Training of Trainers Workshop on:

Positive Deviance and Hearth:
Mechanisms for Community-Based Management of Malnutrition

December 8-12, 2003
Ahmedabad, Gujarat, India

The CORE Group/USAID/Counterpart India
Lead trainer: Donna Sillan

ACRONYMS

ARI	Acute Respiratory Illness
CDD	Control of Diarrheal Disease
CHT	Community Health Team
CORE	Child Survival Collaborations and Resources Group
CPI	Counterpart International
EPI	Expanded Program for Immunization
ICDS	Integrated Child Development Scheme
LNGO	Local Non-Governmental Organization
NERS	Nutrition Education and Rehabilitation Session
NGO	Non-Governmental Organization
ND	Negative Deviant
NPD	Non-positive Deviant
PD	Positive Deviant
PVO	Private Voluntary Organization
TOT	Training of Trainers
UP	Uttar Pradesh
USAID	United States Agency for International Development
VHC	Village Health Committee

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Foreword:

The PD/Hearth Training of Trainers workshop in Ahmedabad, India is part of a larger dissemination process, after being tried and tested in many settings both rural and urban, in many countries in all regions of the world.

This workshop was conducted for 27 participants from 8 countries in Asia working within 13 different non-governmental organizations, a government program, UNICEF, and a university. The years of experience in the training room totaled several centuries with a high level of professional expertise. There were nutritionists, physicians, and managers of nutrition and development programs, government program officers and community workers. The seeds of a network between the participants were planted and will hopefully bloom into fruitful exchanges, including not only information sharing, but actually thinking and working together. The PD/Hearth TOT workshop was an excellent opportunity for networking.

Counterpart International provided an excellent example of an urban Hearth, which served as a "living university" site. The urban slum communities of Ahmedabad that are implementing Hearths are to be thanked for their openness and receptivity to the visitors, who came to learn from them. The CPI staff members proved to be the most hospitable hosts, providing a week of seamless logistics, and lively participants at the same time.

CORE, The Child Survival Collaborations and Resources Group, had the vision to sponsor this workshop, selecting the setting and inviting the participants. The CORE Group, a membership association of U.S. NGOs strengthens local capacity on a global scale to measurable improve the health and well-being of children and women in developing countries through collaborative NGO action and learning. Many thanks to USAID, the sponsor of this workshop through its funding of the CORE group.

In my Heart of Hearths,
Donna Sillan, Lead Trainer

A. <u>Introduction:</u>

The Hearth Nutritional Model using the Positive Deviant Approach is one approach to combating malnutrition. It started in the 1960's in Haiti, and until just recently has begun to receive more global attention as an effective approach as its proven success has been shared and documented.

What is Positive Deviance?
It is a departure, a difference, or deviation from the norm that results in a positive outcome. It is a process of inquiry and action that looks for children who are well-nourished in spite of the forces working against their nutritional status, and examines the behaviors, beliefs, and practices which enable that child to cope and thrive. A positive deviant is a poor member of the community who has a well-nourished child while most of their neighbors do not.

Why is it labeled "positive"? We are looking at what is working, what people are doing right. Utilizing what resources are available, not what is needed and missing. It is asset-based, rather than needs based.

Why is it called "deviant"? The practices deviate from the norm of malnutrition within a family and community. It is a departure from the conventional wisdom, a change of course, which turns from the current path and takes a new path.

What is a Hearth? It is a home kitchen, community volunteers volunteering their homes where their hearths are, inviting caregivers with malnourished children to a sequence of two-week workshops to cook, feed, and practice ways of treating malnutrition which are already being practiced in their community.

What is the relationship between PD and HEARTH?
A Positive Deviance Inquiry (PDI) is a process of discovery that occurs before a Hearth directly informing the content to be shared during the Hearths. A PDI is carried out by community volunteers who examine current practices that are being practiced today by neighbors of well-nourished children, who do not differ socio-economically and are able to maintain health for their children.

What is the basic difference from other approaches?

Solutions to community problems already exist within the community!

It is an approach that identifies the unique practices of some community members that set them apart from others within the same community and allow them to cope more successfully within the same resource base. It finds the high performers amidst the same adverse conditions that "out-perform" their neighbors. It taps those that have learned to adapt, cope and successfully deal with nutrition before economic improvements occur or clean water and sanitation are accessible to all.

GOALS of HEARTH: (three-fold purpose: not simply rehabilitation)

1. To **rehabilitat**e identified malnourished children in the community
2. To enable their families to **sustain** the rehabilitation at home on their own
3. To **prevent** malnutrition in young children in the community

B. Workshop Summary

The participants for the workshop were mainly PVO program staff from India, Bangladesh, Pakistan, Philippines, Indonesia, Nepal, Tajikistan and Uzbekistan and UNICEF India Nutrition Unit, a Government of West Bengal project officer and representatives from local NGOs. See ***Attachment A*** for a list of participants.

Four facilitators facilitated this five-day participatory training of trainers. The training team, lead by Donna Sillan, included Monique Sternin, the grandmother of Hearth now at Tufts University, Vanessa Dickey, a Hearth practitioner in Indonesia and Krishna Soman, an advocate of Hearth working within a research institute.

The workshop began on the eve of the first day, to get a jump start on registration and to show the video produced by BASICS, entitled *PD/Hearth: Finding Community-based Solutions to Malnutrition.* The training approach utilized adult participatory techniques, including daily warm-ups, brainstorming sessions, small group work, evening discussion circles, participant presentations, field visits which included practical observation of the PDI process and a working Hearth in action. A volunteer participant did a daily wrap-up at the end of the day to summarize the learning. Daily evaluations were conducted to inform the next day's activities for the trainers. The evaluation results were shared the following day to start off the day.

The Orientation and Training for the Design and Implementation of a Positive Deviance/Hearth Program, a facilitator's guide that was compiled by the members of the CORE Nutrition Working Group, was a useful guide for the training process. Although there was some variation from the guide, in response to the trainees' needs assessment and knowledge base, it provided many exercises and processes. A *Learning Needs Assessment* was sent out to the participants prior to the workshop. The results guided the facilitators in the workshop design. See ***Attachment B*** for a summary of the results from the Learning Needs Assessments.

The Resource Guide for Sustainably Rehabilitating Malnourished Children through Positive Deviance/Hearth, published by CORE in February 2003, was used as a reference guide throughout the workshop. Participants received a hard copy and a CD-Rom copy of the guide.

PowerPoint presentations which were prepared by Monique and Jerry Sternin were used to illustrate and provide an *Overview of PD/Hearth and the 6 steps* or 6 D's of the model.

The logistics of the workshop were arranged by Counterpart International, India staff, the host organization for the workshop. Mr. Ramesh Singh, Country Director and Ms. Heer Choksi, Health Education Specialist, Mr. Jaydeep Mashruwala, Program/HMIS Manager and Mr. Milesh Hamlai, Finance and Adminstration Officer, and Ms. Anupama, Program Officer, prepared the logistics impeccably. See ***Attachment C*** for the logistics plan.

The list of participant packet materials and other resources provided are found in ***Attachment D***. The list of evening discussion circles are in ***Attachment E***.

C. Workshop Goals and Objectives

Overall Workshop Goal:

To enable communities to reduce their levels of childhood malnutrition and prevent malnutrition in the future through the implementation of the PD/Hearth Methodology.

Workshop Objectives:

1. Introduce participants to the Positive Deviance/Hearth Approach and its potential benefits for addressing and sustaining nutrition improvements in resource poor communities.

2. Equip participants with community mobilization skills to support communities in the implementation of PD/Hearth activities.

3. Equip participants with tools to monitor, evaluate and expand PD/Hearth interventions for addressing malnutrition among children

4. Provide participants with technical resources, tools and links to operational and advocacy networks for the support of implementing PD/Hearth activities.

Schedule:

Day 1	Overview of Hearth Experience Introduction of Concepts Community Mobilization
Day 2	Positive Deviance Inquiry
Day 3	Field Visit: PDI exercise and Hearth Observation
Day 4	Hearth Planning
Day 5	Monitoring and Evaluation/Next Steps

D. PD/HEARTH INDIA WORKSHOP DETAILED AGENDA

Facilitator Code:
D=Donna K= Krishna M= Monique V= Vanessa P= Participant H= Heer J=Jaydeep T= Team

7:00-9:30 pm	Registration and Hearth video viewing (Sunday night)
	DAY 1
8:30	Arrival
9:00 – 9:30 **CPI** 9:30-10:15	-Welcome/ Introductions/lighting of lanterns -Tea and breakfast Hearth - Network with officials
10:15-10:30 **D** 10:30-11:00	-Review of Workshop Objectives -Review of Training Agenda -Expectations, Norms, Logistics, Introductions - Experience with different nutritional models
11:00-12:15 (1.25hr) **V**	-Storytelling -Overview of PD/Hearth -6 D's of PD/9 Key Steps
12:15– 1:15 **M**	-PD /Hearth Field Experiences & Program Results -Key Objectives of PD/Hearth
1:15-2:15 (1h)	**LUNCH**
2:15-3:45 (1h 30m) **D**	STEP 1: Determining the Feasibility of PD/Hearth for the Target Comm. -Characteristics of Program Area -Alternatives to PD/Hearth
15:45– 16:00 (15m)	**BREAK**
16:45 – 5:15 (1hr 15m) **K & M**	STEP 2: Community Mobilization -Fostering Ownership -Strengthening Community Structures -Lessons Learned
5:15 5:45 (30m)**D**	STEP 2: Selection of Project Staff & Community Resource Persons (Organogram)
5:45 – 6:00 (15m) **P**	Review of key learning highlights from participants

	DAY 2
9- 9:15 (15m) **V**	Review of Day's Agenda Logistical Updates
9:15 – 10:45 (1.5 hr) **K & M**	*(DEFINE the Problem)* STEP 3: Preparing for the PDI: Gathering & Using Data -Situational Analysis -Wealth Ranking -Nutrition Baseline: M & E
10:45-11 (15m)	**BREAK**
11:00 – 12:45 (1 hr45m) **V**	(*DETERMINE individuals who have desired behavior*) STEP 3 con't: Identifying Positive Deviants -Criteria for Choosing Households -Case Study work
12:45 – 13:45 (1hr)	**LUNCH**
13:45 – 15:30 (1h	(*DISCOVER Uncommon Behaviors)*

45m) **H & J**	STEP 4: Conducting the PDI -Process, Methods, Tools, Training -Good practices: Feeding, Caring, Health-seeking & Hygiene -Sample Instruments: Semi-structured Interviews, Observation, Home Visits
15:30 – 15:45 (15m)	**BREAK**
15:45 – 16:30 (45m)	-Role Plays & Puppet show of PDI, PDI practice **P & H**
16:30-17:00 (30m)	Q & A on PDI process & training, use of instruments, analysis and feedback **TEAM**
17:00 – 17:30 (30m)	Organizing for field work: Team & Logistical Preparations **CPI**
17:30 – 17:45 (30m)	Review of Key Learning Highlights (from participants) **P**

DAY 3	
8 – 9	Departure for field exercise (lunch in field)
9 – 17:00	Conduct PDI in sample slum pockets (7)
	After completing PDI in households, debrief in small team to synthesize PDI findings, analysis of information gathered p. 99-100 M
	LUNCH in field office
	Travel to Village for Hearth Demonstration sites (2)
	Visit villages to observe Hearth Session in operation (if possible, some teams observe rural sites and others urban sites)
	Return to workshop site and debrief in small groups
DAY 4	
9 – 9:15 (15m) **K**	Review of Day's Agenda Logistical Updates
9:15 – 10:15 (1hr) **M**	Debrief from Field -Conducting the PDI -PDI Analysis – Implications for Hearth Design
10:15- 10:45 **CPI**	Community Feedback: Mobilization continued Puppet Show
10:45-11 (15m)	**BREAK**
10:15 – 10:45 (30m) **V**	STEP 5: Designing Heath Sessions -Hearth Protocols: Criteria & Choices -Monitoring and Supervision
12:45 – 13:45 (1 hr)	**LUNCH**
13:45 – 14:30 (45m) **D**	STEP 5 con't: Participatory Health Education -Incorporating PDI behaviors -Learning by Doing -Developing Schedule
14:30 – 15:30 (1h) **CPI**	STEP 6: Conducting the Hearth Session -Debrief from Hearth Demonstration (Q&A) -Hearth Session Non-negotiables -Local adaptations to meet contextual needs -Seasonal Adaptations
15:30 – 15:45 (15m)	**BREAK**

