- Flip chart with the title 'What PD/Hearth Volunteers Do'
- Flip chart with the title 'Skills Needed by Volunteers'
- Flip chart with blank paper

STEPS

5 Min

1. Reiterate that PD/Hearth is a human resource–intensive programme. Though the programme does not require large investments in infrastructure, the hard work and commitment of staff and volunteers are critical to its success.

2. 

Discuss the importance of having the commitment of WV leadership and the support of key sectors for PD/Hearth. How can the participants begin to achieve this commitment? *(use data to raise awareness of levels of malnutrition; give orientation on principles of PD/Hearth; stress importance of other sectors to address underlying causes and how this contributes to child well-being; include all sector leaders in discussions, planning and trainings)*

3. Briefly describe the roles of Hearth manager/lead trainer (e.g. National Office level Health and Nutrition Coordinator), supervisor/trainer (e.g. ADP level Health, Nutrition and HIV/AIDS Officer), village health committee (VHC), and Hearth volunteer. Review each position and its corresponding responsibilities, based on the text in the *CORE PD/Hearth Guide*. Ask what titles the participants use for the staff members who fill these positions in their ADPs. Refer to the sample job descriptions in the *CORE PD/Hearth Guide* (pp. 39–42) and ask participants to read these as homework.

5 Min

4. Discuss the total number of volunteers/staff and beneficiaries, using the chart in the *CORE PD/Hearth Guide* (p. 24) or give practical examples from your

experience of implementing PD/Hearth. Ask participants and other facilitators to suggest circumstances that might lead to adapting these suggested numbers and/ or roles.

5 Min

5.

Use the remaining time to discuss other questions, including:

- **Can the programme manager have other non-Hearth responsibilities?** *Yes.*
- **Can the trainer/supervisors have other non-Hearth responsibilities?** *While the Hearth is being actively implemented, these people will be unable to have other responsibilities.*
- **Can the volunteer health worker be a Hearth volunteer?** *Yes, but he or she must have sufficient time to devote to the full Hearth session (training, baseline assessment through preparation, PDI and Hearth). This job provides immediate satisfaction, which might motivate a Hearth volunteer for a future role in the community.*
- **Do the staff need to be full-time from the start?** *Yes.*
- **Why are community involvement and transparency in selection of staff (for example, supervisors) and volunteers important?** *Community involvement and the way staff are selected contribute to the credibility of these people in the eyes of the community.*
- **What is the role of a Health/Hearth Committee or Working Group?** *To ensure there is a clean water source; ensure GMP conducted and all children under five years attend; monitor vital community events; supervise Community Health Workers (country contextual – in some countries the Village Health/Hearth Committee or working group may support the Community Health Workers rather than supervise); and oversee Hearth sessions.*

5 Min

6.

Ask participants what PD/Hearth volunteers are expected to do. Write their answers on the flip chart under the title 'What PD/Hearth Volunteers Do'. *(manage Hearth Sessions; conduct follow-up household visits; encourage caregivers to continue practicing new behaviours; help caregivers find solutions to challenges they face)*

5 Min

7.

Ask what skills PD/Hearth Volunteers need to be able to do these tasks. Write their answers on a flip chart under the title 'Skills Needed by Volunteers'. *(train caregivers; demonstrate good practices; monitor and weigh children; follow up with home visits; record information; give messages, counsel and support)*

Based on the answers to the questions in the above steps, ask how volunteers should be selected. Probing questions could include the following (all of these may not be needed):

- Who should select the volunteers? (*community members and leaders)*
- What qualifications does a volunteer need*? (able to read and write, live in the community, committed, good behaviour, respected by the community, familiar with the area)*
- Is it possible to find someone with these qualifications in your community? (*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).*

5 Min

8.

Ask participants how volunteers will learn the necessary skills. Ask them to put an 'E' beside those skills they will learn through experience and a 'T' beside those skills they will learn through training. Emphasise that volunteers will learn primarily through doing and practise. For example, they will discover unusual and good practices that contribute to good health and nutrition by participating in the PDI, and they will learn good cooking and feeding by practising cooking the menu together.

9.

Ask the following questions:

- Who will train the volunteers? *(a trainer trained at the ADP staff level)*
- Who will train the trainer? *(National Office/technical staff)*
- Who will train the ADP staff person? *(National Office/technical staff)*
- Who will train the National Office/technical staff? *(PD/Hearth Master Trainer or recognised international trainer)*

This process is called cascade training.

5 Min

10.

Ask participants to line up in one straight line (or in a circle if the room is small). The facilitator whispers a sentence in the ear of one participant, who whispers the sentence to the next person, and so on, to the last person in the line. Each person says the sentence only once. The last person says the sentence aloud for all to hear. (Possible sentences: '_______ is the most beautiful country in the world' or 'Healthy children are active and eat well'. The sentence must be original, not a common phrase or saying.)

After the last person repeats aloud what he or she heard, the facilitator says the original sentence aloud to compare. Repeat the exercise with another sentence. Did the sentences become distorted? Participants may return to their seats at this point to consider the following questions.

- Can this kind of 'distortion' happen with cascade training?
- What can we do to ensure that volunteers learn the same information as those who will train as TOTs?
- How will the training methodology for volunteers differ from that for TOTs? Why? What examples can you share from your experiences in the ADPs?

Refer participants to the *Training of PD/Hearth Volunteers Curriculum* as well as the *CORE PD/Hearth Guide* (pp. 53–56) for examples of methods used to train volunteers. All training curricula require adaptation to local contexts.

10 Min

11.

Discuss the following questions with the group:

- What is the best way to ensure that volunteers can conduct PD/Hearth with confidence? *(ADP staff can accompany them every day for the first week or ten days to offer support and encouragement while the volunteers lead the activities.)*
- During the next rotation of PD/Hearth, how often might staff need to visit the Hearth session or accompany the volunteer during home visits? *(At least once a week.)*

Explain that supervision and supervision tools will be discussed in a later session.

SESSION 14

Situational Analysis – Wealth Ranking (STEP 3)

30 MIN DAY 2

By the end of this session, participants will be able to

1. Explain the purpose and process of wealth ranking using community criteria
2. Use pre-defined criteria to rank households by wealth status
3. Complete filling out and compiling of wealth-ranking data on Situational Analysis Excel template.

Reference in *CORE PD/Hearth Guide*: pp. 65–66

Preparation

- Print copies of Handout 14.1, 14.2 and 14.3
- Provide participants with soft copy of Situational Analysis (refer to Resource CD)

Materials

- Small objects in two different variations, such as stones of different colours
- Print copies of Handout 14.1 and 14.2 for each participant
- Handout 14.1: Case Examples for Wealth-Ranking Exercise
- Handout 14.2: Case Examples for Wealth-Ranking Exercise ANSWER KEY
- Handout 14.3: Wealth Ranking for PD/Hearth
- Soft copy of Situational Analysis Excel template.

STEPS

5 Min

1. Ask how many participants have done a wealth-ranking exercise. Explain that it is a way to identify the different socioeconomic classes within a community.

Why do we need to do this to prepare for implementing Hearth in a given community?

It is necessary to determine the poorest families in order to identify positive deviants among them. To believe that the practices of the PD families can be done by the poorest in the community, the volunteers, caregivers and others in the community must believe that the PD families are truly among the poorest.

Explain that it is important to do this exercise with community members because only they know how to define *poorest* in their community. They must agree with the final assignment of families in order to believe later that there are PD families.

The objective of the wealth-ranking exercise is to understand the way the community classifies its economic differences and to determine criteria for

classifying extended families or households. If people share food, resources and income in nuclear units, then wealth ranking is done by household. If the food, resources and other income are shared across multiple, related households, then wealth ranking must consider the extended family instead.

15 Min

2.

Divide participants into two groups, each representing a village. Included are leaders, representatives of different ethnic groups, women and men, and all socioeconomic classes. Facilitators represent the PD/Hearth staff who will lead a 'village' through a wealth-ranking exercise. Explain that we want to learn how some families with few resources keep their children healthy. Community members know which families have few resources and which are better off. We would like their help to identify the poorest families.

Choose two different versions of an object, for example, two stones of different colours. Lay the stones out on the ground with some distance between them. Explain that one stone represents the non-poor families and the second represents the poorest people. Have everyone look at the non-poor stone and reflect silently on which families in their community would go with this stone. Ask participants how they know these families are not poor. What do these families have that families in the poor category (stone) don't have? List all the characteristics. Prompt them to think about housing, farm implements, livestock, clothing, transport, occupations, amount of land owned, and so on. Does everyone agree that families in the poor category don't have these characteristics?

Now focus attention on the second stone. Remind participants that these are the poorest people. What don't they have that the non-poor families have? What income do they have? What about their houses? jobs? clothing? Do they own any livestock? What kind and how many? It may be necessary to add a third stone if the participants say there is another group which is even poorer. If so, ask for characteristics of those people.

To validate the criteria, ask the participants to think silently about the poorest family they know. Do these families meet the criteria for poorest that were just agreed upon?

10 Min

3.

HANDOUT
14.1 – 66m/H 35

The PD/Hearth team can now use these criteria to identify the wealth status of each child it has weighed and determine whether or not a family is positive deviant.

Distribute Handout 14.1 and have each participant work through the examples of identifying the wealth status of each child. Discuss the answers together.

Case Examples for Wealth-Ranking Exercise

To be classified as poor, a family must meet at least three of the following criteria:

- lives in one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- no more than one person in the family working.

Child's name and family name	Child's age in months	Wealth ranking information for family	Wealth ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent a one-room house, bamboo, dirt floor	
Dani (M) Rohimah/Nadi	12	Single mother, works periodically, rents one room, bamboo, dirt floor	
Nisrina (M) Onih/Etorasta	30	Father works on salary, rent two rooms, two families in house, cement floor	
Agus (M) Sriali/Wiarso	18	Father works part time, mother works part time, rent block house	
Lia (F) Ponira/Hendrik	6	Father is temporary taxi driver, owns bamboo house, dirt floor	
Kiki (M) Nengkiyah	31	Mother works as servant on regular salary, rent two-room house, cement floor, father has small shop	

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

HANDOUT 14.3

Wealth Ranking for PD/Hearth

World Vision

Day 2 Session 14

DATE .... ADP .... DISTRICT .... COMMUNITY NAME ....

WEALTH STATUS	WEALTH CLASSIFICATION CRITERIA
POOR	
NON–POOR	

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

SESSION 15

95 MIN | DAY 2

By the end of this session, participants will be able to

1. Explain the importance of and methods for conducting the nutrition baseline and ongoing monitoring activities
2. Describe the methods to measure child growth recommended for use within PD/Hearth activities and cite important issues for proper weighing technique
3. Use Excel-based PD/Hearth database to calculate Z-scores.

Reference in *CORE PD/Hearth Guide*: pp. 57–66, 70–83

Preparation

- Gather country and/or regional nutrition information
- Obtain growth cards (country-specific and/or others used in the region); if unavailable use the WHO growth charts, one for each participant
- Print Handout 15.1 and 15.2
- Review 'Training of PD/Hearth Volunteers Curriculum' before training - use Anthro Job Aids if necessary
- Soft copy of Excel-based PD/Hearth database (found in Resource CD)
- Refer to Handout 36.10
- Each participant will take MUAC and weight of 1 child.

Materials

- Local growth-monitoring chart or

  WHO Growth Charts for Girls: http://www.who.int/childgrowth/standards/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 15.1: Community Assessment Monitoring Sheet
- Handout 15.2: WHO Weight-for-Age Reference Table
- Handout 15.3: Initial Assessment Worksheet
- WHO Guidelines for Inpatient Treatment of Severely Malnourished Children: http://www.who.int/nutrition/publications/guide_inpatient_text.pdf
- Training of PD/Hearth Volunteers Curriculum and its job aids for taking ANTHROs
- Blank flip charts

- Soft copy of Excel-based PD/Hearth database
- Hanging scales and weighing pants
- MUAC tapes
- Pencils
- Recording chart
- a copy of the NCOE Measuring and Promoting Child Growth tool (available from nutrition@wvi.org)
- weight monitoring charts, Anthro tables, and attendance charts (these will be used in the Hearth sessions)
- A picture of a healthy child and a picture of a malnourished child
- Sheets of flip-chart paper, cut or torn in half, one for each group of three or four volunteers
- Paper cut into a circle, one for each volunteer

STEPS

1.

Refer to the steps on Handout 1.2: 'Agenda for PD/Hearth training of trainers' and explain that Step 3 consists of the (1) nutrition baseline assessment; and (2) situation analysis (e.g. FGDs, transect walk, social mapping, market survey), including wealth ranking. These will help to provide a comprehensive understanding of the current situation in the community. Each of these components will be discussed in detail.

10 Min

2. Nutrition Assessment

Ask what the three different types of malnutrition are. How are they measured? Write the words for classifying malnutrition and the abbreviations on a flip chart and be sure participants understand the definitions.

- *underweight* is measured by weight-for-age (WA)
- *stunting* is measured by height-for-age (HA)
- *wasting* is measured by weight-for-height (WH)

Show an example of a growth chart (if a local growth chart is not available, use the WHO Growth Chart as a model). Hand out one local growth card or WHO growth chart to each participant.

Methods for determining age: *Ask caregivers for child health/growth cards or certificates. If they do not have them, work with the community to establish a calendar of locally important events to help determine when each child was born.*

Why PD/Hearth uses weight-for-age: Weight-for-age is the easiest measure to take accurately and is the most sensitive to change. It is also the measurement that most Ministries of Health use, so both health workers and caregivers are familiar with it.

The goal of PD/Hearth is to quickly rehabilitate children who are malnourished according to weight-for-age measurements. Weight-for-age is used to determine which children are well nourished. We will be able to learn from those families what they do to keep their children growing well. Weight-for-age is also used to determine which children are malnourished. All children 6-59 months who are mildly, moderately or severely underweight (despite the household's wealth ranking or socioeconomic status) will enter the PD/Hearth sessions. Priority should be given to children that are poor and severely underweight. Children with oedema, kwashiorkor or other medical complications should ***not*** be included in the PD/Hearth programme, but instead be referred to a health facility or hospital.

Each participant should have a copy of a growth chart. Ask what measurement is used for these growth charts (*weight-for-age*). **Look at the growth chart from your country. How can you tell a child is growing well?** *(he or she is in the green zone)*

What do the lines on the chart indicate? *The rate of growth for a child. We want to see children following the 'normal' trend of weight gain. If they grow slower, their line will curve down or be flat. This is not good.*

During the Hearth sessions children need to achieve 'catch-up growth'. What is catch-up growth? *Catch-up growth occurs when a child who is malnourished gains weight at an accelerated rate so that he or she is 'catching-up' to the normal-rate-of-growth line for his or her age.*

Draw a large growth chart on a flip chart. Draw a line for a malnourished child's growth and then a sharp spike up in the line when the child enters the Hearth session. The aim is to achieve this fast growth in order to boost the child into being well nourished. It is also important for children to continue growing well after the Hearth sessions by having the caregiver continue the practices learned in the Hearth sessions. A child may not recover completely from malnutrition in one Hearth session, especially if he or she was moderately or severely malnourished. The child may need to repeat Hearth sessions.

5 Min

3. Nutrition Baseline Discussion

Outline the background information for the nutritional assessment used in PD/ Hearth based on the following questions:

What determines the target age group? Only include children older than six months (before that, exclusive breastfeeding is strongly promoted); the upper limit on the target age may go up to two, three or five years, depending on 'anticipated load' and budget. However, special emphasis should be placed on children 6–36 months of age because that is the period when the greatest impact can be made. Age determination can be identified using a growth chart, birth certificate or calendar of events.

Why are growth-monitoring data not sufficient? Growth-monitoring data does not capture all children, and those most likely to be missed are the poorest or those from the most at-risk families.

Where does growth monitoring fit into Hearth? Growth monitoring may help raise awareness of adequate growth and is an ongoing monitoring tool. The growth-monitoring programme serves to identify additional malnourished children over time and to support maintenance of rehabilitated children. *This very important element is often overlooked in PD/Hearth implementation.*

What about severely malnourished children and Hearth? Children who are severely malnourished with complications such as oedema, kwashiorkor or other health complications need more specialised medical treatment. These children should be referred to a health care provider. Refer to the WHO *Guidelines for Inpatient Treatment of Severely Malnourished Children* to clarify the protocol for the most severely malnourished children (not Hearth). If available, refer participants to the TALC publication *Caring for Severely Malnourished Children* (Ashworth and Burgess, 2003) ,Training of PD/Hearth Volunteers Curriculum and its job aids for taking ANTHROs or provide the website for obtaining this useful reference: www.talcuk.org/a-z_booklist.hH.

5 Min

4. Weighing Techniques

Refer to the **PD/Hearth Volunteers Curriculum** and its job aids for taking anthros or the NCOE *Measuring and Promoting Child Growth Tool* (http://www.wvi.org/nutrition/publication/measuring-and-promoting-child-growth) for specifics on proper weighing techniques. Briefly discuss types of scales and weighing issues (calibration, disrobing children, alternatives to the sling), drawing on participants' experiences.

25 Min

5. Calculating Nutritional Status of Children

HANDOUT
15.1 – 75m/H 38

Distribute a copy of the 'Community Assessment Data' handout (Handout 15.1). Assign one child (from rows 1-16) to each participant. First plot the child's weight-for-age on the growth chart that was previously distributed in step 2 above. Next, fill in the child's nutritional status by colour in the colour column on Handout 15.1. Is the child growing well? Read out the nutritional status answers for each child on Handout 15.1, as participants check their results.

If computers are available, teach participants to use Excel-based PD/Hearth database to calculate Z-scores and obtain the nutritional status of children (Refer to Resource CD). Refer to Handout 36.10: 'User Guide for the PD/Hearth Excel Database'.

25 Min

6.

HANDOUT
15.2 – 77m/H 40

Distribute Handout 15.2 (WHO Anthro Tables). Explain that another way to calculate weight-for-age is by using the WHO weight-for-age reference tables (Handout 15.2), which are more precise than the community assessment form (Handout 15.1) because they also include the 'mild' status, while the WHO Growth Charts (handed out in step 2 above) only include normal, moderate and severe. Have the participants find the Z-score for the child they are assigned.

Compare the Z-score value to the colour in the 'Community Assessment Monitoring Sheet'. Are they the same? Which is easiest for caregivers to understand? Which would be used to monitor the programme?

25 Min

7.

Divide into pairs and practise counselling the caregiver about the growth of the child. Remember to be encouraging, to explain how the child is growing, to ask what the child has been like at home. Agree on one thing the caregiver could do at home to help the child's growth. Make sure each person has a chance to practise each role. Ask one or two pairs to role play their scenario for the whole group. Discuss the role plays together.

8.

HANDOUT
15.3 – 81m/H 44

Distribute Handout 15.3 and go through the indicators. Explain that this will be the handout we use when we go out to the field to collect the Nutrition Assessment Data of the community. **Point out that the community wealth ranking exercise must be completed before weighing of children begins so that the wealth ranking of the households could be completed while weighing the children.**

The last two columns of Handout 15.3 ("Classification of PD, NPD, and Non-PD" and "Nutritional Status") should be filled out back in the training room, after all the data is collected and not during the field work to save time.

Community Assessment Monitoring Sheet

Community: Sunshine – ADP Light and Hope | **Date of Weighing:** March 11, 2011

Total number of children under 36 months in community:
Total number of children under 36 months weighed:

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
1	M	6/3/2009	24	10.70	1	Non-Poor			
2	F	28/3/2010	11	6.8	4	Poor			
3	F	30/7/2009	19	7.1	6	Poor			
4	M	14/4/2008	35	10.1	1	Non-Poor			
5	F	3/8/2010	7	7.3	3	Poor			
6	M	3/10/2009	17	8.5	7 (twin)	Poor			
7	F	3/10/2009	17	10.7	7 (twin)	Poor			
8	M	20/5/2008	34	9.8	8	Poor			
9	F	21/111/2009	16	8.2	1	Poor			
10	F	8/2/2008	37	11.4	8	Non-Poor			
11	F	6/5/2010	10	8.6	3	Poor			
12	M	25/3/2010	12	7.4	6	Non-Poor			
13	F	25/9/2009	17	8.1	3	Poor			
14	F	25/9/2009	17	6.1	7	Poor			
15	F	23/7/2009	20	8.3	2	Poor			
16	M	9/12/2009	15	8.5	9	Poor			
17	F	28/8/2009	18	6.2	1	Poor		-4.20	
18	M	18/7/2009	20	8.4	1	Poor		-2.64	
19	M	15/5/2010	10	6.3	4	Poor		-3.33	

Community Assessment Monitoring Sheet

Child Name	Gender (F/M)	DOB (DD/MM/YY)	Age (months)	Weight (kg)	Child birth order	Wealth Ranking	Nutrition Status (Colour)	WAZ	Positive Deviant (✓)
20	M	15/5/2010	10	8.3	3	Non-Poor		-0.87	
21	F	3/3/2009	24	11.5	5	Poor		-0.02	
22	F	22/10/2008	29	8.9	2	Poor		-2.80	
23	F	6/6/2009	21	9.4	4	Poor		-1.21	
24	F	3/2/2008	37	10.8	3	Poor		-2.13	
25	M	9/9/2009	18	8.1	5	Non-Poor		-2.69	
26	M	3/6/2009	21	10.1	1	Poor		-1.22	
27	M	22/9/2009	18	9.5	4	Poor		-1.20	
28	F	24/9/2010	6	9.5	3	Non-Poor		2.35	
29	M	17/3/2010	12	8.2	5	Poor		-1.44	
30	M	6/6/2010	9	8.7	3	Non-Poor		-0.25	
31	F	4/4/2009	23	11.2	2	Non-Poor		-0.08	
32	M	28/1/2010	13	10.6	10	Poor		0.57	
33	M	7/12/2008	27	9	1	Non-Poor		-3.02	
34	F	4/12/2008	27	11.0	6	Poor		-0.80	
35	M	8/9/2009	18	10.0	8	Poor		-0.81	
36	F	30/11/2008	27	9.2	6	Poor		-2.34	
37	F	16/12/2008	27	9.4	4	Non-Poor		-2.07	
38	M	10/11/2010	4	10.2	7	Poor		3.47	
39	F	21/11/2009	16	9.8	4	Poor		0.06	
40	M	10/3/2010	12	7.0	4	Non-Poor		-2.91	
41	F	12/9/2008	30	8.4	3	Poor		-3.44	

WHO Weight-for-Age Reference Table

World Vision

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

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'mild' status)

BOYS						GIRLS					
Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.9
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	9.0
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.1
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.3
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.4
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.5
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.6
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.7
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.8
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.9
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	10.1
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)*									
BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	0	2.9	2.5	2.1	F	0	2.8	2.4	2.0
M	1	3.9	3.4	2.9	F	1	3.6	3.2	2.7
M	2	4.9	4.3	3.8	F	2	4.5	3.9	3.4
M	3	5.7	5.0	4.4	F	3	5.2	4.5	4.0
M	4	6.2	5.6	4.9	F	4	5.7	5.0	4.4
M	5	6.7	6.0	5.3	F	5	6.1	5.4	4.8
M	6	7.1	6.4	5.7	F	6	6.5	5.7	5.1
M	7	7.4	6.7	5.9	F	7	6.8	6.0	5.3
M	8	7.7	6.9	6.2	F	8	7.0	6.3	5.6
M	9	8.0	7.1	6.4	F	9	7.3	6.5	5.8
M	10	8.2	7.4	6.6	F	10	7.5	6.7	5.9
M	11	8.4	7.6	6.8	F	11	7.7	6.9	6.1
M	12	8.6	7.7	6.9	F	12	7.9	7.0	6.3
M	13	8.8	7.9	7.1	F	13	8.1	7.2	6.4
M	14	9.0	8.1	7.2	F	14	8.3	7.4	6.6
M	15	9.2	8.3	7.4	F	15	8.5	7.6	6.7
M	16	9.4	8.4	7.5	F	16	8.7	7.7	6.9
M	17	9.6	8.6	7.7	F	17	8.9	7.9	7.0
M	18	9.8	8.8	7.8	F	18	9.1	8.1	7.2
M	19	10.0	8.9	8.0	F	19	9.2	8.2	7.3
M	20	10.1	9.1	8.1	F	20	9.4	8.4	7.5
M	21	10.3	9.2	8.2	F	21	9.6	8.6	7.6
M	22	10.5	9.4	8.4	F	22	9.8	8.7	7.8
M	23	10.7	9.5	8.5	F	23	10.0	8.9	7.9
M	24	10.8	9.7	8.6	F	24	10.2	9.0	8.1
M	25	11.0	9.8	8.8	F	25	10.3	9.2	8.2
M	26	11.2	10.0	8.9	F	26	10.5	9.4	8.4
M	27	11.3	10.1	9.0	F	27	10.7	9.5	8.5
M	28	11.5	10.2	9.1	F	28	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without 'mild' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

World Vision

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'mild' status)

BOYS					GIRLS				
Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Moderate)	Red (Severe)
M	29	11.7	10.4	9.2	F	29	11.1	9.8	8.8
M	30	11.8	10.5	9.4	F	30	11.2	10.0	8.9
M	31	12.0	10.7	9.5	F	31	11.4	10.1	9.0
M	32	12.1	10.8	9.6	F	32	11.6	10.3	9.1
M	33	12.3	10.9	9.7	F	33	11.7	10.4	9.3
M	34	12.4	11.0	9.8	F	34	11.9	10.5	9.4
M	35	12.6	11.2	9.9	F	35	12.0	10.7	9.5
M	36	12.7	11.3	10.0	F	36	12.2	10.8	9.6
M	37	12.9	11.4	10.1	F	37	12.4	10.9	9.7
M	38	13.0	11.5	10.2	F	38	12.5	11.1	9.8
M	39	13.1	11.6	10.3	F	39	12.7	11.2	9.9
M	40	13.3	11.8	10.4	F	40	12.8	11.3	10.1
M	41	13.4	11.9	10.5	F	41	13.0	11.5	10.2
M	42	13.6	12.0	10.6	F	42	13.1	11.6	10.3
M	43	13.7	12.1	10.7	F	43	13.3	11.7	10.4
M	44	13.8	12.2	10.8	F	44	13.4	11.8	10.5
M	45	14.0	12.4	10.9	F	45	13.6	12.0	10.6
M	46	14.1	12.5	11.0	F	46	13.7	12.1	10.7
M	47	14.3	12.6	11.1	F	47	13.9	12.2	10.8
M	48	14.4	12.7	11.2	F	48	14.0	12.3	10.9
M	49	14.5	12.8	11.3	F	49	14.2	12.4	11.0
M	50	14.7	12.9	11.4	F	50	14.3	12.6	11.1
M	51	14.8	13.1	11.5	F	51	14.5	12.7	11.2
M	52	15.0	13.2	11.6	F	52	14.6	12.8	11.3
M	53	15.1	13.3	11.7	F	53	14.8	12.9	11.4
M	54	15.2	13.4	11.8	F	54	14.9	13.0	11.5
M	55	15.4	13.5	11.9	F	55	15.1	13.2	11.6
M	56	15.5	13.6	12.0	F	56	15.2	13.3	11.7
M	57	15.6	13.7	12.1	F	57	15.3	13.4	11.8
M	58	15.8	13.8	12.2	F	58	15.5	13.5	11.9
M	59	15.9	14.0	12.3	F	59	15.6	13.6	12.0
M	60	16.0	14.1	12.4	F	60	15.8	13.7	12.1

Initial Assessment Worksheet

DATE .... ADP .... DISTRICT .... COMMUNITY NAME ....

