World Vision

Sustainable Health

MANUAL

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

THIRD EDITION

World Vision International

World Vision

Training of Facilitators for Positive Deviance/Hearth

FACILITATORS MANUAL

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World Vision International

Terms of Use

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DAY 2

DAY 3

DAY 4

DAY 9

List of Acronyms

AP	Area 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
DO	Disability Organization
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
PDH	Positive Deviance/Hearth
PDH+	Positive Deviance/Hearth Plus
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
VHC	Village Health Committee
VHSC	Village Health & Sanitation Committee
WASH	Water, Sanitation & Hygiene
WAZ	Weight-for Age Z-score
WHO	World Health Organisation
WHZ	Weight-for Height Z-score
WV	World Vision

Welcome to the Facilitation Manual for Training of Facilitators (TOFs) for Positive Deviance (PD)/Hearth

INTRODUCTION

Through increasing experience, World Vision (WV) has recognised the need to develop competent Trainers of Facilitators (ToFs) for Positive Deviance/Hearth (PDH) nutrition programmes implemented within the Area Programme (AP) 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 PDH programmes.

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

For questions, comments or feedback contact the Health & Nutrition, WVI:

health@wvi.org

About the Curriculum

The training manual provides the framework and materials for a 8-10 day face-to-face course or a six week online course blended by a 5-day face-to-face course. It covers all components of the PDH programme, with emphasis on the essential elements of the methodology and the integration of PDH into the AP context.

A group size of a maximum of 30 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 AP, 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 PDH is an appropriate intervention
2. Articulate how PDH can and should be integrated with other AP programmes/sectors
3. Practise the steps in implementing PDH
4. Use essential elements and principles of PDH to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level
6. Complete a training curriculum adapted to their country context (National ToF Curriculum and Volunteer Training Curriculum)
7. Practise facilitation techniques for PDH volunteer training.

PDH Short Overview

PDH is an internationally proven community-based model for rehabilitating malnourished children in their own homes. It targets at risk, moderately and severely underweight children aged between 6 and 35 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 at risk underweight children as well.

PDH empowers communities to take responsibility for addressing the causes of malnutrition by helping to identify local solutions to overcome malnutrition. The PDH 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.

PDH 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 2020, PDH has been successfully implemented within WV contexts since 1999, in more than 40 countries, and in all four operational regions of WV.

PDH Training

The PDH Training is aimed at building the cadre of staff within World Vision who are qualified and certified as Trainers of Facilitators.

The level of staff targeted is not limited to Support Office (SO), Regional Office (RO), National Office (NO) or AP, 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 PDH training and implementation, and so will contribute to alleviating the burden of undernutrition in WV APs.

The ToFs will extensively cover PDH Methodology, the use of PDH tools and the menu design. Participants are required to complete assignments during the training and may be expected to facilitate volunteer training sessions during the event that will be graded both by peers and the expert trainers in order to provide feedback on how to improve on facilitation skills[1].

To maintain good standard quality in PDH training and implementation, there are certain qualifications that need to be met before a participant is approved to become a Facilitator or Co-facilitator. These qualifications include:

The participant has:

a. Successfully completed a PDH Training of Facilitators (ToFs)

b. Demonstrated clear understanding of PDH methodology and key principles.

c. Successfully conducted PDH volunteer training under supervision of a Master Trainer.

The number of participants in the ToFs course will be limited to a maximum of 30 in order to maximise the learning potential of the initial face-to-face training.

1. For countries planning to introduce PDH, a National level Training of Facilitators for PDH 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 Health & Nutrition team at health@wvi.org). Once training has occurred and experience in PDH 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.

At the end of the face-to-face event, each participant will have a one-on-one discussion with the Master Trainer to receive feedback on their performance, and to discuss follow up and requirements in order to complete the certification process.

Full Certification as a Facilitator or Co-facilitator in PDH will be earned upon:

1. Satisfactory completion of ToFs with a grade of 75% or higher (Facilitator certification with a final grade of 85% or higher; Co-facilitator certification with a final grade of 75-84%)
2. Demonstrate clear understanding of PDH Methodology and key principles
3. Satisfactory co-facilitation of a PDH volunteer training, supervised by a Master Trainer

Flow of Training: (Refer to summary flow chart on pp. xxv)

Please note: *it is recommended that all PDH trainings are facilitated by at least 2 Master Trainers.*

National PDH Training of Facilitators Workshop

(National and Sub National Level):

Purpose: To train the national and sub-national level staff in PDH 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 PDH in APs and training local level staff (See Handout 3.2 for more details). Participants must complete pre-workshop readings and pass two quizzes to qualify for PDH ToF Workshop.

Duration: 5 days of training if participants completed the PDH eWorkshop or 8-10 days depending on whether a translator is needed. The training must be close to a community/AP planning to implement PDH or a community/AP with PDH programming already. There must be fieldwork incorporated into the training. The number of days required for training may vary depending on whether translation is required and the distance between training venue to the field.

Curriculum: Adapted ToF Curriculum with CORE PDH manual and orientation of PDH Volunteer Training manual

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

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

Volunteer Trainings (Community level):

Purpose: To train community volunteers to fulfill their role in implementation of the PDH model

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

Participants: Volunteers responsible for implementing PDH

Duration: 3 full days and 1 full day after the first round of Hearth session or 5 half days and 1 full day after the first round of Hearth session at AP level

Curriculum: PD/H Volunteer Training Manual

Outcome: PDH Volunteers ready to implement PDH with all key essential elements

PDH Competencies

Four levels of PDH implementers are included:

- Volunteer
- AP/District-level staff (e.g. Development facilitators, Health and Nutrition Officers, Ministry of Health, Local NGO partners, etc.)
- Regional or Provincial Health and Nutrition Coordinator
- National Health and Nutrition Coordinator

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

PDH Volunteer

Skill	Volunteer	Knowledge Required
Community mobilisation	• Motivational skills • Identify key stakeholders in community • Identify key locations to promote PDH (e.g. church setting, community meeting, communal gardens) • Mobilise a PDH Committee (consists of leaders, fathers, grandmothers of community)	• Understand Theory of PDH and importance of PDH • Various roles important to success of PDH 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

AP/District-level Staff

Skill	Supervisor	Knowledge required
Community mobilisation	• Motivational skills • Identify key stakeholders in community • Identify key locations to promote PDH (e.g. church setting, community meeting, communal gardens) • Mobilise a PDH Committee (consists of leaders, fathers, grandmothers of community)	• Understand Theory of PDH and importance of PDH • Various roles important to success of PDH in community • Who the decision-makers are at household level

Measuring growth	• Participate in identifying nutrition status of children to select participant children for PDH 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 PDH • 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 PDH 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 PDH 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 PDH 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 PDH 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/ AP manager/community leaders	• Written and verbal communication skills
	• Communicate to volunteers the next group of identified participant children for PDH - should identify from monthly GMP results	• List of underweight children from most recent monthly GMP results (monthly screening required)

Regional 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/ AP 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 AP/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 PDH Supervisors • Supervise and support PDH Supervisors and support Supervisors in training of volunteers	• Adult learning methodology • Ability to teach technical material in actively and in simple language • Facilitation skills

National Health and Nutrition Coordinator

	National Health and Nutrition Coordinator	**Knowledge/skills required**
Skills	• Adult learning methodology • PD/H theory and methodology • Demonstrated ability in training others in PD/H, Hearth menu calculation tool/ software and PD/H Database • Is deployable	• In the various areas listed below is able to lead others in the processes and/or train others in practical, hands-on ways • Computer processing skills (Competent in MS Excel and Internet use)
Area of Expertise		
Basic Public Health Science	• Population health, disease prevalence, prevention, health determinants, promotion, improving health outcomes • Applies epidemiological knowledge, approaches, methodologies • Understands and uses research methodologies and scientific evidence for health problems	• Use of secondary and primary data to identify gaps in nutrition and recommend appropriate interventions • Ability to advise on other relevant health interventions that would support improvement in community nutritional status

Analytical/ Assessment	• Defines gaps and top priorities for health in country aligned with WV strategic direction	• Identify situations where PD/H methodology would be feasible and beneficial • Advise when PD/H would have limited applicability and not be recommended
	• Use of quantitative /qualitative data	• Identify areas where nutrition is a problem and PD/H could be relevant • Identify contributing factors to low nutritional status that would need to be addressed • Use of data to 'advocate' for PD/H programmes • Ability to advise on PD/H field research or evaluation
	• Selects and defines relevant variables	
	• Applies ethical principles to data collection, storage, use and reporting	• Ability to set up monitoring systems following WV and PD/H standards
	• Knowledge of standardised data collection and management process and computer systems.	
	• Knowledgeable of risks and benefits to communities through assessment and planning	
Programme Planning and Policy Development	• Translates assessment information and data into programmes • Able to assess feasibility, applicability, risk management for WV APs • Uses standard techniques in decision making and planning • Develops PD/H programme plans, goals, objectives, expected outcomes, implementation process • Knowledgeable of assumptions that affect PD/H	• Uses data to mentor staff in improved programming

Leadership	• Creates shared vision and team learning • Manages team information, contracts, external agreements • Manages staff; motivates, conflict resolution, performance monitoring • Identifies factors that may impact programme delivery • Facilitates collaboration with internal and external stakeholders • Represents PD/H at internal and external forums • Monitors and maintains ethical and organisational performance standards	• Able to build and lead multi-cultural team around common goals • Able to advocate and collaborate with relevant nutrition and PD/H networks
Communication at multi-country/ regional level	• Written and verbal communication of health issues Facilitates and participates in diverse cultural, educational and professional groups • Solicits input from relevant team members • Advocates for top priority health issues aligned with 7-11 programming • Presents demographic, statistical. scientific and programme information for lay and professional audience	• Able to communicate technical PD/H information simply and clearly to non-technical audiences • Ability to communicate with other technical experts in health/nutrition or other relevant disciplines. • A learner's attitude

Flow Chart of World Vision PD/Hearth Reporting Lines

Community Volunteers

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

PDH Coordinators

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

Zonal and/or Provincial Coordinators

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

National Health & Nutrition Coordinator

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

Field Preparation Required for Situation Analysis and PDI:

Community/Social Mapping:

4-5 community leaders (men and women) and 1-2 CHWs and 2 caregivers with children with disability (if program is looking at disability inclusion)

Seasonal Calendar/Transect Walk:

Good to have 1-2 CHWs or volunteers who could help navigate in the village/community

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 6-35 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 6-35 months of age on a specific day and time). Weighing children house to house is most accurate, but may require more time and resources.

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.

Focus Group Discussion (Optional):

5-7 Adolescents or Disability Organization members and other Disability Advocates in the community

Welcome, TOF Objectives, Agenda, Introductions

SESSION 1

60 MIN | DAY 1

By the end of the session participants will

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

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. 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.

HANDOUT
1.2 – 5m/H 10

10 Min

5. Introduce all facilitators and describe their involvement with PDH to date. Have all the participants briefly introduce themselves.

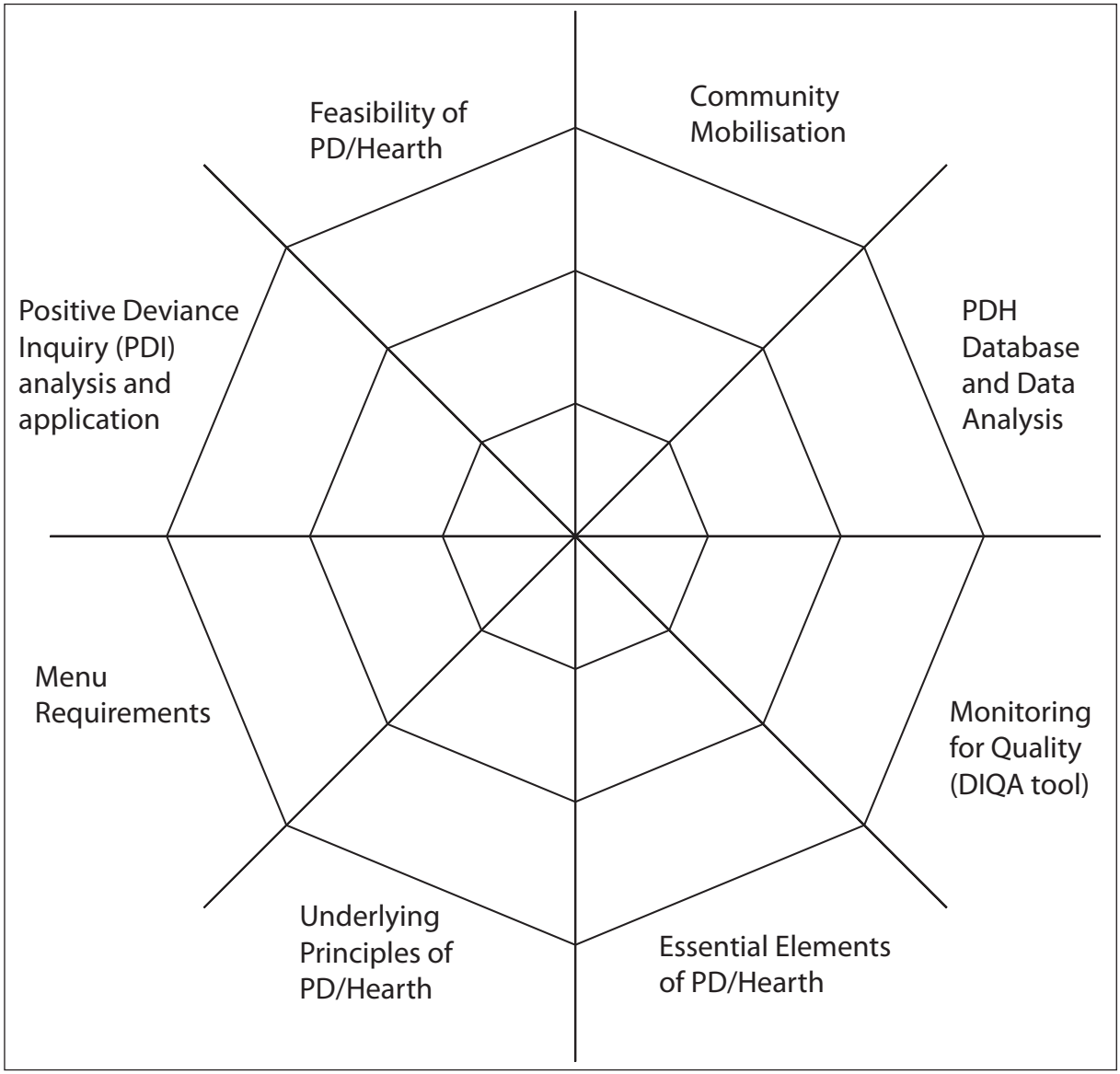
10 Min

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.

Goal

WV staff and partners develop knowledge, skill and competencies in PDH to

- train others
- provide technical support
- monitor implementation.

Training objectives

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

1. Distinguish where PDH is an appropriate intervention
2. Articulate how PDH can and should be integrated with other AP programmes/sectors
3. Practise the steps in implementing PDH
4. Use essential elements and principles of PDH to guide project decisions and strengthen implementation
5. Use monitoring tools to ensure quality implementation at the community level

Day and Date	Session	Activities	Time
Day 1:			
1		Devotion	15 min
	1	Opening remarks Introductions (Ice breaker) Expectations and Objectives, Parking Lot Workshop Norms (Form Review Volunteer Groups) Target Evaluation Brief Overview of training (Evaluation method and go through overview/field visits) Admin issues & logistics	90 min
	2	Pre-test	35 min
	3	What is Malnutrition? – Activity (3 types of malnutrition: underweight, stunting, wasting; Malnutrition cycle; Local terminologies)	95 min
		National prevalence (5 min) & AP context (10 min)	15 min
	4	What is Good Nutrition?	30 min
	5	Overview of PDH – Goals/objectives; Definitions	45 min
	6	How PDH Addresses Malnutrition – Causes of malnutrition (UNICEF Framework (Problem Tree): Immediate, underlying, basic/root causes	45 min
		Key steps of PDH (20 min)	20 min
	7	(STEP 1) Determining the Feasibility of PDH Approach for the Target Community – Case study using AP's communities (Identify existing other sectors in APs)	45 min
	8	Daily Summary and Evaluation	10 min
Day 2: *"Practicing to go out to the field" – Situation Analysis of the community*			
2		Devotion	30 min
	9	Review of Day 1 and Agenda for Day 2	30 min

Day and Date	Session	Activities	Time
2	10, 11, 12	(STEP 2) Community Mobilisation: Mobilization strategies for various PDH stakeholders (70 min) 1. Identifying stakeholders involved in child care and nutrition within the community (Venn Diagram); Outlining the Existing Local Health System Structure; Community Resources/Staffing Required for PDH implementation (WV & local NGOs) (50 mins) Creating Community Ownership 1. Preliminary steps: Meeting with leaders after receiving invitation (Practice through role play) (20 mins) 2. (OPTIONAL) Increasing Community Involvement to include Children with Disability into PDH (130 min) 3. (STEP 2) Identifying and Selecting Volunteers – Mobilization strategies for various PDH stakeholders (35 min)	305 min
	13,14, 15	(STEP 3) Situation Analysis with the community members 1. Community/Social Mapping & Transect Walk, (e.g. who is taking care of the children, what types of foods are people growing, do children wear shoes, look for latrines, etc.) 2. Wealth Ranking 3. Measuring nutritional status (underweight & wasting) of all children in the village (weighing scales – salter scales and MUAC) 4. Market Survey & Seasonal Calendar (ask shop keepers how many bars of soap they sell per week)	220 min
		Feedback to the community – Practice how we will share children nutritional status with community	30 min
	16	(STEP 3) Preparing for Situational Analysis Field Visit: Review situation analysis formats and go through field logistics (assigning groups, tasks, schedule)	60 min
	17	Daily Summary and Evaluation	10 min

Day and Date	Session	Activities	Time
Day 3: Field Visit (Situational Analysis)			
3	18	Field Visit to Conduct Situational Analysis Travel to field (activities can run simultaneously) 1. Introduction to leaders and volunteers (30 mins) 2. Social Mapping (40 mins) &Transect Walk (45 mins) 3. Wealth ranking with community members including volunteers (40 mins) 4. Weigh children (Plot children on giant growth chart if wanted) (45 mins to 180 mins – depends on how many children are weighed) 5. Seasonal Calendar (45 mins) & Market Survey (60 mins) Travel back to hotel	4.0 hours to 6.5 hours plus travel time (depends on how much time is spent weighing children and travel time to/ from the field)
Day 4:			
4		Devotion	30 min
	19	Review of Day 3 Field Visit and Agenda for Day 4 – Reflection of field work (what worked, what needs improvement, etc.)	45 min
	20	Analyzing Situational Analysis Data Brief orientation on Database Compile, summarize and document findings from field visit (flip chart, Excel templates) – Enter nutrition status/wealth ranking into Excel spreadsheets situation analysis Present findings: Nutritional profile of children – Initial assessment. Data interpretation Documentation of assets, current common practices & challenges	180 min
		How to conduct community feedbacks – Assign someone to share findings tomorrow. Have person practice for preparation of field visit in front of participants and receive feedback	30 min

Day and Date	Session	Activities	Time
4	21	(STEP 4) Identifying Positive Deviants – Selection criteria for PDs; Identification of NPDs, PDs, and ND households (Use findings from field visit to identify NPD, PDs, ND households)	60 min
	22	(STEP 4) Preparing for the Positive Deviance Inquiry (PDI) 1. Review and adapt generic tools 2. Do's & Don'ts for home visits 3. Further practice with tools (Role plays) 4. Logistics for home visits	105 min
Day 5: Field Visit (PDI)			
5	23	Field Visit to Conduct PDI Travel to field 1. Feedback to community on nutrition status findings (60 min) 2. PDIs in the field for AP village (At least 4 PD HH & 2-4 NPD HHs & 2 ND per village) – home visits Travel back to hotel	4.5 to 6.5 hours plus travel time
One-day Break: Compile PDI data and post charts including results from situation analysis (compile in Excel Templates) and begin working on Action Plans			
Day 6:			
6		Devotion	30 min
	24	Review of Day 5 Field Visit and Agenda for Day 6 – Reflection of field work (what worked, what needs improvement, etc.)	45 min
	25	(STEP 4) PDI Interpretation and Feedback: Determining Positive Deviance and Identifying 6 Key Hearth Messages 1. Presentation of PDI findings – Identify PD behaviours & Non-PD behaviours 2. Develop 6 key Hearth messages based on PDI Findings & quotes from villagers	170 min

Day and Date	Session	Activities	Time
6	26	Community Feedback Meetings – Preparation to share PDI Findings 1. Exploration of ways to share PDI findings (eg. skits, cultural events) 2. Role plays 3. Identify possible gaps in understanding context and have them clarified through FGDs after feedback meeting 4. Practice FGD and developing some questions with target group, adolescents (sibling care), and/or disability organization members/advocates (disability inclusion)	60 min
	27	(STEP 5) Designing Hearth Sessions	80 min
	28	Daily Summary and Evaluation	10 min
Day 7:			
7		Devotion	30 min
		Reflection of Day 6	30 min
	29	(STEP 5) Menu Design and Cooking 1. Use food composition tables 2. Menu to meet energy, protein, iron, Vitamin C, A & Zn requirements 3. Convert recipes from grams to home measures 4. Menu Calculation Tool Orientation (~30 min) Cooking practical – at training site Menu preparation, testing and selection of hearth menus Presentation of menus (60 min)	390 min
Day 8:			
8		Devotion	30 min
	30	Menu Calculation Assessment	60 min
	31	Essential Elements of PDH	55 min

Day and Date	Session	Activities	Time
8	32, 33	Setting up Hearth Sessions: 1. PDH participant selection, number of children per site 2. (STEP 6) Conducting the Hearth Session (40 min) 3. (STEP 7) Supporting New Behaviours through Reflection and Home Visits (60 min)	100 min
	34, 35	(STEP 8) Admission, Graduation, Repeating as Needed (75 min) (STEP 9) Expanding PDH (10 min) (Total 85 min) (STEP 8) Monitoring and Evaluation (Monitoring tools) (105 min) 1. Hearth rotation 2. Home visit protocols and Follow-up: HH follow-up visits 3. Referral to Health Centre 4. Overview of PDH Excel Database and Data Analysis (30 min)	220 min
Day 9:			
9		Devotions	30 min
		Review of Day 8 – Go through outstanding Parking Lot Topics	30 min
	36	Training Volunteers – review monitoring tools for volunteers and importance of community monitoring	60 min
	37	Post-test	35 min
	38	PDH+ and Integration	60 min
	39	Factors for the Success of PDH	30 min
	40	PDH Action Plans	45 min
	41	Final Evaluation and Closing Target Evaluation, Workshop Evaluation	40 min
		Certificate Presentation & Closing Remarks	40 min

Pre-test

SESSION 2

35 MIN | DAY 1

Materials

- PDH Pre-test (Provided in the MS Word document in the Resource CD)

STEPS

1. Distribute Handout 2.1: Pre-test

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

3. Facilitators mark the tests during the break. The marked pre-tests will be returned with the post-test results on the last day.

SESSION 3

What Is Malnutrition?

95 MIN | DAY 1

Purpose

- To learn what malnutrition looks like in children
- To learn some causes of malnutrition

Materials

- To learn the results of being malnourished
- two table-tennis balls, one perfectly round and the other crushed (or find a healthy branch of leaves and a dying branch of leaves)
- flip-chart paper and markers
- one litre boiled water
- a clean large bottle to mix oral rehydration solution
- a teaspoon
- salt
- sugar
- a small glass for each participant
- samples of healthy snack foods and 'junk foods' on a table

STEPS

15 Min

1. What does a malnourished child look like?

Ask the participants to think of a young child who is not growing well. What shows that the child is not well? Ask several participants to describe the child they are thinking of.

(listless, sad, irritable, sickly, no interest in playing, hesitant, thin arms and legs, may appear normal but be much older than the child looks)

The girl on the right is stunted. She is 52 months old (about 4 years), while the girl on the left is twenty-six months old (about 2 years). Child stunting is very common but often goes unrecognised. It is more common than other forms of malnutrition, such as being underweight (low weight for age) or wasting (low weight for height).

Explain: 'While these signs help, we can't always tell that a child is not growing well, so we need to measure. Tomorrow, we will learn how to measure weight and mid-upper arm circumference (MUAC) to tell if a child is growing well.'

3 Types of Malnutrition

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

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

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

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

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

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

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

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

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

Identifies *children who are 'wasted', that is, thinner than expected for a healthy, well-nourished child of the same height*. These children have lost a significant amount of weight in a short period of time due to poor food security and nutrition and/or illness. ***This means wasted children will also be underweight, that is, they weigh less than a healthy, well-nourished child of the same age.*** Wasting *reflects recent, short-term (acute) malnutrition or illness*. It is a sign that a child is extremely undernourished and will die within several days to several hours if not addressed. A severely wasted (severe wasting) child must be referred to a health centre or hospital, but if the child is moderately wasted (moderate wasting) the parents can improve the child's nutrition at home and the child can recover from wasting.

Wasting is the most severe form of undernutrition out of the three nutrition indicators, including: wasting, stunting, and underweight. MUAC can also be used to enable health and nutrition workers to quickly identify a severe acutely malnourished child. It is useful for **screening or assessing nutritional status of individual children 6 - 59 months of age** as well as for **assessing the nutritional situation of a community in an emergency situation.** The proportion of wasted children in an area may vary by the season, due to annual periods of food insecurity or seasonal illness. Thus, wasting is appropriate for examining short-term effects such as seasonal changes in food supply or short-term nutritional stress brought on by illness. Wasting is addressed through treatment and preventive nutrition activities.

Triggers for Action for 3 Types of Malnutrition

% of children 0-59 months moderately and severely undernourished

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

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

15 Min

2. Why is malnutrition a problem?

If you have table tennis balls:

Use the two table-tennis balls to demonstrate how a well-nourished child has a healthy growing pattern compared to a malnourished child.

Ask two participants to take turns bouncing the balls on the floor. Other participants should observe which ball bounces higher.

Ask two other participants to draw on a flip chart the height and pattern of the bounce of each table-tennis ball. Why does the perfect ball bounce higher?

Discuss the exercise:

How does the perfect table-tennis ball compare to a healthy child? The healthy child has more regular and more 'well rounded' growth and shows more energy. A malnourished child is like the crushed ball. This child's growth is not regular and he or she has very little energy.