15:45 – 16:15 (30m) **K**	STEP 7: Supporting New Behaviors through Home Visits & Community Ownership
16:15 – 17:30 (1h 15m) **D**	STEP 8: Repeating Hearth Sessions as Needed -One Year Activity Plan -Exit Strategy
17:30 – 17:45 (15m) **P**	Review of Key Learning Points (from participants)
	DAY 5
9 - 9:15am (15m) **M**	Review of Day's Agenda Logistical Updates
9:15 – 9:45am (30m) **M** -	Hearth Key Objectives -Essential Elements for Hearth -Key Steps for PD/Hearth
9:45 – 10:45am (1hr) **D**	Staffing & Resources Required -Job Task Analysis -Training Plan -Budget
10:45 – 11 (15m)	**BREAK**
10:45 – 11:15am (30m) **V**	Performance Supervision of PD/Hearth Activities
1l:15 - 12:45 (1h 30m)	(*DISCERN Effectiveness of Intervention*) Monitoring & Evaluation -Determining Indicators & frequency of measurement -Tools for Tracking Progress -Using Data for Decision Making -Sharing results with the community (Scorecards) & other stakeholders (small groups)
12:45 – 13:45 (1 hr)	**LUNCH** **POP QUIZ :Charades**
13:45 – 14:45 (1h) **M**	(*DISSEMINATE Successful Practices/Scale UP*) STEP 9: Expanding PD/Hearth -Steps & Critical Success Factors
14:45 – 15:30 (45m) **D**	-Technical Resources available for PD/Hearth -Q&A clarifications on PD/ Hearth Implementation -Next Steps: Existing & Establishing Networks
15:30 – 15:45 (15m)	**BREAK**
15:45 – 16:15 (30m) **T**	-Workshop Eva luation & Closing Ceremony -Presentation of Certificates

E. <u>Inauguration Ceremony</u>:

In a very auspicious and meaningful ceremony, the workshop was opened with the lamp lighting ceremony. This symbolized the lighting of new ideas that would be introduced during the workshop and how the group will spread the light to each other's and others outside of the workshop.

Speakers:

1. Ramesh Singh, Director of Counterpart International/India:
Welcome the trainers, participants, chief guest and dignitaries. Invited Technical Advisory Committee members and partners to the dais.

2. Darshana Vyas, Director of Health for Counterpart International, headquarters:
"In the land of Gandhi who promoted social change and working with communities, we are here working on this community-based program. We have been implementing Hearth for 16 months and we are preparing for expansion. We are working with in partnership with a local NGO and the Ahmedabad Municipal Corporation. Hearth is a shining example of social change. This workshop is to learn from each other."

3. Dr. DN Pandey, Honorable Secretary and Commissioner MOH Gujarat:
"Let me welcome all of you. I am really grateful to Counterpart International and CORE for holding this workshop for this important issue of reducing malnutrition. ICDS, micronutrient initiatives have all been used without nutritional improvement. But, the benefit of *this* program, the success is clear because it is sustainable. Government at local and provincial level has already adopted this approach. I want to see this in the field after the workshop is over and if the results are excellent the government can extend financial and non-financial assistance."

4, Donna Sillan, lead trainer:
I am grateful and humbled by the Jeevan Daan program and the active community members and caregivers who bring their children to the Hearths. I am glad that Darshana Vyas took the leap of faith to try Hearth here. She had reservations whether Hearth could work in an ethnically diverse urban setting. When I came to conduct the Hearth training in August 2002, I was impressed at how the staffs understood and embraced the PD/Hearth concept. I salute CORE for selecting this program as training site and USAID for funding CORE activities such as this workshop. This Hearth site deserves to be show cased, as it is a stellar example of a Hearth.

This program started slow and steady, piloting the process is 6 slum pockets so far and starting up to 10 Hearths. There was 88% malnutrition, 66% of them being female. It has already reached 120 children, 91% have gained weight and graduated. From 0% normal at baseline to 20% normal at follow up. The rest are growing according to international growth standard rate.

Why did CPI decide to pilot the PD/Hearth? While implementing their Child Survival program, the Child Survival staff realized that malnutrition was undermining all their public health efforts. Interventions in EPI, ARI and CDD were compromised by the high prevalence of malnutrition. They also saw that children were hungry today, were hungry yesterday and months if not years before yesterday. They wanted to intervene quickly and efficiently to address this urgent need.

CPI staff also wanted to dispel the myth that poverty is the main cause of malnutrition. They had seen richer families with malnourished children and poorer families with well-nourished children. The aim of the PDI is to examine this phenomenon whereby well-nourished children can come from poor families. They also felt that culturally, the Hearth concept was already embedded in the Indian tradition of the "Chula." This would make the intervention more socially acceptable.

In spite of the major setbacks to this program: a highly destructive earthquake in 2001 and tragic civil disturbances in 2002, the city is in its healing period. After the storm, CPI selected Hearth as an entry point, to start with combating malnutrition and to demonstrate their commitment through a highly visible activity, which rallies a lot of attention and energy in any community.

During the training, two separate Hearths were set up, one in Muslim community and one in a Hindu community. One year later, beyond my wildest dreams, Hearths were being conducted within the two groups together. The Hearth is a living organism that evolves. In this case it served to overcome differences and go beyond caste and creed and build a bridge of understanding and peace. The behavioral change of the Hearth brought about a social change as well. The power of PD/Hearth!

What brought success? The key ingredients are:

- ✓ Large commitment of Counterpart (community mobilization is in their blood)
- ✓ Community commitment through volunteers in Community Health Teams and local leaders support
- ✓ Participation of caregivers: the 1st handful of food at the Hearth was from a beggar woman
- ✓ Strong NGO leadership: Local Director and Headquarters Dir. of Hearth
- ✓ Strong NGO team: staff are highly motivated and lean
- ✓ Partnerships with LNGO and AMC
- ✓ TAC (technical assistance committee), a team of top Indian public health experts providing program advise
- ✓ Dr. Panday, the Sec. of MOH of Gujarat is a "positive deviant" himself in the government system, being very receptive and open to NGO innovations.

This program is close to my heart as I've witnessed its growth and success. As each Hearth is opened with a similar lamp lighting ceremony, I hope that this workshop nourishes you and lights your fire. We are here to create a "hearth" together and I thank my fellow trainers for being here, as one does not do it alone. I hope that this workshop sparks partnering and networking within India as well as within Asia. There is enough interest and expertise among Hearth implementers for a Pan-India network. An Asia Regional Network could be started as we have representatives from Nepal, Bangladesh, Philippines, Uzbekistan and Indonesia. We need to join together to foment a movement. Create a revolution to combat malnutrition and make malnutrition unacceptable. We can only fight this battle if we join forces. Namaste.

F. Day 1 – 8 December 2003 Overview of PD/Hearth and Community Mobilization

<u>Today's Objectives:</u>

① Overview of PD approach as applied to malnutrition – Hearth
② Key objectives of PD/hearth
③ Feasibility of PD/hearth
④ Community mobilization

a. Expectations of Participants:

- ✓ Learn PD/Hearth by doing and from those who are implementing
- ✓ Discover how to use PD in a variety of settings and situations
- ✓ Lessons learned
- ✓ Approaches to sustainability of PD/Hearth
- ✓ New approaches to community mobilization
- ✓ Make hearth more interesting
- ✓ Measures to monitor and evaluate PD/Hearth

- ✓ Understand PD process
- ✓ Integration of PD into CS program
- ✓ Transfer knowledge to others
- ✓ Make friends
- ✓ Enjoy India
- ✓ Apply Hearth in different cultures
- ✓ Learn new skills
- ✓ Expand PD
- ✓ Urban vs. rural
- ✓ Living university
- ✓ Feasibility
- ✓ Program that fits broad needs but generic enough to scale up

b. Norms*: *determined by participants

- Participatory
- Active (share experience)
- No cell phones
- Tap the CPI staff
- Evening discussion circles for those who are interested in presenting.
- 3 posters ongoing (burning questions, key elements, innovations, bright ideas)
- Wear name tags

c. *Introductions:*

Introduce yourself by telling your name, designation and what brought you to PD/Hearth?

Donna Sillan, an independent PH consultant: Working in Child Survival since 1985. All those years of GMP and giving nutrition education I was starting to feel discouraged. We were weighing children to death and so little results and it was undermining all other CS programs and finally there was a breakthrough method that I saw could really make a difference and when I started the Drs. Berggrens who started in Haiti in the 1960s started the foyer where they fed children and looked at PD. It didn't start moving until a couple years ago and it's a big buzz in the PH world because it works.

Dr. Rajeev, CRS India: We don't call it PD but many of us are doing this kind of work. We are doing a larger behavior change program. This is similar to what we are doing so I wanted to see more in other India projects.

Ramin, CPI CS in Uzbeckistan: In the Aral Sea region we have a nutrition component as part of our breastfeeding program. Malnutrition esp. micronutrient deficiency. I'm excited to be here to learn and hope to implement something like this in our region.

Matvi,Environmental Health Project intern: Background social work. I read about PD and realized that it had been existing in the community for a long time. I wanted to learn more.

***Orla O'Neil, Concern Bangladesh*:** Urban nutrition. Freedom to explore different options. Bangladesh integrated nutrition program. Want to think about a hearth-type approach. Behavior change component is weak in nat'l program. Want to learn your ideas.

***Dr. Pradeep, CRS India*:** Tech advisor for s. Asia. Food assisted Child Survival. 240,000 children. Implement through NGOs. Interested in learning methodology.

Jasmine MD MPH, Project Concern Int'l: W. Bengal, Rajistan and UP HIV AIDS project nominated to learn and take PD/Hearth back to colleagues.

Vani, PhD. PD. Experiment with PD in slums on small scales. I wanted to break free from the idea treating people like subjects. People say that what is done in academia cannot be done in the field

Rushi, Project Concern Int'l. Initiating reproductive health program a

Kumud, CCF: Problem starts well but sustainability is not there. How to make our programs more sustainable?

Ashish, CPI, India: Learn more from you and might help us to make our program better.

Farheen, UNICEF Kolkata: Implementing PD in 4 districts. This is going to be a sharing and learning forum. How can I over come the challenges I face in the field.

Pyali, UNICEF nutritionist: PD story started in 2000-01. We have a huge ICDS program all over country and in west Bengal struggling with this. Initiatives for quality improvement for ICDS. Went to Vietnam and that took me off. I was like…where are the malnourished children? Then Monique has been coming every 6 months to west Bengal. 4 districts, 17 blocks and lots of government support.

Raj, CARE India: Recently joined. We work through INHP. Part of grad strategy is to come out of demo sites and make community program for sustainability. Interested in PD in other fields.

Dharmendra, CARE India: Impact is not happening so we are looking at different approaches. PD/Hearth could be another way.

Cel Habito, SC Philippines: I relate to what Donna said after working teaching masters students I started to feel despair. I read about PD and it gives me hope. Interested because in Philippines we have urban and rural setting

Nanang, PATH, Indonesia : I'm a nutritionist. Many nutrition problem in my district like anemia, goiter, and malnutrition. Many programs are not sustainable. I am excited because I want to expand our program

Dr. Mothabir, Concern Bangladesh: We are weak in community mobilization but we believe it is important to sustain impact

Suhrid, West Bengal: 8 yrs exp in field work. 1 yr 2 months doing PD. Want to expand it to other centers.

Azamat, CPI Uzbeckistan: I am excited to visit India. In Uzbekistan malnutrition is not a big problem so we are more interested in prevention. Anemia, iodine deficiency are big problems. I am interested in learning to teach others in my program.

Mary Helen Carruth, Mercy Corps: Starting with mercy corps in Jan in Tajikistan. We have CS program and nutrition will become bigger part of it. Like to see if this is appropriate for Tajikistan. There is quite a lot of stunting.

Godfred, WV India: Counterpart have already helped us with training
7 centers for 157 children. Temp stopped. Purpose of my participation is to learn from those who have experience.

