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IMPLEMENTATION OF HEARTH MODEL GUIDELINES AFRICARE/TANZANIA CS PROGRAM

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A

TABLE OF CONTENTS

ACRONYMS

TRIP ACTIVITIES 1
- Feedback on Nutrition Survey to Village Council and Health Committee (Agenda) 2
- Feedback on Positive and Negative Deviant Inquiries to Village Council and Health Committee (Agenda) 4
- Neighborhood Meetings (Agenda) 5

LESSONS LEARNED 5

FEEDBACK ON THE NERP GUIDELINES DEVELOPED BY SAVE THE CHILDREN 7
- Specific Comments 7

APPENDIXES

Appendix A Neighborhood Register for Nutrition Survey and Tabulation of Weights Form
Appendix B Data on Children weighed in Lenjulu and Chamkoroma Villages by Neighborhood
Appendix C Standard Questionnaire for Interviews with Caretakers During PDI (Home Visits)
Appendix D PD/ND Family Matrixes for Lenjulu and Chamkoroma Villages
Appendix E Overview of Positive Deviant Findings
Appendix F Hearth/NERP Messages Identified for Mlali CS Program
Appendix G Draft Hearth/Nutrition Education Rehabilitation Program Implementation Schedule

B

ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival
CBHF	community-based health facilitators
CS	child survival
GM	growth monitoring
MCH	maternal and child health
MOH	Ministry of Health
NERP	Nutritional Education Rehabilitation Program
ND	negative deviant
PD	positive deviant
USAID	United States Agency for International Development
VHW	village health worker

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TRIP ACTIVITIES

Sunday, 19 July, 1998
Arrival in country

Monday, 20 July
Travel to Mlali child survival field office in Kongwa district capital

Tuesday, 21 July
Overview of NERP with MCSP staff at the field office Travel to Chamkoroma (population 4096) and Lenjulu (population 2115) villages identified for the pilot Hearth activity Debriefing with village council, including members of the village health committee and community-based health facilitators (CBHFs) Discussions about health and nutrition with village leaders had already taken place on several occasions These two villages were chosen by the program staff due to the fact that most community members have relatively easy access to water, facilitating Hearth activities that include the use of clean water and the promotion of hygiene

Wednesday, 22 July
Survey of targeted population, 6-23 month old children, with one team of five to six people for each village The teams consisted of a program manager or supervisor, a district health staff member, a health facility MCH aide, an Africare field officer, and a couple of Africare trained community-based health facilitators The survey activity was previously scheduled with government health workers and the community For the activity, the MCH aide from the health facility did the weighing of children with the assistance of the CBHF One of the Africare field officers filled in the roster of children being weighed by neighborhood, and a program manager or training officer gave the mothers feedback, especially if there was clear need for counseling and education Many of the children did not have a health card, but had a book that indicated the dates that the child was weighed and the weight in kilograms

A problem encountered in Lenjulu was the fact that the days chosen for this survey were about 10 days or so after the scheduled growth monitoring activity had taken place Several of the nine neighborhoods were located one to two hours' walk from the normal weighing site and we, therefore, had a low turnout from those neighborhoods We immediately decided that the following day we would split up the Lenjulu team into two teams and go to sites located closer to neighborhoods in the outskirts

Another thing that was noted was the fact that the Tanzania growth monitoring card does not reflect first, second, or third degrees of malnutrition and normal, it has only three categories normal, moderate, and severe malnutrition (100, 80-60, and <60 percentiles) This posed a problem initially when trying to categorize childrens' weights because we wanted to be able to differentiate between those who were on the high side of normal and moderate and those who were on the lower end of those ranges So, to have categories that more closely reflected four

levels of nutritional status, we subsequently placed children in the following categories 1) normal high, 2) normal low/moderate high, 3) moderate (medium/low), and 4) severe