Why do we care if a child grows well? *(Answers will vary, but ensure that the points below are made)*

If you have a healthy and unhealthy branch of leaves:

Use the healthy and unhealthy branch of leaves to demonstrate how a well-nourished child has a healthy growing pattern compared to a malnourished child.

Ask one participant to draw a tree that has access to a lot of rain and sunlight. Ask another participant to draw a tree that does not receive rain and only receives sunlight.

Discuss the exercise:

How does the tree with access to a lot of rain and sunlight compare to a healthy child? The healthy child has more regular growth and is "greener". A malnourished child is like the unhealthy branch. The leaves have no strength and little energy, like a malnourished child.

Why do we care if a child grows well? *(Answers will vary, but ensure that the points below are made)*

Review the consequences of malnutrition:

The results of malnutrition are very great. Malnourished children do not have much energy, are not very active, may cry often or seem very sleepy. They are much more likely to be ill with infections such as diarrhoea, pneumonia, tuberculosis and malaria. They also have an increased risk of becoming infected with HIV. When a child is malnourished, infection or illness is more likely to become serious or even cause death.

Small and sickly children are more likely to be enrolled in school late – or never – and they tend to stay in school less time. These children struggle to learn and often do not do well at school. This lack of healthy growing, both physically and mentally, will affect them throughout their lives.

As these malnourished children become adolescents, they may not have the knowledge and skill they need to become independent adults. Over their lifetime they will not be able to do as much work and will earn less than their friends who were well nourished as children. They will be less able to support

their own children when they become parents. Girls will have difficulty with pregnancy or have small babies.

While all stages of a child's growth are important, the most critical time is earliest years of life. Thus children between 6–35 months who are malnourished come to the Hearth. Babies younger than six months need exclusive breastfeeding for healthy growth so are not included in Hearth.

15 Min

3. What causes a child to not grow well?

Tell the following story about Tomi. (Adapt the story to the community culture.)

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

Lead a discussion using the following questions:

- Who were the people in the story? What happened in the story? What was the problem? Why is Tomi too thin?

  Some of the reasons will not be clear in the story, but volunteers should think of possible causes for the problem. Have them call out reasons. You might need to ask them 'why?' to help them think more deeply. *(Tomi doesn't eat enough, not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, unclean water, worms, no shoes, grandmother tries to help but the tea and thin porridge are not good foods for babies)*

- Which is the biggest problem? Why? Does it happen in your community?

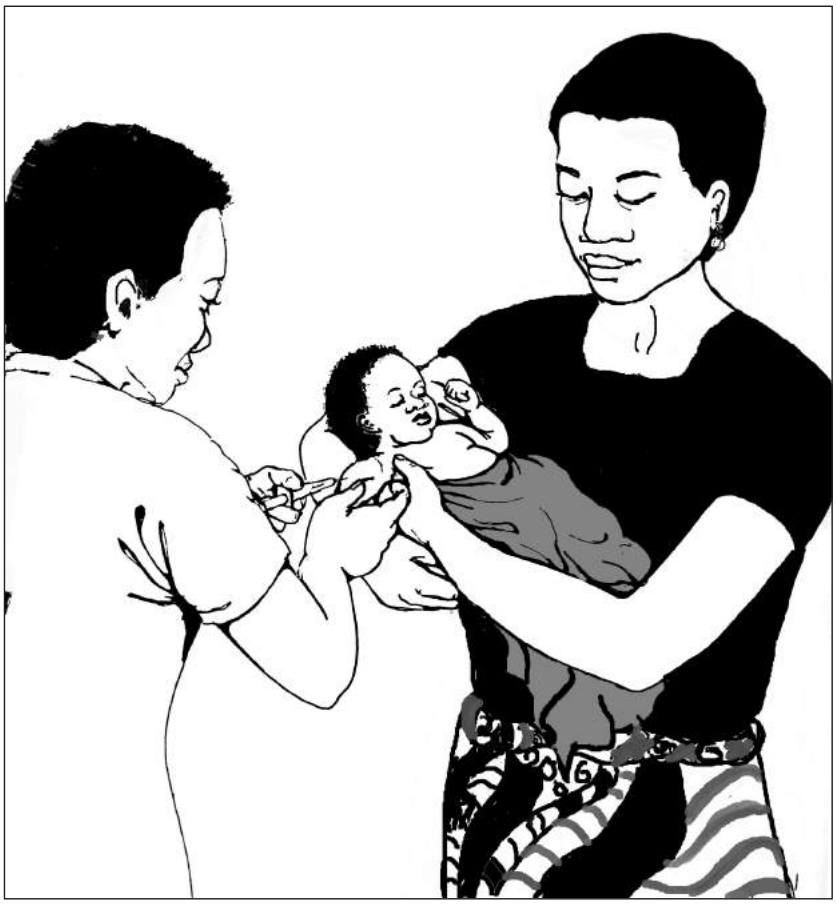
Summarise the discussion by saying there are many reasons children might not grow well. These can include practices related to:

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

15 Min

4. Nutritional status is also affected by illness

Explain that the body needs food to fight infection, but illness makes the child not want to eat. When the child eats less, the illness lasts longer or gets worse and can even lead to death. Children who are sick also will not grow well. It is important to help children not to become sick or to help children get better quickly.



What Is Malnutrition?

Lead a discussion on childhood illnesses in the local community:

What illnesses do children in our community get?

(diarrhoea, colds, cough, fever, malaria, tuberculosis, pneumonia)

How can we help children not get sick?

Immunisation – When do children need to be immunised?

(refer to the Ministry of Health immunisation schedule)

Deworming – Why is deworming important?

(child may not feel like eating, body will not be able to use the food the child does eat, more loss of nutrients from the gut)

When do they need to be dewormed?

(refer to the Ministry of Health national protocol)

Vitamin A supplement – Why is this important?

(helps child see better, prevents blindness, helps fight infection and disease)

When do children need a vitamin A supplement?

(every six months, usually given at Health Post)

How do we treat children who are sick?

(continue to feed breast milk and give food and liquids during illness, go to the health post if the child is not getting better)

What do we do for a child with diarrhoea?

(give extra breastfeedings and other foods and liquids; give oral rehydration solution)

Review the method for mixing oral rehydration solution.

Before children enter the Hearth sessions, they should have completed their immunisations, received vitamin A supplements and been dewormed. This will give each child the best chance to recuperate from malnutrition. Volunteers will need to talk with the caregivers about this, and either send them or go with them to the health post to make sure each child has received all of these interventions.

30 Min

5. Prepare and eat snack together

Discuss the importance of hand washing and the importance of snacks. Make a display of common snack foods. Include both healthy snacks (banana, papaya, mango, cooked milk, coconut, egg, groundnut, corn, yam, tortilla) and unhealthy snacks (soda, sweets, candy, crisps, junk food).

One way to help children grow is to make sure they eat at least three to five times during the day. This includes meals and snacks. Lead a discussion using the following questions:

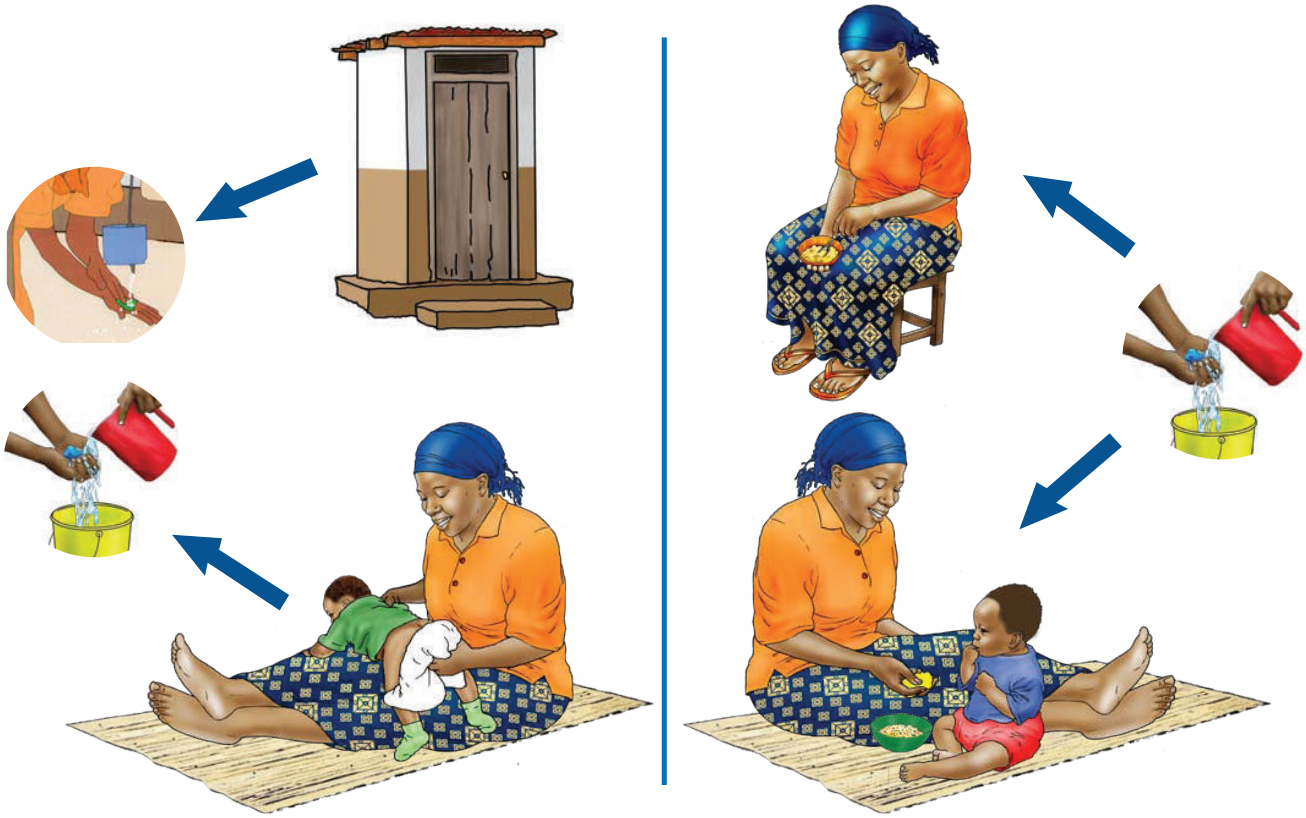
Why are snacks important for children?

(stomachs are small so they can only eat small amounts at once, it is a chance to give a variety of foods such as fruit)

Which of these snacks (on the table) are healthy and which are unhealthy? Why? Which are affordable?

Pick one of the healthy snacks, such as papaya, for the participants to prepare and eat together.

Have them wash their hands before preparing the snack. Discuss the reasons for hand washing together.



How do we wash hands? *(soap/ash and water, rub well, rinse)*

Why is it important to wash hands? *(to keep germs from spreading, getting into our food, mouths, making us sick)*

When do we need to wash our hands? *(before preparing food, before eating, after using latrine, after changing a diaper, after helping a child use the toilet, after helping a sick child)*

Prepare and eat the snack together. Wash germs and dirt are not transferred to the flesh of the fruit, and cut with a clean knife.

5 Min

6.

Ask participants to think of one new thing they learned today.

Ask them to name the three goals of PDH. *(to rehabilitate malnourished children quickly, to help families keep their children healthy and to prevent malnutrition from happening in the future)*

Ask them to name the four main reasons why children may not grow well. *(inadequate food, care, hygiene, health-seeking behaviours)*

What Is Good Nutrition?

SESSION 4

30 MIN | DAY 1

Purpose

- To learn about a variety of foods needed to help children grow well

Materials

- A variety of food available in the community set on a table. Make sure there are eggs, protein sources, fruit, vegetables, nuts, oil and staple foods. If food is unavailable, use pictures. Use examples of foods that were found to be locally available and affordable in the community.
- a cooking pot
- three large stones, each with a large label: GO GROW GLOW
- a large cooking pot
- a variety of healthy and unhealthy snacks
- hand-washing facilities (basin, water, soap or ash)

STEPS

5 Min

1. Explain

'To grow well children need to have good food and to be free from illness. Children need enough food and a variety of different types of food. We will look at what types of food to eat and how to treat illness.'

10 Min

2.

Have participants call out what types of food they eat in their community.

1. What is the main food they eat? *(rice, maize, millet)*
2. What are other foods they eat? *(any foods they list)*
3. Why do we need to eat different types of food? *(they taste good, some help us not get sick, some help us not to get hungry, they help children grow)*

10 Min

3.

Set up a cooking pot that rests on three large stones, with the names on the stones turned to the inside. Discuss this cooking method.

Use the cooking pot and stones to explain. What happens if we have fewer than three stones? (Take out a stone to demonstrate.)

To make sure our cooking pot does not spill we need to place it on three stones.

If we take away one stone, the pot will fall over. For us to be healthy and not 'fall', we need different types of food. We are going to call each stone a different name to remind us of the types of food we need: Energy Giving, Body Building, and Protective (GO, GROW and GLOW). (Turn the stones so they can see the names.)

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

Can our pot balance on one stone? *(no)*

What happens to it? *(falls over, puts out the fire, spills the food)*

We need all three stones to keep the pot balanced. Another stone is called

Body Building (GROW). What do you think Body Building or GROW foods do? *(help our bodies build muscles and nerves and grow strong)*

These foods often come from animals.

Which foods on the table are Body Building (GROW) foods? *(eggs, milk, fish, fowl, meat, groundnuts, beans, peas, nuts, seeds)*

Can our pot stand on two stones? *(no)*

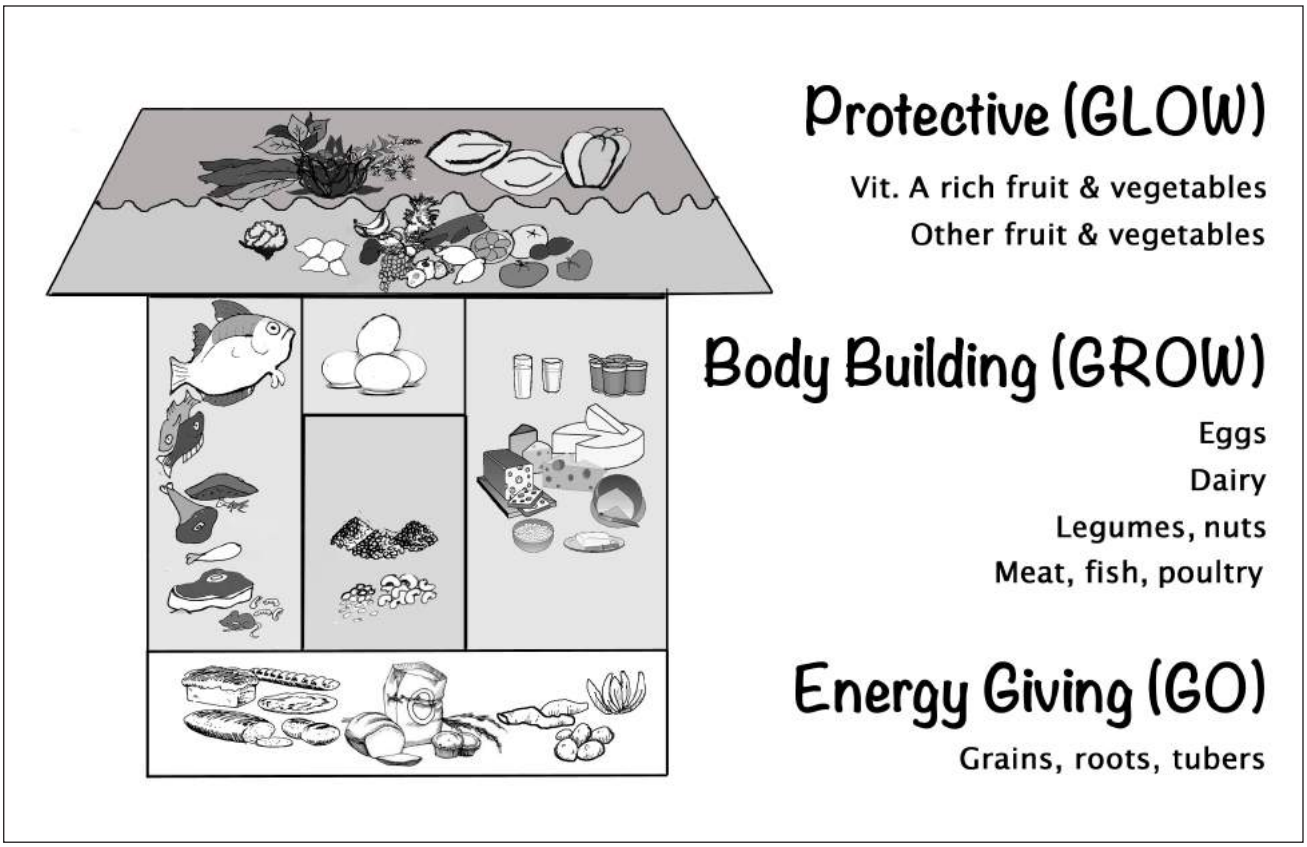
We need another stone. This one is called Protective (GLOW). What do you think Protective or GLOW foods do? *(protect our bodies from illness, make our hair, eyes and skin glow).*

They are often fruits and vegetables.

Which foods on the table are Protective (GLOW) foods?' *(carrots, pumpkin, tomatoes, dark-green leafy vegetables, papayas, mangos, oranges)*

Have each participant pick different types of food from the table. Make sure all the foods are taken. Now have the participants place the foods they picked by the proper stone.

When all the foods are placed, ask if all the foods are in the right places. Gently make any corrections.



Discuss how most people eat a low-cost staple food that forms the main part of the meal and provides energy. In many homes not much else is eaten. But to be healthy more than just this main food must be eaten. It is very important to also eat other foods in the Energy Giving (GO), Body Building (GROW), and Protective (GLOW) groups.

Discuss one food not included yet which is very important for babies and small children:

What is it? *(breast milk)*

Why is breast milk important?

(It contains exactly what a baby needs to be healthy and grow. For six months a baby does not need any other food or water.)

Why not give a baby other food or water before six months?

(baby is more likely to get diarrhoea, will take less breast milk and that will cause the supply of breast milk to decrease)

When do babies need to start to eat other foods? *(at six months)*

How long do babies need breast milk? *(up to 24 months)*

Why do babies need food at six months?

(they are more active, they need more energy and nutrients than they can get in breast milk, their gut has developed more and they can digest other food)

What happens if a baby does not get other foods at six months?

(will stop gaining weight and growing well, may not be interested in other foods later)

Overview of Positive Deviance/Hearth

SESSION 5

45 MIN | DAY 1

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

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

Reference in *CORE PDH Guide*: *pp. 1–14*

Preparation

- Prepare a flip chart with the three goals of PDH

Materials

- Flip-chart paper
- Fresh foods (e.g. vegetables, eggs), plates, cooking pot, etc. for role play
- Glass half filled with water

STEPS

10 Min

1.

PD/Hearth combines two approaches proven to successfully reduce child malnutrition and promote the normal development of the child at the community level.

Positive Deviance is based on the premise that some solutions to community problems already exist within the community and just need to be discovered. In the Hearth approach, community volunteers and caregivers of malnourished children practice new cooking, feeding, hygiene, caring, and health-seeking behaviours shown to be successful for rehabilitating malnourished children.

The common belief is that poor households will have malnourished children and rich households will have healthy children. However, you will find in any community that there are poor households with healthy children. These are the positive deviants. We want to learn the key positive behaviours in feeding, hygiene, caring, and health-seeking practices that are allowing these positive deviant children to be healthy. These few number of positive and affordable practices are the key messages we want to share during a 10-12 Days Hearth session with 6-10 caregivers of malnourished children. During the Hearth session, the caregivers will be asked to bring an ingredient and will be the ones who cook a nutritious Hearth meal, and as they are feeding their malnourished children, a key Hearth message is shared. At the end of the 10-12 Days of Hearth, the caregivers will learn 6 key Hearth messages and how to cook 2 nutrient-dense meals. Then volunteers will conduct home follow-up visits to re-enforce and encourage caregivers to continue the positive practices at home and to help overcome any barriers that are preventing them from practicing at home. The follow-up visits are conducted 2-3 times a week for two weeks.

Key Definitions for PDH

Positive Deviants (PD): Healthy children from poor households (Additional criteria will be elaborated in Session on Identifying Positive Deviants)

Negative Deviants (ND): Malnourished children from rich households

Non-positive Deviants (NPD or non-PD): Malnourished children from poor households and healthy children from rich households

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

2.

Ask how each of the three goals is accomplished through PDH.

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 PDH differs from more traditional nutrition-education efforts:

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

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

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

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

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

How PD/Hearth Addresses Malnutrition

SESSION 6

45 MIN | DAY 1

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

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

Reference in *CORE PDH 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 PDH Approach' on a flip chart or use Handout 6.1: Flip Chart 6 – Ten Key Steps in the PDH Approach

Materials

- Two table tennis balls: one round, one crushed
- UNICEF model of malnutrition (refer to *CORE PDH Guide*, pp. 11–12, or print as a handout)
- Flip chart and markers
- Handout 6.1: Flip Chart 6 – Ten Key Steps in the PDH Approach
- Sticky notes and markers for participants

STEPS

5 Min

1.

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

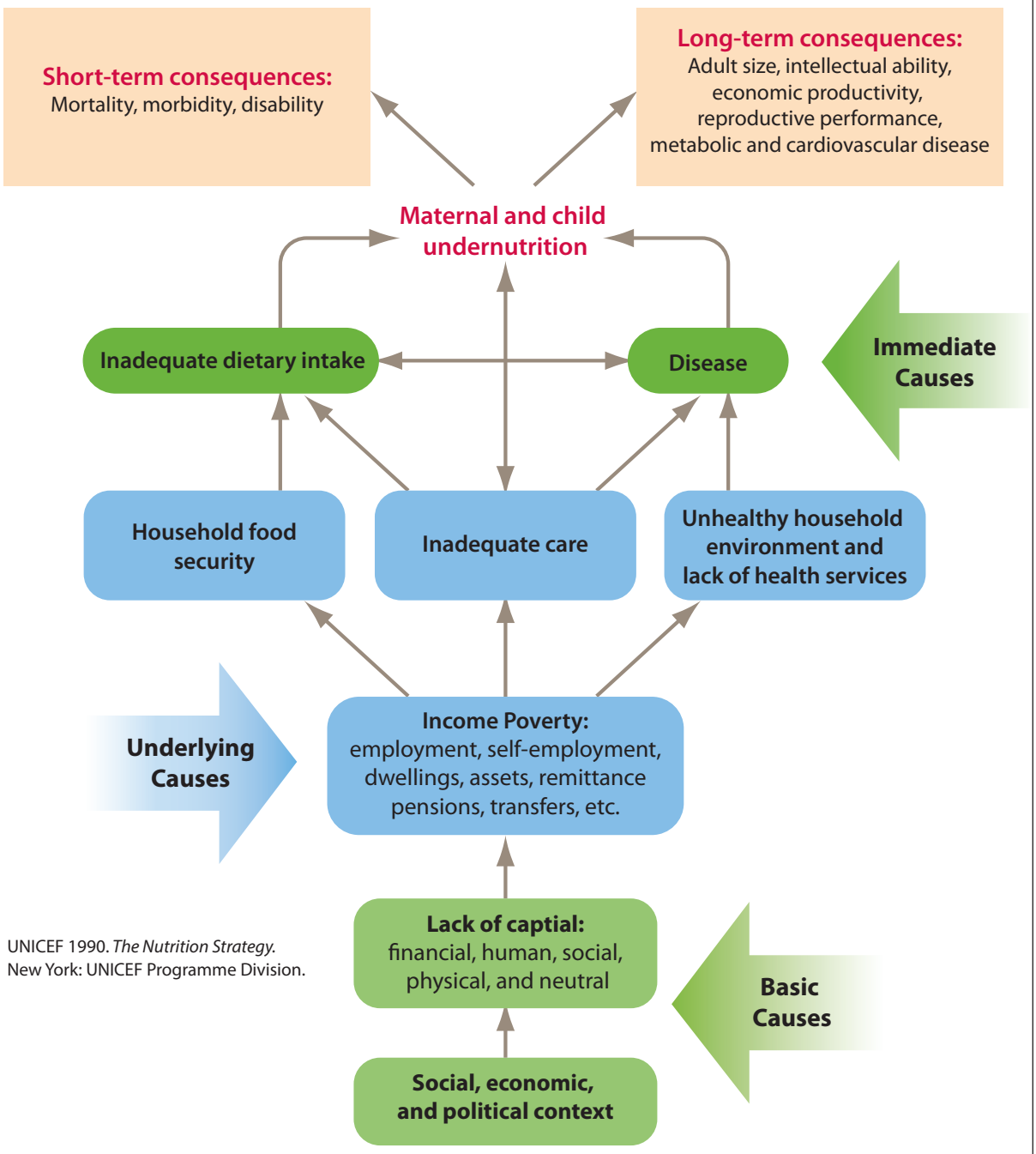
5 Min

2.

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

10 Min

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



UNICEF 1990. *The Nutrition Strategy.* New York: UNICEF Programme Division.

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

The causes of malnutrition can be broken into three levels: immediate, underlying and basic. Briefly review what factors come under each level of causes of malnutrition. Post the cards with these headings to the wall with space between each heading for participants to add sticky notes.

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

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

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

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

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

5 Min

4.

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

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

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

20 Min

5.

HANDOUT
6.1 – 35m/H 16

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

6.

Summarise the session, emphasising that the PDH 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 PDH *(to rehabilitate malnourished children quickly, to sustain rehabilitation, and to prevent future malnutrition).*

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

	STEPS	**APPROXIMATE TIME REQUIRED**	
Step 1	Decide whether the PDH approach is feasible in the target community.		
Step 2	Begin mobilising the community (mobilise or create Village Health/Hearth Committee or working group within the community); select and train staff.	Mobilising the community can take several months and takes place throughout the entire project period. Steps 2 to 4 can take approximately 2–3 weeks, including: 2 days of training 2 days for situational analysis 2 days for PDI 2 days for analysis and feedback to the community	Monitor and Evaluate
Step 3	Prepare for a PDI (situational analysis).		
Step 4	Conduct a PDI.		
Step 5	Design Hearth sessions.	2 days	
Step 6	Conduct Hearth sessions.	2 weeks	
Step 7	Support new behaviours through follow-up visits.	Every 2-3 days in the 2 weeks immediately after the Hearth session, and continuing less frequently after that	
Step 8	Repeat Hearth as needed. Monitor progress of Hearth graduates and track growth of all young children.		
Step 9	Expand the PDH programme to additional communities.		
Step 10	Exit strategy for once underweight is eliminated or AP phases out		

SESSION 7

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

World Vision

45 MIN | DAY 1

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

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

Reference in *CORE PDH Guide*: pp. 17–25

Preparation

- Flip chart for step 1. Write on the top: 'Essential Considerations for PDH Programme'
- Flip chart (1 for each small group) with the questions for the exercise in step 2 written on it
- Print out Handout 7.1and 7.2

Materials

- Handout 7.1: Case Studies: Is PDH Appropriate for These Settings?
- Handout 7.2: Where to Implement PDH

STEPS

10 Min

1.

