Positive Deviance/Hearth Facilitator's Guide

Orientation and Training Curriculum for Staff Backstopping Positive Deviance/Hearth Programs

The Child Survival Collaborations and Resource Group
Nutrition Working Group
October 2003

The Child Survival Collaborations and Resources Group (The CORE Group) is a membership association of more than 35 U.S. nongovernmental organizations working to promote and improve primary health care programs for women and children and the communities in which they live. The CORE Group's mission is to strengthen local capacity on a global scale to measurably improve the health and well being of children and women in developing countries through collaborative NGO action and learning. Collectively, its member organizations work in over 140 countries, supporting health and development programs.

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Supplemental Resource:

Assessment of Active, Experiential Training on Program Expansion: Living University in the Positive Deviance/ Hearth Program in Vietnam, 2002

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This orientation and training is the culmination of strong interagency collaboration to bring the success of the PD/Hearth approach to life for a broader spectrum of programs around the world. Following on the publication of the detailed PD/Hearth Resource Guide (CORE, February 2003), this manual supports the training of nutrition program managers and staff who support field projects. The workshop sessions in this manual were tested and evaluated during two workshops in May 2003 (Alexandria, Virginia) and August 2003 (Davis, California). The facilitators of those workshops brought vast experience and a keen desire to share the PD/Hearth approach. They have continued to contribute time and energy to realize this final workshop design and, from it, to build an in-depth training program for field staff in PD/Hearth. Contributions from the following are gratefully acknowledged.

Members of the CORE Nutrition Working Group, particularly **Judiann McNulty**, Mercy Corps, Co-Chair of the Nutrition Working Group.

Facilitators of the Alexandria Workshop:
Lead trainer **Anne Siegle**, **Judiann McNulty, Monique Sternin** (consultant), **Kathryn Bolles** (Save the Children, formerly with CMMH), and CORE staff members **Karen Leban** and **Lynette Walker**.

Facilitators of the Davis Workshop:
Judiann McNulty, **Vanessa Dickey** (Mercy Corps), **Donna Sillan** (consultant), and **Cathy Speraw** (CMMH).

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Finally, great appreciation is owed those pioneers of the PD/Hearth approach who, through their dedication and hard work, have helped to shape an active role of the community in resolving problems of child malnutrition:
Monique and Jerry Sternin, for their work with the Positive Deviance approach and the 'living university' in Vietnam;
Gretchen and Warren Berggren, for pioneering the Hearth approach (nutrition demonstration foyers) in Haiti;
and the **numerous community volunteers and local staffs** where PD/Hearth was born.

Introduction

Orientation and Training for the Design and Implementation of a Positive Deviance/Hearth Program is a two and a half day workshop to enable managers to better design, implement and support sustainable community-based nutrition initiatives. These program managers include headquarters, regional and country-level staff of private voluntary/non-governmental organizations (PVOs/NGOs) and consultants; Ministry and district health officials; and others who manage nutrition programs. These are the people who would design a positive deviance/Hearth (PD/Hearth) program and/or provide backstopping/technical assistance during implementation and scale-up.

The lesson plans and materials in this manual are designed to be used in conjunction with *Positive Deviance/Hearth: A Resource Guide for Sustainably Rehabilitating Malnourished Children* (CORE, February 2003). This workshop is designed to provide program managers with a solid understanding of the principles of and criteria for a successful PD/Hearth program, as laid out in the PD/Hearth Resource Guide. It may help programmers to determine whether to pursue a PD/Hearth approach or clarify essential considerations for successful programming.

The workshop by itself, however, is not sufficient training for field staff that will actually implement a PD/Hearth program. Once the decision to undertake a PD/Hearth program has been reached, field staff should take additional training. Several CORE members have implemented country field trainings, which include hands-on practice with positive deviance inquiry and other important elements of the approach in a community setting. More information on such trainings is available through the CORE Group Secretariat.

Design of the Workshop

Initial design of the orientation and training workshop was guided by a learning needs and resources assessment sent to US-based NGO staff who had enrolled for the first (pilot) training session in May 2003. Approximately half of those first participants responded to the survey regarding their motivation for attending the workshop. Those respondents cited several expectations from a workshop on the Positive Deviance approach:

- Increased capacity to provide technical assistance to PD/Hearth programs in the field and to increase the quality of existing programs;
- Increased capacity to incorporate PD/Hearth into new project designs, to initiate pilot projects;
- Increased ability to contribute to the training of field staff and improved staff competency in PD/Hearth programming;
- Increased integration between Food Security and Health divisions;
- Increased awareness of the PD/Hearth approach and consideration of its potential use within interventions; application of the Positive Deviance approach to behavior change and safe motherhood activities.

The two and a half day workshop consists of 25 sessions, which follow the nine-step process outlined in the PD/Hearth Resource Guide:

Introduction/Overview of PD/Hearth	Sessions 1-3, 19
Step One	Session 4
Step Two	Sessions 5a & 5b, 20
Step Three	Sessions 6a & 6b
Step Four	Sessions 7 & 10
Step Five	Sessions 11, 12a & 12 b
Steps Six To Eight	Session 13, 14, 15, 21
Step Nine	Session 16
Monitoring and Evaluation	Session 22
Issues for Program Managers	Sessions 23, 24, 25

Beginning on page 8, a detailed Workshop Session and Materials Guide precedes the session plans. It indicates for each session the title, session objectives and time, and handouts and flipcharts used in that session.

Individual session plans are presented in three parts:

1. Session Preparation
   - Session objectives
   - Resource Guide reference pages
   - Any required advance preparation by the facilitator
   - A list of materials for the session, including handouts and flip charts

2. Session Steps, with approximate time for each step
   This workshop is centered on adult learning through active participation and discussion. The facilitator should guide discussion and group work to assure maximum participation. Important points that the facilitator should be sure are covered are noted in *italics, small font*.

3. Session Handouts and/or Flip Charts
   All supplemental materials follow the session plan, and have been numbered to correspond to the session in which they are used. For example, flip charts for Session 3 are numbered FC 3a, 3b, 3c, and so on. Handout 4 is used in Session 4. In the case of a split session (Session 12a and Session 12b), the numbering continues through both (Handouts 12a-12d in Session 12a; Handouts 12e and 12f in Session 12b).

Preparing for Training

- **Identify the lead facilitator and other members of the training team**
  It is recommended that trainers have PD/Hearth experience.
  The lead facilitator may be a consultant or PD/Hearth staff from an ongoing program. The CORE Nutrition Working Group can help identify qualified candidates for this important role.

  All facilitators should familiarize themselves with the workshop manual as well as the PD/Hearth Resource Guide prior to beginning the workshop. Each session plan for this workshop references the corresponding pages in the PD/Hearth Resource Guide.

  Identify small group leaders This workshop emphasizes hands-on work. Therefore there are numerous small group exercises throughout. It is best to change the composition of the small groups several times throughout the workshop to maximize the sharing of ideas and experiences. Some small group exercises continue from one session to the next and for these the group should remain the same. This is the case for sessions 3 and 4 on Day 1; and for sessions 10, 12a and 12b on Day 2. It is helpful for small group leaders to practice an exercise prior to the workshop to assure that it flows smoothly.

  Orient all facilitators It is important for the facilitation team to meet prior to the workshop, to practice exercises and role plays, gather sufficient examples of program materials, and review the session plans together.

- **Identify participants**
  Planning for implementing the Hearth approach should include careful consideration of potential partners in the program. This may include international partners, key programmers from the Ministry of Health or other ministries, child survival management staff of local NGOs, or frequently used consultants. The number of participants in a workshop should not exceed 25, in order to facilitate open discussion and active learning.

  If time permits, it is helpful to survey participants to learn about their expectations for the training as well as to learn what previous experience they may have had with positive deviance, Hearth, community development, situation analysis and other related topics. This knowledge will help facilitators to involve participants more and to build on their experience. (As with the PD/Hearth approach, the answers can often be found within the group.)

- **Secure an appropriate training site**
  Identify a training site that is accessible to all participants, and has adequate space for the large group as well as break-out space for small group exercises. There should be food service capabilities, as the training plan does not allow sufficient time for participants to go out for lunch and breaks.

Materials

As soon as possible, gather the resources needed to for the workshop. Several of the materials should be obtained in advance of the workshop from the CORE Group. This includes copies of the Resource Guide, this Orientation and Training Manual, and the SCF/BASICS video. Send the request by email: contact@coregroup.org. This manual comes with a CD-Rom that includes copies of reference materials as well as all handouts and illustrations referenced in the session plans.

- **The PD/Hearth Guide (Resource Guide)**
  The Resource Guide is the foundation of this workshop. Every participant will need to receive a copy of *Positive Deviance/Hearth: A Resource Guide for Sustainably Rehabilitating Malnourished Children* at the beginning of the workshop. Facilitators should receive a copy well in advance of the workshop. [1]
  To reduce the volume of handouts, wherever possible workshop sessions refer to materials already included in the Resource Guide (e.g. tables and charts; supervisory checklists).

- **Other resource materials**
  General reference materials
  Provide supplemental reference materials that have proved useful for programmers. These can be displayed on a table in the meeting room so that participants can look through them during breaks in the workshop.

  There have been many important documents published on subjects that are crucial to quality nutrition programming: community participation, adult learning, health education, monitoring and evaluation, nutrition, etc. The Resource Guide (pp. 185-188) lists some useful sources and websites to supplement knowledge in these areas. Additional information can be found on a website sponsored by the Positive Deviance Initiative with support from the Ford Foundation**: www.positivedeviance.org**

  Supplemental materials referenced in specific sessions
  Some resources are referenced in particular sessions. (Consult the session plan for source or website where these can be located.)

Session 3	See Handout 3c—a list of important PD/Hearth studies
Session 5a	Community Participation Resources (Guide, p. 185)
Session 6a	FANTA bookmarks (see next section); TALC publication & WHO guidelines on severe malnutrition
Session 12a	Palm Pilot (see below)
Session 14	A. Trinh article
Session 16	Articles by Pyle/Tribbets and by Sternin, Sternin and Marsh

[1] The Resource Guide is available in pdf format in English, French and Spanish on the CORE website at http://www.coregroup.org/working_groups/nutrition.cfm. For hard copies, email a request to CORE.

The training team should obtain at least one copy of each of the print materials, to be placed on the reference table. Brief articles may be copied as handouts, as appropriate.

Palm Pilot for Nutrient Calculation
Pocket PC Applications for Hearth Nutritional Rehabilitation Programs is a computer/palm pilot aid for calculating the nutritional value of Hearth menus. It also indicates whether a menu meets the requirements for nutritional rehabilitation in a Hearth program. A follow-up database allows the user to track changes (weight and nutritional status) in children attending Hearth. For a detailed description of the application and ordering information, see the CORE website (Nutrition WG) at **http://www.coregroup.org/working_groups/Pocket_PC_Applications_Hearth.doc.**
If several are available, participants may use the palm pilot during the menu planning exercise in session 12a.

Have facilitators bring materials to share
Facilitators from established PD/Hearth programs should bring with them:

- Samples of BCC materials used in PD/Hearth
- Forms used by the program, including local growth charts
- Any significant documentation of results

- **Handouts, Flip Charts, Other Session Needs**
  All materials designated as handouts should be copied in sufficient quantity for participants and facilitators in advance of the training. Prepare a similar number of folders and other participant materials. Facilitators should also prepare flip charts in advance as indicated for their sessions.

  FANTA bookmarks
  The bookmark contains information on nutritional assessment as discussed in session 6a. Orders can be placed on the FANTA website at www.fantaproject.org or by emailing fanta@aed.org. A printable copy is also included in the session plan (Handout 6e).

  Equipment needs:
  Session 3 requires the use of an LCD projector for PowerPoint. (Alternatively, an overhead projector may be used.)
  Session 11 requires a Video Cassette Player and the SCF/BASICS video on PD/Hearth. Request a copy from CORE (contact@coregroup.org).

During the workshop

- **Use a timeline/flip chart with PD/Hearth steps as a reference to guide participants and illustrate progress throughout the workshop**
  The timeline described in Session 3 should be prepared in advance with the PD/Hearth Steps clearly marked. This visual should be used to emphasize the steps.
    - Refer to the corresponding PD/Hearth step for each session.
    - Use to help clarify the progression/overall process as the training advances through the steps.
    - At the end of each day of the workshop, use the timeline to indicate progress made and to help review material covered.

- **Adapt materials and exercises** as needed **to reflect local resources and local realities** (for workshops done in-country). Wherever available, use local or national growth charts and nutrition composition tables, health care protocols (e.g. de-worming), etc.

- **Draw on the experience of the group—both participants and facilitators**, throughout the training. This is especially useful when describing adaptations to the PD/Hearth approach that may be necessary to meet local realities.

Workshop Session & Materials Guide				
Time	**Session #**	**Session Title**	**Session Objectives**	**Materials**
Day 1				
8:00 - 8:30	1	Arrival & Registration	▪ Receive needed materials to participate in the workshop. ▪ Resolve logistics.	PD/Hearth Guide Name tags Registration forms
8:30 - 8:50	2	Welcome/ TOT Objectives / Agenda / Introductions	▪ Review the workshop goal and desired outcomes. ▪ Meet the hosting agency and facilitation team. ▪ Summarize expectations and group norms.	Agenda (HO2)
8:50 - 10:20	3	Overview of PD/Hearth PD/Hearth as a Behavior Change Strategy	▪ Describe the PD/Hearth approach. ▪ Summarize the history of the PD/Hearth methodology and important influences. ▪ Explain the advantages of positive deviance and Hearth as behavior change strategies.	WHO/UNICEF diagrams (Guide) PD/Hearth Studies & Conclusions (HO3c) FC3a,b,c&d PD/Hearth PowerPoints (3 files)
10:20 - 10:35		**BREAK**		
10:35 - 12:00	4	**STEP 1**: Determining the Feasibility of PD/Hearth Approach for the Target Community	▪ Describe the assessment process and essential considerations for determining feasibility of the PD/Hearth approach in a target area. ▪ Evaluate the feasibility of the PD/Hearth approach for a target community (case study). ▪ Review alternative approaches to use when PD/Hearth is not feasible or appropriate.	Feasibility Analysis Case Studies (HO4) FC4—Essential Considerations for PD/Hearth
12:00 - 12:30	5a	**STEP 2**: Community Mobilization	▪ Describe successful community mobilization methods for involving key stakeholders and community members. ▪ Identify key stakeholders.	Reference copies of Community Participation Resources FC5a,b,c&d—Community Participation Discussion
12:30 - 1:15		**LUNCH on site**		
1:15 - 1:45	5b	**STEP 2** con't: Selection of Project Staff & Community Resource Persons	▪ Describe roles and responsibilities of staff and volunteers required for PD/Hearth, with overview of the organizational structure.	FC5a-d from Session 5a

1:45 - 3:00	6a	**STEP 3**: Preparing for the PDI - Gathering Data -Situational Analysis -Wealth Ranking -Nutrition Baseline	▪ Describe a situational analysis and identify potential sources of information. ▪ Identify the standards for and challenges of conducting a wealth ranking exercise. ▪ Explain the importance of and methods for conducting the nutrition baseline and ongoing monitoring activities. ▪ Describe anthropometric measurements recommended for use within PD/Hearth activities, and cite important issues for proper weighing technique.	PLA Tool (HO6a) Wealth Ranking Case Studies & Instructions (HO6b&c) WHO Guidelines for Severe MN (HO6d) FANTA bookmarks (or HO6e) Sample Growth Cards
3:00 - 3:30	6b	**STEP 3** con't: Identifying Positive Deviants	▪ Explain the criteria and process for selecting PD families. ▪ Practice selecting PD families utilizing nutrition baseline and wealth ranking exercise data.	FC6—PD definition Identifying PDs exercise (HO6f) Blank growth cards
3:30 - 3:45		**BREAK**		
3:45 - 5:00	7	**STEP 4**: Conducting the PDI: -Process, Methods, Tools and Training for conducting the PDI: Observation, Semi-structured Interviews, Home Visits	▪ Describe the process, tools and methods for conducting the PDI. ▪ Identify resource tools for conducting semi-structured interviews and observation during visits to PD households. ▪ Develop a logistical plan for training and conducting the PDI.	Guidelines from Monitrices (HO7) Flip Charts from previous sessions FC6—PD definition FC3b—Child Care Components
5:00 - 5:10	8	Day Summary and Wrap-up	▪ Identify key highlights from the day's activities.	FC3a—PD/Hearth steps FC for daily feedback
Day 2				
8:00 - 8:15	9	Review of Day's Agenda	▪ Summarize the workshop objectives and activities for Day 2.	FC3a—PD/Hearth steps
8:15 - 9:15	10	**STEP 4** con't: PDI Analysis & Feedback: Determining Feeding & Care Behaviors	▪ Describe the categories of behaviors that are identified during the PDI analysis. ▪ Describe the participatory processes for analyzing PDI data and selecting PD feeding, caring, hygienic and health-seeking behaviors to be used in Hearth sessions.	FC10—PDI Field Exercise Examples from PDIs (HO10a,b&c)
9:45 – 10:20	11	Overview of Hearth Sessions: SCF/BASICS Video Presentation	▪ Describe the activities that occur within a Hearth session.	FC3a—PD/Hearth steps SCF/BASICS Video FC11—What is Hearth? (discussion questions)
10:20 – 10:35		**BREAK**		

10:35 – 12:30	12a	**STEP 5**: Designing Hearth Sessions Hearth Protocols–Criteria & Choices Nutrients, Meals & Menu Preparation	▪ Discuss the two main objectives of the Hearth session (2-week Hearth + 2-week follow-up). ▪ Discuss Hearth logistics, criteria and choices. ▪ Describe important elements of planning nutritionally and culturally appropriate meals/menu for Hearth sessions. ▪ Calculate calorie and nutrient requirements to determine Hearth menu recipes/meals.	Food scale and local 'market' set-up For Menu Planning: Form (HO12a); Food composition tables(HO12b); Market surveys (HO12c); Instructions (HO12d); Palm Pilot, if available De-worming protocols FC3d (3 goals) FC11—What is Hearth? FC12a—Nutrients required
12:30 – 1:30		**LUNCH on site**		
1:30 – 2:00	12b	**STEP 5** con't: Health Education Schedule: Incorporating PDI Behaviors Participatory Education Methods	▪ Describe participatory health education methodologies that have been successful with Hearth Sessions. ▪ Identify the opportunities during a Hearth session for health education.	Sample Hearth schedule (HO12e) Exercises from Session 10 (HO10a,b&c) Samples of Hearth education materials and schedules, if available FC3d—Goals of PD/Hearth
2:00 – 2:30	13	**STEP 6**: Conducting the Hearth Session – Practitioners' Experiences	▪ Identify key factors that have contributed to the success of Hearth Sessions. ▪ Discuss adaptations made to meet contextual needs in successful Hearth programs.	Malawi Lessons Learned (HO13a) Haiti Monitrice Meeting Notes (HO13b)
2:30 – 3:00	14	**STEP 7**: Supporting New Behaviors through Home Visits & Community Feedback	▪ Summarize the objectives, activities, and frequency for home visits. ▪ Explain the objective and activities for providing community feedback.	Reference copies of A. Trinh article
3:00 – 3:15		**BREAK**		
3:15 – 4:00	15	**STEP 8**: Repeating Hearth Sessions as Needed Hearth One-Year Activity Plan Exit Strategy	▪ Describe an activity plan for year one of Hearth. ▪ Discuss considerations for children graduating from or repeating the Hearth sessions (Hearth protocols). ▪ Discuss ways to work with the community to design an exit strategy and/or to link Hearth with other programs.	Case studies for Hearth protocol (HO15a) Sample One-Year Hearth Plan with Haiti example (HO15b)
4:00 – 4:45	16	**STEP 9**: Expanding PD/Hearth: Steps for Expansion & Critical Success Factors	▪ Identify the critical factors for success in expanding a PD/Hearth program. ▪ Review steps for expansion of a PD/Hearth program. ▪ Discuss experiences from successful large programs in Viet Nam (Living University) and Nepal.	FC5a&b—Community Participation FC16—Process for Expansion Articles for facilitator background by Pyle/Tribbets; Sternin, et.al.; etc.
4:45 – 5:00	17	Day Summary and Wrap-up	▪ Identify key highlights from the day's activities. ▪ Address questions and concerns from participants about progress of the workshop.	FC3a—PD/Hearth steps FC for daily feedback

Day 3				
8:00 - 8:15	18	Welcome, Review of Day's Agenda	▪ Summarize the workshop objectives and activities for Day 3.	FC3a—PD/Hearth steps
8:15 - 8:45	19	Essential Elements & Key Steps for Hearth	▪ Identify the essential elements of a Hearth program. ▪ Discuss ways to begin a Hearth program, either as a stand-alone program, or integrated with other programs.	
8:45 - 9:30	20	Staffing & Resources Required: Job Task Analysis & Training Plan	▪ Conduct a task analysis to determine important attitudes and skills and identify which are inherent qualities and which are trainable skills. ▪ Discuss important criteria for selection of staff and volunteers. ▪ Describe important considerations in the design and implementation of training for community volunteers and staff.	FC20a—for task analysis exercise FC20b—Training: next steps
9:30 – 10:00	21	Performance Supervision of PD/Hearth Activities	▪ Identify several key quality indicators for monitoring PD/Hearth activities. ▪ Describe supervision tools that are available to ensure the quality of PD/Hearth activities.	FC21—Questions on Supervision
10:00 - 10:15		**BREAK**		
10:15 - 11:15	22	Monitoring & Evaluation -Fundamentals of M&E -Tools for Tracking Progress	▪ Review important indicators and tools for tracking progress (monitoring) and assessing impact (evaluation). ▪ Explain the purpose and use of the behavioral and weighing monitoring tools.	Haiti examples of Daily & Supervisor's Monthly Hearth Reports (HO22a&b) FC22a,b&c—3 goals FC22d—Triple A Cycle
11:15 - 11:45	23	Preparing the Program Proposal & Budget	▪ Identify the main components of a PD/Hearth program budget. ▪ Discuss funding potential and budget issues from program experiences.	FC3a—PD/Hearth steps Sample proposals, if desired
11:45 - 12:15	24	Getting Started in PD/ Hearth – Effective Use of Consultants	▪ Discuss key issues for program start-up. ▪ Outline potential roles for consultants.	Consultant's Tasks Checklist (HO24a) Sample Consultant SOW (HO24b) FC4a—Criteria for a PD/Hearth program
12:15 - 12:45	25	Follow-on Activities, Resources, Support Networks Workshop Evaluation & Closure	▪ Evaluate workshop activities and provide feedback on effectiveness of training methods.	Workshop Evaluation Form
12:45	**LUNCH on Site**			

Session 1: Arrival and Registration

Total time: 30 min **Led by:** Host agency/Lead organization

By the end of the session, participants will have:

1. Received materials needed to participate in the workshop.
2. Resolved logistics for their participation.

Preparation:

- Set up meeting logistics
- Assure that all facilitators are briefed and have necessary materials.