Thursday, 23 July

the nutrition survey in two villages continued Although splitting the Lenjulu team in two helped, we were not able to reach a large enough percentage of the target population in those neighborhoods As a result, it was decided that for the purpose of the PD inquiries, the program would only focus on the four neighborhoods in Lenjulu where there were large numbers of children weighed The survey activity in Chamkoroma went very smoothly, as the date coincided with the normally scheduled growth monitoring session There appeared to be a very good showing from all six neighborhoods One hundred and forty children aged 6-23 months were weighed in Lenjulu, and 127 children in that same age group were weighed in Chamkoroma In Lenjulu, more than 50 children had to be weighed before we encountered a positive deviant (PD) After weighing a total of 140 children, less than 10 children could really be considered positive deviants

It is important to note that although we were informed by the Ministry of Health/Growth Monitoring (MOH GM) staff and community leaders that we would find 150 or so children in Lenjulu and approximately the same in Chamkoroma, due to logistical and other pre-scheduled program priorities, we did not take the time to collect exact information, including names, on the target population of children aged 0-23 months In retrospect, looking at the fact that the total population of Chamkoroma is close to double that of Lenjulu, it is difficult to understand why there were not substantially more children attending the GM session/survey in Chamkoroma Clinic records for newborns in Chamkoroma are incomplete, due to staff absenteeism during several months, and all other children are lumped together (ages 7-72 months) Obtaining the exact population of children aged 0-23 months is something that will take more time than was expected This is something that will be done for both villages, ensuring that all those who should and who desire to participate in this pilot Hearth activity will be given the opportunity

Friday, 24 July

A meeting/discussion with village council members, village health committee, community volunteers and invited women was held to give feedback of survey results, define poor and better off for the area, and identify PD and ND mothers for the inquiry The meeting in Lenjulu had 22 community members attending, and Chamkoroma had 15 community members in attendance

Feedback on Nutrition Survey to Village Council and Health Committee (Agenda)

1 Reminder of nutrition survey objectives, share results on number of normal, mild, moderate, and severely malnourished children found in each neighborhood

2 Participatory discussion on malnutrition signs and symptoms (elaboration on flip chart paper)

3 Brainstorming on causes of malnutrition in the community (elaboration on flip chart paper)

4 Defining goals of Hearth/Nutrition Education Rehabilitation Program (NERP)

- Find a community-based, sustainable solution for the nutritional recuperation of young children
- Rehabilitate identified malnourished children and maintain their enhanced nutritional status
- Improve the behavior of families in relation to feeding practices and health care

5 Discussion session on current feeding, caring, and health-seeking practices in the community, including foods given to young children and the number of meals/snacks per day (elaboration on flip chart paper to be used as baseline information assisting with the identification of positive deviant foods)

6 Define what is considered poor and what is considered more advantaged in the community (develop list of criteria)

Sunday, 25 July
Program managers discuss draft PD inquiry questionnaire and observation instrument in the guidelines and prepare for inquiry

Monday, 26 July
Four teams conduct a total of eight PD and 4 ND inquiries in Chamkoroma and Lenjulu (over a three day period) Each team conducted one inquiry per day, between 11 am-3 pm (average of three to five hours) A matrix table summarizing the results of the PD and ND was done at the end of each day or the following morning Team members for the inquiry were a program manager or training officer, MOH district staff, child survival (CS) field officer, and a community-based health facilitator

Tuesday, 27 July
PD inquiries continued

Wednesday, 28 July
ND inquiries

Thursday, 29 July
Inquiry teams review and discuss results Conclusions written up on flip chart A meeting/discussion was held with village council member, village health committee, and community volunteers to discuss PD inquiry results, with a presentation and analysis of case-

studies, and identification of PD foods Discussion was held on important health messages Also accomplished were an assessment of volunteer capacity and planning for neighborhood motivation, as well as polling the interest level of parents and mothers availability to participate

Feedback on Positive and Negative Deviant Inquiries to Village Council and Health Committee (Agenda)

1 Presentation of PD and ND inquiry findings family Information (if deemed appropriate), feeding practices, care practices, and health seeking practices

2 Discuss conclusions drawn from the inquiry good foods, good child care, good health care, and poor practices and behavior