No.	Date of Survey	Child's Name	Sex (M/F)	Caregiver's Name	DOB (dd/mm/yyyy)	Age (Months)	Birth Order	Odema (Y or N)	Weight (kg)	Nutritional Status (Indicate Colour)	MUAC (<115mm) (Green, Yellow, Red)	Wealth Rank (Poor, Non-Poor)	Classification (PD, ND, NPD)	PDI HHs
1														
2														
3														
4														
5														
6														
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)

DAY 2

By the end of this session, participants will be able to

1. Describe a situational analysis, identify potential sources of information, and know how to collect information through FGDs, transect walks, community mapping, and market surveys
2. Identify the standards for and challenges of conducting a wealth-ranking exercise.

Reference in *CORE PD/Hearth Guide*: pp. 62–75

Preparation

- Prepare a flip chart with a matrix to record FGD on feeding practices
- Print Handout 16.1 16.2A, 16.2B and 16.3.
- Soft copy of Situational Analysis Excel template (refer to Resource CD)

Materials

- Handout 16.1: Model Matrix for Focus Group/Guided Discussion on Feeding Practices for Children under Three Years
- Handout 16.2A: Market Survey for PD/Hearth Cost Variance
- Handout 16.2B: Market Survey for PD/Hearth Quantity Variance
- Handout 16.3: Seasonal Calendar for PD/Hearth
- Blank flip charts and coloured markers
- 60 stones or leaves or other common material to use as markers
- Soft copy of Situational Analysis Excel template

STEPS

10 Min

1.

The situation analysis activities are generally used to understand the context of the community such as existing resources, the functionality of resources, the seasonality foods available, existing common diseases and sicknesses, the common practices within the households, food taboos, and other myths associated with child feeding and caring practices, etc. It is important to involve the community through this process of discovery to mobilize the community and to create community ownership for the program and it is an effective tool to help the community discover the resources that already exist so that they are empowered and motivated to overcome the problem of malnutrition as a community.

Wealth Ranking/Nutritional Assessment

Wealth ranking and initial nutritional assessment are used to identify the PD, non-PD, and ND households, it is important to identify these households in order to conduct PDIs. During the PDI, it is strongly recommended to visit 4 PD households, 2 ND households and 2-4 non-PD households.

Focus Group Discussions

Focus group discussions help implementers understand the existing practices and beliefs of caregivers, fathers, and elderly women around child feeding, caring, hygiene, and health seeking practices. The information given during the focus group discussion may not be 100% true and many times correct answers are given and not necessarily the true behaviors that are being practiced. For example, mothers may say they exclusive breastfeed their children up to 6 months, but in reality when you conduct household interviews during the PDIs or transect walks, majority of women may still feed water, porridge, and other foods starting at 3 months of age. Thus, it is important to grasp what statements are questionable and verify those facts during the PDIs and household interviews on the transect walks. Three separate FGDs are recommended with mothers' group, fathers' group, and elderly women's group. There should be approximately 7-10 participants in each group. It is advisable to include 2-3 mothers with children from each target age group: 0-6 months, 6-12 months, 12-24 months, and 24 -59 months.

Community/Social Mapping

Community/social mapping is used to mobilize the community and create community ownership of the program, as is wealth ranking. Community/social mapping is also used to help the community identify the existing resources within their surroundings such as the water sources, major roads where the market, farms, schools, and health centres are. It also helps the PD/Hearth implementers to understand the environment and the community existing resources and needs. The community map can be used to guide the Transect Walk.

Transect Walks

The transect walks are used to verify the information in the community mapping and also to get additional information about the existing resources. For example, if the community map shows 3 bore holes, the transect walk would help verify whether 3 bore holes are functioning well or if 2 are functioning and 1 requires repair. Thus the transect walk helps implementers to understand the current contexts of the community. It is also useful to visit 1 or 2 households on the transect walk and to get a glimpse of what the 'norm' is in the community such as seeing what the community grows in the gardens, whether it is common for fathers to work in the city, mothers to work in the garden, and mother-in-laws to primarily take care of children at home, etc.

Seasonal Calendar

The seasonal calendar is also useful for mobilizing the community and creating ownership of the program by involving the community in the program design. The seasonal calendar helps implementers understand what types of foods are available during various seasons and what sicknesses and diseases are common in certain seasons. By understanding what foods are available during certain seasons this information can be taken into account when conducting market survey and in the menu design. The sickness and disease information could be used to ask questions during the PDI especially to the PD households and how they seek health care services or how they treat children for these sicknesses or illnesses at home.

Market Survey

The market survey is used to identify the approximate cost and variability in cost or quantity of certain foods during different seasons. This information can be used to design a low cost and affordable Hearth menu. It can also help in the menu design so foods that are easily accessible and available included in the Hearth meal. The market survey is recommended to be conducted during different seasons. For example, if there is a rainy season and a dry season, a market survey should be conducted once during the rainy season and once during the dry season. The nutrient-dense, low cost foods available during the dry season could be used for Hearth menu A and the nutrient dense, low cost foods available during the rainy season could be used for Hearth menu B.

2.

Use the following questions to generate a discussion of situational analysis:

What kinds of information do we need in order to know what is normal in the community?

Programmers need general information on health, including immunisation coverage; incidence and case management of major childhood illnesses; micronutrient situation/supplementation; care-seeking; levels and causes of under-five mortality; current beliefs and behaviours.

Who are sources for this information?

In addition to volunteers and health staff, consult grandmothers, mothers and other caregivers, community leaders, fathers, grandfathers, vendors. Volunteers and health staff may have misinformation or lack information. They may be of slightly higher socioeconomic status than caregivers, so be cautious about 'information' that may be based on stereotypes. *Community members themselves have the best information about the local situation.*

How can we gather information?

Look for quantitative information, e.g. health-system documents, KPC and other surveys, as well as qualitative information such as interviews with key informants, group discussions, and PLA/PRA. (Participatory Learning for Action and Participatory Rapid Appraisal – PLA/PRA – are the two names commonly applied to participatory assessment methodology.) See *CORE PD/Hearth Guide* (p. 62) and the specific list of methodologies (p. 64).

How can we and the community learn the common feeding and health practices of families with malnourished children?

We can either conduct household interviews and observations using the same tools we will use for the PDI, or we can conduct guided group discussions with many poor non-PD caregivers and/or families to learn what are the existing practices, what are the existing beliefs (e.g. food taboos). Such discussions allow us to get a sense of the 'norm' within the community. This will later help to identify the PD practices.

10 Min

3. Focus Group Discussions

Gather the participants in a group. C*hoose one person to act as your recorder.* Explain that the remainder of the participants are 'community members', 'caregivers' and 'grandmothers'. Role play a **Focus Group Discussion** (FGD), using the following questions to guide the discussion to learn what are the existing practices, what are the existing beliefs (e.g. food taboos). Such discussions aloow us to get a sense of the 'norm' within the community. This will help later to identify the PD practices.

My name is ________. I am so glad you all came today to talk with us. We would like you to help us understand how families in this village feed their children. We would like to discuss this together. Everyone is welcome to say something. We'll go around the group so each of you can tell me your name and how many children you have. Would you mind if ___________ takes some notes?

Point to a newborn child. What do people in this community feed newborn children? How often? How much? What else?

Point to a child that is 0–5 months of age. What do people in this community feed a baby of this age? How often? What else do they eat? Who feeds them?

Point to a child 6–8 months of age. What do people in this community feed a baby of this age? How often? What else do they eat? Who feeds them?

Point to a child 9–11 months of age. What do people feed a child this age? How much? Show me the amount with a fist or pile of rocks. How often?

Do the same for a child 12–24 months and then a child older than 24 months.

Are there any foods that you don't give children?

What do you feed a sick child?

Use probing questions to encourage group members to give more details. The goal is a flow of information that will allow us to capture the 'norm' within the community in feeding practices so we can easily identify PD practices during the PDIs. Conclude by thanking the participants for taking part. Point out that they have helped us understand how they feed children in this village.

***Note:** In this practice FGD it will not be possible to discuss all the questions. The purpose is to give the participants an idea of how to ask questions and then probe further.*

10 Min

4. Discuss the Role Play

FGDs are not simply question-and-answer sessions. The facilitator needs to present a set of carefully chosen key issues. Remember to:

- Introduce yourself and have the participants introduce themselves.
- Create a comfortable atmosphere with a joke or casual talk.
- State the topic of the conversation or use a visual aid to begin the conversation.
- Request permission to use a cassette recorder or to take notes during the discussion.
- Do not ask simple 'yes/no' question, but ask open-ended questions instead.

The facilitator can use pictures, storytelling and other techniques in addition to asking questions to promote a lively discussion. The goal is for the group to discuss the issues rather than simply answering questions. Encourage all the participants to voice their ideas and opinions.

HANDOUT
16.1 – 91m/H 45

Review the questions used to guide the discussion. (List them on a flip chart.)

The recorder might use a chart like the one in Handout 16.1 to list the points made in the discussion.

Discuss the following questions with the group:

- What other information might you discover through a focus-group discussion? *(common childhood illnesses, levels of malnutrition, immunisation, health services available, attendance at GMP)*
- With whom might you have a FGD to discover that information? *(health practitioners, traditional birth attendants, caregivers, leaders, VHC)*

5 Min

5. Transect Walk

Ask if anyone has done a transect walk. Ask one person to describe how it is done. (If no one has done this, explain it yourself.) What is the purpose of a transect walk? *(to work with some community members to orient us to the community; to observe what resources are in the community , to understand what some of the challenges might be, to note especially those factors that might affect nutrition and health of children for good or bad)*

It is also good to conduct 1 household visit while on the transect walk to observe what is being planted in the gardens' of the households and to observe general hygiene and child caring practices. Please refer to the table below for positive feeding, caring, hygiene and health seeking practices.

Review the main reasons a child might not be growing well, as discussed on Day 1. Ask participants to name the ones they can remember.

(not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, unclean water, worms, no shoes, grandmother tries to help but doesn't always give good advice on practices)

Show the pictures of the two children. Which child looks healthy? unhealthy?

Post the picture of the healthy child on the wall.

Ask what feeding/food, caring, hygiene and health practices would have helped this child be healthy. Probe to help participants come up with as many positive behaviours as possible.

Feeding/Food	Caring	Hygiene	Health
Continued, frequent breastfeeding of infants up to 24 months	Positive interaction between child and others	Use of latrine and latrine cover	Complete immunisations (preventive)
Introduce other foods at six months	Supervision at all times	Hand washing with soap or ash after toilet, before eating, before food preparation	Mosquito nets used in malaria endemic areas
Feed 3–5 times / day	Father providing attention / affection	Safe water (boiled, covered)	Regular deworming , wearing of shoes
Variety in food; giving snacks between meals	Grandmother supports caregiver with good advice and practical care	Use of drying rack	Home treatment of sick child for minor illnesses
Active feeding	Father provides money to buy good foods for children	Keeping kitchen clean	Use of oral rehydration solution during diarrhoea
Continued breastfeeding along with appropriate liquids and foods during and after diarrhoea		Using windows and doors to air out the rooms during the day	Child is promptly taken to the health post for illnesses not responding to home treatment

20 Min

6. Community Mapping

Ask if anyone has done community mapping. If so, ask one person to describe the process. What information can be depicted on a community map?

Break into four groups. Each member of the group is from the same imaginary village. Work with them to develop a community map. Mark main landmarks, water points, fields, houses. Show which parts of the community have malnourished children. Remember to develop a key.

Discuss how these maps might be used for PD/Hearth. *Mark where malnourished children live; locate where PD families live; locate where volunteers live; select children for Hearth sessions by how close they live to the volunteer; change the colour of the house when the child becomes well nourished, and so on.*

Ensure the following landmarks and resources are mapped:

- water sources (such as ponds, rivers, lakes, swamps, boreholes/boleholes, wells, and springs)
- gardens or farms
- school
- health centres
- latrines
- markets and shops
- church or other religious buildings
- mountains or other geological barriers
- houses of children under 59 months of age
- houses of volunteers
- roads (major roads and smaller paths)

30 Min

7. Seasonal Calendar

HANDOUT
16.3 – 94m/H 48

Demonstrate how to make a seasonal calendar to show what foods are available to families throughout the year. Ask the participants if they know the food groups (for example, cereals, proteins, fruits, vegetables, fats). For each food group list the foods that the community grows. Do one food group at a time. Mark a grid of 12 months on the ground. Down the left side pile a sample of each of these foods (cereals: maize, sorghum, millet). Give the group a pile of 60 stones. Ask the group to distribute the stones to show the proportion of households with access to the different food items during the year. For example, if no families have a crop in certain months, there are no stones in those squares; if a food is available to families at all times of year in the same quantity, then each month would have an equal number of stones. Do this for all cereal crops and then for each of the other food groups. Create the seasonal calendar with the food groups the country uses. Make sure the results are recorded on a piece of paper after drawing on the ground.

Distribute Handout 16.3 and advise to use it to record the results. Write out the food items commonly used in the country and the common diseases that exist. Indicate with an ‘x’ as to when they are in high season for the various months.

5 Min

8. Market Survey

HANDOUT
16.2A – 92m/H 46
16.2B – 93m/H 47

A market survey provides information on the availability and price of foods in the community. It is carried out by visiting the market where the community buys its food and recording information in Handouts 16.2A and 16.2B.

5 Min

9.

Discuss together the expected outcomes for situational analysis:

- Community involvement and commitment
- All activities done with community members
- Learn the common illnesses, health services and practices
- Learn the normal feeding practices and be able to highlight existing good/best practices
- Learn what harmful practices affect child health and nutrition
- Learn about the community's understanding of causes of malnutrition in its children
- Learn about food availability and affordability.

Tell participants that the next step in community mobilisation is to feed back all this information to the community. This will be discussed later in the course.

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

DATE .... ADP .... DISTRICT .... COMMUNITY NAME ....

Child's Age	**Foods given,** including breastmilk and other liquids (name or pictures)	**Amounts** (bowl, cup, can, fist, spoonful)	**Frequency** (daily, weekly, rarely)	**Food taboos** (forbidden foods)	**Comments** Why?
Newborn					
0–5 months					
6–8 months					
9–11 months					
12–23 months					
≥24 months					
When child is sick					
When recovering					

HANDOUT 16.2A

Market Survey for PD/Hearth (Cost Variance)

World Vision

Day 2 Session 16

DATE .... ADP .... DISTRICT .... COMMUNITY NAME ....

FOOD	RAW						
	Units of Smallest Quantity Purchased	High Season (Months)	Cost during High Season ( )	Cost per 100 gram*	Low Seasons (Months)	Cost during Low Seasons ( )	Cost per 100 gram*

* NOTE: Do not fill out these columns while out in the field/market. Calculate and fill out these columns when you are back at the office or training site

Market Survey for PD/Hearth (Quantity Variance)

World Vision

HANDOUT 16.2B

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

HANDOUT 16.3

Seasonal Calendar for PD/Hearth

World Vision

Day 2 Session 16

DATE .... ADP .... DISTRICT .... COMMUNITY NAME ....

Items (e.g. foods available, diseases, etc.)	MONTHS											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Identifying Positive Deviants (STEP 4)

SESSION 17

30 MIN | DAY 2

By the end of this session, participants will be able to

1. Explain the criteria and process for selecting PD families
2. Practise selecting PD families utilising nutrition-baseline and wealth-ranking-exercise data.

Reference in *CORE PD/Hearth Guide:* p. 68

Preparation

- If using data from a local village, be sure it is correct and that there are positive deviants.
- Write the definition of positive deviants on flip chart (see definition below).
- Make several large copies of the optical illusion pictures below.
- Print Handout 15.1

Materials

- Flip chart with definition of positive deviants:

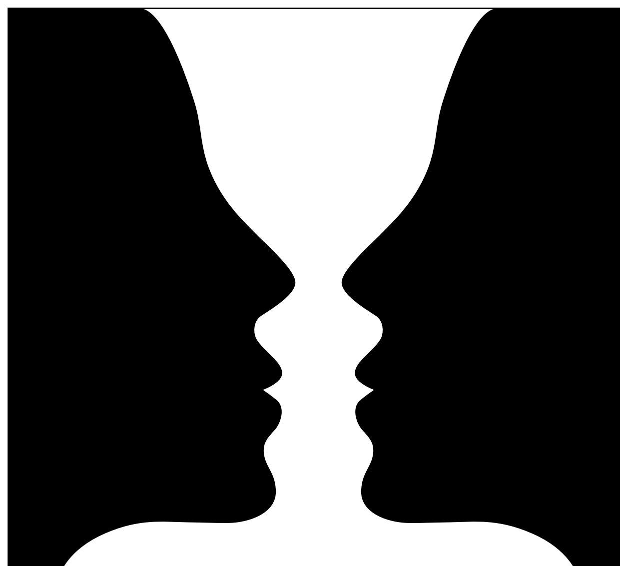
  Positive deviants are individuals or groups (families, clans) whose special or uncommon practices and behaviours enable them to find better ways to prevent malnutrition than neighbours who share the same resources and face the same risks.

- Handout 15.1: Community Assessment Monitoring Sheet (this is from Session 15)
- Copies of Step 1 pictures

STEPS

5 Min

1.



Pass copies of these pictures around the group and ask participants what they see. There are two ways of looking at each photo. Make sure the participants see both ways. Point out how this is like PD, that is, there are different ways to look at reality, at problems. Solutions are sometimes 'hidden' in plain sight.

Discuss: Where should we look for solutions to malnutrition? (*caregivers, families who have children who are well nourished)*

5 Min

2.

Review the definition of positive deviants on the flip chart. In terms of nutrition,

Who are positive deviants? *Positive deviants are well-nourished children from poor families.*

Who cannot be positive deviants? *Only children, first-born children, a well-nourished child with malnourished siblings, children with atypical social or health problems, food-aid families, a child younger than seven months (the child's nutritional status is most likely due to breastfeeding), and/or children from non-poor families. See the list in the CORE PD/Hearth Guide (p. 68).*

Who identifies the positive deviants? *Supervisors and volunteers identify positive deviants.*

5 Min

3.

HANDOUT 15.1 – 75m/H 38

Review the criteria for identifying PD families, that is, good nutritional status *and* low wealth ranking. Divide the participants into pairs. Using Handout 15.1: 'Community Assessment Monitoring Sheet,' each pair decides which children are positive deviants by considering their weight, wealth ranking and birth order.

4.

This will provide a list of the potential PD children. However, the information needs to be confirmed by looking at the children's growth cards. Children who are truly PD will have been well nourished throughout their lives. If a child's growth card shows that he or she has only recently become well nourished or is not consistently growing well, do not accept that child as a PD.

An alternative way to teach this is to use data from the community to be visited during the course. If the ADP has done the nutritional assessment before the course, use the data collected on nutritional status and wealth ranking. Enter the data in the same format as Handout 15.1 and use the information to identify the PDs.

15 Min

5.

Discuss the list of potential PD children as a group. Be sure to cover the following:

- **Who knows which families are PD? Who has access to this information?** Only the staff should have this information, and staff members should not share it because there is a risk that PD families will be socially rejected.
- **What if there are no PD families in the community?** At least one PD family is needed. If none is identified, it will be necessary to conduct the PDI in an adjacent, very similar community using the team from the target community. If there are many PD families, choose a few that are most appropriate for conducting the PDI.

SESSION 18

Preparing for the Positive Deviance Inquiry (PDI) (STEP 4)

75 MIN

DAY 2

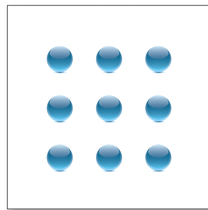
By the end of this session, participants will be able to

1. Describe the process, tools and methods for conducting the PDI
2. Identify resource tools for semi-structured interviews and observations during visits to PD households
3. Discuss the behaviours that influence the nutritional status of children
4. Develop a logistical plan for training and conducting the PDI.

Reference in *CORE PD/Hearth Guide*: pp. 85–89, 94–103

Preparation

- Print copies of Handout 18.1, 18.2, and 18.3.
- Adapt and practise telling the story of Nasirudin.
- Identify and orient trainers who will conduct the structured role play.
- Have three or four participants prepare the skit on visiting skills.
- Prepare a flip chart with nine large dots in three rows.



- Print and cut apart two sets of 24 behaviour cards (see sample in step 3 below).

Materials

- Print copies of Handout 18.1, 18.2, and 18.3.

STEPS

5 Min

1. Tell the story of Nasirudin

Nasirudin lived in a town. Often he would take a couple of donkeys laden with grass and cross the border of the town to enter the neighbouring territory. The customs officers at the border had a strong suspicion that Nasirudin was smuggling out some goods, but they could not find any. Nasirudin had only heaps of grass, which they examined very, very closely. They thought there might be small rings of gold or tiny diamonds. They even burned the grass, but in vain. Nasirudin's several crossings of the border did not reveal any smuggled goods, and he entered the neighbouring territory several times after giving a

big respectful salute to the officers. But there was always a cunning smile on his face. Their police instinct told them he was smuggling *something*, but they couldn't figure out what.