Bradley Thompson, WV India: Want to learn from you and your experiences and learn about how it can be scaled up.

Maya, West Bengal. Dept women/child development. 2000-2001 starting working with PD part of ICDS and UNICEF. Want to learn.

Manjushree, SPCO: Last 5 years doing nutrition awareness program but only involved mothers (not sustainable) came to learn and share our experience

Rupa, Child in Need Institute: Started PD program with gov't of west Bengal. It's been amazing

Deepak, MPH, CARE Nepal: Health is one of 4 tech sectors CS, family health, HIV etc. programs. Evaluation found that we have succeeded in some areas but not in nutrition so I decided to look at innovative ideas. Planning to implement after training.

Dr. Ejaz, Pakistan, Pediatrics: Many programs but not successful. Malnutrition just increases. Children are treated for malnutrition but come back again and again. Judiann assigned me to this program.

JayDeep, CPI: CS program in Ahmedabad and Hearth on a pilot basis. We are young and learning organization so it is a pleasure to get feedback from others. We want to scale up so we can incorporate feedback into it.

Monique, PD/Hearth Grandmother:
I worked on child stimulation program in Bengal to look at other parts of malnutrition not just food but they went back to slums and there was not much follow up. I was exposed to shortcomings of the hospital-based programs. We were working in Vietnam with little support and we were asked by the government of Vietnam to create a model at the community level. BP funded the program. Malnutrition was near famine. Gretchen came to help design the approach. Decided to capitalize on what was already there.

Krishna, Research Institute, West Bengal, PH scientist: Worked with west Bengal team to initiate PD for 2 years. Find it fascinating because it focuses on the strengths of people.

Heer, Counterpart India: Health ed specialists. I find that PD Hearth allows for other behavior change communication.

Darshana, Counterpart D.C. Hqtrs: We had requests from WV India and then asked CORE to fund a workshop for the region.

Harry, VP CFO Counterpart Hqtrs: I'm here to learn what counterpart does.

Ramesh, CPI, India: Communication during DIP and evolution over 16 months of implementation. Several assumptions have broken down. With this group something will happen…regional support group to move us further.

Vanessa, Mercy Corps, Indonesia: Came to PD/hearth in graduate school. Didn't like the focus of PH, which was on problems. Learned about PD, which focused on solutions.

BRAINSTORM:
Various models that have been tried to combat malnutrition

- ✓ Hospital/health center based rehabilitation
- ✓ Crèche (day care centers)
- ✓ TIPS (trials of improved practices)
- ✓ Nutrition education
- ✓ Take home rations
- ✓ Food distribution/food for work
- ✓ Supplementary feeding (ICDS)
- ✓ Education through the media
- ✓ Food fortification
- ✓ GMP

① **Overview of PD approach as applied to malnutrition – Hearth**

The PD words bring to you before the workshop?

- ✓ Somebody that's different
- ✓ How can a deviant be positive?
- ✓ How can two words combine?

6 Ds of Positive Deviance	*9 Steps – Based on CORE manual*
Define	*1. Decide feasibility of PD/Hearth*
	2. Begin Mobilizing community and select and train staff
Determine	*3. Prepare for the PDI with the community*
Discover	*4. Conduct a PDI with the community*
Design and Implement	*5. Design Hearth sessions with community*
	6. Conduct Hearth
	7. Support new behaviors through home visits
Discern	*8. Repeat Hearth sessions as needed*
Disseminate	*9. Expand PD/Hearth*

Discussion:

- ✓ Vani-do we introduce a PD food eaten by a community that may be different than the other, but live together. The differences in culture and lifestyle would be unacceptable with the other?
- ✓ Issue of 2 weeks for the Hearth- two weeks are important since the first few days what does t she just practices the behavior, then she begins to see some change and her attitude change, finally she develops the knowledge of how to feed her child, which she internalizes.
- ✓ Get together- it is exciting for the children, who seem interested in playing with one another, women have a good time together.
- ✓ Contribution- ownership, sustainability, localizing effect, introducing the buying behavior of a PD food, especially in the urban setup, practice decision making for food allocation.
- ✓ Contribution from the organization- community sees that the organization is doing such good work for the children, owner ship of the Hearth. Give iodized salt from the Ngo to show it costs just a little more.
- ✓ Problem since food has been given through the food aid programs of CRS, ICDS.
- ✓ Rajastan had a famine, how do we do hearth there.

e. PD/Hearth Milestones

Year	**PD**	**Hearth**
1960s	Term 'positive deviant' children appears in nutrition research literature	Mothercraft centers (CERN) in Haiti and elsewhere (Berrgrens)
1970s, 1980s	Same	NDF in local kitchen 2 week sessions 20-25 children
1990	Publication of Positive Deviance in child nutrition by Zeitlin, Hossein, Ghassemi and Mohamed mansour	Shift from monitrices to volunteer mothers to run the Hearth. Haiti, Bangladesh

1993	Experimental use of PD approach in Viet Nam pilot phase	Introduction of NERP in Viet Nam
1995	Expansion of PD/NERP Viet Nam and Nepal, evaluation	Expansion of Hearth WRC
1999	Living University – Viet Nam other NGOs, MOH, etc. SC?US: Bangladesh, Mali, Egypt	Hearth nutrition model: Applications in Haiti, Viet Nam and Bangladesh (1997 – Basics) available for free on the BASICS website: http://www.basics.org
1999	✓ Living University ✓ Evaluation Hearth (Haiti) ✓ USAID, Child Survival (PD/Hearth component) ✓ CORE group. PD/Hearth package ✓ Use of the PD/Hearth by many organizations worldwide (INGO, indigenous NGO, MOH, UNICEF etc.	
2002	Publication of Nutrition Bulletin (December 2002)	
Current	PD Approach initiative – Ford Foundation Grant (http://www.positivedeviance.org) Regional workshop funded by CORE	

PD in Argentina.
Children do not finish finish 3rd year of school. Teachers, administrators, schools, parents define the problem. Invited 5 worst performing schools to come together and talk about situation and then determined if there were schools in the vicinity who were able to overcome the problem. Let the people to select themselves (gave them the data). They designed a tool to discover what they do. Went to school and found out what was happening. Then designed a way to use strategies. Some they could use the next Monday.

② Key objectives of PD/hearth

- Rehabilitate malnourished children
- Sustain rehabilitation
- Prevent future malnutrition

Break for lunch 2:00

Warm-Up: Shrinking paper exercise
Groups of 5 people are all asked to stand on a piece of flip chart paper. Then they are asked to step off and fold the paper and stand on it again and fold it and again and again try to all steps on the paper again.

What does this have to do with PD? There are other ways
When resources are reduced, how do you cope? What creative ways are found to adapt? One group thought outside of the box and cleverly put their feet on the small paper as they sat on the floor. There were no rules to ban this. We put on our own blinders.
Referred to Manual page 171 to see examples from other countries.

③ Feasibility of PD/hearth
Criteria for implementing Hearth:

- ✓ > 30 % malnutrition based on weight for age
- ✓ availability of local foods
- ✓ proximity of homes
- ✓ community commitment
- ✓ same social conditions
- ✓ presence of health volunteers
- ✓ community leaders
- ✓ referral system for health services
- ✓ budget
- ✓ organization commitment

Small groups take one case and decide if the scenario would be a good PD/Hearth site: Each group presents their conclusions to the large group and request feedback.

Case studies Case 1 - India

Percent low weight for age mild, moderate, and severe: 35% among 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 crèche cared for by two paid employees. The estate provides food in the crèche. After three years of age, children stay with grandparents during the day until they start school at age five. The crèche 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.

Group conclusion:

Enough malnutrition, food provided (able to monitor the food), Challenges – scattered areas, mothers work fulltime. Hearth can be done at crèche and suggest to management to give some time during the day to come to Hearth/crèche. This skill can be done for grandparents for children > 3 years. Could have grandparents travel to crèche. Could look at the tea estates too do discover the PD tea estates since children spend so much time there. PD is a community mobilization process.

Case 2 – Urban Tajikistan

The community is defined as a large urban apartment block of approximately 400 families. Percent low weight for age: 28% ,-2z scores; Percent low height for age: 45% ,-2z scores; Percent low weight for height: 11% ,-2z scores for children between 6 and 36 months 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.

Group conclusion:

No need to do Hearth because 28% malnutrition but maybe we should do a micronutrient program. Or we could do Hearth and the grandmothers could come to Hearth, good access to health services. Food aid could be seen as positive and negative. Could use food aid at the center. Not many people have regular income. Fruits are expensive. Difficulty with the seasonality. Could have winter Hearth and summer Hearth. Could do food for work or BCC program. Strengthen the health facility.

Case 3 – Lowland Nepal

Percent low weight for age (yellow or red on growth chart) – 39% for 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, and 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.
Group conclusion:
Families live in close clusters. This is very ideal situation for a Hearth. Proximity – in clusters easy walking distance. Cheap food available. Time available, food available, VHCs are there and leaders. Challenge is the different groups. Quarter of group is untouchables. Start different groups and then see what evolves or start one. We should get the leaders together and ask them what they think.

Case 4: Rural Mountain Peru

Percent low weight for age at <-1 z score: 32% among children 6-59 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.
Group conclusion:
May not be appropriate in this case. Malnutrition is low. Population is dispersed. Health facility is far away. Difficult to manage Hearth in this case. Few households with malnourished children.

Case 5: Peri-urban Mozambique

Percent low weight for age mild, moderate, severe: 42% among 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.
Group conclusion:
Densely populated urban setting. It is possible because 42% malnutrition, close proximity of homes, food availability, health access. Challenges: water at a distance, sanitation is a problem, mothers work, families migrate.

Case 6 – Rural Desert Eritrea

Percent low weight for age at <–2z scores: 40% among children 6-36 months;
Percent stunting at <-2z scores 51%, percent wasting at,-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.
Group conclusion:
Nomadic people. It could be possible. We need to focus on why some do certain things – it is not just food. Men buy the food and the gender component is very important. We need to look for PD men.

Case 7 – Zambia

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. 45% of the children between 6 months and 3 years are >-2z scores weight for age.

Group conclusion:

Hearth is possible.

Tea break

④ **Community Mobilization**

It was clear from participants' expectations that Community Mobilization is an important issue. It will be initiated today but it will continue throughout the workshop. In this session:

1. What is community mobilization?
2. Why do we want to do community mobilization?
3. Groups to look at strengths, challenges, lessons learned, questions

Group presentations

Group #1

Long complicated discussion. Came up with four words: think globally, act locally.

Why?

- ✓ Key mechanism for sustainability, ownership, acceptability, community development, empowerment

Strengths

- ✓ Participatory involving all sectors of the community and different levels, integrated

Challenges

- ✓ Motivation – how to keep communities, groups motivated?
- ✓ Inability to reach certain populations

Strategies

- ✓ Certificates for motivation

Lessons

- ✓ Strategy needed, know the audience
- ✓ Respect – make sure community leaders are respected, recognized
- ✓ Establish linkages between government, community, VHCs, support groups, community based organizations (strengthening the horizontal system)
- ✓ Capitalize on existing formal and informal networks
- ✓ Appreciative community mobilization – drawing on the community to appreciate the results of their own efforts. Designing what and why and how and making objectives.
- ✓ We can inspire on the individual level, break down the helplessness, give people a voice
- ✓ Develop exit strategy (how long do you support a community?)

Group #2

Community means a group of people working together for common goal. Could be many groups in one. Mobilization at design, planning and monitoring stages. They know best the what, why and how of their needs. Mobilization can maximize the resources and make appropriate use.

Strengths
- ✓ Identifying change agents
- ✓ Accountability of government and non-government agencies services to the community
- ✓ Advocacy becomes better when the mobilization is good because they can speak for themselves
- ✓ Maximize output through minimum input because you have person power

Challenges
- ✓ Getting and sustaining volunteers
- ✓ Migration
- ✓ Working with minority groups (HIV AIDS) how to bring them to Hearth, stigma
- ✓ Different ways of eating (heterogeneity)

Lessons Learned
- ✓ Need to believe community can do it for themselves

Group 3
Challenge
- ✓ How to act like a catalyst

Lessons Learned
- ✓ Community must monitor their own progress

Hearth is a catalyst for social change. It starts with malnutrition. Participants want to know how is this community mobilization different from what we already do in our programs?