3 Participatory discussion replicability of PD practices

4 Discuss sample menus (if time allows)

5 Plan and schedule neighborhood meetings for reporting on nutrition assessment, sensitization of parents on the issue of malnutrition, assessing interest in participation in NERP, discussion on NERP implementation schedule and site, and the recruitment of neighborhood volunteers to finalize plans, logistics, and menus and to register participants

In discussions that took place in both Lenjulu and Chamkoroma, the idea that Africare would need to contribute food items to the rehabilitation sessions was never raised The program staff was very pleased with the enthusiasm with which community leaders took on the idea of developing a community-based rehabilitation of malnourished children Due to the issue of sustainability of this activity, which could be ongoing, Africare would not consider getting involved in subsidizing food supplies, despite the fact that this was a recommendation made in the draft NERP guidelines

Suggestions that came out of the Chamkoroma meeting were that the church groups found in most neighborhoods could be pivotal, and that men in the neighborhood should be included in all neighborhood meetings and planning, as their support is primordial This was especially emphasized because of the requirement that participants bring all the food necessary to carry out the rehabilitation program

Wednesday, 5 August

CS field officers and supervisors in NERP pilot village neighborhood with community volunteers assessing parent's interest and availability of mothers to participate, looking at food supply for Hearth menus Motivation and sensitization for NERP activity Planning and scheduling

Neighborhood Meetings (Agenda)

1 Report results of nutrition survey (how many children weighed were normal, mild, moderate, and severely malnourished) and PD and ND findings

2 Sensitize neighborhood parents on the issue of malnutrition signs, symptoms, and consequences

3 Assess neighborhood interest in NERP

4 Discuss NERP implementation schedule and identify potential site(s)

5 Recruit women volunteers within the neighborhood to finalize plans and register participants (identify ideal volunteer profile)

Thursday, 6 August
Neighborhood meeting continued

Friday, 7 August
Neighborhood meetings continued

LESSONS LEARNED

1 It is important to schedule time to obtain the exact numbers and possibly names for your survey target population, either from the local health facility or from the local government Gathering this information is likely to take longer than envisaged, due to the fact that registers and record keeping is not always straight forward

2 It is useful to schedule the survey activity on the dates that routine growth monitoring are scheduled Mothers are used to attending these sessions and carrying out this activity simultaneously saves them having to take additional time out of their daily workload

3 It is a good idea when working in villages with large populations (i e , several thousands) and more than five or six "neighborhoods," to think about targeting only part of the village at a time for a Hearth activity

4 It was noted that it is important to specify eligible birth dates when planning the survey activity with the survey team members, i e , the target for this activity were children 0-23 months of age, and as the survey was done in July 1998, only children born from August 1996 through January 1997 were designated as being in our target age group

5 It is important to take a look at the child growth monitoring card ahead of time, verifying how the levels of malnutrition are designated in order to know how the weights of surveyed children will be categorized

6 It is important during the survey activity to be assured of the child's age and that the child does fit into the target population This may mean sending the mother back to get a birth certificate if she does not have a child health card, i e , in Lenjulu, a mother insisted to the survey team that her child was born in August of 1996, making the child 23 months old In looking at the child, a program manager suspected that the child looked so healthy and large that she was more likely to be 3 years old, but since the mother repeatedly insisted that she was born in 1996, the child was then identified as a PD A PD inquiry date was later set up, only to find out upon arrival at the house that the child was indeed 3 years old

7 During the actual survey, we found it to be useful to immediately investigate whether a child would or would not be considered a positive deviant If the child was particularly healthy with a very good weight, we would ask preliminary questions such as "What is being fed to the child?" In the case of a 7 month old weighed in Lenjulu, it turned out that the child is still only on breastmilk—this is a case whereby the team may choose another candidate for the PD inquiry, perhaps a child who is either older or eating different foods The team would also ask the community-based health facilitator whether he knew the mother, her economic status, and the general location of her house This facilitated the notification of these individuals later and reduced the chances of misidentification in the event that the child is identified as a PD This was also done for NDs