Many years later, long after Nasirudin had stopped his comings and goings from that town and lived in another town, one of the customs officers, who had by then retired, suddenly met him.

'Tell me, Nasirudin', the ex-customs officer asked, 'what were you were smuggling in those days?'

Nasirudin looked up and with the same cunning smile said, '*Donkeys,* of course'.

Discuss: What do you think is the message behind the story? *(the solution to something is often right in front of us but we don't see it; look for unexpected things; don't be misled by obvious things – the grass – and miss other things – the donkeys; be open minded)*

Brief the participants on the PDI process: 'We will be visiting families in our community to learn from them how they feed and care for their children who are under three years old. We will visit during the time that the caregivers feed their children. That way we can observe how they feed them, the care they give them and the relationship between the caregiver and other members of the family. We want to talk to the caregivers and observe what they do. But we will not make any comments. We need to have open minds and look for unexpected practices or ways of doing things. The positive deviance inquiry is intended to help discover that which is right in front of us. We expect to find something positive; we are like detectives looking for clues, and we need to get rid of any preconceived notions.' (**Note:** Volunteers may not be able to lead the PDI visit but will be valuable observers on the team.)

5 Min

2.

Discuss the kinds of information that will help us learn about feeding and caring practices. We will discover with community members foods which poor families use to keep their children healthy and strong. These foods are 'good foods'. We will discover the 'good care' these families give to their children. In the same way we will discover 'good health care' and 'good hygiene'.

By learning about these 'good' things from poor families with healthy children, we will be helping address the community's nutrition problems with solutions from its own people. These solutions will help other families in the community learn and understand how to help their children to be healthy and strong.

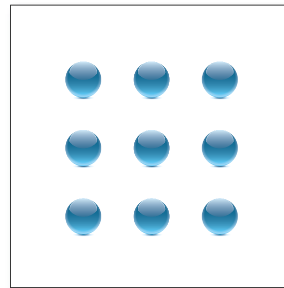
- **What categories of home-based behaviours are we looking at?** (*feeding practices; caring practices; hygiene practices; and health-care practices).* Ask

participants for an example of a positive practice for each category. (Refer to pp. 90–91 in the *CORE PD/Hearth Guide*.)

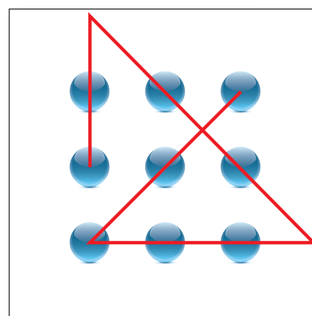
- **What are we trying to discover through the PDI?** The PDI seeks to identify unusual, successful and culturally acceptable behaviours and strategies practised by very poor families which can be more widely practised by others in the community who have similar resources. How does the PD family overcome the challenges and constraint that it shares with other families? For example, saving for health expenses is a positive but uncommon practice. The PDI should answer the question: How is *this* family able to save money?
- **The content for each category can be different according to cultural context. What are some examples of issues in feeding, caring, hygiene and health-seeking practices that are culturally specific?** Issues identified during the PDI can be explored for cultural appropriateness during the later process of sharing with the community (see Session 20, 'PDI Interpretation and Feedback').
- **Who should explore these?** The PD team and local partners.
- **Who is required on the PDI team?** The volunteers and supervisors must be on the team. Additional participants might include VHC members or Ministry of Health staff. It is very important that volunteers be part of the PDI team because they are most familiar with the community. Some of them may not be comfortable or have the skills to lead the interviews. With good training, however, they will become valuable team members who help us understand important community information. When selecting personnel, look for the following characteristics: belief in the approach, openness to learning from one less educated, and willingness to be led instead of leading. Note that PDI requires a change in attitude for Hearth managers and trainer; they are going to the community as learners, not as experts.
- **The PDI has an interviewer and observers.** Both roles are important. The interviewer may be a community member, a PD/Hearth volunteer, or a trainer/supervisor.
- **Training the PDI team.** Training should emphasise communication skills, listening skills and observation skills. It is particularly important to be able to probe into the issues in a culturally acceptable manner. Use role plays to practise skills and also to practise a home visit in the neighbourhood with a feedback session. The role of observer is awkward. Training is important to increase the comfort level.
- **What are some cultural filters that influence behaviours and how we view them?** In searching for behaviours that are positive and those that are problematic, the PDI team needs to look through the lens of local culture. Team members should look at family structure; socio-cultural norms; food taboos; patterns of decision making; traditional practices or customs; religion; beliefs; gender; and presence of informal or traditional health systems.

The role of grandmother may be particularly relevant to understanding the behaviours practised within the home. It is important to observe and engage the grandmother in the visit.

Ask each participant to draw nine dots on a piece of paper in the following pattern.



The goal of the puzzle is to connect all nine dots, using four or fewer straight lines, without lifting the pencil from the paper. Allow some time and then ask if anyone was able to do it. Have the person illustrate the solution on the flip chart. If no one solves the puzzle, draw this solution on the flip chart.



How is this like PD? PD is about *thinking outside the box!* It is finding solutions that are in the community but might not be obvious or easily seen.

The following exercise helps participants understand behaviours and skills that are important to the nutritional status of children.

5 Min

3.

Divide participants into two teams. Each team gets one set of 24 behaviour cards. Have the team members separate the cards into two piles: those with behaviours that *directly* affect the nutritional status of children, and those that do not. Tell them to be prepared to justify their choices.

10 Min

4.

Bring the teams together. Call out each behaviour and have the team members put both hands in the air if the behaviour directly influences the nutritional status of children or put their hands behind their back if it does not. Have team members explain their choices, especially when there is disagreement about the behaviours.

Behaviour cards sample

Make two sets of cards. Write one behaviour on each card.

Thanks given for food	Nails are clipped	Use of home remedies for illness	Child is bathed every day	Boils water for children under six months old	Child eats five times a day
Mother tells stories and sings to child	Use of soap to wash hands	Child is given fruit for snack	Child breastfeeds during the day	Grandmother cares for child	Adds oil to porridge
Child is dewormed	Seeks medical help when ill	Eggs, snails, watercress, groundnuts are included in meal	Parent hits the child for not obeying	Kitchen pots are washed and left to dry on rack	Child feeds often during illness
Brushes child's teeth	Someone helps the child eat	Sleeps with window open	Child eats from own bowl	Washes hands after using latrine	Child wears sandals

5 Min

5.

What tools can be used to gather information about child-care behaviours (feeding, health-seeking, caring and hygiene)? Refer the participants to the 'Observation Checklist for PDI' and the sample 'Semi-structured Interview' in *the CORE PD/Hearth Guide* (pp. 99–103). Allow a few minutes for them to look these over.

Observation Exercise. Have the participants stand in pairs, facing each other. Each person carefully observes his or her partner for 30 seconds. Then tell the partners to turn and stand back to back. Each partner is to change one thing about his or her appearance (take off an earring, put on glasses, button a cuff, etc.). Then ask the partners to face each other again. Each is to tell the partner what has changed. Ask how many were able to identify the change. Emphasise the importance of *good observation* in order to explore behaviours through the cultural lens of the community.

10 Min

6. A simplified 24-hour recall exercise

The purpose of this exercise is to find out from the caregiver everything the child ate in the last 24 hours.

Demonstrate this method with a participant who acts as the caregiver of a young child. Ask the 'caregiver' what the child ate when he or she got up the previous day. Probe for more information, asking about amounts the child ate (ask to see the bowl), how the caregiver prepared the food, whether she added anything else, whether the child ate or drank anything else. Then ask about the next thing the child ate. Did the child eat anything between the first meal and the second? Continue with these probing questions until the full day has been covered. Be sure the observer is taking notes on the foods, quantities and frequencies.

HANDOUT
18.1 – 107m/H 49

Distribute Handout 18.1 and divide the participants into pairs. Have them practise doing a 24-hour recall with one acting as 'caregiver' and the other as 'interviewer'.

10 Min

7.

Use the following role play to demonstrate and practise the skills necessary for conducting a PDI. Begin with three facilitators for scenario 1 (interviewer with questionnaire; mother of child; older sibling; may use doll or additional facilitator as PD child).

Scenario 1: This role play portrays part of a PDI; during the part shown, the interviewer is focusing on feeding practises. The PD child is a well-nourished, 30-month-old girl. Her mother says the child eats only during the two daily meals. However, a sibling in the room is sharing a snack with the child (who is fed constantly by older siblings, her grandmother and neighbours). The mother talks very little. While the mother is being interviewed, the sibling washes the child's hands, scolds the child when she drops something and tries to pick it up to eat it, plays with the child, gives the child a drink, etc. (The interviewer and mother don't interact with the child or sibling during this time.)

After the role play, lead participants in discussing what is necessary for a successful PDI:

- The quality of the interviewer's probing skills. Note that probing was needed when information from the caregiver was not consistent with observation. It is all right to ask what the family does for a healthy child. But there should be no leading questions and no pre-formed ideas about what is 'right'. Listen to what family members say.
- The importance of knowing local languages and customs.
- Conducting the inquiry without a questionnaire in hand. Small talk can be employed to create a comfort level (this role play was brief, but an actual PDI is more often a two-hour visit in the village). Encourage caregivers to continue with whatever tasks they need to do. The interviewer may even help (getting water, stirring pot, playing with the child, etc.).
- Role of the observer. The second person/observer (a supervisor, volunteer or other community leader) may recognise positive behaviours that the interviewer from the community does not see or recognise.
- Seeking strategies, not just behaviours. Carefully probe to learn how the family manages to practise a behaviour that their peers seem unable to practise. For example, if the family is feeding the child an egg frequently, how do they afford this? If the house and children are very clean in spite of lack of water, how does the caregiver accomplish this good hygiene?

10 Min

8. Role play

Ask three or four participants to prepare a skit using all the wrong approaches to a visit. There should be two interviewers and a mother. The interviewer uses comments like 'We know you are poor and want to find out why'. The mother is busy and asks the interviewers to return at another time. They invite themselves in anyway. The interviewers are eating candy and talking on their cell phones. They use big words and ask offensive questions. They are not respectful. The mother is obviously annoyed, upset and then angry.

Ask participants how the interviewers could improve their visiting skills. Summarise the skills that are important for conducting a PDI home visit: probing in a culturally acceptable manner; mixing observation with conversation; good interaction to put the caregiver at ease.

10 Min

9.

HANDOUT
18.1 – 107m/H 49
18.2 – 109m/H 51

Give out Handout 18.2. Divide into groups of four or five people. Using Handouts 18.1 (interviewer) and 18.2 (observer), tell participants to role play a home visit with two participants acting as 'interviewer' and 'observer', and the others being 'family members'. Practise until the participants feel comfortable talking about the four 'goods' – feeding practices; caring practices; hygiene practices; and health-care practices – without referring to a list on a sheet of paper. Try to get the conversation to flow. Observe what the family members are doing as well as what they are saying.

10.

HANDOUT
18.3 – 110m/H 52

Ask participants to develop a logistical plan for the PDI in their country context, as a homework exercise. Distribute Handout 18.3 and instruct the participants to use Handout 18.3 to summarise the PDI findings of all households from the upcoming PDI field visit.

Purpose of a PDI

Through the situational analysis (FGDs, market survey, seasonal calendar, transect walk and community mapping), we now know what resources are available in the community and understand the common feeding, hygiene, caring, and health seeking practices. Overall, the findings provide us with a better knowledge of what the 'norm' is in the community.

By conducting a PDI in non-PD households, we can further identify:

- common practices, both good and poor behaviours,
- what are the barriers and challenges households face in practicing positive behaviours,
- what is the reasoning for some of their behavioural or food choices.

Once the reasoning, challenges and barriers are identified and understood, the PDI in PD households is used to observe and identify how the PD households overcome those very challenges and barriers that everyone else in their community cannot overcome. It is also an opportunity to understand the PD caregivers' thinking and reasoning behind the practices. Sometimes the PD caregivers will be practicing positive practices without any knowledge of it being a positive behaviour; it may just be a decision made because of family circumstances. Thus, PDI in PD households is used to find the local solutions.

The 24-hour recall during the PDI is also used to identify the PD foods. PD foods are the foods that only PD households feed their children and non-PD households do not feed their children. It is important to understand why non-PD households do not feed their children the PD foods and why the PD households do. This understanding could be used to explain why it is important to feed the children the PD foods during the Hearth session. PD foods are nutrient-dense, locally available, low in cost, and easily accessible in various seasons or even all year round.

(Participants are to create their own questions and guidelines for use in the field visit.)

House Visits

1. Be wise; respect the family.
2. Don't ask why they are poor.
3. Point out that you are here to learn, not to criticise.
4. Introduce yourself, congratulate the family on its good work, and ask permission to observe.
5. Make sure the information collected regarding child information (e.g. age, birth order, wealth ranking, etc.) is correct to ensure the child is a PD child.
6. Spend two to three hours in each PD house. It is good to go during a meal time to observe the child's feeding practices, but ensure you do not disturb the family.
7. Try to engage both the caregiver and grandmother (if present) while conducting the visit.
8. Conduct a 24-hour diet recall on the food the child ate yesterday. Fill out form.

24-Hour Dietary Recall Question Guide

1. What is the first thing the child ate yesterday after waking up?
2. How much did you give (of each feed)? How much of it did the child eat? Can you show me the bowl the child used?
3. How did you prepare the food? Fried? Boiled? Steamed?
4. What did you add? Any oil? Vegetables?
5. Did the child eat anything else?
6. Did the child drink anything?
7. What is the next time the child ate? What? How much? How prepared? What else did the child eat?
8. Did the child get anything else between first and second meal? And between second and last meal? (Note: food quantity, frequency and consistency).

Good Food/Feeding

1. Is the child breastfeeding? If not, at what age did the mother wean the child?
2. What foods is the child being fed today?
3. Who decides what the child will eat? What role do other family members play in child feeding decisions?
4. How many times did you see the child eat or drink?
5. Where does the family buy food? Who buys the food? How much money is spent on food each day?
6. How many meals and snacks does the child eat a day?
7. Are there any foods the caregiver does *not* give the child?

Sample Guiding Questions for Conducting a PDI

Good Child Care (try to observe without asking)

1. Who is the primary caregiver of the child?
2. What roles do other family members play in caring for the child?
3. Who is in the house during the day?
4. Does the caregiver take the child to the vaccination post? How often? Is the child on schedule?
5. Does the caregiver or others play with the child? How? How often?
6. How is the child disciplined? By whom?
7. What does the caregiver do to encourage the child to eat if he or she doesn't want to?

Good Health Care (ask for health card, ask caregiver questions)

1. How do you know when your child is sick?
2. Was the child sick in the past six months? If so, how many times?
3. What illnesses has the child had?
4. When the child was sick, what did you do? Did you feed the child anything differently?
5. What steps do you take to prevent illnesses?

Good Hygiene (observe body, food and environment)

1. Is the house clean? Is the kitchen clean?
2. Are the people clean?
3. If there is a latrine, how does it look?
4. Make observations about the water source.
5. Do pigs, mules, dogs or other animals go in and out of the house?

Observation Checklist

Questions	Remarks
Personal Hygiene	
Wash hands before/after?	
Plates washed?	
Nails	
Shoes	
Clothes	
Food preparation	
Handwashing (Check for soap and running water)	
Washing the food before cutting or cooking	
Food/water covered (before and after cooking)	
Household measures used (e.g. size of cup, spoon sizes, do they use fist sizes?)	
Home Environment	
Food availability (gardens)	
Animals present (cage, play with children?)	
Storage facilities (for water, food)	
Household waste management	
Toilets (cleanliness, distance, type)	
Water (boiled/filtered, distance, source)	
Interaction between caregiver and child	
Loving and caring behaviour	
Playing with the child	
Feeding Practices	
Does child pick up food from ground and eat it?	
Do you help the child to eat and watch child eating?	
Amount of food the child is eating?	
How many times do you feed per day?	
Feeding Practices **Health Seeking Practices**	
Do you see any ORS packets?	
Do you see an ITN? Is it in good condition?	
Do you feed the child differently when the child is sick (e.g. more or less food; more or less liquid; feed more frequently)?	

HANDOUT 18.3

Results and Observations from the PDI

World Vision

Day 2 Session 18

DATE .... ADP .... DISTRICT .... COMMUNITY NAME ....

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

Preparing to Conduct a Situational Analysis and PDI (STEP 4) (Preparing for the field visit)

SESSION 19

60 MIN | DAY 2

By the end of this session, participants will have

1. Prepared questionnaires and tools for collecting data in the community in various ways.

Reference in CORE PD/Hearth Guide: pp 62–112

Preparation

- The host country staff will need to prepare communities for this activity. Ideally, these will be new ADP communities which will begin PD/Hearth for the first time. Select one community for every five workshop participants. In each community conduct a nutrition baseline of weights of at least 20 children, selected randomly, between the ages of 6 and 36 months. With existing community health volunteers and community leaders, conduct a wealth-ranking exercise. Using this information, classify the children who were weighed according to their family's wealth ranking. This information must be ready by the start of the training. Host country staff need to arrange with the community for a field visit on the third day of the training. They need to organise a focus group of caregivers, invite community leaders to a brief meeting during the visit, and ask if participants can visit selected families.

Materials

- Local growth chart for plotting weights, or WHO ANTHRO software to calculate nutritional status
- Flip chart with blank paper

STEPS

5 Min

1\. Explain to the workshop participants that we are going to conduct a situational analysis in actual communities the next day of the course. Explain that the National Office and cooperating ADP have already weighed children and conducted a wealth ranking. Based on their work, we can identify PD families to visit. We need to prepare the questionnaires and tools we will use for the activities we will conduct. Write the activities on a flip chart:

- **PDI** – We will conduct a PDI with several families.
- **Focus group** – We will investigate existing social norms and practices related to feeding and care of small children in a focus group with caregivers and family members, particularly grandmothers, from poor households who have children under three years of age.
- **Market survey** – We will take a market survey to assess food costs and what foods are available in markets and shops.

- **Social mapping and transect walk** – Social mapping and a transect walk with a few community leaders will help us identify local resources related to health and nutrition (availability of piped water and latrines, wild foods, health services etc.). The map should include health risk factors such as standing water where mosquitoes breed, garbage dumps etc., as well as the services available and their locations relative to the houses of the poor.
- **Seasonal calendar** – A seasonal calendar created with a few community members will identify the availability of food sources for families at different times of year.

2.

Divide the participants into five groups. Each group will develop questionnaires, observation forms and tools to conduct one of five different activities in the community. If they type these and a printer is available, they may print out the materials. If a printer is not available, ensure that each small group has at least one copy of each of the questionnaires, forms and tools. The facilitators circulate among the groups to provide guidance and support.

3.

Divide the participants into groups of no more than three people. These are the groups in which they will conduct the household visits tomorrow. Two small groups may join together for the other activities, such as the focus group discussions, the market survey, seasonal calendar and transect walk.

Personalise the Curriculum
Daily Summary and Evaluation

SESSION 20

30 MIN | DAY 2

By the end of this session, participants will be able to

1. Adapt the content of the day to their own cultures
2. Evaluate personal learning for the day

Preparation

- Make a flip chart with the daily evaluation sentence starters listed below.

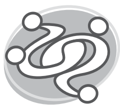
Materials

- Half sheet of paper for each participant
- Each participant's curriculum

STEPS

20 Min

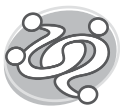
1.



Each participant reflects on the day's sessions and writes down ideas to improve or adapt the various presentations so they are more appropriate for the participant's specific culture. This is done by adapting case studies, games and hands-on exercises, developing role plays and including local stories. Ask the participants to be ready to share some of their good ideas.

5 Min

2.



Daily evaluation. Distribute a half sheet of paper to each participant. Ask the participants to respond to the three phrases written on the flip chart:

- Something I learned today that I will apply in our PD/Hearth programme is

  ____

- Something new that I learned about PD/Hearth today is

  ____

- Something I'm still confused about is

  ____

Facilitators will review these evaluations at the end of the day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.

3.

Explain the departure time and transportation arrangements for the next day and quickly outline the agenda for the afternoon session following the field trip.

Remind participants the order of the exercises that will take place tomorrow during the field visit. 1 group will conduct the FGD with the caregivers, 1 group will conduct the FGD with the grandmothers, and 1 group will conduct the FGD with the father group. Simultaneously 1-2 groups will be conducting the wealth ranking exercise with a diverse group of community members. Once the FGD and wealth ranking is complete, the wealth ranking criteria should be shared with the rest of the participants so everyone knows the wealth ranking criteria prior to weighing the children (if weighing of children is needed). Transect walk and seasonal calendar could be completed at any time, and all participants should get an opportunity to conduct a market survey after the weighing of children.

2 Min

4. Thank participants for good work today. Mention any highlights of the day. Remind them of the meeting time for the morning.

Field Visit to Conduct Situational Analysis and PDI

Total field visit time of 4.5 hours includes transportation time.

By the end of this session, participants will be able to

1. Confidently conduct a FGD, wealth ranking transect walk, market survey, household visits, and PDIs.
2. Identify PD and Non-PD Behaviours during a PDI.

Materials

- Questionnaires and tools created by each group the previous day plus 120 mins for compiling results or Print out Handouts 14.3, 15.3, 16.1, 16.2A, 16.2B, and 16.3.
- Flip charts and markers

STEPS

4.5 Hours

1. Field Visit

HANDOUT
14.3 – 68m/H 37
15.3 – 81m/H 44
16.2A – 92m8/H 46
16.2B – 93m/H 47
16.3 – 94m/H 48

Distribute copies of Handouts 14.3, 15.3, 16.1, 16.2A, 16.2B, and 16.3 to each participant and remind them in how to fill-out the Handouts. Also, remind participants to refer children with 'red' coloured MUAC (severe acute malnutrition/wasting) to Health Centres or OTPs.

2 Hours

2. Compiling Feedback

HANDOUT
18.3 – 110m/H52

At the end of the visit each group will record the information it gathered on flip charts for all participants to see. The information will come from the FGD, PDI, transect walk, market survey and seasonal calendar. Create a summary of the information. Have the group reflect on the three questions again:

1. What are the different practices between PD and NPD/ND? (record findings in format shown in Handout 18.3)
2. What are some of the challenges faced in the community? (e.g. don't like feeding Sprinkles, breastfeeding but only up to 3 months, only feed rice porridge)?
3. What is the PD household doing to address these challenges at home? Identify the local solution for these challenges.

Use Question 1 to fill out the entire table on Handout 18.3 and use Question 2 to add important findings into the non-PD practices section of the table on Handout18.3. Use Question 3 to add important findings into the PD practices section. Put a star beside the PD foods listed under 'PD Food/Feeding' on Handout 18.3.

PDI Field Exercise: Identifying PD and Non-PD Behaviours

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

Review of Day 3 Field Visit and Agenda for Day 4

STEPS

15 Min

1.

Engage participants in a discussion based on questions such as

- How did you feel about the visit yesterday?
- What did you find easy?
- What did you find difficult?

2.

Address any issues that may arise.

3.

Review the agenda for today, explaining that we will analyse the information gathered and decide how to use it for Hearth planning

SESSION 23

PDI Interpretation and Feedback: Determining Positive Deviance (STEP 4)

World Vision

80 MIN DAY 4

By the end of this session, participants will be able to

1. Describe the categories of behaviours identified during the PDI analysis
2. Describe the participatory processes for analysing PDI data and selecting PD feeding, caring, hygiene and health-seeking behaviours to be used in PD/Hearth sessions
3. Demonstrate skills for sharing the PDI findings with the community.

Reference in CORE PD/Hearth Guide: *pp 89–98, 104–12.*

Materials

- Flip chart
- Matrix for each small group to record PD and non-PD behaviours

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

STEPS

15 Min

1.

Each group posts its field-visit summary sheet on the wall. The groups circulate around the room to read the behaviours/practices discovered by each group. In small groups the participants discuss each behaviour and place it in the matrix under the appropriate column for the PD families and then for the non-PD families for contrast. If a behaviour is repeated by more than one family, the group should highlight it and indicate how many times that behaviour was observed. This serves to illustrate common threads among the PD families and non-PD families.

Do not include positive practices that non-PD households practise and common practices that everyone practises. The key is to identify the unique positive practices that only PD households are practising that allow their children to be healthy. Especially point out local solutions that the PD households are practising.