Materials:

- PD/Hearth Guide for each participant
- Name tags
- Registration forms

Steps:

1. Set up a registration table at the arrival location with staff from facilitating and co-facilitating organizations to help register participants.

2. Review arrangements for the meeting room(s), including seating, table placements, and breakout rooms; and equipment set-up (flip chart boards, easels, LCD projector or overhead, VCR). Confirm lunch and break times with providers (hotel or conference center management staff).

3. At the registration table, provide a registration form and nametags. Participants should be asked to sign in on the registration form and fill out a nametag. Each participant should receive a copy of the PD/Hearth Guide.

4. A separate table should be set up near the entrance to the main meeting room (or in the back of the room) to place extra copies of handouts, reference materials, etc. that participants may consult during breaks throughout the workshop.

5. Greet guests as they come in and review any logistics issues they may have.

Session 2: Welcome, TOT Objectives, Agenda, Introductions

Total time: 20 min **Led by:** Lead Facilitator

By the end of the session, participants will have:

1. Reviewed the workshop goal and desired outcomes.
2. Been introduced to the hosting agency and facilitation team.
3. Summarized participant expectations and group norms.

Preparation:

- Prepare flip chart with overall workshop goal:
  Equip program staff with the skills necessary to design, implement, monitor and evaluate a quality Positive Deviance/ Hearth intervention.

Materials:

- Agenda (Handout 2)
- Blank sheet of flip chart paper

Steps:

1. (5 min) The organization hosting the event should welcome participants and introduce the lead facilitator, as well as special guests in attendance for the opening session.

   Cover workshop logistics such as location of bathrooms and development of ground rules (promptness, cell phone etiquette, etc.). Encourage full participation in all discussions and small group work.

2. (5 min) Read the overall goal of the workshop. Based on this goal, solicit expectations and list on a separate sheet of flip chart paper.

3. (5 min) Distribute the workshop agenda and briefly review the planned workshop content. Note that the activities have been planned to encourage maximum discussion and hands-on work by participants. This is a 'hands-on' training.

4. (5 min) Introduce all facilitators and provide an overview of their involvement with PD/Hearth to date. If appropriate, have all participants briefly introduce themselves to the group.

   Review the group's expectations from step 2 and ask for questions on plans for the workshop.

PD/HEARTH Training of Trainers Workshop Agenda

Day 1	
Time	**Title/ Content**
8:00-8:30	Arrival & Registration
8:30 – 8:50	Welcome/ TOT Objectives / Agenda / Introductions
8:50 – 10:20	Overview of PD/Hearth PD/Hearth as a Behavior Change Strategy
10:20 - 10:35	**BREAK**
10:35 - 12:00	STEP 1: Determining the Feasibility of PD/Hearth Approach for the Target Community
12:00 - 12:30	STEP 2: Community Mobilization
12:30 – 1:15	**LUNCH on site**
1:15 - 1:45	STEP 2 (con't): Selection of Project Staff & Community Resource Persons
1:45 - 3:00	STEP 3: Preparing for the PDI - Gathering Data -Situational Analysis -Wealth Ranking -Nutrition Baseline
3:00 - 3:30	STEP 3 (con't): Identifying Positive Deviants
3:30 - 3:45	**BREAK**
3:45 - 5:00	STEP 4: Conducting the PDI -Process, Methods, Tools and Training for conducting the PDI Observation, Semi-structured Interviews, Home Visits
5:00 - 5:10	Day Summary and Wrap-up
DAY 2	
8:00 - 8:15	Review of Day's Agenda
8:15 - 9:15	STEP 4 (con't): PDI Analysis & Feedback: Determining Feeding & Care Behaviors
9:45 – 10:20	Overview of Hearth Sessions: SCF/BASICS Video Presentation
10:20 – 10:35	**Break**
10:35 – 12:30	STEP 5: Designing Hearth Sessions Hearth Protocols –Criteria & Choices Nutrients, Meals & Menu Preparation
12:30 – 1:30	**LUNCH on Site**
1:30 - 2:00	STEP 5 (con't): Health Education Schedule: Incorporating PDI Behaviors Participatory Education Methods
2:00 - 2:30	STEP 6: Conducting the Hearth Session – Practitioners' Experiences
2:30 - 3:00	STEP 7: Supporting New Behaviors through Home Visits & Community Feedback
3:00 - 3:15	**Break**
3:15 - 4:00	STEP 8: Repeating Hearth Sessions as Needed Hearth One-Year Activity Plan Exit Strategy
4:00 - 4:45	STEP 9: Expanding PD/Hearth: Steps for Expansion & Critical Success Factors
4:45 - 5:00	Day Summary and Wrap-up

DAY 3	
8:00 - 8:15	Welcome, Review of Day's Agenda
8:15 - 8:45	Essential Elements & Key Steps for Hearth
8:45 - 9:30	Staffing & Resources Required: Job Task Analysis & Training Plan
9:30 – 10:00	Performance Supervision of PD/Hearth Activities
10:00 - 10:15	**Break**
10:15 - 11:15	Monitoring & Evaluation -Fundamentals of M&E -Tools for Tracking Progress
11:15 - 11:45	Preparing the Program Proposal & Budget
11:45 - 12:15	Getting Started in PD/ Hearth – Effective Use of Consultants
12:15 - 12:45	Follow-on Activities, Resources, Support Networks Workshop Evaluation & Closure
12:45	**LUNCH on Site**

Session 3: Overview of Positive Deviance/Hearth

Total time: 90 min

By the end of this session, the participant will be able to:

1. Describe the PD/Hearth approach.
2. Summarize the history of the PD/Hearth methodology and important influences.
3. Explain the advantages of positive deviance and Hearth as behavior change strategies.

Reference in PD/Hearth Guide: pp. 1-14

Preparation:

- Preview the exercise on page 48 (example 5), to be done in step 1 below.
- On a flip chart, write steps 1-9 of PD/Hearth, with space to add approximate time ranges (Flip chart 3a); Prepare Flip chart 3b.
- Review studies listed on Flip chart 3c for familiarity.
- Obtain and assure proper setup of a projector for the PowerPoint presentation in step 8 below. (If it is not possible to view the PPT slides, photocopy the pertinent slides in advance for all participants, or prepare as overheads.)

Materials:

- Half-sheet of flip chart paper per four participants
- Mortality Chart/Causes of Malnutrition (WHO/UNICEF diagrams) (Refer to Guide, pp.11-12 or print as HO3a/3b)
- PD/Hearth Studies and Conclusions (HO 3c)
- Flip chart 3a: Key Steps in the PD/Hearth Approach
- Flip chart 3b: Components of Child Care
- Flip chart 3c: Three Goals of a PD/Hearth Program
- PowerPoint presentation in 3 files: Positivedeviance.ppt; hearth1.ppt; hearth2.ppt

Steps:

1. (10 min) Divide participants into groups of four and give each a half-sheet of flip chart paper or similar-sized piece of cloth. Explain that they have a problem for which they need to work to find a solution. They need to get all group members completely onto the sheet of paper with no parts of their bodies touching the floor. They should let the facilitator know when they have achieved their goal.

   When all groups have succeeded, congratulate them. Then instruct them to step off, fold the sheet of paper in half and repeat the exercise. Continue in this manner, repeating the exercise by folding the paper in half again each time, until only one group is able to stay within the bounds of their piece of paper. Congratulate the winning group.

2. (5 min) Return to the large group and discuss. This is an exercise of teamwork, confidence and trust.
   - **Ask what the groups did to solve the problem? What did they observe? On what did success depend (e.g. outside resources)? What coping skills do some individuals or groups develop to face a crisis?**
     See characteristics of the group that succeeded: e.g. creativity, drawing on strengths from previous experience, leadership,...

3. (10 min) Show the PowerPoint slides to highlight how the Positive Deviance/Hearth approach seeks sustainable behavior change. [See Table of Contents for Power Point presentations]

   PowerPoint on Positive Deviance 'Positivedeviance.ppt':
   slides 1-10: Show quickly as an overview of positive deviance. (It is not necessary to read slide 7—the PDI process, as this will be covered in detail in Sessions 6a, 6b, and 7.)
   slides 11-14: What to look for?, with examples.
   slides 15&16: Illustrate the BCC strategy of PD/Hearth—community validation of findings and creation of a PD-informed activity in order to enable other community members to access and adopt new demonstrably successful behaviors.

   PowerPoints on Hearth Nutrition Program
   'Hearth1.ppt':
   slides 1&2: Focus on the behavior change strategy of Hearth (daily food contribution and characteristic features).
   'Hearth2.ppt':
   slides 2 & 4: Emphasize community awareness and ownership as the BCC strategy—the new behaviors become conventional wisdom, thus achieving the second and third goals of Hearth.
   slides5-9: Sum up how behaviors are sustained beyond the initial households
   [5:Commune data & 6: the lasting impact of Hearth; 7: Living University;
   8: expansion country-wide in Vietnam; 9: global].

4. (10 min) Help participants connect the exercise from Step 1 with the PD/Hearth methodology, by asking the following questions:

   - **How was the paper exercise similar to Positive Deviance?**
     As resources diminish, some deal better with fewer resources. (Note that all were able to succeed with the largest piece of paper/sufficient resources.)

   - **What is an asset-based approach?**
     It focuses on strengths and resources even in at-risk situations, instead of focusing just on needs and deficits.

   - **How does PD differ from traditional development problem-solving tools?**
     Positive Deviance relies on solutions within the group, not outside solutions.

   Point out the usefulness of an exercise like this one (a conceptual game) at the village level.

5. (10 min) In the large group, introduce malnutrition and note its contribution to child deaths from all causes, with the aid of the WHO chart (Guide, p.12 or

PowerPoint slide). Refer participants to the UNICEF diagram on page 11 of the Guide, and discuss causes of malnutrition. Give directions for the small group exercise using this diagram (see next step).

6. (10 min) In the small groups, participants use the UNICEF diagram to discuss how Positive Deviance/Hearth addresses the causes of malnutrition (to see which aspects might be positively influenced by the PD/Hearth approach). [See Table of Contents for diagram] Small group leaders should guide discussion only if needed.

7. (10 min) Ask each group to share the main points of their discussion. (Alternatively, have each group discuss one level of the diagram, with added input from others.)
   PD/Hearth is a short-term/immediate intervention, addressing immediate causes. It responds especially to the first level of the diagram—inadequate dietary intake and disease (hygiene, etc.). At the secondary level, the potential for impact of the PD/Hearth approach is more limited. Discuss the implications for PD/Hearth with: 1) insufficient household food security; 2) insufficient health services (creates demand) and unhealthy environment (helps to improve in a locally feasible way); and finally 3) insufficient maternal and child care.

8. (5 min) Lead the discussion to define 'Child Care', as part of the center topic on the secondary level of the UNICEF chart. Note that the PD/Hearth approach emphasizes four components of child care, as outlined on the flip chart (FC 3b) and provide examples of each component.

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

9. (5 min) Distribute handout 3c and briefly introduce the landmark multi-country study and other key PD/Hearth historical documents (Tufts, Haiti, SC/Vietnam). (If hard copies are available, show participants where these resources will be placed so they can look at them during breaks.)

10. (10 min) Use flip chart 3c to introduce the three goals of PD/Hearth. Provide an overview of the steps (1-9), as outlined in the Guide, and indicate these on the large flip chart (FC 3a) on the wall. Explain that approximate time ranges will be added as the workshop progresses through these steps, though for some steps, the time will vary widely according to the situation.

    Provide examples of an estimated cost per beneficiary for PD/Hearth programs, as identified in *Wollinka O, et al. (eds.) Hearth Nutrition Model: Applications in Haiti, Vietnam and Bangladesh. BASICS Project, VA, 1997.*

    Haiti/Hopital Albert Schweitzer: $7 per participating child

VietNam: $3.92 per participating child, including the CHW, food, seed money, etc.
Bangladesh: budget of $14,000/year for approx. 1482 children, including 6 paid staff, food, fuel, incentives

11. (5 min) Summarize the session, emphasizing how the PD/Hearth approach seeks sustainable behavior change, at the individual and family level as well as the community level, in order to achieve the three goals outlined above.

Findings of PD/Hearth Studies and Conclusions

1) Zeitlin, Marian F. Child Care and Nutrition: The Findings from Positive Deviance Research. Final Report to UNICEF from Italian Government and Tufts University Positive Deviance in Nutrition Research Project, 1987-1992.

   Landmark multi-country study; defined Child Care as "a complex set of interrelated behaviors that are culturally embedded."

2) Zeitlin M, Ghassemi H and Mansour M. Positive Deviance in Child Nutrition: with Emphasis on Psychosocial and Behavioral Aspects and Implications for Development. Tokyo: The United Nations University, 1990.
   http://www.unu.edu/unupress/unupbooks/80697e/80697E00.htm

   Conclusion: "Identifying, honoring and building on local strength should be an underlying principle of all types of assessment, analysis and action to improve child care."

3) Mansour M. and Berggren G. The Nutrition Demonstration Foyer Guide. Save the Children, CT. 1994
   For additional information on the Haiti program, see Bolles, Kathryn, et.al. Ti-foyer (hearth) community-based nutrition activities informed by the positive deviance approach in Leogane, Haiti: A programmatic description. *Food and Nutrition Bulletin* 23(4):9-15, 2002
   http://www.coregroup.org/working_groups/FNB_PDHearth_supplement.pdf

4) Wollinka O, et al. (eds.) Hearth Nutrition Model: Applications in Haiti, Vietnam and Bangladesh. BASICS Project, VA, 1997.

   Paper commissioned to document knowledge and experience with PD/Hearth.
   http://www.basics.org/publications/pubs/Hearth/hearth.htm

5) Sternin M, Sternin J, and Marsh D. Scaling up a poverty alleviation and nutrition program in Viet Nam, In: Marchione T., ed. Scaling Up Scaling Down: capacities for overcoming malnutrition in developing countries. Amsterdam: Gordon and Breach, 1999: 97-117.
   See also: Sternin M, Sternin J, and Marsh D. Scaling Up a Poverty Alleviation and Nutrition Program in Vietnam BASICS Impact papers, 1999.
   http://www.basics.org/publications/pubs/pvo_presentations/19_Vietnam.htm

6) Sternin M, Sternin J and Marsh D. Designing a Community-Based Nutrition Program Using the Hearth Model and the Positive Deviance Approach - A Field Guide. Save the Children, December 1998.
   http://www.positivedeviance.org/pd/pdf/fieldguide.pdf

7) Marsh DR and Schroeder DG. The Positive Deviance Approach to Improve Health Outcomes: Experience and Evidence from the Field. *Food and Nutrition Bulletin Supplement v.* 23(4):3-6, 2002.

   This article demonstrates that the PD behaviors used in Hearth are sustained at the household level and in the community. The entire supplement of the Food and Nutrition Bulletin is devoted to articles on PD/Hearth and is available in pdf format at
   http://www.coregroup.org/working_groups/FNB_PDHearth_supplement.pdf

Key Steps in the PD/Hearth Approach

NOTE to trainers: *The amount of time for each step will be highly variable depending on the individual environment, with the exception of Steps 6&7. An example of the timing is included for Steps 2-4 to guide discussion with planners.*

		Approx. Time Required
Step 1	**Decide whether the PD/Hearth approach is feasible in the target community**	
Step 2	**Begin mobilizing the community and select and train staff**	| |-->approx 2-3 weeks | | | | | |-->approx 2 weeks (training 2 days, PDI 2 days, analysis & feedback to community 2 days)
Step 3	**Prepare for a PDI**	
Step 4	**Conduct a PDI**	
Step 5	**Design Hearth Sessions**	
Step 6	**Conduct Hearth Sessions**	2 weeks
Step 7	**Support new behaviors through follow-up visits**	2 weeks immediately after session, and continuing
Step 8	**Repeat Hearth as needed**	
Step 9	**Expand PD/Hearth program to additional communities**	

Components of Child Care

Role of Caretaker	**Feeding Practices**	**Caring Practices** (psycho-social care)	**Hygiene Practices**	**Health-seeking/ Health Care Practices**
Macro planning & management	ex: prepare meal			
Micro attentive responsiveness	ex: feed patiently			
Teaching facts & skills	ex: show how to hold spoon			
Training values & behaviors	ex: train not to refuse good food			

Note to facilitator: *Prepare flip chart in advance with column and row headings only. Add examples in 'feeding practices' column during discussion with participants (step 6 of session 3).*

Three Goals of a Positive Deviance/Hearth Program

1. **Rehabilitate malnourished children**
2. **Enable families to sustain the rehabilitation of these children at home on their own.**
3. **Prevent malnutrition among the community's other children, current and future.**

Session 4: STEP 1—Determining the Feasibility of PD/Hearth Approach for the Target Community

Total time: 85 min

By the end of this session, the participant will be able to:

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

Reference in PD/Hearth Guide: pp.17-25

Preparation:

- Designate and orient small groups leaders; maintain same small groups (approx 4-5 participants/group) for the morning session of day 1.

Materials:

- Case studies (Handout 4)
- Flip Chart for step 1 with title only: 'Essential Considerations for a PD/Hearth Program'
- Flip chart (1 per small group), with questions for the exercise in step 2.

Steps:

1. (20 min) Announce to the group that Hearth does not work everywhere. Ask the group to think about **what might be criteria for implementing Hearth**. Begin with a discussion of the first criteria—malnutrition over 30 percent. Help participants define malnutrition, then continue with other essential considerations, writing each on a flip chart, one at a time, and guide discussion by participants of each requirement (refer to the list on pp 17-20 in the Guide):

    - Malnutrition > 30%:
      For the purposes of PD/Hearth, malnutrition is defined as low weight for age
      How would you know the general level of malnutrition without doing your own assessment?
      Seek existing sources of information, such as an ongoing growth monitoring program (GMP); national or local assessments; survey information, DHS data for the region, KPC baseline from a child survival program; or even visual assessment in an acute situation.

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

    - Geographic proximity of homes
      Cite some advantages and disadvantages of urban and rural programs.