Emphasise that PDH does not work everywhere. Quickly introduce the following criteria (Refer to Handout 7.2) for determining when PDH is appropriate:

1. **At Risk, moderate and severe underweight, based on weight for age, affects more than 30 per cent of children 6 to 35 months old o*r* 30 underweight children between the ages of 6-35 months.** PDH is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include at risk, moderate and severe underweight, but programmes concerned with cost efficiency may want to focus PDH activities on those who are moderately or severely underweight and use less intensive methods to address the children at risk of underweight. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely underweight children in the 6–35 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: *PDH 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 PDH 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. PDH 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. PDH 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 PDH programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PDH need to devote themselves full time to PDH, 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 PDH to their existing responsibilities. Since PDH is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.

10 Min

2.

HANDOUT
7.1 – 40m/H 17
7.2 – 41m/H 18

Divide participants into small groups and pass out the case studies (Handout 7.1), the implementation criteria (Handout 7.2) and a flip chart with the following questions to each group. For each case the group should answer the following questions and summarise for the large-group discussion:

- Does this case meet the criteria for a PDH programme?
- What are the strengths that would help PDH succeed in this community? Advantages?
- What are the challenges of doing PDH in this community? Disadvantages?
- If PDH 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 PDH. Ask for comments and discussion by the large group. Be sure to discuss alternative strategies if PDH is considered inappropriate.

Case study notes:

Coast village – level of malnutrition does not warrant the effort of PDH.

North interior – PDH 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 – PDH 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 PDH; however, it may be more important to put together menus of street foods since women don't cook at home. Although underweight level are less than 30 per cent, there are still greater than 30 malnourished children in a densely populated community.

5 Min

4. Recap the important criteria and take questions from the group on PDH Step 1 (determining the feasibility of PDH).

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

Read and analyse the following cases. Decide whether PDH 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 PDH 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 6-35 months.

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

1. **At Risk, moderate and severe malnutrition, based on weight for age, affects more than 30 per cent of children 6 to 35 months old or 30 underweight children between the ages of 6-35 months.** PDH is cost efficient only where there is a sizeable concentration of malnourished children. The 30 per cent cut-off may include at risk, moderate and severe malnutrition, but programmes concerned with cost efficiency may want to focus PDH activities on those who are moderately or severely malnourished and use less intensive methods to address the children with at risk malnutrition. **In large communities an alternative criterion may be the presence of at least 30 moderately or severely underweight children in the 6–35 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: *PDH 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 PDH 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. PDH 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. PDH 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 PDH programme, the implementing agency must be willing to adjust budget, devote adequate staff time, and monitor quality. The staff and volunteers implementing PDH need to devote themselves full time to PDH, 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 PDH to their existing responsibilities. Since PDH is self-limiting and can be phased out of a community after a year or two, when there are no more malnourished children, the increased numbers of staff and volunteers will not be a long-term burden.

Daily Summary and Evaluation

SESSION 8

10 MIN | DAY 1

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

1. Evaluate their personal learning for the day.

Preparation

- Make a flip chart with the daily evaluation questions (listed below)

Materials

- Half sheet of paper for each person

STEPS

1.

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

2. Daily Evaluation

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

1. Something I learned today that I will apply in our PDH programme is

_____.

2. Something new that I learned about PDH today is

_____.

3. Something I'm still confused about is

_____.

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

3.

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

SESSION 9

Review of Day 1 and Agenda for Day 2

30 MIN | DAY 2

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

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

Preparation

- Review questions for Day 1.

Materials

- Ball
- Prizes for winning team members

STEPS

1.

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

Possible questions:

- What is one goal of PDH? (ask the question three times; people give different goals)
- What is one of the ten key steps in the PDH Approach?
- What is a criterion to determine if PDH is feasible?
- What is a responsibility of a Facilitator?

2.

Review agenda for today.

Community Mobilisation (STEP 2)

SESSION 10

70 MIN | DAY 2

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

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

Preparation

- Print out Handout 10.1
- Prepare one flip chart titled 'Whom do you need to mobilise for PDH?' with a simple Venn diagram on it.
- Prepare one flip chart with the Triple A cycle (see below).
- Prepare a flip chart with the following discussion questions:
  - What is the role of the Ministry of Health?
  - What is the role of the Village Health Committee?
  - How do you get maximum buy-in and support? How do you keep this involvement?

Materials

- 10.1 Handout: Community Mobilsation (STEP 2)

STEPS

30 Min

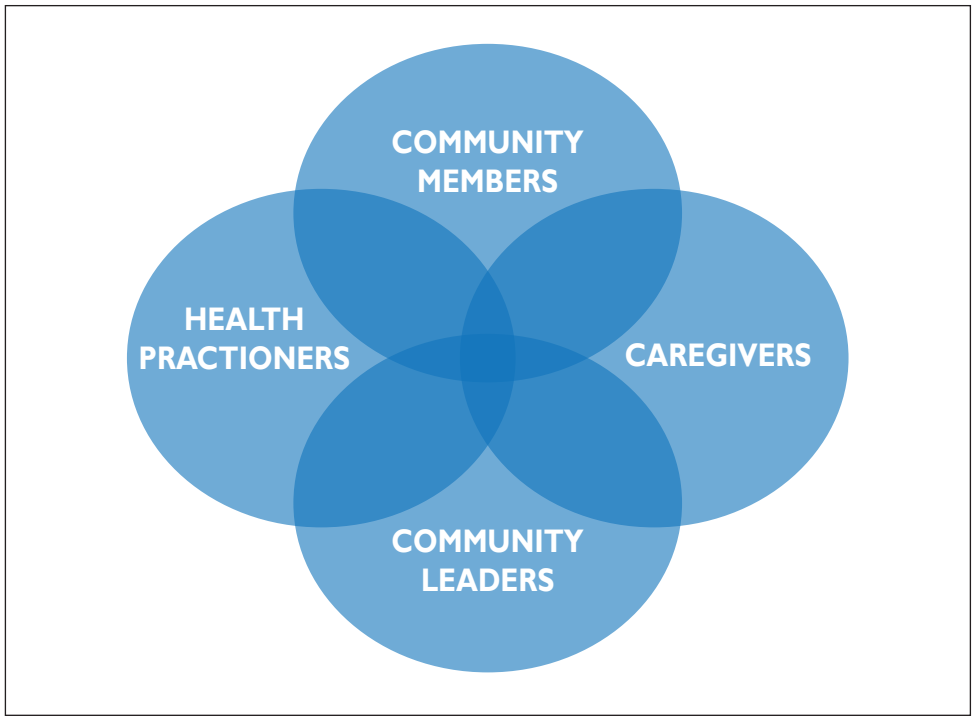
1. Introduce PDH Step 2

Stress the importance of community mobilisation. PDH 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. PDH Facilitators should have a solid background in community mobilisation. Indicate that community mobilisation is a big topic, and many participants have a lot of experience with it. The discussions in this course will focus on the context of community mobilisation for PDH, but will also pull from the expertise of the group. Use key questions to brainstorm and guide discussion, writing group input on flip charts.

*(**Note:** uncover the previously written questions one at a time.)*

HANDOUT
10.1 – 47m/H 20

Whom do you need to mobilise for PDH? Show the participants the diagram of overlapping circles (Venn diagram) on a flip chart. Each large circle represents a group of people in the community who may need to be mobilised for PDH. 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 PDH *(community leaders; fathers, grandmothers, mothers and other caregivers; health staff, volunteers and their families [large time commitment]; traditional healers; traditional birth attendants; school teachers; and many others can contribute to the success of a PDH 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 PDH 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 PDH 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 PDH. The following activity will help to illustrate the importance grandmothers have, especially in maternal and child care, and the necessity to include them in PDH.

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

- Consider grandmothers for leadership roles, including VHC and Hearth volunteer positions
- Consult grandmothers during situational analysis
- Interview grandmothers during PDI and/or involve grandmothers in conducting the PDI
- Engage grandmothers as participants in Hearth, either as caregivers, volunteers or part of caregiver-grandmother pairs
- Include grandmothers in follow up home visits, including review of child's progress and discussion of challenges to implementing PD practices at home.

15 Min

2.

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

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

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

Discuss the following questions:

How do you get maximum commitment and support?

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

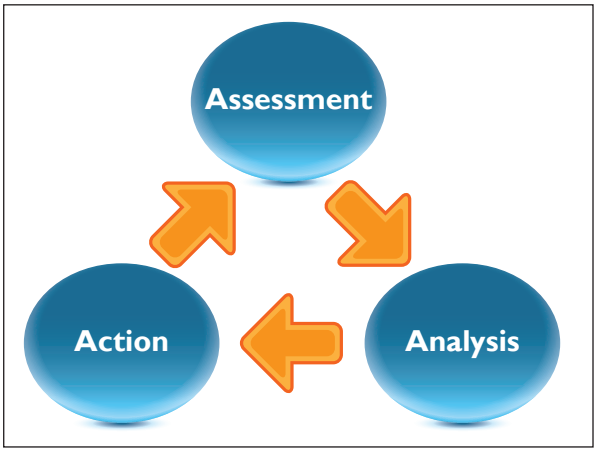
How do you keep this involvement throughout the project?

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

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

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

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



STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP:

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

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

Step 2B Ask about the existing local health systems (e.g. Village Health and Sanitation Committee (VHSC), VHC (Village Health Committee), 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 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: Mobilise the community members and leaders and share the baseline information (results of the nutrition assessment) using visual posters to show the current nutritional status within the community (avoid using technical terms). Also, if time allows share the visuals that the 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 PDH so the entire community can see the effectiveness of the programme.)

Step 10 Appreciation Day/Graduation Day

Step 11 Program Monitoring and Review

3.

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

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

15 Min

4.

Summarise some of the key challenges to community involvement and some of the solutions developed by the group. If programmes are including disability, ask participants what some challenges would be with including children with disability *(possible answers: stigma and exclusion of children with disability and their caregivers, poor identification/screening, etc)*. Refer participants to additional exercises for mobilising communities in the *CORE PDH 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. It is important to intentionally include households and children with disability into PDH programmmes more than other children if disability inclusion is a priority for the AP or FO.*

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.

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

1. Describe 3 ways disability has been approached by the development sector.

   Use the Game of Life to mobilize the community and improve awareness around disability inclusion.

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

Preparation

- Prepare flip chart with the headings: *1. Medical Approach; 2. Charity Approach; 3. Inclusive Approach* and prepare the diagrams of the models under each heading (refer to Handout 11.1)
- Print out Handout 11.1 and 11.2

Materials

- Flip-chart paper
- Post-it notes to distribute to each group
- Markers
- Handout 11.1 and 11.2

STEPS

45 Min

1. Introduction to the different approaches to disability

Development programmes often ignore disabled people – or treat them as a special case. This session deals with different models of understanding of disability, and is central to understanding how to include children with disability into PDH. As facilitator you need to be comfortable with the differences in approaches before you lead the training, because participants will probably want to challenge many aspects before accepting them.

Essentially, both the medical and charity approaches (known as the 'individual' models as they focus on the disabled person as the 'problem') have targeted disabled people as a separate group – needing specialist or dedicated services, chosen on their behalf by 'experts'. This is characterised by development initiatives such as provision of prosthetic limbs, rehabilitation or speech therapy programmes; setting up specialist income-generating projects or vocational training centres for people with disabilities under the charity model. These models do not address inclusion of people with disabilities and their participation and rights in the community and society. These services may be needed, but the decision-making power is often with the "experts" and not with people with disabilities.

By contrast, the social model makes the assumption that disabled people should participate in all development activities. But it also assumes those actions may need to be adapted for accessibility. It means taking responsibility for understanding how to include disabled people as stakeholders in all mainstream work – and looking for ways to support their participation in community life.

Primary caregivers' knowledge on disability and care is low in many contexts. Also, caregivers of children with disability do not bring them to health centres or GMP sessions due to stigma associated with disability. It is important to increase awareness of the community and increase the confidence of primary caregivers to seek support to know how to better care for their children with disability and create an environment where children with disability feel valued and empowered. We must mobilize the community leaders and influencers to ensure they understand the importance of including children with disability into society and giving them more attention to ensure they get the necessary access to rehabilitation, therapy, or other health and nutrition services.

Note to Trainers: *Try not to make the mistake of saying medical and charity approaches are 'bad' and social is 'good'. Not only is this too simplistic, but it may also provoke strong reactions from people who've followed the individual approach to disability throughout their career. It's especially difficult for medical and welfare personnel. Disabled people do often require medical assistance and specialist support. The main issue is choice – often decisions are made on behalf of disabled people, rather than at their request or in consultation with them.*

Individual vs. Social Models focusing on Disability (Group Work)

1. Ask participants – 'What words do you associate with disability? What words or images come to your mind when you say or think the word "disabled"? What are some words that are used to call people with disabilities?'
2. Divide participants into small groups of between four and six. Ask them to talk about the words they've come up with.
3. Ask them to write the words they'd like to share with the whole group onto the cards provided (one word or picture on each card and only on one side). Each group needs to keep their cards safe, ready to share with the others later.

HANDOUT
11.1 – 57m/H 24

4. Bring the whole group back together. Using the diagrams, explain the concepts of medical, charity (individual) and social models of disability. Use the information in Handout 11.1 to describe each model. Explain to participants they will be given handouts afterwards so they don't need to take notes.
5. Having carefully explained each of the different approaches, ask each small group to lay out their collective words on the floor or on the wall in front of the wider group under the heading of medical, charity or social. Discussions will follow as participants try to explain why they placed words under particular headings. Encourage people to question whether they think the words are under the most appropriate headings.

6. It is strongly recommended you take time to ensure at the end of the activity participants understand the differences between individual and social models of disability.
7. Advise participants to share these 3 diagrams with the community when conducting the first community feedback meeting to help them to better understand how to include disabled population into the community.

40 Min

2. Examining Issues of Discrimination – 'Game of Life'

Setting up the room/area is important. You may need to spend time reorganising the chairs. You'll need enough space for four people to stand side-by-side, with the other participants seated around the edges of the room/area you are using, facing towards the volunteers. Creating a 'corridor or path' in the middle of the room/area, enabling you to use the full length of the room for the exercise, is ideal.

1. Ask for four volunteers from among the group (ideally, two men and two women), willing to stand for about 30 minutes to represent the following groups:
   - non-disabled men;
   - disabled men;
   - non-disabled women;
   - disabled women.

   Emphasize that this is NOT a role-play exercise – the volunteers will be representing a group of people from within a village as we want to be respectful of peoples with disability and not be offensive.
2. Assign each volunteer a role. Explain how you'll be telling a life story, taking the characters on a journey from birth to old age. As you reach each significant life event, you'll ask them to respond as they think their character (or their family) would react. They'll need to take:
   - two steps forward for a very positive or very successful experience;
   - one step forward for a positive or successful experience;
   - one step back for a not-so-positive or not-so-successful experience;
   - two steps back for a negative or unsuccessful experience.

   Once your volunteers understand what they'll be required to do, reinforce they are representing a group of people, so they should respond accordingly. Encourage them to avoid thinking about specific impairments or basing decisions on their own life experiences. Also, their response should be based on what they think is currently accurate for their culture and situation – not what it ought to be.

After each life stage and volunteers' responses, allow time for the others to react and comment. If there's disagreement, the group should decide by consensus and the volunteer may be asked to alter their move. The facilitator's role is to assess when to intervene and comment to clarify reasons for decisions and to bring out and discuss any prejudicial points. The specific impairment is not relevant to the main point of this exercise, so try not to focus on this too much.

3. Set the scene for the story. Since you want to emphasize links between disability and poverty, consider placing the story in a typical village. Describe it in as much detail as you can, explaining that income poverty levels are generally quite high – although most families have land and access to safe water. For entrepreneurs, opportunities exist in the nearby town where there are also health and educational facilities.
4. Start with the first life event, as if telling a story…ask for comments and suggestions from the rest of the group. *'One fine day, after a long wait of nine months, your character is born. How does your family feel when they see who you are? Make your moves.'* Note these are examples of what might happen:
   - family is very happy (non-disabled son born), two steps forward;
   - quite happy (disabled son/non-disabled daughter), one step forward;
   - not happy (disabled son), one step back;
   - very unhappy (disabled daughter), two steps back.

Additional Scenarios:

'Now you are a bit older, and it's time to start thinking about school. How likely is it that you will be able to attend school? Make your moves.'

'Now you are 20. You'd like to get married, or form a relationship. How much do you think this will be possible for you? Make your moves.'

'You like to keep busy and want to make some money for your family. You try to get a job. How easy will it be for you to find one?'

'A few years go by. Everyone in your age group is having babies. How much will this be a possibility for you?' Check if the disabled woman takes two steps back, or is instructed to do so by the group. Why did this happen? They may say it's because most disabled women are physically unable to have children – a common myth. Two steps back may well be an accurate response for a different reason – disabled women often don't have children because society thinks they can't or shouldn't.

'Now you're in your 40s. You have a lot of experience of life. You want to help your community by becoming involved in local politics. How likely are you to achieve this goal?'

5. Ask the group:
    - Who is in the best position now? Who is in the worst place?
    - Volunteers, (who represented the various roles) how does this make you feel?
    - Were there any parts that surprised you?
    - How helpful was this game for understanding the effects of disability and social exclusion on people's abilities to avoid poverty?
    - If the non-disabled man who ended up at the front by the end of the exercise was still regarded as living in poverty - what would this imply for people with disability?

The most powerful way to end this session is to ask the group to look once again at where the characters are standing. Recall that this was all taking place in a rural location where general levels of poverty are quite high. Even though the non-disabled characters are well ahead of the disabled ones, they are by no means wealthy. Ask the group – who benefits from your development programmes at the moment? If disability inclusion is part of your PDH intervention design for your AP, TP, or project, play the 'Game of Life' with the community members during the first community feedback session.

45 Min

3. Why Disabled Populations are Excluded

Why are disabled children are excluded from most health and nutrition services or programmes? That's the core question. And it's tackled head-on in this section.

1. Ask the whole group (participants and later on, community members) the following questions:
    - Do you actively include disabled children (or measure their participation) in your development programmes or community activities?
    - If not, why don't you actively include disabled children?

The key part of these questions is the word 'actively'. This should be stressed when you pose the questions. Encourage people to be honest about their answers – this will give them the best opportunity to analyse the issue.

2. Assuming the group does not actively include disabled children, list down all the reasons people give onto flip chart paper. Possible answers will include – it's expensive; time-consuming; we don't have the experience; we don't know how to; why should we, this is one more marginal group amid many others; it's not practical in our type of work; etc.

3. Explain the most likely common misconceptions – and their responses – given overleaf (see Handout 11.2 – Common myths about inclusion for further analysis):


HANDOUT
11.2 – 58m/H 25

'We need to sort out the problems of "normal" people first'.

'It's not cost effective'.

'There aren't many disabled people here, so it's not an issue'.

'We don't "do" disability'.

'We don't have the skills'.

'Let's create a special programme'

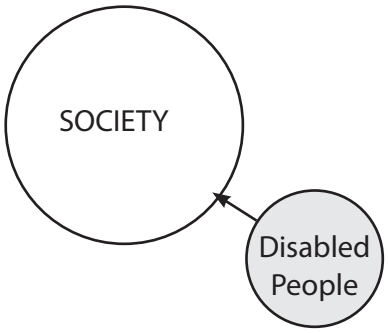
4. Divide participants into groups of four to six. Give each group a selection of the excuses they've come up with. Ask them either to turn them into positive statements about how we could mobilize the community so PDH could include disabled children and we could overcome the stigma that exists in the community – or develop a reply refuting the statement. They need to imagine they're facing people who are coming up with all these reasons why they do not want to include disabled children in GMP, PDH, or other community-based programs. Their job is to reassure them that inclusion is good development practice – and this will improve the effectiveness of the programme as a whole.
5. Ask the groups to present a selection of their favourite responses to the rest of the participants. They can do this in whatever format they choose. Some groups might like to illustrate their ideas with pictures, perform a short dialogue highlighting the debate or simply describe their ideas. These illustrations could be shared with the community members during the first community feedback session to help community members better understand why disability inclusion is important and necessary.

INTRODUCTION

Everyone has a right to such things as health, education and income generation. But the needs of disabled people have traditionally been treated as separate and specialised which has put them outside mainstream society. The UN Convention on the Rights of Persons with Disabilities challenges this narrow approach. The emphasis for inclusion is placed on society rather than on disabled people. They should be seen as whole people with the same needs as others, able to choose how they are supported. There are three ways disability has been approached in development. The first two models – medical and charity approaches – focus on barriers to participation being with the disabled individual. The third way – the social model – focuses on barriers being with society's view of disabled people.

INDIVIDUAL MODELS:

MEDICAL APPROACH

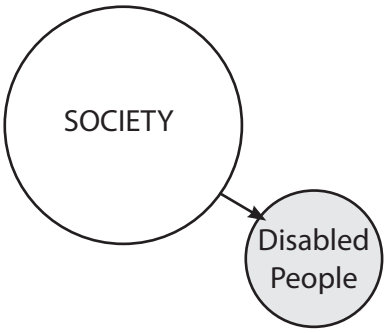


Activities 'fix' disabled person, who is 'sick', so they can join 'normal' society

- disability is a problem in the person
- a traditional understanding of disability
- focuses on a person's impairment as the obstacle
- defines the disabled person only as a patient with medical needs
- segregates disabled people from the mainstream
- offers only medical help, carried out by specialist
- expensive, tends to benefit relatively few

INDIVIDUAL MODELS:

CHARITY APPROACH

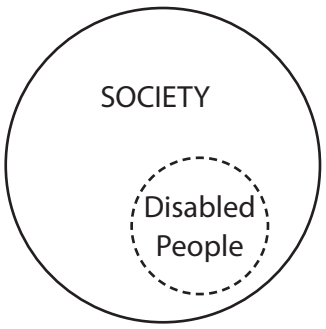


Activities 'help' disabled person who is 'helpless' and outside 'normal' society

- disability is a problem in the person
- they are seen as 'unfortunate', 'dependant' or 'helpless'
- they are regarded as people who need pity and charity
- assumes people with impairments cannot contribute to socieity or support themselves
- provides them largely with money or gifts, such as food or clothing
- disabled people become long-term recipients ofwelfare and support
- aid provided by specialist organisations not mainstream development
- disabled people viewed and kept as separate group

SOCIAL MODEL:

INCLUSIVE APPROACH



Activities focus on inclusion – disabled people are part of society

- focuses on society, not disabled people, as the problem
- regards disabled people as part of society, rather than separate
- people are disabled by society denying their rights and opportunities
- sees disability as the social consequences of impairment
- disabled people's needs and rights are the same as non-disabled people's–e.g. love, education, employment
- activities focus on identifying and removing attitudinal. environmental and institutional barriers that block inclusion

A whole range of reasons are given when you ask why disabled people are not travelling on the 'main road' of development. Here are some of the most commonly held views – along with informed common-sense responses.

'We need to sort out the problems of "normal" children first'.

Disability IS normal. Disabled children are in every community. It's an expression of the diversity of the human race. Our perceptions are distorted by social norms which keep disabled people out of the public arena, and by the narrow vision of beauty presented in media images. Good development work challenges conditions which exclude the oppressed – disabled people are among the most oppressed.

'It's not cost effective'.

Including disabled children is often seen as an 'extra'. It happens in an ideal world. It's a luxury. Saying 'we only have enough money for the basics, so we can't afford to include them' denies the reality that disabled peoples' needs ARE the basics. It doesn't necessarily cost much more to include them in development, especially if it is planned from the outset. For example, physical accessibility is estimated to account for additional construction costs of between 0.1 and 3.0 per cent.

'There aren't many disabled children here, so it's not an issue'.

Disability is treated as a specialist area, often because of the misconception that their number is insignificant. This myth arises because many disabled people are invisible. In reality, they may be hidden away due to stigma, or are excluded from meetings because of a lack of access. If frontline workers don't see disabled children in their work, they tend to assume they don't exist in the community. Disability affects the family as well as the individual, and they also face discrimination and increased poverty.

'We don't "do" disability'.

Disabled people are often regarded as a distinct target group for separate programming. So some agencies specialise in disability and others do not, thinking their needs are already being dealt with. However, only a small number of disabled children participate in programmes of specialised agencies or targeted work. By not including disabled children, mainstream programmes fail to address the needs of a group who account for at least ten per cent – and perhaps up to 20 per cent – of any given population. Worldwide, more than one billion people have some form of disability.

'We don't have the skills'.

Working with disabled children is not significantly different from working with any other group. Many needs are the same. Sometimes the approach to meeting them is different. Disabled children themselves are the best experts and can often suggest modifications to make things work for them. It's largely about changing attitudes. Sometimes low-tech simple solutions can have a major impact on accessibility for disabled children.

'Let's create a special programme'.

It's unrealistic to expect a single specialist intervention programme to address all the needs and rights of all disabled children – who are a diverse group. Many of these needs are shared by other children and are not disability-specific. They are best addressed within the framework of the whole community.

Perhaps you have come across other reasons why inclusion of disabled people isn't happening – what should a common-sense response to them be?