G. Day 2 – 9 December 2003 Positive Deviance Inquiry

Today's Objectives:
① Tips for community mobilization
② Preparing for the PDI (situational analysis)
③ Identifying PDs
④ Conducting the PDI

***Warm-Up*: Blind Game**
Participants divided into groups of two. One person pretended to be a blind person and the other pretended to be the guide. The guide walked the blind participant around the center 3 minutes then they switched roles.

How did you feel?

Blind	Guide
• Helplessness • Apprehension • Mistrust • Cautious • Unsure of the person's ability to lead you • Lack of confidence • Safe • Vulnerable	• Sense of responsibility • Safety • Careful • Unsure you can gain the trust of the blind person • The more trust you gain, they more you can do • Controlling a lot at first so she would feel that I was there, to build the trust

• Dependent	but then I relaxed my grip • Assumed they had no senses, overcompensating (not being aware that she had other senses • Underestimated the capacity of the other person (blind) • Meeting the need • Non verbal communication to know where she would like to go , to find out whether it was fine • Desire to speak

For the person who was blind first, it is different. There is more trust built if you are the second blind person. You trust the person will lead you as you lead them.

How does this relate to PD?

- Trust
- Respect community's strengths/capacity
- Resources
- Role reversal
- We learn from the community
- Feel like one of them, we are part of the community
- Empathy
- Some of the pairs would be different (some cope better than others)
- Things are there but we cannot see
- Interdependence
- Cycle of experience will lead you to understanding better
- Pace, speed, the tiny steps, there is no point in striding out when leading the blind
- Learning to be lead
- Best practices vs. local best practices

➀ **Tips for community mobilization**
Challenges and what has worked – small group work

1. Motivation
2. Working with diverse groups
3. Catalyst role
4. Exit strategy, Sustainability of skill building

1. Motivation group

- Find self-motivated volunteer, identify volunteer those interested
- Don't over burden, limit time, daily chores
- Define goals – tasks clear
- Messages
  - Use real life success
  - Religious messages
  - Traditional beliefs
- Don't give tangible benefits

*Hearth is not to be sustained. Motivation doesn't need to be sustained either. The Hearth is temporary. The best motivation for a volunteer in the hearth is when they see children gaining weight.

2. Diverse groups
   - Find reason why there is diversity (inter/intra)
   - Working on it
     - Try to find PDs
     - Common agenda, common ground
     - Similarities in felt needs
   - Could do separate Hearths
   - Don't bang on the issue of community unity but talk instead about the issue of health and nutrition
   - Hearth can serve as a catalyst for brining together diverse groups but it is not the goal so don't force it

3. Catalyst Role
   - VHC should feel the ownership
   - Important to bring leaders into the limelight
   - Link the leaders and VHCs with different resources (banks, organizations
   - Once their capacity is built up they can select more volunteers
   - Experience from the field, CORE VHC group brought most motivated volunteers together to talk about issues to officials, facilitators in the trainings
   - Different levels of catalyst

4. Exit strategies
   - Early negotiation with community to discuss skills, activities they want to get out of the NGOs
   - Survey in community
   - Tell community the time limit from the start
   - Making local partnerships, working within the current structures
   - Building sustainable structures within the community
   - Teach skills – example from CRS – built capacity of institution so they are now like barefoot doctors, can give basic care in community and she is paid by community
   - Convergence of different systems that exist in the community

Tea break

② **Preparing for the PDI:** STEP 3. Prepare for the PD Inquiry (Situational Analysis)
Why?
1. Learning the conditions of community.
2. Learn current practices
3. Identify problems
4. Develop an anthropological understanding of what is going on in the community (myths, informal systems, behaviors, health systems)
5. Existing resources
6. So community knows
7. For comparison at the end (baseline)

Who needs to know?

1. Community should realize themselves

Situational Analysis

What	How	By whom
Nutritional status	GMP	NGO/institution with community volunteers
Knowledge, attitudes, practices related to malnutrition (feeding, caring, healthy seeking and hygiene	KPC survey, PLA, focus group discussions, house visits, community meetings, community leaders, opinion leaders, health staff, private and traditional healers, social influence analysis, chapatti diagrams	Community with help of NGO/institution, leaders, village health committees
Economic conditions	Wealth ranking mapping	Community, health volunteers, VHC

Do we have to do wealth ranking in every community?
Some will say, I can't do that behavior because that is what rich people can do. We have to dispel the myth. Need it to identify the PD.

③ **Identifying PDs**
Criteria (page 68 in Hearth manual)

PD child should be:

- from poor family
- normal nutritional status of child
- minimum of two children
- family should be representative of geographical and social groups living in village
- no severe health problems
- PD family must belong to community
- Head of household should have same occupation as the majority of villages
- Must have access to same resources as others in community
- Family is found in the identified minority (if program targets minority communities only
- Gender of PD child can be a criterion in gender-biased cultures

PD child should not be:

- A big baby is now losing weight
- Be a child with a begging or scavenging background
- Be a first-born or only child
- Have any severely malnourished siblings
- Have atypical social or health problems

Can plot children's weight for age and their wealth ranking on a giant growth chart to show a picture of well-nourished children from poor families, well-nourished children of rich families, malnourished children from poor families and malnourished children from rich families.

	# in poor households	# in wealthier households
Well nourished	PD	NPD
Malnourished	NPD	ND

Exercise: Used the CPI/India data and determined who were PDs, NPDs and NDs. See ***Attachment F*** for the list of children from the CPI/India project area (real data).

④ **Conducting the PDI**
Should visit some PDs (about 4), some Non PDs to look at their positive behaviors and Negative deviants to look at their negative practices (risks).

How do you notify the family that you will visit them?
West Bengal experience: We start with a general chat and then we go into the PDI questionnaire but we don't fill it out there, we fill it out later.

Counterpart: We don't share the data but we tell them that we have come to learn about how you take care of your child. It is important to be informal and relaxed and build rapport.

Monique: We must discover something. It is not a survey, it is an inquiry.

Do we give advice or say they are doing something right or wrong?
No we just go to discover.

West Bengal experience. While doing a PDI, we took a picture and then many people from the community were around and said – well you are taking a picture so you must be giving this child a benefit. They didn't understand what we were doing. Have to tell them what we are coming there for.

Break for lunch

What should we look for when we do the PDI?

Feeding Practices	Caring (psychosocial)	Hygiene	Health seeking
• Breastfeeding • Weaning • Cultural practices/superstitions, beliefs, traditions • Foods and quality (variety, consistency) • Frequency and quantity of food and measurements used	• Decision-maker • Time spent with child • Time with their family member • Importance of child to mom • Who watches after child? • When child doesn't eat • If unhappy what? • Toys given?	• Bath • Hand washing (soap?) when? • Water source • Clothes clean? • Sanitation – latrine • Environment • Drainage/disposal of garbage • Nail cutting	• Feeding during illness • EPI • Weighing • Referral to whom when sick? • Danger signs knowledge • Who decides to send to health facility? • Saved money for illness? • Mortality/mor

• Own plate? • Eating pattern • Order of eating • Feeding style • Cooking technique • Who feeds • when does she feed • food storage • Place of cooking	Play mat? • What do you play? • Spoiled? • Story telling • Games, singing • Ambition for child • Male/female dreams		bidity

PDI Team

1. Interviewer – semi structured interview
2. Observer – checklist

Who?

Community members' community health team members, supervisors and volunteer, NGO members

Skills needed

- Body language/dress
- Communications skills
- Greeting
- Probing
- Good listener
- Patience
- Humble
- No camera
- Learner not preacher
- Respect
- Cultural knowledge
- Not biased
- Local terms/no medical terms
- Local language

Role Plays: 2 parts and discussion

Positive points	Negative
Interviewer • Proper greeting • Engaging • Observer more interactive • Explained the roles of interviewer and observer • Good body language • Used personal name • More respectful • Included the other members of the family • Asked for health card • Didn't write down the information during the PDI • Non judgmental	• observer not paying attention • anxious to leave • ignored other members of the family during the interview • talked more and listed less • got off topic • made judgment about 'fathers'

Tea break

Warm-up: Observation game**:** partner look at each other then turn around and change something and then turn back to each other and find out what they changed .

Panel of experts – how to do PDI? Participants who have conducted a PDI were invited to the front to sit in a panel. The other participants were free to ask them questions.

Is it difficult to convince health worker to do Hearth?
W. Bengal: At first they feel over burdened but then they realize this work (caring for malnourished children) is their responsibility.

Challenges for PDI:

- counterpart: process hasn't been difficult because we have rapport but
    - time of cooking and feeding, sometimes we miss it because it is early in the morning or late so we have to go back
    - kids playing outside or sleeping
  - want to attend to guests so they will stop doing what they do
- Indonesia: sometimes people don't answer appropriately so we have to probe and be like detectives
- W. Bengal – interpretation of the questions

Have you ever found a PD family with no positive behaviors?
W. Bengal: yes. Child seemed healthy but actually he was bloated and had a health problem (maybe kwashiorkor)

Counterpart: One PD had worst behaviors and we couldn't figure out why child was healthy. We decided to look for other PD families.

How long is PDI?
W. Bengal: 3-4 hours over 2 days
Indonesia: 1.5 hours

Gretchen Berggren suggests you not bring interview guide with you to the house but fill it out after the visit.

Have the communities begun to apply PD to something else*?* No, not yet.

Have you done a PDI in a different season in the same community?
w. Bengal: No but we have a seasonal calendar in the Hearth with the fruits and vegetables that are available during that season and they choose the foods from that calendar for the menu.

Have you published BCC messages?
Be careful with publishing because then people will assume that PDI results in one community can be used in another community.

How do you analyze the data?
W. Bengal: VHC conducts the PDI and then analyzes it by deciding the practices are positive and accessible.

Indonesia: We draw a picture of a well-nourished child and a malnourished child and the community decides if the behaviors are positive or negative and then if they are accessible.

How do you transfer skills to partners?

- Indonesia: We do a lot of 'social marketing' to other teams.
- Counterpart: use competition. If you engage those who have experience in PDI in training others, the others will want to be the next trainees so they will have a greater motivation.

***Preparation for site visit* – what to observe about the Hearth**

- Place and space
- Cleanliness
- # of participants
- volunteers
- # of items and contributions
- type of food
- menu
- water
- toilet
- soap
- attendance
- what has mom learned
- children's behavior
- mom's behavior
- volunteers behavior
- IEC
- Whose cooking
- Social interaction
- Time
- Distraction
- Problem solving

Ground Rules for the Field Visit:

*Non-judgmental, not an evaluation
*No need to wear badges
*Avoid all political discussions/issues
*Quiet observer
* Stay with the assigned staff member

H. Day 3 – 10 December 2003 FIELD VISIT

① Visit to slums to conduct PDI in PD, ND and NPD families
② Visit to Hearths

See ***Attachment G*** for list of participant groups to project areas and Hearths.

a. Feedback from PDI in local office after observing the PDI process:
Each group presented their observations as it was compiled on a large matrix, simulating the PDI process in the community.