- Community commitment
  Look for evidence of peer support, leadership, sense of community. (Note: Transient populations—refugees, IDPs—may lack a sense of community.) It may be necessary to form a village health committee, if there is no existing committee to work with..

- Complementary health services
  A functioning health center, for example, can provide important inputs that are not available at the Hearth, such as de-worming, immunizations, micronutrient supplementation and referrals.

- Systems for identifying and tracking malnourished children
  A growth monitoring program is not a precondition, but may need to be added.

- Existence of food aid
  This can pose an issue for program sustainability.

- Organizational commitment of the implementing agency

2. (20 min) Divide participants into small groups and hand out case examples and a flip chart with questions to each group. For each example, the group should answer the following questions and summarize for the plenary discussion.

   - **Does the case example meet the criteria for a PD/Hearth program?**
   - **What are the strengths for doing PD/Hearth in this community? Advantages?**
   - **What are the challenges, disadvantages of doing PD/Hearth in this community?**
   - **If Hearth is not appropriate, what are other strategies to address the nutrition problem?**

3. (40 min) Return to the large group, and allow each small group to informally discuss case studies and conclusions about the appropriateness of PD/Hearth, with comment and discussion by the large group. Be sure to discuss alternative strategies, if PD/Hearth is considered not feasible.

   Case study notes:
   India—PD/Hearth is not appropriate; will need to work with the creche, not the home.
   Urban Tajikistan—Leadership and food scarcity are barriers, < 30% WAZ (weight-for-age).
   Nepal—PD/Hearth would work here, if done with 3 groups (for 3 castes).
   Peru—Distances are too great. Use creative approaches to promote appropriate breastfeeding and complementary feeding at clinics, markets, by radio, etc.
   Mozambique—PD/Hearth would work for permanent residents; and for the mobile group-only while in the city.
   Eritrea—Hearth might work, if it moves with them. Now, however, food and income are scarce.
   Zambia—This situation has some potential for successful PD/Hearth.

4. (5 min) Recap the important criteria and take questions from the group on PD/Hearth Step One (Determining the feasibility of PD/Hearth).

Is Hearth Right for You?

Case 1 - India

Low weight for age (mild, moderate, and severe): 35% of children 6 months to 3 years

Families live in very small villages scattered through the tea estates. There are 10 to 20 families in each village. It can take 30 minutes to one hour walking to reach the main estate village over very hilly terrain. 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 a creche cared for by two paid employees. Food in the creche 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 creche is located next to the good health clinic provided by the estate management. There is a Joint Management Body made up of representatives of workers and management.

Case 2 – Urban Tajikistan

Low weight for age (<-2z scores): 28%
Low height for age (<-2z scores): 45%
Low weight for height (<-2z scores): 11% of children 6 to 36 months

The community is defined as a large urban apartment block of approximately 400 families. Some mothers work away from home all day and children are left with grandmothers. Few families have any regular income. One third are receiving food aid. All families purchase food in the market. Fresh fruits and vegetables are very scarce and expensive from November through April. Health services are readily accessible but of poor quality. All leadership is vested in the government officials of a political unit, which contains dozens of apartment blocks.

Case 3 – Lowland Nepal

Low weight for age (yellow or red on growth chart): 39% of children 6 to 36 months

Families live in clusters of houses within easy walking distance. Approximately 500 families live within two square kilometers. Of these, one-fourth are "untouchable" caste, ten percent are ethnic Tharus, who are considered as slaves, and the rest are immigrants from the hill country who are of similar caste. (The proportion of malnutrition is equally spread among the different groups.) Each group has their own traditional leaders. There is also a government leadership structure (VHC) that encompasses a broader geographic area. Women work in the fields only during planting and harvest. This is an area of abundant, cheap food all year around. Health services are readily accessible. There is a system of Female Community Health Volunteers.

Case 4 – Rural Mountain Peru

Low weight for age (at <-1 z score): 32% of children 6 to 59 months

Some families live in the village, but most live on their land outside the village, with houses strung along roads and streams, sometimes 2 or 3 kilometers apart. For many families, it is one or two hours walk into the village. It may be twice that far to a town with health services. Most families produce sufficient food for their needs and many wild foods are available. There is no "hungry" season. Villages have strong formal and informal leadership, including women leaders.

Case 5 – Peri-urban Mozambique

Low weight for age (mild, moderate, severe): 42% of children 6 to 36 months.

Families live in densely populated squatter settlements in simple straw-roofed houses with no sanitation. Water is fetched from central spigots some distance away. About half the families migrate back to their land during the agricultural season. This may be one or two days away. While in the city, men work as day laborers and a few women work in the markets, but take their children along. Families bring some food from their land, but purchase most all food. Food prices go up in the dry season, but there are always fruits, vegetables, rice, and fish available. Some families keep ducks or chickens. Families have easy access to health facilities.

Case 6 – Rural Desert Eritrea

Low weight for age (<–2z scores): 40% of children 6 to 36 months
Stunting (<-2z scores): 51%
Wasting (-2z scores): 14.5%

Most families are nomads who settle in "communities" with their livestock for several months of the year. These small nomadic groups move together. While they are settled in one place, they go to the market and health services in the nearest town. Men do the shopping. Virtually all grains, fresh fruits and vegetables are expensive because they are brought in from other regions.

Case 7 – Zambia

Low weight for age (<-2z scores): 45% of children 6 months to 3 years

People live in towns, which have easily defined neighborhoods of 100 or more families with informal leadership. Approximately 15% of households have lost one or more adults to AIDS. The children are being raised by relatives and are the most likely to be malnourished. Currently, there is a famine because of a multi-year drought. Prices for staple foods are very high. One half of families are receiving food aid – wheat, oil, and corn-soy-blend (CSB). Health services are available. Each town has formal leadership and many have health committees.

Session 5a: STEP 2—Community Mobilization

Total time: 30 min

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

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

Reference in PD/Hearth Guide: pp. 27- 29; see also p. 185: Resources for Community Participation

Preparation:

- Prepare one flip chart with each of the key questions for discussion:
  - Who do you need to mobilize for PD/Hearth?
  - What is the role of the MOH?
  - What is the role of the Village Health Committee?
  - How do you get maximum buy-in and support? How do you keep this involvement?

Materials:

- If possible, have available on reference table copies of resources for community participation:

  How to Mobilize Communities for Health and Social Change
  http://www.coregroup.org/imci/CoreItemDetail.asp?ID=212 (information for ordering)

  Participation for Empowerment: A Manual for Development Agents
  http://www.coregroup.org/imci/CoreItemDetail.asp?ID=18

  Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A Manual for CRS Field Workers and Partners
  http://www.catholicrelief.org/what_we_do_overseas/RRA_Manual.pdf

Steps:

1. (15 min) Introduce PD/Hearth Step Two, stressing its importance: PD/Hearth relies on involvement by the community in order to succeed. Indicate that community mobilization is a big topic and many participants have a lot of experience with it. The discussions in this training will focus on the context of community mobilization for PD/Hearth, but will pull from expertise of the group. Use key questions to brainstorm/guide discussion, writing group input on flip charts: (Note—uncover previously written questions one at a time.)

   Who do you need to mobilize for PD/Hearth?
   Community leaders; fathers, mothers, other caretakers; health staff, volunteers and their families (large time commitment); traditional healers, TBAs; school teachers; etc. can all contribute to the success of a PD/Hearth program.

What is the role of the Ministry of Health? (How do you incorporate them?)

What is the role of the Village Health Committee? (Does it exist? need to be revived?)
The VHC manages and coordinates health activities at local level; sets criteria for, selects and supervises community health volunteers; and collaborates with implementing organization and district health staff.

Can you do PD/Hearth without a Village Health Committee?
In the absence of a VHC, it is important to identify management resources at grass roots level; build on existing resources.

2. (10 min) Have participants work in pairs to come up with as many strategies as possible for mobilizing the community, maximizing buy-in and support. After a few minutes, call on volunteers to contribute ideas. Note: Work from the participants' knowledge--***The solutions are in the group***.
   Some key questions to consider:

   How do you get the maximum buy-in and support?
   Engage the community as primary partner, with a role in selection criteria of volunteers. Be sure to involve in the process people who might raise barriers if not included: See examples on p. 28.

   How do you keep this involvement across the project continuum?
   Establish partnership with the community from the beginning and continue throughout. See the 'Triple A' cycle on p. 29.

3. (5 min) Summarize some of the key challenges to community involvement and some of the solutions developed by the group. Refer participants to additional exercises for mobilizing communities in the Guide, pp.43-52. Field any remaining questions.
   It is vitally important to fully understand the community, players, conflicts, priorities, existing structures and resources.

   If hard copies are available of resources for community participation, suggest that participants look at these during breaks; and/or list websites for participants to obtain them later.

Session 5b: STEP 2 (continued)—Selection of Project Staff and Community Resource Persons

Total time: 30 min

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

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

Reference in PD/Hearth Guide: pp. 20-24, 39-42

Preparation:

- Post flip charts from session 5a (discussion in step 1) on wall for reference.
- One flip chart for each staff/volunteer position, labeled only with the title of the position (Hearth Manager/Lead Trainer; Supervisor/Trainer; Village Health Committee; Hearth Volunteer)

Materials:

- Organogram (See p. 24 in the Guide)

Steps:

1. (10 min) Reiterate that Hearth is a human resource-intensive program. Though the program does not require large investments in infrastructure, the hard work and commitment of staff and volunteers are critical to its success. Briefly describe the roles of Hearth Manager/Lead Trainer, Supervisor/Trainer, Village Health Committee, and Hearth Volunteer. Begin with a review of each position and the corresponding responsibilities, based on the text in the Guide.

   Refer to sample job descriptions in the Guide (pp.39-42) and ask participants to read these before Session 20. (In anticipation of preparing a task analysis in Session 20, it might be useful to post a blank flip chart on the wall for each position. As important ideas about the requirements for each position arise during sessions 5-19, e.g. training issues, qualities and qualifications, these can be noted on the appropriate flip chart, to be consulted during session 20.)

2. (10 min) Discuss total numbers of volunteers/staff and beneficiaries, using the chart on p.24. Ask participants and other facilitators, based on their own experiences, to suggest circumstances that might lead to adaptations on these suggested numbers and/or roles, (e.g. In Haiti, because the pay is very low, the program is able to maintain 1 supervisor (*monitrice*) per village, rather than 1 per 5 villages as in most programs. This person assumes many roles done by volunteers in other programs.)

3. (10 min) Use the remaining time to discuss other questions, including:

   - **Can the program manager have other non-Hearth responsibilities?**
     Yes
     The trainer/supervisors?
     While the Hearth is being actively implemented, these people will be unable to hold other responsibilities.

   - **Can the VHW be a Hearth Volunteer?**
     Yes, but s/he must have sufficient time to devote to the full Hearth session (training, baseline assessment through preparation, Positive Deviance Inquiry, and Hearth). This job provides immediate satisfaction, which might reinvigorate a VHW for a future role in the community.

   - **Does the staff need to be full-time from the start?**
     Yes

   - **Why are community involvement and/or transparency in selection of staff (e.g. supervisors) and volunteers important?**
     Both contribute to the credibility of these people in the eyes of the community.

Session 6a: STEP 3—Preparing for the Positive Deviance Inquiry (PDI)

Total time: 75 min

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

1. Describe a situational analysis and identify potential sources of information.
2. Identify the standards for and challenges of conducting a wealth ranking exercise.
3. Explain the importance of and methods for conducting the nutrition baseline and ongoing monitoring activities.
4. Describe anthropometric measurements recommended for use within PD/Hearth activities, and cite important issues for proper weighing technique.

Reference in PD/Hearth Guide: pp. 57-66, 70-83

Preparation:

- Gather country and/or regional nutrition information
- Gather sample growth cards (country-specific and/or others used in the region)

Materials:

- PLA Tool for Participatory Situation Analysis (Handout 6a)
- Instructions and Case examples for wealth ranking exercise (Handouts 6b, 6c)
- WHO Guidelines for management of severely malnourished children, with formula composition (Handout 6d)
- FANTA bookmark (or Handout 6e)
- Blank flip charts for step 2
- Local growth monitoring chart

Steps:

1. (5 min) Referring to the timeline of steps, explain that Step 3: Preparing for the Positive Deviance Inquiry, consists of the situation analysis, wealth ranking and nutrition baseline. A situation analysis helps to provide a comprehensive understanding of the current situation in the community.

2. (15 min) Use questions to generate a discussion of the situation analysis:
   What kinds of information do we need to know about the local situation? Generate a list:
   Programmers will need general information on health, including immunization coverage; incidence and case management of major childhood illnesses; micronutrient situation/supplementation; care-seeking; levels and causes of under-five mortality; and current beliefs and behaviors.

Who would be sources for this information? Caution about stereotyped information from some sources.
Consult other sources in addition to volunteers and health staff: mothers and other caretakers, community, leaders, fathers, grandparents, vendors. The volunteers and health staff may be of slightly higher socioeconomic status than mothers and have stereotypes, misinformation, or lack information, e.g. Indonesia staff didn't know what families in the slums fed their children.

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

How can we learn the common feeding and health practices of families with malnourished children?
We can either conduct household interviews and observations using the same tools we will use for the PDI, or we can conduct guided group discussions with many poor non-PD mothers.
Pass out handout 6a, and explain that this is an example of how to carry out such a group discussion about feeding. It would be necessary to do similar discussions about health and caring practices.

3. Wealth Ranking Exercise: Explain that this exercise is a PLA/PRA.
   a. (5 min) Ask how many participants have done wealth ranking in some context (to differentiate socio-economic classes within a community)?

      Why do we need to do this to prepare for implementing Hearth in a given community?
      It is necessary to determine the poorest families in order to identify positive deviants among them.

      Explain that it is important to do this exercise with community members because only they will know how to define "poorest" in their community and they must agree with the final assignment of families in order to later believe there are PD families. Refer to examples of wealth ranking criteria in the PD/Hearth Guide (p. 66). Ask those who have done wealth ranking to share the process used and examples of criteria.

   b. (15 min) Distribute the case examples to small groups, with instructions for completing a wealth ranking (HO 6b/6c). A facilitator should oversee the work of each small group to assure they remain on task. As soon as they have finished, participants should return to the large group.

   c. (5 min) Quickly have groups report back on the wealth ranking exercise. (Important note: This process of establishing community wealth criteria should be accomplished before the nutrition baseline, to allow for observation for these criteria at the time of the weighing.)

4. Nutrition Baseline:
   a. (10 min) Classifying malnutrition: Hand out FANTA "bookmarks" (or handout 6d) with definitions of common terms used in measuring and defining malnutrition. Write the three different methods for classifying malnutrition and the abbreviations on a flip chart and be sure participants understand the definitions.
      - weight for age (WA) = underweight
      - height for age (HA) = stunting
      - weight for height (WH) = wasting

      Show example of a growth chart with colors. (If a local growth chart is available, use this as a model.) Share growth charts/systems used around the world for nutritional assessment/growth monitoring. Review definitions and classifications for malnutrition; z scores; Gomez classification; etc. (See Guide p.59-60.) Guide a brief discussion of

      - **Methods for determining age**
        Work with the community to establish a calendar of locally important events to help determine when each child was born.

      - **Why the Hearth approach uses weight-for-age**
        This method is the easiest to do accurately, and is most sensitive to change.

   b. (10 min) Nutrition baseline discussion: Elicit a discussion based on the following key questions:

      What is a nutrition baseline?
      The baseline includes a census and weighing all children in the target age in the community. This is best done by going house to house.

      What determines the target age group?
      Only include children >6 mos.(0-6 mos = exclusive breastfeeding); The target age may go up to 5 yrs or 3 yrs or 2 yrs, depending on 'anticipated load' and budget.

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

      Where does Growth Monitoring fit into Hearth?
      GM may be an entrée into the community, helping to raise awareness of adequate growth and is an on-going monitoring tool. The GMP with continually up-dated census will serve to capture additional malnourished children over time and to support maintenance of rehabilitated children.

      What about severely malnourished children and Hearth?
      Hand out the WHO guidelines (Handout 6d), to clarify the protocol for the most severely malnourished children (not Hearth). If available, refer

participants to the TALC publication *Caring for Severely Malnourished Children* (Ashworth and Burgess, 2003) or provide the website for obtaining this useful reference: www.talcuk.org/a-z_booklist.htm

c. (5 min) Weighing techniques: Refer to the Guide (pp. 78-83) for specifics on proper weighing techniques. Briefly discuss types of scales and weighing issues (calibration, disrobing children, alternatives to the sling), drawing on participant experiences.

5. (5 min) Summarize the three parts of the PDI preparation above, and clarify as needed.

PLA Tool for Participatory Situation Analysis

Part 1:

Focus Group Discussion (FGD)

Focus groups are not simply question-and-answer sessions. The facilitator presents a set of carefully chosen key issues that have emerged from other PLA activities through community participation. To raise key issues the facilitator can use visual aids (pictures), story telling and other means, besides asking questions to involve the group in a lively discussion.

The group discusses the issues, rather than simply answering a set of questions from the facilitator.

All participants are encouraged to voice their ideas and opinion.

The content of discussion is either recorded by hand or via a cassette recorder.

Directions to carry out Focus Group Discussion

(1) Introduce yourselves to the group members and have every body introduce themselves.
(2) Create a comfortable atmosphere with a joke or light talk.
(3) State the topic of conversation or use a visual aid to generate the conversation.
(4) Request permission to use a cassette recorder or to take notes of the discussion. (See questionnaire attached to facilitate the discussion.)

Part 2:
Model matrix for Focus Group/Guided Discussion on current feeding practices of children under 3 (Situation Analysis)

Child's age **0 to 36 mths** **milestones**	**Food given** including breastmilk & other liquids (name or pictures)	**Amounts** Bowl, cup, can, fist, spoonful	**Frequency** **3, 2,1***	**Food taboos** forbidden	**Comments** **Why**
Newborn 0 to 3 months 2 to 6 months 7 to 12 months 13 to 24 months When child is sick When recovering					

* 3 = every day, 2= twice a week 1= rarely i.e. once or twice a month

Part 3:
Participatory Situation Analysis/ Baseline For A Community

Topic:	**Traditional and current feeding practices concerning children <3**
Activity:	Matrix, Focus Group Discussion
With whom:	Mothers with child <3 yrs old; Grandmothers
Duration:	2 hours
Materials:	Paper; notebook; pictures of food, of practices; magic markers; beans

What do we want to know?
Introduction of complementary feeding, what kind?
Typical diet of a 1year old, 2 year old (variety, amounts, frequency)
Food taboos for child <3, What are they? Why?
What do caregivers do when the child has little appetite?
Special diet (food & liquids) for sick children (diarrhea, fever)? less breastfeeding? for recovering children?

Directions to carry out the session

(1) Explain purpose of activity to participants
(2) Create a matrix with 6 columns (see model), ask the question: "In your village, what are children **usually** fed between 0 months to 3 months, 4 to 6 months, etc.?". Create 1 column for age group, 1 column for food, 1 for amounts, 1 for frequency.
(3) Ask participants to list the food or use card size pictures of local common foods fed to children for each age group. Probing: What are the practices to enrich porridge? What foods are added to porridge over time? When?
(4) Then they put amount of food (bowl, spoonful, can size, fist, pieces, etc.) Then frequency of feeding every day.
(5) Then have participants list foods that are **not** recommended for young children and ask them **why**.
(6) Ask participants how they feed their young children (chewing, finger, spoon, etc), from a common or individual bowl.
(7) How do they feed the sick child (diarrhea, ARI, malaria, etc.)? the recovering child?
(8) What do you do when your child has poor appetite?
(9) Summarize the activities and the findings; emphasize good practices existing in the community.
(10) Document findings on current feeding practices in a matrix.

Expected outcome for situation analysis
Identify and document current normal feeding practices, to highlight existing good/best practices.
Identify and document harmful practices for program intervention.
Identify lack of beneficial practices.
Identify participants' understanding of what causes malnutrition in their children.

CONDUCTING WEALTH RANKING

Understanding how the community classifies people as poor is important for PD/Hearth. To believe that the practices of the PD families can be done by the poorest in the community, the volunteers, mothers and others in the community must believe that the PD families are truly among the poorest.

The objective of any wealth ranking exercise is to understand the community classification of economic differences and to determine criteria for classifying individual families or households. If people share food, resources and income in nuclear units, then wealth ranking is done by household. But if the food, resources and other income are shared across multiple, related households, then wealth ranking must consider the extended family instead.

Assemble a group of community members together. Ideally, the group will include leaders, representatives of different ethnic groups, women and men, and all socio-economic classes. Alternatively, the activity can be done with different groups, such as men and women, separately.

