World Vision

Sustainable Health

FACILITATORS
HANDOUTS

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

THIRD EDITION

World Vision International

World Vision

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

FACILITATORS HANDOUTS

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World Vision International

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Orientation and Training Curriculum for Staff Backstopping Positive Deviance/Hearth Programmes. The publication of the original Facilitator's Guide was made possible by support of the United States Agency for International Development (USAID) under cooperative agreement FAO-A-00-98-00030.

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A previous version of the manual was lead authored by **Naomi Klaas (consultant) and Diane Baik**. The first draft was developed with support from **Judiann McNulty (consultant) and Donna Sillan** who was the primary author of the PDH CORE Manual.

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PLEASE NOTE: There can be more than one page for a handout. Page counts appear in the item lines for any handouts having more than one page. Multiple page handouts are designated on their respective pages as "page # of # pages".

The (page #m) refers to where each handout appears in the PD/Hearth Facilitator Manual. You can reference the "#m" at the bottom of each handout page as well.

DAY 1

DAY 2

DAY 5

DAY 6

DAY 7

DAY 8

DAY 9

Goal

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

- train others
- provide technical support
- monitor implementation.

Training objectives

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

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

Day and Date	Session	Activities	Time
Day 1:			
1		Devotion	15 min
	1	Opening remarks Introductions (Ice breaker) Expectations and Objectives, Parking Lot Workshop Norms (Form Review Volunteer Groups) Target Evaluation Brief Overview of training (Evaluation method and go through overview/ field visits) Admin issues & logistics	90 min
	2	Pre-test	35 min
	3	What is Malnutrition? – Activity (3 types of malnutrition: underweight, stunting, wasting; Malnutrition cycle; Local terminologies)	95 min
		National prevalence (5 min) & 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

Flip Chart 6
Ten Key Steps in the PD/Hearth Approach

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

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

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

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

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

Case 2 – North interior – 35 per cent malnutrition

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

Case 3 – Northeast – 32 per cent malnutrition

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

Case 4 – South farming community – 39 per cent malnutrition

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

Case 5 – Peri-urban – 20 per cent malnutrition

Families live in densely populated squatter settlements in simple houses with no sanitation. Water is fetched from central water taps some distance away. Families have easy access to health facilities. Because the houses are so small, most families do not cook at home. They buy cooked food from street vendors and snacks from the many small shops. Most women are at home during the day. Those who work leave their children in the care of older women. There are approximately 40 moderately and severely underweight children between the ages of 6-35 months.

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

1. **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.

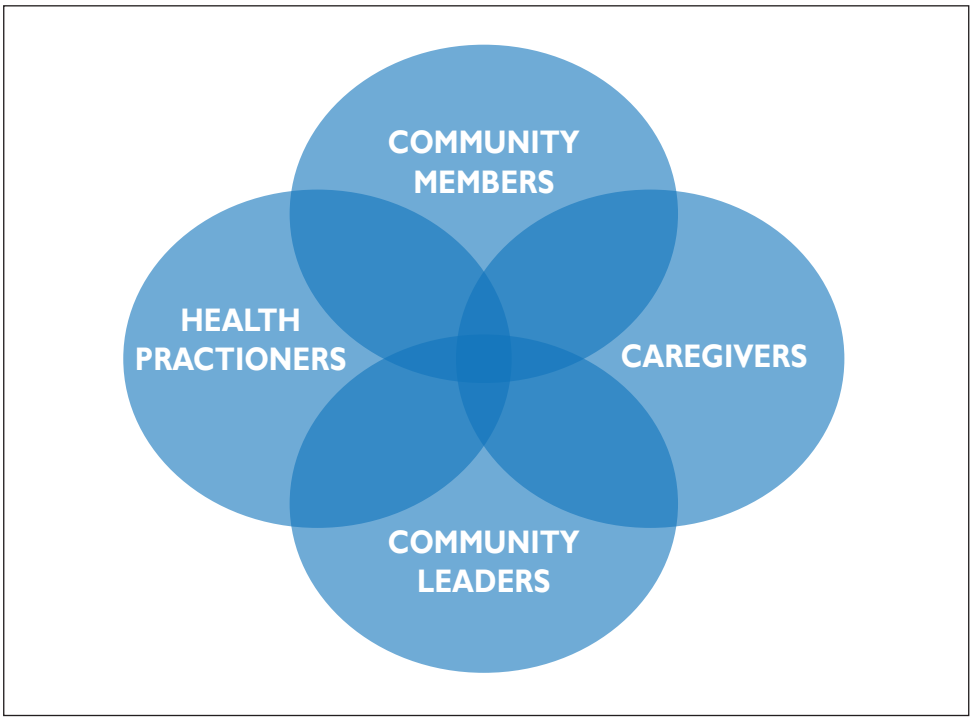
5. ***There is access to basic complementary health services.*** Health services are necessary for the children to receive inputs not available at the Hearth, such as deworming, immunisations, malaria treatment, micronutrient supplementation and referrals. Children receive the needed services ***before*** 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. PD/Hearth is intended to be only one phase of a wider nutrition programme.