8 It is important to encourage mothers who come with children in the age range outside of the target population by weighing those children as well, especially when the mother has walked a long distance for this service This applies if the program should chose to do the survey on a date other than the normal GM date, whereby all under-5s are weighed and the target age group for the purpose of the survey is registered separately

9 Once the nutrition survey and positive deviant inquiries have taken place, planning a neighborhood Hearth or Nutrition Education Rehabilitation Program with individual neighborhoods is a process that takes time up to two to three weeks in order to carry out sensitization, ensure interest, and make sure that all is put into place and necessary steps taken, including the training of the volunteers, planning with participants parents about food contributions, and the identification of a site or scheduling site rotations If community enthusiasm and volunteerism is absent, then the program may need to consider not carry out a Hearth activity

10 In discussions with village health council and village health committee members, it was felt that the use of PDs as models and volunteers for Hearth activities may not always be a good idea, due to jealousy As these mothers may be ostracized or looked upon with

contempt because they have been given special merit or identified as being different, it may be a better idea to let neighborhood women offer themselves as volunteers for this activity It was also realized that PDs would likely not have enough time to volunteer full time for such an intensive, time-consuming program As there were very limited numbers of them, other volunteers would need to be recruited to assist anyway

11 It is important to take the cultural environment into consideration when beginning to undertake surveys, inquiries, and rehabilitation program designs In Lenjulu, a PD parent identified was adamant about not being interviewed and was angered by the arrival of the team, although this visit had been requested/announced prior to the team's arrival He denied that his child was healthy The rationale behind this was the fact that it is sometimes felt that if one is too happy or "showing off" one's fortunes, these may be taken away from you Parents will often say at a GM session that their children are not that well or sick from time to time, when in fact that children might be very healthy

12 In promoting the rehabilitation of malnourished children, it is important to keep in mind people's possible interpretation of health messages When encouraging the increased consumption of food, this could lead mothers to increase the carbohydrates (such as the maize-meal-based staple, ugali) as opposed to increasing other food groups in the diet

13 It is important for PD and ND inquiries that parents be advised that they do not have to go out of their way for the inquiry team

14 The agenda for community meetings was sometimes found to be quite full, due to discussion and community interest in particular topics Flexibility is important When meetings for survey and PD and Hearth Model planning start going beyond two hours, it is probably a good idea to adjourn and schedule a continuation meeting

FEEDBACK ON THE NERP GUIDELINES DEVELOPED BY SAVE THE CHILDREN

Overall commentary was that the guidelines were clear, thorough, and easy to follow

Specific Comments

Pg 7, 2nd paragraph-Phase 1 The guideline seems to suggest that children actively attend NERP sessions for 10-12 months, which is probably not what it is trying to say Later on, the guideline gives a sample schedule of a month-long NERP activity

Starting on Pg 8 #5 It is not necessarily clear what the word "hamlet" is referring to The word "neighborhood" is used later and is more clearly understood It might be a good idea to just use the latter throughout the guidelines

Pg 15, Step 3 How realistic is it to undertake an activity as extensive as making a map of all the households in the neighborhoods, when you might be talking about a village population of two to five thousand people? That activity in and of itself entails a lot of extra time spent by community leaders and members and would likely have to be done at the individual neighborhood level—meaning anywhere from 5 to 10 meetings When working with community leaders and existing health workers, it was found that most people will be relatively well acquainted with the families in their neighborhoods and can more or less assure that volunteers identified can serve all corners of the community

Pg 16, Criteria for HV selection It was felt that since this is a short-term activity to be implemented by neighborhood members and involved time away from other duties, it would be better to have individuals volunteer themselves and not try to suggest that there should be a criteria for selection, as one would do for a VHW

Pg 18 It would be useful to add the comment that when scheduling for a nutrition survey with community leaders and local health workers, it might be advantageous to plan it for the same day as the regularly scheduled GM session, especially in places that have routine monthly or bi-monthly weighing, so that mothers are not displaced twice This should also help to get the level of attendance required