Choose five different versions of an object, for example three stones of different colors. Lay the stones out on the ground with some distance between them. Explain that one stone represents the rich families in the village, another represents the middle-income families, and the third represents the poorest people. Have everyone look at the rich stone and ask the participants to reflect silently on which families in their community are rich and would go with this stone. Ask participants to describe how they know these families are rich. What do these families have that families in the middle and poor categories (stones) don't have? List all these characteristics. Prompt them to think about type of housing, farm implements, livestock, clothing, transport, occupations, amount of land owned, etc.

Does everyone agree that families in the middle category don't have these characteristics? Now, focus on the middle-income stone. Have the participants visualize the middle-income families. How are they different from the poor families? What do they have which sets them apart from the poor? Probe again into housing, livestock, jobs, etc.

Focus attention on the last stone. Remind participants that these are the poorest people. What don't they have that the rich and middle-income families have? What kind of income do they have? Houses? Jobs? Clothing? Do they own any livestock? What kind and how much? It may be necessary to add a fourth stone if the participants say there is yet another group which is even poorer and then ask for characteristics of those people.

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

The PD/Hearth team can now use these criteria in conjunction with each child's weight to determine whether or not a family is Positive Deviant.

Case examples for Wealth Ranking Exercise

To be classified as poor families, they must meet 3 of these criteria:

- renting one-room house
- house made of bamboo
- house has dirt or cement floor
- no regular salary
- only one person in family working

Child's name and Family name	Child's age in months	Wealth ranking for family*	Wealth Ranking
Risa (F) Heni/Sali	31	Both parents work as vendors, rent 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 2 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, own 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	

Part 1:

WHO Guidelines for Management of Severely Malnourished Children

Note: The sample protocol is a summary drawn from a WHO manual for the Treatment of Severe Acute Malnutrition. For greater detail, including specific nutrient requirements, see **http://www.who.int/nut/documents/manage_severe_malnutrition_eng.pdf**

THERAPEUTIC FEEDING PROTOCOL EXAMPLE:

ADMISSION PROTOCOL	Orient caregiver to facility and treatment protocols and schedule
	Clinical evaluation & Medical history of the patient including wt and height measurements
	Prophylatic dose of Vitamin A (check card and interview to ensure Vitamin A not recently provided)
	Special ORS – presence of dehydration in all patients – start special ORS (Resomal or ½ strength ORS to account for potassium depletion/sodium excess in patients) and continue through phase I
	Screen and treat for micronutrient deficiencies (all patients started on Folic acid with iron being introduced on day 10 of treatment to avoid toxic effects)
	De-worm (mebendazole 1 time dose – interview to ensure patient has not been recently de-wormed)
	Vaccine status checked and outstanding vaccines provided
	Treatment of Acute infections – all admissions receive basic course of antibiotic (cotramoxizole or ampicillin)
	If malarious area: provide anti-malarial and Insecticide treated nets

PHASE I/ INITIAL duration 2 to 7 days	**PHASE II/ REHABILITATION** duration 14-20 days
Goal: Stabilize patient and correct electrolyte imbalance (potassium depletion, sodium excess)	**Goal:** Rebuild body tissue resulting in weight gain and restore to normal weight for height
Phase I Protocol: -Provide small frequent feeding of high-energy milk with minerals and vitamins every 2 to 4 hours. F-75 given at 100kcal/per kg/per day increasing to 200ml/per kg/per day divided into at least 8 and preferably 12 feedings per day (F-75 contents DSM, cereal Flour, Oil, Sugar & mineral and vitamin mix) *[see handout part 2, next page]* -Continue medical treatment and manage for complications: antibiotic course, folic acid, warmth (kangaroo method for hypothermia), special ORS; manage for complications: hypothermia, hypoglycemia, cardiac failure, severe anemia, septic shock -Daily Weight, temperature regulation, monitor for hypoglycemia -Daily nutrition and health education sessions -Support mother/caregiver to feed the child with cup (& spoon) -Advance to phase II when complications are managed and patients is tolerating F-75 200ml/kg/day	**Phase II Protocol:** -Provide high-energy milk F-100 (DSM, Oil, Sugar, mineral/vitamin mix) starting at 200kcal/kg/day increasing to 300kcal/kg/day as tolerated. Divide feedings into 4 to 6 times per day. - Also introduce high-energy porridge made from CSB or WSB, sugar and oil as soon as child is tolerating F-100 at 200kcal/kg/day. -Support mother / caregiver to feed the child -Monitor weight three times per week -Refer patients who are not gaining weight for additional screening and medical treatment. -Continue medical treatments including rehydration with special ORS, folic acid, introduce iron at day 10 of treatment. -Daily nutrition and health education sessions -Patient prepared for discharge once adequate weight for height maintained and free from illness -Refer to ongoing supplemental feeding program when present -Coordinate with CHWs in home area to follow-up patient in the community

Part 2:

Composition of F75 and F100 formulas for severely malnourished children

Preparation of F-75 and F-100 diets (per liter)

Ingredient	Amount	
	F-75[a-d]	**F-100**[e,f]
Dried skimmed milk	25 g	80 g
Sugar	70 g	50 g
Cereal flour	35 g	-
Vegetable oil	27 g	60 g
Mineral mix[g]	20 ml	20 ml
Vitamin mix[g]	140 mg	140 mg
Water to make	1000 ml	1000 ml

a-d, e,f: References contain directions for preparation of both formulas, including reasonable substitutions. These appear in Chapter 4 of the WHO manual referenced on the preceding page.
g: See composition of mineral and vitamin mixes that follow.

Composition of mineral mix solution (per liter)

Substance	Amount
Potassium chloride	89.5 g
Tripotassium citrate	32.4 g
Magnesium chloride ($MgCl_2 \cdot 6H_2O$)	30.5 g
Zinc acetate	3.3 g
Copper sulfate	0.56 g
Sodium selenate*	10 mg
Potassium iodide*	5 mg
Water to make	1000 ml

* If it is not possible to weigh very small amounts accurately, this substance may be omitted.

Composition of vitamin mix (per liter)

Vitamin	Amount per liter of liquid diet
Water-soluble:	
Thiamine (vitamin B_1)	0.7 mg
Riboflavin (vitamin B_2)	2.0 mg
Nicotinic acid	10 mg
Pyridoxine (vitamin B_6)	0.7 mg
Cyanocobalamin (vitamin B_{12})	1 µg
Folic acid	0.35 mg
Ascorbic acid (vitamin C)	100 mg
Pantothenic acid (vitamin B_5)	3 mg
Biotin	0.1 mg
Fat-soluble:	
Retinol (vitamin A)	1.5 mg
Calciferol (vitamin D)	30 µg
α-Tocopherol (vitamin E)	22 mg
Vitamin K	40 µg

FANTA bookmark

[see Table of Contents]

Session 6b: STEP 3 (continued)—Identifying Positive Deviants

Total time: 30 min

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

1. Explain the criteria and process for selecting PD families.
2. Practice selecting PD families utilizing nutrition baseline and wealth ranking exercise data.

Reference in PD/Hearth Guide: p. 68

Preparation:

- Identify and orient small group leaders; change make-up of small groups.

Materials:

- Flip chart 6: Definition of Positive Deviance
- 'Identifying Positive Deviants' exercise (Handout 6f)
- Blank growth charts
- Black and red marker for each small group

Steps:

1. (5 min) Briefly review the following:
   Who are the Positive Deviants? Repeat definition and write on the flip chart the other terms that have been used in other countries (see discussion on p.94).

   > 'Positive Deviants': Individuals whose special, or uncommon, practices and behaviors enable them to find better ways to prevent malnutrition than their neighbors who share the same resources and face the same risks.

   Who would determine the PDs?
   Supervisors and volunteers help to determine Positive Deviants.

2. (10 min) Review the process for identifying PD families: Good nutritional status and low wealth ranking. Divide the participants into small groups and give each a copy of the exercise (Handout 6f) and a blank growth chart. Have them look at the weight and wealth ranking data for each child and determine who are the positive deviants. Group leaders will need to oversee the process.
   Note to Trainers: *There are several children who are well-nourished from poor families (# 4, 7, 10, 12, 16, 20). However, child #4 is an only child; child #10 has a malnourished sibling; and child #12 is only 6 months old. Therefore only children # 7, 16, and 20 qualify as PD.*

3. (15 min) Have each group briefly present their work. Guide discussion and questions, being sure to cover the following:

- **Who would know which families are PD? Who has access to this information?**
  Only the staff should have the information and they should not share it, because we do not want the PD families to be socially rejected.

- **Who cannot be positive deviants?**
  See the list on p.68 in the Guide. Be sure to include: special families, non-homogenous, only children, well-nourished child with malnourished siblings, those with atypical social or health problems, food aid family. (Also, the child must not be younger than 7 months, since their nutritional status is most likely due to breastfeeding.)

- **What if there are no positive deviant families in the community?**
  You need at least one PD family. If none is identified, it will be necessary to conduct the positive deviance inquiry (PDI) in an adjacent, very similar community using the team from the target community. (If there are many PD families, narrow these down to the best few for conducting the PDI.)

- **What are negative deviants?**
  Negative deviants are wealthy *families with* malnourished *children. If there is time, it is helpful to conduct PDIs with these families as well. You also may conduct focus groups with mothers of malnourished children to determine their current behaviors and have a basis for comparison.*

Identifying Positive Deviants

Instructions for the Exercise

- Using the list below, plot children's weight for age on the growth chart with the corresponding color of marker.
- If a child is rich (R under wealth rank), then use a black marker.
- If a child is poor (P under wealth rank), then use a red marker.
- Once you have plotted all weights on the growth chart, circle those children who would qualify as positive deviants according to the PD criteria in the Guide (p.68)

No	Child's Name	Parent's Name	Sex	Age (mos)	Weight KG	Status *Color on Growth chart*	# U5 *Children Under 5 yrs*	Wealth Rank
1	Sintiya	Sarmini	F	36	11		1	R
2	Arip Agustianto	Triwidianti	M	30	13.2		1	P
3	Padilah	Lilis	M	9	6.8		2	R
4	Tarmizi	Gomas	M	19	11.6		1	P
5	M. Pahri	Yayah	M	19	8		2	P
6	Dwi Irawan	Een	M	25	10.4		2	R
7	Andi Iradana	Nyai	M	15	8.8		2	P
8	Elvia	Tumiati	F	33	13		1	R
9	Revalia A	Mala	F	31	10.4		3	P
10	Mesya Hanolaya	Mala	F	9	8		3	P
11	Ilham		M	16	9.6		2	R
12	Paujiah	Iis	F	6	7.4		3	P
13	M. Taufik	Dede	M	21	9.3		1	P
14	Nabila	Uniah	F	18	7.6		3	R
15	Wulan	Suryana	F	23	9.2		1	R
16	Ahmad Maulana	Upit	M	33	12		3	P
17	Andini	Nok	F	33	11.3		2	P
18	Wulandari	Ela	F	29	11.4		1	R
19	Silvi	Siti	F	28	9.8		1	R
20	Satrio Bagus	Rubidin/Srim	M	10	9.7		2	R
21	Savitri	Yuli	F	27	9.2		1	P
22	Budi	Evie	M	34	15		1	R

Session 7: STEP 4—Conducting the Positive Deviance Inquiry (PDI)

Total time: 75 min

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

1. Describe the process, tools and methods for conducting the PDI.
2. Identify resource tools for conducting semi-structured interviews and observation during visits to PD households.
3. Develop a logistical plan for training and conducting the PDI.

Reference in PD/Hearth Guide: pp. 85-89, 94-103

Preparation:

- Identify and orient trainers who will conduct the structured role play

Materials:

- Flip chart from Session 6b with definition of a positive deviant (Flip chart 6)
- Flip Chart from Session 3—Components of Child Care (Flip chart 3b)
- Guidelines from *Monitrices* for Conducting a PDI (Handout 7)

Steps:

1. (5 min) Tell the participants the story of Nasirudin (Guide p. 38). After the story, summarize the connection to the positive deviance inquiry: have participants look at the definition of positive deviant (on the flip chart), and emphasize that the positive deviance 'inquiry' is intended to help discover that which is right in front of us. *The team needs to believe it will find something positive—they are like detectives looking for clues, and without preconceived notions.*

2. (10 min) Use the child care framework from Session 3 to guide discussion of the following questions in relation to the positive deviance inquiry:

    - **What categories of home-based behaviors are we looking at?**
      During the PDI, examine and observe feeding practices; caring practices; hygiene practices; and health care practices. Ask participants for an example of a positive practice for each category. (Refer to pp.90-91 in the Guide.)

    - **What are we discovering through the PDI?**
      The PDI seeks to identify good, culturally-acceptable behaviors practiced by very poor families which can be 'made common', i.e. more widely practiced by others in the community who have similar resources.

- **The content for each category can be different according to cultural context—What are some examples of issues in feeding practices that are culturally specific?**

- **Who should explore these?**
  The PD team and local partners
  When?
  Issues identified during the PDI can be explored for cultural appropriateness during the later process of sharing with the community (see Session 10—PDI Analysis and Feedback).

- **Who has to be on the PDI team?**
  The volunteers and supervisors must be on the team. Additional participants might include Village Health Committee members or MOH staff. Volunteers may not be able to conduct the interviews but can be good observers after being trained.

- **What are some cultural filters that influence behaviors and how we view them?**
  In searching for behaviors that are positive and those that are problematic, the PDI team will need to explore through the lens of local culture. They should be attentive to:
  - *family structure/sociocultural norms*
  - *religion*
  - *gender*
  - *presence of informal or traditional health systems*

3. (5 min) The PDI is a qualitative inquiry. Ask participants what type of tools can be used to gather information about child care behaviors (feeding, health-seeking, caring and hygiene). Refer participants to the Observation Checklist for PDI and the sample Semi-structured Interview on pages 99-103 in the Guide, and allow a few minutes to look these over. Emphasize the importance of **good observation** in order to explore behaviors through the cultural lens of the community and of **probing** communication to glean information without bias.

4. (40 min) Use the following role play to demonstrate and practice the skills necessary for conducting a PDI. Begin with three facilitators for scenario one (interviewer with questionnaire; mother of child; older sibling) (may use doll or additional facilitator as PD child):

   Scenario 1: **Indonesia: This role play portrays part of a PD inquiry; during the part shown, the interviewer is focused on feeding practices. The PD child is a well-nourished 2½ year-old girl. Her mother says the child only eats during the 2 daily meals. However, a sibling in the room is sharing a snack with the child (who is fed constantly by older siblings, grandmother and neighbors). In this culture, 'meals/feeding' = a meal with rice. The mother talks very little. While the mother is being interviewed, the sibling washes the child's hands, scolds the child when she drops something and tries to pick it up to eat, plays with the child, gives the child a drink, etc. (The interviewer and mother don't interact with the child or sibling during this time.)**

After the role play, lead participants in discussing tips for a successful PDI:

- The quality of the interviewer's probing skills
  Note that probing was needed when information from the mother was not consistent with observation.
- The importance of knowing local languages and local customs
- Conducting the inquiry without a questionnaire in hand
  Small talk can be employed to create a comfort level (This role play was brief, but an actual PDI is more like a 2-hour visit in the village.)
- Role of the observer

In discussing the importance of the observer role, note that during this role play, the audience effectively became the second member of the interview team (observer). Use their observations to point out the importance of having two people on the interview team. The second person/observer (a supervisor, volunteer or other community leader) may recognize positive behaviors that the interviewer from the community does not see or recognize.

5. (10 min) Guide discussion about the role play, and the implications for

   - The kinds of information sought
     Details about amounts and frequency are important. There should be no leading questions and no preconceived notions about what is right—but it is okay to ask what the family does for a healthy child. Listen to what they do, not what they do right.

   - Selecting interviewers
     The interviewer may be a community member, a PD/Hearth volunteer, or a trainer/supervisor. [Note—Create a new flip chart to add to the flip charts on the wall that will be used in session 20, for the job `'PDI interviewer'.` As suggested characteristics come up during this discussion, they may be added for reference during the later session.]

   - Training of the PDI team
     Training should emphasize communication skills, listening and observation skills, specifically probing in a culturally acceptable manner. Utilize role plays for practice of skills and practice a trial home visit in the neighborhood with a feedback session. The role of observer is awkward—training is important to increase the comfort level.

   - Important qualities for Hearth personnel
     When selecting personnel, look for the following: belief in the approach, and ability to learn from one less educated, and to be led instead of leading. Note that PDI requires an attitudinal change for Hearth managers and trainers.

6. (5 min) Summarize the skills that are important for conducting a home visit

   - *Probing in a culturally acceptable manner*
   - *Mixing observation with conversation*
   - *Good interaction to draw the mother out/put her at ease*

and reemphasize the importance of practice through role plays. Clarify or answer questions on this step. Hand out the guidelines from the Haiti program for conducting a PDI (Handout 7).

Guidelines from Monitrices for Conducting a PDI

House visits

1. Be wise, respect the family.
2. Don't ask them why they're poor.
3. We are here to learn, not criticize.
4. Introduce yourself, congratulate the family on their good work, ask permission to observe.
5. Spend 2-3 hours in each PD house.

General Information

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

Good Food: BON MANJE

1. Conduct 24-hour diet recall on child's food eaten yesterday. Fill out form.
2. Is the child breastfeeding? If not, at what age did mother wean?
3. What foods is the mother giving today?
4. How many times did the child eat or drink while you observed?
5. Where does mother buy food? How much money does she spend a day?
6. How many 'meals' does the child eat a day?
7. Are there any foods the mother does NOT give the child?

Good Child Care: BON SWEN TIMOUN (try to observe without asking)

1. Who is the primary caregiver of the child?
2. Who is in the house during the day?
3. Does the mother take the child to the vaccination post? How often? Is the child on schedule?
4. Does the mother or others play with the child? How? How often?
4. How is the child disciplined? By whom?
5. What does the mother do if the child doesn't want to eat to encourage him/her?

Good Health Care: BON SWEN SANTE (ask for health card, ask caregiver questions)

1. When the child is sick, what do you do?
2. What kinds of illnesses has the child had?
3. How many times in the last 6 months has the child been sick?
4. What steps do they take to prevent illnesses?

Session 8: Workshop Day 1 Summary and Wrap-up

Total time: 10 min **Led by:** Lead Facilitator

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

1. Identify key highlights from the day's activities.

Preparation: None

Materials:

- Flip Chart from Session 3-- PD/Hearth steps
- Flip chart for daily feedback:
  - *What did you like the most?*
  - *What impressed you most?*
  - *What did you like least?*
- Notecard or half sheet of paper per participant

Steps:

1. Referring to the flip chart of PD/Hearth steps, briefly highlight the steps covered during the first day of the workshop. Wherever available and appropriate, include an estimated time for completing each step.

2. Allow participants to ask questions.

3. Pass out notecards or half sheets of paper and ask the participants to write responses to the three questions on the Daily Feedback flipchart. Collect their responses.

Session 9: Review of Day 2 Agenda

Total time: 15 min **Led by:** Lead Facilitator

Session Objectives:

1. Summarize the workshop objectives and activities for Day 2.

Preparation:

- Flip Chart of Day 2 agenda, if desired

Materials:

- Flip Chart of PD/Hearth steps from Session 3.

Steps:

1. Using the PD/Hearth Steps on flip chart, rapidly review what was covered during Day 1. Allow participants to ask questions on anything that still needs clarification.

2. Summarize the feedback from Day 1.

3. Indicate on the PD/Hearth timeline the steps to be covered during Day 2.

Session 10: STEP 4 (continued)—PDI Analysis and Feedback: Determining Positive Deviance

Total time: 60 min

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

1. Describe the categories of behaviors that are identified during the PDI analysis.
2. Describe the participatory processes for analyzing PDI data and selecting PD feeding, caring, hygienic and health-seeking behaviors to be used in Hearth sessions.

Reference in PD/Hearth Guide: pp 89-98, 104-112

Preparation:

- Identify small group leaders and orient to the case study
- Identify three new small groups. Provide each group with the compilation of a specific country's PDI findings (a matrix of the raw results of the PDI home visits)
- Prepare a flip chart (Flip chart 10) for each group to use to discuss the categories of behaviors from the individual households.
  NOTE: If the group decides to separate "hygiene" from "caring", there will be 4 categories rather than 3.