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

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



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

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

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

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

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

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

What is the role of grandmothers?

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

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

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

15 Min

2.

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

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

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

Discuss the following questions:

How do you get maximum commitment and support?

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

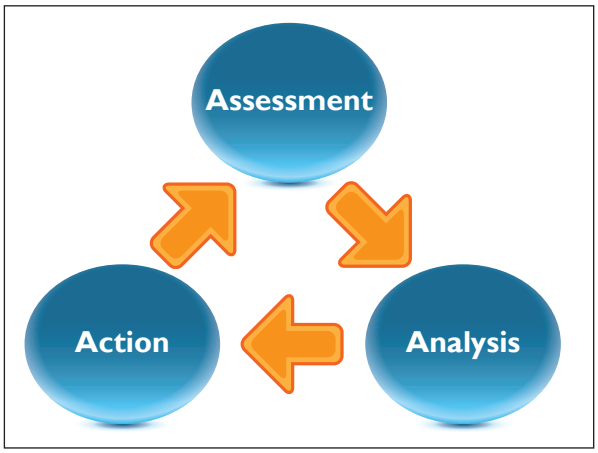
How do you keep this involvement throughout the project?

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

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

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

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



STEPS FOR COMMUNITY MOBILISATION AND OWNERSHIP:

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

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

Step 2B Ask about the existing local health systems (e.g. Village Health and Sanitation Committee (VHSC), VHC (Village Health 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.

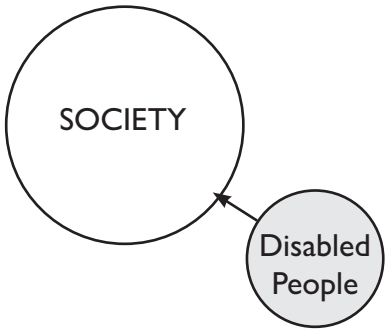
The 3 Approaches to Disability

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

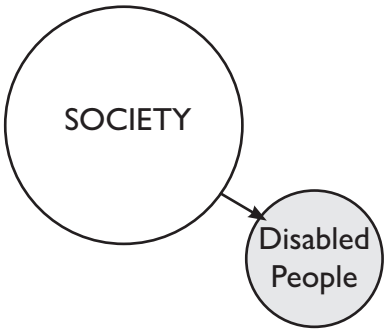


Activities 'fix' disabled person, who is 'sick', so they can join 'normal' society