Material from Session 11 was taken from: Coe, S and Wapling, L. (2010). *Travelling together: How to include disabled people on the main road of development*. World Vision. (Internet). "https://assets.worldvision.org.uk/files/6513/8053/8823/Travelling_together.pdf"

SESSION 12

Identifying and Selecting Volunteers (STEP 2)

World Vision

35 MIN | DAY 2

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

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

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

Materials

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

STEPS

5 Min

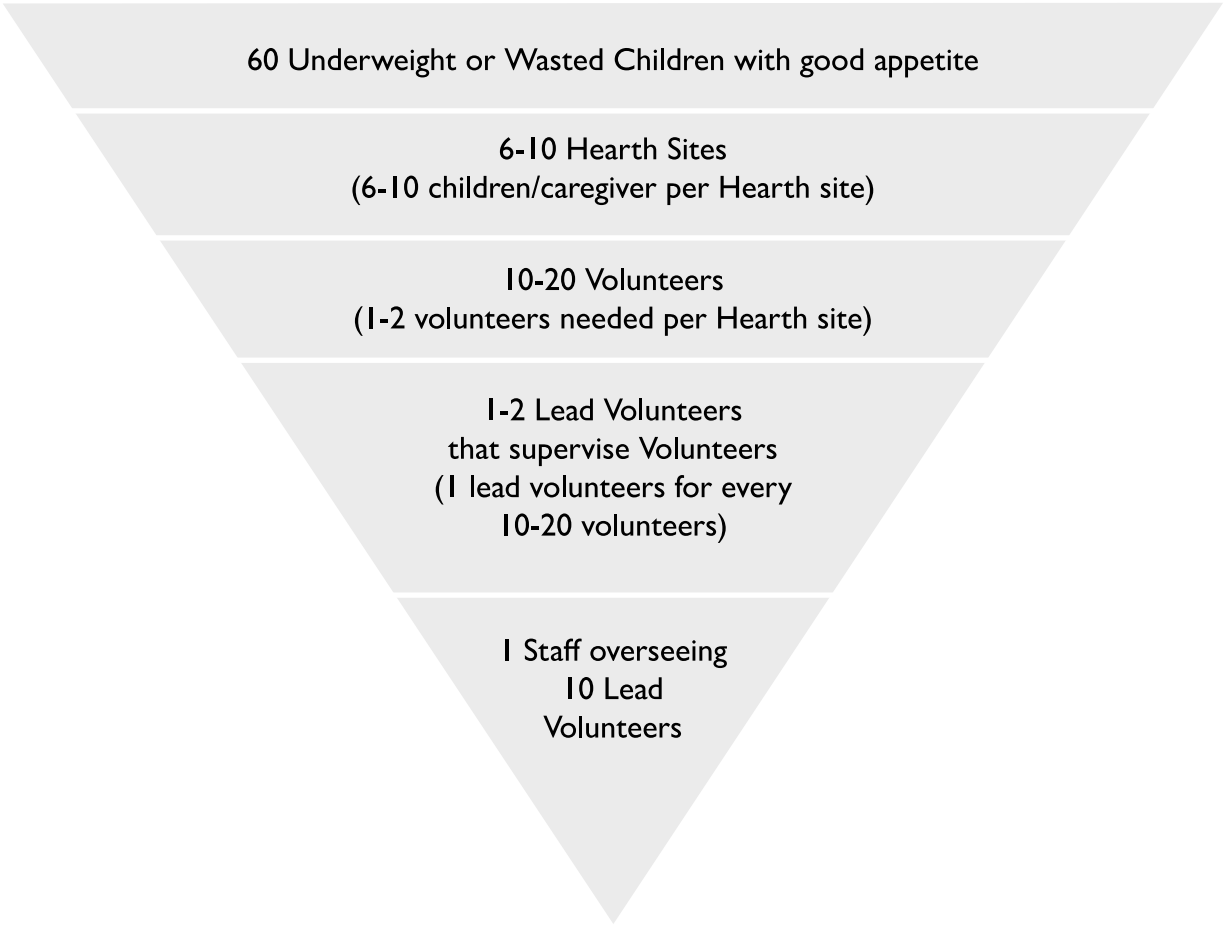
1. Reiterate that PDH is a human resource–intensive programme. Though the programme does not require large investments in infrastructure, the hard work and commitment of staff and volunteers are critical to its success.

2. Discuss the importance of having the commitment of WV leadership and the support of key sectors for PDH. How can the participants begin to achieve this commitment? *(use data to raise awareness of levels of malnutrition; give orientation on principles of PDH; 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. AP 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 PDH Guide*. Ask what titles the participants use for the staff members who fill these positions in their APs. Refer to the sample job descriptions in the *CORE PDH Guide* (pp. 39–42) and ask participants to read these as homework.

Identifying and Selecting Volunteers (STEP 2)

Discuss the total number of volunteers/staff and beneficiaries, using the chart below. You could also give practical examples from your experience of implementing PDH. Ask participants and other facilitators to suggest circumstances that might lead to adapting these suggested numbers and/or roles.



SESSION 13

Situational Analysis – Community Mapping, Transect Walk, and Wealth Ranking

World Vision

105 MIN | DAY 2

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

1. Describe a situational analysis, identify potential sources of information, and know how to collect information through community mapping, transect walks, wealth ranking, nutrition assessments, seasonal calendars, and market surveys
2. Explain the purpose and process of wealth ranking using community criteria
3. Identify the standards for and challenges of conducting a wealth-ranking exercise
4. Use pre-defined criteria to rank households by wealth status
5. Complete filling out and compiling of wealth-ranking data on Situational Analysis Excel template.

Reference in *CORE PDH Guide*: pp. 65–66

Preparation

- Provide participants with soft copy of Situational Analysis (refer to Resource CD).

Materials

- Print copies of Handout 13.1 and 13.2 for each participant
- Handout 13.1: Case Examples for Wealth-Ranking Exercise
- Handout 13.2: Case Examples for Wealth-Ranking Exercise ANSWER KEY
- Handout 13.3: Wealth Ranking for PDH

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 comming diseases, disability, and/or sicknesses, the common practices within the households, food taboos, and other myths associated with child feeding and caring practices, etc. It is important to involve the community through this process of discovery to mobilize the community and to create community ownership for the program and it is an effective tool to help the community discover the resources that already exist so that they are empowered and motivated to overcome the problem of malnutrition as a community.

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

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

Programmers need general information on health, including immunisation coverage; incidence and case management of major childhood illnesses; disability prevalence; attitudes and services; 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 PDH Guide (p. 62) and the specific list of methodologies (p. 64). For more information on Barriers that Block Participation, refer to *Traveling Together Manual Session on Barriers that Block Participation* - https://assets.worldvision.org.uk/files/6513/8053/8823/Travelling_together.pdf

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 and care/feeding practices for disabled children). Such discussions allow us to get a sense of the 'norm' within the community.This will later help to identify the PD practices.

10 Min

2.

How to prepare the field for the situational analysis activities?

To prepare the caregivers and community members for the situational analysis activities, refer to Session 16.

The situational analysis includes the following activities (in this order):

1. Community mapping
2. Transect walk
3. Wealth ranking

Other activities (can be done in any order or simultaneously):

4. Nutrition assessment
5. Seasonal calendar
6. Market survey

Let's now have a closer look at each of these activities:

15 Min

3. Community Mapping

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

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

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

Discuss how these maps might be used for PDH. *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.*

For disability inclusion, mobilize 2-3 caregivers with children with disability and ask them to indicate the homes of households with children with disability. Disability can be generally defined as children with restrictions in mobility, hearing or vision impairment, and/or cognitive impairment. Draw the homes on the community map with a separate symbol to easily identify the homes for the nutrition screening assessment step later on.

Ensure the following landmarks and resources are mapped:

- water sources (such as ponds, rivers, lakes, swamps, bore holes/bole holes, wells, and springs)
- all houses of children under 59 months of age with disabilities in the village
- houses of children under 59 months of age
- gardens or farms
- schools, childcare centres
- health centres, hospitals, outreach posts for GMP and insitutional rehabilitation centres for children with disability
- latrines
- markets and shops
- church or other religious buildings
- mountains or other geological barriers
- houses of volunteers
- roads (major roads and smaller paths)

After the community members have shared their community map, facilitators then ask questions about the map, for example:

- How did you decide to define the boundaries of the community?
- Where do people in the community access food (whether grown, collected or bought)? (You may probe for different kinds of food like meat, fish, eggs, green leafy vegetables, fruits, beans, nuts, legumes, grains)
- How often do people go to markets? To shops? Which markets or shops do people access most? Why would people go to shop in the market or shop? How do they get there? Who goes to the markets and shops within the household?
- How do households access water? (Talk about the different landmarks on the map or perhaps there are other sources that were not yet noted.) What sources are commonly used? What sources are less used?
- Where do households access sanitation? (Probe whether households have shared or non-shared latrines, the distance, who uses them commonly, any difference between women, men, girls, boys and groups among them, like those with disabilities.)
- Where do people take their children (younger than five years of age in particular) if they are sick? How do they get there?
- Looking at the map, what features support good nutrition? What features contribute to malnutrition?
- What spaces are safe? Who are they safe for?
- What spaces are dangerous? Who are they dangerous for?

20 Min

4. Transect Walk

The transect walk is a systematic walk across the community/project area together with the local people to explore the conditions by observing, asking, listening, and looking. They 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.

The observations of the community during the transect walk can also help us in the wealth ranking exercise (e.g. Do all households have iron sheets? Do most households have a TV? If so, then these items cannot be used as part of the wealth ranking criteria because most households have iron sheets as roofs and most households have TVs, even though the household may be 'poor').

To do the transect walk, it is good to be accompanied by 1– 2 community health workers, community leaders, or volunteers who could help navigate in the village/ community.

Ask if anyone has done a transect walk. Ask one person to describe how it is done. (If no one has done this, explain it yourself.) What is the purpose of a transect walk? *(to work with some community members to orient us to the community; to observe what resources are in the community, to understand what some of the challenges might be, to note especially those factors that might affect nutrition and health of children for good or bad practices. It is also good to conduct one household visit while on the transect walk to observe what is being planted in the gardens' of the households and to observe general hygiene and child caring practices. Please refer to the table below for positive feeding, caring, hygiene and health seeking practices.)*

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

(not enough food, too many children, mother is gone all day, father is not there, not enough money, diarrhoea, sickly, disabled, 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.

	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
Caregivers talk to child and make eye contact while feeding	Family members sing and play with children to stimulate learning	Keeping kitchen clean	Use of oral rehydration solution during diarrhoea
Continued breastfeeding along with appropriate liquids and foods during and after diarrhoea	The home is a safe environment for children to play	Using windows and doors to air out the rooms during the day	Children with disability referred for rehabilitative services and feeding support

15 Min

5. Wealth Ranking

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. The objective of the wealth-ranking exercise is to understand the way the community classifies its poor vs. non-poor households and to determine criteria for classifying the households.

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, i.e. the PD, non-PD, and ND households. It is important to identify these households in order to be able to conduct Positive Deviant Inquiries (PDIs).

Wealth ranking is used to develop wealth ranking criteria for the community and needs to be completed before the nutrition assessment/screening. This is because the wealth ranking questions need to be asked to the caregivers when the children's weights are being recorded during the screening. If the weighing is done first, you must go household to household to ask the wealth ranking questions again. Thus, do not make this mistake and make sure you conduct the wealth ranking exercise before conducting a nutrition assessment.

It is important to do this exercise with 5 or 7 community members because only they know how to define the poor households in their community. They must agree with the final criteria that define families as poor or non-poor. Only then they will later believe that there are poor households with healthy children (PD families). An odd number of community members are needed for this activity to make the voting on the criteria simpler.

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.

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.

20 Min

6. Practicing Wealth Ranking

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 PDH 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? Verify the criteria.

Mention that many times, community members only think of the poorest families when defining the 'poor' households. However, the difficult role is to mediate the wealth ranking activity so a line can be drawn between the poor vs. non-poor households without a gap between the two classifications.

For example, if the community members say you are 'non-poor' if you have 10 goats, but poor if you have 0 goats, where does that leave a household if they have 1-9 goats? Thus, it's good to define a poor household and anything above can be considered 'non-poor'. For example, if the community members say even a 'poor' household can have up to 1 goat, the criteria for non-poor would become '>1 goat'.

15 Min

7.

HANDOUT
13.1 – 70m/H 27

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

Distribute Handout 13.1 and have each participant work through the examples of identifying the wealth status of each child. Discuss the answers together.

Case Examples for Wealth-Ranking Exercise

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

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

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

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

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

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

Wealth Ranking for PD/Hearth

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

WEALTH STATUS	WEALTH CLASSIFICATION CRITERIA
POOR	
NON–POOR	

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

SESSION 14

105 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 PDH activities and cite important issues for proper weighing technique
3. Use Excel-based PDH database to calculate Z-scores.

Reference in *CORE PDH Guide*: pp. 57–66, 70–83

Preparation

- Gather country and/or regional nutrition information
- Obtain growth cards (country-specific and/or others used in the region); if unavailable use the WHO growth charts, one for each participant
- Print Handout 14.1, 14.2, 14.3 and 14.4
- Review 'Training of PDH Volunteers Curriculum' before training - use Anthro Job Aids if necessary
- Soft copy of Excel-based PDH database (found in resource CD)
- Refer to Handout 35.8
- Each participant will take MUAC and weight of at least 1 child.

Materials

- Local growth-monitoring chart or
  WHO Growth Charts for Girls: http://www.who.int/childgrowth/standards/cht s_wfa_girls_z/en/index.hHl

  WHO Growth Charts for Boys: http://www.who.int/childgrowth/standards/cht s_wfa_boys_z/en/index.hHl
- Handout 14.1: Case Study of Sunshine and Light Village
- Handout 14.2: WHO Weight-for-Age Reference Table
- Handout 14.3: Child Disability Screening Questions for PDH
- Handout 14.4: Initial Assessment Worksheet
- WHO Guidelines for Inpatient Treatment of Severely Malnourished Children: http://www.who.int/nutrition/publications/guide_inpatient_text.pdf
- Training of PDH Volunteers Curriculum and its job aids for taking ANTHROs
- Blank flip charts
- Soft copy of Excel-based PDH database

- Hanging scales and weighing pants or SECA standing scales
- MUAC tapes
- Pencils
- Recording chart
- a copy of the NCOE Measuring and Promoting Child Growth tool (available in resource CD from ToF Workshop or MS Teams PDH+ Channel)
- 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 PDH training of Facilitators and explain that Step 3 consists of the (1) nutrition baseline assessment; and (2) situation analysis (e.g. transect walk, social mapping, market survey), including wealth ranking. These will help to provide a comprehensive understanding of the current situation in the community. Each of these components will be discussed in detail.

10 Min

2. Nutrition Assessment

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

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

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

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

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

Why PDH 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 PDH 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 At Risk, moderately or severely underweight (despite the household's wealth ranking or socioeconomic status) will enter the PDH 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 PDH 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.* For children with disabilities, their nutritional status or standard weight may be different from children without disability. However, all children with disabilities should also be gaining weight over time. If the growth trend or line on the growth chart begins to curve down or be flat, regardless of the nutritional status, the child is not growing healthy and needs to be referred to PDH or therapy.

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 PDH 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 6–35 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, including disabled children who may not be brought to growth monitoring sessions.

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 PDH 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. If available, refer participants to the TALC publication *Caring for Severely Malnourished Children* (Ashworth and Burgess, 2003), Training of PDH Volunteers Curriculum and its job aids for taking ANTHROs or provide the website for obtaining this useful reference: https://www.ennonline.net/careforsam.

20 Min

4. Weighing Techniques

Refer to the **Training of PDH Volunteers Curriculum** and its job aids for taking anthros or the NCOE *Measuring and Promoting Child Growth Tool* (https://www.wvi.org/nutrition/publication/measuring-child-growth-surveys-workbook) 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.

Context of a Nutrition Assessment:

When you do a nutrition assessment it gets very hectic because you are going to have over 100 caregivers with their young children standing in line waiting to be weighed. They want to go home because it is hot outside, children are crying, everyone is hungry, and caregivers must go back to work or home to cook. So, they want to get weighed as quickly as possible and, a lot of times, this makes our staff and volunteers very disoriented.

We can prevent poor data collection or wrong and missing data if we are well organized to start with. We need to set up 3 different stations and have a person at each station.

1. **Weighing station:** At this station, children are weighed. The person in charge of the weighing station will ask the caregiver to undress the child. Little pieces of paper should be prepared beforehand. Weigh the child and record the weight on the little piece of paper. Weight must be measured to the nearest 1 decimal place. For example, 12.1kg and not 12kg. Then give the piece of paper with the weight information to the caregiver and tell her/him to take the child to the next station.
2. **MUAC station:** At that station, the person in charge will be someone sitting down. They will have another seat for the caregiver to sit with the child. Use the MUAC tape to measure the child's MUAC and indicate the number to the nearest 1 decimal place again or the colour on the same piece of paper that has the weight information. Ask the caregiver to take the piece of paper to the next station.
3. **Recording station:** At the recording station, caregivers will be asked sensitive questions to identify the wealth ranking of the household along with asking disability screening questions to identify children with disabilities and recording child's weight and MUAC in the register.

The recording station should be a bit further away or isolated from everyone to allow caregivers to feel comfortable with answering sensitive questions freely. The recorder/interviewer at this station must know the wealth ranking criteria and needs to know the 5 or 7 wealth ranking questions.

Out of the 5 or 7 questions, if majority of the criteria fall under poor (for example, 3 out of the 5 criteria) then the household will be considered 'poor'. If 3 or more criteria out of 5 fall under non-poor then the household will be considered as 'non-poor' in the register.

When you are asking questions to the caregivers, make sure you ask for all the information you need to re-identify the household for the PDI, such as the name of the caregiver, the name of the father, phone number, address, etc. If you need to, go get the community map and ask the caregiver to identify where their

household lives on that map and then indicate the child's ID number on the map with a little house and add a picture of a house as part of the legend or key for U5 children.

The child that you are recording may be a PD, non-PD, or ND household but we want to revisit all 3 types of households so this household might be selected as one of the households we want to revisit during the PDI. Also, make sure you record the birth order of the child because firstborn children are not identified as PD children (more details about this will be covered later).

25 Min

5. Calculating Nutritional Status of Children

HANDOUT
14.1 – 80m/H30

Distribute a copy of the Handout 14.1 - Case Study of Sunshine & Light Village's Initial Nutrition Assessment Monitoring Form. Read the wealth ranking criteria together as a group and discuss if needed. Then ask the participants to fill in all the columns on the monitoring form, except the 'underweight status' column for Child 1 and 2. Use the provided information on the post-it notes and answers from the interview with the caregivers. Read out answers for Child 1 and 2, as participants check their results (answers can be found on the second page of Handout 14.1).

If computers are available, teach participants to use Excel-based PDH database to calculate Z-scores and obtain the nutritional status of children (Refer to Resource CD). Refer to Handout 35.8 User Guide for the PDH Excel Database. The participants can then fill out the 'underweight status' column. If computers are not available, move on to the next step.

25 Min

6.

HANDOUT
14.2 – 82m/H 32

Distribute Handout 14.2 (WHO Anthro Tables). Explain that another way to calculate weight-for-age is by using the WHO weight-for-age reference tables (Handout 14.2), which may be easier to use than growth charts for volunteers. Have the participants find the underweight status colour for Child 1 and Child 2 by using the Handout 14.2, gender, age in months , and weight data.

1. Select the correct table to use depending on the child's gender.
2. Look for the age in months on the left most column.
3. Then in the row of the age, go horizontally on the table to find in which colour range the child's weight falls under. For example, if the child's weight is 12.3kg, and this weight falls between green (13.1kg) and yellow (11.7kg), the child is considered 'green'. However, if the child weighs 11.5kg, then the child would be 'yellow' for underweight status. You must use the color on the left column if the weight falls between a range.

10 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.

HANDOUT
14.4 – 87m/H 37

Distribute Handout 14.4 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.

10 Min

8. Disability Screen Questions During Nutrition Assessment

HANDOUT
14.3 – 86m/H 36

Please go through the disability screening questions in Handout 14.3 for children with disability to fill in the columns:

- Child is Disabled (Y/N)
- Disabled child has feeding difficulties (Y/N)
- Disabled child has poor appetite or eats less (Y/N)

Indicate with a 'N/A' if child is not disabled for the latter 2 columns.

If a child with disability is identified during the nutrition assessment, please have the caregiver indicate in the community map where his/her home is located and indicate the child's name and ID number on or beside the symbol as the households of children with disability should have already been marked with a unique symbol from the community mapping exercise. At the end of the nutrition screening, if on the community map, there are still some children with disability who were not screened, conduct a household visit to ensure all children with disabilities are screened for their weight and MUAC.

Refer all children to the health centre during the initial assessment screening who have either:

1. 'Red' MUAC or A disability AND difficulty eating/drinking due to his/her disability

Date: 15 January 2019
District: Capital Federal
Community: Sunshine and Light

Wealth Ranking	Wealth Ranking Criteria
Poorest	• Lives in 1-room house • House made of bamboo • House has dirt floor • No regular salary • Only 1 person in family working
Non-Poor	• More than 1 room house • Cement block house • Cement or tile floor • Regular salary • More than 1 person in the family working

You are conducting a situational analysis in the fictional community 'Sunshine and Light'. A wealth ranking was conducted with 5 community members. The description of the poor and non-poor families is shown in the chart to the left.

You are in the middle of conducting a nutrition assessment and you are the recorder. Record the information of two children into the register along with the wealth status. For each child we have a piece of paper with the anthropometric measurements and additional information found in their health cards.

Kiki
Nengkiyah
9.6 kg
12.4 cm
male

Risa
Heni Sali
9.2 kg
12.1 cm
female

Please use the information gathered during your nutrition assessment – on the piece of paper, health card, and interview with the caregiver to fill in the registry below for Baby Kiki and Risa.

Child No.	Date of Survey	Child's Name	Caregiver's Name	Father's Name	DOB (dd/mm/yyyy)	Age (mo)	Gender (M/F)	Birth Order	Weight (kg)	MUAC (cm)	Nutrition Status (Colour)	Wealth Rank	Child is Disabled (Y/N)	If disabled, child has feeding difficulties? (Y/N)	If disabled, child has poor appetite or eats less (Y/N)
1	10/07/2019	Risa Heni Sali													
2	10/07/2019	Kiki Nengkiya Kenan													

Correct Answers

Child No.	Date of Survey	Child's Name	Caregiver's Name	Father's Name	DOB (dd/mm/yyyy)	Age (mo)	Gender (M/F)	Birth Order	Weight (kg)	Nutrition Status (Colour)	MUAC (cm)	Wealth Rank	Child is Disabled (Y/N)	If disabled, child has feeding difficulties? (Y/N)	If disabled, child has poor appetite or eats less (Y/N)
1	10/07/2019	Risa Heni Sali	Leah Heni	Geoffry Sali	13/06/2018	13	F	1	9.2	Green	12.1	Poor	N	N/A	N/A
2	10/07/2019	Kiki Nengkiya Kenan	Margret Ashanti	Seven Kenan	12/12/2016	31	M	3	9.6	Orange	12.4	Non-Poor	N	N/A	N/A

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'At Risk' status)*											
BOYS						**GIRLS**					
Sex	**Age (mon)**	**Green (Normal)**	**Yellow (At Risk)**	**Orange (Moderate)**	**Red (Severe)**	**Sex**	**Age (mon)**	**Green (Normal)**	**Yellow (At Risk)**	**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 'At Risk' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (With 'At Risk' status)											
BOYS						**GIRLS**					
Sex	**Age (mon)**	**Green (Normal)**	**Yellow (At Risk)**	**Orange (Moderate)**	**Red (Severe)**	**Sex**	**Age (mon)**	**Green (Normal)**	**Yellow (At Risk**	**Orange (Moderate)**	**Red (Severe)**
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.8
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	8.9
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.0
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.1
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.3
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.4
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.5
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.6
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.7
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.8
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	9.9
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without 'At Risk' 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 'At Risk' status WHO weight-for-age reference table.

WHO Weight-for-Age Reference Table

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

Child Disability Screening Questions for PDH

Screening Questions	Concerning Answer	Reason for Concern	Next Step/Referral
1. **Observation:** Does the child have any physical disabilities? Note: *'Physical disability' can include impairment in crawling, walking or having physical deformities.*	Yes	If yes to this question, the child has a higher probability of being malnourished	If **'Yes'**, indicate the child as 'Y' for disabled in the overall monitoring register (Handout 14.4), and skip to Question 4. If **'No'**, then indicate the child as 'N' for disabled in Handout 14.4, and continue to Question 3.
2. Does your child have any difficulties with the following: **1) Children <24 months of age:** ☐ Seeing ☐ Hearing ☐ Crawling (for children > 8 months of age) ☐ Picking up small objects with his/her hand ☐ No difficulties at all **II) Children ≥24 months of age:** ☐ Seeing ☐ Hearing ☐ Walking ☐ Picking up small objects with his/her hand ☐ Understanding you ☐ Speaking ☐ Playing ☐ Behavioural issues ☐ No difficulties at all	Yes to any of the difficulties	If the child has any difficulties, the child is most likely suffering with a disability. Children with disabilities have a higher probability of being malnourished and being excluded in community activities and interventions.	If **'Yes'**, indicate the child as "Y" for disabled in the overall monitoring register (Handout 14.4), and continue with Question 3. If **'No'**, then indicate the child as 'N' for disabled in the overall monitoring register (Handout 14.4), end this Questionnaire and thank the caregiver for their time.
3. Compared to other children his/her age, does your child have difficulty eating and/or drinking due to his/her disability? ***Note:*** *Difficulty eating and/or drinking can include difficulty chewing or child frequently chokes on food or liquids.*	Yes	Children with disabilities who have feeding difficulties are more likely to be malnourished.	If Question 3 is **'Yes'**, refer child to health facility or district hospital for therapy. Inform the caregiver that the child will be referred to the PDH program after receiving some therapy. If answer is 'No', go to Question 4.
4. Compared to other children his/her age, does your child have a poor appetite (does not like to eat)?	Yes	Poor appetite for food indicates a child who is unwell or is having feeding difficulties with a higher chance of being malnourished	If Question 3 is **'No'**, but Questions 4 and/or 5 are **'Yes'**, refer the child to PDH programming.
5. Does your child eat less than other children his/her age?	Yes	A child who eats less than other children are more likely to be malnourished	

DATE ..... AP ..... DISTRICT ..... COMMUNITY NAME .....

No.	Date of Survey	Child's Name	Sex (M/F)	Caregiver's Name and other info needed to ID household	DOB (dd/mm/yyyy)	Age (Months)	Birth Order	Odema (Y or N)	Weight (kg)	MUAC (<115mm) (Green, Yellow, Red)	Wealth Ranking (Very Poor, Poor, Non-Poor)	Child is Disabled (Y/N)	Disabled Child has feeding difficulties (Y/N)	Disabled child has poor appetite or eats less (Y/N)

SESSION 15

Situational Analysis – Seasonal Calendar, Market Survey (STEP 3)

World Vision

50 MIN | DAY 2

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

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

Reference in *CORE PDH Guide*: pp. 62–75

Preparation

- Print Handout 15.1A, 15.1B, and 15.2
- Soft copy of Situational Analysis Excel template (refer to Resource CD)

Materials

- Handout 15.1A: Market Survey for PDH (Cost Variance)
- Handout 15.1B: Market Survey for PDH (Quantity Variance)
- Handout 15.2: Seasonal Calendar for PDH
- 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. Seasonal Calendar

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

HANDOUT
15.2 – 93m/H 40

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

Distribute Handout 15.2 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

2. Market Survey

HANDOUT
15.1A – 91m/H 38
15.1B – 92m/H 39

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

A market survey provides information on the availability and price of foods in the community. It is carried out by visiting the market where the community buys its food and recording information in Handouts 15.1A and 15.1B.