Materials:

- Flip chart labeled "PDI Field Exercise" with three categories of good behaviors followed by non-PD behaviors (Flip chart 10)
- Examples for the PDI Exercise from Haiti, Indonesia, Bangladesh (Handouts 10a, b, c)

Steps:

1. (15 min) Explain that the next small group exercise resembles a community meeting to provide feedback on the PDI. This process helps to develop community ownership and enable community members to identify immediately accessible solutions to childhood malnutrition. Break participants into three groups and give each group a copy of Flip Chart 10 and a handout of a set of PDI raw data (Handouts 10a,b&c) containing behaviors/practices from PD and non-PD families (Group 1: Haiti; Group 2: Indonesia; Group 3: Bangladesh). Explain that the behaviors were 'discovered' during a PDI (visits to a PD or a non-PD family). In their small group, they should discuss each behavior and place it in the matrix under the appropriate column for the PD families and then for the non-PD families for contrast. If a behavior is repeated by more than one family, the group should highlight it and indicate how many times that behavior was found; this serves to illustrate how a common thread weaves between the PD families.

2. (15 min) In the large group, ask each group to explain the findings of their PD data. Show what behaviors were found in the PD families' homes and what behaviors were found in the non-PD homes.

   For those behaviors that are considered positive, lead the group to select whether the behavior could be practiced by a poor family, or only by a rich family, i.e. is it feasible, easily replicable, affordable? Point out to participants how this exercise mirrors the process used in the community to analyze information from the PDI.

   *By leading a group of villagers to identify the **uncommon good behaviors**, you have facilitated community validation of choices ('buy-in'). Note: Village volunteers may need help in analyzing which behaviors are beneficial and which are harmful.*

   It will be important for participants to train the PDI team in this process. At the end of this discussion, ask participants to keep their case studies easily accessible (handouts 10 a, b, and c); they will be used again during Session 12b.

3. (15 min) Refer participants to pages 106-112 in the Manual with country and regional examples of good and bad PD behaviors. While reviewing these examples, discuss some ways that different countries have adapted the technique to local realities, including seasonal variations, e.g.:

   - *Train interviewers for PDI with a non-poor family so that they can improve their probing and discovering technique (including not criticizing bad behavior).*
   - *If seasonal variations have a strong influence in child care, repeat PDI during a different season.*
   - *Train interviewers to recognize unusual behaviors that don't seem positive, but may not need to be discouraged.*
   - *Use 24-hour dietary recall or other appropriate time blocks that are easily recognized. (In Haiti, where 24-hour recall is utilized, it was found that the* quantity *and* frequency *of feeding were more important as PD behaviors than the types of food. For recall, it will be necessary to identify who was with the child throughout the period (e.g. if not the mother).*
   - *Deciphering whether a food is beneficial may require someone with nutrition expertise.*
   - *In Haiti, the paid monitrices from the village—who were better trained than the volunteers—conducted the PDI; health volunteers hosted the Hearth, with the monitrice as supervisor.*

4. (15 min) Briefly summarize all the steps in the Positive Deviance part of PD/Hearth (6 steps):
   1) Select PDI team
   2) Train (with lots of role play)
   3) Select sample PD households and conduct practice PDI (These households are informed in advance; the PDI team gets to practice and share notes.)
   4) Conduct PDI (may also conduct in non-PD and negative deviant households for comparison)
   5) Compile the findings
   6) Share findings with the community

   Use this opportunity to reiterate/clarify important points and answer any questions.

PDI Field Exercise: Identifying PD and Non-PD Behaviors

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

PDI Findings from Haiti

	PD Family	Non-PD Family
1	Meals and snacks given 5-6 times per day Baby was breastfed exclusively to 5 months, continued to be breastfed to 18 months Child left with father or grandmother when mother goes to market Child bathed twice daily Mother regularly attends vaccination posts Snacks consist of boiled chunks of pumpkin and sweet manioc from garden sprinkled with salt and lime or sugar	Mother died in childbirth; father prepares "milk" using flour and water Child bathed once a day, does not wash hands before eating When child has diarrhea for more than 3 days, will visit VHW; does not know how to prepare ORS
2	Mother gives child traditional meals consisting of cornmeal cooked with coconut milk, black bean sauce, and vegetable sauce (with some combination of chayote, cabbage, carrots, green leafies, and eggplant). Mother prepares ORS from scratch when child has diarrhea- gives each time child has watery stool In the evening, mother prepares cornmeal pudding with sugar, lime, and fresh boiled milk	Mother prepares one large meal of rice and whole beans a day, infrequent snacks Sporadic vaccination post attendance Leaves child with young sibling when attends market
3	Mother plays with child Mother prepares porridge made from dried, pulverized plantains and guavas with boiled fresh cow's milk Child immunizations are up-to-date Child's hands are washed before eating Child drinks fresh carrot and passionfruit juices, or grapefruit juice when grapefruit is in season Mother boils water for child's juice	Prepares large plates of boiled breadfruit, yams or plantains with oil sauce for big noon meal Gives candy when child will not eat
4	Mother prepares peanut butter from peanuts in garden, and gives with bread as snacks Mother prepares vegetable sauce with crayfish and watercress she finds for free in the river Mother visits the VHW when her child has diarrhea for more than 1 day Mosquito coils are used at night Mother uses family planning	Breastfed exclusively for 1 month; weaned child completely at 5 months. Often gives child fried plantains and pork from street venders for meals Provides powdered sweetened fruit drinks to child with meals Stops all feeding when child has diarrhea- provides juice on demand
5	Mother gives child pieces of avocado or mango as a morning snack Mother gives traditional meal of millet or boiled yams, breadfruit, and plantains, with a sauce made from oil, smoked herring, magi cubes, and watercress or olive buds from garden Child drinks sweetened lime juice Older siblings play and sing songs with child	Child given cheese puffs for snacks Child given cornmeal prepared with leaves from garden and coconut. Attends vaccination posts only when vaccines are available- does not understand GM

PDI Findings from Indonesia

	PD Family	Non-PD Family
	Tempe and tofu frequently given Mother cooks child's food with coconut milk Baby was breastfed exclusively to 5 months Sibling and mother play with baby Father cares for and washes baby Baby's hands washed before eating Mother takes child to GM and understands card	Child is given Chiki (potato chips) often Child has no regular meal schedule Child is usually fed rice porridge Mother leaves child with siblings for hours Mother takes child to Growth Monitoring Child is washed with soap frequently during the day Child has never had diarrhea, but often has ARI
	Mother gives child traditional snacks including serabi, green bean porridge and chicken porridge Mother gives rice water when child had diarrhea Mother gives child spinach soup with peanuts, chicken foot soup with vegetables, cheap fish	Mother buys most food ready prepared from vendors Child is given broth from soups, cooked vegetables Family takes child outside to play in a clean area Child is bathed daily and hands washed before eating Mother uses Oralit when child had diarrhea Mother doesn't understand growth chart
	Mother makes for child tempe, cheap fish, vegetable soup made with coconut milk, and tofu Mother cooks outside the house to keep smoke out Mother puts chicken foot in child's soup Child plays with traditional wooden toys with family members Father made a bamboo walker for child to learn to walk The child's hands are washed with soap after toilet Family saves money for medical emergencies	Child is still breastfed at 15 months. Child is given broths, spinach soup with peanuts, tofu Mother buys foods from vendors, stores food covered Child's hands are washed before eating Father does not touch or play with child Siblings play with child Cooking fire is inside house with leaky chimney
	Mother prepares rice and tofu porridge (about ½ bowl) frequently Mother makes thick vegetable soup Mother or grandmother spoon feed the child Always wash vegetables twice with pump water Child is washed before and after snacks and meals Child is only given traditional snacks Child has play schedule, plays with family members Mother takes child to health center when needed and to GM. She understands growth chart.	Child is given candy, chips for snacks Mother says child is not hungry at meals Child is given rice porridge, tempe, tofu, some fish Mother buys most food from vendors Child plays alone, adults are too busy to play Child does not appear clean

PDI Findings from Bangladesh

RABEYA, Girl, 20 months

General information	Feeding practices	Caring practices	Health practices
• Still breasfed, • Well-nourished • 5 member family • Grandmother, secondary caretaker • Father day labor, home every 20 days • Environment not clean • Mother runs small shop • No latrine • Presence of soap and water • Drink tube well water	• Yesterday diet: rice, dhal, egg, fish, biscuit • Fed 4 to 5 times a day • Fed egg twice a week • Complementary feeding started at 8th month • Fed biscuits when has poor appetite	Good mother-child interaction Mother plays with child Father always ensures that food is available for his family Child eats by herself Good grandmother-child interaction Plays with clay toys and a doll Neighbors are helpful	• Child immunized (no card) • Home management of diarrhea with ORS • Cooling head for fever • Wash hands with soap • Regular bathing • House environment is clean • All food is covered

SOHEL, Boy, 20 months

General information	Feeding practices	Caring practices	Health practices
• Breastfed, malnourished • 9 member family • Father: agricultural farmer, landowner, hire day labor • People and cattle sleep together (fear of theft) • Big house, CI sheeting • No latrine • No vegetable garden	• Yesterday diet: cow's milk, rice, fish, meat, sag & pulse • When child not hungry, not fed • Fed 3 or 4 times a day • No active feeding • During illness, only breastmilk • Mother is careless about feeding (how?) • Mother does not have extra food for breastfeeding	• Father is not close to child • Mother does not show affection to child, does not interact • Husband wife relation aggressive • Mother does care if children play or not • Child displays no interest in strangers • Child is not clean, muddy • Child is unattended	• No toilet/latrine • No washing hands • Immunization completed (no card) • Mother does not know about home management of illnesses, or diarrhea • Clean kitchen utensils in the pond, then put it to dry on cow dough

ZAHER, Age = 26 months

General information	Feeding practices	Caring practices	Health Practices
9 member family Three brothers & three sisters—four of them in primary school. Father – only earning member. Income - 600 taka per month . Open latrine with fence Vegetable garden	• Child still breastfed. • Daily diet: Khichuri, cow's milk, egg, banana, biscuit, rice, leafy vegetable, fish • 4 times feeding /day. • Takes meal with other family members. • No practice of force-feeding. • Use fun ways of feeding by mother, elder sister. • Good interaction during breastfeeding.	• Caring attitude towards children (both parents). • Give guidance to elder siblings to take care of the child. • Use traditional songs, rhymes, lullabies, stories. • Have home made and market made toys. • Use different kinds of social rewards. • Use pictures on the wall for stimulating language skills. • Keep home environment safe. • No physical punishment or making child afraid. • Husband and wife supporting each other.	• Complete Immunization of all children, including polio. • Vitamin A given. • Knows ORS preparation & have regular practice • De-worming medicine given. • Child defecates on open place and stool is cleaned immediately. • Use safe water for drinking. • Hand washing with soap and water after cleaning the child. • Regular bathing. • Use cold sponging during fever. • Clean environment.
	•	•	•

RABEYA, Age = 19 months

General information	Feeding practices	Caring practices	Health Practices
Malnourished, Delayed physical development. 10 member family 5 sisters & 2 brothers. Only one child goes to school. Father is farmer, only earning member. Courtyard was not clean. No vegetable gardening. Open latrine.	• Still breastfeeding. • Cow's milk given from the 2nd month. • Feeding twice a day. • Force-feeding. • Provide physical punishment for not eating. • Usually feeds rice and milk.	• Child unattended. • No toys. • No practice of stimulation. • Elder siblings get no guidance from parents. • No picture on the wall. • Sharp knife was kept within child's reach. • Delayed communication development. • No practice of social reward. • Use physical punishment. • Parents quarrel in front of children. • Mother was passive, shy, sick.	• Mother knows ORS preparation and uses it. • Child is immunized. • Child suffers from worm infestation. • Confusing statement regarding de-worming. • Goes to village doctors when the child is sick.

SHAPLA, age =23 months (This chart was written in Bangla)

General information	Feeding practices	Caring practices	Health Practices
• Nutritional status was good. • Look nice & healthy. • Colostrum was given. • 4 sisters, 2 brothers. • Secondary caretakers were elder sisters, uncle, aunt. • In & outside clean environment. • Vegetables on the roof of the house, around the house. • Hen & goat were present. • Drink water from tubewell, other water pots were covered. • Father has no job now, no own land; house was broken. • Health of other children was also good. • No latrine.	• Rice, fish, vegetable, dry fish, egg, milk, khichuri . • 5 –6 feedings /day. • Saline, breastfeeding, sweetmeat during illness. • Provide food according to child's likeness & banana, sweetmeat from market. • Yesterday had taken rice with dry fish & vegetable. • Introduce soft rice with lentil's water, rice with salt since 7th month. • Still breastfeeding. • Child eats food from neighbourhood, eats all family food	• Good child & father interaction, father helps in bathing, gives company. • Good interaction with mother; buys & makes toy, encourages in games. • Child also plays with elder sister, uncle, aunt and others. • Child takes food with different persons. • Parents are caring about the child. • Child plays different games. • Feeding, bathing, sleep at time. • Child laughs and comes to the stranger.	• Open latrine , wash hands after defecation • Wash hands before taking food. • Wash the vegetable after cutting but before cooking. • Drink tubule water, wash utensil with tubewell water. • Regular bathing. • Complete immunization, but there was no card. • Vitamin A was given. • Cold sponging during fever, Garlic-mastered oil massage during cold & cough, saline during diarrhoea, refer to hospital during emergency. • De-worming was given. • Consult to village doctor.

RUBINA, Age = 22 months (was in Bangla)

General information	Feeding practices	Caring practices	Health Practices
Nutritional status was not good. 4 sisters. Father was teacher. Secondary caregiver was elder sister. Surrounding environment was not cleaned. Vegetable on the roof of the house. Drink tubewall water, use pond water for household activities. All the water-containing pots were covered.	• Rice, fish, egg, vegetable. • 3 feedings/day. • Biscuit, sweetmeat during illness. • During poor appetite, first try for normal food, if fail then give sweet biscuit. • Complementary feeding with soft rice & salt since 9/10th month.	• Father works outside village, so comes home once/week. • Mother takes care, help in bathing. • Elder sister, aunt play with the child. • Play with toy during stimulation. • Regular feeding & bathing in time. • Child non reactive with stranger. • Parents were not attentive about the child's care.	• Non-hygienic behaviour. • Defecate in pond. • Use pond water for washing. • Immunized but there was no card. • Vitamin A was given. • Saline during diarrhoea, Oil/garlic massage during cold/cough. • No de-worming. • Refer to hospital during high fever. • Consult with village doctor at initial stage.

Family from Nurpur (written in Bangla)

RABEYA, age 20 months

General information	Feeding practices	Caring practices	Health Practices
Normal nutritional status. No absolute breastfeeding. Still breastfeeding. Two brothers. Dirty environment. Secondary caregiver, grand mother. NO latrine. Father daily labour, has a small shop. Drink tubewell water.	• Rice, lentil , egg, vegetable , fish , biscuit. • 4-5times/day. • Only breastfeeding during illness. • During poor appetite, child eats biscuit, • Complementary feeding with only rice since 8th month.	• Father takes care, but does not get much time. • Good child-mother interaction. • Child-grandmother interaction was really good. • Child takes his food by himself, no need of force-feeding. • Play with grandmother, has toy. • Child plays with other children and feeds with them also.	• Wash the hands with soap. • Regular bathing. • NO sanitary latrine. • Immunized but no card. • All foods were under covered. • Saline during diarrhoea, cold sponging during fever. • Child becomes lethargic during illness • Consult to village Doctor.

NUR –UZ –ZAMAN, age 20 months

General information	Feeding practices	Caring practices	Health Practices
• Third degree malnourished. • Breastfeeding, but drinks cow's milk since 8th day after birth. • Family members: 9 (two wives). • Father is farmer. • Secondary caregiver is elder sister. • Dirty surroundings, cows and men live in same house. • They have food for whole year. • No latrine. • Drink tubule water.	• Rice, lentil, fish, vegetable. • 3-4 feeding /day. • Only breastfeeding during ill ness. • Do not try much during poor appetite. • Parents were not attentive about child's feeding. • Introduced complementary feeding since 10th month with rice only. .	• Less interaction with father. • Average interaction with mother. • Average interaction with secondary caregiver. • All were non-attentive about child's feeding. • Mother does not take care about child's play • Child remains unattended. • Child was not cleaned	• DO not wash hand. • Less aware about cleanliness. • No latrine. • Not properly physically clean. • Immunized but there was no card. • Can prepare ORS; do not have any idea about ARI. • Wash everything with pond water. • Goes to village doctor.

Session 11: SCF/BASICS Video—Overview of Hearth Sessions

Total time: 35 min

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

1. Describe the activities that occur within a Hearth session.

Reference in PD/Hearth Guide: Chaps. 5-8

Preparation:

- Arrange for VCR and assure proper working order
- Preview video and set tape to begin with Hearth session
- Write the questions for step 3 (below) and step 1 in session 12a on a flip chart (FC 11).

Materials:

- SCF/BASICS video
  Order from contact@CORE.org
- Flip chart of PD/Hearth steps from session 3

Steps:

1. (5 min) Introduce the video, explaining what to expect and what to be alert for. In this close-up view of Hearth, participants should observe the setting, what activities happen during the Hearth, and who does them, etc. (Briefly refer to the list of questions written on Flip chart 11.)

2. (15 min) Show the second half of the video. ***Note: If there is time, show the entire video—37 minutes***. Even though it repeats some of the PowerPoint presentation from Session 2, the repetition is useful for pulling important points together.

3. (15 min) Guide a brief discussion of the participants' observations, explaining that the elements of the Hearth will be covered in greater detail during the following session (Session 12a).

   What are the mothers doing?
   What does the volunteer do?
   What is happening with the malnourished children?
   Were there older siblings? Younger infants? What happened with them during the Hearth?

Session 12a: STEP 5—Designing Hearth Sessions

Total time: 115 min

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

1. Discuss the two main objectives of the Hearth session (2-week Hearth + 2-week follow-up).
2. Discuss Hearth logistics, criteria and choices.
3. Describe important elements of planning nutritionally and culturally appropriate meals/menu for Hearth sessions.
4. Calculate calorie and nutrient requirements to determine Hearth menu recipes/meals.

Reference in PD/Hearth Guide: pp. 113-119,124,129-133, 136-137

Preparation:

- Orient small group leaders (same group composition from morning exercise—session 10)
- Purchase a 'market basket' of local foods from the market and set out these foods plus a selection of very small containers and spoons/knives for dividing and weighing as the "market area". *[Note: If eggs are used, bring them hard-boiled to prevent breakage during the session.]*
- Obtain current protocols for de-worming in the country (or region) and print on a handout or write on a flip chart.

Materials:

- Flip Chart with the 3 goals of PD/Hearth (from Session 3)
- Flip Chart 11—list of discussion questions (con't)
- Flip Chart 12a: Nutrients Required in the Meal
- Sample Menu Planning Form (Handout 12a)
- Case studies (market survey findings) from one or more countries (Handout 12b=market survey from Indonesia, Haiti, Malawi) AND local food composition tables (or food composition tables from Indonesia) (Handout 12c)
- Directions for the menu planning exercise (Handout 12d)
- Plates, spoons for dividing bulk foods, a sharp knife, and small containers (little plastic cups); and local foods for market area
- Scales to weigh food (in grams)

Steps:

1. (40 min) Hearth is held for 12 days (6 days/week), followed by two weeks of follow up visits. The first goal of the two-week Hearth session is to rehabilitate the malnourished child. The hands-on nature of the session sets the stage for sustained behavior change, which will be reinforced during the follow-up home visits, (and

later by the community). Refer to the flip chart with the goals of PD/Hearth and indicate the first two:

- Goal 1: The malnourished child will be recuperated, and
- Goal 2: The mother will learn new behaviors (so that rehabilitation is sustained at home).

Keep these goals in mind as you continue the discussion from the previous session of observations from the video. Use the questions on Flip Chart 11, to continue leading the discussion:

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

Where should the Hearth session be held?
Site selection is important—it will require a central, adequate space, preferably a house. While the hearth should be large enough to accommodate the group, it should not be very different from the homes of the participating families.

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

What equipment needs to be there?
See the list on p. 136 in the Guide.