- 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

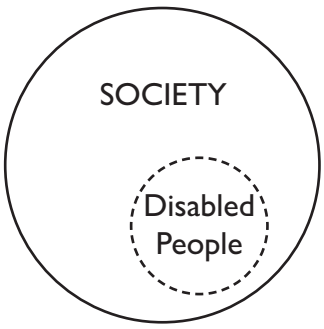


Activities 'help' disabled person who is 'helpless' and outside 'normal' society

- 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

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

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

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

Case Examples for Wealth-Ranking Exercise ANSWER KEY

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

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

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

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

WEALTH STATUS	WEALTH CLASSIFICATION CRITERIA
POOR	
NON-POOR	

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 (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	0	3.3	2.9	2.5	2.1	F	0	3.2	2.8	2.4	2.0
M	1	4.5	3.9	3.4	2.9	F	1	4.2	3.6	3.2	2.7
M	2	5.6	4.9	4.3	3.8	F	2	5.1	4.5	3.9	3.4
M	3	6.4	5.7	5.0	4.4	F	3	5.8	5.2	4.5	4.0
M	4	7.0	6.2	5.6	4.9	F	4	6.4	5.7	5.0	4.4
M	5	7.5	6.7	6.0	5.3	F	5	6.9	6.1	5.4	4.8
M	6	7.9	7.1	6.4	5.7	F	6	7.3	6.5	5.7	5.1
M	7	8.3	7.4	6.7	5.9	F	7	7.6	6.8	6.0	5.3
M	8	8.6	7.7	6.9	6.2	F	8	7.9	7.0	6.3	5.6
M	9	8.9	8.0	7.1	6.4	F	9	8.2	7.3	6.5	5.8
M	10	9.2	8.2	7.4	6.6	F	10	8.5	7.5	6.7	5.9
M	11	9.4	8.4	7.6	6.8	F	11	8.7	7.7	6.9	6.1
M	12	9.6	8.6	7.7	6.9	F	12	8.9	7.9	7.0	6.3
M	13	9.9	8.8	7.9	7.1	F	13	9.2	8.1	7.2	6.4
M	14	10.1	9.0	8.1	7.2	F	14	9.4	8.3	7.4	6.6
M	15	10.3	9.2	8.3	7.4	F	15	9.6	8.5	7.6	6.7
M	16	10.5	9.4	8.4	7.5	F	16	9.8	8.7	7.7	6.9
M	17	10.7	9.6	8.6	7.7	F	17	10.0	8.9	7.9	7.0
M	18	10.9	9.8	8.8	7.8	F	18	10.2	9.1	8.1	7.2
M	19	11.1	10.0	8.9	8.0	F	19	10.4	9.2	8.2	7.3
M	20	11.3	10.1	9.1	8.1	F	20	10.6	9.4	8.4	7.5
M	21	11.5	10.3	9.2	8.2	F	21	10.9	9.6	8.6	7.6
M	22	11.8	10.5	9.4	8.4	F	22	11.1	9.8	8.7	7.8
M	23	12.0	10.7	9.5	8.5	F	23	11.3	10.0	8.9	7.9
M	24	12.2	10.8	9.7	8.6	F	24	11.5	10.2	9.0	8.1
M	25	12.4	11.0	9.8	8.8	F	25	11.7	10.3	9.2	8.2
M	26	12.5	11.2	10.0	8.9	F	26	11.9	10.5	9.4	8.4
M	27	12.7	11.3	10.1	9.0	F	27	12.1	10.7	9.5	8.5
M	28	12.9	11.5	10.2	9.1	F	28	12.3	10.9	9.7	8.6