Qualities of PDI interviewer

- Humble
- From community
- Puts mother at ease, good rapport
- Semi-formal
- Curiosity – digging deeper
- Local dialect
- Trust
- Respect
- Receptivity
- Good listening
- Confidence
- Sensitive
- Keen observer
- Respectful of other passers by or visitors
- Patience

PDI General Information:

PD	• Large family (100 people) • 2 children • steady income • 50 rupees/day
PD	• 2 children, 1 girl 30 months, older boy • shoe shiner • support from grandmother • father away all day
PD	• 3 children • Father works 7-7 • Mother does stitching work at home • Older children go to school • Mother completed 10th grade and father completed 12th
Non PD	• 6 kids, wife with mother in law • father earns 50 rupees/day
Non PD	• 9 children, mother, father • twins 1.5 years (1 girl, 1 boy) • father works as coolie (and son)
Non PD	• father earns 50 rupees daily • 2 kids • pregnant mother
ND	• 4 children • 7 family members • income 450 rupees/day
ND	• 4 children • both parents work • 150 rupees per day combined income

Feeding Practices

PD	• exclusive breastfeeding • complementary feeding at 6 mos • veggie and mutton • not eating food outside
PD	• active feeding (mother supervision) • mixed roti with veg curry • feeding on demand • fruit sharing
PD	• pulse • fruits • snack before lunch • eats all vegetables • still BF • gave colostrums • child eats often
NPD	• Exclusive BF 6 months on demand (< 5 mins) • Chapatti • Potatoes • Mutton (infrequently • Husband eats first

NPD	• Male child breastfed more and received more attention • Both children marasmic (girl more severe) • 2 meals/day • fed by 7 year old sister
NPD	• Eat together • Eat ready made food from vendor • Water kept in dirty container
ND	• Exclusive BF • Complementary feeding at 6 months • Family food • Junk food • Still breastfeeding • Eats 2 xs per day • Insufficient amount of food
ND	• No colostrums • EBF for 1 year (?) • Water and milk given • Child fussy eater • Snacks = papa dam, sweets, fruit

Caring and hygiene practices

PD	• Tap water • Latrine • Hand washing • Good interaction
PD	• Hand washing • Clean appearance • Support from neighbor for childcare • Shared latrine, very clean
PD	• Father special play time • Toys for child • Nails clean • Organized • Covered food and water • Knew child's weight
NPD	• Clean toilet • Al children delivered at home unassisted • No ANC • Soap • Dirty nails • Naked • Gender disparity
NPD	• One bathroom • Unhygienic • No soap • Had water from tap but not covered • Bathe at grandmother's place • Looked dirty • Unclean child's mother
ND	• Fathers gives time to child • Child very attached to father • Surroundings unhealthy • House clean • Utensils clean • No drainage • Mosquitoes and flies • Water scarcity • Latrine • Washing hands • Bathing regularly
ND	• Grandmother main daily caregiver and sibling • Weekly outing with family

	• No father input in care giving

Health seeking practices

PD	• Refer to health center • Birth spacing 2.5 yrs • Fully immunized
PD	• Knowledge of ARE, vaccination, immunized • Use of birth spacing
PD	• Well spaced • Delivery at hospital • Immediate care for worms
NPD	• Home remedies • Illness brought to health facility • Stopped breastfeeding when mother ill • 1 time diarrhea given oral rehydration salts • aware of pneumonia symptoms
NPD	• had births in hospital/c-section • only went to doctor when emergency • lack of birth spacing • children not vaccinated
NPD	• lime juice, khichiri during diarrhea • mother has no idea about any diseases • vaccine dose is completed • mother compete tetanus but no IFA • delivered at home because afraid of hospital (often going to hospital means getting an operation)
ND	• repeated attack of diarrhea/ARE • immediate care from professionals
ND	• local PHC, gov't private • EPP yes • Grandmother poor practices for diarrhea and ARI

Implications for Hearth

Quasi analysis of PDI – NOTE: must do a situational analysis to understand norms before you can analyze PDI. This exercise was an example of what could be done to analyze results but this is not a true analysis process without the "baseline" norms to compare.

Feeding:

Exclusive breastfeeding
Complementary feeding at 6 months
Active feeding/ inside
Nutritious snacks between meals
Vegetables in the diet/fruits
Giving colostrums
Frequency

Caring:

Father's involvement
Hand washing
Cutting nails
Clean toilets

Covering food and water

Health seeking:

Birth spacing
Completed regular immunization
Immediate health care

② Visit to Hearths

Participants were divided into two groups and attended two separate Hearth sessions.

I. Day 4 – 11 December 2003: HEARTH

Today's Agenda

① **PDI feedback**
② **Designing Hearth sessions**
③ **Participatory Health education – opportunities throughout the Hearth for education**
④ **Debriefing from Hearth**
⑤ **Hearth Panel Q & A**
⑥ **Home visits**
⑦ **Repeat Hearth as needed (monitoring)**
⑧ **Review/evaluation**

Opening game – What are you doing my dear?

Participants stand in a circle. The first to start does one thing yet says they are doing something else. The person next to them have to do what they *said* they were doing but they should say they are doing something different when their neighbor asks "what are you doing my dear?"

① How to discuss PDI findings with community – example from Counterpart India

Puppet show with older woman and married woman talking about the home visits and the findings and suggesting the collective practice of these findings in the Hearth.

② Step 5. Designing the Hearth

- Choose the site
- Plan the menu
- Determine the schedule

Planning Hearth Menus:

Hearth menu criteria:

- 500-800 calories
- 18-28 grams of protein
- micronutrients
- PD food
- Extra fat/oil
- Animal products if culturally acceptable and available

Meal planning exercise: Create a Hearth meal, which meets these criteria and is small enough for a child 2-3 years old. Hint: stomach capacity is about 350g.

Refer to ***Attachment H*** for a copy of the Indian Food Composition Tables and results of a Market Survey (actual CPI/India project data).

How to calculate calories and protein:
10 grams of rice

Calories: In Indian food composition table rice has 345calories per 100 grams:
345/100 * 10 = 34.5calories
Protein: In Indian food composition table rice has 6.8 grams of protein per 100 grams:
6.8/100*10 = 0.68grams

Group presentation of Menus:
Group 1

Food items	**Grams**	**Calories**	**Protein (g)**	**Price (rupees)**
Rice	20	69	1.36	0.32
Groundnut oil	10	90	-	0.50
Egg	50	86.5	7.38	0.75
Lentils	20	69.6	4.88	0.45
Peanuts	10	56.6	2.52	0.34
Tomato	50	17.5	0.75	0.75
Spinach	15	4.87	0.37	0.15
Carrot	20	12	0.22	0.40
Pumpkin	10	2.94	0.16	0.10
Banana	35	57.9	0.5	0.10
Peanuts	10	57	2.52	0.34
	250g	468.11	20.16	4.33

Group 2:
Snack: Paustik Laddu

Food items	Grams	Calories	Protein (g)	Price (rupees)
Groundnut	10	90		0.50
Jaggery	20	77.6	0.08	0.40
Bengal Gram	20	73.8	4.5	0.60
Wheat	20	69.6	2.4	0.20
Total	70	310	6.98	1.70

Meal: Postik khichiri

Ingredients	Cooked	Household	Kcals	Protein (g)	Iron	Vitamin A	Cost
Rice	100	1k	103	2.04	0.21	-	0.48
Tur Dal	60	2tbsp	67	4.46	0.54	265	0.60
Spinach	50	2tbsp	6.5	0.5	0.23	1395	0.20
Ghee	15	3tsp	135	-	-	375	0.75
Total	225		312	7	0.98	1796	2.03

Group 3: Mixed Khichuri

Food	**G**	**Calories**	**Protein**	**Iron**	**Vit. C**	**Vit. A**	**Calcium**
Rice	50	172	3.4	0.3	-	-	5
Lentil	20	70	5	0.8	-	10	15

Egg	25	43	3.3	0.5	-	90	0.01
Spinach	50	13	1	0.6	0.14	2790	36
Papaya	35	16	0.3	0.25	28	333	8.5
Peanut	10	57	2.5	0.25	-	3.7	9
Oil	15	135	-	-	-	375	-
Potato	50	49	0.8	0.5	9	12	5
Beans	18	3	0.7	0.21	10	40	26
Coriander	40	22	1.7	0.7	62	3459	92
Total	313	580	18.7	4.11	109.14	7112.7	196.51

Group 4:

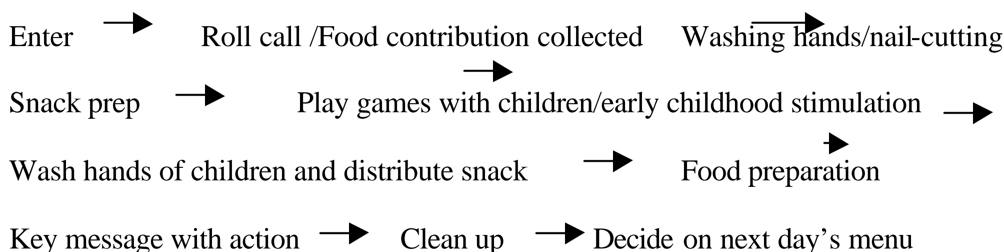
Food	**G**	**Calories**	**Protein**	**Cost**	**Calcium**	**Iron**	**Vit C**	**Vit A**
Rice	50	172	3.4	0.8	5	0.36		19.6
Lentil	40	139.2	9.8	1.4	30	1.56		1046.2
Spinach	50	13	1	0.15	13.7	0.12	5.25	35.1
Tomato	10	3.5	0.15	0.15	12	0.1	2.7	7.4
Peanuts	20	113	5.06	0.7	18			125
Oil	5	45	0.02	0.25				
Potato	20	19.4	0.32	0.18	2	0.096	3.4	4.8
Jaggery	10	38.3	0.04	0.2	8	0.264		
Banana	20	23	0.24	0.75	8	4.5	11.36	222
Total		616.67	20	4.58	82	2.6	13	1260

Feedback of menu presentations:

- Can use coriander instead of spinach since spinach become bitter when cooked
- Add oil instead of ghee, less expensive
- 1 gram of rice or dahl is 4 calories, 1 gram of oil 9 calories
- use home measurements
- give snacks that child can feed him/herself
- coriander, garlic, ginger are all spices but also immune boosters
- add lemon, tomatoes just towards the end of cooking (in general all the glow foods late in the cooking process to preserve the nutrients)
- be careful about promoting too many sweet foods, food habits are hard to break/change
- promote a colorful bowl with lots of variety
- lower the quantity of rice
- look at calorie/protein ratio to make an energy dense food

③ **Health education messages**

Hearth protocol:



Enter → Roll call /Food contribution collected → Washing hands/nail-cutting →

Snack prep → Play games with children/early childhood stimulation →

Wash hands of children and distribute snack → Food preparation

Key message with action → Clean up → Decide on next day's menu

At each step in the Hearth protocol, there are learning opportunities. Groups walked around to share their ideas related to what those learning opportunities or messages could be. Each station was on a flip chart paper and colored post-its were distributed to each small group to put up the health messages that could be imparted at each station.

1. *Mothers arrive/roll call*
    - Brochure on topic of the day
    - Schedule of the day
    - Roles and responsibilities
    - Introductions and greetings
    - Thought of the day
    - Games
    - Sing a song
    - Call a roll and name of a vegetable
    - Draw a mascot for attendance
    - Growth monitoring
    - Involve children while snack is being prepared
    - Good you came

2. *Collection of food contribution*
    - Congratulate and praise for contributing
    - Food groups (glow, grow, go)
    - Green vegetables
    - Washing collected food
    - 3 colored baskets for collection
    - you suggest contribution
    - importance of participation for health
    - calorie and protein content discussed
    - encourage home garden

3. *Washing hands and nail cutting*
    - Why are we hand washing?
    - When should we wash hands? (after defecation, before meal)
    - Prevention of worms, diarrhea
    - How should we wash hands (soap and water)

4. *Mothers snack preparation*
    - Tasty
    - Affordable
    - Less bulky
    - All the mothers share
    - Healthy
    - prepared, give prizes
    - New
    - IEC on snack preparation
    - Snacks in form of dolls
    - Competition for best recipe

5. *Play time*
    - Stimulation
    - Milestones
    - Prepare dolls with rags
    - Involvement of father and other caregivers
    - Toys as food groups
    - No small toys
    -
    - Mothers make pre school materials for their children
    - Colorful toys
    - Child development
    - Puppet show

6. Children's hand washing and snack distribution

- Personal hygiene
- Wash between fingers
- When?
- Clean water
- Puppet show
- Proportionate distribution
- Have to wash hands before you can get snack

7. Mother feeding child

- Eye to eye contact
- Be patient
- Sing songs and show kids
- Clean hands, plate, food
- Active feeding
- Age wise feeding
- Managing the child who doesn't want to eat
- Types of food
- Make child sit on lap – physical
- Tell a story
- Observation of child while eating
- Proper feeding (i.e. amounts)

8. Key Messages

- Diarrhea ORT
- Deworming
- Pneumonia
- ARI
- Variety of food
- Breast feeding
- Micronutrients
- Eat food with calorie and protein content
- Supplement not a substitute
- Hygiene and sanitation
- Safe drinking water
- Frequency of feeding
- Don't worry be happy
- Continue at home
- Place of health services
- Birth spacing

9. Clean up

- Hygiene
- Clean up the utensils
- Keep your home clean
- Proper disposal of food
- Germs contaminate next days food
- Cover food and water
- Cleaning will keep flies off
- Proper storage of food

10. Decide menu and contribution next day

- Food groups
- Variety
- Color of foods (food groups, variety)
- Age related requirements of nutrients
- Good choices for snack foods
- Reason for selecting the food

⑤ **Hearth panel discussion (re placed by small group discussion on PD applications)**
The large group brainstormed on how they might apply PD to their program. There were four small groups which tackled: Reproductive Health Group: STDs for adolescents, anemia prevention, TB Program Group, and Street children group.
This was an opportunity to start thinking out loud with others to help determine how the methodology could look like in their programs at home. It was a peer counseling session.