Conclude the discussion by briefly summarizing the important elements of the Hearth session, including who does what. Be sure to discuss

- Importance of de-worming and micronutrient supplementation *prior to* Hearth (Provide protocols for de-worming, either on flip chart or handout.)
- Selecting and inviting mothers to the session (avoiding stigmatization)
- Importance of food contributions and full attendance
  Each mother should supply the PD food at least once, staple foods on other days.
- Health messages throughout the Hearth (during prep, cooking, other activities)—i.e. not as a stand-alone activity
- Time required (2-3 hours each day)
- Importance of accommodating other children in mother's care
- Importance of site selection (latrine, water)
- Equipment needs
- Importance of the 'extra meal'
  At each session, ask the mother what she fed the child at regular meals, to be sure the Hearth meal is 'extra'. After recuperation, mother should enrich regular meals on a permanent basis, e.g. with PD foods.
- Importance of a snack during the Hearth session
  A 'snack' provides nourishment for children while they play and the mothers cook, reinforces the idea that children need to eat small amounts frequently, and supplements the nutrients provided by the main menu.
- When to weigh children and why

Children should be weighed on days 1 and 12. It is also important to assure that a village GMP continues; weighing helps to confirm nutritional rehabilitation and reinforce the new behaviors.

Describe variations from program experience (these may be included instead during session 13):

- Food contributions—a key component of Hearth:
  In case of an extremely poor mother, she may be asked to bring firewood or water, an extra pot, etc. Africare/Guinea program staff make a pre-visit, prior to Hearth, to make a contract with family detailing expectations, including pre-Hearth work-up and contributions. In a peri-urban area, to reduce the mother's time commitment, mothers bring food, 2 people stay to cook, and the others return with children at meal time.

- Obtaining equipment for the Hearth sessions

- Finding an appropriate Hearth setting
  If one volunteer cannot host all 12 days, or to accommodate a dispersed group, the program may set up a rotation among several hearths/sites.

- Prior visit to health center
  It is helpful for volunteer to accompany each mother and child to the health center—this establishes more comfort, assures compliance.

- Assuring fuel for Hearth
  Fuel scarcity can influence the type of food cooked. The program can have fuel be the community's contribution to lessen the burden on an individual mother.

2. (15 min) Menu preparation
   Refer to the Hearth objectives shown on the flip chart, explaining that for the Hearth session to assure 'recuperation of the child', the extra meal must be 'extra' and must include sufficient intake of protein and calories to have the desired impact.

   Show the flip chart with nutrient requirements for recuperation and briefly caution about the consequences of varying from the recommended levels. Explain the motivational effect of a mother seeing dramatic improvements in her child's health and demeanor for reinforcing her acceptance of new behaviors. She should see the child's appetite return, and overall mood and energy improve. The extra food is 'medicine.'

   Explain that the first step in menu planning is for the volunteer or supervisor to do a market survey. The purpose of this is two-fold: a) to reinforce the idea that the PD and other nutritious foods are affordable; and b) to assure that the menus planned will be affordable for mothers to replicate at home. In the next exercise, small groups will use sample market survey results to create two menus for each country example. Food composition tables (preferably country-specific) are needed for menu preparation. *These may be available through the local UNICEF office or*

the MOH; for a fairly comprehensive one, see www.usda.gov. Otherwise, the attached tables from Indonesia provide information for most of the foods listed for the three country examples.

3. (30 min) Small group menu preparation activity
   Provide each small group with a sample menu planning form (handout 12a), a food composition table (handout 12b), a market survey (from Haiti, Indonesia, or Malawi) (handout 12c), and directions for completing the activity (handout 12d). Small group facilitators should work actively with their group to guide the development of a menu and calculate nutritional composition (micronutrients, calories, and protein) for each menu. Verify that each proposed menu meets nutrient requirements for recuperative feeding. (If palm pilots are available, allow groups to experiment with their use (see 'palm pilot' explanation in Introduction).

4. (30 min) Debrief in large group. Have each small group explain its menus, the difficulties they encountered, and solutions proposed. Guide discussion on each proposal.

   - **Does the menu contain the correct protein/calorie and micronutrient composition?**

   - **Is the quantity (volume) of food in the proposed menu a realistic amount for a child to eat?**
     The menu must be energy dense.
     Use the scale and local foods to provide a visual guide to food volume (e.g. if 30 gms of rice is recommended, weigh 30 gms of dry rice and allow participants to determine whether this would be a realistic amount for a 3-year old child to eat). Remind participants that for the actual Hearth session these specific weights/measures will need to be translated into locally used household measures familiar to the mothers.

Nutrients Required in the Meal

What the meal must have to assure recuperation:

Calories: 600-800 (500-600*)

Protein: 25-27g (18-20g*)

Note: Amounts in parentheses are the minimum for a region with food insufficiency; recuperation will take longer with these amounts. (See Guide, p. 114)

Vitamins and minerals:

- Vitamin A 400-500 RE (RE=retinal equivalent)
- Iron 10mg
- Zinc 3-5 mg
- Vitamin C 15-25mg

Sample Menu Planning Form

Menu A:

Food	Who	Home Measure	Quantity (grams)	Calories	Protein	Vit. A	Vit. C	Iron	Zinc	Cost/amount

Menu B:

Food	Who	Home Measure	Quantity (grams)	Calories	Protein	Vit. A	Vit. C	Iron	Zinc	Cost/amount

Indonesia Food Composition Tables

(Nutrients per 100 grams)

	% edible	calories	protein	calcium	iron (mg)	Vit C (mg)	Vit A (mcg)
Carbohydrates							
Rice	100	349	6.8	10	0.8	0	0
Potato	100	345	0.3	20	0.5	0	0
Wheat flour	100	357	8.9	16	1.2	0	0
Protein							
Green lentils	100	351	22.2	125	6.7	47	6
Tofu	100	79	7.8	124	0.8	0	0
Tempe	100	160	18.3	129	10	0	15
Red beans	100	346	23.1	80	5	0	0
Peanuts	100	534	26	75	1.9	0	0
Coconut milk with water	100	128	20	25	0.1	2	0
Coconut milk/cream	100	348	4.2	14	1.9	2	0
Chicken	58	95	18.2	14	1.5	0	243
Chicken eggs	90	158	12.8	54	2.7	0	270
Duck eggs	90	184	13.1	56	2.8	0	369
Fish (kembung)	80	97	22	20	1	0	9
Fish (salted)	70	182	42	200	2.5	0	0
Rebon fish	100	283	59.5	230	21.4	0	0
Fish (teri)	100	73	16	500	1	0	1
Fish (bandeng)	80	123	20	20	2	0	45
Vegetables							
Cassava leaf	87	90	6.8	165	2	275	3300
Long beans	75	45	2.7	49	0.7	20	100
kangkung (leaf like spinach)	65	36	3	73	2.5	30	1890
Carrots	800	46	1.2	39	0.8	6	3600
Cabbage	82	26	0.7	14	0.4	84	78
Spinach	70	45	3.5	267	3.9	60	1827
Fruit							
Papaya	75	52	0.5	23	1.7	78	110
Banana	66	98	1.2	8	0.6	10	129
Banana (smaller variety)	75	110	1.2	8	0.5	3	44
Watermelon	46	32	0.5	7	0.2	6	177
Fats							
Coconut oil	100	886	1	3	0	0	0
Sugars							
White cane sugar	100	376	0	5	0.1	0	0
Palm sugar	100	316	3	76	37	0	0
Honey	100	319	0.3	5	0.9	4	0

Case Studies: Indonesia Results of Market Survey

$1US = 8600Rp

No	Item	Unit	Price (Rp)	Seasonal
1	Rice	liter	2,500	No
2	Cassava leaves	bunch	500	No
3	Mung bean	kilo	8,000	No
4	Dry small shrimp	kilo	10,000	No
5	Tempe	block (approx 200g)	1,000	No
6	Tofu	piece (approx 100g)	100	No
7	Egg	kilo	7,500	No
8	Coconut	whole	1,500	No
9	Vegetable Oil	kilo	5,000	No
10	Banana	1	500	No
11	“Kembung” Fish	kilo	10,000	No
12	Spinach	bunch	500	No
13	Peanut	kilo	8,000	No
14	Kidney bean	kilo	10,000	No
15	Carrot	kilo	6,000	No
16	Stringbean	kilo	4,000	No
17	Papaya	kilo	2,000	No
18	Green long bean (kacang tolo)	kilo	10,000	No

Case Studies: Haiti Results of Market Survey

Item	Unit	Price (in gourds)	Seasonal
Black beans	1 sm. can	20	no
Plantain	Each	3	no
Carrot	Bundle of 4 small	2	no
Olive tree buds	Bunch	free	Available for 3 months (can use pumpkin buds as substitute)
Yam	Each	5	no
Sweet Potato	Pile of 3	5	no
Breadfruit	Each	5	no
Passionfruit	Pile of 4	5	Available for 3-4 months in summer
Sugar	Small baggie	5	no
Grapefruit	Pile of 4	5	Available for 3-4 months in fall
Millet	1 sm. can	9	no
Sweet manioc	Pile of 4	5	no
Crawfish	Pile of 4	5	no
Pumpkin	Each	15-25 (depending on size)	no
Cornmeal flour	1 baggie	5	no
Fresh cow milk	1 liter	25	no
Avocado	1	2	Available for 3 months in late summer
Watercress	1 bunch	2	no
Spinach	1 bunch	1	Available year-round in cities, in Leogane villages generally avail. in spring
Peanut butter	-Small jar -Spoonful	75 5	no
Flour	1 small can	12	no
Spices (garlic, leek, pepper, parsley)	1 bunch	2	no
Oil	Ladle	5	no
Coconut	Each	5	no
Potatoes	Pile of 4 small	2	no
Maggi Bouillon cubes	2	1	no
Bread	1 small piece	1	no
Lime	Pile of 5-6	2	no (2x price in winter)
Mango	Each	1	Readily available in Spring, 2-3x price in other seasons
Chayote	Each	2	no
Eggplant	Each	2	no
Cabbage	Small head	3	no
Smoked herring	1 piece	2	no
Pork	1 piece	5	no
Cornmeal	1 small can	10	no
White rice	1 small can	13	no
Salt	1 baggie	2	no

Case Studies: Malawi Results of Market Survey

Item	Unit (Kg, handful, dozen—however sold)	Price in Kwacha	Months available
Bean leaves	Handful	K 10	Jan – April
Pumpkin leaves	3 leaves	K 2	Jan – May
Black jack	Handful	K 10	Nov – Mar
Bwenkha	Handful	K 20	Nov – Mar
Bananas	Each	K 2	All year round
Cassava	Each	K 10	All year round
Mangos	Each	K 5	Dec – March
Avocado	Each	K 10	March – June
Oranges	Each	K 5	March-July
Fish	Each	K 70	All year round
Mnthopa	Handful	K 5	Nov – Feb
Rice	/Kg	K 50	All year round
Soya	/Kg	K 15	May – November
Orange sweet potato	Bunch	K 20	April – Nov
Mntchesi	Handful	K 10	Nov – Feb
Ground nuts	/Kg	K 30	May – Nov
Eggs	Each	K 10	All year round
Masuku	/5 fruits	K 10	Nov – Feb
Chicken	Each	K 350	All year round
Meat from goats	/Kg	K 150	All year round
Guava	Each	K 5	March – June
Green maize	Each	K 10	Feb – April

LOCAL/COMMON NAME ENGLISH NAME

belekete,	Amaranth
kabata	Blackjack
bwenkha,	Okra
mnthopa	Custard Apple
masuku	Wild loquats
mntchesi	Sesame

Directions for the Menu Preparation Exercise

Each group can go to the "market area" and take foods for their menu:

- Take the amount you think a small child would eat. Remember that a child's stomach is no larger than a woman's fist.

- After weighing your group's choices, place them on a plate.

- Use the food composition table to calculate nutrients and complete the menu planning form. (Refer to the Guide, p. 116, on how to use a food composition table to calculate nutrients.) The snack must be included. It may take several adjustments to get the menu right.

Session 12b: STEP 5 (continued)—Health Education Schedule: Incorporating PDI Behaviors

Total time: 30 min

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

1. Describe participatory health education methodologies that have been successful with Hearth Sessions.
2. Identify the opportunities during a Hearth session for health education.

Reference in PD/Hearth Guide: pp. 119-123, 132

Preparation:

- Have facilitators bring Hearth education materials from their programs to augment those shown in the Guide.
- Set out blank flip chart papers on the walls around the room for the exercise in Step 3, below.

Materials:

- Flip Chart from Session 3, with 3 Goals of PD/Hearth (FC 3d)
- Sample Hearth education materials (see 'Preparation')
- Sample Hearth schedule from Haiti (Handout 12e)
- PDI examples from Session 10 (handouts 10a-c)

Steps:

1. (5 min) Point out that the second and third goals of PD/Hearth rely on the caregiver adopting new (PD) behaviors and other members of the community learning the new behaviors from them.

    - Goal 2: Rehabilitation will be sustained at home (Mother will learn new behaviors).
    - Goal 3: Future malnutrition will be prevented among children born in the community.

2. (5 min) Reiterate that the strength of the PD/Hearth approach is that it looks for the positive behaviors and strengths that exist in the community and builds upon them. Each village's practices are different, so the health education messages—built around those practices, will likewise be different for each village. The PD/Hearth approach follows the three-step process for behavior change:
    1) Discovery (Positive Deviance Inquiry)
    2) Demonstration (Hearth sessions)
    3) Doing (in Hearth sessions and at home—with follow-up visits to reinforce)

    Highlight some other strengths of this method of behavior change:

    Role modeling*: If the Hearth volunteer is a PD mom, she becomes an excellent role model.*

    Experiential: *Hearth sessions avoid didactic teaching; the mothers are involved in all steps (hands-on).*

    Based on cultural/social norms*: Norms are reinforced with community support. Interventions are culturally appropriate and often use songs and/or stories that are part*

of the culture. In Haiti, a contest was held during training to develop songs for Hearth. This was very successful—it animated the training process and enhanced Hearth education.

3. (20 min) Ask different participants to write an activity that happens during a Hearth session on the top of one of the blank flip charts around the room. (If the activities are not quite in order, they can be quickly rearranged before proceeding to the small group work.) Be sure the following are included:

   - Mothers and children arrive; roll call
   - Food contribution is collected
   - Some mothers wash their hands and begin to prepare snack
   - Other mothers organize and play games with children
   - Wash children's hands and distribute snack
   - Mothers feed children *Problems can become 'teachable moments'.*
   - Key Message *This is a participatory activity.*
   - Clean up
   - Decide on menu and contributions for next day *The Hearth Volunteer will need to allow time and patience for negotiations on what each mother will bring.*

   Divide participants into groups of 3-4 and give each group a different colored marker. Spread the groups out to begin at different 'stations' (see flip charts above). At each station, participants decide whether the activity that is listed presents an opportunity for education. If no, note 'NA' on the chart; if yes, write one example of what might be learned, and move on to the next station. Allow no more than 10 minutes to complete this task. Then return to the large group to discuss the results, beginning with the first station ('Arrival of mothers and children'). Explain that this exercise is intended to emphasize the opportunities for education *throughout* the Hearth session. Note that health education messages from week 1 should be repeated during week 2 and during home visits for reinforcement. Hand out the sample daily Hearth schedule from the Haiti program (handout 12e).

4. (10 min) Have participants refer to the PDI raw data from the small group exercise in Session 10 (Handouts 10a, b and c: PDI Findings from Haiti, Indonesia, and Bangladesh). Give participants 2-3 minutes to study them and identify which PD behaviors they would select as the "key messages" for Hearth sessions. List these on a flipchart. Have the group reach consensus on just five. How might the others be promoted? (This should lead back to the activity in Step 3.)

Haiti Hearth (Ti-Foyer) Daily Calendar

Order	Activity	Person responsible
1.	Mothers arrive with children. Welcome, sing and pray.	MotherVolunteer (MV)
2.	Roll call: is everyone there? If not, send a mother out to pick up.	MV
3.	Collect contribution.	MV
4.	Wash mothers hands. Begin to prepare snack.	MV with mothers
5.	Wash children's hands. Distribute snack.	MV with mothers
6.	Organize and play games with children.	MV with mothers. Some mothers will help with food preparation; others will play with children.
7.	Key Message	Monitrice
8.	When food is ready, mothers feed children. (Some ti foyers will have mothers who want to eat as well.)	Mothers with children. Monitrice will give advice as needed (caress child, give a little bit of food at a time, etc.)
9.	Discuss nutritional attributes of that day's meal while children eat.	Monitrice and MV
10.	Clean plates and kitchen together.	All
11.	Decide on menu for tomorrow, discuss why you've selected certain foods, incl. PD foods.	Monitrice with mothers
12.	Fill out day evaluation.	Monitrice

Session 13: STEP 6—Conducting the Hearth Session (Practitioners' Experiences)

Total time: 30 min

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

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

Reference in PD/Hearth Guide: pp135-139 and 143-145

Preparation:

- Identify facilitators with experiences to share.

Materials:

- Malawi: Lessons learned (Handout 13a)
- Haiti: Monitrice meeting notes (Handout 13b)

Note: To reduce papers for the participants, copy these on front/back of one page.

Steps:

1. (5 min) Introduce the session, explaining the need to adapt and remain flexible, while maintaining a focus on the purpose of Hearth. Refer to the flip chart with Hearth objectives and briefly reiterate the importance of adequate food intake, of local feasible interventions, and of mother's participation. Introduce panelists.

2. (15-20 min) Ask each panelist to briefly describe their experience with PD/Hearth. Include a particular adaptation, why it was made, and how it remained true to the principles of Hearth/why it was successful.

3. (5-10 min) Questions from participants. **Which elements might need to be tailored (what considerations might prompt adaptations)? Ideas?**
   See situations detailed in Guide, pp. 143-14. The discussion should include examples of ways to follow up defaulters; avoid stigma of participation; and ways to incorporate working mothers and/or multiple child caretakers.

The following adaptations may be included here, as well as any mentioned in earlier session plans, but not yet discussed.

- *In Haiti, 1 meal/day is customary, with extra nibbling throughout the day. In order to encourage the child to eat 5 small meals/day, the program promoted a 'child's plate', on which the 1 cooked meal was placed, so the child could eat off it all day. Peanuts and other energy dense foods were added to this plate, thus assuring the child an adequate portion, without the undue hardship to the mother of preparing several additional meals/day.*

- *The Haiti program put a monitrice in a local hospital, to create a better link between the community and the hospital (for referrals and for other health services).*

- *In many urban settings, no homes have sufficient space to hold a Hearth session. In India, plastic sheets were used to create a 'roof' over a dead-end alleyway between houses, thus erecting a space to hold the sessions.*

- *Some NGOs are experimenting with ways to use Hearth along with food distribution programs. In Indonesia, the volunteers are paid 'Food for Work' and the commodity rice and oil are used in the sessions. These are staples all families have so the emphasis is still on their contributing the PD foods. The sessions show families how they can feed their children well without US government or other rations.*

Hand out the notes from the Haiti meeting of Monitrices and Malawi's experience as a brief reference for participants (Handout 13 a/b).

Practitioners' Experiences – Malawi

The case for Malawi Hearth is that it has been very successful so far. The latest Embangweni session has registered 70% adequate + catch-up weight while DGMH has 75%. However there are a number of lessons we have gleaned so far and these became useful to inform subsequent Hearth sessions. Particularly we have noted that the group size during Hearth has a direct effect on the session's success. Also personal contact between volunteer and mothers during Hearth and subsequently during follow-ups is important for lasting behavior change

HAITI MONITRICE MEETING NOTES

CMC DARBONNE
FEBURARY 4/02

NAN JARDIN: All went well and the children ate for the first week. The second week mothers started complaining that their husbands did not agree and complained about not having anything to contribute. Some mothers said that they could feed their child at home.

BINOT: Many problems; several MP's dropped-out of the ti foyer after the first day. Mothers did not want to bring their contribution; many absentees. Had to go and get mothers from their homes to convince them on coming to the ti foyer. Mother participants (MPs) thought they were bringing their child to a health center/distribution. (The child Wadson is starting to crawl on his hands/knees--something he could not do before entering the 'ti foyer' program; hi is very active and starting to respond to his name.)

DUNY: Mothers thought ti foyer was going to consist of some kind of special medicated food. Did not want to contribute to the menu. Had to go and get mothers every day. They want food to go give to their child.

LAZIL: Some of the children were sick and did not eat well during the first week. Mothers complain about traveling the distance with child to the ti foyer. Neighbors criticize MPs about bringing child to the ti foyer. MPs would like program to donate the food to cook in their own house and not come to the MV's house. (Frantz Baptise is doing well after taking the med. and drinking the *lait enrichie*.)

KAY PITI: The first day we had to round up all the MPs to convince them in participating. The mothers that did not participate explained that they already know how to prepare food for their child. One father's refusal was the reason a mother dropped out. Some mothers would send the child with the food and not attend the ti foyer. They view the program as a good opportunity to have someone babysit their child. MPs would like the program to donate all the food.