30 Min

2.

Ask each group to explain the findings of its PD data in the large group. Show what behaviours were found in the PD families' homes and what behaviours were found in the non-PD homes. Answer the following questions:

1. What are the different practices between PD and NPD/ND? (record findings in format shown in Handout 18.3)
2. What are some of the challenges faced in the community? (e.g. don't like feeding Sprinkles, breastfeeding but only up to 3 months, only feed rice porridge)?
3. What is the PD household doing to address these challenges at home? Identify the local solution for these challenges.

For those behaviours that are considered positive, lead the group to select whether the behaviour could be practised by a poor family or only by a non-poor family. Is it feasible, easily replicable, affordable? Point out to participants how this exercise mirrors the process used in the community to analyse information from the PDI. Together, develop a summary chart of PD behaviours/skills/practices/messages that will need to be emphasised in Hearth sessions. Ensure the PD foods are used in the menu design in session 26.

25 Min

3.

Have each small group role play how to give this information back to the community. This will help to develop community ownership and enable community members to identify immediately accessible solutions to childhood malnutrition. Have at least one group present its role play and discuss it afterward with the large group. What was positive? What was difficult? What other ways could have the information been communicated?

Point out that by leading a group of villagers to identify uncommon good behaviours, you have facilitated community validation of choices ('buy-in').

Note: *Village volunteers may need help in analysing which behaviours are beneficial and which are harmful.*

10 Min

4.

Briefly summarise the steps in the PDI. Use this opportunity to repeat and clarify important points and answer any questions. The steps in the PDI are the following:

- Select the PDI team.
- Train the team (include lots of role play).
- Select sample PD households and conduct a practice PDI. These households are informed in advance, and the PDI team has the opportunity to practise and share notes.
- Conduct the PDI (may also conduct the PDI in non-PD and negative-deviant households for comparison purposes).
- Compile the findings.
- Share the findings with the community
- Plan the Hearth sessions using the information discovered about food (Hearth menu), active feeding, hygiene around eating/food, child development games, role of men (perhaps invite fathers to one Hearth day), role of grandmothers and other family members.
- Document other community initiatives resulting from the sharing with the community.

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.

World Vision

Designing Hearth Sessions (STEP 5)

By the end of this session, participants will be able to

1. Describe what happens in a Hearth session
2. List the activities that occur during Hearth sessions
3. Describe lessons caregivers will learn during different Hearth activities.

Reference in the CORE PD/Hearth Guide: Hearth Session Protocols, pp. 132, 135–40

Preparation

- Review Handout 25.1.
- Prepare one flip chart for each of the activities of a Hearth session.
- Review the equipment list on page 136 in the CORE PD/Hearth Guide. Ask several participants to develop a role play of what happens in a Hearth session.
- Ask participants to prepare a skit demonstrating what a Hearth session is like. Ask a person who has experience with Hearth sessions to act as the 'volunteer' (or a facilitator can be the 'volunteer'). Be sure to include greeting caregivers and their children, collecting the food contributions and mentioning how these can help children to grow well, handwashing and snack, food preparation, games with children, handwashing and feeding children, discussion of what each caregiver or caregiver-grandmother pair will bring the next day, and cleanup.

Materials

- Flip-chart paper
- A marker for each participant
- Handout 25.1: Examples of Learning Opportunities Through PD/Hearth Activities

STEPS

5 Min

1. What are some strengths of the PD/Hearth approach?

Remind the participants to keep these two goals in mind:

Goal 1: The malnourished child will recuperate.

Goal 2: The child's caregiver(s) will learn new behaviours (so that rehabilitation is sustained at home).

Discovers existing strengths: The approach helps identify positive behaviours and strengths that exist in the community and builds upon them. Each community's practices are different, so the health-education messages built around those practices will likewise be different for each village.

The PD/Hearth approach follows a three-step process for behavioural change:

1. Discovery (PDI)
2. Demonstration (Hearth sessions)
3. Doing (in Hearth sessions and at home, with follow-up visits to reinforce learning).

Promotes role modelling: If the Hearth volunteer is a PD caregiver (e.g. mother, grandmother, father, grandfather), he or she becomes an excellent role model.

Is experiential: Hearth sessions avoid lecture-style teaching; instead, caregivers are involved in all steps (hands-on style of learning).

Is based on cultural/social norms: Norms are reinforced with community support. Interventions are culturally appropriate and often use songs and/or stories that are part of the culture. In Haiti, a contest was held during training to develop songs for Hearth. This was very successful; it animated the training process and enhanced Hearth education.

15 Min

2.

Present the role play that illustrates the different activities of a Hearth session. Discuss the role play, covering the following topics:

What activities take place during a Hearth session?
(Caregivers and volunteers work together to prepare food, feed and entertain the children. Children – and perhaps siblings – receive a small snack and have supervised play while the meal is being prepared.)

Where should the Hearth session be held?
(The session requires a central, adequate space, preferably a house. While the 'hearth' should be large enough to accommodate the group, it should not be very different from the homes of the participating families.)

Time required
(A session takes two to three hours each day. Caregivers participating in PD/Hearth programme should decide a time that is convenient for all of them.)

Are there basic requirements at the site?
(The site should have a latrine; water for drinking, cooking, and washing hands; and shade.)

What equipment needs to be at the site?
(See the list on page 137 in the CORE PD/Hearth Guide.)

5 Min

3.

Ask one participant to describe the order of activities during a Hearth session.

Briefly review the activities of Hearth. Have each of the following activities listed on flip chart paper, one activity per sheet, and post the sheets around the room.

- Arrival of caregivers and children; take attendance and track contributions for the day (e.g. menu and cooking materials)
- Weigh children on first and last days of the programme. Collect child growth cards to obtain immunisation, supplementation and deworming information for each child; if child has not been fully immunised, dewormed or received vitamin A supplementation, refer the child to the nearest health facility for proper treatment before joining the Hearth session.
- Collect food contribution
- Hand washing/hygiene
- Snack
- Cook
- Play games with children
- Feed children
- Decide on menu and cooking material contributions and assign roles for next day
- Clean up.

10 Min

4.

Hearth presents many informal learning opportunities for caregivers such as modelling, conversation and learning by doing. The topics in the examples below do not need to be taught through talks; rather, the volunteer reinforces these practices each day through conversations with the caregivers during the activities. Give each participant a marker and have them walk around the room where the Hearth activities are posted on flip chart paper. Ask them to list on the papers what caregivers can learn during each of these activities.

30 Min

5.

HANDOUT
25.1 – 129m/H 53

As a group, review each activity and add other learning opportunities. (See Handout 25.1.) Discuss other lessons caregivers might need to learn and grandmothers can support. Consider especially practices and messages from the PDI. How will caregivers and grandmothers have an opportunity to learn these? During which activities? What activities can contribute to early childhood stimulation? Emphasise that lectures or other formal teaching methods are not used during Hearth; instead, all the messages are conveyed through conversation and learning while doing.

35 Min

6.

Have participants refer to their PDI raw data. Give participants two to three minutes to study them and identify which PD behaviours they might select as the 'key messages' for Hearth sessions. List these on a flip chart. Have the group reach consensus on the most important six messages and the order they will be shared with the caregivers (For example, take into consideration the definition of the 'norm', which was found through the FGDs and PDIs in Non-PD and ND households. Select messages that are essential to address the most commonly practised poor behaviours, which directly affect the nutritional status of a child.). What would be three or four points that could be shared under each key message? How might other points be promoted? (This should lead back to the activity in Step 5.)

Example (refer to CORE PD/Hearth Guide, p. 132):

Key Message: BREASTFEEDING AND COMPLEMENTARY FEEDING

Sub-level Messages:

- Breastmilk is the best food for infants (good for protection, energy, and body building)
- Exclusive breastfeeding for six months, but complementary feeding with continued breastfeeding beginning at the age of six months and continuing up to two years
- Why introduce new food in addition to breastmilk
- Frequency, consistency and quantity of food
- Method of feeding.

Divide participants into six groups. Assign each group a key message. Ask each group to develop a simple song to teach its key message to caregivers and children. A good song will be repetitive, have a catchy tune, and include actions. The groups will present these songs during the remaining sessions as energisers.

10 Min

7.

Ask the first group to finish its song to prepare a 5–10 minute role play on how a first day of Hearth unfolds (refer to CORE PD/Hearth Guide, p. 138).

5 Min

8.

Clarify any questions about Hearth sessions, for example, variations from programme experience

- Food contributions – An extremely poor caregiver may be asked to bring firewood or water, an extra pot, or another item. Or staff may make a contract with families before Hearth, detailing expectations and including a pre-Hearth work up and list of contributions. Or, in a peri-urban area, in order to reduce the caregiver's time commitment, all the caregivers (or caregiver-grandmother pairs) bring food, two people stay to cook, and the others return with the children at meal time.
- Obtaining equipment for the Hearth sessions – If the volunteer does not have pots or dishes, each caregiver can bring the equipment for her own child(ren). Or the community might provide a sitting mat, a large pot, and so on.
- Finding an appropriate Hearth setting – If one volunteer cannot host all 12 days, the sessions may rotate among several homes.
- Prior visit to health centre – The volunteer can accompany each caregiver and child to the health centre in order to establish comfort and ensure compliance.
- Assuring fuel for Hearth – Fuel scarcity can influence the types of food cooked. Fuel can be the community's contribution to lessen the burden on individual caregivers or the volunteer.

Arrival of caregivers and children/attendance

- Volunteer gives positive reinforcement for good hygiene.
- Volunteer asks how things are going at home – troubleshoot and share observations.

Collect food contribution

Discuss:

- Cost and sources of nutritious food
- Food variety, healthy choices
- Safety of food, proper storage
- Where foods can be found, gathered
- Food production/home gardens

Hand washing/hygiene

Discuss:

- Modelling proper hand-washing technique
- Use of soap
- Times when hand-washing is important
- Reason to wash hands: bacteria/germs contribute to illness/diarrhoea
- Treatment of diarrhoea/illness, when to seek health care
- Immunisation, deworming
- Nail cutting
- Orientation to personal hygiene
- Latrine use
- Use of shoes

Snack

Discuss:

- Frequency of snacks and meals
- Why to feed children four to five times a day
- Healthy snacks that require little or no preparation
- Consistency of food
- Food groups and nutritional value of food
- Including a variety of food in a day
- Breastfeeding
- Food storage

Cooking the menu

Discuss:

- Nutritional value of food
- Sources of affordable food: food production/home gardens, barter, collecting wild fruits
- Variety of food
- Good cooking techniques
- Food hygiene and safety, storage
- Promoting thick consistency of food
- Palatability and appetising appearance
- Importance of feeding children four to five times a day
- Hearth is an extra meal

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

Menu Planning: Designing Hearth Sessions (STEP 5)

SESSION 26

245 MIN OR 4 HRS 5 MIN | DAY 14

By the end of this session, participants will be able to

1. Describe important elements of planning nutritionally and culturally appropriate menus for Hearth sessions
2. Calculate calorie and nutrient requirements to determine optimal Hearth menu recipes/meals.

Reference in *CORE PD/Hearth Guide*: pp. 114–19

Preparation

- Purchase a 'market basket' of local foods from the market and set out these foods (*Note:* foods normally eaten cooked must already be cooked).
- Purchase food scales that measure amounts as small as 1 gram.
- Review the PD food or dishes/meals identified during the PDI.
- Use actual prices to calculate the cost per gram of each food item and post this next to the food.
- Obtain copies of and familiarise yourself with the national/regional 'Food Composition Table'.
- Provide copies of the Excel spreadsheet 'Menu Calculation Tool' for participants to install on their computers (if available). Know how to use this programme.
- Print copies of 26.1, 26.2, 26.3, 26.4 and 26.5

Materials

- Flip chart 26 (below): Nutrients Required in the Meal
- Blank flip-chart paper
- Market-survey findings
- Local, national, or regional food composition (if available)
- Handout 26.1: Flip Chart 26 – Nutrients Required in the Meal
- Handout 26.2: Directions for the Menu-Planning Exercise
- Handout 26.3: PD/Hearth Menu Exercise – Food Composition Table
- Handout 26.4: Sample Menu-Planning Form
- Handout 26.5: User Guide for the PD/Hearth Menu Calculation Tool
- Plates, spoons for dividing bulk foods, a sharp knife, and small containers (little plastic cups)
- Scales to weigh food (in grams)

STEPS

10 Min

1.

Hearth is held for 12 days (six days a week), followed by two weeks of follow-up visits. The first goal of the two-week Hearth session is to rehabilitate the malnourished child. The hands-on nature of the session sets the stage for sustained behaviour change which will be reinforced during the follow-up home visits (and later by the community). Keep the goal in mind while reviewing the following points.

Importance of the extra meal

At each session, ask the caregiver what she fed the child at regular meals in order to be sure the Hearth meal is 'extra'. After the child's recuperation the caregiver, supported by the grandmother, should enrich regular meals on a permanent basis, for example, with PD foods.

Importance of a snack during the Hearth session

A snack provides nourishment for children while they play and the caregivers cook, reinforces the idea that children need to eat small amounts frequently, and supplements the nutrients provided by the main menu.

When to weigh children and why

Children should be weighed on Day 1, Day 12 and Day 30. It is also important to ensure that a community growth-monitoring programme (GMP) continues; weighing helps to confirm nutritional rehabilitation and to reinforce the new behaviours.

5 Min

2. Menu Preparation

HANDOUT
26.1 –139m/H 55

Based on the PDI findings and the market survey, menus will be designed which enable children to be rehabilitated quickly from malnutrition. Emphasise that the menu must be 'extra', must include a snack, and must include sufficient intake of protein and calories.

Show Handout 26.1: Flip chart 26 – Nutrients Required in the Meal. Emphasise the importance of Hearth menus meeting these requirements. Explain the motivational effect when caregivers see dramatic improvements in the child's health and behaviour. The child's appetite will return and overall mood and energy improve within 10 to 12 days. Families begin to see that food and caring are making a difference. This encourages them to continue the new practices.

Explain that the first step in menu planning is for the volunteer or supervisor to do a market survey. The purpose of this is twofold: (1) to reinforce the idea that the PD and other nutritious foods are affordable; and (2) to ensure that the menus planned will be affordable for caregivers to prepare at home. The market survey results will be used to create menus. Food composition tables (preferably country-specific ones) are also needed for menu preparation. *These may be available through the local UNICEF office or the Ministry of Health; for a fairly comprehensive table, see* http://ndb.nal.usda.gov/ndb/foods/list

25 Min

3.

HANDOUT
26.3 –141m/H 57

Distribute a sample page from the national/regional food composition table or if this is not available, refer to Handout 263: PD/Hearth Menu Exercise - Food Composition Table. Explore together how the table is set up (based on 100g of the foods listed; the table tells whether the food is fresh or cooked; if not specified, it means 100g of raw food; EP stands for edible portion (for example, we don't eat the shells of eggs, so they aren't part of the edible portion) divided by food groups or alphabetically; foods are listed down the left-hand column and the nutrients across the top (some tables have macronutrients like kcal and proteins divided from micronutrients such as iron, zinc, vitamin A and vitamin C).

Using a flip chart based on Handout 26.3, ask the participants to locate a specific food/ingredient (for example, fresh fig leaves). Guide them through filling out the chart for 100g of this food. Fill in the chart together. For now, don't worry about the columns named 'home measure' and 'cost/amount'.

Pick another ingredient and this time complete the chart for 140g of the food. Help the participants decide how to fill in the table for the nutrients. For example, 140g of whole grain millet:

100g = 361kcal

(level of nutrient in food = amount of nutrient in 100 g * number of grams used)

$$140g = \frac{361kcal * 140g}{100g}$$

$$= 505.4kcal$$

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.

3 Hours

4.

HANDOUT
26.2 – 140m/H 56
26.3 – 141m/H 57
26.4 – 147m/H 63

Small-group menu-preparation activity. Divide the participants into groups of three or four.

Provide each small group with Handout 26.2: Directions for Menu Preparation and Handout 26.4: Sample Menu-planning form. The national/regional food composition table or Handout 26.3: PD/Hearth Menu Exercise – Food Composition Table may be shared among the groups.

- Each group goes to the 'market area' (the place where the food is spread out along with the containers and utensils) and takes foods for the menu it created based on the PDI findings and the market survey. The menu includes one snack and the meal.
- Groups use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the *CORE PD/Hearth Guide*, page 116, on how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Each group takes the amount they think a small child would eat. (Remember that a child's stomach is no larger than the child's fist.)
- Have a group member note the cost per gram of the food the group takes. Multiple the cost per gram of each food item by the number of grams used. Calculate the cost of the menu.
- After weighing the group's choices, place them on a plate.
- Using common household measures, such as bowls, cups, tins, and spoons, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.

***Note:** If participants have computers and work in Excel, they can do the menu calculation using the spreadsheet provided. However, all participants must be able to use the 'Food Composition Table' and do the calculations manually, because they will be training others who will not have computer access. Ensure that local foods are entered into the spreadsheet before it is distributed to participants to load onto their computers.*

HANDOUT
26.5 – 148m/H 64

Excel instructions: Use a LCD projector to introduce the Menu Calculation Tool (Excel document) and to orient participants in how to use the tool. Copy ingredients and their nutrient values (columns A to G) from the master sheet and paste them into the list of ingredients on the worksheet Input Day 01. Ensure that the cost of ingredients (per 100 grams) in the master sheet is updated based on the local market survey. Click on the worksheet Menu Day 01. Enter the quantity of each ingredient to be used (column C). The levels of nutrients will be calculated. Compare the total amounts for each nutrient with the requirements of Hearth menus noted in red. Make adjustments to the menu as needed to adjust the levels of nutrients.

Allow groups to develop their menus before explaining the next steps.

- *Convert the cooked amount of food to a raw amount.* Demonstrate how to do this. When cooked, some foods either increase or decrease greatly in volume. For example, cooked rice has a volume about two times greater than raw rice; cooked beans, lentils and pulses about two times greater than raw. To convert cooked food in grams to raw food in grams, divide or multiply by the difference factor; for example,

  100g of cooked rice ÷ 2 = 50g of uncooked rice

Each group should convert all the ingredients in their menu to raw amounts.

- *Calculate the cost of the ingredients using the cost per gram of each food, then add up the total cost for the entire menu.* If the cost seems too high for a household, look for less expensive sources of food. For example, replace chicken, which might be too costly, with groundnuts or another source of protein commonly available in the community.
- *Change the weights of the ingredients to household measures.* When cooking at home, people do not usually talk about grams or weigh foods. So, the grams must be changed to household measures. Measure the quantity of each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.). Demonstrate how to do this with one ingredient, such as rice. Weigh 50g of raw rice and put it into a household measure. Write the household measure on the calculation sheet. Do the same for each ingredient.

This is the amount of the raw ingredients required for each child at each Hearth session. To calculate the total amount of ingredients required for *all* the children, multiply the measure of each ingredient by the number of children in the Hearth session.

Example: There are six children in one Hearth session. The menu uses 50 g uncooked rice per child – one large handful of uncooked rice. The whole recipe would require six large handfuls of uncooked rice (1 handful of rice x 6 children).

When all group members are satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form (Handout 26.4) to display with the plate.

Facilitators should work actively with the groups to guide the development of a menu and calculate nutritional composition (micronutrients, calories and protein) for each menu. Verify that each proposed menu meets nutrient requirements for recuperative feeding. (If laptops are available, each group may have one person calculate the menus with the Excel programme while others do the manual calculation.)

25 Min

5.

Gather in a large group. Have each small group show their final plate and menu-planning form, explain their menu, and point out the difficulties they encountered and the possible solutions they identified. Guide discussion on each proposal.

- Does the menu contain the correct protein, calorie and micronutrient composition?
- Is the quantity (volume) of food in the proposed menu a realistic amount for a child to eat? *(This has to be visualised, recalling that a child's stomach is the size of the child's fist.)*
- Does the menu include PD foods?
- Does the menu include locally available and accessible foods?
- Does the menu include a snack?
- Is the cost per serving realistic for a very poor family? *(While caregivers are not necessarily expected to replicate the exact menu at home, they should be able to afford all the ingredients in order to serve them regularly to the child.)*
- If a child finishes all the food served, should he or she be offered more? *(Yes, but not another whole portion. Also, the volunteer should visit the home and talk to the caregiver to assure that the child is receiving three other meals and another snack at home each day while attending Hearth. When not attending Hearth, a child 6–8 months of age should be receiving two meals and two snacks plus breastfeeding each day, and a child 9–24 months of age should receive three meals and two snacks daily plus breastfeeding. The Hearth meal is an extra meal.)*

- Considering that some children may need an extra small serving when they finish their first portion, how much extra food should be cooked? *(Cook an extra amount equivalent to two full portions.)*

***Note**: Although time does not allow in this training of Master Trainers, during training of facilitators (TOF) sessions the menus should be cooked and tested. This practice ensures that those being trained understand what will take place in the Hearth session. They can taste the menus and select the two best menus. They can measure out the amounts using local measures that the caregivers will use to serve each child. This is invaluable practice. Caregivers and grandmothers from the community can also be asked to join the tasting as a way of introducing them to what they will learn in the Hearth sessions.*

6.

A good Hearth menu should:

1. Include PD foods (based on PDI findings)
2. Be low in cost (affordable based on PDI)
3. Meet nutrient, calorie and protein requirements
4. Be small enough in volume that child could eat another meal at home soon after (250g–300g)
5. Include a snack (to increase child's appetite)
6. Based on local context and culturally acceptable (use locally available and accessible foods)
7. Have good consistency (doesn't run off of spoon like water, but is thicker)
8. Not consist of foods that are too chunky or bulky, as that makes it difficult for children to consume.

Calories: **600–800 (500–600*)**

Protein: **25–27g (18–20g*)**

Vitamin A: **300 µg RAE (RAE=retinol activity equivalent)**

Iron: **8–10mg**

Zinc: **3–5mg**

Vitamin C: **15–25mg**

*Amounts in parentheses are the minimum for a region with food insufficiency; recuperation will take longer with these amounts (see CORE PD/Hearth Guide, p. 114).

Note: *The vitamin A requirement has been updated since the publication of the CORE PD/Hearth Guide and PD/Hearth Addendum to use the currently accepted measure of Retinol Activity Equivalents (RAE). Make sure that the food composition tables you use lists vitamin content as µg RAE, not RE or IU (conversion rate: 1µg RAE = 3.3 IU).*

Directions for the Menu-Preparation Exercise

Each group can go to the 'market area' (where the food and utensils are laid out) and take different foods for its menu. The menu includes one snack as well as the meal:

- Take the amount you think a small child would eat. Remember that a child's stomach is no larger than the child's fist.
- Note the cost per gram of the food you take.
- After weighing your group's choices, put the foods on a plate.
- Use the 'Food Composition Table' to calculate nutrients and complete the menu-planning form. (Refer to the CORE PD/Hearth Guide, page 116, which discusses how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Calculate the cost per gram used of each ingredient. Then add up the total cost of the menu for one child.
- Using common household measures, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.
- Convert the cooked amount of food to a raw amount. For rice, divide the cooked volume by 2 to get the uncooked measure. For example, 60g of cooked rice divided by 2 equals 30g of uncooked rice.

Conversion of cooked food in grams to raw food in grams:

Cooked rice, divide by 2

Cooked beans, lentils, pulses, divide by 2

Cooked porridge, divide by 2.5

Cooked green leaves, multiply by 1.4

- Change the gram amounts to household measures by measuring the quantity of each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.).
- For example, weigh out 30g of uncooked rice and put it into a cup that would be found in households or measure it by the handful, if that is more common.
- Write the household measure for each food on the calculation sheet.
- Each caregiver or caregiver-grandmother pair will contribute this amount of raw ingredients for their child(ren) at each Hearth session.
- When satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form to display with the plate.