5 Min

3.

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, and whether any disability services exist and who it is run by (e.g. Disabled Peoples Organizations)
- Identify the households with children with disability to ensure they are included
- Identify if there is a stigma towards children with disabilities within households and at commnunity-level
- Learn the normal feeding practices and be able to highlight existing good/ best practices
- Learn what harmful practices affect child health and nutrition
- Learn what barriers prevent children with disabilities from accessing health and nutrition services
- 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.

Market Survey for PD/Hearth (Cost Variance)

DATE ..... AP ..... DISTRICT ..... COMMUNITY NAME .....

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

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

Market Survey for PD/Hearth (Quantity Variance)

DATE ..... AP ..... DISTRICT ..... COMMUNITY NAME .....

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

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

Seasonal Calendar for PD/Hearth

World Vision

HANDOUT 15.2

Day 2 Session 15

DATE ..... AP ..... DISTRICT ..... COMMUNITY NAME .....

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

Preparing for Situational Analysis Field Visit (STEP 3)

30 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 PDH Guide: pp 62–112

Preparation

- The host country staff will need to prepare communities for this activity. Ideally, these will be new AP communities which will begin PDH 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 35 months. With existing community health volunteers and community leaders, conduct a wealth-ranking exercise. Using this information, classify the children who were weighed according to their family's wealth ranking. This information must be ready by the start of the training. Host country staff need to arrange with the community for a field visit on the third day of the training. They need to organise a focus group of caregivers, invite community leaders to a brief meeting during the visit, and ask if participants can visit selected families.

Field Preparation Required for Situation Analysis:

Wealth Ranking:

5 or 7 community members (diverse group and 2 caregivers with children with disability (if program is looking at disability inclusion)

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 6-35 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 6-35 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

Seasonal Calendar/Transect Walk:

Good to have 1-2 CHWs or volunteers who could help navigate in the village/community

Market Survey:

This is done by the team.
Find out when the big market day is and keep in mind when planning the agenda.

Materials

- Local growth chart for plotting weights, or WHO ANTHRO software to calculate nutritional status
- Flip chart with blank paper
- Print Handouts 13.3,14.3, 15.1A, 15.1B, and 15.2

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 AP 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:

- **Social mapping and transect walk** – Social mapping and a transect walk with a few community leaders and caregivers of children with disability 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.
- **Wealth ranking and nutrition assessments**
- **Market survey** – We will take a market survey to assess food costs and what foods are available in markets and shops.
- **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.

10 Min

HANDOUT
13.3 – 72m/H 29
14.3 – 86m/H 36
15.1A – 91m/H 38
15.1B – 92m/H 39
15.2 – 93m/H 40

Divide the participants into 5 groups of 2-3 people if possible. Each group should print out the respective questionnaires, observations forms, and/or tools to conduct one or two of the five different activities in the community (print out at least Handouts 13.3,14.3, 15.1A, 15.1B, and 15.2). 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.

DAY 2

5 Min

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 market survey, seasonal calendar and transect walk.

10 Min

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

Remind participants the order of the exercises that will take place tomorrow during the field visit. 2 – 4 groups will conduct a transect walk and one group will conduct the community mapping exercise simultaneously. Then with some understanding of the norms and resources available in the community, one group will be conducting the wealth ranking exercise with a diverse group of community members. Once the 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). Then all groups could weigh the children (if weighing of children is needed). All participants should get an opportunity to conduct a market survey after the weighing of children.

Daily Summary and Evaluation

SESSION 17

10 MIN | DAY 2

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

1. Evaluate personal learning for the day

Preparation

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

Materials

- Half sheet of paper for each participant

STEPS

1.

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

2.

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

- Something I learned today that I will apply in our PDH programme is

  _____.

- Something new that I learned about PDH today is

  _____.

- Something I'm still confused about is

  _____.

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

3.

Thank participants for good work today. Mention any highlights of the day. Remind them of the departure time for tomorrow's field visit.

SESSION 18

Field Visit to Conduct Situational Analysis

World Vision

4.0 to 6.5 hours plus travel time

DAY 3

Total field visit time of 4.0 to 6.5 hours plus transportation time

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

1. Confidently conduct a community mapping, transect walk, wealth ranking nutrition assessment, market survey, seasonal calendar and household visits.

Materials

- Questionnaires and tools created by each group the previous day or Print out Handouts 13.3,14.3, 14.4,15.1A, 15.1B, and 15.2

STEPS

4.5 Hours

1. Field Visit

HANDOUT
13.3 – 72m/H 29
14.3 – 86m/H 36
14.4 – 87m/H 37
15.1A – 91m/H 38
15.1B – 92m/H 39
15.2 – 93m/H 40

Distribute copies of Handouts 13.3, 14.3,14.4, 15.1A, 15.1B, and 15.2 to each participant and remind them in how to fill-out the Handouts. Also, remind participants to refer children with 'red' coloured MUAC (severe wasting/wasting) to Health Centres or OTPs.

Review of Day 3 Field Visit and Agenda for Day 4

SESSION 19

45 MIN | DAY 4

STEPS

1.

Engage participants in a discussion based on questions such as

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

2. Address any issues that may arise.

3. Review the agenda for today.

SESSION 20

Analyzing Situational Analysis Data

World Vision

225 MIN | DAY 4

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

1. Analyze situational analysis data
2. Practice using the situational analysis template and PDH Excel database.

Reference in *CORE PDH Guide*: pp. 62–75

Preparation

- Distribute soft copy of Excel-based situational analysis template found in Resource CD
- Distribute soft copy of Excel-based PDH database found in Resource CD
- Refer to Handout 35.8: User Guide for the PDH Excel Database

Materials

- Resource CD
- LCD projector
- Flip chart and markers
- A brightly-coloured marker
- Maize or other plant leaves (several healthy green ones and several unhealthy yellow ones)
- Thirty or so stones
- A large 'Road to Health' card and coloured markers

STEPS

60 Min

1.

Provide groups with time to consolidate situational analysis findings into situational analysis template Excel document. Be sure to have one group collect all the nutrition assessment data from the groups and combine it into one excel document to see the overall nutrition assessment of the target area.

90 Min

2.

Have one group present the overall nutrition assessment of the target area (consolidated data). Then have each group present their situational analysis findings about overall initial assessment (nutritional profile of community), and feeding, hygiene, caring and health-seeking practices. Have groups emphasize on the community's existing resources, common practices and beliefs, and challenges that may be contributing to the community's overall high rates of malnutrition.

30 Min

3.

Review and discuss the overall findings as a group. Identify the major challenges and/or poor behaviours in feeding, hygiene, caring and health-seeking practices that are contributing to the high rates of malnutrition in the community. Write the challenges out on a flip chart. Assign to someone among the participants to type out the challenges into a 1 page handout for you (facilitator) so you could print it out for all the participants for the PDI visits.

Inform the participants that they must keep these challenges in mind when conducting the PDIs in PD households. They must identify how the PD households overcome these challenges in order to find the local solutions during the PDI visits.

You will refer to these challenges especially when identifying PD practices and to design the 6 key Hearth messages in future sessions (Please distribute the handout with the list of challenges for each group so they have it handy when going on the PDI household visits. Keep the flip charts that list out the challenges in a safe place so you can refer to them later when analyzing the PDI findings and designing the 6 Key Hearth Messages).

5 Min

4. Preparing for the First Community Feedback Session

As discussed in the community mobilisation session on the second day, it is important to give information back to the community. Referring back to Handout 10.1, we already completed Steps 1-4, and now need to complete Step 5 and share the situational analysis findings, primarily the nutritional status of the community, using non-technical terms. When we go out to the community tomorrow, we will begin with a community feedback meeting and share the baseline information from the nutrition assessment.

Share the consolidated nutrition assessment data with the entire group (number and percentage of children healthy, at risk, moderate, and severely underweight).

Share two examples (below) of how the data can be shared with the community:

Example 1:

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

Link the maize leaves with children. Some children are growing well, and some are not.Why? (not fed enough, not fed often enough, 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?

Example 2:

Make a very large 'Road to Health' card. Plot every child that was weighed in the community on the chart. Use the colours green, yellow and red to show the difference in levels of malnutrition. Talk to the community about how healthy children's growth follows the curve. Ask how many children there are. How many are not growing well? How can they tell? Why do they think they are not growing well? What have they tried before to help children grow better? Do you think some of the ones not growing well have disabilties? What are those disabilities and how are they affecting them? What have you or their caregivers tried to do to help them? Are there any services available for children with disability in your community?

If disability inclusion is a priority for this program area, staff or volunteers should present disability data in the community collected during the community assessment or any other community-wide prevalence data for disability during this time.

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.

30 Min

5. (Group Work)

Divide participants into 4–5 groups. Assign each of the groups one of the situational analysis activities to feedback to the community: Nutrition assessment results, community mapping, and wealth ranking. Encourage the use of many visuals to simplify the technical concepts and language. Circulate and help the groups.

Have the groups present their feedback session and ask participants what was good about the presentation and how the groups could improve in their feedback session.

Select 2–3 groups to lead the community feedback session for the next day in the community. Make sure the participants take their visual aids with them to the community the next day.

Identifying Positive Deviants (Step 4)

SESSION 21

60 MIN | DAY 4

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

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

Reference in *CORE PDH Guide:* p. 68

Preparation

- If using data from a local village, be sure it is correct and that there are positive deviants.
- Write the definition of positive deviants on flip chart (see definition below).
- Make several large copies of the optical illusion pictures below.
- Print Handout 14.4

Materials

- Flip chart with definition of positive deviants:

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

- Handout 14.4: Community Assessment Monitoring Sheet (from Session 14)

STEPS

5 Min

1.

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

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

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

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

How can positive deviants be identified? *We can refer to the weighing and wealth status data collected during nutritional assessment.*

15 Min

2.

HANDOUT
21.1 – 105m/H 41

Review the criteria for identifying PD families, that is, good nutritional status *and* low wealth ranking. Divide the participants into pairs. Using Handout 14.4: 'Initial Nutrition Assessment Monitoring Sheet,' each pair decides which children are positive deviants by considering their weight, wealth ranking and birth order. Have the pair fill out Handout 21.1 as their exercise.

3.

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

An alternative way to teach this is to use data from the community to be visited during the course. If the AP has done the nutritional assessment before the course, use the data collected on nutritional status and wealth ranking. Enter the data in the same format as Handout 14.4 and use the information to identify the PDs.

15 Min

4.

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

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

Identifying the PD, Non-PD and ND Households in Sunshine and Light Community

Fill in the column, "Classification (PD, Non-PD, or ND) taking into consideration the definitions of PD, Non-PD, and NDs.

Child No.	Date of Survey	Child's Name	Caregiver's Name	Father's Name	DOB (dd/mm/yyyy)	Age (mo)	Gender (M/F)	Birth Order	Weight (kg)	Underweight Status	MUAC (cm)	Wealth Rank	Classification (PD, Non-PD or ND)
1	10/07/2019	Risa Heni Sali	Leah Heni	Geoffry Sali	13/06/2018	13	F	1	9.2	Green	12.1	Poor	
2	10/07/2019	Kiki Nengkiya Kenan	Margret Ashanti	Seven Kenan	12/12/2016	31	M	3	9.6	Orange	12.4	Non-Poor	
3	10/07/2019	Judah Silvanio	Jojo Silvanio	Andrew Silvanio	12/02/2018	17	M	2	9.6	Green	13.1	Poor	
4	10/07/2019	Denise Gogo Cumba	Edith Gogo	Eric Cumba	18/10/2017	21	F	3	10.9	Green	13.7	Non-Poor	

Identifying the PD, Non-PD and ND Households in Sunshine and Light Community (Correct Answers)

Correct Answers

Child No.	Date of Survey	Child's Name	Caregiver's Name	Father's Name	DOB (dd/mm/yyyy)	Age (mo)	Gender (M/F)	Birth Order	Weight (kg)	Underweight Status	MUAC (cm)	Wealth Rank	Classification (PD, Non-PD or ND)
1	10/07/2019	Risa Heni Sali	Leah Heni	Geoffry Sali	13/06/2018	13	F	1	9.2	Green	12.1	Poor	Non-PD
2	10/07/2019	Kiki Nengkiya Kenan	Margret Ashanti	Seven Kenan	12/12/2016	31	M	3	9.6	Orange	12.4	Non-Poor	ND
3	10/07/2019	Judah Silvanio	Jojo Silvanio	Andrew Silvanio	12/02/2018	17	M	2	9.6	Green	13.1	Poor	PD
4	10/07/2019	Denise Gogo Cumba	Edith Gogo	Eric Cumba	18/10/2017	21	F	3	10.9	Green	13.7	Non-Poor	Non-PD

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

SESSION 22

105 MIN | DAY 4

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

1. Describe the process, tools and methods for conducting the PDI
2. Identify resource tools for semi-structured interviews, coping strategies, 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 PDH Guide*: pp. 85–89, 94–103

Preparation

- Print copies of Handout 22.1, 22.2, 22.3, 22.4, list of major challenges from Session 20, and possibly the Coping Strategy Index (CSI) tool from: https://www.fsnnetwork.org/sites/default/files/coping_strategies_tool.pdf
- Identify and orient trainers who will conduct the structured role play.
- Have three or four participants prepare the skit on visiting skills.
- Print and cut apart two sets of 24 behaviour cards (see sample in Step 4).

Materials

Print copies of Handout 22.1, 22.2, 22.3, 22.4, list of major challenges from Session 20, and possibly the CopingStrategy Index (CSI) tool from: https://www.fsnnetwork.org/sites/default/files/coping_strategies_tool.pdf

STEPS

15 Min

1. Purpose of a PDI

Through the situational analysis (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.

5 Min

2.

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 directly to the caregivers. We need to have open minds and look for unexpected practices or ways addressing the major challenges identified through the situational analysis and visiting the non-PDH households. 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.)*

10 Min

3.

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 PDH Guide*.)
- **What are we trying to discover through the PDI?** The PDI seeks to identify local solutions to the major challenges identified through the situational analysis, which may be 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 when others do not?
- **The content for each category can be different according to cultural context. What are some examples of challenges in feeding, caring, hygiene and health-seeking practices that were identified through the situational analysis?** Go through the list of challenges identified during Session 20. 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 PDH volunteer, or a trainer/ supervisor.
- **Training the PDI team.** Training should emphasise communication skills, listening skills and observation skills. It is particularly important to be able to probe into the issues in a culturally acceptable manner. Use role plays to practise skills and also to practise a home visit in the neighbourhood with a feedback session. The role of observer is awkward. Training is important to increase the comfort level.

- **What are some cultural filters that influence behaviours and how we view them?** In searching for behaviours that are positive and those that are problematic, the PDI team needs to look through the lens of local culture. Team members should look at family structure; socio-cultural norms; food taboos; patterns of decision making; traditional practices or customs; religion; beliefs; gender; and presence of informal or traditional health systems. The role of grandmother may be particularly relevant to understanding the behaviours practised within the home. It is important to observe and engage the grandmother in the visit.

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

5 Min

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

10 Min

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

Behaviour cards sample

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

Caregiver smiles and makes eye contact when feeding child	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
Caregiver sings to child while washing hands	Use of soap to wash hands	Child is given fruit for snack	Child breastfeeds during the day	Grandmother talks to child with a warm voice and helps the child eat	Adds oil to porridge
Child is dewormed	Seeks medical help when ill	Eggs, snails, 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
Caregiver praises good behaviour	To discipline child, caregiver stays calm and talks to the child in a kind but firm tone	Sleeps with window open	Child eats from own bowl	Washes hands after using latrine	Child wears sandals

5 Min

6.

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 PDH 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

7. 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. 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.

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

HANDOUT
22.1 – 116m/H 43

Distribute Handout 22.1 and divide the participants into pairs. Have them practise doing a 24-hour recall with one acting as 'caregiver' and the other as 'interviewer'.

20 Min

8.

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

9. 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.

5 Min

10.

HANDOUT
22.1 – 116m/H 43
22.2 – 118m/H 45

Give out Handout 22.2. Divide into groups of four or five people. Using Handouts 22.1 (interviewer) and 22.2 (observer), tell participants to role play a home visit with two participants acting as 'interviewer' and 'observer', and the others being 'family members'. Practise until the participants feel comfortable talking about the four 'goods' – feeding practices; caring practices; hygiene

practices; and health-care practices – without referring to a list on a sheet of paper. Try to get the conversation to flow. Observe what the family members are doing as well as what they are saying.

10 Min

11.

HANDOUT
22.3 – 119m/H 46
22.4 – 120m/H 47

Ask participants to develop a logistical plan for the PDI in their country context, as a homework exercise. Distribute Handout 22.3 and instruct the participants to use Handout 22.3 to summarise the PDI findings of all households from the upcoming PDI field visit. Distribute Handout 22.4 and inform participants that it is a PDI checklist they coudl refer to prior to going out to the field to ensure they have all the equipment and tools necessary to conduct the PDI household visits.

5 Min

12. Field Preparation Required for PDI

How to select households to visit for the PDI:

Here is the order of how to select PDI households for the field visit:

1. Divide groups into groups of 3-4 (at least one person must speak the local language)
2. Each group must be assigned 1-2 NPDs or one NPD and/or one ND + 1-2PD Households per group (assign households that are close in distance if possible per group)
3. Provide 1 NPD and 1 PD back-up households per group in case caregivers are not home during the PDI visit
4. Households with children 9-35 months are priority for the household interviews
5. Using the initial assessment data, select sufficient PD, Non-PD, and ND households to visit for the PDI field visit using the criteria below:
   - PD Households should meet the below criteria:
     a. Children aged 9-35 months
     b. Poor or Very Poor Wealth Status
     c. 'healthy'/'green' underweight; if you do not have enough households, then select 'At Risk' underweight children
   - Non-PD Households should meet the below criteria:
     a. Children aged 9-35 months
     b. Moderately wasted children
     c. Poor or Very Poor Wealth Status
     d. 'Moderate' and/or 'Severe' underweight children

- Negative Deviant Households should meet the below criteria:
  a. Children aged 9-35 months
  b. Non-Poor Wealth Status
  c. 'Moderate' and/or 'Severe' underweight children
- If disability inclusion is a priority for your program, you should also conduct PDIs in one or two households with children with disability to learn about their feeding, caring, health-seeking and hygiene practices and any barriers they face in practicing positive behaviours.

6. Ask the group to first visit the non-PD household(s). By visiting the non-PDH household first, each group will be able to verify and to the list of major challenges contributing to malnutrition that were identifed through th situational analysis and understand what the 'norm' is in the community. By visiting the PD household after the non-PD household, the groups will be able to better identify the Positive Deviant behaviours by asking questions of how the PD household overcomes the challenges that the non-PD households face. The positive practices that address these challenges will become key Positive Practices that need to be promoted during the Hearth session. In addition, the interviewers and observers could look out for PD foods (low cost and nutrient dense) that are being fed only in the PD households, that were not being fed in the non-PD or negative deviant households. These foods should be included in the Hearth menu and promoted during the Hearth sessions.

HANDOUT
22.1 – 116m/H 43
22.2 – 118m/H 45
22.3 – 119m/H 46

7. Divide groups into groups of 3-4 people, assign one role of observer, interviewer, recorder, and translator (if needed) to each member of the team. Assign the role of a team leader for each group. To the team leaders, provide weighing scales, weighing pants, a hook, a rope (for weighing scale), a MUAC tape, PDI questionnaires (Handout 22.1), observation forms (Handouts 22.2 and 22.3), pencils/pens, notebooks for recording interview, and a list of households to visit (include back up households to visit in case caregiver and/or child is not home). Use the situational analysis finding template's Nutrition Assessment worksheet to identify and pick out the households to visit for the PDI. 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.
8. If food security is a major problem in the community for 1-3 months of the year, it is highly recommended to use the brief Coping Strategy Index (CSI) tool during the PDI household visits to identify key coping strategies within the PD households and to promote the coping strategies as a key Hearth message. Refer to Session 39 for more information on the CSI tool.

(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?
8. Does your child have difficulty eating or drinking? If so, what challenges are you facing?

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?
8. Does the caregiver have toys and dolls for child to play with at home?
9. Is the home or room a safe environment for the child to freely play in?

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?
6. (Optional) If your child has a disability, do you participate or take your child to a disability service or therapy? If so, which service and for how long? Probe about the service and who provides the service, how long the child has been attending, etc.

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?
6. Do family members sing with the child while washing their hands?

Observation Checklist

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

Results and Observations from the PDI

DATE ..... AP ..... DISTRICT ..... COMMUNITY NAME .....

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

- ☐ Make a list of major challenges that may be contributing to high rates of malnutrition in community through the situation analysis findings (e.g. behaviours, lack of services, poor access to water, etc.) to use as a guide for PDI
- ☐ Include community members, CHWs, volunteers, or mother leaders in the PDI process
- ☐ Ensure a PDI team consists of 2-3 people and a team leader must be a WV staff. If multiple teams are used in the PDI process, every team must be led by a trained WV staff.
- ☐ Optional: If the Coping Strategy Index (CSI) tool was used during the situational analysis, and Food Security questions were identified, include the food security guiding questions in the PDI list of questions to identify coping strategies for food insecure periods/seasons in the PD households
- ☐ Take the list of major challenges (and food coping strategy questions) as a guide for identifying local solutions in PDI process
- ☐ Take child weighing scale, MUAC tape, and wealth ranking criteria to PDI households
- ☐ Take and use PDI observation checklist during PDI
- ☐ Re-weigh and check the MUAC of the child of interest, along with their siblings between 6-59 months of age to ensure all children are healthy if it is a PD household as all children must be healthy and/or 'mildly' underweight is also acceptable. Only check the weight and MUAC of the child of interest if it is a Non-PD or ND household.
- ☐ Re-check the wealth ranking of household before starting PDI to ensure all data is accurate
- ☐ Visit 2-3 Non-PD households and 1 ND household in a community first, before visiting PD households – verify that the list of major challenges are really the major challenges in the non-PD and ND households
- ☐ Visit at least 3-4 PD households to identify how they are addressing the list of major challenges identified through the situation analysis and for food coping strategies during food insecure periods
- ☐ Analyse the PDI data using the Excel document called "PDI findings" and/or flip chart (Session 25 in the PDH ToF Manual)
- ☐ Share the PDI findings with the larger community and/or through other platforms such as Mother Support Groups or Care Groups

Field Visit to Conduct PDI

SESSION 23

4.5 to 6.5 hours plus travel time | DAY 5

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

1. Confidently conduct household visits and PDIs.
2. Identify PD and Non-PD Behaviours during a PDI.

Materials

- Print out list of major challenges from Session 20 and Handouts 22.1 and 22.2

STEPS

1. Field Visit

Distribute copies of Handouts 22.1, 22.2 and the compiled list of the major challenges identified during Session 20 to each participant and remind them in how to use or fill-out the Handouts. Total field visit time of 1 hour to 1.5 hours per PDI HH. Usually the field visit should take approximately 4.5 to 6.5 hours plus travel time to and from the field. Also, distribute copies of the CSI questionnaire if food insecurity is a major challenge and PDIs are being used to identify coping strategies as well.

SESSION 24

Review of Day 5 Field Visit and Agenda for Day 6

45 MIN | DAY 6

STEPS

1.

Engage participants in a discussion based on questions such as

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

2. Address any issues that may arise.

3. Review the agenda for today.

PDI Interpretation and Feedback: Determining Positive Deviance and Identifying 6 Key Hearth Messages (STEP 4)

SESSION 25

170 MIN | DAY 6

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

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

Reference in CORE PDH Guide: *pp 89–98, 104–12.*

Materials

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

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

STEPS

30 Min

1.

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

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

100 Min

2.

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

1. What are the different practices between PD and NPD/ND? (record findings in format shown in Handout 22.3)
2. What are some of the challenges faced in the community? (e.g. don't like feeding Sprinkles, breastfeeding but only up to 3 months, only feed rice porridge)?
3. What is the PD household doing to address these challenges at home? Identify the local solution for these challenges.

Use Question 1 to fill out the entire table on Handout 22.3 and use Question 2 to add important findings into the non-PD practices section of the table on Handout 22.3. Use Question 3 to add important findings into the PD practices section. Put a star beside the PD foods listed under 'PD Food/Feeding' on Handout 22.4

For those behaviours that are considered positive, lead the group to select whether the behaviour could be practised by a poor family or only by a non-poor family. Is it feasible, easily replicable, affordable? Point out to participants how this exercise mirrors the process used in the community to analyse information from the PDI. Together, develop a summary chart of PD behaviours/skills/practices/messages that will need to be emphasised in Hearth sessions. Looking at the major challenges faced in the community, select 6 key PD practices that will address the challenges and directly affect the nutritional status of a child. For example, if exclusive breastfeeding was not commonly being practiced up to 6 months, this will be a major challenge faced in the community. However, if you found the PD households are practicing exclusive breastfeeding up to 6 months of age, make this one of the 6 key Hearth messages. Ensure the PD foods are used in the menu design in session 30.

45 Min

3.

Point out that there are points to consider when designing the selected six key PD practices into Hearth messages[1]. Write out the four points and the note below on Flip Chart #1:

Guidance on how to design 6 key Hearth messages:

1. Define the behavior (behavior is an action that is observable, measurable, and feasible). Describe how the behaviour/action should be done.
2. Specify the time, place, quantity, and/or frequency of the behavior. This helps to clarify what is the prompt or reminder to do the behaviour.
3. Specify the goal of the behavior so it is clear as to what change we are striving for.
4. Develop a creative method to deliver the messages (e.g. songs, pictures or diagrams, interactive games, etc.).

Note:

- The message should be designed to target primary caregivers of children under 5 years of age. Check that you wrote the behaviour from their perspective.
- Keep the message short and clear.
- Select a message that is easily replicable by all primary caregivers of children under 5 years of age (e.g. behavior is feasible).

As a group, take the example PD practice: A PD practice is to use a plate to cover the top of the drinking water storage container to prevent contamination and go through each point on Flip Chart #1 and use a second flip chart to write out corresponding messages according to the element.