⑥ **Home visits**
Why?
Encourage and support behavior change
Monitor impact of program
Who?
Health community
Health volunteers
How?
Based on perceived needs of caregiver
Tailored to the caregiver
Time selection (fixed time or surprise?)
Inquire about receptivity
Document success stories
Do not criticize

Observe
Give positive feedback
Record what was observed, good behaviors can be documented in a poster
Before and after pictures

When?
1 time in 18 days
several times
1 time for general visit, several times if at risk or sick
For whom?
Malnourished children
Hearth participants

Game*:* My nanny is so funny she keeps doing this and this and this…
First participant makes a motion and all say "My nanny is so funny she keeps doing this and this…" then she picks another participant to add another motion to that motion. That participant then makes both motions together and comes to the center and then chooses another participant to add another motion and come to the middle and so on.

⑦ **Step 8: Repeat Hearth as needed**

Ideas for graduation criteria (this should be decided with community):

1. Nutritional status	After child has reached normal or if severely malnourished child has improved to become a moderately malnourished child etc.
2. Weight gain	If child gains at least 400 grams and is growth as fast or faster than international standard median

If a child is not gaining weight:
- Could be underlying illness -- Refer to health center
- If they use the Hearth meal as a substitute
- Quality of hearth menu is inadequate
- Attendance

- Don't practice new behaviors at home during 18 days off (could be because of issues at home which don't allow caregiver to practice)

<u>Case studies</u>: Should this child come back?

a. Budi gained 500 grams during Hearth but lost 500 grams after Hearth.
- Maybe there was diarrhea
- Human error in growth monitoring
- Return to Hearth

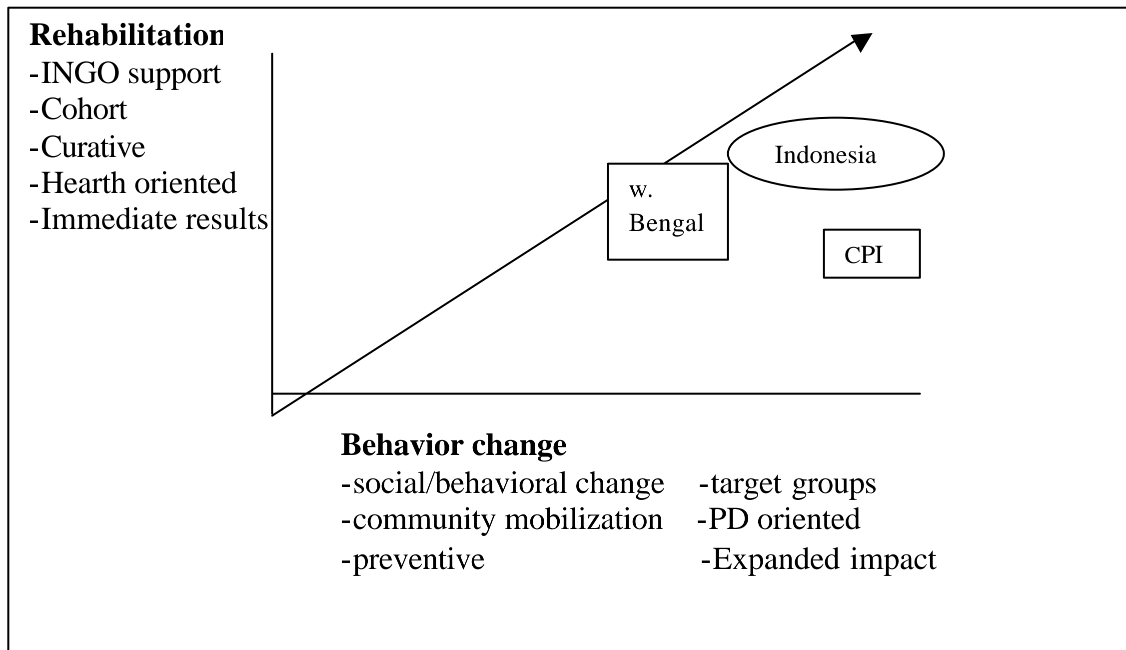
b. Daniel is 23 months old completed 1 Hearth session didn't improve. Health volunteer thinks mother is sharing with whole family at home.
- Counsel at home
- Return to Hearth

c. Aisha is 3 yrs old and only child. She gained 90 grams but still malnourished. Pregnant mother seems to be following PD behaviors but becoming discouraged.
- Identify another caregiver to accompany Aisha
- Refer
- Support and encouragement
- May not want to come to Hearth
- Investigate underlying causes

Some segments are semi nomadic moving to find work. Though mothers like Hearth it is difficult to follow them during the dry season. Many return during rainy season having lost weight again.
- Seasonal Hearths
- Sources of food during the dry season, PDI during dry season (coping strategies during dry season)
- Train some among them to observe how they are doing during the dry season

Page 128 of CORE manual there is a **1-year Hearth plan of activities**. Should be clear from the beginning that Hearth is not a permanent institution. The sustainability of PD/Hearth is the behavior change and nutritional status, not the program. A flipchart with the graph below was presented and three programs implementing PD/Hearth plotted where they felt their program lay.

Spectrum of Emphasis: Rehabilitation/Behavioral Change



J. Day 5 – 12 December 2003: M& E, Scaling Up, Networking

Today's Agenda

① **PD applications reports**
② **Staffing and Technical Assistance**
③ **Performance supervision**
④ **Monitoring and Evaluation**
⑤ **Living University (expansion)**
⑥ **Networking**
⑦ **Burning questions**
⑧ **Wrap up and Evaluation**
⑨ **Closing ceremony**

① PD applications reports:

Tips:

- We must start by defining the problem and not assume we know what they will say. That is best practices! Our preconceived notion of what is right. We might be surprised to find actions, which are totally unexpected.
- Keep in mind the non-nutritional factors related to nutritional problems when you are doing the PDI and Hearth.

Reproductive Health Group:

Find the strategies for why individuals have taken medication, consulted birth control services to prevent teen pregnancy and STDs.

For Anemia: find women who drink less tea and find out why they don't drink as much tea (anemia prevention).

Street Children group:
Find out what made the turning the point for children to save. PD can enable children to solve problems on their own (case of street children).

TB Group:
Look at the behaviors of the patients that are complying with the medication regiment and taking their medicines on time. The DOTS success cases. What are the factors, which determine compliance?

② **Staffing and Technical Assistance**
Sample Staffing needs for malnourished children.
60 children – 10 Hearths – 10 –20 volunteers – 1 supervisor/trainer – 1 Program manager

Costs: staff (2 paid staff), transportation, training, supplies, NGO contribution (some), utensils (in some programs mothers bring their own bowls, cups, spoons), growth monitoring

Costs to family of a malnourished child: lost wages, medications, transportation, rehabilitation center (averaged estimate of $35 per child), hospital costs (averaged estimate of $100 per child).

Training of staff:
Discussed how to use a consultant. Can use consultant to train staff but should first do a feasibility study. Refer to Technical Assistance in ***Attachment I.***

Staff in West Bengal: coordinator, two facilitators per district, and two assistants per district. Initial training of trainers was 12 days then went back and trained departments.

Counterpart volunteers were already trained in child survival so they just added this new content.

③ **Performance supervision**
Counterpart has the following tools:

1. growth card
2. roster to track children's weight, attendance at hearth, referrals.
3. Roster of daily contributions. This is filled out after the feeding as they discuss what menu they will prepare for the next day.
4. Hearth monitoring (quality). Observe cleanliness, contribution, etc. (see page 148)

Nanang – Indonesia
Conduct home visits to see what is happening at home. Use pie diagrams to show results at community meeting.

West Bengal – each center supervisors collect data for the ICDS centers and then compile the results. Analyzed at block level. If a child has not gained 200 grams there is a separate format to counsel that family.

Self-monitoring to discuss what health volunteers/communities would do to improve the program.

④ **Monitoring and Evaluation** see pages 157-184 in CORE manuals

Indicators to monitor rehabilitation

- Weight gain
- Behavior change
- Attendance
- Contribution
- Drop out rate
- Quality of meal
- Quality of facilitator (active participation of mothers)

Indicators to monitor Sustainability

- Weight
- Behavior change
- Health services
- Health provider behavior
- Health promoter
- GMP attendance
- Men's involvement
- Utilization rates
- Ripple effect
- Community involvement
- # Hearths
- # Graduates
- trends of malnutrition

Indicators to monitor Prevention

- siblings' nutritional status
- mothers practices, attitudes, behaviors
- GMP attendance
- Morbidity
- Efforts for problems solving for other problems
- Linkages created
- Economic savings, health expenditure changes
- Immunization status

⑤ **Living University (expansion)**

Vietnam Experience

1. Small successful model
2. Replicate model
    a. Trained 6 Institute of nutrition staff to replicate
    b. Geographical replication
    c. Involving new stakeholders
    d. Invited local leaders, women's union to work together to be trained (this created links between horizontal organizations)
    e. Monitoring and evaluation
        i. Rehabilitation rates improved (less sessions needed to rehabilitate a child
        ii. Came up with idea of Living University
3. Expand PD/Hearth to District Level
    a. Transfer of management to district health administration and local groups
4. Living University
    a. 4 times a year invited NGOs, women's union members from different provinces, medical school department of community health came to learn (30 participants)
    b. Took place in a community, not an institution or building per se
        i. 2-day orientation for high level officials so they understand the process
        ii. district-level health person, women's union, people's committee and counterpart at community level would stay for 2 week training including going to the field to see each activity (GMP, Hearth in different villages that were at different stages of implementation), visit village that had phased out Hearth, talked to mothers in Hearth and those who had graduated, met with counterparts in field to understand how they did it.

iii. Learned facilitation skills. Offered a package of training manuals that they would practice during the training and then take home.
iv. After training they returned to their own province

5. Graduates experimented and then LU staff provided support to new graduates in their settings and monitor for quality.

⑥ **Networking**
Nanang's presentation – Indonesia

Indonesia has a PD Network of NGOs and partners who are implementing PD including CARE, Mercy Corps, Save the Children, PCI, CRS, local and national government, LNGOs. They meet monthly to share lessons learned and share consultant time and trainings. They have also conducted trainings for government collectively.

A list was completed of all the participants' addresses for a potential list serve which CPI/India has agreed to initiate. This would be a "virtual" network to start the communication. See ***Attachment J*** for this list.

⑦ **Review of Burning questions that accumulated over the workshop period. All were answered.**

- Challenges of working with moms
- Community contribution vs. NGO GO contribution (dole?)
- Normal kids caregivers (normal HH visits)
- Scaling up and maintaining quality
- Community mobilization challenges and lessons learned
- Best practices vs. PD practices
- Critical mass for Hearth
- Positive Deviance in well nourished children
- What if can't find Positive Deviance Behaviors?

⑧ **Wrap up and Evaluation**

Review of list of Essential Elements for PD/Hearth written throughout training period:

- 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, deworm 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 Hearth
- Design Hearth session menus based on locally available and affordable foods
- Have caregivers present and actively involved every day of the Hearth session. This 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.
- Include follow visits at home for 2 weeks after the Hearth session
- Actively involve the community throughout the process.