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

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
1. Grains, Roots, and Tubers								
Cassava, boiled	165	1.2	1	13	1.4	0.2		1
Cassava, dried, raw	351	2.1	2	68	3.8	0.8		1
Cassava, raw	157	1.1	1	31	1.7	0.2		1
Maize flour, whole grain, yellow	361	6.93	11	0	2.4	1.7		5
Maize or Sorghum Ugali	110.3	3	2.1	0	1.3	0.5		7
Maize, white, whole, boiled	139	3.5	1	2	1.2	0.5		1
Maize, white, whole, dried, raw	363	9.2	3	8	3.2	1.4		1
Maize, yellow, boiled	136	3.6	35	1	1.6	0.6		1
Maize, yellow, dried, raw	354	9.4	101	4	4.2	1.7		1
Millet flour	373	10.75	0	0	3.9	2.6		5
Millet, whole grain, boiled	144	4.1	0	0	6.4	0.6		1
Potato, boiled	74	1.8	2	11	0.8	0.3		1
Rice Flake, water soaked	356	1.1	0	0	2.0	0.4		9
Rice noodle (mee suah)	320	9.10	0	0	1.6	0.7		10
Rice noodle, fermented	106	1.40	0	0	0.1	0.2		10
Rice steamed, white	131	2.20	0	0	0.4	0.6		10
Rice, brown, boiled	135	3	0	0	0.7	0.7		1
Rice, white, boiled	133	2.8	0	0	1.0	0.4		1
Rice, white, fried	370	6.81	0	0	1.6	1.2		10
Rice, white, raw	355	6.80	0	0	1.2	0.5		10
Rice, white, soaked	370	6.81	0	0	1.6	1.2		10
Sorghum flour	361	7.87	0	0	3.0	1.4		5
Sorghum, whole grain, boiled	153	4.6	2	0	3.6	0.6		1
Steamed sticky rice (white), grilled	229	4.60	0	0	0.1	0.2		10
sticky rice (white), steamed	229	4.60	0	0	0.3	1.0		10
Sweet Potato, boiled	101	1.7	789	15	1.7	0.3		1
Taro, boiled	100	1.9	4	3	0.9	0.2		1
Wheat flour, white	347	10.7	0	0	2.0	4.0		1
Wheat noodle (waiwai), instant	456	10.5	0	0	1.6	1.8		10
Yam, boiled	101	1.7	2	5	1.0	0.2		1
2. Legumes and Nuts								
Beans, kidney, boiled without salt	127	8.67	0	1	2.2	1.0		5
Beans, raw	32	2.4	54	18	1.0	0.3		1
Beans, yellow, cooked, boiled without salt	144	9.16	0	2	2.5	1.1		5
Cashewnut, raw	589	20	0	0	6.4	4.6		7
Chickpea, boiled without salt	164	8.86	1	1	2.9	1.5		5
Chickpea, dry	364	19.3	3	3	6.2	3.4		5
Coconut water	22	0.3	0	2	0.1	0.1		1
Coconut, mature, fresh, raw	387	3.2	0	2	2.5	0.9		1
Cowpea, Leafy tips, boiled and drained	22	4.67	29	18	1.1	0.2		5
Cowpea, seeds, black, dried, boiled	116	7.73	2	0	2.5	1.3		10
Groundnut, dried, raw	578	24.1	2	1	4.3	1.9		1
Groundnut, dried, roasted (also gnut flour)	567	25.8	0	0	4.6	1.7		6
Groundnut, fresh, boiled	236	10.8	0	0	1.9	1.0		6
Groundnut, fresh, roasted	374	17	0	0	3.0	1.1		6
Groundnut, seeds, dried, raw	577	24.8	0	1	2.3	2.8		1

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

World Vision

Day 4 Session 26

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
2. Legumes and Nuts (continued)								
Lentils, boiled without salt	116	9.02	0	2	3.3	1.3		5
Lentils, raw	353	25.8	0	0	7.5	4.8		5
Mongogo Nut, Bok Nut	659	26.00	0	0	3.7	4.0		
Mung Bean, boiled without salt	105	7.02	1	1	1.4	0.8		5
Mung Bean, dried	324	22	19	0	8.0	0.8		2
Soya bean, boiled without salt	173	16.64	0	2	5.1	1.2		5
Soya bean, dried, raw	397	33.2	9	0	8.3	4.7		1
Soya bean, dry roasted	451	39.58	0	5	5.0	4.8		5
Soya bean, roasted without salt	471	35.22	0	2	3.9	3.1		5
3. Dairy Products (milk, yoghurt, cheese)								
Breastmilk, human, mature, raw	69	1.1	62	1	0.2	0.3		1
Milk UHT, Thaidenmark brand (non-fortified)	67	3.30	41	0	0.1	0.3		10
Milk, cow, powder, whole	492	25.3	295	12	0.7	4.0		1
Milk, cow, whole, raw	75	3.7	39	2	0.1	0.4		1
Milk, goat, whole, raw	69	3.4	35	2	0.1	4.0		1
Milk, instant, Anmum brand (fortified)	77	3.20	93	22	2.6	2.2		10
Yoghurt, drinking, foremost brand	84	1.50	14	3	0.1	0.3		10
Yoghurt, wholemilk, natural	75	3.5	33	1	0.1	4.0		1
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats)								
Anchovy (small fish), fillet, raw	123	18.4	15	0	3.3	1.7		1
Anchovy, fillet, grilled	668	27.6	20	2	3.8	2.5		1
Anchovy, fillet, steamed	542	22.4	16	2	2.9	2.1		1
Beef ball, blanched	84	16.5	7	1	5.0	0.0		10
Beef internal organ barbecue	94	14.0	2357	9	5.0	2.0		10
Beef intestine, raw	109	16.4	10	0	3.1	2.0		10
Beef liver, grilled	133	20.3	3841	18	10.1	3.9		10
Beef liver, pan-fried	175	26.52	7744	1	6.2	5.2		5
Beef liver, raw	135	20.36	4968	1	4.9	4.0		5
Beef lung, raw	84	16.0	95	6	6.1	1.7		10
Beef spleen, raw	95	18.2	103	29	0.7	2.1		10
Beef stomach, raw	102	11.0	0	0	1.9	1.3		10
Beef, blanched	150	20.0	2	0	3.0	5.0		10
Beef, dried, grilled	479	38.3	3	0	11.8	3.9		10
Beef, dry, fried	479	38.3	3	0	11.8	3.9		10
Beef, grilled	190	38.5	3	0	4.9	7.6		10
Beef, ground, 20% fat, pan-broiled	246	24.04	0	0	3.6	6.1		5
Beef, ground, 20% fat, raw	254	17.17	0	1	1.9	4.2		5
Beef, raw	273	17.2	3	0	2.3	5.3		10
Chicken, roasted	210	23.8	0	0	0.8	1.5		10
chicken gizzard, raw	102	20.2	34	3	3.1	3.2		10
Chicken heart	112	15.8	75	6	4.0	5.5		10
Chicken Liver	114	16.9	3296	18	9.0	2.5		9
Chicken liver, boiled	121	18.6	3178	14	7.3	3.2		10
Chicken liver, grilled	121	18.6	3273	14	7.3	3.1		10
Chicken liver, raw	121	18.6	3710	14	7.3	3.0		10
Chicken, boiled	193	28.6	5	1	0.6	1.0		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
4. Flesh Foods (Meat, Fish, Poultry, and liver/organ meats) (continued)								
Chicken, cooked	285	26.9	39	0	1.4	1.8		6
Chicken, flesh only, raw	136	20.6	10	0	1.2	1.0		1
Chicken, raw	186	17.3	3	0	0.5	1.0		10
Cricket	127	12.90	0	0	9.5	0.0		11
Dried small fish *(usipa)*, cooked with salt	125	17	0	0	3.3	9.1		6
Duck, roasted	373	18.5	115	0	1.3	2.1		10
Fermented fish with bone	103	13.3	3	0	5.5	3.6		10
Fermented fish, sour, fried	108	19.5	1	0	2.1	2.4		10
Frog legs, raw	73	16.40	15	0	1.5	1.0		5
Lamb, composite of retail cuts, cooked	256	24.54	0	0	1.9	4.7		5
Lamb, meat, raw	217	17.2	10	0	2.3	3.1		1
Mackerel, Pacific and jack, cooked dry heat	201	25.73	23	2	1.5	0.9		5
Mackerel, raw	133	21.1	16	2	1.8	0.5		1
Mussels, boiled	33	3.1	208	0	2.9	1.9		2
Mutton/Lamb Liver	150	19.3	8250	20	6.3	4.0		9
Nile tilapia fish, raw	96	20.1	0	0	0.6	0.3		10
Nile tilapia, roasted	128	26.2	0	0	0.7	0.4		10
Pork blood, boiled	32	7.90	26	0	25.9	0.1		10
Pork liver, grilled	125	19.2	4242	19	15.5	5.3		10
Pork liver, raw	125	19.2	6291	25	15.5	5.6		10
Pork sausage, grilled	369	19.6	14	2	1.2	2.5		10
Pork skin, raw	320	19.8	6	0	2.1	0.3		10
Pork spleen, raw	87	16.1	241	26	1.0	2.3		10
Pork, boiled	204	33.0	0	0	1.5	1.3		10
Pork, fresh, cooked	201	27.51	1	0	1.0	0.1		5
Pork, grilled	249	26.2	0	0	2.5	1.8		10
Pork, meat, approx. 24% fat, raw	289	14.5	0	0	2.0	3.2		1
Pork, meat, approx. 40% fat, raw	405	12.6	0	0	1.9	3.2		1
Pork, raw	116	21.8	0	0	1.0	1.0		10
Pork, shreded, chinese style	357	43.1	0	0	17.8	1.3		10
Prawns or shrimps, cooked in moist heat	119	22.78	0	0	0.3	1.6		5
Rabbit, meat, raw	142	20.7	10	0	0.9	1.7		1
Rabbit, stewed	206	30.38	0	0	2.4	2.4		5
Short bodied mackerel fried	236	25.7	26	2	2.4	1.0		10
Short bodied mackerel, roasted	122	21.4	27	5	1.4	0.6		10
Siamese mud carp, grilled	124	21.1	9	1	0.6	1.5		10
Snail, pond, river	74	12.10	0	0	8.7	0.0		11
Tilapia, cooked dry heat	128	26.15	0	0	0.7	0.4		5
5. Eggs								
Egg, duck, whole, boiled	150	11.8	169	0	3.4	1.2		10
Egg, hardboiled	155	12.58	149	0	1.2	1.1		5
Egg, hen, whole	159	13.2	160	0	2.8	1.1		10
Egg, hen, whole, boiled	170	13.9	164	0	3.5	1.2		10
Egg, raw	139	12.1	207	0	2.4	1.3		1
Hen egg, fried	196	13.6	219	0	1.9	1.4		10
Omelet duck egg	183	12.6	365	0	3.2	1.0		10
Omelet hen egg	259	7.00	255	0	2.2	1.6		10

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

World Vision

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Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
6. Vitamin-A Rich Fruits and Vegetables								
Amaranth, boiled	21	2.11	139	41	2.3	0.9		5
Bean leaves, fresh, cooked with salt	14	1.4	192	12	1.1	0.1		6
Carrot, boiled	33	0.9	1137	3	0.7	0.6		1
Carrot, raw	35	1	1201	7	0.9	0.8		1
Cassava, fresh leaves, cooked with salt	20	2	261	12	1.6	0.6		6
Cassava, fresh leaves, raw	98	0.9	1733	370	5.6	5.0		1
Chinese cabbage blanched	21	1.70	244	33	1.6	0.2		10
Dark Green Leaves, fresh	48	5	950	100	4.0	0.8		2
Dark Green Leaves, fresh, cooked with salt	18	1.1	401	17	0.5	0.1		6
Green amaranth, small, blanched	21	2.11	278	41	2.3	0.9		10
Green amaranth, small, fresh	35	3.60	510	49	3.1	1.2		10
Horse tamarind, young leaves	85	9.20	255	7	3.4	0.6		10
Mango, ripe, fruit, raw	62	0.6	427	35	1.0	0.6		1
Moringa leaves, boiled	91	8.8	699	0	4.8	0.7		1
Moringa leaves, raw	86	8.3	738	0	6.1	0.9		1
Morning glory/Swamp cabbage, blanched	20	2.08	520	16	1.3	0.2		10
Morning glory/Swamp cabbage, fresh	31	2.90	457	28	3.3	0.5		10
Mustard green blanched	19	2.27	708	14	1.1	0.2		10
Mustard green, fermented, sour	21	1.50	161	20	1.3	0.2		10
Mustard green, stem and leaves, boiled	22	1.70	249	43	1.5	0.1		10
Mustard leaves, fresh, cooked with salt	16	1.1	213	0	1.0	0.4		6
Mustard, fresh	28	2.20	317	57	2.5	0.2		10
Okra, leaves, cooked with salt	12	0.7	260	11	0.3	0.7		6
Papaya (paw paw), fruit, ripe, raw	38	0.5	355	59	0.7	1.4		1
Pumpkin, boiled	20	0.5	201	5	0.2	0.2		6
Pumpkin, fresh leaves, boiled	11	0.6	298	11	0.5	0.4		6
Pumpkin, mature, fresh	49	1.30	170	15	0.7	0.9		10
Pumpkin, raw	36	1	250	15	0.8	0.2		2
Squash, raw	47	0.4	240	1	0.3	0.2		2
Squash, winter, all varieties, cooked without salt	37	0.89	261	10	0.4	0.2		5
Tamarind, young leaf, fresh	68	3.80	381	32	1.5	0.5		10
Taro, leaves, cooked without salt	24	2.72	212	36	1.2	0.2		5
Taro, young leaves, raw	30	2.4	389	52	2.0	0.4		1
Wildbetal Leafbush	60	4.20	258	17	4.2	1.0		10
7. Other Fruits and Vegetables								
Apple, prink, fresh	63	0.50	14	2	0.2	0.0		10
Avocado, raw	149	1.6	20	16	1.1	0.6		1
Bamboo shoots, cooked, boiled, with salt	11	1.53	0	0	0.2	0.5		5
Bamboo shoots, cooked, boiled, without salt	12	1.53	0	0	0.2	0.5		5
Banana, flowers, fresh	38	1.60	34	10	1.1	0.3		10
Banana, ripe, raw	100	1.3	19	10	1.0	1.1		1
Banana, ripe, yellow	105	1.00	15	12	0.4	0.1		10
Banana, ripe, yellow, boiled	105	1.00	13	10	0.4	0.1		10
Bean sprouts, fresh	46	4.30	5	23	1.4	0.5		10
Cabbage, blanched	29	1.50	8	32	1.0	0.3		10
Cabbage, boiled	19.8	1.3	11	21	0.4	0.2		1
Cabbage, common, fresh	29	1.50	8	32	1.0	0.3		10

Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Cabbage, raw	26	1.6	10	54	0.6	0.2		1
Cauliflower, boiled	28	2.7	1	47	0.8	0.4		9
Chayote, boiled	21	0.60	6	10	0.4	0.3		10
Chayote, fruit, fresh	21	0.60	6	10	0.4	0.7		10
Chilli pepper, hot, red, fresh	75	3.00	156	142	1.2	0.4		10
Cilantro	23	2.13	337	27	1.8	0.5		2
Coriander, fresh	33	2.50	431	34	2.6	0.2		10
Cucumber, fresh	23	0.80	9	12	0.4	0.2		10
Cumcumber	95.5	0.7	3	0	0.5	0.2		1
Dill, fresh	34	3.10	201	40	2.3	0.7		10
Eggplant, boiled without salt	35	0.83	2	1	0.3	0.1		5
Eggplant, raw	28	1.1	12	6	0.9	1.6		1
Eggplant/brinjal, green, fresh	37	1.50	10	8	0.9	0.2		10
Fennel common leaves, fresh	42	2.50	867	23	2.3	0.2		10
Fig, raw	78	1.4	79	15	6.0	1.5		1
Garlic, fresh	51	2.10	0	10	0.7	0.4		10
Garlic, raw	136	6.1	0	18	1.5	0.6		1
Ginger, raw	72	1.9	0	5	1.1	0.4		9
Guava, fruit, raw	58	1	95	281	1.4	1.8		1
Hairy basil, fresh	39	2.80	279	18	2.1	0.6		10
Jackfruit, raw	94	1.7	18	9	0.6	0.1		2
Lemon grass, fresh	78	0.80	3	1	2.0	0.5		10
Lemon, fruit, raw	36	0.7	2	46	0.6	0.1		1
Lemon, juice	29	1.1	3	53	0.6	0.1		4
Light/Pale Green Leaves, fresh	23	1.5	47	40	0.5	0.8		2
Mango, unripened, fruit, raw	55	0.5	10	86	1.4	0.6		1
Mint, leaf	42	2.90	467	84	4.1	0.8		10
Mushrooms, portabella, grilled	29	3.28	0	0	0.4	0.7		5
Okra, fresh, boiled	21	1.1	38	5	0.8	0.4		6
Okra, fresh, raw	31	1.7	72	29	0.9	3.0		1
Onion	50	1.60	0	8	0.7	0.2		10
onion, cooked	44	1.36	0	5	0.2	0.2		5
Onion, raw	32	1.1	1	7	0.5	0.2		1
Orange, raw	45	0.8	17	47	0.1	0.1		1
Orange, sweet, fresh	52	0.50	6	65	0.4	0.7		10
Pak kha yeng, raw	32	1.50	18	5	5.2	1.0		10
Passion Fruit	94	2.4	64	17	1.2	0.0		3
Pineapple, raw	56	0.4	15	31	0.5	2.2		1
Pomelo (grapefruit), raw	34	0.8	40	44	0.6	0.1		4
Radish, boiled	24	1.2	0	9	0.5	0.4		9
Radish, raw	18	0.9	0	17	0.4	0.4		9
Rumbutam, fresh	69	0.90	0	43	0.7	0.1		10
Shallot, bulb	67	1.70	1	9	0.9	0.3		10
Spring onion, fresh	44	2.20	475	42	2.3	0.4		10
Star fruit	32	0.60	10	29	0.7	0.0		11
Tamarind, fruit, raw	60	2.2	2	10	0.7	0.0		1
Tiliacora triandra diels	95	5.60	329	141	7.0	0.6		10

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

World Vision

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Food (English)	Kcal	Protein (g)	Vitamin A RAE (mcg)	Vitamin C (mg)	Iron (mg)	Zinc (mg)	Cost	Source*
7. Other Fruits and Vegetables (continued)								
Tomato, fresh	25	1.00	88	29	0.9	0.2		10
Tomato, raw	21	1	127	29	0.9	12.0		1
Tomato, red, ripe, cooked	18	0.95	24	23	0.7	0.1		5
Watermelon, fruit, raw	30	0.5	62	7	0.2	0.1		1
Yard long bean, green, fresh	40	2.60	41	20	0.8	0.5		10
8. Fats and Oils								
Butter, cow's milk	700	1	1060	0	0.2	0.1		1
Coconut oil	900	0	0	0	1.5	0.0		1
Ghee, cow	898	0	0	0	0.2	0.0		9
Groundnut oil	903	0	0	0	0.0	0.0		1
Mustard oil	900	0	0	0	0.0	0.0		9
Palm oil	895	0	0	0	0.4	0.0		1
Vegetable oil	884	0	0	0	0.0	0.0		4
9. Miscellaneous								
Fermented fish, liquid	13	1.20	3	0	2.9	0.1		10
Fish souce	48	5.40	5	1	2.4	0.2		10
Honey	322	0.3	0	2	0.6	2.0		1
Horse tamarind, seeds	152	11.8	34	2	4.3	1.4		10
Jaggery	383	0.4	160	0	11.1	0.0		8
Lemon, juice, fresh	24	0.50	1	25	0.1	0.1		10
Oyster sauce	73	2.90	6	7	1.1	0.1		10
Pumpkin seeds, without shell, roasted	594	25.6	0	0	6.0	8.0		11
Salt	0	0	0	0	0.3	0.1		5
Sesame seeds, white, roasted	682	26.1	0	0	13.0	7.2		10
Shrimp paste	85	4.60	21	0	2.2	1.1		10
Sprinkles (per sachet)	0	0	300	30	12.5	5.0		8
Sugar (white), not fortified	369	0	0	0	0.2	0.1		1
Tumeric, dried	335	6.9	1	0	33.2	3.8		9
Vinegar	27	0.2	0	0	0.5	0.0		1
10. Additional Foods								
Banana Porridge	105.3	0.6	65.6	9	0.4	0.1		7
Cassava Stiff Porridge	140	2.7	1.4	7	1.2	0.6		7
Coconut juice, fresh	37	0.10	0	5	0.1	0.2		10
Coconut milk	185	1.90	0	2	0.6	0.5		10
Deep fried banana with powder	373	2.00	11	8	0.4	0.1		10
Maize Porridge (with oil)	414.4	16.9	0.6	1	5.6	2.6		7
Porridge, white rice, boiled	59	4.10	0	0	0.1	0.2		10
Soy milk, Lactasoy brand	82	2.50	40	0	0.4	0.1		10

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Sample Menu-Planning Form

Menu A:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

Menu B:

Food	Home Measure	Quantity (g)	Calories (Kcal)	Protein (g)	Vit. A (µg RAE)	Vit. C (mg)	Iron (mg)	Zinc (mg)	Cost/amount	Quantity for Raw Amount
Hearth Requirements		250–300	600–800	25–27	300	15 –25	8–10	3–5		

User Guide for the PD/Hearth Menu Calculation Tool

The PD/Hearth Menu Calculation Tool is developed to aid in designing low cost and nutrient-dense menus for Hearth sessions using local foods/ingredients that are easily accessible and available to community members. Based on the PDI findings and the market survey, 2-4 Hearth menus with a snack and a meal for each menu will be developed for each community using PD food(s) and locally sourced ingredients. To quickly rehabilitate children from malnutrition, Hearth menus need to meet optimal calorie and nutrient requirements[1]. Particularly, this Tool is useful in checking whether the meal and snack meet the requirements. Also it simplifies other calculations such as the total cost and quantity of ingredients required for all the children attending Hearth as these can be generated automatically.

The PD/Hearth Menu Calculation Tool has six tabs/worksheets: Introduction; Instructions; Master; Menu Day 1; Menu Day 2; Menu Day 3.

Tab 1 – Introduction: Contains a background information on the rationale for the Tool including who should be using this Tool and how it should be used.

Tab 2 – Instructions: Contains a step-by-step detailed guide on how to use the Master and Menu worksheets. Please refer to this worksheet as you design the Hearth menus.

Tab 3 – Master: Contains a Food Composition Table with the nutritional breakdown of 100 grams of edible portions of foods in terms of energy (Kcal), protein (g), Vitamin A RAE (mcg), Iron (mg) and Zinc (mg). The foods are categorised in 10 food groups: 1. Grains, roots, and Tubers; 2. Legumes and nuts; 3. Dairy products; 4. Flesh foods; 5. Eggs; 6. Vitamin A rich fruits and vegetables; 7. Other fruits and vegetables; 8. Fats and oils; 9. Miscellaneous; and 10. Additional foods (In cases where local food items are missing from this Master list, missing foods can be added to 'Additional foods' group by copying the energy and nutrient values from another food composition table).

Tab 4 – Menu Day 1: Contains a Menu Planning Form (calculates the menu requirements for ONE CHILD) and a table that allows automatic calculation of the cost and quantity of each ingredient required in the menu to feed 'X' number of children, depending on the number of participating children in Hearth sessions. The total cost of the menu for all children is also given.

Tabs 5 and 6 – Menu Day 2 and Day 3: Contains additional worksheets (same format as Menu Day 1) to create different menus. Most Hearth sessions should have at least 2 Hearth menus. You should consider changes in food availability or affordability at different seasons (e.g. dry vs. rainy season) when designing Hearth menus. For example, you may want to create a menu for each season. Also, you could inform caregivers of foods you could replace certain ingredients with so that they will be able to continuously use the Hearth menu to feed their children during various seasons.

Step-by-Step Instructions:

Based on the PDI findings and the market survey results, create Hearth menus.

1. (Master worksheet) Enter cost of each food in Cost for Raw Foods column identified from the market survey. Please note that cost should be entered per 100g of edible portion of the raw food (See Step 1 of the Instructions sheet for an example).

2. (Menu Day 1 worksheet) In the Menu Planning Form, use the drop down option to select the food group of choice and then use the drop down option to select the ingredient/food under the Food column, placing each ingredient under appropriate headings (i.e. Meal or Snack).

3. (Menu Day 1 worksheet) Enter quantity in grams for each ingredient under the Quantity (grams) column. Please note that this amount is 'cooked' values in grams that will be used in the menu for ONE child. See Step 3 of the Instructions sheet for how to estimate the amount of ingredient keeping in mind the cook/raw conversions.