BOI OBE: The first week had a full attendance and all the MPs contributed. Second week MPs were not present for the key message or to help with the ti foyer. MPs would come at the end of ti foyer to pick up child. Some MPs believe that only medicated food can help recuperate their child.

HITIN: The first week all went well. The second week MPs complained of not having food to contribute for the menu. They could not find enough firewood to prepare the meals.

NOTE: MOST OF ALL THE WORK IN THE TI FOYER WAS DONE BY THE VMs; PARTICIPATING MOTHERS DID NOT WANT TO SHARE THE WORK LOAD IN THE TI FOYERS.

Session 14: STEP 7—Supporting New Behaviors through Home Visits and Community Feedback

Total time: 30 min

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

1. Summarize the objectives, activities, and frequency for home visits.
2. Explain the objective and activities for providing community feedback.

Reference in PD/Hearth Guide: pp. 141, 143-145

Preparation:

- Review the Trinh article:
  UAT McIntosh, et.al., Sustained Positive Deviance: Child Care Practices and Their Effects on Child Growth in Viet Nam (Food and Nutrition Bulletin, Vol. 23, # 4—Supplement, 2002, pp16-25)
  http://www.coregroup.org/working_groups/FNB_PDHearth_supplement.pdf

Materials:

- Blank flip charts
- Copies of Trinh article for reference

Steps:

1. (5 min) Explain the importance of practicing a behavior over a sufficient length of time for the behavior to become a habit. For this reason, the Hearth approach includes two weeks of Hearth, followed by home visits during the two weeks after the Hearth session, to reinforce the behaviors learned during Hearth.

   Coca Cola has determined that a message needs to be heard 20 times before there will be interest in embracing a behavior. The PD messages need to be heard many times during the 2 weeks of Hearth and 2 weeks following it.

   Ask:

   Who do you think conducts the home visits?
   The Hearth Volunteer should visit each participant's home.

   How frequently?
   Ideally the family is visited every day for two weeks. In some communities, neighbors help monitor children's progress and the volunteer's visits are less frequent.

   What is the volunteer monitoring on these visits?
   It is important to be sure the child continues to receive the 'extra' food, for catch-up growth. All other PD behaviors that were promoted during Hearth should be verified and encouraged.

2. (5 min) Role play a home visit. One facilitator acts as a volunteer and another acts as the mother.

   Role Play Scenario:
   The volunteer 'drops in', chats with the mother about neighborhood news, and inquires about the child. (The child is off playing at the neighbor's—a sign of her recovery.) The volunteer points out to the mother that the child's new-found energy

and interest in playing are good signs of recovery. The mother mentions that the child had a bout of diarrhea. When the volunteer asks how she treated it, she says she had ORS but gave tea instead because she couldn't remember how to prepare ORS. The volunteer explains how and asks her to repeat directions. She asks whether the child's appetite is good and the mother says yes and that she is giving extra food. The volunteer says she will check in the day after tomorrow, reminds the mother of the final weigh-in next Friday and congratulates her for her efforts to make her child healthy.

3. (5 min) After the role play, ask participants:

   What examples of positive reinforcement did you see?
   How did the volunteer help the mother see the change in her child?
   What behaviors and feeding practices did she reinforce?
   How long was this home visit? How many do you think a volunteer could do in one day?
   Reiterate the importance of the follow-up home visit in assuring behavior change and helping families find solutions.

4. (5 min) Home visits for project monitoring: Ask participants to list some potential indicators for behavior change in Hearth. Write these on a flip chart.

   in home
   - *Observe practices during the visit (see the PDI observation checklist on pp. 99-100 in the Guide), and dialogue/chat for more information on practices and to be sure child is receiving extra food.*
   - *Check for better health-seeking behaviors (e.g. attendance at GM and health post records are both fairly easy to measure).*
   - *Verify weight gain (at 1 mo, 2 mo, 6 mo, & 12 mo post-Hearth).*
   - *Observe new siblings' health status.*

   Ask which of the indicators could be observed during home visits. Put a star next to these. Ask whether the supervisor or the volunteer would be more likely to observe and document these indicators.

5. (5 min) Reiterate the importance of community involvement and community-wide change for success with sustaining the achievements of Hearth. Ask participants to suggest ways to incorporate feedback to the community as an important component of reinforcing the long-term practice of PD/Hearth behaviors. Note that attention to community-level indicators reflects the Hearth goal of affecting non-participants. Add examples of these indicators to the flip chart.

   community level
   - *Talk with neighbors (Has PD/Hearth mother talked about Hearth?)*
   - *Look at community aggregate of weights over time (from the GMP).*
   - *Meet with community leaders to share Hearth outcomes.*

   Point out that a growth monitoring program can be a powerful tool for raising community awareness of the nutritional problem, and helping the community to follow progress and provide support to caregivers.

6. (5 min) Explain the findings of the Trinh article. (Have copies available for participants' reference, and/or provide with web citation.) This study investigated communities in Viet Nam that had participated in Save The Children's integrated nutrition program (with PD/Hearth). It looked at whether PD behaviors and nutritional improvements were sustained three and four years after the agency's departure, and concluded that:

> ***"Growth-promoting behaviors identified through PD studies and practiced through neighborhood-based rehabilitation sessions persisted years after program completion. These sustained behaviors contributed to better growth of younger siblings never exposed to the program."***
>
> U. A. Trinh McIntosh, et.al., UNU, 2002

Her findings confirm the importance of building strong community support to reinforce PD behaviors for sustained nutritional improvement in communities.

Session 15: STEP 8—Repeating Hearth Sessions as Needed One-Year Activity Plan and Exit Strategy

Total time: 45 min

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

1. Describe an activity plan for year one of Hearth.
2. Discuss considerations for children graduating from or repeating the Hearth sessions (Hearth protocols).
3. Discuss ways to work with the community to design an exit strategy and/or to link Hearth with other programs.

Reference in PD/Hearth Guide: pp. 124-128, 142

Preparation:

- For handout 15b, photocopy p. 128 from the Guide; may add a program example of a one-year plan (such as Haiti's) to the reverse side.
- Review sample protocols, pp.124-127.

Materials:

- Case studies for Hearth protocol (Handout 15a)
- Sample One-Year Hearth Plan, with Haiti example of reverse (Handout 15b)
- Blank flip chart

Steps:

1. (10 min) Return to the Hearth objectives and schedule (2-week Hearth session + 2 weeks of home visits). Explain the importance of working with the community to establish program objectives and criteria for a child graduating from Hearth. Discuss sensitivity and motivational issues. Like the objectives, the protocols for graduation or repeating a session need to be established before the beginning of the Hearth session. Ask participants:

   What might be the requirements to graduate from the Hearth session?
   What other elements might the community include in its Hearth protocol?

   Lead the discussion so that the important points from pp. 124-127 are highlighted.

   Include

   - *Expected weight gain of 200-400 gms. after 2 weeks following the recommended protein and calorie intake.*
   - *A limit to the number of times a child may repeat Hearth*
   - *When to refer the child for medical intervention*
   - *What to do if attendance is poor*
   - *Micronutrient and other supplemental activities*
   - *Expectations for participation in GMP*
   - *Age limits*

2. (15 min) Break participants into small groups and give each the case studies (Handout 15a). Using the case studies, participants should discuss conditions for enrolling a

child in Hearth, for graduating a child or having him/her repeat Hearth. What action is indicated in the case of a chronic underachiever?

During the final five minutes, have each group briefly explain its case and recommendations.

3. (10 min) Hand out the sample one-year activity plan (Handout 15b) and review with participants, indicating important components each month, and relating those to previous discussions. Answer participant questions. (Note that the standard plan has two weeks of Hearth plus two weeks of home visits, immediately followed by the next Hearth session. The community may prefer a larger gap between sessions, e.g. one per month, or one per quarter. While this is still acceptable, the gap will deter the recuperation of children who are repeating Hearth.)

4. (10 min) Discuss the importance of a growth monitoring program (GMP) in the community, and note that a Hearth program may be developed in response to observations from the GMP or vice-versa. Ask participants to suggest other community programs that might lead to the development of a PD/Hearth program. List these on a flip chart, and discuss issues that might arise with the addition of Hearth to existing programs. Continue with a discussion of other programs that may be linked, either existing programs or new ones added as a result of the community mobilization for PD/Hearth:

   Some examples are a water system, as a result of promotion of handwashing/hygiene; small business support or agricultural projects to supplement income and/or food supply; breastfeeding support groups, etc.

Follow-up Cases

1st case: Aisha is 3 years old, and an only child. After two Hearth sessions, she has gained 90 gms., but is still malnourished. Her mother, who is pregnant, appears to be following the new PD behaviors and working hard to rehabilitate Aisha, but is becoming discouraged.

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

3rd case: Daniel is 23 months old. He and his mother (who also has 2 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.

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

PD/Hearth Year One Plan

Sample from CMM Haiti

	Activity	Month	Week
1	Choose villages with health worker, set up community meetings	1	1
2	Test monitrice candidates	1	2
3	Train VHW, monitrices and volunteers in village registration	1	3
4	Register selected villages, based on nutrition assessment	1	4
5	Plot child WAZ, complete data analysis of village registration	2	1
6	Fill out and distribute child registers to each VHW, train	2	1
7	Monitrice training Group I	2	3,4
8	Monitrice training, cont. including PDI, market survey, exams, contracts	3	1,2,3
9	Mother Volunteer (MV) training	3	4
10	Hearth in MV home	4	1,2
11	Hearth session follow-up in home of participant mothers	4	3,4
12	Month 1 weight	4	4
13	Qualitative surveys for participants and non-participants	4	4
14	Monitrice meeting	5	1
15	Vaccination post for GM and register completion	5	1
16	Enroll mothers in microcredit program and follow progress	5	1,2
17	Repeat session and follow-up in Group I, month 2 weight	5	4
18	Monitrice meeting	6	1
19	Choose new villages for registration, community meetings	6	1
20	Test monitrice candidates	6	2
21	Train VHW, monitrices, and volunteers in registration	6	3
22	Register villages (using monitrices from Group I)	6	4
	Plot child WAZ, complete data analysis of village registration	7	1
	Fill out and distribute child registers to each VHW, train	7	2
23	Monitrice meeting (both groups)	7	3
24	Hearth sessions continue in Group I, if new children qualify for entry	7	4
25	Monitrice Training Group II	8	1-4
26	Monitrice Training, cont., Monitrice Meeting Groups I, II	9	1
27	Group II Hearth session	9	2-4
28	Group II Hearth session cont., Monitrice Meeting	10	1
29	Month 6 weight, Group I; Month 1 weight, Group II	10	2
30	Enroll Group II mothers in microcredit program	10	2
31	Hearth sessions continue in Groups I, II if new children qualify for entry	10	3,4
32	Hearth sessions continue in groups I, II if new children qualify for entry	11	1,2
33	Month 2 weight, Group II	11	2

Session 16: STEP 9—Expanding PD/Hearth

Total time: 45 min

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

1. Identify the critical factors for success in expanding a PD/Hearth program.
2. Review steps for expansion of a PD/Hearth program.
3. Discuss experiences from successful large programs in Viet Nam (Living University) and Nepal.

Reference in PD/Hearth Guide: pp 149-154

Preparation:

- Identify facilitators familiar with Living University, and/or review Pyle, D. and T. Tribbets. *Assessment of Active, Experiential Training on Program Expansion: Living University in the Positive Deviance/Hearth Program in Vietnam, 2002*. http://www.coregroup.org/imci/CoreItemDetail.asp?ID=240
- Review relevant articles on scaling up PD/Hearth programs, including Sternin, Sternin, and Marsh, Impact paper: http://www.basics.org/publications/pubs/pvo_presentations/19_Vietnam.htm

Materials:

- Flip Chart prepared during brainstorming in Session 5a—mount on wall for reference during step 1 below.
- Blank flip chart
- Flip chart 16 (5-Step Process for Expansion of PD/Hearth)

  1) Develop a small successful model
  2) Work out an expanded successful model
  3) Expand the PD/Hearth approach to the district level
  4) Create a 'Living University' or 'Laboratory for Field Learning'
  5) Support new graduates to return to their home base and begin replication

Steps:

1. (10 min) Ask participants to reflect on their experience with scaling up an intervention, and what problems were encountered. Guide the discussion to highlight important guidelines for successfully scaling up an intervention. (See the list on pp. 152-154.) Record these on the blank flip chart, stressing the need to:

   - **Maintain quality**
     Quality of PDI is critical (participatory training). Strengthen supervision as sites are added. Maintain good human resource practices, including performance monitoring of staff and volunteers. Allow sufficient time to develop a feasible and affordable model; replicate first, then scale up.

   - **Adapt to the local situation while remaining true to critical aspects of the approach**
     Visiting a successful program with staff, donors is very helpful. (Note that the 'essential elements' or critical aspects of the approach will be discussed further during Session 19, day 3.)

- **Employ a strong monitoring and evaluation framework to demonstrate success and modify where needed**

- **Assure community ownership and local leadership/MOH support**
  Use the flip charts from session 5a to remind participants of who should be involved. These two element s(community ownership and local leadership) are easily dropped with quick expansion, but are very important to the success of all Hearth programs.

2. (20 min) Describe the Save the Children/Vietnam experience with scaling up, including the Living University. Using Flip Chart 16, introduce the five-step process for expansion and guide the discussion of each step. Relate this process to the participants' previous experiences with scaling up successful projects.

3. (10 min) Discuss other real experiences with scaling up, including Nepal, where the follow-up indicated that local NGOs had received inadequate supervision from international NGOs and hence made unacceptable adaptations that resulted in no impact and low community support.

4. (5 min) Refer participants to the guidelines for successful expansion (pp.152-154) and demonstrate how these were respected in the cases given. Answer any questions.

Session 17: Summary and Wrap-up of Day 2

Total time: 10 min **Led by:** Lead Facilitator

By the end of the session, participants will be able to:
1. Identify key highlights from the day's activities.
2. Address questions and concerns from participants about progress of the workshop.

Preparation: None

Materials:
- Flip Chart from Session 3-- PD/Hearth steps
- Flip chart for daily feedback:

  - *What did you like the most?*
  - *What impressed you most?*
  - *What did you like least?*

- Notecard or half sheet of paper per participant

Steps:

1. (5 min) Referring to the flip chart of PD/Hearth steps, briefly highlight the steps covered during the second day of the workshop. Where appropriate, include an estimated time for completing each step.

2. (5 min) Allow participants to ask questions. Ask participants to reflect on the steps for PD/Hearth and to jot down for Day 3 key elements of PD/Hearth that are *not flexible* (i.e. that must be present for the program to be successful).

3. Pass out notecards or half sheets of paper and ask the participants to write responses to the three questions on the Daily Feedback flipchart. Collect their responses.

Session 18: Review of Day 3 Agenda

Total time: 15 min **Led by:** Lead Facilitator

Session Objectives:

1. Summarize the workshop objectives and activities for Day 3.

Preparation:

- Flip Chart of Day 3 agenda, if desired

Materials:

- Flip Chart of PD/Hearth steps from Session 3
- Blank flip chart

Steps:

1. (5 min) Using the PD/Hearth Steps on the flip chart, rapidly review what was covered during Days 1 and 2. Allow participants to ask questions on anything that still needs clarification.

2. (5 min) Summarize the feedback from Day 2.

3. (5 min) Review the agenda for the final morning of the workshop, indicating that this is where participants will begin to formulate their own plans for applying the lessons of the first two days of the workshop to their programs.

Session 19: Essential Elements and Key Steps for Hearth

Total time: 30 min

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

1. Identify the essential elements of a Hearth program.
2. Discuss ways to begin a Hearth program, either as a stand-alone program, or integrated with other programs.

Reference in PD/Hearth Guide: pp 3-4, 152-155

Preparation: None

Materials:

- Blank flip chart(s)

Steps:

1. (25 min) Remind participants that while flexibility around community needs is very important, there are some principles of the Hearth approach that must be adhered to for the program to succeed. Ask participants to refer to notes they made for their assignment for last evening: **What are the elements essential to Hearth?**
   As participants recall each of the elements below, write it on the blank flip chart, and ask probing questions to be sure they have fully understood it:

   Why is this important to the success of PD/Hearth?
   What might happen if this were modified?

   Be sure the following essential elements are covered.

   - Conduct a PDI in every target community using community members and staff.
   - Utilize community women volunteers to conduct the Hearth sessions and the follow-up home visits.
   - Prior to the Hearth sessions, de-worm all children and provide needed micronutrients.
   - Use growth monitoring to identify newly malnourished children and monitor nutritional progress.
   - Ensure that caregivers bring a daily contribution of food and/or materials to the Hearth sessions.
   - Design Hearth session menus based on locally available and affordable foods.
   - Have caregivers present and actively involved every day of the Hearth session: *their involvement promotes ownership, active learning; builds confidence.* The most important idea is to repeat the practice of new behaviors.
   - Conduct the Hearth session for 10-12 days within a two-week period.
     Note that although there is minor flexibility here (e.g. 4 days + market day + 4 days + market day + 4 days is okay), this frequency is needed to show a change in the child's nutritional status.
   - Include follow-up visits at home for two weeks after the Hearth session *(every day or close to it)* to ensure the average of 21 days of practice needed to change a new behavior into a habit.
   - Actively involve the community throughout the process.

2. (5 min) Discuss ways to begin a Hearth program, either as a stand-alone program, or integrated with other programs, and what issues may be involved in safeguarding the key elements listed above.

   Note: If programs are linked, e.g. PD/Hearth and a child survival project, such as AIN in Latin America, it is important to have dedicated staff for the PD/Hearth part of the program. For example, it may be okay for the child survival or Title II staff to begin the community organization component, and then assign full-time staff and supervisors for the PD/Hearth program .

Session 20: Staffing and Resources Required: Job Task Analysis and Training Plan

Total time: 45 min

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

1. Conduct a task analysis to determine important attitudes and skills and identify which are inherent qualities and which are trainable skills.
2. Discuss important criteria for selection of staff and volunteers.
3. Describe important considerations in the design and implementation of training for community volunteers and staff.

Reference in PD/Hearth Guide: pp 30-56

Preparation:

- Review previous experience of participants to determine whether they will need to complete the task analysis exercise in Step 2, below.
- If necessary, select and orient small group facilitators for four new groups. Prepare one flip chart 20a for each small group.

Materials:

- Organogram (Guide, p. 24)
- Sample job descriptions (Refer to Guide pp 39-41)
- Flip chart for each small group with task analysis questions (Flip Chart 20 a)—see step 2 below
- Flip chart 20 b: Training—Next Steps

Steps:

1. (5 min) Refer participants back to the earlier discussion on the roles of different staff and volunteers in the PD/Hearth program (Session 5b), and use the organogram in the Guide (p. 24) to provide a general description of each role. (If not done during the previous session, emphasize the importance of full-time, dedicated, PD/Hearth staff.) Ask who might require training and discuss the use of task analysis for training design.

2. (15 min) If participants have little previous experience with task analysis, have them break into small groups for a task analysis exercise. Assign a different job description (pp. 39-41) to each group and provide each group with a flip chart containing the questions below. The small groups can share their conclusions in plenary.

    - **What are the knowledge and skills an individual will need to successfully take on this role?**
      Consider areas such as reporting and record keeping, knowledge, technical skills, interpersonal/communication skills, etc.

- **Are there certain attitudes or skills that people will need to have initially that cannot be easily taught? (inherent qualities)**
  For example, what is necessary for the successful role reversal of trainer and trainees?

- **Determine the selection criteria based on these attitudes or skills that they need to come with.**

- **Also ask: Could a richer mother with healthy children be a Hearth volunteer?**
  She would need to be available and respected by the community. She might have more time to volunteer than other mothers. It is helpful to look at who already has a role in the community.

3. (15 min) A representative of each group should take a few minutes to report on their discussions. When the four groups have reported, guide discussion using the following questions:

   Which was the most difficult aspect of the task?
   Determining knowledge and skills takes time and requires careful consideration.

   Why is it important to go through the steps?
   It is critical to clearly separate the trainable skills vs. inherent qualities before selecting candidates.

   Remind participants that this would take more than 15 minutes in real life, but it is critical to follow this process and not jump directly to training.

   Alternative to Steps 2&3: If participants have sufficient experience with task analysis, omit the small group work and guide discussion for each of the job descriptions, referring to the questions on the flip chart (questions in bold in Step 2 above). Emphasize inherent qualities and skills and the importance of performance evaluation and monitoring so that ineffective staff and volunteers can be quickly identified and replaced.