Pg 18, on the creation of rosters Would be clearer if the sentence read, "Create a neighborhood roster of the children to be weighed, with proper identification " The way it currently reads would lead one to assume that an address should be given for each individual child as opposed to keeping separate rosters for each neighborhood and identifying the child's neighborhood prior to writing down the information pertaining to him/her

Pg 18-19, during the survey It would be useful to add that in countries where exercise books are utilized as much or more than growth monitoring charts to record an individual child's information, it is important to carry sample growth charts so as to note where the child's weight falls (nutritional status), or an anthropometric table so as to be able to categorize the child

Pg 19 It might be useful to advise that a preliminary identification of potential PDs and NDs can be done during the survey activity itself A survey team member can ask the mother basic questions and ensure that the community health volunteer or leader involved in the survey sees this individual, has an idea of where she lives, and an idea of her economic status in relation to the rest of the community

Pg 36, on the creation of sample menus It seems more appropriate to spend the time creating menus at the neighborhood level with parents (especially mothers), who will then be expected to supply the food for the rehabilitation session The village council/health committee are working at a higher level, and as facilitators, will not necessarily be involved in the neighborhood-level implementation itself Meetings with the council/committee members are already covering much ground in planning and then presenting survey results, PD foods, and behaviors The latter gives

the village leaders an adequate idea of what the program would be promoting, and encouraging neighborhood mothers to include in sessions

Pg 36, on making the sample menu The statement, "make 4 food squares and write in the name of food that PD families feed their children," is not entirely clear One has to read on to figure out that we are probably not being instructed to write in the PD foods found in the four different families or to write four different foods found in findings It would be clearer to state right off, "make 4 squares and create menus/meals based on the PD foods found in the PD families, including actual ingredients "

Pg 38, on the Note (towards bottom of page) Africare does not support the idea that the cost of food should be borne by the donor, partnering, or implementing agency We would like to promote a rehabilitation and education program that is conducted by the neighborhood with their own resources and can be repeated at different intervals within a given neighborhood when the need arises We do not want a village to be dependant on the program to carry out this activity This is why Africare is suggesting that two to three weeks are needed post PD inquiries to sensitize neighborhoods and to mobilize volunteers and parents to gain interest and commitment to rehabilitating children

Pg 42, first table talking about strategies to support behavior change Regarding the suggestion that a special menu can be used on the last day of the NERP consisting only of PD food—this statement leads one to believe that other meals during the NERP would normally include non-PD foods Are we talking about the implementing agency or donor (participants in the case of Africare) supplying foods that not every family in the community can necessarily afford? When talking about a rehabilitation program based on PD foods, it was understood that the inquiry would identify foods and menus that any family can afford and promote these

Pg 48 I think it would be useful at the end of the guidelines to include a few lessons learned from the Hearth programs in different countries, as elaborated from the Bangladesh experience in the BASICS publication of the Hearth Nutrition Model pg 80

Note The sample forms for the nutrition survey and the standard questionnaire and observation checklist for the PD/ND inquiries were found to be adequate for the needs of the Africare/Mlali CS program These were the instruments used to carry out this activity

APPENDIXES

APPENDIX A

NEIGHBORHOOD REGISTER FOR NUTRITION SURVEY AND TABULATION OF WEIGHTS FORM

Neighborhood Roster for Nutrition Survey

Name of Village _____

Name of neighborhood _____

Name of local chief or leader _____

Name of CBHF _____

Name of MCH aide _____

Date of weighing _____

Name of Child	Father & Mother's Name	Birth Ranking	Female/ Male	Date of Birth Mth/Yr	Weight	Nutritional Status	Comments

TABULATION OF NUTRITION SURVEY WEIGHTS

First weighing of all children 0-23 months of age (baseline)

Village Name _____

District/Region _____

Date of Survey _____

Name of Neighbor hood	Total # of children	Total Children weighed	Normal (A)		1st Degree (B)		2nd Degree (C)		3rd Degree (D)		Total A,B,B,D	
			#	%	#	%	#	%	#	%	#	%