4. (Menu Day worksheet) Repeat Step 2 and 3 for each food you will use. You can also enter the household measure for the ingredients for the raw amounts indicated in the Raw Quantity (grams) column.

5. (Menu Day worksheet) Once you finish entering all the ingredients/foods for the menu, you can check at the bottom of the Menu Planning Form to see whether you have met or exceeded the Hearth menu requirements.

   a. The total values for each nutrient, cost, and 'cooked' quantity of ingredients in the menu for one child are calculated automatically in the row number 36. Depending on the values displayed under each column, you may need to adjust quantity of each ingredient or select different ingredient to develop optimal Hearth menus.

   b. You can check by comparing the total values for each column against what is displayed in each column heading. Or, in the subsequent row, any discrepancies or differences between the total value of each nutrient in the menu and the amount of the same nutrient required in Hearth menu are available. If the menu meets all the nutrient requirements, then all the numbers in red/bracket will be "0". Try to adjust the quantities and/or types of foods included in the menu until you reach something very close to the required amount of nutrient.

   c. The values in red/bracket indicate that these nutrients need to be increased by adding foods/ingredients that are high in these nutrients. For example, if the cell under the Iron column has "(3.50)", then you would need to increase amount of iron by 3.50 mg, by increasing quantity or adding iron rich foods like chicken or fish, still being mindful of the cost.

   d. Also the total quantity of 'cooked' foods should not be too much considering that a child has a small stomach (the size of a child's fist) and will not be able to eat a large volume of food at one sitting. Thus, depending on the total quantity (grams), you may need to select more nutrient dense food. For example, instead of selecting rice you may opt to select groundnut which will have more calories and proteins per gram basis.

6. (Menu Day worksheet) To calculate the total cost and quantity of ingredients required for the total number of children participating in Hearth sessions, enter the number of children who will be eating in a designated cell in the table below the Menu Planning Form chart. Also, determine a household measure for raw food amounts required for each ingredient from the Raw Quantity in grams column so that volunteers will know how much of uncooked ingredients will be needed for the Hearth menu. See Step 5 of the Instructions sheet for additional details.

SESSION 27

Review of Day 4 and Agenda for Day 5

World Vision

35 MIN

DAY 5

By the end of this session, participants will be able to

1. Review and demonstrate understanding of menu calculation process
2. Outline what will be covered today.

Preparation

- Print menu calculation test (provided in PD/Hearth Master Trainer TOT materials) for each participant

STEPS

30 Min

1. Hand out menu calculation tests for participants to complete. Collect the completed tests which will be marked by the facilitatiors and returned to the participants on the final day of the training.

5 Min

2. Review agenda for today.

By the end of the session, participants will be able to

1. Identify times to give information back to the community
2. Practise creative ways of presenting information to the community.

Materials

- A flip chart
- A brightly-coloured marker
- Maize or other plant leaves (several healthy green ones and several unhealthy yellow ones)
- Thirty or so stones (Step 2)
- A large 'Road to Health' card and coloured markers

STEPS

10 Min

1.

As discussed in the community mobilisation session on the second day, it is important to give information back to the community. When should information be given to the community? Develop a flip chart with the group (see sample below). Use a brightly-coloured marker to highlight the different times information is given back to the community.

SAMPLE STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP

Step 1: Ask for the community's permission and **invitation** to use the PD approach (finding existing solutions to malnutrition problems within the community).

Discuss a way to describe the PD concept in local language, using proverbs or stories.

Step 2: Engage the community in defining the problem. Weigh *all* the children in the target group.

Step 3: Share the results of the weighing with the whole community.

Step 4: Discuss childhood malnutrition with community members: its causes, and common challenges and constraints. Ask for their ideas or suggestions for solutions.

Step 5: Have a community meeting to share the baseline information (results of weighing) again and to give feedback on the findings from the group discussions (community analysis). Explore together with the

community members the links between the information discovered in the focus group discussion and the number of malnourished or well nourished children.

Step 6: Invite community members to participate in the PDI.

Step 7: Share the PDI findings with the whole community, examine the PD behaviours and strategies identified, and invite them to develop a plan of action that will include Hearth sessions.

At different times different information needs to be shared. This is extremely important in building community ownership and commitment. What are some ways to communicate with the community? *(Engage their attention, build on their ideas, and communicate in ways they can understand. Object lessons, skits, dance and song can be effective.)*

20 Min

2.

Divide into four groups. Assign each group one step (steps 3, 4, 5, 7). Each group must come up with a creative presentation of the information gathered from the community. Circulate and help the groups. Some examples follow.

Steps for presenting data on levels of malnutrition in the community and discussing possible causes

Step 1

Use green and yellow maize leaves to show healthy and unhealthy plants. Discuss why the yellow leaves are unhealthy and ways to make the plants healthy. *(use manure, weed them, space them properly, fertilise them)*

Link the maize leaves with children. Some children are growing well, and some are not. Why? (*not fed enough, not fed often enough, births not well spaced, sickly, not enough variety of food, parents absent)*

Use stones to show proportion of children who are like yellow leaves (malnourished) and those who are like green leaves (well nourished). What makes the difference between these groups of children? How have caregivers in the community tried to help their children grow better? What do some families do to keep their children well nourished?

Step 2

Make a very large 'Road to Health' card. Plot every child that was weighed in the community on the chart. Use the colours green, yellow and red to show the difference in levels of malnutrition. Talk to the community about how

healthy children's growth follows the curve. Ask how many children there are. How many are not growing well? How can they tell? Why do they think they are not growing well? What have they tried before to help children grow better?

Are any children growing well? Why do they think that is? Are there things these families do that we could learn from? What have they tried? What has worked? Introduce PD/Hearth – discovering together what these families do so all can have well-nourished children.

Presenting information comparing community norms with the PDI information

Step 3

Present two skits. The first shows a family with children who are sick. The family demonstrates poor behaviours *(caregiver goes to the field in the morning without feeding the children, eat only maize without washing hands, poor overall hygiene, grandmother tells mother not to feed the child when s/he has diarrhoea).* Include behaviours that are seen in the community. Exaggerate to make the skit funny.

The second skit shows a family with happy, healthy children demonstrating good practices (*feeding a variety of foods, washing hands, helping child eat, giving snacks, talking to children, grandmother supports caregiver's active feeding of children, gives separate bowl for young child to eat).* Include any practices that have been discovered in the PDI.

Talk with the community about how poor families with good practices have been able to keep their children healthy. Talk about the practices discovered in the PDI. Do they contribute to children being healthy? Could every family in the community do them?

Step 4

Hold a discussion with the community to create an action plan, including a discussion to identify mothers who will volunteer for the first PD/Hearth session in the community (among families with either underweight or healthy children).

30 Min

3.

Have the groups present the skits to the others. Discuss the presentations and encourage the participants to offer as many ideas as possible.

SESSION 29

Conducting the Hearth Session (Panel Discussion) (STEP 6)

World Vision

40 MIN DAY 5

By the end of the session, participants will be able to

1. Identify key factors that have contributed to the success of Hearth sessions
2. Discuss adaptations to meet contextual needs in successful Hearth programmes.

Reference in *CORE PD/Hearth Guide*: pp. 135–39 and 143–45

Preparation

- Ask participants with PD/Hearth experience to take part in a panel discussion.
- Have the flip chart with the PD/Hearth objectives at the front of the room.

STEPS

10 Min

1.

Review together what takes place in a typical Hearth session. Ask participants to list the activities that take place. Mention that there are several days when other activities happen. The day before the Hearth sessions begin the volunteer must gather the caregivers in his or her session together. They will discuss what PD/Hearth is about, what each caregiver or caregiver-grandmother pair needs to bring, time and place to meet, and so on. Sometimes caregivers are invited to come after the volunteers have practised making the menu. The caregivers taste the food and discuss how they will learn to make these foods to help their children grow well.

On Day 1 and Day 12 all the children in the session will be weighed before they eat the food. The weights are recorded on the monitoring sheets. This will enable volunteers, supervisors, and caregivers to see whether each child is gaining sufficient weight.

5 Min

2.

Introduce the session, explaining the need to adapt the programme and to remain flexible while still focusing on the purpose of Hearth. Refer to the flip chart with the PD/Hearth objectives, and briefly go over the importance of adequate food intake, of local feasible interventions, and of the caregivers' participation. Introduce the panellists.

15–20 Min

3.

Ask each panellist to describe briefly his or her experience with PD/Hearth. If any adaptations were made, explain why. Did the adapted programme remain true to the principles of Hearth? Was the programme successful? Why?

5–10 Min

4.

Questions from participants.

Which elements of the programme might need to be tailored? What considerations might prompt adaptations? Ideas? (See the situations detailed in the *CORE PD/Hearth Guide*, pp. 143–45. The discussion should include examples of ways to follow up defaulters; how to avoid the stigma of participation; and methods to incorporate working mothers, grandmothers and/or multiple caregivers.)

Discuss the following adaptations, as well as any mentioned in earlier sessions that merit further discussion:

- The Haiti programme placed a volunteer in a local hospital to create a better link between the community and the hospital (for referrals and for other health services).
- In many urban settings the homes do not have sufficient space to hold a Hearth session. In India, plastic sheets were used to create a 'roof' over a dead-end alleyway between houses, thus creating a space to hold the sessions.
- Some NGOs are experimenting with ways to use Hearth along with food-distribution programmes. In Indonesia, volunteers are paid 'food for work' and the rice and oil are used in the sessions. These are staples all families have, so the emphasis is still on the caregivers contributing the PD foods. The sessions show families how they can feed their children well without donated rations.
- In Mali, one programme has each participating caregiver lead the Hearth session one day. On the previous afternoon the staff person visits the home to help the caregiver prepare the session. There is no volunteer.

SESSION 30

Supporting New Behaviours through Reflection and Home Visits (STEP 7)

World Vision

60 MIN | DAY 5

By the end of the session, participants will be able to

1. Help caregivers reflect on changes in their child to motivate on-going practice
2. Summarise the objectives, activities and frequency of home visits
3. Explain the objective and activities for providing community feedback.

Reference in *CORE PD/Hearth Guide*: pp. 141, 143–45

Further training on counselling for behaviour change is covered in the World Vision CHW/TTC training materials (available by contacting nutrition@wvi.org).

Preparation

- Ask six participants to act as 'caregivers' in the reflection skit.

STEPS

5 Min

1. Learning new habits takes time

Caregivers get a good start during the Hearth sessions, but need help to recognise the changes they see in their children and relate those changes to the extra food and care they are giving them. This can be done this having a reflection time together on the last day of Hearth. They also need to be encouraged to continue the new practices, so volunteers will visit caregivers in their homes during the two weeks after the Hearth sessions. These visits are intended to help caregivers overcome any problems they might be having in following the new practices.

10 Min

2. Role play a reflection time

Gather all the 'caregivers' in a circle on a mat. Point out that this is the last day of Hearth. Ask the 'caregivers' what they think, allowing time for them to answer. 'What did you like about Hearth?' 'What was your child like before the Hearth sessions started?' 'What is your child like now?' 'What do you think has made the difference?' 'Do you think you will be able to continue these same practices at home?' 'What obstacles do you think you might have?' Congratulate them on their great work.

5 Min

3. Discuss the role play together

Brainstorm for ways to solve the problems that caregivers might have. What do we want caregivers to learn from the reflection time? Why?

5 Min

4.

Explain the importance of practicing a new behaviour over a sufficient length of time for the behaviour to become a habit. The Hearth approach includes two weeks of Hearth followed by home visits during the two weeks after the Hearth session to reinforce the behaviours learned during the sessions. Each caregiver or caregiver-grandmother pair is briefly visited every two or three days by the volunteer to be sure the child continues to receive the 'extra' food and that the other PD behaviours are being practised. Reiterate the importance of the follow-up home visits.

10 Min

5.

Present the following scenario to demonstrate a home visit:

The volunteer 'drops in', chats with the mother and grandmother about neighbourhood news, and inquires about the child. (The child is playing at a neighbour's house.) The volunteer points out to the mother and grandmother that the child's newfound energy and interest in playing are signs of recovery. The mother mentions that the child had a bout of diarrhoea. When the volunteer asks how she treated it, she says she had oral rehydration solution but gave tea instead because she couldn't remember how to prepare the solution and the grandmother couldn't either and so suggested tea. The volunteer explains how to prepare ORS both to the mother and grandmother and asks them to repeat the directions. The volunteer asks whether the child's appetite is good, and the mother says yes and that she is giving the child extra food. The volunteer says she will check in the day after tomorrow, reminds the mother and grandmother of the final weigh-in on the following Friday, and congratulates them for their efforts to make their child healthy.

10 Min

6.

After the role play, ask participants:

- What was the purpose of the home visit? (*encourage caregivers to continue feeding and caring practices; encourage grandmother to support and advise caregivers of the practices; see that the child is continuing well; help caregiver and grandmother think of solutions to challenges)*
- What examples of positive reinforcement did you see?
- How did the volunteer help the mother and grandmother see the change in their child?
- How long was this home visit? *(brief, 10–15 minutes)* How often are caregivers visited by the volunteer? *(every two or three days)* How many visits can a volunteer could do in one day? *(two or three)*

Repeat yet again the importance of the follow-up visits in behaviour change and helping families find solutions.

15 Min

7.

Ask participants what challenges caregivers might have in practicing Hearth behaviours at home. Brainstorm possible solutions to each situation. Possible problems include:

- Forgetting what was taught
- Not having the ingredients for the menu
- Not knowing where to get affordable fish or vegetables
- Having a husband or mother-in-law who is resistant
- Having a child who is sick
- Having a child who refuses to eat.

By the end of the session, participants will be able to

1. Discuss considerations for children graduating from or repeating the Hearth sessions (Hearth protocols)
2. Discuss ways to work with the community to design an exit strategy and/or to link Hearth with other programmes.

Reference in *CORE PD/Hearth Guide*: pp. 124–28, 142

Preparation

- Print Handout 31.1
- Refer to Handout 15.2
- Blank flip chart

Materials

- Handout 15.2: WHO Weight-for-Age Reference Table
- Handout 31.1: Follow-up Cases

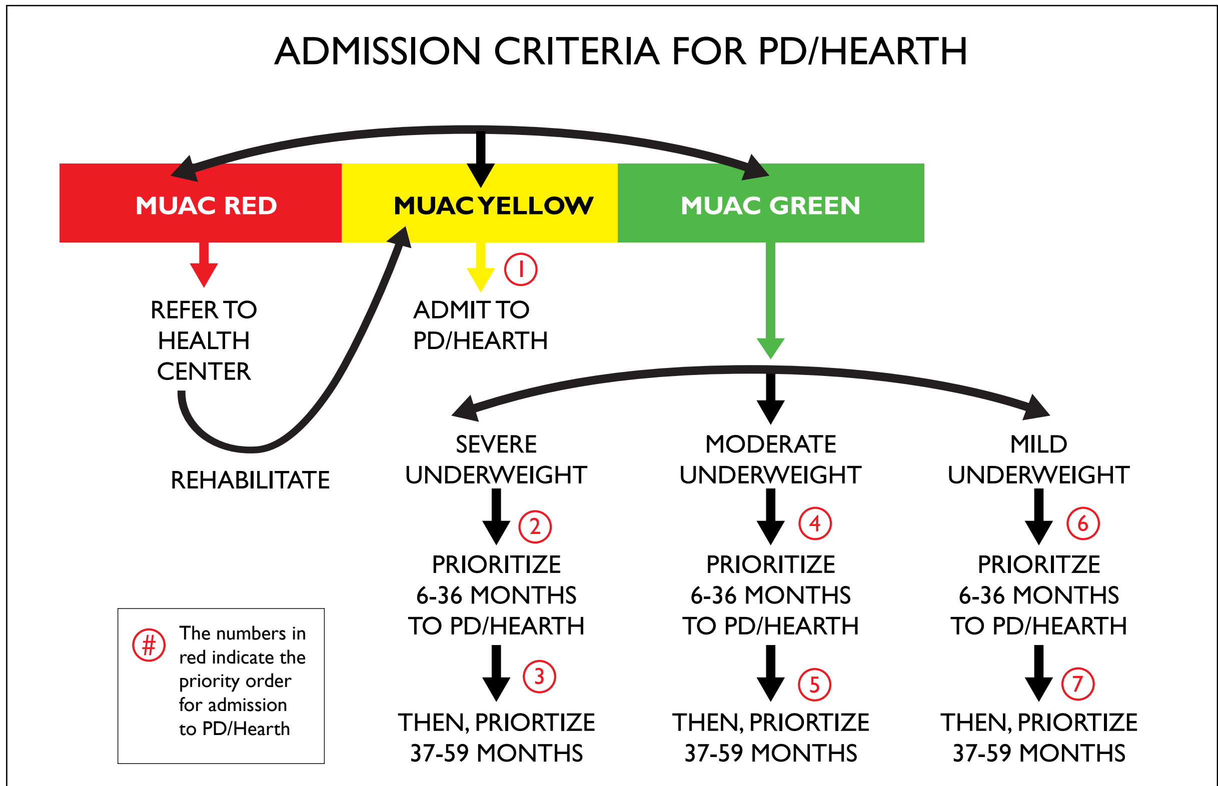
STEPS

10 Min

1. Please explain PD/Hearth Admission Criteria to the participants. If a child's MUAC is red, refer him/her to a health centre, otherwise follow this table for the order of admission.

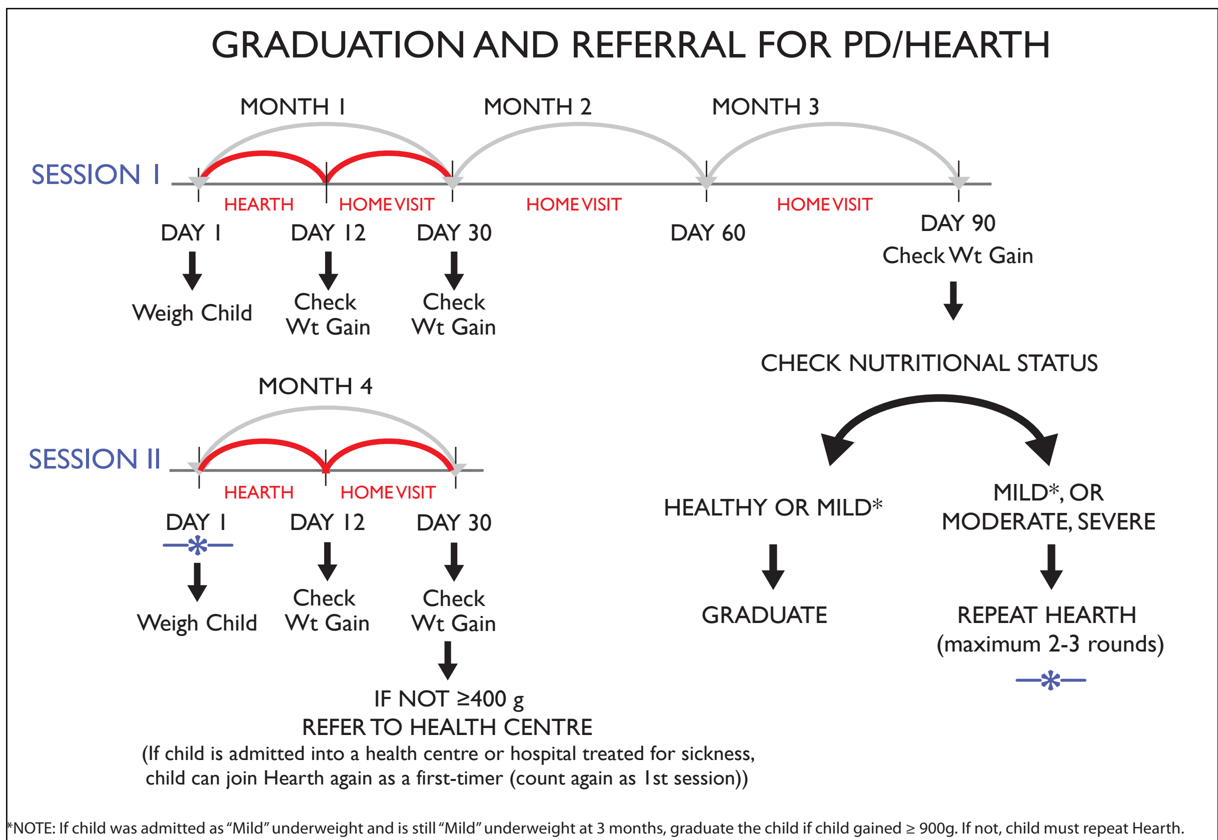
PD/Hearth Admission Criteria

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



Please explain PD/Hearth graduation criteria to the participants.

PD/Hearth Graduation Criteria



1. **Graduation Criteria (Graduation declared at 3 months follow-up)**

   - **Nutritional Status Graduation Criteria**

     - **3 months**: Must be **"Healthy or Mild"** for underweight nutritional status for children to graduate, regardless of weight gain. If child is still "Moderate" or "Severe" underweight, repeat Hearth after 3 months (can be part of Hearth session, maximum 3 times – depends on the country; we recommend 2)

     - **3 months:** If child was admitted as "Mild" underweight, but child is "Healthy" nutritional status, graduate the child. If child was admitted as "Mild" underweight and is still "Mild" underweight at 3 months, graduate the child if child gained ≥ 900g. If not, child must repeat Hearth.

   - **Weight gain requirements (encourage mothers are doing a good job if they meet these requirements, but it is not used for graduation criteria):**

     - **12 Days:** ≥ 200g

     - **30 Days:** ≥ 400g (If child did not gain close to 400g at 30 days, ensure mother is practicing the positive practices encouraged during Hearth session. If child seems to be sick, refer child to health centre)

     - **3 months:** ≥ 900g

2. **For Home Follow-up Visits (Frequency during 2 weeks after Hearth; 2 years after Hearth; Monitoring of weights with GMP – also what to do with children who don't attend)**

   - Conduct home visits for 2 weeks after 12-days of Hearth session (2-3 times a week)

   - Visit HH of PD/Hearth participants every month after 30 days for up to 1 year (if possible)

   - Conduct "Health meeting" led by community every 1-3 months for community monitoring of PD Children's growth, share Health/Nutrition messages and meet with PDH participant caregivers after meeting

   - Pay a special visit to HH to check weight of child and provide counseling as needed for children who have MUAC 'yellow' and for children severely underweight

3. **When to Refer child for medical attention?**

   - During Initial Assessment or 1st Day of Hearth, if child is found to be "RED" for MUAC, refer to health centre and do not admit into PD/Hearth (follow-up with child and admit into PD/Hearth after child returns from Health Centre is and "YELLOW" or "GREEN" for MUAC

- If before Hearth, child has not received full immunization, Vitamin A supplementation and was not dewormed 6 months ago (need to make sure child is given all 3 before being admitted into Hearth)
- During **Hearth session**, child becomes ill (if child is referred to health centre, once child is back, reset the number of times child was in Hearth session)
- During **Follow-up visits**, child becomes ill (if child is referred to health centre, once child is back, reset the number of times child was in Hearth session)
- **Child doesn't gain at least 400g of weight after 2 consecutive Hearth sessions in 30 days, refer child to Health Centre for medical check-up**

4. Age limits for Participation in Hearth (how to deal with siblings not identified for Hearth)

- 6-59 months (Prioritize children 6-36 months of age first)

HANDOUT
15.2 – 77m/H 40

It is important to monitor not only the child's weight gain, but also to calculate the child's nutritional status using either the 'Road to Growth' charts or the WHO Anthro Table (Handout 15.2). A malnourished child is expected to gain 400 grams in one month with one Hearth session. If a child's nutritional status advances to green (normal) in one session, the child must continue to grow at the average expected rate (approximately 200–250 grams a month, depending on the child's age). Thus after 3 months the child should have gained 900 grams.

A 400 gram gain in Hearth will usually not move a child from one level of malnutrition to another, especially if the child is moderately or severely malnourished. The average gain needed to change from moderately malnourished to mildly malnourished is about 1.2 kilograms. This can be demonstrated with the WHO Weight-for-Age Reference (refer to Handout 15.2, 18 months for girls or boys). Look at the weight in the moderately malnourished column and subtract the weight in the mildly malnourished column. This is the amount of weight a child needs to gain to move from moderately malnourished to mildly malnourished. Notice that as the child gets older, more weight is needed to 'cross' from one level of nutrition to another.