1.*The Technical and Operational Performance Support (TOPS) Technical and Operational Performance Support Program. 2017. Designing for Behavior Change: A Practical Field Guide.* Washington, DC: The Technical and Operational Performance Support Program.

1. **Define the behavior (behavior is an action that is observable and measurable). Describe how the behaviour/action should be done.**

   Example 1: Use one designated cup to scoop water out of the pot and put the cover (plate) back the storage container.

2. **Specify the time, place, quantity, and/or frequency of the behavior. This helps to clarify what is the prompt or reminder to do the behaviour.**

   Example 1: When you draw water from your water storage containers, use one designated cup to scoop water out of the pot and put the cover (plate) back the storage container.

3. **Specify the goal of the behavior so it is clear as to what change we are striving for.**

   Example 1: When you draw water from your water storage containers, use one designated cup to scoop water out of the pot and put the cover (plate) back the storage container **to prevent contamination**.

4. **Develop a creative method to deliver the messages (e.g. songs, pictures or diagrams, interactive games, etc.).**

   Example 1: When you draw water from your water storage containers, use one designated cup to scoop water out of the pot and put the cover (plate) back the storage container to prevent contamination.

   Delivery: Demonstrate the message using a water storage container covered with a large plate and a designated cup to scoop water from the pot and ensure the designated cup is stored in a clean environment when not in use

Have participants check that the messages are:

- Targeted for primary caregivers of children under 5 years of age. Check that you wrote the behaviour from their perspective.
- Easily replicable by all primary caregivers of children under 5 years of age (i.e. the behaviour is feasible).
- Short and clear.

Now, divide participants into six groups and assign one of the six selected PD practices to each group. Have each group go through the four points to design a key Hearth message for the assigned PD practice and have them write out the Key Hearth message on a flip chart when done.

Have the groups post up their designed Key Hearth message on the wall and go through them together to see if any of them can be further improved looking at the four points and making sure the messages are target to caregivers with children U5, message are easily replicable and are short/clear.

30 Min

4.

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

5.

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. May also conduct PDI in one or two households with children with disability to learn about their feeding, caring, health-seeking and hygiene practices and any barriers they face in practicing these behaviours).
- 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.

SESSION 26

Community Feedback Meetings

60 MIN (or 130 MIN with optional sections)

DAY 6

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

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

Materials

- A flip chart
- A brightly-coloured marker
- Print out Handout 26.1

STEPS

10 Min

1. Steps for Community Mobilisation and Ownership

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.

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.)*

50 Min

2. Presenting Information Comparing Community Norms With The PDI Information

Divide into four groups. Have each group come up with a creative presentation to share the 6 key Hearth messages and list of PD foods with the rest of the community. Circulate and help the groups.

Step 1

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

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

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

Step 2

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

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

20 Min

3. Focus Group Discussions (OPTIONAL)

Focus group discussions (FGDs) help implementers understand the existing practices and beliefs of caregivers, fathers, elderly women, and older siblings around child feeding, caring, hygiene, and health seeking practices. It is a useful tool to try and grasp more information about the context that you cannot fully comprehend from the situational analysis and PDI findings. It is optional to use FGDs after the PDI if needed to understand the context further regarding food taboos, barriers due to disability, feeding, hygiene, health-seeking and caring practices if further understanding of the context is needed. FGDs could also be used with adolescents to understand the role of older siblings in the care of younger children or caregivers of children with disability and/or representatives from Disabled Peoples Organization (DPO) to understand the major barriers and existing services available in the community to support children with disability. Refer to Pg. 51 Handout 6 in the Guide to Disability Organizations and their role at: https://assets.worldvision.org.uk/files/6513/8053/8823/Travelling_together.pdf

HANDOUT
26.1 – 132m/H 48

A smaller group of 4-5 participants of the target group could be mobilized. 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. If older siblings take on a key role in caring for younger children in the household, please refer to Handout 26.1[1]

20 Min

4. Optional: Guidance on FGD for Older Siblings (10-13y and 14-18y old) of Children 6-35 months old

Make sure everyone is comfortable and take time to explain the process. You may need an icebreaker and/or a walking tour of the community with the group of children to help them feel comfortable to sit down for a discussion.

Tell them that you are all there to discuss about taking care of younger siblings. You have some questions you'd like to ask so you can understand how they care for younger siblings and because you want to hear their thoughts and ideas. Share with them that their discussion will help the community better understand how to address child malnutrition. They will receive feedback on how their contribution was used to learn more about the nutrition situation in the community and it will be shared in a community feedback session. Depending on the age of the group and whether they can read you may want to give them a list of the questions prior the focus group discussion so they are better prepared.

1. Adapted from Focus Group Discussion in the Child Participation Toolkit for Boys and Girls (World Vision 2013)

Ask them if it's okay if you record the conversation and explain the role of the note taker. If possible, the note taker should be someone they know and are comfortable sharing around.

Now begin the discussion. Explain each question clearly and give the children time to respond. Give everyone who wants to a chance to share, and encourage those who are less timid to voice their opinions. Try not to let one child dominate the conversation, but try to create and maintain a calm, safe place where everyone feels comfortable. Use energizers if the energy levels are low to keep the group engaged.

30 Min

5. Optional General FGD Role Play

Inform the participants that FGDs are not simply question-and-answer sessions. The facilitator needs to present a set of carefully chosen key issues. Only conduct the FGD to further understand the context, especially if there are gaps in the information from the situational analysis and PDI. 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.

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

Discuss the following questions with the group:

- What are some findings from the situational analysis and PDI that we need further information on to understand the context better? (food taboos, disability services available for children or caregivers with disabilities, common childhood illnesses, seasonality and how it affects food security of households, coping strategies during food insecure time periods, health services available, attendance at GMP, etc.)
- Who should be the target group you should include in the FGD to discover that information? (health practitioners, traditional birth attendants, caregivers, leaders, VHC)

Focus Group Discussion for Older Siblings (10-13 years old and 14-18 years old) of Children 6-35 months

Questions:

1. When do older siblings help take care of younger siblings?

Note: *Probe for the various situations and length of time, if necessary. If it comes up as a question, children can share times with an adult (like your mother, father, grandmother, grandfather or other adult family member) and when the older sibling takes care of younger siblings on their own.*

1. What do you or others do when you are taking care of your younger siblings (play, cook, feed, bathe, sing, etc.)?

2. Why do you help take care of younger sibling?

3. What kind of instructions or rules do you have from adults for taking care of younger siblings? Do you also have rules of your own?

4. What do you give your younger sibling to eat? To drink?

5. Are there any foods or drink that you're not suppose to give to your younger sibling?

6. What do you do if you need help with caring for your younger sibling?

7. What happens in your family if your younger sibling is sick?

Report back to children on the findings of the focus group discussion as a separate meeting before the community feedback session, as part of our accountability to children. The children's contribution should be mentioned in the community feedback session as well. Be sure that they can see how their ideas are being used and how it's influencing their community's programme. State the findings in a way the protects the child, particularly if you were discussing a sensitive issue.

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 PDH Guide:
Hearth Session Protocols, pp. 135–40

Preparation

- Review Handout 27.1.
- Prepare one flip chart for each of the activities of a Hearth session.
- Review the equipment list on page 136 in the CORE PDH 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 27.1: Examples of Learning Opportunities Through PDH Activities

STEPS

5 Min

1.

What are some strengths of the PDH 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 PDH 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 PDH programme should decide a time that is convenient for all of them. Caregivers must meet for 12 days: six consecutive days followed by one day break and another six consecutive days.)

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

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

5 Min

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

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

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

10 Min

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

30 Min

5. In addition to the 6 key Hearth messages that were designed what other feeding and nutrition, caring, hygiene and health-seeking messaging could be shared throughout the Hearth sessions at the different stations, including cooking station, handwashing station and caring station.

HANDOUT
27.1 – 137m/H 49

As a group, review each activity and add other learning opportunities. (See Handout 27.1.) Discuss other lessons caregivers might need to learn and grandmothers can support. Consider especially practices and messages from the PDI. How will caregivers and grandmothers have an opportunity to learn these? During which activities? What activities can contribute to early childhood stimulation? Emphasise that lectures or other formal teaching methods are not used during Hearth; instead, all the messages are conveyed through conversation and learning while doing.

10 Min

6.

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

5 Min

7.

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

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

Arrival of caregivers and children/attendance

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

Collect food contribution

Discuss:

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

Hand washing/hygiene

Discuss:

- Modelling proper hand-washing technique
- Use of soap
- Times when hand-washing is important
- Reason to wash hands: bacteria/germs contribute to illness/diarrhoea
- Treatment of diarrhoea/illness, when to seek health care
- Immunisation, deworming
- Using the handwashing station to play and stimulate the child through singing songs on handwashing and/or counting children's fingers
- 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 (have age appropriate toys prepared using local materials to stimulate learning for children)
- Social skills/sharing/cooperation
- Cognitive Development and stimulate children – have songs, stories with pictures, and games prepared to keep children occupied and encourage learning, which helps in child's cognitive development *(**naming** foods, objects, body parts, animals, **talking** about colours, shapes, and sizes, **counting** fingers, people, trees, etc.)*
- Safe environment to play (be sure to have a mat and safe/clean play environment for children to freely play)
- Positive reinforcement (Praise good behaviours of children to motivate them to engage in positive activities)
- Show appropriate touching and affection to help child's social and emotional development (Love your child and show affection especially when they are upset by hugging, cuddling, and talking with them softly and calmly throughout the day)

Feeding children

Discuss:

- Importance of responsive feeding: Smiling and making eye contact with child while feeding the child
- Talking to the child while feeding (telling them about the food, narrating using warm voices to encourage learning)
- Content of foods (colours, nutrients)
- PD foods and why they are good
- Importance of meal frequency (four to five times a day)
- Breastfeeding
- Portion sizes
- Troubleshooting feeding problems
- Food taboos
- Stimulating a child's appetite

Planning for the next day

Discuss:

- Local and affordable foods, including the PD foods.
- Quantity of food
- Food combinations – variety, colour
- Nutrient value of food – importance of variety
- Where to find foods
- Planning menus and budgets

Cleaning up

Discuss:

- Hygiene – clean surfaces and utensils
- Use of leftovers
- Food safety
- Food storage
- Reuse water, compost
- Latrine use and cleanliness

Daily Summary and Evaluation

SESSION 28

10 MIN | DAY 6

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

1. Evaluate personal learning for the day.

Preparation

- Write the daily evaluation questions on a flip chart.

Materials

- Half sheet of paper for each person

STEPS

1.

Ask each participant to reflect on the day's sessions. They will write in their curriculum ideas to improve or adapt the various presentations methodologies so they are more appropriate for their own contexts. Participants should be ready to share any good ideas they might have.

2. Daily Evaluation

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

1. Something I learned today that I will apply in our PDH programme is

   _____.

2. Something new that I learned about PDH today is

   _____.

3. Something I'm still confused about is

   _____.

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

3.

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

SESSION 29

Menu Design and Cooking (STEP 5)

World Vision

390 MIN OR 6.5 HRS

DAY 7

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

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

Reference in *CORE PDH Guide*: pp. 114–19

Preparation

- Purchase a 'market basket' of local foods from the market and set out these foods.
- Review the PD food or dishes/meals identified during the PDI.
- Use actual prices to calculate the cost per gram of each food item and post this next to the food.
- Electronic or non-digital weighing scales that measure to 1g.
- 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 29.1, 29.2, 29.3, 29.4 and 29.5
- Prepare basic cooking materials such as cooking pots, frying pans, bowls, cutting boards and cooking utensils.

Materials

- Flip chart 29 (below): Nutrients Required in the Meal
- Blank flip-chart paper
- Market-survey findings
- Local, national, or regional food composition (if available)
- Handout 29.1: Flip Chart 29 – Nutrients Required in the Meal
- Handout 29.2: Directions for the Menu-Planning Exercise
- Handout 29.3: PDH Menu Exercise – Food Composition Table
- Handout 29.4: Sample Menu-Planning Form
- Handout 29.5: User Guide for the PDH Menu Calculation Tool
- Plates, spoons for dividing bulk foods, a sharp knife, and small containers (little plastic cups)

- Electronic or non-digital weighing scales that measure to 1g.
- Basic cooking materials such as cooking pots, frying pans, bowls, cutting boards and cooking utensils

STEPS

10 Min

1.

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

Importance of the extra meal

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

Importance of a snack during the Hearth session

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

When to weigh children and why

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

10 Min

2. Menu Preparation

HANDOUT
29.1 – 148m/H 51

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

Show Flip chart 29, 'Nutrients Required in the Meal'. Emphasise the importance of Hearth menus meeting these requirements. Explain the motivational effect when caregivers see dramatic improvements in the child's health and behaviour. The child's appetite will return and overall mood and energy improve within 10 to 12 days. Families begin to see that food and caring are making a difference. This encourages them to continue the new practices.

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

30 Min

3.

HANDOUT
29.3 – 150m/H 53

Distribute a sample page from the national/regional food composition table or if this is not available, refer to Handout 29.3: PDH 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 29.3, ask the participants to locate a specific food/ingredient (for example, fresh fig leaves). Guide them through filling out the chart for 100g of this food. Fill in the chart together. For now, don't worry about the columns named 'home measure' and 'cost/amount'.

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

100g = 361kcal

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

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

$$= 505.4kcal$$

Fill in the rest of the values, making sure that the participants understand how to do the calculations.

Choose one more ingredient and show the same calculation using a quantity less than 100g. For example, 40g of fresh camel meat:

$$100g = 188kcal$$

$$40g = \frac{188kcal * 40g}{100g}$$

$$= 75.2kcal$$

Fill in the remaining values for camel meat. Make sure that the participants understand how to do the calculations.

Add the total values for each of the nutrients. Compare the totals with the requirements for the optimal Hearth menu. What is missing in this sample menu? What foods might supply those nutrients? Look on the food tables under Vitamin A for foods high in that vitamin. Are any of those foods available and affordable in the community?

A child's stomach has the capacity of about 200–250g (the size of a child's fist). The total quantity of the menu cannot exceed that amount. Remember that the menu must also include a snack as well as the meal. What could be added to this meal?

What follows is not a sample menu to be copied for PD/H menu designs, it is only to be used as an example for menu calculation.

Food	Home Measure	Quantity g	Calories Kcal	Protein g	Vit. A µg RAE	Vit. C mg	Iron mg	Zinc mg	Cost/ amount
Fig leaf, fresh, EP*		100	22	1	13	20	0.2	0.1	
Millet, whole grain		140	505.4	16.24	28	0	11.2	4.34	
Camel meat, fresh		40	75.2	6.96	0	0	.48	1.16	
TOTAL		280	602.6	24.2	41	20	11.88	5.51	
Hearth Requirements		200–250	600–800	25–27	300	15–25	10	3–5	

* Edible Portion

In addition to selecting high calorie, protein, vitamin, or mineral-rich foods, various cooking methods could be promoted to improve the nutrient value of certain foods (e.g. boiling vs. drying/roasting).

Examples:

Germination:

1. Sort and clean cereal grains.
2. Soak for 1 day.
3. Drain and place in a sack or covered container.
4. Store in dark, warm place for 2-3 days until grain sprouts.
5. Dry sprouted grains in sun.
6. Grind and sieve the flour.

Fermentation:

1. Grind cereal grain into flour.
2. Soak flour in water (3 cups of flour to 7 cups of water).
3. Leave to ferment for 2-3 days.
4. Cook into porridge.

4.5 Hours

4.

HANDOUT
29.2 –149m/H 52
29.3 –150m/H 53
29.4 – 156m/H 59
29.5 – 157m/H 60

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

Provide each small group with Handout 29.2: Directions for Menu Preparation, Handout 29.4: Sample Menu-planning form and Handout 29.5: User Guide for the PDH Menu Calculation Tool. The national/regional food composition table or Handout 29.3: PDH 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 PDH Guide*, page 116, on how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.
- Each group takes the amount they think a small child would eat. (Remember that a child's stomach is no larger than the child's fist.)
- Have a group member note the cost per gram of the food the group takes. Multiple the cost per gram of each food item by the number of grams used. Calculate the cost of the menu.

- After weighing the group's choices, place them on a plate.
- Using common household measures, such as bowls, cups, tins, and spoons, measure the portion each child will eat. This will be the serving size that each child receives during the Hearth sessions.

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

Excel instructions: Use a LCD projector to introduce the Menu Calculation Tool (Excel document) and to orient participants in how to use the tool. See Handout 29.5 'User Guide for the PDH Menu Calculation Tool' for instructions. Ensure that the cost of ingredients (per 100 grams) in the master sheet is updated based on the local market survey. Click on the worksheet Menu Day 01 and use drop down option to insert food group and ingredients. Then enter the quantity of each ingredient to be used. The levels of nutrients will be calculated. Compare the total amounts for each nutrient with the requirements of Hearth menus noted in red. Make adjustments to the menu as needed to adjust the levels of nutrients.

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

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

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

Each group should convert all the ingredients in their menu to raw amounts using conversion factors found in Handout 29.2.

- *Calculate the cost of the ingredients using the cost per gram of each food, then add up the total cost for the entire menu.* If the cost seems too high for a household, look for less expensive sources of food. For example, replace chicken, which might be too costly, with groundnuts or another source of protein commonly available in the community.
- *Change the weights of the ingredients to household measures.* When cooking at home, people do not usually talk about grams or weigh foods. So, the grams must be changed to household measures. Measure the quantity of

each ingredient weighed into a common household measure (cup, spoon, tin, palm of hand, etc.). Demonstrate how to do this with one ingredient, such as rice. Weigh 50g of raw rice and put it into a household measure. Write the household measure on the calculation sheet. Do the same for each ingredient.

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

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

When all group members are satisfied with the calculations on nutrients and cost, fill in a clean copy of the menu-planning form (Handout 29.4) to display with the plate.

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

After the groups have finalized their Hearth menus, they can start cooking/ preparing the meal and snack using the menus they developed.

60 Min

5.

Gather in a large group once all small groups have finished cooking. Ask each group to measure out the portion (serving size) for one child using local measures that the caregivers will use to serve each child during the Hearth sessions. Have each small group show their final plate and menu-planning form, explain their menu, and point out the difficulties they encountered and the possible solutions they identified. Guide discussion on each proposal.

- Does the menu contain the correct protein, calorie and micronutrient composition?
- Is the quantity (volume) of food in the proposed menu a realistic amount for a child to eat? *(This has to be visualised, recalling that a child's stomach is the size of the child's fist.)*
- Does the menu include PD foods?

- Does the menu include locally available and accessible foods?
- Does the menu include a snack?
- Is the cost per serving realistic for a very poor family? *(While caregivers are not necessarily expected to replicate the exact menu at home, they should be able to afford all the ingredients in order to serve them regularly to the child.)*
- If a child finishes all the food served, should he or she be offered more? *(Yes, but not another whole portion. Also, the volunteer should visit the home and talk to the caregiver to assure that the child is receiving three other meals and another snack at home each day while attending Hearth. When not attending Hearth, a child 6–8 months of age should be receiving two meals and two snacks plus breastfeeding each day, and a child 9–24 months of age should receive three meals and two snacks daily plus breastfeeding. The Hearth meal is an extra meal.)*
- Considering that some children may need an extra small serving when they finish their first portion, how much extra food should be cooked? *(Cook an extra amount equivalent to two full portions.)*

Following the discussion, have the participants taste the menus and select the two best menus as a group, considering criteria listed in Step 6.

***Note**: Caregivers and grandmothers from the community can be asked to join the menu tasting as a way of introducing them to what they will learn in the Hearth sessions.*

6.

A good Hearth menu should:

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

Calories: 600–800 (500–600*)

Protein: **25–27g (18–20g*)**

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

Iron: **8–10mg**

Zinc: **3–5mg**

Vitamin C: **15–25mg**

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

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

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

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

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

Cooked rice, divide by 2

Cooked beans, lentils, pulses, divide by 2

Cooked porridge, divide by 2.5

Cooked green leaves, multiply by 1.4

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

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

World Vision

Day 7 Session 29

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

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

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

World Vision

Day 7 Session 29

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

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

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

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

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Menu A:

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

Menu B:

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

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

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

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

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

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

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

Step-by-Step Instructions:

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

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

1. Hearth menus should meet the following energy and nutrient requirements: Energy: 600-800 kcal; Protein: 25-27g; Vitamin A: 300 mcg RAE; Iron: 8-10 mg; Zinc: 3-5 mg; and Vitamin C: 15-25 mg.

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

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

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

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

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

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

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

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

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

Menu Calculation Assessment

SESSION 30

60 MIN | DAY 8

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

1. Review and demonstrate understanding of menu calculation process

Preparation

- Print menu calculation test (found in Resource CD) for each participant

STEPS

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

2. Review agenda for today.

SESSION 31

Essential Elements of PD/Hearth

55 MIN | DAY 8

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

1. List the 14 essential elements for PDH 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** https://www.yumpu.com/en/document/read/25447957/core-group-positive-deviance-hearth-essential-elements

Preparation

- Review Handout 31.1 and 31.2

Materials

- Handout 31.1: Positive Deviance/Hearth Essential Elements
- Handout 31.2: PDH Essential Elements – Detailed Observations and Key Questions
- Flip-chart paper, cut or torn in half
- A paper circle for each participant (four circles should fit easily on the half sheet of flip-chart paper without overlapping)

STEPS

5 Min

1.

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

10 Min

2.

HANDOUT
31.1 – 162m/H 62

Distribute Handout 31.1 and ensure that all 14 essential elements have been named. Divide into pairs. Assign two essential elements to each pair. Each pair is to list the reasons its two elements are essential. Those who finish early can look at the other essential elements and discuss the reasoning behind them.

20 Min

3.

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

10 Min

4.

HANDOUT
31.2 – 166m/H 66

Discuss who is responsible for assuring that PDH in each community adheres to the essential elements. *(AP staff that supervises, community Hearth committee, or volunteers, depending on the element)*. Ask for examples. Present Handout 31.2: PDH Essential Elements – Detailed Observations and Key Questions, which can be used as a tool to monitor essential elements in a Hearth project.

10 Min

5.

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

- The AP wants to provide the food for PDH 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 PDH.

Essential Elements of PD/Hearth

Several elements are essential to the implementation of an effective PDH 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 PDH implementation will facilitate the community's involvement and learning as grandmothers are key influencers in addressing child malnutrition. In the different steps of the PDH 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 PDH 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 so means that the second community loses the process of the discovery that results from the PDI.

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.

If there are no poor families with well-nourished children in a particular community, the PDI may need to look at families with only at risk underweight 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: this	8–10 mg (may need iron supplementation or a fortified product to meet 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 PDH 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 PDH 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 at risk 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 PDH Guide*.

Summary components and sample questions to guide discussion on essential elements

Essential PDH 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 PDH integrated with other programmes/ sectors? How was this achieved? What were the results?
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated. If growth monitoring is not already in place, begin monitoring those who complete Hearth sessions and all children in target group over time. Growth monitoring must include counselling and explanations of a child's growth.	• Is routine growth monitoring present in the community? • Is counselling included? • How are children monitored after graduation?
3. Conduct a PDI in every community. A PDI is an opportunity for the community to make discoveries, not just to provide information to WV. To ensure community ownership, integrate the PDI into the Hearth sessions. A PDI may need to be done at different seasons. The goal is to identify PD practices, not only PD person.	• How were the families to visit identified? • How was the PDI conducted? By whom? • How was information analysed? • Were PD foods/practices identified? • How were grandmothers involved? • How was the information utilised? Menus/ messages? • Was there sufficient technical skill to complete the PDI well?
4. Prior to sessions, deworm all children and provide immunisations and micronutrients. The purpose is to support rapid recuperation. Refer families to the local health centre before Hearth sessions so recuperation is not attributed to these activities. In endemic areas, malaria may need treatment before Hearth sessions.	• Was a situation analysis completed (nutritional assessment, feeding practices, expanded programme of immunisation coverage, vitamin A)? • Were all children under three years of age weighed? • Were children dewormed, immunised, vitamin A supplementation completed? • Were pre-existing underlying illnesses treated?

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

Essential Elements of PD/Hearth Detailed Observations and Key Questions

Essential PDH 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 PDH 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?

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 PDH Guide*: pp. 135–39 and 143–45

Preparation

- Ask participants with PDH experience to take part in a panel discussion.
- Have the flip chart with the PDH 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 PDH 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 PDH objectives, and briefly go over the importance of adequate food intake, of local feasible interventions, and of the caregivers' participation. Introduce the panellists.

20 Min

3.

Ask participants to do a role play of the first day of Hearth. Make sure the role play includes the following:

- have 1-2 volunteer(s) meet with participant caregivers to decide on a time and place to meet for Hearth (ensure Hearth site has a latrine)
- assign roles to participant caregivers and ask caregivers to bring a bowl and spoon for the children to eat from
- ask primary caregivers which of the ingredients from the Menu A they could possibly bring and assign caregivers to bring various ingredients

Next day within the role play:

Act out the Day 1 of a Hearth session. Make sure the role play includes the following:

- registering of the children (refer children to health facility or hospital when MUAC is 'red' or child has a disability and has difficulty feeding due to the disability)
- correct weighing and reading of MUAC of children
- collection of ingredients
- dividing up of caring station, handwashing station, and cooking station
- mothers taking on various roles that were assigned to them previously
- handwashing of children before being given snacks
- children being given snacks while waiting for caregivers to cook Hearth meal
- children singing a song about handwashing
- volunteers providing various messages at the 3 different stations
- volunteer sharing menu for cooking caregivers (prepare giant menu chart)
- after cooking is complete, caregivers feeding the children
- volunteer sharing the key Hearth message while caregivers are feeding children Hearth meal
- end with caregivers standing up to clean up the dishes and cooking utensils

5–10 Min

4.

Questions from participants.

Which elements of the programme might need to be tailored? What considerations might prompt adaptations? Ideas? (See the situations detailed in the *CORE PDH 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 33

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

World Vision

60 MIN | DAY 8

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

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

Reference in *CORE PDH 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 health@wvi.org).

Preparation

- Ask six participants to act as 'caregivers' in the reflection skit.

STEPS

5 Min

1. Learning new habits takes time

Caregivers get a good start during the Hearth sessions, but need help to recognise the changes they see in their children and relate those changes to the extra food and care they are giving them. This can be done this having a reflection time together on the last day of Hearth. They also need to be encouraged to continue the new practices, so volunteers will visit caregivers in their homes during the two weeks after the Hearth sessions. These visits are intended to help caregivers overcome any problems they might be having in following the new practices.