Innovations/bright ideas accumulated over training period

- Start with menu that has fewer calories and increase it over the first week. This allows mothers to feel successful and creates habit of finishing bowl.
- Have 3 colored baskets for collecting food items
- Community (mothers/children) can prepare small wall hanging of vegetables/fruits so they look bright and work as IEC
- Use folk songs, dramas to promote PDI. Sometimes mothers/caregivers can enact and get prizes)

Final Examination: Pop Quiz: The participants were divided into pairs and given a slip of paper with an "inversion" of the normal process that PD/Hearth makes. The two had to act out the inversions in a charade type fashion and the large group had to guess what they were representing:

INVERSIONS in PD/Hearth:

1. Trainee vs. Trainer (in a PDI the community becomes the trainer of ours)
2. Best practices vs. working practices
3. Needs based vs. assets based (glass half empty/half full)
4. KAP vs. PAK
5. Hearth-based vs. Center-based
6. Poverty leads to malnutrition vs. Malnutrition leads to poverty
7. Acting into new thinking vs. Thinking into new acting
8. Food Aid vs. food contributions from community
9. PDI vs. nutritional survey (KPC style)
10. Listening vs. Speaking
11. Solutions from the inside vs. solutions from the outside
12. Outside experts knowledge vs. PD mothers knowledge

   - **Review Expectation List:** expectations were met
   - **Review Workshop Goals and Objectives:** goal and objectives met
   - **Review Objectives of PD/Hearth and the 9 Steps and 6 Ds**

⑨ **Closing ceremony**

Lead Trainer's Ending Words:

"I'd like to thank the caregivers in the community who believe in the Hearth and taught us during this training. They provided an excellent example of how to conduct a Hearth. I'd like to thank the Hearth volunteers as well who facilitated the community mobilization. And I'd like to thank the community leaders who support the Hearths and who want to eliminate malnutrition in their neighborhoods.

I'd like to thank the engaged and engaging participants. The lively participation of the trainees was much appreciated. Of course, I must mention that the trainers became the trainees…we learned a lot as trainers, from your participation. Your insights and expertise were humbling.

I'd like to thank my co-facilitators. Each of you provided a different perspective and skill that created a whole. The teamwork was complementary and fun.

I'd like to thank CPI, the hosts with the most! The staff could not have been more helpful, accommodating and polite. Their organizational and Hearth technical skills are outstanding. Thank you for inviting us all and making our stay most enjoyable.

I'd like to thank CORE for valuing PD/Hearth and being the main mover for the dissemination process. And thank you to USAID for funding the CORE group and supporting new innovations as well as the tried and true interventions in the public health field.

We created a virtual Hearth this week. It was a training of 5 days, (not 12!) to demonstrate new behaviors and practice new skills. It was an opportunity to see what works today for program implementers in terms of program behavior. Hopefully after this workshop, you are able to adopt successful practices that work in your programs to combat malnutrition and make it unacceptable. I hope you all feel nourished by this experience and that the nutrition will be sustained. In hopes that a movement has been fomented here today, I thank you all".

Closure:

The Workshop was closed with a Candle lighting ceremony similar to the way the workshop was opened. Participants stood in a circle and from the first candle which was lit, each participant lit the next candle held by the person standing next to them, until the entire circle of light was completed. This symbolized the light that was illuminated through the workshop learning and the light that will be spread through the new skills attained. It was also a sign of the circle of friends that was formed as participants return to their projects throughout Asia. Krishna Soman sang a beautiful Hindi song of Peace, along with Darshana Vyas as the candles shone bright.

Certificates of completion were presented to each participant.

Final Evaluations: Summary of results in ***Attachment K.***

The **Press Release** from the Times of India is found in ***Attachment L.***

K. Epilogue:

This workshop is just a beginning of a continued dialogue between participants. The potential for a rich network between the participants has been sparked. Even if there are not formal workshops such as this one, the Internet offers many opportunities to exchange ideas, ask each other questions, request advice and share successes as well as challenges instantly.

Overall, the workshop was very fulfilling and enriching for the training team. There are a few regrets:

The size of the workshop was limited due to the type of training (TOT), which was topped off at 27 participants with 4 facilitators and 2 Counterpart resource persons/participants, Ms. Heer and Mr. Jaydeep.

We missed two CCF Sri Lanka participants who were "no-shows." The organizers were not informed of their absence. Therefore, there were two spots, which were left unfilled. The demand for participation was higher than space and design allowed, so it is unfortunate that two alternatives were not identified and invited to attend in their place.

We missed participation from the Government of Gujurat, who has been unusually involved and active partners in the CPI/Hearth program. They would have offered another government perspective along with the Government of West Bengal participants. Besides participation from the state level, the target audience included representatives from the Government of India MOH staff and Nutrition Division representatives, who did not attend.

We missed Ms. Sandhya, the Program officer of Sanchetana, the partner NGO of Counterpart, who unfortunately had a conflicting schedule. She is a very strong Hearth advocate and implementor in Ahmedabad. It also would have been valuable to invite some of the local community members who are implementing Hearths in the CPI program. Since we were observing their program in the slum areas, it would have been even better to have some members (a community leader or Hearth volunteer) attend the sessions and offer their perspective. In addition, the Community Organizers/Health Promoters of CP staff would have been excellent resources during the workshop period. Inviting them to attend as resource persons or as participants would have been worthwhile.

We missed participation from the USAID PHN Office and the Child Survival Technical Officer in India who are involved in all the Child Survival projects in India by US PVOs and other health, nutrition and population projects.

We missed Stephanie Ortolano, CORE member designated for logistics, who regrettably was unable to attend due to a visa issue. She would have added a tremendous amount of support. Vanessa Dickey, co-facilitator, remarkably filled in many of the gaps and worked especially hard to compensate for our loss.

Attachment A:

List of Participants

	Name	Organization
1.	Vani Sethi	PD Researcher
2.	*Dr. Rajmohan Panda*	CARE, India
3.	Dr. Dharmendra Panwar	CARE/India
4.	Mr. Deepak Poudel	CARE/Nepal
5.	Dr. Rajeev Mohan	Catholic Relief Services/India
6.	Pradeep K. Goel	Catholic Relief Services/India
7.	Mr. Kumud Prabha	CCF/India
8.	Ms. Rupa Chottoraj	Child In Need Institute
9.	Dr. Mothabir	Concern Worldwide Bangladesh
10.	Orla O'Neil	Concern Worldwide Bangladesh
11.	Donna Sillan	CORE
12.	Krishna Soman	CORE
13.	Monique Sternin	CORE
14.	Ahshish Yadav	Counterpart/India
15.	Ramine Bahrambegi	Counterpart/Uzbekistan
16.	Azamat Matkarimov	Counterpart/Uzbekistan
17.	Madhvi Mathur	EHP/India
18.	Mr. Suhrid Kr. Das	Government of West Bengal
19.	Ms. Maya Das	Government of West Bengal
20.	Vanessa Dickey	Mercy Corps - Indonesia
21.	Dr. Ejaz Ahmed Buzdar	Mercy Corps/Pakistan
22.	Mary Helen Carruth	Mercy Corps/Tajikistan
23.	Dr. Jasmine Gogia	PCI/India
24.	Ruchi Chopra	PCI/India
25.	Nanang Sunarya	PATH - Indonesia
26.	Raymundo Celestino F. Habito	Save the Children/US - PhFO
27.	Ms. Manjushree Guha Biswas	Sibpur's People Care Organization
28.	Ms. Farheen Khurshid	UNICEF
29.	Ms. Piyali Mustaphi	UNICEF
30.	Bradley Thompson	World Vision of India
31.	Godfred Victor Singh	World Vision of India

Attachment B:

PD/Hearth TOT Workshop
Learning Needs and Resources Assessment

Dear Participant,
We look forward to your participation in the upcoming PD/Hearth TOT Workshop. We hope it will equip you to better support, design and implement sustainable community based nutrition initiatives. In order to better tailor the course to your needs, we would like you to answer the following questions and email your response to Stephanie Ortolano (stephanie.ortolano@tufts.edu) and cc: to Donna Sillan (dmsillan@comcast.net) by November 25, 2003.

1. Job title and main job responsibility

2. Explain what motivated you to register for this workshop.

3. Experience with growth monitoring, if any (number of years, extent of training, etc.).

4. Type of nutrition interventions you have been involved in and its results (success, failures, etc…)

5. Briefly describe what you think PD/Hearth is:

6. Please share one or two challenges you currently face in supporting, designing or implementing PD/Hearth or other community based nutrition initiatives.

7. Below is a list of proposed topics for the workshop. Some of the terms may not be familiar to you. Nonetheless, which topics appeal most to you? Why? Which topics, if any, are not of interest to you? Why?

Topic	Appeals / Explain Why	Not of Interest/ Explain Why
Positive Deviance Approach		
Community Mobilization/ Ownership		
Nutrition Baselines		
Wealth Ranking Exercises		

Identifying Positive Deviants		
Conducting Positive Deviant Inquiries		
Designing Hearth Sessions		
Conducting Hearth Sessions		
Supporting New Behaviors		
Monitoring & Evaluation of PD/Hearth Activities		

8. Imagine the workshop is over and five months have passed. What would you have hoped to accomplish personally in your work as a result of participating in this workshop?

9. What would you hope to see changed in your organization as a result of your participation in this workshop?

10. Would you be interested in sharing your (or your organization's) experiences with PD/Hearth at an evening session during the workshop?

Attachment C. Logistics Plan

Sr. No.	Description of Events	Logistical Checklist	CPI person In charge for Logistics
1.	Airport Transfers	• Arrival Details with Names, Flight no. Timing • Placard and a person to receive the participants • Vehicles to drop the participants from Airport to Hotel Eden	Milesh/ Anupama/ Ashish
2.	Hotel Check-in	• Accommodation plan; Single or Double Occupancy • Rooms are ready/ clean/ stocked with drinking water etc.	Milesh/ Anupama/ Ashish
3.	Workshop registration	• Registration forms • Indian currency converter	Ashish
4.	Video show in CPI office	• TV, Video, VCD Player • Seating arrangements/ Chairs/ Durries • Tea/ Coffee, Biscuits • Welcome kit for participants • Display of materials for the workshop	Heer/ Jaydeep
5.	Welcome kit for participants	• Welcome letter • Ahmedabad city info • Emergency contact numbers • Agenda for training • Workshop folders to be distributed to participants	Heer/ Jaydeep
6.	Inauguration on 8th December 2003	• Welcome note • List of people to be called on the Dais • Lamp, Candles, Matchbox, Flower Bouquets • Seating arrangements • Banners; outside the venue and inside the seminar hall	Heer/ Jaydeep
7.	"Training stationery" for workshop	• Boxes containing general stationery with markings	Heer/ Jaydeep
8.	Daily transfer of participants from Hotel to Venue	• Cars at the Hotel by 8:30 am and arrival at venue by 9 am	Milesh/ Anupama

Sr. No.	Description of Events	Logistical Checklist	CPI person In charge for Logistics
9.	Workshop Logistics at the Venue	• Seating arrangements • Food and water • Presentation tools; LCD Projector, OHP • Hygiene in Toilets etc.	Jaydeep/ Heer
10.	Field visit on Wednesday, 10th December 2003 for PDI	• List of places to be visited for PDI and Live Hearth • PD/ NPD/ ND data for slums where PDI to be conducted • Division into teams • Field plan • Lunch at the field office • Cars • Arrival to the Workshop venue by 4 pm, and arrangement of Tea/ Coffee/ Snacks	Jaydeep/ Heer/ Ashish
11.	CPI Presentations	• Draft copy of Hearth report and presentation • Photo Journey of CSP • BCC materials	Heer/ Jaydeep

Materials:

1. Flip charts and paper
2. Markers
3. Tape
4. Scissors
5. Name tags
6. Registration forms
7. Folders with paper, pen and Workshop Objectives
8. PD/Hearth Resource Guides (1 per participant)
9. Fanta Bookmarks (handouts)
10. All handouts during course of workshop
11. Cups (5) and plates (5) and utensils for small group work

Equipment:

1. Power Point projector
2. Overhead projector
3. Video player and TV
4. Digital camera

Attachment D: Materials List

Welcome Packet:

1. Goals and Objectives
2. Agenda
3. Participant list
4. Phone list of CPI staff
5. Sites of Ahmedabad
6. Highlights One-Pager of CPI Program
7. Findings of PD/Hearth Studies and Conclusions
8. Websites for PD/Hearth