*NOTE: Depending on the country guidelines, each country can use either with or without '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 (Mild)	Orange (Moderate)	Red (Severe)	Sex	Age (mon)	Green (Normal)	Yellow (Mild)	Orange (Moderate)	Red (Severe)
M	29	13.1	11.7	10.4	9.2	F	29	12.5	11.1	9.8	8.8
M	30	13.3	11.8	10.5	9.4	F	30	12.7	11.2	10.0	8.9
M	31	13.5	12.0	10.7	9.5	F	31	12.9	11.4	10.1	9.0
M	32	13.7	12.1	10.8	9.6	F	32	13.1	11.6	10.3	9.1
M	33	13.8	12.3	10.9	9.7	F	33	13.3	11.7	10.4	9.3
M	34	14.0	12.4	11.0	9.8	F	34	13.5	11.9	10.5	9.4
M	35	14.2	12.6	11.2	9.9	F	35	13.7	12.0	10.7	9.5
M	36	14.3	12.7	11.3	10.0	F	36	13.9	12.2	10.8	9.6
M	37	14.5	12.9	11.4	10.1	F	37	14.0	12.4	10.9	9.7
M	38	14.7	13.0	11.5	10.2	F	38	14.2	12.5	11.1	9.8
M	39	14.8	13.1	11.6	10.3	F	39	14.4	12.7	11.2	9.9
M	40	15.0	13.3	11.8	10.4	F	40	14.6	12.8	11.3	10.1
M	41	15.2	13.4	11.9	10.5	F	41	14.8	13.0	11.5	10.2
M	42	15.3	13.6	12.0	10.6	F	42	15.0	13.1	11.6	10.3
M	43	15.5	13.7	12.1	10.7	F	43	15.2	13.3	11.7	10.4
M	44	15.7	13.8	12.2	10.8	F	44	15.3	13.4	11.8	10.5
M	45	15.8	14.0	12.4	10.9	F	45	15.5	13.6	12.0	10.6
M	46	16.0	14.1	12.5	11.0	F	46	15.7	13.7	12.1	10.7
M	47	16.2	14.3	12.6	11.1	F	47	15.9	13.9	12.2	10.8
M	48	16.3	14.4	12.7	11.2	F	48	16.1	14.0	12.3	10.9
M	49	16.5	14.5	12.8	11.3	F	49	16.3	14.2	12.4	11.0
M	50	16.7	14.7	12.9	11.4	F	50	16.4	14.3	12.6	11.1
M	51	16.8	14.8	13.1	11.5	F	51	16.6	14.5	12.7	11.2
M	52	17.0	15.0	13.2	11.6	F	52	16.8	14.6	12.8	11.3
M	53	17.2	15.1	13.3	11.7	F	53	17.0	14.8	12.9	11.4
M	54	17.3	15.2	13.4	11.8	F	54	17.2	14.9	13.0	11.5
M	55	17.5	15.4	13.5	11.9	F	55	17.3	15.1	13.2	11.6
M	56	17.7	15.5	13.6	12.0	F	56	17.5	15.2	13.3	11.7
M	57	17.8	15.6	13.7	12.1	F	57	17.7	15.3	13.4	11.8
M	58	18.0	15.8	13.8	12.2	F	58	17.9	15.5	13.5	11.9
M	59	18.2	15.9	14.0	12.3	F	59	18.0	15.6	13.6	12.0
M	60	18.3	16.0	14.1	12.4	F	60	18.2	15.8	13.7	12.1

WHO Weight-for-Age Reference Table

Weight-for-age Standard Table – Boys and Girls 0–59 months (WHO) (Without '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: **I) 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	

Initial Assessment Worksheet

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)

Market Survey for PD/Hearth (Cost Variance)

World Vision

Day 2 Session 15

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

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

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

Market Survey for PD/Hearth (Quantity Variance)

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

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

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

Seasonal Calendar for PD/Hearth

World Vision

Day 2 Session 15

DATE ..... ADP ..... 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																

Identitfying 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	

Identitfying 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

(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?

Sample Guiding Questions for Conducting a PDI

Good Child Care (try to observe without asking)

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

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

Day 4 Session 22

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

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

- ☐ 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

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.

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

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

Calories: 600–800 (500–600*)

Protein: 25–27g (18–20g*)

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

Iron: 8–10mg

Zinc: 3–5mg

Vitamin C: 15–25mg

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

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

Directions for the Menu-Preparation Exercise

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

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

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

Cooked rice, divide by 2

Cooked beans, lentils, pulses, divide by 2

Cooked porridge, divide by 2.5

Cooked green leaves, multiply by 1.4

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

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

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

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

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

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

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

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

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

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

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Sample Menu-Planning Form

Menu A:

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

Menu B:

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

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

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

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

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

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

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

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

Step-by-Step Instructions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. **Design optimal Hearth menus based on locally available and affordable foods.** Participating families must be able to replicate meals in their own homes with limited resources. This is the only way they will be able to sustain the improved nutritional status of their children and prevent future malnutrition in the family. The affordability of foods is verified through the PDI, which

discovers the foods used by the poor families with well-nourished children, and the market survey, which explores the costs and nutritional content of foods available for purchase.

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

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

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

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

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

10. **Conduct the Hearth session for 10–12 days within a two-week period.** Within 8–12 days of starting the Hearth sessions caregivers will see notable improvement in their children. They may need some guidance to recognise the changes in their child, such as improved appetite, increased activity, less irritability, higher level of alertness. Recognising these changes motivates the caregivers to adopt new feeding, caring and health practices. If a child is not fed the special extra meal over sequential days, recovery will be so slow that the caregiver will not have the satisfaction and motivation to continue the programme. There may be breaks of one or two days during the Hearth

sessions to allow for weekends, holidays, or market days *(e.g. 4 days + market day + 4 days + market day + 4 days)*. The family must be encouraged to prepare the special meal at home on the days off. This Hearth session may be repeated the next month as some children will not experience 'catch-up' growth within a month.