10 Min

2. Role play a reflection time

Gather all the 'caregivers' in a circle on a mat. Point out that this is the last day of Hearth. Ask the 'caregivers' what they think, allowing time for them to answer. 'What did you like about Hearth?' 'What was your child like before the Hearth sessions started?' 'What is your child like now?' 'What do you think has made the difference?' 'Do you think you will be able to continue these same practices at home?' 'What obstacles do you think you might have?' Congratulate them on their great work.

5 Min

3. Discuss the role play together

Brainstorm for ways to solve the problems that caregivers might have. What do we want caregivers to learn from the reflection time? Why?

5 Min

4.

Explain the importance of practicing a new behaviour over a sufficient length of time for the behaviour to become a habit. The Hearth approach includes two weeks of Hearth followed by home visits during the two weeks after the Hearth session to reinforce the behaviours learned during the sessions. Each caregiver or caregiver-grandmother pair is briefly visited every two or three days by the volunteer to be sure the child continues to receive the 'extra' food and that the other PD behaviours are being practised. Reiterate the importance of the follow-up home visits.

10 Min

5.

Present the following scenario to demonstrate a home visit:

The volunteer 'drops in', chats with the mother and grandmother about neighbourhood news, and inquires about the child. (The child is playing at a neighbour's house.) The volunteer points out to the mother and grandmother that the child's newfound energy and interest in playing are signs of recovery. The mother mentions that the child had a bout of diarrhoea. When the volunteer asks how she treated it, she says she had oral rehydration solution but gave tea instead because she couldn't remember how to prepare the solution and the grandmother couldn't either and so suggested tea. The volunteer explains how to prepare ORS both to the mother and grandmother and asks them to repeat the directions. The volunteer asks whether the child's appetite is good, and the mother says yes and that she is giving the child extra food. The volunteer says she will check in the day after tomorrow, reminds the mother and grandmother of the final weigh-in on the following Friday, and congratulates them for their efforts to make their child healthy.

10 Min

6.

After the role play, ask participants:

- What was the purpose of the home visit? (*encourage caregivers to continue feeding and caring practices; encourage grandmother to support and advise caregivers of the practices; see that the child is continuing well; help caregiver and grandmother think of solutions to challenges)*

- What examples of positive reinforcement did you see?
- How did the volunteer help the mother and grandmother see the change in their child?
- How long was this home visit? *(brief, 10–15 minutes)* How often are caregivers visited by the volunteer? *(every two or three days)* How many visits can a volunteer could do in one day? *(two or three)*

Repeat yet again the importance of the follow-up visits in behaviour change and helping families find solutions.

15 Min

7.

Ask participants what challenges caregivers might have in practicing Hearth behaviours at home. Brainstorm possible solutions to each situation. Possible problems include:

- Forgetting what was taught
- Not having the ingredients for the menu
- Not knowing where to get affordable fish or vegetables
- Having a husband or mother-in-law who is resistant
- Having a child who is sick
- Having a child who refuses to eat.

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

SESSION 34

75 MIN | DAY 8

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

1. Discuss considerations for children graduating from or repeating the Hearth sessions (Hearth protocols)
2. Discuss ways to work with the community to design an exit strategy and/or to link Hearth with other programmes.

Reference in *CORE PDH Guide*: pp. 124–28, 142

Preparation

- Print Handout 34.1
- Refer to Handout 14.2 and 14.3
- Blank flip chart

Materials

- Handout 14.2: WHO Weight-for-Age Reference Table
- Handout 34.1: Follow-up Cases

STEPS

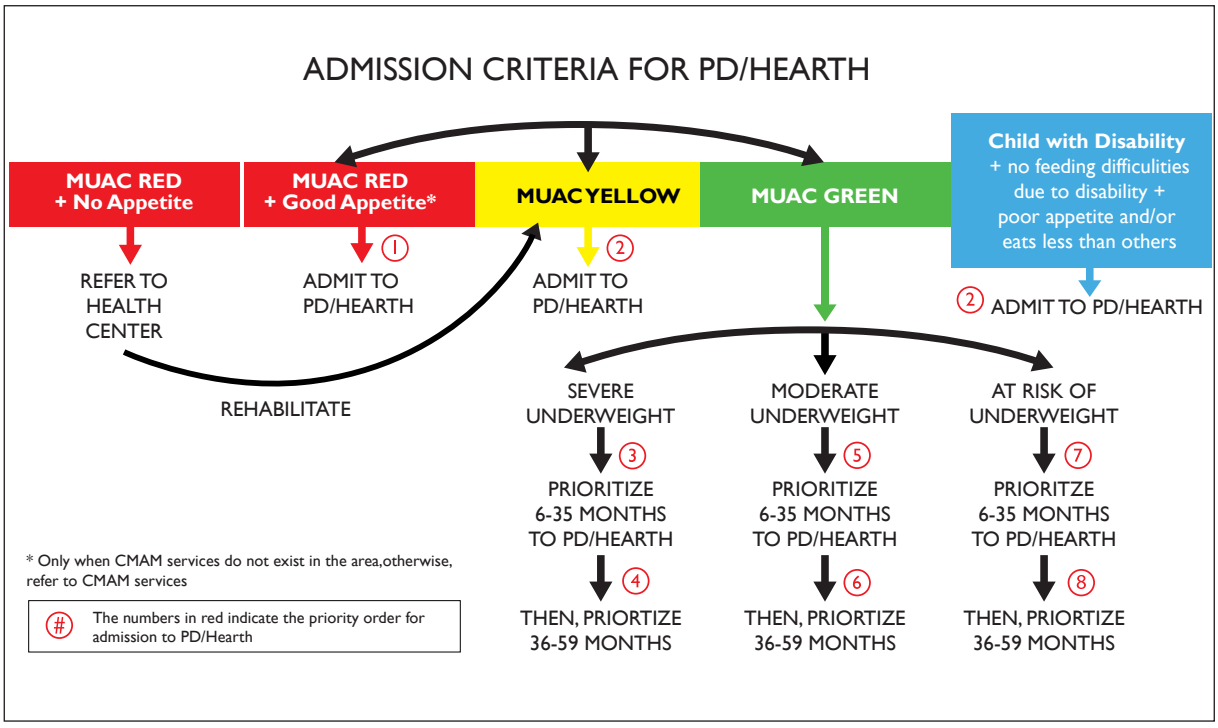
50 Min

1.

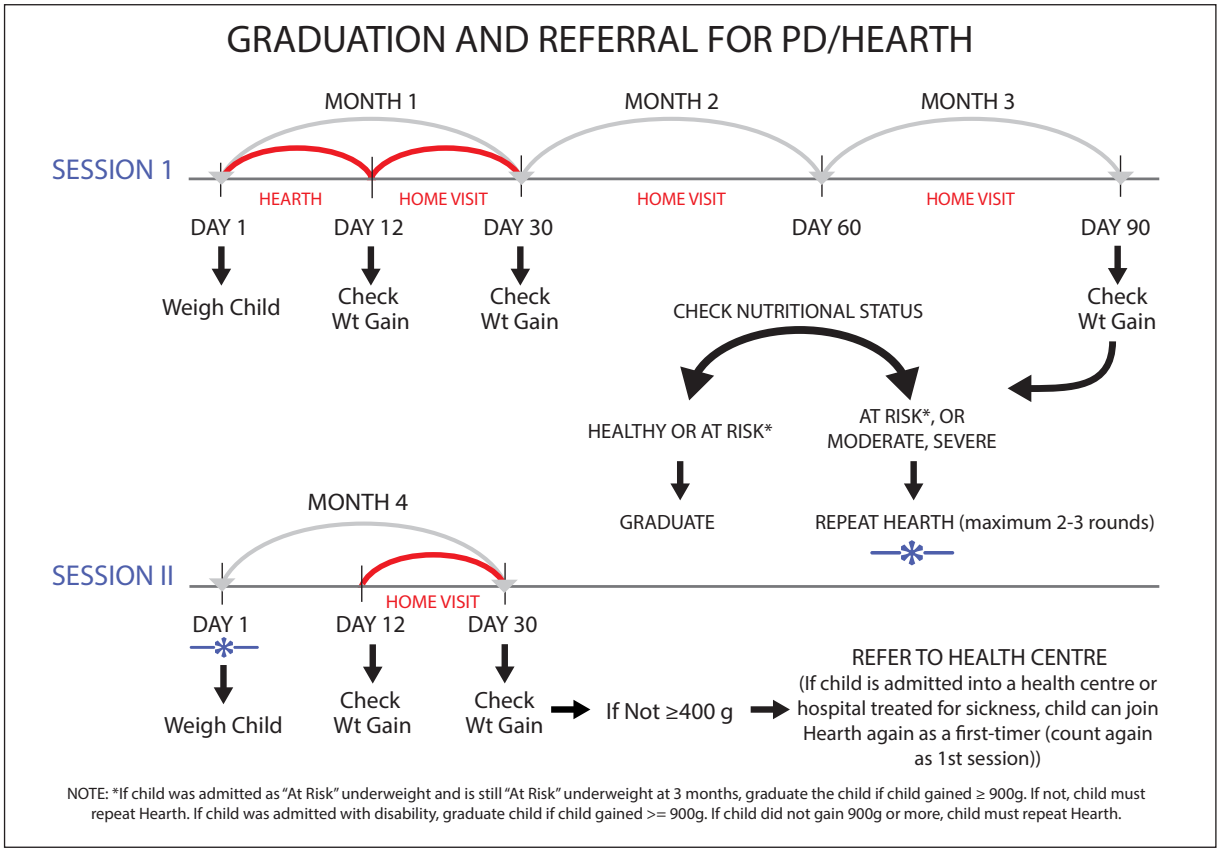
Please explain PDH Admission Criteria to the participants. If a child's MUAC is red, refer him/her to a health centre for CMAM services. If CMAM services are not available in the area and child with red MUAC has good appetite, refer to PDH. If child does not have good appetite, please refer the child to the health centre for medical treatement. The child can be admitted into PDH once the child's appetite returns. Please follow the table on the next page for the order of admission.

PDH Admission Criteria

Priority	MUAC	Underweight	Age
1	No CMAM services Red (Severe) with good appetite	Severe	6-59 months
2	Children with Disability, and no difficulty with eating and/or drinking due to disability, but has a poor appetite or eats less than other children his/her age (MUAC and underweight status is irrelevant for admission as long as criteria above is met)		6-59 months
	Yellow (Moderate)	Severe	6-59 months
3	Green (Healthy)	Severe	6-35 months
4	Green (Healthy)	Severe	36-59 months
5	Green (Healthy)	Moderate	6-35 months
6	Green (Healthy)	Moderate	36-59 months
7	Green (Healthy)	At Risk	6-35 months
8	Green (Healthy)	At Risk	36-59 months



Please explain PDH graduation criteria to the participants.



PDH Graduation Criteria

1. Graduation Criteria (Graduation declared at 3 months follow-up)

- **Nutritional Status Graduation Criteria at 3 Months (see table below):**

1. Admission (Day 1): Underweight Status	2. Disability Status	3. At 3 Months: Underweight Status	4. Next Step
Moderate or Severe	Yes or No	Healthy or At Risk	Graduate
At Risk, Moderate or Severe	Yes or No	Moderate or Severe	Repeat Hearth
At Risk	Yes or No	Healthy	Graduate
At Risk	Yes or No	At Risk, but gained ≥900g	Graduate
At Risk	Yes or No	At Risk, and gained <900g	Repeat Hearth
Healthy, At Risk, Moderate or Severe	Yes and child has a disability that makes assessing weight difficult (e.g. missing an arm, little person, etc.)	WAZ remain same or improved in 3 months (For example, Day 1 WAZ=-2.2 vs. 3 Months WAZ=-2.1)*	Graduate
Healthy, At Risk, Moderate or Severe	Yes and child has a disability that makes assessing weight difficult (e.g. missing an arm, little person, etc.)	WAZ decreased in 3 months (For example, Day 1 WAZ=-2.2 vs. 3 Months WAZ=-2.5)*	Repeat Hearth
***Note:** If child has a disability that makes it difficult to measure or assess weight, look at growth trend and not underweight status when graduating the child			

- If child was admitted as **"Moderate or Severe" underweight**, child must be "Healthy or At Risk" underweight status at 3 months for child to graduate, regardless of weight gain and regardless if child has a disability. If child is still "Moderate or Severe" underweight, repeat Hearth (repeat max. 3 times – depends on the country, but we recommend 2 times)
- If child was admitted as **"At Risk" underweight**, and child is "Healthy" underweight status at 3 months, graduate the child, regardless if child has a disability or not. If child was admitted as "At Risk" underweight, and the child is still **"At Risk" underweight** status at 3 months, graduate the child if child gains ≥900g, regardless if child has a disability or not. Otherwise, child must repeat Hearth.

Special Exception to above is when child has a disability that makes it difficult for measuring/assessing weight-for-age status:

- If child was admitted due to a disability that makes it difficult to accurately weigh or assess a child (e.g. child without an arm or a little person), regardless of the underweight status of the child on admission or Day 1, refer to the child's Day 1 Weight-for-Age Z-score (WAZ) and compare it to the 3 Month WAZ. If the WAZ has stayed the same or improved, graduate the child (look at the growth trend). If the WAZ decreased within the 3 months, the 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; 1 year 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 PDH 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 HHs to check weight of child and provide counseling as needed for children who have MUAC 'yellow' or 'red', for children severely underweight, and/or children who have a disability (visit monthly or more fequently between 1-3 months after Hearth session)

3. When to Refer child for medical attention or therapy?

- 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 PDH (follow-up with child and admit into PDH after child returns from Health Centre is and "YELLOW" or "GREEN" for MUAC
- During the initial assessment or 1st Day of Hearth, the child is found to have a disability and has difficulty feeding because of the disability, refer the child to the health facility or district hospital fortherapy and admit into PDH after child completes therapy or the hospital refers the child to PDH
- 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 back to 0)
- 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 6-35 months of age first, but if child is severely wasted with good appetite or has a disability, prioritize the child regardless of the age as long as the child is 6-59 months of age.)

HANDOUT
14.2 – 82m/H 32

It is important to monitor not only the child's weight gain, but also to calculate the child's nutritional status using either the 'Road to Growth' charts or the WHO Anthro Table (Handout 14.2). A malnourished child is expected to gain 400 grams in one month with one Hearth session. If a child's nutritional status advances to green (normal) in one session, the child must continue to grow at the average expected rate (approximately 200–250 grams a month, depending on the child's age). Thus after 3 months the child should have gained 900 grams.

A 400 gram gain in Hearth will usually not move a child from one level of malnutrition to another, especially if the child is moderately or severely underweight. The average gain needed to change from moderately underweight to at risk of underweight is about 1.2 kilograms. This can be demonstrated with the WHO Weight-for-Age Reference (refer to Handout 14.2, 18 months for girls or boys). Look at the weight in the moderately underweight column and subtract the weight in the at risk of underweight column. This is the amount of weight a child needs to gain to move from moderately underweight to at risk. Notice that as the child gets older, more weight is needed to 'cross' from one level of nutrition to another.

A PDH 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. 400g 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 *PDH 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
- Decentralising growth monitoring programmes to the village or sub-village level to increase GMP coverage and to ensure disabled children are included in the GMP sessions
- Age limits.

15 Min

2.

HANDOUT
34.1 – 181m/H 69

Break participants into small groups and assign each group one of the case studies (Handout 34.1). 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.

At what time should PDH be replicated? Where and how? *(It is important that PDH implementers learn in a small pilot project. Once one project is successful, consider replicating it in other communities or other APs. 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 35

Monitoring and Evaluation (STEP 8)

World Vision

135 MIN | DAY 8

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

1. Identify several key quality indicators for monitoring PDH activities
2. Describe supervision tools that are available to ensure the quality of PDH activities.

Reference in *CORE PDH 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 PDH Guide*.
- Print copies of 35.1, 35.2, 35.3A, 35.3B, 35.4, 35.5, 35.6, 35.7 and 35.8

Materials

- Handout 35.1: Checklist of Materials Needed for PDH Sessions
- Handout 35.2: PDH Menu and Cooking Materials Tracking Sheet
- Handout 35.3A: Child Registration and Attendance Form
- Handout 35.3B: Child Registration and Attendance Form (including Grandmothers)
- Handout 35.4: PDH Register and Monitoring Form
- Handout 35.5: Volunteer Home Visit Form
- Handout 35.6: Supervision of PDH Session
- Handout 35.7: PDH Monitoring Case Study Questions
- Handout 35.8: User Guide for the PDH Excel Database
- Blank flip chart
- LCD Projector
- Soft copy of Excel-based PDH database (found in Resource CD)

STEPS

20 Min

1.

Remind the participants of the three goals of PDH 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 PDH 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 PDH 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 including children with disabilities and their caregivers/households, 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 wasting (CMAM) or rehabilitative therapy or services for children with disability, which might be coordinated with PDH. After severely malnourished (wasted) children have completed the CMAM programme, they should participate in a PDH session so that their caregivers will learn new behaviours necessary to sustain the recuperation.*

Who Monitors? The AP/NGO monitors PDH 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
- Use of **Design and Implementation Quality Assurance (DIQA tool)** which provides a program fidelity score. The tool is a self-check/reporting tool to identify which areas of the program need to be improved to see better results. It should be used 1-2 times a year per AP/project. Refer to Orientation video at link: https://youtu.be/J0wH-AKcAKw and the tool can be found on WV NutritionNet

Analysis should be shared during a feedback session with the volunteer and with the Village Health Committee. Stress the positive first. Dwell on the outcome – How many children graduated? Look at key quality indicators together. *Remember: positive feedback, analysis of problems, identification of solutions and follow up.*

5 Min

2.

Ask participants to list potential indicators of behavioural change in Hearth. Write these on a blank flip chart.

- Observe practices during the visit (see the PDI questions/checklist in Session 22).
- Talk with the caregiver and grandmother for information on practices and if child is receiving extra food.
- Check for better health-seeking behaviours (what does the caregiver do and/or grandmother advise when the child is sick: attendance at health post, extra feeding, etc.).
- Verify weight gain (at one month, three months, six months, and twelve months following the Hearth session).
- Observe the health status of any new siblings.

Ask which of the indicators can be observed during home visits. Put an asterisk (*) next to these. Ask whether the supervisor or the volunteer would be more likely to observe and document these indicators.

20 Min

3.

HANDOUT
35.1 – 188m/H 70
35.2 – 189m/H 71
35.3A – 191m/H 73
35.3B – 192m/H 74
35.4 – 193m/H 75
35.5 – 195m/H 77
35.6 – 196m/H 78
35.7 – 197m/H 79

Distribute the sample checklists and monitoring forms (Handouts 35.1 to 35.8). Review these together. Volunteers will use the following forms:

- Handout 35.1 as a checklist of the materials needed for the PDH sessions
- Handout 35.2 to track caregivers' menus and cooking materials
- Handouts 35.3A/B and 35.5 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 35.4, 35.6, and 35.7 to track PDH 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 PDH 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 PDH caregiver has talked about Hearth).
- Review the weights of the children in the community over time (from the GMP). Invite the community health committee to share the results of the GMP with the entire community on a regular basis. Help the committee develop posters to show progress (to promote social change).
- Meet with community leaders to share Hearth outcomes.
- Document success stories and share them within the village and beyond.

45 Min

6. Monitoring Case Study

HANDOUT
35.7 – 197m/H 79

Distribute Handout 35.7, 'PDH Monitoring Case Study Questions' and 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
35.8 – 198m/H 80

Please briefly go over the PDH Excel Database with the participants. Refer to Handout 35.8: User Guide for the PDH Excel Database.

Checklist of Materials Needed for PD/Hearth Sessions (Job Aid)

Checklist of Materials Needed for PDH Sessions

The supervisor and volunteers ensure the following items are available for the PDH Sessions

	Provided by:		
	Community	**Caregivers**	**Implementing Agency**
Weighing scales			
Register to track attendance and weights			
Daily menu and recipes			
Cooking pots			
Frying pan			
Cooking utensils			
Bowls			
Cups			
Spoons			
Soap or ash			
Basin			
Towels			
Nail cutters			
Water pitchers			
Mats			
Cutting boards			
Mortar and pestle			
Fuel/wood			
PD food			
Staple food (rice, fufu, yams)			
Oil			
Other ingredients			

PD/H Menu & Cooking Material Tracking Sheet of Caregivers for Volunteers

No.	Name of Caregiver	No. of Children in PD/H Programme
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

No.	DAY 1	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 2	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 3	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 4	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 5	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 6	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

PD/Hearth Menu and Cooking Materials Tracking Sheet (Job Aid)

Day 8 Session 35

No.	DAY 7	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 8	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 9	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 10	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

No.	DAY 11	INGREDIENTS	COOKING MATERIALS	ROLE	DAY 12	INGREDIENTS	COOKING MATERIALS	ROLE
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Child Registration and Attendance Form

AP 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)	Disability (Y/N)	Deworming (Y/N)	Vitamin A (Y/N)	Full Immunisation (Y/N)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

#	**Attendance and Appetite Test for Hearth Participant Child AND Primary Caregiver*** Attendance (Att, Appetite (App)																							
	1		2		3		4		5		6		7		8		9		10		11		12	
	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								

***IMPORTANT:** Indicate with a checkmark (✓) under the column 'App' if the PDH child AND Primary Caregiver attended the Hearth session for the corresponding day under the column 'Att'. Please also indicate with a check mark (include (✓)) under the column 'App' if child passes the appetite test. If the child is 'Red' for MUAC and does not pass the appetite test, please refer the child to the health centre urgently.

Child Registration and Attendance Form (including Grandmothers)

AP 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)	Disability (Y/N	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*** Attendance(Att), Appetite(App)																							
	1		2		3		4		5		6		7		8		9		10		11		12	
	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App	Att	App
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 (✓) under the column 'App' if the PDH child AND Primary Caregiver attended the Hearth session for the corresponding day under the column 'Att'. Please also indicate with a check mark (include (✓)) under the column 'App' if child passes the appetite test. If the child is 'Red' for MUAC and does not pass the appetite test, please refer the child to the health centre urgently.

Hearth Register and Monitoring Form

AP 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)											
Child with Disability (Y/N)											
Hearth Session/Round # (e.g. if it is the child's second time attending Hearth, please write '2')											
At Day 1 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Green, yellow, red < 115mm)										
At Day 12 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight Gain (Day 12 - Day 1) in grams										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										

*NOTE: Please write "DEFAULT" in the column for weight if child has defaulted and explain reason for default in the 'Comments' section.

HANDOUT
35.4

Hearth Register and Monitoring Form

World Vision

Day 8 Session 35

2 OF 2

AP 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.

AP 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							

HANDOUT
35.6

Supervision of PD/Hearth Session

World Vision

Day 8 Session 35

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 caregivers able to recite Key Hearth messages				
Key message discussed during PDH supervision visit				
Caregivers express being motivated by changes in child				
(Optional) Caregivers with disabled child(ren) express confidence in caring/feeding of child				
Caregivers can say what to do when child is sick				

Refer to the PDH ToF Resource CD, USB, or MS Teams File for PDH Master Trainers files on NutritionNet for the most up-to-date Monitoring Case Study and questions.

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** page 193.

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 AP name and use the drop-down menu to select or enter a fiscal year.

Tab 6 – GRAPH Follow-up: This tab contains a bar graph showing overall changes in underweight nutritional status of PDH participant children (%) at different time points (e.g. baseline/Day 1, 12, 30 of PDH, and 3, 6, 12 months of post-PDH).

Tab 7 – GRAPH Graduation & Weight Gain: This tab contains six pie charts. The first three charts show the percentage of children whose nutritional status improved (i.e. Mild/healthy vs. still moderate/severe) at Day 12, Day 30 and 3 months. The last three charts show the percentage of children who gained adequate weight (i.e. ≥ 200g at Day 12; ≥ 400g at Day 30; ≥ 900g at 3 months).

Tab 8 – GRAPH Default: This tab contains a bar graph on child default rate. The breakdown of number of children based on reasons for default at different time points (at Day 12, 30, and 3, 6, 12 months) is given.

NOTE:

To change the default date format on your computer:

1. *Go to Control Panel, click Regional and Language Options.*
2. *Under the Formats tab, click Additional settings (or Customize this format) button.*
3. *Click the Date tab.*
4. *Use the drop-down menu to select "DD/MM/YYYY" as the default Short date format.*
5. *Click Apply and close.*

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

1. Describe the roles and responsibilities of volunteers required for PDH.

Materials

- Flip chart with the title 'What PDH Volunteers Do'
- Flip chart with the title 'Skills Needed by Volunteers'
- Flip chart with blank papers

STEPS

10 Min

1.

Ask participants what PDH volunteers are expected to do. Write their answers on the flip chart under the title 'What PDH 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). You can provide them with headings in the table below to start. The skill column headings could also be provided, if more guidance is needed for the group.

PDH Volunteer

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

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

10 Min

2.

Based on the skills and responsibilities identified for a PDH volunteer, ask the group how volunteers should be selected. Probing questions could include the following (all of these may not be needed):

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

- Are the people who have these qualifications in a 'higher' social group, and might that make it more difficult for them to interact with poor caregivers?
- If no women in the community are literate, what might be an alternative way to fill out the register and reports? *(enlist a literate adolescent girl to assist her; one of her own children might be able to help with the writing; in some communities women are not available or have died of AIDS and fathers are volunteers)*
- Does the volunteer have to be a mother of a child under age two? (*No. Experience has shown that it is actually better if the woman's children are older so that she isn't preoccupied with caring for her own small child. Grandmothers may be a good choice for this reason and because of their influential role in they care and feeding of young children.)*
- Why do we not automatically recommend that the mother of the PD child be the volunteer? *(in some cultures this could cause her to become socially isolated, may not have the qualifications, may not necessarily be a model in all ways).*

10 Min

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

30 Min

4. Discuss the following questions with the group:

- What is the best way to ensure that volunteers can conduct PDH with confidence? *Explore ways for supportive supervision and management of volunteers, like frequency of supervision visits by AP staff to Hearth sessions (i.e. ideally, for the first round of Hearth, the AP staff support all days of Hearth and thereafter, visit one day per round of Hearth to support/observe volunteers).*
- *Refer to supervision tools found in Session 36.*

SESSION 37

Post-test

35 MIN | DAY 9

Materials

PDH Post-test (provided in Resource CD)

STEPS

1. Distribute Post-test provided in the MS Word document.

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

3. Facilitators mark the tests while the participants complete their PDH Action Plans (Session 41). The marked post-tests will be returned with the pre-test results.