A PD/Hearth programme needs to ensure that children are not only gaining the initial 400 grams in one month but are continuing to gain weight in a pattern consistent with the growth charts. This means that the programme does not expect the nutritional status of the child to improve (e.g. continuous catch-up growth) at home, but only to maintain healthy growth after the initial catch-up growth with the Hearth session. However, if catch-up growth is seen at home, that is a commendable achievement and the household's strategy to do this could be shared with others in the community. In many programmes children who gain 400 grams but are still malnourished enter another Hearth session in order to continue their catch-up growth.

When a child is not gaining adequate weight, this should be assessed together with the caregiver and family members. There may be understandable causes (for example, child may have had diarrhoea which prevented adequate weight gain of 400g in one month or 900g in three months). Continue to monitor the child at home. In some cases there may seem to be no clear reasons why the child has not gained adequate weight. In this situation, it may be decided together with the caregiver and family that it would be best to repeat the Hearth sessions in order to reinforce new skills and practices and allow the child to have another period of accelerated growth. If the child does not gain the graduation weight in the second round of Hearth (i.e. 400 g or more by the end of the month), the child should be referred to the local health facility to assess for underlying diseases.

Each child's situation is unique and graduation should be assessed individually.

What other elements might the community include in its Hearth protocol?

Be sure the important points from the *PD/Hearth Guide* (pp. 124–27) are highlighted. Include:

- A limit to the number of times a child may repeat Hearth
- When to refer the child for medical intervention
- What to do if attendance is poor
- Micronutrient and other supplemental activities
- Expectations for participation in growth monitoring programmes
- Age limits.

15 Min

2.

HANDOUT
31.1 – 165m/H 66

Break participants into small groups and assign each group one of the case studies (Handout 31.1). Participants should discuss the conditions for enrolling a child in Hearth and for graduating a child or having the child repeat Hearth. What action is indicated in the case of a chronic underachiever?

During the final five minutes, have each group briefly explain its case and recommendations.

10 Min

3.

Discuss the importance of a growth monitoring programme in the community, and note that a Hearth project may be developed in response to observations from the growth monitoring programme or vice-versa. Ask participants to suggest other community programmes that might lead to the development of a PD/

Hearth project. List these on a flip chart, and discuss issues that might arise with the addition of PD/Hearth to existing programmes. Continue with a discussion of integrating PD/Hearth with other programmes, either existing ones or new ones added as a result of the community mobilisation for PD/Hearth. *(Examples could include a water system, as a result of promotion of hand washing and overall hygiene; small business support or agricultural projects to supplement income and/or food supply; breastfeeding support groups, etc.)*

10 Min

4. At what time should PD/Hearth be replicated? Where and how? *(It is important that PD/Hearth implementers learn in a small pilot project. Once one project is successful, consider replicating it in other communities or other ADPs. One very successful project could become a learning centre to train other communities and staff. Do not proceed too quickly or replicate weak or unsuccessful projects.)*

1st case: Aisha is three years old, and an only child. After two Hearth sessions, she has gained 800 grams but is still moderately malnourished. Her mother, who is pregnant, appears to be following the new PD behaviours and working hard to rehabilitate Aisha, but she is becoming discouraged. The grandmother is taking care of Aisha during her pregnancy and advising her to continue feeding Aisha with what they learned at Hearth. The grandmother is confused that her daughter-in-law is discouraged and that the volunteers say that Aisha is still malnourished when she is looking very healthy, active and growing well.

2nd case: Tobir Village has many malnourished children, and Hearth sessions are proceeding well. However, some segments of the population are semi-nomadic, moving with the seasons to find work. Though these caregivers have been enthusiastic participants, it is difficult to follow their children during the dry season. Many return during the rainy season having lost weight again.

3rd case: Daniel is 23 months old. He and his mother (who also has two older children) just completed one Hearth session. His weight has not improved. The supervisor suspects, from her home visits, that the mother is preparing some extra food but sharing it with the whole family. The grandmother may support sharing the extra food with the entire family too.

4th case: During the sessions Budi gained 500 grams. By the end of the follow-up period he had lost the 500 grams.

SESSION 32 Monitoring and Evaluation

120 MIN | DAY 5

By the end of the session, participants will be able to

1. Identify several key quality indicators for monitoring PD/Hearth activities
2. Describe supervision tools that are available to ensure the quality of PD/ Hearth activities.

Reference in *CORE PD/Hearth Guide*: pp 140, 146–48, 157–84

Preparation

- Write each of the 3 Hearth goals on separate pieces of flip chart paper.
- Prepare a flip chart to show the Triple 'A' Cycle (**A**ction-**A**ssessment-**A**nalysis) – see page 168 of the *CORE PD/Hearth Guide*.
- Print copies of 32.1, 32.2, 32.3A, 32.3B, 32.4, 32.5, 32.6, 32.7, 32.8, 32.9 and 32.10

Materials

- Handout 32.1: Checklist of Materials Needed for PD/Hearth Sessions
- Handout 32.2: PD/Hearth Menu and Cooking Materials Tracking Sheet
- Handout 32.3A: Child Registration and Attendance Form
- Handout 32.3B: Child Registration and Attendance Form' (including Grandmothers)
- Handout 32.4: PD/Hearth Register and Monitoring Form
- Handout 32.5: Volunteer Home Visit Form
- Handout 32.6: Supervision of Hearth Session
- Handout 32.7: PD/Hearth Annual Report
- Handout 32.8: Monitoring Case Study Data Sheet
- Handout 32.9: PD/Hearth Monitoring Case Study Questions
- Handout 32.10: User Guide for the PD/Hearth Excel Database
- Blank flip chart
- LCD Projector
- Soft copy of Excel-based PD/Hearth database (found in Resource CD)

STEPS

20 Min

1.

Remind the participants of the three goals of PD/Hearth and ask them to discuss together some indicators that can be used to monitor and evaluate progress toward each of the three goals. Write each suggested indicator on the flip

chart for the goal to which it applies and indicate whether it is a qualitative or quantitative indicator.

Goal One: Malnourished Children Are Rehabilitated

Observe during the household visit if the child is eating PD foods. Caregivers may report a change (qualitative); measure weight gain (quantitative).

Note that PD/Hearth is a time-limited activity compared to other types of child-survival programmes. Therefore, monitoring and evaluation can lead to direct, immediate and simple modifications to the programme. For example, in Haiti the percentage of those attending was low. Therefore, after the first cycle, the staff interviewed both women who didn't attend and those who participated fully. The programme was modified for the second cycle to correct issues identified in the interviews.

Goal Two: Families Are Able to Sustain Rehabilitation at Home

Are PD behaviours maintained after six months (for example, if five key behaviours were discovered in the PDI, are caregivers still practising at least three of them) with the PD child and with siblings (qualitative)? Measure for sustained weight gain at three months, six months, 12 months etc. (quantitative). Identify the percentage of children who regularly attend the growth-monitoring programme and/or immunisation programmes (quantitative).

Goal Three: Future Malnutrition Is Prevented (Community Level)

Gather information through informal interviews with neighbours and friends (qualitative); gather data through a review of community weights or other nutritional assessment (quantitative). PD families that have graduated from the Hearth programme may formally mentor incoming participants (this, too, can be monitored/measured).

What External Factors Might be Monitored?

The quality of the existing health-care system can be evaluated for impact from the PD/Hearth programme: increased attendance; increased immunisation coverage; improved/more accurate weighing in the growth monitoring programme; referrals, etc. Indicators of community mobilisation and social change can be evaluated as well (new leadership, involvement of disadvantaged population, conflict resolutions, impact beyond nutrition, etc.).

Note: *The local hospital may need to budget for recuperation of severely malnourished children, because they will be more readily detected and referred early in the programme. Keep apprised of Ministry of Health policies for rehabilitation that may include community-based management of acute malnutrition (CMAM) which might be coordinated with PD/Hearth. After severely*

malnourished (wasted) children have completed the CMAM programme, they should participate in a PD/Hearth session so that their caregivers will learn new behaviours necessary to sustain the recuperation.

Who Monitors? The ADP/NGO monitors PD/Hearth activity; the community monitors the volunteer; and the volunteer monitors the caregivers and children.

Why Monitor?

- Supervision helps to ensure quality and consistency in the programme; is useful for troubleshooting; and provides an opportunity to reinforce training and strengthen skills.
- Supervision is an ongoing process. It helps motivate people, reinforces good performance, creates a sense of achievement, and serves as a way to share good ideas.
- Supervision provides an opportunity for adapting to situations as they occur. For example, participant attendance was found to be a problem in Haiti. In response, the supervisor determined that for the next session, the participant contribution would be dropped off early in the morning of the session. This allowed time for the supervisor to locate anyone who did not show up and encourage them to attend the session.

What to Monitor?

Monitor volunteer skills, communication skills, and adherence to Hearth protocols; menus (taste, consistency, nutritionally adequate, affordable, use of PD foods); food safety; caregivers' attendance all 12 days; recording of weights and other appropriate activities. Assessments are made through observation, conversations with volunteers, caregivers and grandmothers, and verification of records. The protocol for a supervisory visit includes:

- Observation
- Sharing in conversation
- Applying information – provide feedback

Analysis should be shared during a feedback session with the volunteer and with the Village Health Committee. Stress the positive first. Dwell on the outcome – How many children graduated? Look at key quality indicators together. *Remember: positive feedback, analysis of problems, identification of solutions and follow up.*

5 Min

2.

Ask participants to list potential indicators of behavioural change in Hearth. Write these on a blank flip chart.

- Observe practices during the visit (see the PDI questions/checklist in Session 18).
- Talk with the caregiver and grandmother for information on practices and if child is receiving extra food.
- Check for better health-seeking behaviours (what does the caregiver do and/or grandmother advise when the child is sick: attendance at health post, extra feeding, etc.).
- Verify weight gain (at one month, three months, six months, and twelve months following the Hearth session).
- Observe the health status of any new siblings.

Ask which of the indicators can be observed during home visits. Put an asterisk (*) next to these. Ask whether the supervisor or the volunteer would be more likely to observe and document these indicators.

20 Min

3.

HANDOUT
32.1 – 171m/H 67
32.2 – 172m/H 68
32.3A – 174m/H 70
32.3B – 175m/H 71
32.4 – 176m/H 72
32.5 – 177m/H 73
32.6 – 179m/H 75
32.7 – 180m/H 76

Distribute the sample checklists and monitoring forms (Handouts 32.1 to 32.7). Review these together. Volunteers will use the following forms:

- Handout 32.1 as a checklist of the materials needed for the PD/Hearth sessions
- Handout 32.2 to track caregivers' menus and cooking materials
- Handouts 32.3A/B and 32.5 to keep track of Hearth attendance and home visits, respectively.

Discuss options if literacy is a challenge for volunteers. (*older child could help with forms, develop pictorial forms, pair volunteers with at least one person who is literate)*

The supervisor of the volunteers (usually the trainer) will use the following monitoring forms:

- Handouts 32.4, 32.6, and 32.7 to track PD/Hearth programmes.

5 Min

4.

Refer to the Triple 'A' Cycle (on the flip chart) to demonstrate the continuous monitoring process. Emphasise the importance of feedback to volunteers and supervisors as well as to the community. Sharing results with the community increases ownership, encourages discussion and problem solving, and celebrates achievement.

How Can This Information be Used to Improve Programme Quality?

Seek mutual solutions, monitor the community taking charge, and provide refresher training.

Frequency of Supervision?

Supervise a new site frequently at first; try to be present on the last day of Hearth.

Implication for Budgeting (transport and time spent in the field)?

Supervision is time consuming. It is important to budget sufficient staff time.

10 Min

5.

Reiterate the importance of community involvement and community-wide change for success with sustaining the achievements of Hearth. Ask the participants to suggest ways to incorporate feedback to the community as part of the process of reinforcing the long-term practice of PD/Hearth behaviours. Note that attention to community-level indicators reflects the Hearth goal of affecting non-participants. Add examples of these indicators to the flip chart.

Community level

- Talk with neighbours (ask whether the PD/Hearth caregiver has talked about Hearth).
- Review the weights of the children in the community over time (from the GMP). Invite the community health committee to share the results of the GMP with the entire community on a regular basis. Help the committee develop posters to show progress (to promote social change).
- Meet with community leaders to share Hearth outcomes.
- Document success stories and share them within the village and beyond.

60 Min

6. Monitoring Case Study

HANDOUT
32.8 – 181m/H 77
32.9 – 185m/H 81

Distribute Handout 32.8: Monitoring Case Study Data Sheet and Handout 32.9: PD/Hearth Monitoring Case Study Questions. Ask the participants to work on and discuss each section before moving on to the next section. Work through all the sections.

30 MIN

7.

HANDOUT
32.10 – 187m/H 83

Please briefly go over the PD/Hearth Excel Database with the participants. Refer to Handout 32.10: User Guide for the PD/Hearth Excel Database.

Checklist of Materials Needed for PD/Hearth Sessions

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice,fufu, yams)			
Oil			
Other ingredients			

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

World Vision

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1 INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2 INGREDIENTS	COOKING MATERIALS	ROLE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

No.	DAY 3 INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4 INGREDIENTS	COOKING MATERIALS	ROLE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

No.	DAY 5 INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6 INGREDIENTS	COOKING MATERIALS	ROLE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

No.	DAY 7 INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8 INGREDIENTS	COOKING MATERIALS	ROLE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

No.	DAY 9 INGREDIENTS	COOKING MATERIALS	ROLE	DAY 10 INGREDIENTS	COOKING MATERIALS	ROLE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

No.	DAY 11 INGREDIENTS	COOKING MATERIALS	ROLE	DAY 12 INGREDIENTS	COOKING MATERIALS	ROLE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

HANDOUT 32.3A

Child Registration and Attendance Form

World Vision

Day 5 Session 32

ADP Name .... Village Name .... Name of Hearth ....

Hearth Session Dates (dd/mm/yyyy): From .... To .... Number of Children Participating .... Name of Volunteer ....
....

#	Name of Child	Caregiver's Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	Attendance for Hearth Participant Child AND Primary Caregiver*											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Child Registration and Attendance Form (including Grandmothers)

ADP Name .... Village Name ....Name of Hearth ....

Hearth Session Dates(dd/mm/yyyy): From ....To .... Number of Children Participating .... Name of Volunteer ....

#	Name of Child	Caregiver's Name/Grandmother Name	Child's Gender (M/F)	Date of Birth (dd/mm/yyyy)	Age (months)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

#	Attendance for Child and Caregiver*											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

#	Attendance for Grandmother											
	1	2	3	4	5	6	7	8	9	10	11	12
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

***IMPORTANT:** Indicate with a checkmark (✓) if the PD/Hearth child AND Primary Caregiver attended the Hearth session for the corresponding day.

Hearth Register and Monitoring Form

World Vision

Day 5 Session 32

ADP Name .... Village Name ....

Name of Hearth .... Volunteer's Name(s) ....

Child's Name										
Caregiver's Name										
CHILD	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Child's Sex (M/F)										
Date of Birth (dd/mm/yyyy)										
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')										
At Day 1 of Hearth – Date (dd/mm/yyyy)										
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

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 32.5

Volunteer Home Visit Form

World Vision

Day 5 Session 32

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 32.6

Day 5 Session 32

Village Name .... Hearth Name ....

Volunteer's Name(s) ....Today's Date..

OBSERVATION LIST	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.				
Location of Session:				
Water is from safe source (borehole or protected well or protected spring)				
Water is treated (Boiled/ chlorine)				
Toilet/latrine available				
Handwashing station with soap exists (e. g. tippy tap)				
House is clean				
Food utensils are clean				
Session Is conducted by volunteers and/or lead mother				
Primary caregivers are assigned roles during Hearth				
Primary caregivers are the ones cooking the meal				
Primary caregivers can tell you how to cook Hearth menu for one child (using household measures)				
Number of caregivers attending				
Number of children attending				
Evidence of community participation/support				
Hand Washing is practised: by caregivers				
by children				
Number of caregivers who bring contribution to meal				
Menu used based on local and affordable food				
Menu is nutrient dense				
Food is prepared according to menu				
Consistency of Hearth meal is thick enough to slowly run on a spoon (not runny like water)				
Snack is given to children as the caregivers cook the Hearth meal				
Caregivers can recite different types of protective, body building and energy-giving foods				
Number of caregivers present and actively participating:				
in food preparation				
in child care				
in discussion of key messages				
Size of portion served is age appropriate				
Number of caregivers who actively feed their child				
Number of children who eat entire portion				
Number of children who are offered more food				
Key message discussed during PD/Hearth supervision visit				
Caregivers express being motivated by changes in child				
Caregivers can say what to do when child is sick				

PD/Hearth Annual Report

World Vision

Day 5 Session 32

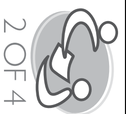
PD/Hearth ADP Facilitator ______	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Total
In PD/Hearth Session (12 days) Weight gain (in grams) # of children	# of children												
Catch up (graduation): ≥ 200g													
Inadequate: < 200g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
In Rotation at 1 month (12 days + 2 weeks follow up) Weight gain (in grams)	# of children												
Catch up (graduation): ≥ 400g													
Inadequate: <400g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 3 months post hearth	# of children												
Adequate weight gain ≥ 900g													
Inadequate weight gain < 900g													
Total # of children weighed													
Referrals													
Defaulters													
Deaths													
Non-responders													
Follow up at 6 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Follow up at 12 months post hearth	# of children												
Green													
Yellow													
Orange													
Red													
Total # of children weighed													
Defaulters													
Deaths													
Non-responders													
Total number of Re-admissions													
Round/Session #2													
Round/Session #3													

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	7.0		24/3/2007	7.6	0.6		12/4/2007	7.6				
3	Helena	1	f	27/08/2005	19	12/03/2007	9.8		24/3/2007	10.1	0.3		12/4/2007	9.9				
4	Kalpana	1	f	05/10/2005	17	12/03/2007	7.5		24/3/2007	7.5	0.0		12/4/2007	7.5				
5	Saidur	1	m	21/10/2005	17	12/03/2007	6.6		24/3/2007	7.2	0.6		12/4/2007	7.3				
6	Sumana	1	f	06/06/2006	9	12/03/2007	6.0		24/3/2007	6.2	0.2		12/4/2007	6.5	0.5			
7	Swourav	1	m	19/02/2005	25	12/03/2007	9.0		24/3/2007	9.3	0.3		12/4/2007	9.5	0.5			
8	Simul	1	m	17/02/2005	25	12/03/2007	7.6		24/3/2007	7.9	0.3		12/4/2007	7.5	-0.1			
9	Tanvir	1	m	15/08/2005	19	12/03/2007	8.5		24/3/2007	8.7	0.2		12/4/2007	9.0	0.5			
10	Ruman	1	m	28/04/2005	22	12/03/2007	8.9		24/3/2007	8.5	-0.4		12/4/2007	9.4	0.5			
11	Ritu	1	f	11/05/2004	34	12/03/2007	9.7	O	24/3/2007	9.9	0.2	Y	12/4/2007	10.2	0.5	Y	O	N
12	Zashim	1	m	29/01/2005	25	12/03/2007	8.7	R	24/3/2007	9.0	0.3	Y	12/4/2007	9.3	0.6	Y	O	Y
13	Bashakhi	1	f	29/04/2005	22	12/03/2007	8.8	Y	24/3/2007	9.0	0.2	Y	12/4/2007	9.2	0.4	Y	Y	N
14	Sritimoni	1	f	25/10/2005	17	12/03/2007	7.5	O	24/3/2007	7.8	0.3	Y	12/4/2007	7.8	0.3	N	O	N
15	Farjana	1	f	25/03/2006	12	12/03/2007	6.0	R	24/3/2007	6.5	0.5	Y	12/4/2007	7.1	1.1	Y	O	N
16	Riyon	1	m	25/01/2005	26	12/03/2007	7.9	R	24/3/2007	8.1	0.2	Y	12/4/2007	8.4	0.5	Y	R	N
17	Sharmin	1	m	23/10/2004	29	12/03/2007	9.5	O	24/3/2007	9.7	0.2	Y	12/4/2007	10.2	0.7	Y	O	N
18	Rabbi	1	f	03/09/2004	30	12/03/2007	10.0	Y	24/3/2007	10.3	0.3	N	12/4/2007	11.0	1.0	Y	Y	N
19	Kurban Ali	1	m	20/01/2006	14	12/03/2007	6.8	R	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	Y	R	N
20	Himel	1	m	11/11/2005	16	12/03/2007	7.2	R	24/3/2007	7.2	0.0	N	12/4/2007	7	-0.2	N	R	N
21	Anika	1	f	29/03/2004	35	12/03/2007	9.8	O	24/3/2007	10.0	0.2	Y	12/4/2007	10.5	0.7	Y	O	N
22	Afra Abiyat	1	f	29/03/2004	35	12/03/2007	10.5	O	24/3/2007	10.8	0.3	Y	12/4/2007	10.9	0.4	Y	Y	Y
23	Laboni	1	f	25/11/2005	16	12/03/2007	7.3	O	24/3/2007	7.5	0.2	Y	12/4/2007	7.2	-0.1	N	O	N

Monitoring Case Study Data Sheet

World Vision



Day 5 Session 32

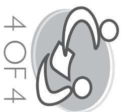
#	Name of Child	Hearth session # for the child	Child's Sex (M/F)	Date of Birth (dd/mm/yyyy)	Age (month)	At Day 1 of Hearth			At Day 12 of Hearth				At Day 30 of Hearth					
						Date (dd/mm/yyyy)	Weight (Kg.g)	Nutritional Status (Red, Orange, Yellow or Green)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight Gain (Day12 - Day1) in kg	Gained 200g+ (Y/N)	Date (dd/mm/yyyy)	Weight (Kg.g)	Weight gain (Month 1 - Day 1 weight) in kg	Gained 400g+ (Y/N)	Nutritional Status (Red, Orange, Yellow or Green)	Change in Status (Y/N)
24	Maruf	1	m	01/07/2006	8	12/03/2007	10.5	G	24/3/2007	10.3	-0.2	N	12/4/2007	10.9	0.4	S	G	N
25	Shanta	1	f	04/02/2006	13	12/03/2007	6.6	R	24/3/2007	6.7	0.1	N	12/4/2007	7.0	0.4	S	O	Y
26	Jesmin	1	f	27/09/2006	6	12/03/2007	6.8	G	24/3/2007	6.6	-0.2	N	12/4/2007	6.6	-0.2	N	Y	Y
27	Shakib	1	m	01/02/2006	13	12/03/2007	6.8	O	24/3/2007	6.9	0.1	N	12/4/2007	7.1	0.3	N	R	N
28	Shati	1	f	01/02/2006	13	12/03/2007	6.8	O	24/3/2007	7.0	0.2	Y	12/4/2007	7.2	0.4	S	O	N
29	Nurjahan	1	m	01/04/2005	23	12/03/2007	7.4	R	24/3/2007	7.7	0.3	Y	12/4/2007	7.9	0.5	S	R	N
30	Beauti	1	f	03/04/2005	23	12/03/2007	7.6	R	24/3/2007	7.7	0.1	N	12/4/2007	7.8	0.2	N	R	N
31	Salina	1	f	07/04/2005	23	12/03/2007	9	Y	24/3/2007	9.2	0.2	Y	12/4/2007	9.5	0.5	S	Y	Y
32	Marjina	1	f	07/09/2004	30	12/03/2007	9.1	O	24/3/2007	6.0	-3.1	N	12/4/2007	9.1	0.0	N	R	Y
33	Alam	1	m	10/07/2004	32	12/03/2007	10.1	O	24/3/2007	10.3	0.2	Y	12/4/2007	10.6	0.5	S	O	N
34	Shaila	1	f	18/10/2005	17	12/03/2007	7.3	O	24/3/2007	7.9	0.6	Y	12/4/2007	7.9	0.6	S	O	N
35	Abir	1	m	14/01/2005	26	12/03/2007	9.1	O	24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	S	O	N
36	Mim	1	f	05/04/2006	11	12/03/2007	6.1	R	24/3/2007	6	-0.1	N	12/4/2007	6.4	0.3	N	O	Y
37	Mamin	1	f	13/02/2006	13	12/03/2007	6.2	R	24/3/2007	6.5	0.3	Y	12/4/2007	6.7	0.5	S	O	Y
38	Alika	1	f	27/12/2004	27	12/03/2007	8.5	R	24/3/2007	8.8	0.3	Y	12/4/2007	8.9	0.4	S	O	N
39	Sumia	1	f	05/03/2006	12	12/03/2007	6.1	R	24/3/2007	6	-0.1	N	12/4/2007	6.0	-0.1	N	R	N
40	Nadia	1	f	03/04/2006	11	12/03/2007	10.3	G	24/3/2007	10.6	0.3	Y	12/4/2007	10.8	0.5	S	G	N
41	Aklima	1	f	01/04/2004	35	12/03/2007	9.1	R	24/3/2007	9.3	0.2	Y	12/4/2007	9.5	0.4	S	R	N
42	Lipa	1	f	20/04/2004	35	12/03/2007	9.6	R	24/3/2007	9.9	0.3	Y	12/4/2007	10.1	0.5	S	O	N
43	Mahamuda	1	m	23/05/2004	34	12/03/2007	9.6	R	24/3/2007	9.8	0.2	Y	12/4/2007	9.9	0.3	N	O	Y
44	Shapna	1	f	21/03/2005	24	12/03/2007	9	O	24/3/2007	9.1	0.1	N	12/4/2007	9.5	0.5	S	Y	N
45	Laboni	1	f	11/12/2004	27	12/03/2007	10	Y	24/3/2007	10.2	0.2	Y	12/4/2007	10.9	0.9	S	Y	N
46	Maria mim	1	f	02/02/2004	37	12/03/2007	10.2	O	24/3/2007	10.5	0.3	Y	12/4/2007	10.9	0.7	S	O	N
47	Arif	1	m	25/02/2005	25	12/03/2007	6.9	R	24/3/2007	7	0.1	N	12/4/2007	7.1	0.2	N	R	N
48	Rakkib	1	m	10/03/2004	36	12/03/2007	10	R	24/3/2007	11.2	1.2	Y	12/4/2007	11.1	1.1	S	Y	Y
49	Sabekun	1	m	25/03/2005	24	12/03/2007	9	O	24/3/2007	10	1.0	Y	12/4/2007	9.6	0.6	S	Y	Y

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

World Vision



Day 5 Session 32

#	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

World Vision

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?