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

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

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

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

Essential Elements of PD/Hearth Detailed Observations and Key Questions

Summary components and sample questions to guide discussion on essential elements

Essential PD/Hearth project elements	Key questions to consider
1. Actively involve the community throughout the process. Leaders and/or the village health committee (VHC) provide support in organising weighings, finding volunteers, conducting PDIs, contributing supplies and participate in monitoring implementation/results. Individuals with influence on child care and feeding, particularly grandmothers, are engaged as advisors, mobilisers, volunteers, Hearth participants etc. The higher the exposure and involvement, the greater the impact on community overall nutrition status. Raising the consciousness of the community is empowering.	• How was the community mobilised? • What did the community contribute to the project? • How were grandmother and other influential figures engaged? • What information was given back to the community? When? • Have structures/policies that support child nutrition changed? • Was PD/Hearth integrated with other programmes/ sectors? How was this achieved? What were the results?
2. Use growth monitoring to identify malnourished children and to monitor participants who have graduated. If growth monitoring is not already in place, begin monitoring those who complete Hearth sessions and all children in target group over time. Growth monitoring must include counselling and explanations of a child's growth.	• Is routine growth monitoring present in the community? • Is counselling included? • How are children monitored after graduation?
3. Conduct a PDI in every community. A PDI is an opportunity for the community to make discoveries, not just to provide information to WV. To ensure community ownership, integrate the PDI into the Hearth sessions. A PDI may need to be done at different seasons. The goal is to identify PD practices, not only PD person.	• How were the families to visit identified? • How was the PDI conducted? By whom? • How was information analysed? • Were PD foods/practices identified? • How were grandmothers involved? • How was the information utilised? Menus/ messages? • Was there sufficient technical skill to complete the PDI well?
4. Prior to sessions, deworm all children and provide immunisations and micronutrients. The purpose is to support rapid recuperation. Refer families to the local health centre before Hearth sessions so recuperation is not attributed to these activities. In endemic areas, malaria may need treatment before Hearth sessions.	• Was a situation analysis completed (nutritional assessment, feeding practices, expanded programme of immunisation coverage, vitamin A)? • Were all children under three years of age weighed? • Were children dewormed, immunised, vitamin A supplementation completed? • Were pre-existing underlying illnesses treated?

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

Essential Elements of PD/Hearth Detailed Observations and Key Questions

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

1st case: Aisha is three years old, and an only child. After two Hearth sessions, she has gained 800 grams but is still moderately malnourished. Her mother, who is pregnant, appears to be following the new PD behaviours and working hard to rehabilitate Aisha, but she is becoming discouraged. The grandmother is taking care of Aisha during her pregnancy and advising her to continue feeding Aisha with what they learned at Hearth. The grandmother is confused that her daughter-in-law is discouraged and that the volunteers say that Aisha is still malnourished when she is looking very healthy, active and growing well.

2nd case: Tobir Village has many malnourished children, and Hearth sessions are proceeding well. However, some segments of the population are semi-nomadic, moving with the seasons to find work. Though these caregivers have been enthusiastic participants, it is difficult to follow their children during the dry season. Many return during the rainy season having lost weight again.

3rd case: Daniel is 23 months old. He and his mother (who also has two older children) just completed one Hearth session. His weight has not improved. The supervisor suspects, from her home visits, that the mother is preparing some extra food but sharing it with the whole family. The grandmother may support sharing the extra food with the entire family too.

4th case: During the sessions Budi gained 500 grams. By the end of the follow-up period he had lost the 500 grams.

Checklist of Materials Needed for PD/Hearth Sessions

The supervisor and volunteers ensure the following items are available forthe PD/Hearth Sessions

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

PD/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 s (✓)) 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.

HANDOUT 35.3B

Child Registration and Attendance Form (including Grandmothers)

Day 8 Session 35

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 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.

World Vision

Hearth Register and Monitoring Form

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.

Hearth Register and Monitoring Form

World Vision

Day 8 Session 35

2 OF 2

ADP Name ..... Village Name .....

Name of Hearth .....Volunteer's Name(s) .....