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

1. Describe how PDH can be integrated into PDH+
2. Plan how to advocate with managers for integration.

Preparation

- Print copies of Handout 38.1.

Materials

- Flip Chart
- Markers
- Handout 38.1: PD/Hearth+: An Integration of PDH with Food Security and Prevention Interventions

STEPS

45 Min

1.

Discuss with the participants the following questions:

- What is an overall goal for your AP, community partners and/or CSOs?
- What core project models or activities does your AP have to reach that goal?
- What special projects and/or technical programmes (TPs) do you have within your AP?
- How does each of these projects or TPs contribute to the overall goal?
- What happens when each of those programmes and projects are planned and implemented as a separate entity? (*there is less impact; the overall goal of the AP may not be affected as greatly; there is competition among projects*)

Additional Questions for Discussion

- With whom does PDH 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 PDH 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 PDH TOFs is possible) to ensure key messages and unique findings from PDIs are incorporated into the existing system for sharing Health and Nutrition messages (selection of only six key messages for a 12-day PDH Session may be limiting so it would be good to scale-up the learnings from PDH)
- Share with community during visits to the health facility, counselling sessions for caregivers, mother care groups, family 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, AP managers and Zonal/ National Office leadership, as well as with community members and other entities such as the Ministry of Health.
  - Use real data – from your assessments, PDIs, and so forth to inform leaders about the extent of nutrition problems and the potential positive outcomes using resources already in the community.

15 Min

2. What is PDH+?

Write on the flip chart the following: PDH+ is the revised core project model that includes PDH integrated with (an) additional prevention intervention(s), which can include any number of the following interventions:

- Decentralized Growth Monitoring and Promotion (GMP)
- Micronutrient Powders
- IYCF counselling
- Nurturing Care Groups
- Biofortification
- Kitchen Gardens
- Savings Groups
- Animal cooperatives or revolving funds (e.g. chickens, goats, etc.)

HANDOUT
38.1 – 209m/H 83

Inform the participants that the main advantage of implementing PDH+ compared to only implementing PDH is that PDH+ includes additional nutrition or food security interventions that can increase activities around prevention of malnutrition, strengthening the overall program to achieve the three objective of PDH (prevention, rehabilitation, and sustaining rehabilitation) and the goal of reducing child malnutrition in the community. Go through the table in Handout 38.1 with particiants and enlighten the participants in how they could use the table to improve the integration of the different interventions with PDH.

20 Min

3. Decentralized Growth Monitoring and Promotion (GMP)

Inform participants that it is highly recommended to ensure GMP is being conducted regularly in the communities and that it is decentralized to the village or sub-village level if possible to increase the coverage of nutrition screening and IYCF counselling. On a flip chart, please write out the following and discuss:

1. Why is GMP important?

- Regular GMP (monthly or quarterly) prevents malnutrition. How?
  a. GMP screens for malnutrition in children aged 5 years or younger to identify growth faltering children
  b. GMP allows for infant and young child feeding (IYCF) counselling when the child is growth faltering before the child is malnourished
  c. Regular GMP allows for timely and appropriate referrals to health facilities or rehabilitation programs like PDH when child is malnourished or children with disabilities have feeding difficulties

2. What are the challenges with GMP?

- Not regular (takes place once every 6 months or once a year)
- Long wait times because of limited number of GMP posts
- GMP posts are far in distance for many households because they are centralized at health facilities
- Health facility staff or CHWs have limited time to run GMP sessions
- Limited functioning equipment
- Poor capacity in anthropometric measurements (weighing, height, MUAC) and analysis
- Poor capacity in IYCF counselling
- Caregivers do not find the GMP sessions helpful in improving child caring practices

3. What is the result of poor irregular GMP?

- Poor identification of malnourished children
- Poor referral of children to appropriate services
- High rates of all 3 types of malnutrition (underweight, wasting, and stunting)

4. What can we do to address the major challenges?

- We can implement decentralized GMP

5. What is decentralized GMP and what is needed for decentralized GMP?

- GMP is conducted regularly (monthly or quarterly and even bi-weekly when in crisis scenario like droughts or pandemics)
- Designate multiple GMP posts per village or sub-village (recommend 1 post for every 20-30 U5 households, but dependent on context's household size and population density)
- Increase in number of days and hours GMP services are offered (e.g conduct GMP at community-level 2-3 days per month at multiple locations)
- Increase in number of trained personnel in GMP (anthro and IYCF counselling)
- More functioning equipment
- Target for ≥80% coverage of GMP (nutrition screening)
- Utilize a strong monitoring system (WV's GMP mHealth application or database)
- Try to integrate GMP into existing activities or platforms that meet regularly, such as Savings Groups or Family Groups

6. What can be done if food insecurity is a major challenge for 1– 3 months of the year in the target area you are trying to implement PDH+? How can we identify coping strategies?

- The brief ***Coping Strategy Index (CSI) tool***[1] can be used to measure what people do when they cannot access enough food. It is a series of questions about how households manage to cope with a shortage in food for consumption and results in a simple numeric score. This tool could be used during the PDI household visits to identify coping strategies
- The coping strategy(ies) identified in PD households could be a key Hearth message and shared during the Hearth sessions and with the larger population through existing platforms like Nurturing Care Groups, Savings Groups, Parents or Family Groups, etc.
- PDH can be integrated with the additional food security interventions above (Refer to Handout 38.1)

HANDOUT
38.1 – 209m/H 83

[1]Coping Strategy Index (CSI) tool can be found at the following link: https://www.fsnnetwork.org/sites/default/files/coping_strategies_tool.pdf

Interventions	Points of Integration	Key Contributing Success Factors to Consider	Resources (most resources below are available on WV's NutritionNet)
Nutrition Prevention Interventions			
1. Growth Monitoring and Promotion and IYCF	• Share contextualized key Hearth messages during the GMP or IYCF messaging session (1-2 per session) to address prevention • Promote PD foods during GMP and IYCF sessions • Identify new participant children for Hearth sessions through GMP • Conduct 3, 6, and 12 month follow-up weight and MUAC through GMP (PDH+GMP mHealth monitoring app available)	• To increase coverage, decentralize GMP (decreases # of children measured per session and less time spent on anthros) • Conduct GMP during existing community platforms where caregivers with children U5 attend (e.g. savings groups, nurturing care groups, mother support groups, family groups, etc.) • Need to train an additional cadre of frontline workers supervised by the existing government frontline workers in anthro measurements and how to conduct IYCF counselling (e.g. Community Health Workers (CHWS)) because usually CHWs cannot do all the work if GMP is decentralized • Conduct at least quarterly, if not more frequently	• Measuring Child Growth tool • GMP Database • National IYCF Training Manuals • PDH+ adaptations to COVID guidance (covers decentralized GMP)
2. Micronutrient Powders (MNPs)	• Use MNPs for Hearth meals (1 sachet per child) for 10-12 days, especially for contexts that can easily access MNPs and have difficult time meeting required iron levels for Hearth meal • Provide 75 days worth of MNP sachets if budget allows after completing PDH sessions to PDH participant households	• MNPs can help to meet Hearth meal criteria especially during food insecure time periods since it's difficult to meet iron, zinc minimum requirements of Hearth meals in food insecure contexts	• NCOE MNP manual • PDH menu calculator

Interventions	Points of Integration	Key Contributing Success Factors to Consider	Resources (most resources below are available on WV's NutritionNet)
Nutrition Prevention Interventions			
	• Education in how to use MNP sachets should be provided during Hearth session and caregivers should practice using it before feeding children • Message should be clear that the MNP sachets provided are ONLY for the PDH participant child		
3. Community Health Worker (CHW) programming	• Share contextualized key Hearth messages during household visits (1-2 messages per session) to address prevention • Share list of PD foods with households starting complementary feeding of child at 6 mo	• Use mHealth app for monitoring and providing counseling messages to build CHW confidence, increase their sense of value to MoH and community, and	• ttC Manual • ttC Project Model doc • ttC log frame • ttC DIQA
4. Health/ Nutrition delivery platforms: Nuturing Care Group (NCG), Mother Support Groups, Family Groups, Youth Clubs, Mobile Clinics, etc.	• Share contextualized key Hearth messages during the GMP or IYCF messaging • session (1-2 per session) to address prevention • Share list of PD foods with households (micronutrient-rich • Teach caregivers how to construct tippy taps or create handwashing stations while sharing important handwashing messages	• Involve both mothers and fathers (and in some contexts where grandmothers and grandfathers play a significant role in child caring, involve grandparents too) during the group sessions or for some selective sessions to increase involvement of all family members in child caring practices and increase family support	• Nurturing Care Groups (NCG) PM manual • NCG training manual • Family Group implementation manual

Interventions	Points of Integration	Key Contributing Success Factors to Consider	Resources (most resources below are available on WV's NutritionNet)
Food Security/Resilience Interventions			
1. Kitchen Gardens	• Share list of PD foods to promote in kitchen gardens • Provide kitchen garden supplies and seeds to PDH participant caregivers	• Pair kitchen garden trainings with trainings on how to produce organic fertilizer using animal manure (e.g. goat) to increase yield	• Possible indicators: https://www.wvcentral.org/community/health/Documents/Home%20garden%20indicators.pdf#search=kitchen20%garden • Manuals on How to build kitchen gardens: • https://www.crs.org/sites/default/files/tools-research/homestead-gardening.pdf
2. Biofortification	• Through ADAPT tool identify the vitamins and minerals that may be deficient in the larger population • Through Hearth menu design, identify the vitamins and mineral requirements that are most difficult to meet and try to identify biofortified crops high in those specific vitamins/minerals (e.g. iron requirements are difficult to meet and population commonly consume beans, thus, explore biofortified high iron beans)	• Utilize farmer's associations to be seed multipliers for the biofortified crops and to increase demand in community	• https://www.fh.org/2016/03/14/build-your-own-keyhole-garden/

Interventions	Points of Integration	Key Contributing Success Factors to Consider	Resources (most resources below are available on WV's NutritionNet)
Food Security/Resilience Interventions			
3. Farmers Associations	• Promote biofortified crops and encourage farmers associations to become seed multipliers • Promote micronutrient crops (especially PD foods) and share Hearth message during farmer association meetings • Create a demand in the market for micronutrient-rich crops	• Try to practice climate smart agriculture	• National protocols and guidelines • USAID's Adoption of Climate-Smart agriculture in Africa: • https://issuu.com/integralllc/docs/adoption_of_climate_smart_agricultu
4. Savings Groups	• Conduct GMP sessions at Savings Groups sessions (as caregivers wait for members to arrive) – make sure to include people trained in taking anthros in the Savings Groups • Share key Hearth messages (1 message per session) during Savings Groups meetings as well		• Can contact TSO Livelihoods team for support in TOF or follow national protocols and guidelines

Interventions	Points of Integration	Key Contributing Success Factors to Consider	Resources (most resources below are available on WV's NutritionNet)
Food Security/Resilience Interventions			
5. School Gardens	• Share Hearth messages and PD food list with schools so some PD foods and micronutrient-rich foods can be planted in school gardens	• Ensure the PD foods are promoted to the students to also try and plant these foods at home as they are locally available micronutrient rich foods	• See kitchen garden resources
6. Animal revolving scheme/ livelihoods cooperatives	• Provide PDH volunteers with animal cooperatives (e.g. rabbit or chick cooperative) as incentive rather than monetary incentive if possible (varies by context) • Can include PDH participant households as part of animal revolving scheme	• Select animals where manure could be turned into organic fertilizer • Try to avoid animals that are highly susceptible to disease and require little feed and maintenance • Animals that can provide animal source foods are an added benefit • Animals that reproduce quickly are another added benefit	• National guidelines and training manuals

SESSION 39

PDH Implementation and Scale Up Strategy

World Vision

55 MIN | DAY 9

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

1. Describe the implementation strategy of PDH including: Staffing, beneficiaries, repetition of Hearth sessions, integration of PDH, and monitoring of programs to ensure program quality.
2. Develop a plan to expand and scale-up PDH and PDH+.

Preparation

- Prepare flip chart with the headings: 1. Staffing; 2. Beneficiaries; 3. Repetition; 4. Integration of PDH and PDH+; 5. Monitoring Systems; and 6. Key Supplementary Documents and write out the italicized/bolded points under each heading

Materials

- Flip chart paper
- Markers

STEPS

45 Min

1. Implementation Strategy

The following needs to be taken into consideration when implementing PDH:

1. Staffing

The ADP/AP or special project needs to ***highly invest into PDH for 2 to 3 years and PDH+ for about 5 years.*** This requires leadership support and intensive human resources. It is ***highly recommended to have one person at the ADP/AP or cluster level devoted to overseeing PDH+ programming***. This is strongly recommended if PDH is a feasible project model for your area because it is a highly effective programme that ***can reduce the prevalence of underweight and even wasting significantly in just 3-5 years.***

Without this support, you may not see as great of an impact and you will have to continue to implement PDH for many years. By highly investing into PDH for 2 to 3 years and PDH+ for 5 years, you could aim to bring the prevalence of underweight to less than 6 children per village at risk of underweight, underweight, or wasted, in which case PDH could be phased out to just focus on the prevention interventions of PDH+ such as growth monitoring and promotion and infant and young child feeding (IYCF) counselling.

2. Beneficiaries

Include all underweight (including 'at risk' underweight) and moderately wasted children with good appetite into PDH at the same time in the community (with a maximum of 10 caregivers per Hearth session; maximum 12 children per Hearth session). For example, if there are 40 underweight children, run 4 Hearth sessions simultaneously in the community. ***The Hearth sessions should be run at the community-level (decentralised).***

In contexts where Community-based Management of Acute Malnutrition (CMAM) services do not exist for severely wasted children, admit uncomplicated severely wasted cases to PDH only if they pass the appetite test. If disability services are available at the district health hospitals, screen for disability and include all children with disability, without feeding difficulties due to the disability, yet who eat less than other children their age into PDH. All children with disability and with feeding difficulties due to the disability should be refered to the district health hospital for additional services.

3. Repetition

Hearth sessions do not need to be repeated monthly. ***Only repeat Hearth sessions every 3 months (quarterly) since you are including even those children that are at risk of underweight into a Hearth session at one time.***

If healthy children are slowed in their growth, it will take several months to reach an 'underweight' status. Therefore they can wait to join the next Hearth session in 3 months. ***Repeating Hearth every 3 months will reduce the workload of staff and keep the monitoring of the programme simpler.***

4. Integration of PDH

The 6 key contextualised Hearth messages and recipes can be shared through mother support groups or care groups as they are simple messages. ***PD foods should be promoted through such groups and farmers associations*** so more households can grow and consume micronutrient rich low-cost foods.

By integrating the PD messages derived from the formative research within the community, ***there will be a promotion of high impact behaviour changes to the larger population beyond households with malnourished children.***

PDH+ is able to integrate prevention or food security interventions to better address the outcomes of preventing and rehabilitating malnourished children holistically. PDH+ can be implemented in a phased approach, for example, focusing on implementing decentralized GMP in the first two years of implementation and then integrating PDH implementation for the following three years. Other prevention or food security interventions could be implemented as contextually appropriate.

5. Monitoring systems

It is ***important to ensure standard World Vision monitoring systems*** like the PDH database or any mobile phone application and the Design and Implementation Quality Assurance (DIQA) tool are used. It is important to use these systems on a regular basis. Data should be entered into the PDH database monthly or quarterly. The IQA tool should be used bi-annually or annually to assess the programme fidelity and to identify areas needed to be improved for better results. ***(Use PDH Database or mobile phone applications monthly or quarterly; DIQA tool bi-annually or annually).***

10 Min

2. Key Supplemetary Docs

Go through each of the key documents that may assist in planning for PDH and PDH+ implementation and scale up including*:

1. ***PDH DIQA tool***
2. ***PDH Costing Tool***
3. ***PDH Log Frame***
4. ***PDH Target setting formula***
5. ***List of PDH+ core global indicators***
6. ***PDH Action Plan Template***
7. ***PDH Budget Table Template***

*Documents can be found on PDH+ Microsoft Teams Channel or wvCentral's document library.

PD/Hearth Action Plan

SESSION 40

45 MIN | DAY 9

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

1. Draft a AP or district or region/province group PDH action plan
2. Receive feedback on their plans from national adviser and facilitators.

Preparation

- Print Handout 40.1

Materials

- Handout 40.1: PDH Action Plan

STEPS

15 Min

1.

HANDOUT
40.1 – 218m/H 88

Participants from each AP or district or region/province group work together to develop an action plan based on the questions on Handout 40.1: 'PDH Action Plan'.

30 Min

2.

Each AP or district or region/province group briefly presents its action plan. Participants and facilitators give feedback on the plan.

Prepared By_____Date_____

	Activities	Person(S) Responsible	People To Involve	People To Attend	# Of Participants	Dates	Materials Required
1.1	Setup a regular Growth Monitoring Program and decentralize if possible						
1.2	Decide whether PDH approach is feasible in the target community using secondary data or recent GMP data (within last 6 months, more recent, the better)						
2.1.1	Meet with MoH staff (e.g. Health Centre, District Health office) and explain the PDH approach to obtain buy-in and support						
2.1.2	Identify community leaders using existing community health volunteers and plan to meet with community leaders, religious leaders and women representatives						
2.2.1	Ask community leaders for their permission and invitation to use the PD approach						
2.2.2	Ask the existing local health systems committees (e.g. Village Health and Sanitation committee or Village Health committee) for their support with PD approach and discuss ways to describe PD concept in local language through stories or skits. Discuss volunteer selection if particular volunteer group does not already exist or if existing volunteers have high workload.						

Prepared By_____Date_____

	Activities	Person(S) Responsible	People To Involve	People To Attend	# Of Participants	Dates	Materials Required
2.3	Engage the community to define the problem - conduct first community introduction meeting. Discuss about the issue of childhood malnutrition, some causes and common challenges and constraints and PD concept and PDH program. Involve men, grandmothers and mothers, health centre staff, traditional birth attendants (TBAs), traditional healers and religious leaders.						
3.1	Conduct community mapping and transect walk						
3.2	Conduct Wealth Ranking with community members						
3.3	Conduct Weighing of all children 0-35 months of age; Seasonal Calendar; and Market Survey						
3.4	Analyze the situation analysis findings						
3.5	Conduct community feedback session: share the results of the situation analysis. Share results of the weighing with the community and re-explain the PD concept through visual posters or skits. Also can share the community mapping and seasonal calendar flip charts. Discuss the volunteer identification if volunteers have not been selected yet and select volunteers.						
4.1	Prepare for PDI - identify 4 PD, 2-3 Non-PD and 1-2 ND HHs to visit. Visit 1-2 HHs with children with disabilities yet who are healthy (Optional if including disability). Have volunteers help locate the households.						

Prepared By_____Date_____

	Activities	Person(S) Responsible	People To Involve	People To Attend	# Of Participants	Dates	Materials Required
5.1	Analyze the PDI data/results						
5.2	Design the 6 key Hearth messages						
5.2	Conduct community feedback session: Share PDI findings with community.						
5.3	Design the Hearth menu						
5.4	Conduct volunteer training (3 full days or 5 half days) - teach Hearth messages and menu; monitoring forms; etc.						
5.5	Identify PDH participant children and primary caregivers. Meet with PDH participants 1-2 weeks before first day of Hearth to discuss location and time for meeting and decide what and how much of ingredients each primary caregiver will bring. Check the child's health card to ensure child received full immunization for age, Vitamin A in last 6 months and deworming (if appropriate).						
5.6	Inform volunteers and Health centre staff of PDH participant children and primary caregiver and ask for their support in providing participant children with immunization, Vitamin A and/or deworming if necessary for some children.						
6.1	Ensure all cooking equipment and monitoring forms are available for Hearth volunteers before the 1st day of Hearth.						
6.2	Conduct first Hearth session 10-12 days long.						

Prepared By_____Date_____

	Activities	Person(S) Responsible	People To Involve	People To Attend	# Of Participants	Dates	Materials Required
7.1	Conduct follow-up training day with volunteers to provide feedback						
8.1	Volunteers conduct 2-3 days of Household follow-up visits for 2 weeks after Hearth.						
8.2	Repeat Hearth as needed. Monitor weight of PDH participant children at 1 month, 3 month, 6 month, and 12 month from 1st day of Hearth.						
8.3	Enter monitoring data into PDH Excel or Online Database						
8.4	Involve community in monitoring progress in the nutritional status of all children in the target group or PDH participant children (optional).						
8.5	Conduct Appreciation/Graduation Day for community (optional).						
9.1	Involve community in monitoring progress in the nutritional status of all children in the target group or PDH participant children (optional).						
10.1	Expand PDH program to additional communities if needed						
10.2	Develop an exit strategy for once underweight is eliminated or ADP phases out						

SESSION 41

Final Evaluation and Closing

World Vision

40 MIN | DAY 9

By the end of the session, participants will have

1. Identified key areas of learning
2. Provide feedback on the training
3. Received a certificate of participation.

Preparation

- Flip chart with 'Target Evaluation Dart Board'
- Print Handout 41.1
- Certificates for all participants

Materials

- 'Target Evaluation' flip chart from Day 1 for comparison
- Eight small stickers for each participant
- Handout 41.1: 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 41). 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
41.1 – 224m/H 92

Have participants fill out Handout 41.1: 'Evaluation Form' (an evaluation form for the course).

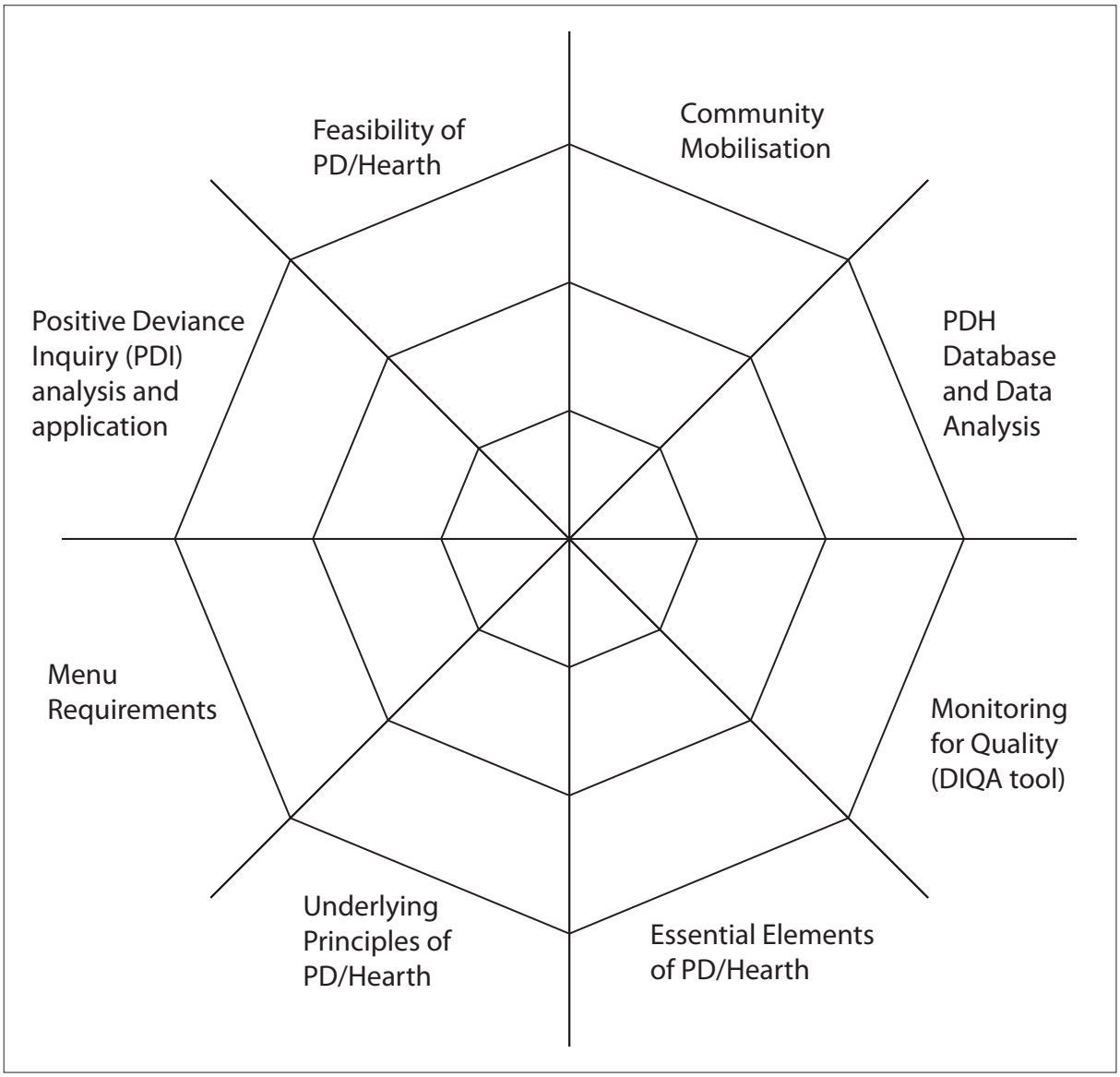
Flip Chart 41
Target Evaluation Dart Board

10 Min

3. Explain the next steps in TOF training:

- Each participant will submit to the national adviser his or her action plans.
- Each participant will receive his or her final marks and next steps from the national office.

4. Thank the host country, planners and logistics people. Thank participants for their great work.



Workshop Evaluation: World Vision PD/Hearth Training of Facilitators Workshop

EVALUATION

Thank you for attending this year's PDH Training of Facilitators. We hope you enjoyed your time, and that the workshop was a meaningful experience for you. Please take a few minutes to complete this evaluation. Your feedback is valuable and provides helpful information that will be used to plan the next workshop.

1. What did you expect from the workshop?

   _____
   _____
   _____

2. What do you feel was the most helpful part of the workshop? (for example, a particular session, a working group, a contact you made, certain resource material you obtained)

   _____
   _____
   _____

3. Please share some specific ways that you and/or your programme will apply the helpful information you noted in question #2.

   _____
   _____
   _____

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

   _____
   _____
   _____

5. What would you do to improve this?

   _____
   _____
   _____

6. What would recommend for the next workshop?

   _____
   _____
   _____

7. What themes or topics would you suggest that we focus on or go into in more detail?

   _____
   _____
   _____

8. Should more background information be provided at the beginning of the workshop/training? What information?

   _____
   _____
   _____

9. Other:

_____
_____
_____

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent).

Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent).

Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

For you, what was the highlight of this workshop?

_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

Thank you for your feedback!

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