4. (10 min) Using Flip chart 20 b, guide discussion of the next steps in training for PD/Hearth.
   - Task analysis and recruitment criteria (covered during steps 1-3 above)
   - Recruitment: based on task analysis
   - Needs assessment: of actual people to be trained
   - Course content & training strategy: what topics, when (at what point in the process), where, etc.
   - Training methodology: (see examples and resources in the Guide);
     Important note: Role play is critical for active learning and for PD/Hearth. In Haiti, supervisors in training visit the hospital to see first-hand cases of kwashiorkor and marasmus.
     Idea for hands-on work: Have trainees cook the foods brought from the market analysis and eat them.

- Preparation of materials for training and evaluation
- Training

  Note: *Once training has been conducted, it is important to evaluate how the individuals trained are using the training and to plan for future training needs. Good monitoring and evaluation of performance is critical.*

Session 21: Performance Supervision of PD/Hearth Activities

Total time: 30 min

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

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

Reference in PD/Hearth Guide: pp 140, 146-148

Preparation:

- Prepare flip chart 21: Questions on Supervision, with space to add group input (see questions in step 1 below)

Materials:

- Supervisory checklist (Refer to Ch 6, pp 146-148 in Guide)

Steps:

1. (10 min) With the aid of the job descriptions, guide the participants in discussing the questions below and on Flip chart 21. This should be fairly familiar territory to participants. Therefore, during the discussion, seek examples from participants' experiences. Use the information in italics only to supplement and guide the discussion.

    - **Who supervises?**
      The PVO/NGO supervises the PD/Hearth activity; the community supervises the volunteer.

    - **What is the purpose of supervision?**
      Supervision helps to assure quality and consistency of program delivery; is useful for troubleshooting; and provides an opportunity to reinforce training and strengthen skills. Supervision is an ongoing process. It helps motivate people, reinforces good performance, creates a sense of achievement, and serves to share good ideas.
      It provides an opportunity for adapting to situations as they occur: e.g. in Haiti, participant attendance was found to be a problem. In response, the supervisor helped determine that for the next session, the participant contribution would be dropped off early in the morning of the session. This allowed time for the supervisor to locate anyone who did not show up and encourage her to attend the session.

    - **What to assess?**
      Assessment should include volunteer skills, communication skills, adherence to Hearth protocols; menus: taste, consistency, nutritionally adequate, affordable, use of PD foods; food safety; caregivers' attendance all 12 days; recording of weights and other appropriate activities; etc.
      Assessments are made through observation, conversations with volunteers and caregivers, verification of records.

2. (15 min) Supervision Tools

   - **Who develops the supervision/monitoring tools and when?**

   - **Criteria for the tools?**
     K*eep them simple; develop tools during training; field test them.*
     Example from West Bengal: To encourage attendance, each day another line is added to a 'stick figure of a child', so that after 12 days of full attendance, the child is complete.
     Solicit other examples from participants.
     Refer participants to the forms in the Guide on pp. 146-147: the Observation Checklist and Caregiver Interview Guide.

   - **Format for supervision visit**
     Note the protocol for a supervisory visit includes:

     - Observe
     - Share in conversation
     - Apply information—provide feedback
       Analysis should be shared during a feedback session with the volunteer and with the Village Health Committee: Stress the positive first, dwell on the outcome—did any children graduate? Look at key quality indicators together. Remember: positive feedback, analysis of problems, identification of solutions and follow-up.

     Refer to the Supervisor Feedback and Troubleshooting Guide on p. 148.
     Ask participants for examples of ways they have involved the community in supervision.

   - **How do you use this information to improve the program quality?**
     Seek mutual solutions, monitor the community taking charge, provide refresher training.

   - **Frequency of supervision?**
     Supervise a new site frequently at first; try to be present on last day of Hearth.

   - **Implication for budgeting (transport & time spent in the field)?**
     Supervision is time-consuming. It is important to budget sufficient staff time.

3. (5 min) If time remains in the session, allow participants to discuss other examples of successful supervisory techniques from their own experience (simple; good feedback; application of results to modify program or training).

Session 22: Monitoring and Evaluation

Total time: 60 min

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

1. Review important indicators and tools for tracking progress (monitoring) and assessing impact (evaluation).
2. Explain the purpose and use of the behavioral and weighing monitoring tools.

Reference in PD/Hearth Guide: pp 157-184

Preparation:

- Review the list of indicators on pp 161-162 of the Guide
- Prepare 1 flip chart for each of the three PD/Hearth goals, with the goal written across the top (FC 22 a-c)
  - malnourished children are rehabilitated
  - families are able to sustain rehabilitation at home
  - future malnutrition is prevented in community
- Prepare a flip chart to show the Triple 'A' Cycle (Action-Assessment-Analysis)—see p. 168 (FC 22d)

Materials:

- Daily Hearth Report and Supervisor's Monthly Report: examples from Haiti (Handouts 22a and 22b)—may be copied on front and back of one sheet

Steps:

1. (30 min) Remind participants of the three goals of PD/Hearth and ask them to brainstorm some indicators that can be used to monitor and evaluate the achievement of each of the three goals. Write each suggested indicator on the flip chart for the goal to which it applies, and indicate whether it is a qualitative or quantitative indicator.

   - **For goal one: malnourished children are rehabilitated**
     During household visits, can monitor child eating PD foods, mothers who report seeing a change (qualitative); percent attendance and weight gain (quantitative). (*Note that PD/Hearth is a time-limited activity compared to other types of child survival programs. Therefore, M&E can lead to direct/immediate and simple modifications to the program. For example, in Haiti, percent attendance was low. Therefore, after the first cycle, staff interviewed both women who didn't attend and those who participated fully. The program for cycle 2 was modified to correct issues identified in the interviews.)*

   - **For goal two: families are able to sustain rehabilitation at home**
     Observe sustained application of PD behaviors (e.g. 3 of 5 key behaviors after 6 months), with PD child and with siblings (qualitative). Measure for sustained weight gain at 2 mos, at 6 mos, etc.; Identify percent who have regular attendance at GMP &/or immunization (quantitative).

- **For goal three: future malnutrition is prevented (community level)**
  Information can be gathered through informal interviews with neighbors, friends (qualitative) and through review of community weights or other nutritional assessment (quantitative). Graduated PD families may formally mentor incoming participants; this, too, can be monitored/measured.

What external factors might you be able to monitor?
The quality of the existing health care system is an external element that can be evaluated for impact from the PD/Hearth program: e.g. increased attendance, increased immunization, improved/more accurate weighing in the GMP, referrals, etc.
Note: *The local hospital may need to budget for recuperation of severely malnourished children, as they will be more readily detected/referred early in the program.*

2. (5 min) Share examples from Haiti, other programs. Ask participants to think about immediate program modifications that might be implemented as a result of the sample information.
   Haiti program: looks for opportunities to bring monitrices together to share difficulties and successes (as part of ongoing monitoring), and uses this as an opportunity to make immediate program adjustments.

3. (10 min) Hand out the sample supervisory report forms from Haiti (daily Hearth report and supervisor's monthly report—handouts 22a and b). Refer participants to the series of forms and roster books on pp. 176-184 and describe how these forms are used and analyzed. Briefly describe the Behavioral Monitoring Tool and the Weighing Monitoring Tool (pp. 183-184), and their particular usefulness to PD/Hearth.

4. (10 min) Explain the Triple 'A' Cycle (on flip chart) to demonstrate the cycle of the continuous monitoring process. Reiterate the importance of feedback to volunteers and supervisors, as well as to the community. Sharing results with the community increases ownership, stimulates discussion and problem-solving, and celebrates achievement.

5. (5 min) Allow time for questions and answers on all issues covered in supervision, monitoring and evaluation.

Daily Hearth Report (sample from CMM Haiti)

Name of Monitrice:_____ Name of Monitrice: _____
Ti Foyer Location: _____ Name of Volunteer Mother:_____

ATTENDANCE (T=child; M=mother)

Child's Name	House	Person resp(M)	Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		Day 7		Day 8		Day 9		Day 10	
			M	T	M	T	M	T	M	T	M	T	M	T	M	T	M	T	M	T	M	T
1.																						
2.																						
3.																						
4.																						
5.																						
6.																						
7.																						

HEARTH ACTIVITY

Day	**Menu**	**Key Message**	**Observations**
Week 1 Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Week 2 Day 6			
Day 7			
Day 8			
Day 9			
Day 10			

Supervisor's Monthly Report (sample from CMM Haiti)

Name of Monitrice:_____ Name of Monitrice: _____
Location: _____ Hearth Date _____Name of Volunteer Mother:_____

Child's Name	Age at 1st wt.	Sex	House No	1st weight	Date	Nutr Status	2nd weight	Nutritional Status Follow-up (NS)								
								wt 1st mo.	date	NS	wt 2nd mo.	date	NS	wt 6th mo.	date	NS
1.																
2.																
3.																
4.																
5.																
6.																
7.																

OBSERVATIONS: (referral to hospital, illness, new sibling, playing well, faltering,...)

Child 1 _____
Child 2 _____
Child 3 _____
Child 4 _____
Child 5 _____
Child 6 _____
Child 7 _____

Session 23: Preparing the Program Proposal and Budget

Total time: 30 min

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

1. Identify the main components of a PD/Hearth program budget.
2. Discuss funding potential and budget issues from program experiences.

Reference in PD/Hearth Guide: p. 25

Preparation:

- Review the PD/Hearth budget worksheet in the Guide, p. 25

Materials:

- Flip chart 3a—PD/Hearth steps
- Sample proposals (if facilitators have any they would like to share)

Steps:

1. (20 min) Use the PD/Hearth timeline (Steps) to review important elements and major cost categories that should be included in a program proposal and budget. Have participants turn to the budget worksheet on page 25 of the Guide, allowing a brief period to look this over. Suggest that programs begin with realistic (i.e. conservative) goals and objectives and a one-year budget.

   Start small, e.g. a PD/Hearth program proposal may be bundled with a nutrition/child survival or food security proposal. However, be sure to provide sufficient resources so that PD/Hearth can be managed appropriately (e.g. dedicated staff).

2. (5 min) Guide discussion about potential funding channels and ways to market the proposal.

   Know your donor
   Visit an active program with potential donor
   Have realistic goals and objectives

   Note that Title II and Child Survival funds are two potential US Government funding sources. It may be appropriate to suggest donors in the country or region that have more familiarity with PD/Hearth. Donors less familiar with the program may be more inspired by a field visit to a successful program. If desired, facilitators may share samples of proposals or make these available on the reference table. Participants may also contact the CORE Office for further advice on preparing a proposal for a PD/Hearth program.

3. (5 min) Highlight examples of
   - a stand-alone program (Indonesia)
   - an integrated program

Most programs to date have been integrated with Child Survival Projects. In Indonesia, several NGOs are integrating Hearth with food programs. Haiti (CMM) started out of a hospital program, and eventually partnered with a microcredit program.

Session 24: Getting Started in PD/Hearth; Effective Use of Consultants

Total time: 30 min

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

1. Discuss key issues for program start-up.
2. Outline potential roles for consultants.

Reference in PD/Hearth Guide: N/A

Preparation: None

Materials:

- Flip chart 3c—PD/Hearth steps
- Flip chart from Session 4 (Flip Chart-4a: Criteria for a PD/Hearth Program)
- Consultant's Tasks Checklist (Handout 24a)
- Sample SOW (Handout 24b)

Steps:

1. (10 min) With the aid of the PD/Hearth timeline, remind participants of the key issues for start-up discussed in session 4. Pay particular attention to the following issues:

   - Determine feasibility: (Refer to the flip chart from session 4, regarding feasibility)
     - Feasibility in the country/region
       Note that where there are impediments to conducting Hearth, it may be possible to apply PD concepts without Hearth (i.e. PDI as a formative research technique).
     - Organizational interest, leadership, community interest

   - Determine potential for interagency collaboration:
     - Other PVO/NGOs in the same country or region already implementing PD/Hearth; value of cross-site visits/visits to working sites
     - Potential for different NGOs (local and international) to be exposed to PD/Hearth and start collaborative programming; potential for a joint TOT of several organizations in a country or region

   - Select the Hearth manager and other key staff to train.

   - Select two initial communities; PD/Hearth may be launched in one of these as part of the training.

2. (5 min) Explain that PD/Hearth may be initiated either as a new project (start-up) or integrated into ongoing programs. (Recall examples of each from previous discussions.) Reiterate the importance of feasibility analysis and community buy-in for both types of program approach.

3. (10 min) Programs may find it necessary to use a consultant to help launch a PD/Hearth program and get the program up and running until a team is in place. The consultant's role might include initial advocacy with key policy-level partners. In some cases, consultants may be asked to return after 3-6 months, and again when scaling up. Hand out the consultant's tasks checklist for PD/Hearth initiation (Handout 24a), which gives an idea of the types of tasks a consultant might help with. Review the checklist and answer questions as needed. Handout 24b, the scope of work (SOW), is a model on which to base a consultant scope of work.

   In selecting a consultant to assist with the launch of a PD/Hearth program, consider the following:

   - Draw on the experience of field workers in a similar culture, same continent; access TA from staff in a successful program.

   - Latin America programs have geographic specificity: there are ongoing programs in several countries (Nicaragua, Guatemala, Honduras, Bolivia).

4. (5 min) Answer questions from participants.

Consultant's Tasks Checklist for PD/Hearth Initiation

Step 1: Assess feasibility of using the PD/Hearth approach with collaborating in-country agency (i.e. level of nutrition problem, potential community volunteers, etc.)

Step 2: Make necessary preparations for in-country tasks of the consultant (average 3-week consultancy)
A: Identify in-country partners (local NGOs, MOH district-level, administrative authorities, etc..)
B: Plan introduction workshop on the PD/Hearth approach (1 or 2 days) for critical partners (MOH, local USAID Mission staff, other NGOs, etc.)

Step 3: Consultant reviews logistics and develops TOT curriculum with agency and identified Hearth manager/leader including:
- Selection of community(ies) for TOT; criteria including proximity to training site, prevalence of problem, willingness of community to host training activities (nutrition assessment, situation analysis, PDI and one model Hearth session)
- Selection of PD/Hearth trainers/facilitators (criteria) to participate in TOT, including key MOH district-level partners

Step 4: Facilitation of 2 weeks TOT training on site, including action plan by trainers for first implementation of PD/Hearth, 2 communities per trainer (up to 10 Hearth centers)

Step 5: Development of a timeline for first implementation of PD/Hearth, including training of Village Health Committee (VHC) members and health volunteers for implementing PD/Hearth (situation analysis, PDI, feedback to community, setting up Hearth sessions, monitoring & evaluation at village level, etc.)

Step 6: Possible technical assistance at critical junction of program implementation, 3 or 6 months. Topics or issues include: quality of program delivery (training review), lessons learned integrated into the program, monitoring & evaluation framework (impact & process objectives, indicators, tools and collection time frame), documentation of community initiatives (community mobilization), replication and scaling up strategies, etc.

Sample Scope of Work
Hearth Consultant

Background
In late summer 2002, the NGO will be incorporating a Hearth nutrition education program into its ongoing USAID-funded Transitional Activities Program (TAP) in Jakarta, Indonesia. The Hearth program, which will run for 18 months, will target children less than three years in communities receiving TAP food assistance. The majority of these children currently suffers, or is at risk of, malnutrition. The Hearth program will make use of positive deviance (PD) methodology to identify those households that are currently providing adequate nutrition to their children, although their resource base is the same as that of their neighbors. Behaviors from those positive deviant households will be shared with families of malnourished children, so that practical, sustainable local solutions to malnutrition can be spread within the community.

The Hearth consultant will provide guidance during the start-up stages of the Hearth program, while it is still being integrated into TAP. The consultant will provide training on positive deviance inquiries (PDI) and analysis, as well as other issues requiring technical expertise.

Objectives

1. To provide the Hearth program with technical expertise during its initial positive deviance inquiries, providing a solid, professional, replicable model for future PDIs.
2. To consult during the start-up phase of the program on the integration of Hearth with TAP, the selection of Hearth program areas, criteria for local NGO partners, plans for expansion and other steps in the planned implementation of the program.
3. Develop training curriculum outline for local volunteers (*kaders*).

Tasks

1. Meet with the NGO management staff: discuss goals and logistics of the consultancy
2. Introduce the Hearth concept to the staff (1 day of theory training)
3. Facilitate Hearth staff, local NGOs and volunteers in:
   - Leading focus group discussions to determine community norms
   - Conducting the positive deviance inquiry (PDI)
   - Analyzing PDI
   - Designing a Hearth based on the results of the PDI
   - Presenting findings to community leaders and discussing starting a Hearth
   - Conducting Hearth sessions (cooking, feeding, weighing, gathering caregiver contributions, creating a roster to track children's attendance and progress, facilitating health education discussions)
4. Present program and next steps to NGO staff and management.
5. If time allows, set up a Hearth monitoring system

Preparatory work (to be conducted by field staff prior to consultant's visit):

1. Assess the prevalence of malnutrition in the area and comparison to Growth Monitoring data from the local health posts

2. Select 2-3 possible pilot sites for the Hearth based on:
   - At least 30% malnutrition among young children
   - Availability of affordable local foods
   - Availability of local women as volunteers
   - Presence of committed leadership in the community

3. Visit 2-3 selected pilot sites and identify health resources

4. Meet with local leaders and key informants in selected pilot areas and discuss the nutrition situation and the Hearth's objectives to solve it. Also, choose existing health volunteers and/or volunteer mothers to participate in Hearth training.

Deliverables:

a) Two operational Hearths set up and running
b) An outline of the training curriculum for volunteers

Location

The TA will be carried out in one or two Hearth/TAP sites, located in one poor area in East and one area in West Jakarta

Period of Implementation

October 10-29, 2002

Session 25: Follow-on Activities, Resources, Support Networks Workshop Evaluation and Closure

Total time: 30 min **Led by:** Lead Facilitator

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

1. Evaluate workshop activities and provide feedback on effectiveness of training methods.

Reference in PD/Hearth Guide: N/A

Preparation: None

Materials:

- Workshop evaluation form

Steps:

1. (20 min) Allow participants time to ask questions, request specific information. Provide information on support networks:

   - See www.positivedeviance.org for ideas and contacts.
   - The CORE Nutrition Working Group is also a good resource for consulting and feedback on consultants.

2. (10 min) Handout workshop evaluation forms. Request that they be filled out and turned in before departure. Resolve any other logistics issues (copies of resources, etc.).

3. If a formal closing ceremony is planned, introduce guests and proceed.

EVALUATION FEEDBACK FORM
PD/HEARTH TRAINING

1. Workshop Objectives

Please check the box that most closely reflects your opinion:

As a result of this workshop….	**Strongly Agree (4)**	**Agree (3)**	**Disagree (2)**	**Strongly Disagree (1)**
a. I considered the potential impact of utilizing the Positive Deviant approach as a basis for facilitating sustainable behavior change in the community				
b. I evaluated the feasibility of utilizing the PD/Hearth Approach for a target community based on the recommended criteria				
c. I can plan and conduct a wealth ranking exercise in a target community				
d. I selected positive deviant families utilizing nutrition baseline and wealth ranking exercise data				
e. I identified positive deviant behaviors utilizing the PDI results				
f. I calculated calorie and nutrient requirements as a part of the process for determining the Hearth menu				
g. I defined quality indicators to be used in the monitoring of PD/Hearth activities				
h. I examined key factors that contribute to the success of Hearth Sessions				
i. I analyzed the essential elements of PD/Hearth Initiatives and will ensure these are incorporated into future PD/Hearth Program Designs				
j. I reviewed the core components of developing a PD/Hearth program proposal				
k. I acquired new skills that I can directly apply to my job				

2. Workshop Processes & Logistics

Please check the box that most closely reflects your opinion regarding this workshop;	**Strongly Agree (4)**	**Agree (3)**	**Disagree (2)**	**Strongly Disagree (1)**
a. The objectives of the workshop were clearly stated				
b. The workshop was presented in an organized and interesting manner				
c. The workshop included a good mix of formal presentations and participatory activities				
d. I was satisfied with the quality of the materials distributed at this workshop				
e. The workshop organizers were responsive to my logistic needs				

3. General Feedback and Forward Planning:

a. What workshop activities did you find most useful?

b. What workshop activities did you find least useful?

c. What PD/Hearth content areas would you have liked to spend more time discussing?

d. What areas of PD/Hearth programming are still unclear?

e. What changes would you recommend for any future PD/Hearth trainings?

f. What additional technical or training support will you or your organization require to increase the quality and or scale of their PD/Hearth programming initiatives?

g. Any additional comments you would like to make?