	CHILD	1	2	3	4	5	6	7	8	9	10
At Day 30 of Hearth	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Weight gain (Month 1 - Day 1 weight) in grams										
	Gained 400g+ (Y/N)										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 3 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	Change in Status (Y/N)										
	MUAC (Optional)										
At 6 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
At 12 months (since 1st day of Hearth)	Date (dd/mm/yyyy)										
	Weight (Kg)*										
	Underweight Nutritional Status (Indicate colour)										
	MUAC (Optional)										
	CHILD	1	2	3	4	5	6	7	8	9	10
	COMMENTS (Explain reason for default if child has defaulted due to death (D), migration (M), referred to hospital (H), etc.)										

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

ADP Name ..... Village Name .....Caregiver's Name .....

Child's Name ..... Dates of Sessions.....Name of Hearth ..... Volunteer .....

OBSERVATION LIST	Day #	Day #	Day #	Day #	Day #	Day #	COMMENTS
Answer with Yes (Y) or No (N) or Somewhat (S) or a number where appropriate. Add comments to explain answers.							
Drinking water from safe source (borehole or protected well)							
Water is treated (Boiled/ chlorine)							
Water is covered with fitted cover or lid							
Clean separate cup is used for pouring drinking water from the pot							
Handwashing station exists (e.g. tippy tap)							
Jerry cans or water storage containers are clean							
Toilet/latrine is available and used or hole is dug and covered for defecation							
House and/or kitchen is clean							
Food utensils are clean							
Handwashing with running water and soap is practised by: Caregivers							
Children							
Other family members							
Food prepared is nutrient dense as learned in Hearth (includes all 3 food groups: protective, body building and energy foods)							
Size of portion served is age appropriate							
Caregiver actively feeds the child							
Child is offered more food after finishing first portion							
Caregiver says child is fed 4 - 5 times / day (including snacks)							
Child uses separate (own) plate, bowl, or cup							
Caregiver is motivated by changes in the child							
Yesterday night, mosquito net was used by the primary caregiver and all children U5 in the household							
Caregiver can say what to do when child is sick (example: feeds more liquid when child has diarrhea and feeds more frequently)							
Caregiver expresses being able to continue practising what was learned in Hearth at home							
Problems and questions about child feeding and care is discussed with the volunteer							

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.

User Guide for the PD/Hearth (PDH) Excel Database

The PDH Excel Database is used to compile all the data collected during the initial assessment (situation analysis), PDH registration, and for monitoring and follow up of children in the PDH programme. This allows easier access and utilisation of data by staff. For example, clear summary tables are generated and available under different tabs. From the data collection forms (e.g. Child Registration, Hearth Register and Monitoring Form), staff can transfer recorded information into appropriate cells/columns in the PDH database. Some of the cells/columns contain a drop-down menu or a formula. This formatting is convenient and helps to reduce data entry or calculation errors. For example, child's age (months), underweight nutritional status, WAZ scores, and weight change (g) are calculated automatically.

In the PDH Excel Database, there are eight tabs or worksheets: Initial Assessment; Assessment Report; Monitoring Form; Table; Annual Report; Graph Follow-up; Graph Graduation & Weight Gain; and Graph Default. However, you only need to enter data under two tabs: Initial Assessment and Monitoring Form. All other tabs contain summary charts (e.g. tables, graphs) automatically generated from the compilation of inputted data. ***Please note, when entering the dates, follow the format provided i.e. DD/MM/YYYY.*** Make sure the default date on your computer is set as DD/MM/YYYY for smooth operation of the database. To change the default date format on your computer, see ***Note** below.

Tab 1 - Initial Assessment: Enter the registration, initial nutrition assessment and wealth-ranking data for PDH participant children under this tab. From this data, the PD, non-PD, and negative deviant households are identified and displayed under the "Classification" column.

- First, select an appropriate option for the Wealth Ranking Category (i.e. Very Poor, Poor, Rich or Poor, Non-Poor) and the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu for each at the top of the worksheet.
- Enter values under each column according to the headings. Enter values only in the "WHITE" cells as the values in grey-coloured cells (e.g. Current Age, Underweight Nutritional Status, Classification columns) are calculated automatically by the computer. For the Sex, Oedema, MUAC, Wealth Rank and PDI HHs columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 2 - Assessment Report: This tab contains a table and a pie chart which categorizes the total number of children from the initial assessment based on their underweight nutritional status (i.e. % of children who are normal weight or mildly, moderately or severely underweight). This gives a clear picture of the initial level of childhood malnutrition in the community.