PD/Hearth Monitoring Case Study Questions

3. The measurements are repeated three months after the Hearth session. Look at the results and complete the 'Nutrition Status' column using the WAZ (weight for age Z-scores).

    a. Calculate the number and percentage of children who have gained adequately.

    b. Do you see any trends that concern you? What does the data tell you about the programme?

    c. What action do you need to take?

4. The children are measured again six months after the hearth sessions. Calculate their nutritional status using WAZ.

    a. Choose two children and answer the following questions for each, using all the data provided in this case study:

        - Describe the child's progress throughout the monitoring period. What could be some reasons for the child's growth pattern?
        - Was the child successfully rehabilitated? How can you tell?
        - How would you follow up with this child?
        - How would you communicate the child's progress and current status to his or her caregiver?

    b. What is your opinion of the overall growth of the children involved in the programme?

    c. How many children were successfully rehabilitated? How can you tell?

    d. What might be some reasons for the growth pattern between three and six months?

    e. How would you follow up with this programme?

The PDH Excel Database is used to compile all the data collected during the initial assessment (situation analysis), PDH registration, and for monitoring and follow up of children in the PDH programme. This allows easier access and utilisation of data by staff. For example, clear summary tables are generated and available under different tabs. From the data collection forms (e.g. Child Registration, Hearth Register and Monitoring Form), staff can transfer recorded information into appropriate cells/columns in the PDH database. Some of the cells/columns contain a drop-down menu or a formula. This formatting is convenient and helps to reduce data entry or calculation errors. For example, child's age (months), underweight nutritional status, WAZ scores, and weight change (g) are calculated automatically.

In the PDH Excel Database, there are eight tabs or worksheets: Initial Assessment; Assessment Report; Monitoring Form; Table; Annual Report; Graph Follow-up; Graph Graduation & Weight Gain; and Graph Default. However, you only need to enter data under two tabs: Initial Assessment and Monitoring Form. All other tabs contain summary charts (e.g. tables, graphs) automatically generated from the compilation of inputted data. ***Please note, when entering the dates, follow the format provided i.e. DD/MM/YYYY.*** Make sure the default date on your computer is set as DD/MM/YYYY for smooth operation of the database. To change the default date format on your computer, see ***Note** below.

Tab 1 – Initial Assessment: Enter the registration, initial nutrition assessment and wealth-ranking data for PDH participant children under this tab. From this data, the PD, non-PD, and negative deviant households are identified and displayed under the "Classification" column.

- First, select an appropriate option for the Wealth Ranking Category (i.e. Very Poor, Poor, Rich or Poor, Non-Poor) and the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu for each at the top of the worksheet.
- Enter values under each column according to the headings. Enter values only in the "WHITE" cells as the values in grey-coloured cells (e.g. Current Age, Underweight Nutritional Status, Classification columns) are calculated automatically by the computer. For the Sex, Oedema, MUAC, Wealth Rank and PDI HHs columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 2 – Assessment Report: This tab contains a table and a pie chart which categorizes the total number of children from the initial assessment based on their underweight nutritional status (i.e. % of children who are normal weight or mildly, moderately or severely underweight). This gives a clear picture of the initial level of childhood malnutrition in the community.

Tab 3 – Monitoring Form: This tab contains a monitoring form to track changes in child's weight, weight-for-age Z score, and underweight nutritional status in the hearth sessions and the follow-ups, including reasons for default. Additional registration information, such as deworming, vitamin A supplementation, presence of oedema, and full immunisation status is also entered under this tab. Based on the child's nutritional status at 3 months, next course of action is identified for each child (i.e. not graduate and repeat hearth, or graduate and continue monitor).

- First, select an appropriate option for the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu at the top of the worksheet.
- Enter values under each column according to the heading. Enter values only in "WHITE" cells as the values in grey-coloured cells (i.e. Current Age, WAZ, Nutritional Status, Weight Change, Adequate Weight Gain columns) are calculated automatically by the computer. For the Oedema, Deworming, Vitamin A Supplementation, Full Immunisation, Sex, Round/Session # and Default Reason columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 4 – Table: This tab contains nine summary tables based on the monitoring data. The tables show the number of children (and %) based on underweight nutritional status at different time points (e.g. baseline, Day 12, Day 30, 3 months, 6 months and 1 year), number of children (and %) with adequate or inadequate weight gain and amount of average weight gain (at Day 12, 30 and 3 months), and number of children (and %) with improvement or no improvement in their nutritional status to mild/healthy status (at Day 12, 30 and 3 months), as well as the breakdown of the reasons for child default from PDH.

Tab 5 – Annual Report: This tab contains a PDH summary report for the selected fiscal year. The table contains information about number of children who gained adequate or inadequate weight in PDH session (Day 12) and at follow ups (1 and 3 months), as well as number of children in different underweight nutritional status categories (i.e. green, yellow, orange, red) at 6 and 12 months post-Hearth. Also, information about the total numbers of children weighed and those who defaulted is provided along with the breakdown of children based on their enrollment (i.e. 1st, 2nd or 3rd round/session).

- To generate a report, enter ADP name and use the drop-down menu to select or enter a fiscal year.

Tab 6 – GRAPH Follow-up: This tab contains a bar graph showing overall changes in underweight nutritional status of PDH participant children (%) at different time points (e.g. baseline/Day 1, 12, 30 of PDH, and 3, 6, 12 months of post-PDH).

Tab 7 – GRAPH Graduation & Weight Gain: This tab contains six pie charts. The first three charts show the percentage of children whose nutritional status improved (i.e. mild/healthy vs. still moderate/severe) at Day 12, Day 30 and 3 months. The last three charts show the percentage of children who gained adequate weight (i.e. ≥ 200g at Day 12; ≥ 400g at Day 30; ≥ 900g at 3 months).

Tab 8 – GRAPH Default: This tab contains a bar graph on child default rate. The breakdown of number of children based on reasons for default at different time points (at Day 12, 30, and 3, 6, 12 months) is given.

NOTE:

To change the default date format on your computer:

1. *Go to Control Panel, click Regional and Language Options.*
2. *Under the Formats tab, click Additional settings (or Customize this format) button.*
3. *Click the Date tab.*
4. *Use the drop-down menu to select "DD/MM/YYYY" as the default Short date format.*
5. *Click Apply and close.*

SESSION 33

Personalise the Curriculum Daily Summary and Evaluation

World Vision

30 MIN

DAY 5

By the end of this session, participants will be able to

1. Adapt the content of day to their own culture
2. Evaluate personal learning for the day.

Preparation

- Write the daily evaluation questions on a flip chart.

Materials

- Curriculum for each person
- Half sheet of paper for each person

STEPS

20 Min

1.

Ask each participant to reflect on the day's sessions. They will write in their curriculum ideas to improve or adapt the various presentations methodologies so they are more appropriate for their own contexts. Participants should be ready to share any good ideas they might have.

8 Min

2.

Daily Evaluation

Distribute a half sheet of paper to each participant. Ask the participants to complete the three phrases written on the flip chart.

1. Something I learned today that I will apply in our PD/Hearth programme is

   ____.

2. Something new that I learned about PD/Hearth today is

   ____.

3. Something I'm still confused about is

   ____.

The facilitators will review these evaluations at the end of each day and spend a few minutes at the beginning of the next day clarifying any issues raised in number 3.

2 Min

3.

Thank the participants for their good work during the day. Mention any highlights of the day. Remind them of the meeting time for the next session.

Review of Day 5 and the Agenda for Day 6

SESSION 34

30 MIN | DAY 6

By the end of this session, participants will have

1. Reviewed the content of Day 5
2. Anticipated what will be covered today.

Materials

- Coloured cards/post-its
- Markers
- Prizes for winning team
- Blank flip chart

STEPS

25 Min

1.

Place three cards of different colours and some markers on each table. Working in small groups (one group at each table)

- Ask each group to develop three questions about the key concepts they have learned during the workshop.
- Ask the participants to write each question on one side of a coloured card and then turn the card so the written side is down.
- Ask the participants at each table to select a name for their team and to decide who will select a card from one of the other tables for the first turn.
- Have one facilitator keep score on the flip chart.
- Ask the representative from one table to select a card from another table. The team members may discuss the question but will have only one minute to give their answer to the question.
- For each correct response, the team wins 1 point. The team that wrote the question judges whether or not the response is correct.
- Select another table to draw a card. Continue until each table has had a chance to respond to a card. Give a prize to the winning team.

5 Min

2.

Review the agenda for today.

SESSION 35

Factors for the Success of PD/Hearth

World Vision

45 MIN DAY 6

By the end of this session, participants will be able to

1. Identify success factors for PD/Hearth
2. Receive solutions to their challenges from other participants
3. Develop an 'elevator speech' to promote key issues with National Office staff

Preparation

- A flip chart with the questions for the 'elevator speech'

STEPS

10 Min

1.

Ask participants what they believe the factors for the success of PD/Hearth might be. Make sure the following points are discussed:

- Commitment and support from the Regional Office, National Office, Support Office and ADPs.
- A small start. Initiate just one PD/Hearth in one community to learn from that experience before starting others in other communities.
- Frequent supportive supervision of volunteers – perhaps daily during their first rotation and then weekly.
- Quality training at each level.
- Integration of PD/Hearth with other sectors in the ADP to work together to address some of the underlying issues affecting the nutrition status of children; collaboration and support from other sector specialists; a team of people working collaboratively.
- Networks with government and non-governmental organisations that will work together to address nutrition issues for children.
- Change in community social norms through nutrition activities that involve all caregivers of young children, regardless of the children's nutritional status, and also the older women who influence them. This can include growth monitoring with good counselling, cooking and feeding demonstrations, breastfeeding support groups, grandmother groups, nutrition messages targeted to fathers and community leaders, health fairs, etc. PD/Hearth changes to behaviour will not 'last' if the community social norms with regard to child feeding do not also change.

5 Min

2.

Ask participants to think about their own programmes in light of the factors of success and the course so far. Each participant should write one main activity that would enable their programme to be more successful. Example: 'The menus for the Hearth sessions need to be improved to meet the nutrient requirements' or 'The community needs to be better informed of PD practices'.

15 Min

3.

Divide into pairs. One person in each pair will read his or her objective to the partner. In one minute the partner offers one or two ideas for actions it might be possible to try. The first person quickly jots the ideas down. Neither person makes any judgment, asks questions, or develops the ideas. Now the second person reads his or her objective, the partner offers one or two ideas, and the person writes them down. This step will take less than four minutes.

At the end of the four minutes, find new partners and repeat the process.

Repeat the process again. By this time each participant will have a list of creative ideas to consider in his or her own programme.

15 Min

4.

Develop an 'elevator speech'.

Present this activity to the participants:

You are returning home from your course with many ideas to try. You have approximately two minutes to explain to the National Director or Operations Director what you learned and what you want to do now. This is the amount of time it takes to ride the elevator from the ground floor to the third floor, so this is your 'elevator speech'. Think about what you will say. Fill in these statements (written on the flip chart) using only ***one*** line. Practise your 'elevator speech' with a partner.

Flip Chart 35

1. The most important or striking or insightful or valuable thing I learned was

---

2. I am going to capitalise on this learning by

---

3. The benefit to the organisation will be

---

4. I need the following help to make this happen

Post-test

SESSION 36

30 MIN | DAY 6

Materials

- PD/Hearth Post-test (provided in MT Trainers' Package)

STEPS

30 Min

1. Distribute Post-test provided in the MS Word document called "MT Trainers' Package".

2. Have the participants complete it and hand it in.

3. Facilitators mark the tests while the participants complete their PD/Hearth training plan (Session 37) and personalise their training curriculum (Session 38). The marked post-tests will be returned with the pre-test results.

PD/Hearth Training Plan

By the end of the session, participants will be able to

1. Draft a country PD/Hearth training plan
2. Receive feedback on their plans from regional adviser and facilitators.

Preparation

- Print Handout 37.1

Materials

- Handout 37.1: PD/Hearth Training Plan

STEPS

15 Min

1. Participants from each country work together to develop a country plan based on the questions on Handout 37.1: PD/Hearth Training Plan.

HANDOUT
37.1 –197m/H 86

30 Min

2. Each country group briefly presents its plan. Participants and facilitators give feedback on the plan.

PD/Hearth Training Plan

Trainer's name:

Who will be trained?

Projected timetable of trainings:

Where trainings will take place? (number and names of ADPs currently implementing in this fiscal year):

Support required to fulfil plan?

SESSION 38

Personalise the Training Curriculum

World Vision

90 MIN | DAY 6

By the end of the session, participants will have

1. Adapted their training curriculum for PD/Hearth
2. Received feedback from the facilitator on their curriculum.

Preparation

- Print Handout 38.1

Materials

- Handout 38.1: Training Agenda and Methodology

STEPS

90 Min

1.

HANDOUT
38.1 – 199m/H 87

Distribute Handout 38.1. Ask the participants to fill in the methodology they will use during their trainings. Participants from one country may choose to work together to finalise their training curriculum. Some activities on the agenda might not be included in their TOF. Some other sessions might be added in. Encourage them to use creative methods – stories, songs, games, role plays, case studies, etc.

2.

The facilitators rotate among the participants to review the curriculum and offer feedback.

3.

The curriculum needs to be submitted to the regional adviser for review before they conduct their TOF.

PD/Hearth Agenda and Methodologies		
Day	**Topics**	**Methodology**
Day 1		
	Devotion	
	Welcome Ice breaker Workshop rules (parking lot) Introductions and expectations Overview of workshop purpose, objectives and agenda Target evaluation	
	Pre-test	
	Defining the role of a PD/Hearth Master Trainer	
	Learning styles and facilitation	
	Overview of PD/Hearth	
	Essential elements and key principles	
	How PD/Hearth addresses malnutrition	
	Step 1 – Determining the Feasibility of PD/Hearth	
	Integration and PD/Hearth	
	Personalise the training curriculum	
	Daily Summary and Evaluation	
Day 2		
	Devotion	
	Review of Day 1 and present Day 2 agenda	
	Step 2 – Community Mobilisation	
	Step 2 – Staffing Needs; selecting and training volunteers	
	Step 3 – Situational Analysis – wealth ranking	
	Step 3 – Situational Analysis – nutritional assessment	
	Step 3 – Situational Analysis – transect walk, household visits, focus-group discussions, market survey	
	Step 4 – Identifying Positive Deviants	
	Step 4 – Preparing for the PDI: home visits, 24-hour recall, observation	
	Step 4 – Conducting the PDI	
	Personalise the training curriculum	
	Daily Summary and Evaluation	

Training Agenda and Methodology

World Vision

Day 6 Session 38

Day	Topics	Methodology
Day 3	Field Visit	
	Review of Day 2 and explain logistics for field visit	
	Field Visit – PDI, FGD, transect walk, market survey, household visits	
	Compile results of PDI on flip charts	
Day 4		
	Devotion	
	Review of Day 3 field visit and present day 4 agenda	
	Step 4 – PDI interpretation and feedback	
	Promoting behavioural change	
	Step 5 – Designing Hearth Sessions (Incorporating PD behaviours)	
	Step 5 – Menu planning	
Day 5		
	Devotion	
	Review of Day 4 and present Day 5 agenda	
	Community feedback meetings	
	Step 6 – Conducting Hearth sessions	
	Step 7 – Supporting new behaviours through reflection and home visits	
	Step 8 – Admission and graduation criteria and repeating Hearth sessions Exit strategy and reaching the rest of the community	
	Step 9 – Expanding PD/Hearth	
	Monitoring and evaluation	
	Personalise the training curriculum	
	Daily Summary and Evaluation	
Day 6		
	Devotion	
	Review of Day 5 and present Day 6 agenda	
	Factors for the success of PD/Hearth	
	Post-test	
	Training plan	
	Personalise the TOT training curriculum – review by facilitators	
	Target evaluation, final evaluation	
	Workshop Closing	

Final Evaluation and Closing

SESSION 39

30 MIN | DAY 6

By the end of the session, participants will have

1. Identified key areas of learning
2. Provide feedback on the training
3. Received a certificate of participation.

Preparation

- Flip chart with 'Target Evaluation Dart Board'
- Print Handout 39.1
- Certificates for all participants

Materials

- 'Target Evaluation' flip chart from Day 1 for comparison
- Eight small stickers for each participant
- Handout 39.1: Workshop Evaluation

STEPS

10 Min

1.

Repeat the 'Target Evaluation' exercise from Day 1.

- Give each participant eight stickers. Ask the participants to consider their understanding and skill in each of the eight areas on the 'Target Evaluation Dart Board' (Flip Chart 39). The more competent they feel in an area, the closer to the centre of that area they place a sticker. For areas in which they feel less confident or knowledgeable, the closer to the outer edge they place a sticker.
- Compare the first day's chart with the final day's chart. Discuss where participants feel they have grown in knowledge and skill. Congratulate them on their great work.

10 Min

2.

HANDOUT
39.1 – 203m/H 89

Have participants fill out Handout 39.1: Evaluation Form (an evaluation form for the course).

Flip Chart 39
Target Evaluation Dart Board

World Vision

10 Min

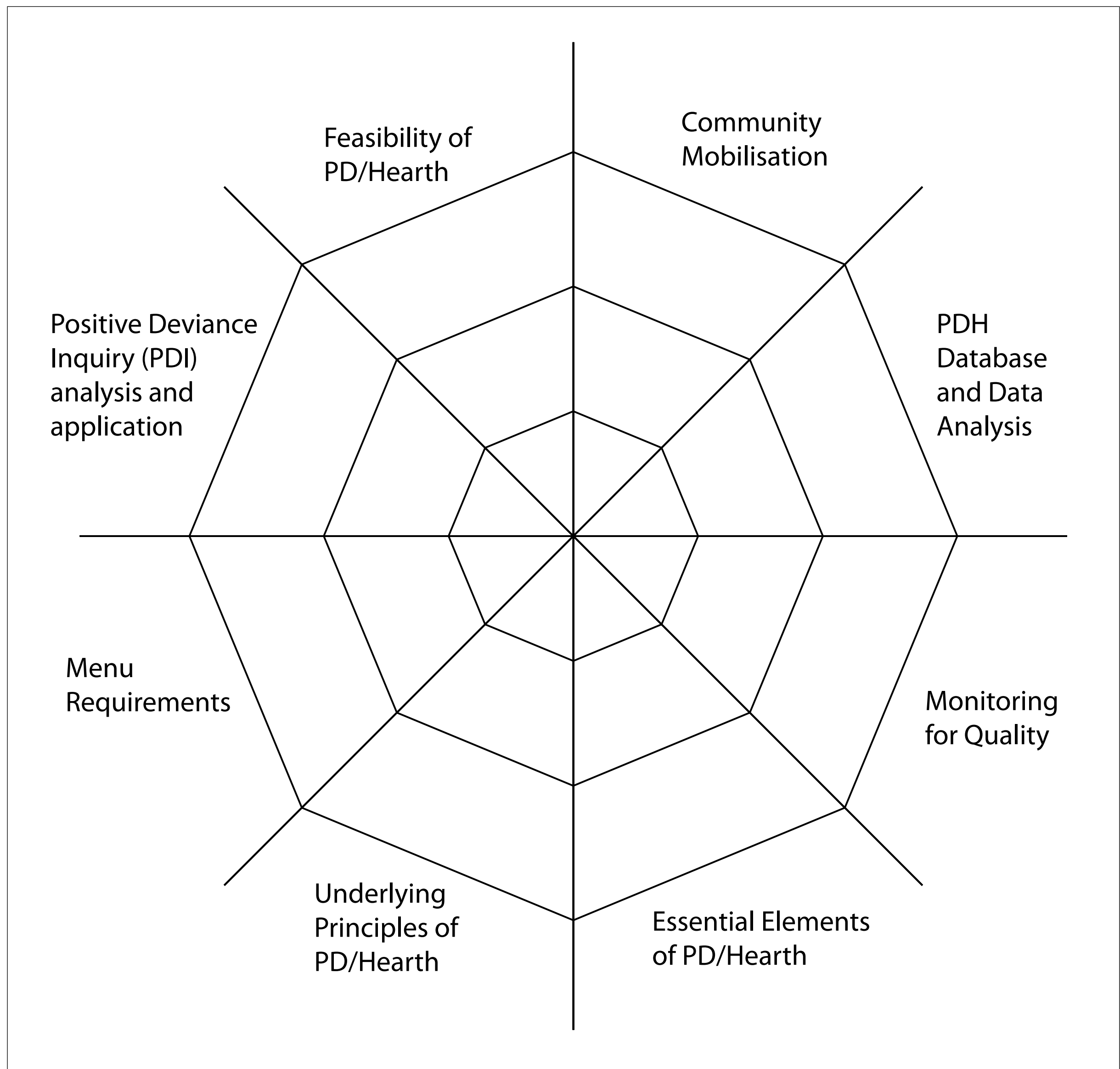
3.

Explain the next steps in master training:

- Each participant will submit to the regional adviser his or her country training plan and agenda and methodology forms.
- Each participant will receive his or her final marks and next steps from the regional office.

4.

Thank the host country, planners and logistics people. Thank participants for their great work.



EVALUATION

Thank you for attending this year's PD/Hearth Master Training of Trainers Workshop. We hope you enjoyed your time, and that the workshop was a meaningful experience for you. Please take a few minutes to complete this evaluation. Your feedback is valuable and provides helpful information that will be used to plan the next workshop.

4. What did you expect from the workshop?

____
____
____

5. What do you feel was the most helpful part of the workshop? (for example, a particular session, a working group, a contact you made, certain resource material you obtained)

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____
____

6. 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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____
____

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

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____
____

8. What would you do to improve this?

____
____
____

9. What would recommend for the next workshop?

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____

10. What themes or topics would you suggest that we focus on or go into in more detail?

____
____
____

11. Should more background information be provided at the beginning of the workshop/training? What information?

____
____
____

Workshop Evaluation: World Vision PD/Hearth Master Training of Trainers Workshop

World Vision

12. Other:

____

____

____

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator____________________

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator____________________

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

For you, what was the highlight of this workshop?

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

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Thank you for your feedback!

For more information on this publication contact

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