APPENDIX B

DATA ON CHILDREN WEIGHED IN LENJULU AND CHAMKOROMA VILLAGES BY NEIGHBORHOOD

LENJULU

Total number of children weighed - 140

LENJULU A

48 children weighed

a 18 (37 5%) - Normal/normal high
b 20 (41 7%) - Normal low/moderate high
c 7 (14 5%) - Moderate
d 3 (6 25%) - Severe

LENJULU B

22 children weighed

- 9 (41%) - Normal/normal high
- 7 (31 8%) - Normal low/moderate high
- 5 (22 7%) - Moderate
- 1 (4 5%) - Severe

MAGENGE

33 children weighed

- 11 (33 3%) - Normal/normal high
- 7 (51 5%) - Normal low/moderate high
- 3 (9 1%) - Moderate
- 2 (6 1%) - Severe

LOBILO

21 children weighed

- 5 (23 8%) Normal/normal high
- 8 (38%) Normal low/moderate high
- 6 (28 5%) Moderate
- 2 (9 5%) Severe

MANDEBWA

12 children weighed

- 6 (50%) - Normal low
- 6 (50%) - Moderate

CHIMEHE

1 child weighed

- Normal low

SUGUTA

3 children weighed

- 1 (33 3%) - Normal low
- 2 (66 6%) - Moderate

MBELESELO & NGOIKO

Non weighed

APPENDIX C

STANDARD QUESTIONNAIRE FOR INTERVIEWS WITH CARETAKERS DURING PDI (HOME VISITS)

Standard Questionnaire For Interview With Caretakers During PDI (Home Visits)

I General introduction questions

14 How old is (name of selected child)? _____
15 How many children do you have?_____
16 How old are they?_____
17 How many people live in this household?_____

II Questions on feeding practices

18 Are you (still) breast-feeding this child (name)? (If no move to #9)_____
19 (If yes) how many times a day do you breast-feed your child?_____
20 Do you give food to your child in addition to breast-milk? (If no move to #15)_____
21 (If yes) what food do you give your child beside breast-milk?_____
_____
_____

22 When did you wean your child?_____
23 How many times a day do you feed your child? How much?_____
_____

24 What food did you feed your child yesterday in the morning, midday, in the evening?_____
_____
_____
_____
_____
_____

25 Does your child eat from the family dish?_____
26 What do you do when your child does not want to eat?_____
_____

27 Do other people in your neighborhood feed your child? If yes what food?_____
_____
_____

28 In your opinion what food are not good for young children? And why?_____
_____
(Ask this question to other family members such as mother-in-law, father)_____
_____
_____

APPENDIX D

PD/ND FAMILY MATRIXES FOR LENJULU AND CHAMKOROMA VILLAGES

FAMILY HISTORY	FEEDING PRACTICES	CARE PRACTICES	HEALTH SEEKING PRACTICES
Family # 6- Lenjulu ND Agnes Lameck 13 months Malnourished child 1st born Still breast feeding Maria Lameck (mother) Farmers No home gardens, there is cat, chicken and goat Normal cooking and eating place	Breast feeding every time she wants No special food 3 times daily Very small amount Porridge, cows milk, ugali and vegetables Ugali, vegetables of pumpkins, groundnut soup, sweet potatoes mixed with beans Sweet potatoes Drinking water	She doesn't like to eat well Normal hygiene Low standard body hygiene Low standard feeding hygiene Low standard care and supervision No good relationship	No diarrhea episode Giving the child tetracycline purchased from the shop Child is given porridge with milk Fever, crying without reason She purchase drugs and sometimes goes to Gairo hospital Completed immunization