Tab 3 - Monitoring Form: This tab contains a monitoring form to track changes in child's weight, weight-for-age Z score, and underweight nutritional status in the hearth sessions and the follow-ups, including reasons for default. Additional registration information, such as deworming, vitamin A supplementation, presence of oedema, and full immunisation status is also entered under this tab. Based on the child's nutritional status at 3 months, next course of action is identified for each child (i.e. not graduate and repeat hearth, or graduate and continue monitor).

- First, select an appropriate option for the Nutritional Status Category (i.e. Severe, Moderate, Mild, Normal or Severe, Moderate, Normal) based on your country context, using the drop-down menu at the top of the worksheet.
- Enter values under each column according to the heading. Enter values only in "WHITE" cells as the values in grey-coloured cells (i.e. Current Age, WAZ, Nutritional Status, Weight Change, Adequate Weight Gain columns) are calculated automatically by the computer. For the Oedema, Deworming, Vitamin A Supplementation, Full Immunisation, Sex, Round/Session # and Default Reason columns, use the drop-down menu to select an appropriate choice for each cell.

Tab 4 - Table: This tab contains nine summary tables based on the monitoring data. The tables show the number of children (and %) based on underweight nutritional status at different time points (e.g. baseline, Day 12, Day 30, 3 months, 6 months and 1 year), number of children (and %) with adequate or inadequate weight gain and amount of average weight gain (at Day 12, 30 and 3 months), and number of children (and %) with improvement or no improvement in their nutritional status to mild/healthy status (at Day 12, 30 and 3 months), as well as the breakdown of the reasons for child default from PDH.

Tab 5 - Annual Report: This tab contains a PDH summary report for the selected fiscal year. The table contains information about number of children who gained adequate or inadequate weight in PDH session (Day 12) and at follow ups (1 and 3 months), as well as number of children in different underweight nutritional status categories (i.e. green, yellow, orange, red) at 6 and 12 months post-Hearth. Also, information about the total numbers of children weighed and those who defaulted is provided along with the breakdown of children based on their enrollment (i.e. 1st, 2nd or 3rd round/session).

- To generate a report, enter ADP name and use the drop-down menu to select or enter a fiscal year.

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

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

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

***NOTE:**

To change the default date format on your computer:

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

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/Resileince Intervcentions			
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/Resileince Intervcentions			
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/Resileince Intervcentions			
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

Action Plan for PDH Implementation

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.						

Action Plan for PDH Implementation

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						

Workshop Evaluation: World Vision PD/Hearth Training of Facilitators Workshop

Day 9 Session 41

EVALUATION

Thank you for attending this year's PD/Hearth Training of Facilitators. We hope you enjoyed your time, and that the workshop was a meaningful experience for you. Please take a few minutes to complete this evaluation. Your feedback is valuable and provides helpful information that will be used to plan the next workshop.

1. What did you expect from the workshop?

   _____
   _____
   _____

2. What do you feel was the most helpful part of the workshop? (for example, a particular session, a working group, a contact you made, certain resource material you obtained)

   _____
   _____
   _____

3. Please share some specific ways that you and/or your programme will apply the helpful information you noted in question #2.

   _____
   _____
   _____

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

   _____
   _____
   _____

5. What would you do to improve this?

   _____
   _____
   _____

6. What would recommend for the next workshop?

   _____
   _____
   _____

7. What themes or topics would you suggest that we focus on or go into in more detail?

   _____
   _____
   _____

8. Should more background information be provided at the beginning of the workshop/training? What information?

   _____
   _____
   _____

9. Other:

_____
_____
_____

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

Please rate the facilitator on the following, from 1 (Poor) to 5 (Excellent). Name of facilitator_____

Knowledgeable and interesting	1	2	3	4	5
Clear in communicating concepts, ideas, systems	1	2	3	4	5
Approachable	1	2	3	4	5
Responsive to participants' questions/comments	1	2	3	4	5

For you, what was the highlight of this workshop?

_____
_____
_____

_____
_____
_____

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

_____
_____
_____

_____
_____
_____

Thank you for your feedback!

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