FAMILY HISTORY	FEEDING PRACTICES	CARE PRACTICES	HEALTH SEEKING PRACTICES
Family #1 - Chamkoroma PD			
Neighborhood- Makole Juu Loy Mbaigwa 10 months Very health 2nd born Still breast feeding E Mbaigwa (mother) Donald Mbaigwa (father) Nyemo Mbaigwa (sister) Grandfather Grandmother Peasant farmers (Groundnuts, maize, beans, vegetables, cassava, sweet potatoes) 4 hk of land Fruits and vegetable garden (masada fruits), tomatoes Hens and dog three stones (mafiga) Eating on the ground The place was not clean & disorganized	Breast feed continuously all the day long Maize porridge with groundnuts eggs, milk, beans & vegetables Breast feeding is continuously Other meals 2 - 3 times a day Quantity of meal - more than enough (sufficient) Snacks - groundnuts, sugar cane (Ugali, green vegetable, mixed with groundnut) plus breast milk	The mother feeds the child well and actively Kitchen and utensils not clean Hands washed after work, before eating and after eating also before feeding the baby but not using soap The baby is washed 3 times a day Other family members are not clean clothes are dirty, and their compound is dirty (not very clean) Mother is main caretaker Father, sister and other family members also took after the child The child is the focus of the whole family, she is coves by all members of the family	No diarrhea episode Use of ORS for treatment of diarrhea Giving extra milk and extra porridge Frequent breast feeding during child illnesses Yes, there were signs of skin rushes, body temperatures, refuse to eat They seek help from the local dispensary for serious illnesses they go to hospital Completed or taken all vaccination

APPENDIX E

OVERVIEW OF POSITIVE DEVIANT FINDINGS

Overview of Positive Deviant Findings

Chamkoroma Good foods common to all PD Children (available to Everyone)

1 Groundnuts (Everyday)

2 Beans/peas (2 - 3 times a week)

3 Green vegetables (2 - 4 times a week)

4 Sweet potatoes/paw paw (fruits) (4 - 5 times a week)

Extra special foods not available to all

1 Fish(4 - 5 times a week)

2 Milk/yogurt (Approx 2 times a week)

3 Eggs (1 time a week)

Lenjulu Good foods common to all PD and ND children (Available to all)

1 Green vegetables (Everyday)

2 Beans (Everyday)

3 Milk (Everyday)

4 Ugali (Everyday)

5 Sweet potatoes/cassava (1 - 2 times a week)

Extra special foods not available to all

1 Eggs (Once a week)

2 Dried fish/dagaa (Once a week)

3 Meat (Once a week)

APPENDIX F

HEARTH/NERP MESSAGES IDENTIFIED FOR MLALI CS PROGRAM

NERP Messages

1 Exclusive breast feeding for first 4 6 months

2 Increased use of PD foods groundnuts, beans, milk and fruits/vegetables

3 Increase number of meals/snacks per day

4 Improve household, feeding and body hygiene

5 Management of diarrheal disease with ORS, continued feeding and fluids, and supplemental feeding after illness

6 Importance of child spacing

7 Prompt care-seeking in the case of illness (malaria, diarrhea)

8 Use of impregnated mosquito net

9 Importance of active feeding and close supervision

APPENDIX G

DRAFT HEARTH/NUTRITION EDUCATION REHABILITATION PROGRAM IMPLEMENTATION SCHEDULE

DRAFT
NUTRITION EDUCATION REHABILITATION PROGRAM
IMPLEMENTATION SCHEDULE

Week 1 - Debrief community leaders, schedule and prepare for nutrition survey with health facility workers (Ideal to do survey during normal scheduled growth monitoring sessions)

Week 2 - Implement nutrition survey, analyze results, identify Positive Deviant and Negative Deviant mothers, schedule Inquiries

Week 3 - Conduct PD and ND Inquiries (Total of 4 PDs and 2 NDs per village), analyze results with community leaders/volunteers, discuss feasibility of implementing NERP activity

Week 4 - Preparations for NERP Neighborhood meetings for sensitization and assessment of interest Selection of neighborhood volunteers, NERP menus, site , registration of participants, scheduling

Week 5 - Training of neighborhood volunteer women who will facilitate the NERP activity (2-3 days)

Week 6 -10 - Implementation of NERP activity (Start up date for NERP sessions will be decided by the neighborhood)