Hand-outs over the 5 days:

1. UNICEF Conceptual Framework
2. Feasibility: Is Hearth Right for you?
3. Core Group Brochure
4. CD of Hearth Video
5. CORE Manual
6. General Resources
7. Findings of Studies
8. WHO Guidelines for Management of Severely Malnourished
9. Wealth Ranking
10. CPI's Market Survey, Food Composition Table, PDI Findings, ID PDs
11. Supervisory Checklist
12. Social Change Model
13. Community Participation
14. Interaction of Social and Individual Change

Resources to Share (Optionals):

1. Marilyn Zeitlin's book: Positive Deviance in Child Nutrition
2. Food and Nutrition Bulletin *v.* 23(4), 2002.
3. Positive Deviance Approach folder: Monique

Flip Charts

1. Goals and Objectives
2. Agenda
3. Daily Objectives
4. Daily Schedule
5. 9 Steps of PD/Hearth
6. Triple A Cycle
7. Spectrum Continuum
8. Triangle of Human Resources
9. Daily Evaluation

HAND-OUTS:

Websites:

Look on page 188 of the Manual for a list of internet sites. In addition, here are some latest ones:

www.positivedeviance.org
General and latest

http://www.coregroup.org/working_groups/nutrition.cfm
Lists many of the new publications and latest reports.

www.coregroup.org/working_groups/Pocket_PC-Applications_Hearth.doc
For a look at applications of Nutrition Calculation using the Palm Pilot

www.fantaproject.org
For Fanta Bookmarks

www.coregroup.org/imci/CoreItemD
For PLA tools

www.catholicrelief.org/what_we_do_overseas
Rapid Rural Appraisal Manual

www.talcuk.org/a-z_booklist.htm
Publication "Caring for Severely Malnourished Children"

www.earthprint.com
Participatory Learning, a newest guide

www.coregroup.org/imci
social change, participation and empowerment

Findings of PD/Hearth Studies and Conclusions [HO 3c]

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 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 in the *Food and Nutrition Bulletin* 23(4):9-15, 2002
   http://www.positivedeviance.org/pd/pdf/fnb23_9-15.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), 2002.
   http://www.unu.edu/unupress/food/fnb23-4s.pdf

   The entire supplement is devoted to articles on PD/Hearth; this article demonstrates that the PD behaviors used in Hearth are sustained at the household level and in the community.

Participatory model of social change model:

The key components of such a model:

- Sustainability of social change is more likely if the individuals and communities most affected *own* the process and content of communication.

- Communication for social change should be empowering, horizontal (versus top-down), give a voice to the previously unheard members of the community, and be biased towards local content and ownership.

- Communities should be the agents of their own change.

- Emphasis should shift from persuasion and the transmission of information from outside technical experts to dialogue, debate and negotiation on issues that resonate with members of the community.

- Emphasis on outcomes should go beyond individual behavior to social norms, policies, culture and the supporting environment.

Evaluation

1) Members of the community who want to know how well their effort has achieved the objectives they set for themselves and would like to share the results with the rest of the community: **SELF EVALUATION**

2) External change agents involved in the process who need to document how well a community has performed to inform funding agencies as well as the community: **EXTERNAL EVALUATION**

3) Social scientists who want to conduct a systematic analysis of the relationship between the process and its outcomes across a sample of communities, to share with practitioners as well as other scholars. **EVALUATIVE RESEARCH**

Community Participation

Community participation can be defined in many ways. Here is a "ladder of participation" with four levels, reflecting the varying degrees of community involvement and responsibility in health programs:

Level 1 Participation: Programs are developed entirely by the MOH/NGO. Communities are involved at the implementation level.

Level 2 Participation: Program priorities are defined by the MOH/NGO. Communities are involved in problem analysis, strategy development, implementation and evaluation. Health and development workers play the lead role.

Level 3 Participation: Program priorities are jointly defined by communities and MOH/NGO staff. Together they identify problems, develop action strategies, and implement and evaluate programs. Community members play the lead role. health and development workers provide technical and organizational support.

Level 4 Participation: Program priorities are identified by communities themselves. they take the lead role in action planning, implementation and evaluation. They request support for their program from MOH/NGO staff.

While some PVOs give the impression that their projects are at level 3 or 4, in reality many projects re still at level 1 or 2. Most communities lack the skills and experience required to conduct a project independently.

Urban HEARTH Offers Nutrition and Peace: Builds a Bridge to Good Nutrition and Good Relations!

Counterpart International is piloting the Positive Deviance (PD)/*Hearth* approach in the urban slum areas of Ahmedabad, India. Hearth taps into the indigenous knowledge of the mothers that exists within the community. A Hearth is a two-week cooking and feeding PRACTICE session for mothers of children with malnourished children for rehabilitation and education based upon positive deviance, the exploration of the behaviors of successful neighbors.

In March 2002, riots broke out in Gujurat state, particularly in the slum areas of Ahmedabad. Muslims and Hindus took to the streets setting off a wave of extreme communal violence. Six months later, the Child Survival team was trained in PD/Hearth in August of 2002. Two separate demonstration Hearths were set up during the training, one in each of a Muslim and Hindu community as the eating and caring practices of the two religious groups differed, and the two communities would not think of sitting together. Upon return a year later, the same Hearth trainer evaluated the program and was surprised to visit a Hearth that had both Hindu and Muslim children, sitting and eating together in a joint Hearth. When it came to feeding their children, the mothers could overcome their differences and pain. They understood that they both shared similar hopes for healthy children. The intervention itself served as an important avenue for building peace.

Not only did the Hearth bring two divergent groups together into one small group, the results of the pilot studies surpassed everybody's expectations: every child registered gained weight and those that have already graduated have sustained their growth after 2 months. There were 7 hearths conducted for 76 children, Muslim and Hindu alike. Now there is a demand from community leaders to expand the Hearth in neighboring slums as they see it as a powerful mobilizing force, which produced positive results. The community could visibly see the change among the participating children as they were rehabilitated. They could see that the caregivers themselves were successfully learning new behaviors to rehabilitate their own children. This would prevent future malnutrition in their families.

The Hearth served as an entry point to build up community trust again after the tumult of violence. Other CS interventions subsequently benefited from the success of the Hearths, as the CS team continued to flesh out the program into an integrated CS program. The program has successfully improved immunization rates, control of diarrheal disease and pneumonia case management. Through volunteer community health teams, health education activities using creative BCC methods based on the BEHAVE model, and creating a strong partnership with AMC, the municipal medical corporation and Sanchetana, a local NGO, the program has experienced tremendous success at midterm. Immunization rates have risen from 29% to 55%, ORT use has increased from 18% to 52% and pneumonia prevalence has been halved. The Hearth intervention helped facilitate the work of the health volunteers, since their credibility among the community was visible and included all women from different groups.

Child Survival was able to make considerable in-road towards greater social harmony. The spillover effect of such a program goes well beyond the measurable outcomes and impact in Health. Social issues, which are unplanned, are also positively affected. These unforeseen desirable impacts on society are part and parcel of the growing body of benefits that encompass Child Survival programming and the implementation of Hearth.

Table 1. Interaction of Social and Individual Change

		Individual Health Behavior Change: NO	Individual Health Behavior Change: YES
Social Change	NO	Maintenance of the status quo	Limited health improvement
	YES	Increased potential for health improvement	Self-sustained health improvement

Attachment E. List of Evening Discussion Circles:

Presenters: PowerPoint presentations available upon request

A. UNICEF in collaboration with the Government of West Bengal:
   By Team from West Bengal

B. Monitoring and Evaluation: Government of West Bengal: Malnutrition Surveillance
   By Mr. Suhrid Das

C. Counterpart Uzbekistan: Overall Program
   By Ramine Bahrambegi and Azamat Matkarimov

D. Jeevan Daan Program: Hearth Component: Counterpart India
   By Heer Choksi and Jaydeep Mashruwala

Question and Answer Periods:

Two participants requested an evening session to present their questions and gather answers from the group:

1. Vani Sethi: PHD Candidate: Hearth Researcher: hearth project
2. Madhvi Mathur: EHP/India: urban slum sanitation project

Attachment F: PDI Selection -- Dhudeshwar: Aalampura

No	Child's Name	Mother's Name	Address/Reference	Sex	Age Month	Weight	On Chart		Wealth Rank
							Grade	Color	
1	Vaishali	Hansaben Dilipbhai Chauhan	In Front of Anganwadi	F	10	7.200	Normal	Green	Rich
2	Anjali	Bhartiben Senghaji Chauhan	B/h. Anganwadi	F	27	8.400	II	White	Rich
3	Senghaji	Gulabben Khodidas Chauhan	In Front of Balwadi	M	16	8.800	Normal	Green	Rich
4	Ashik	Jyotiben Jayeshbhai Dabhi	Lane in Front of Anganwadi	M	17	7.600	II	White	Poor
5	Ankit	Hansaben Dhahyabhai Chavda	Lane in Front of Anganwadi	M	14	7.400	I	White	Poor
6	Vikas	Shardaben Kamlesh Kumar	Lane in Front of Anganwadi	M	18	10.300	Normal	Green	Rich
7	Kishan	Jyotsnaben Maheshbhai Chauhan	In Front of Anganwadi	M	32	11.000	Normal	Green	Rich
8	Kamlesh	Shobhaben Vadilal	Lane in Front of Anganwadi	M	31	11.000	Normal	Green	Poor
9	Karan	Manjulaben Mukeshbhai	Nr. Anganwadi	M	32	10.400	I	White	Rich
10	Babo	Geetaben Prakashbhai Lohana	Nr. Anganwadi	M	7	6.400	Normal	Green	Rich
11	Aarti	Shobhaben Vikrambhai	Lane in Front of Anganwadi	F	27	9.800	I	White	Rich
12	Pooja	Gulabben Rajubhai Chauhan	On Main Road	F	18	7.900	II	White	Average
13	Sonal	Meenaben Bharatbhai	Ugamben's House	F	18	7.400	II	White	Rich
14	Savan	Jayshreeben Maheshbhai Chudasana	In Front of Balwadi	M	27	10.400	Normal	Green	Average
15	Mahesh	Gomtiben Dilipbhai Chauhan	Nr. Ramdev Pir Temple	M	16	8.400	I	White	Average
16	Tina	Mayaben Dineshbhai Vaghela	B/h. Anganwadi	F	15	7.800	I	White	Poor
17	Rakesh	Gulabben Somabhai Chauhan	Lane in Front of Anganwadi	M	15	9.700	Normal	Green	Average
18	Rohit	Meenaben Bharatbhai	Lane in Front of Anganwadi	M	28	9.100	I	White	Average
19	Gayatri	Geetaben Mukeshbhai Chauhan	In Front of Anganwadi	F	5	5.000	-		Average
20	Babo	Manjulaben Ramchandrabhai	In Front of Ramdev Pir	M	15	8.000	I	White	Average
21	Anjali	Parvatiben Shaileshbhai	Lane in Front of Anganwadi	F	11	7.400	Normal	Green	Average
22	Khushi	Geetaben Navin Lohana	B/h. Anganwadi	F	6	6.600	Normal	Green	Average

Attachment G: Field Plan for Wednesday, 10th December 2003

Team no.	Field Area	CPI field coordinator for PDI	Team members	Car type and No.	PD/NPD/ND family to be visited
Team no. 1	Bhilvas, Danilimda	Veena	Monique, Nanang, Bradley, Rajeev	Car no. 1, Sumo	Positive
Team no. 2	Bhilvas, Danilimda	Heer	Vanessa, Krishna, Vani, Pradeep		Positive
Team no. 3	Mohajan no vando, Jamalpur	Padma	Ramine, Godfred, Kumud	Car no. 2, Qualis	Positive
Team no. 4	Mohajan no vando, Jamalpur	Anupama	Azamath, Manjushree, Jasmine		Non- Positive
Team no. 5	Raikhad cluster 1	Seema	Deepak, Raymundo, Ruchi	Car no. 3, Qualis	Non- Positive
Team no. 6	Raikhad cluster 1	Samana	Donna, Maryhelen, Raj		Non- Positive
Team no. 7	Alampura, Dudheswar	Priti	Orla, Dharmendra, Rupa	Car no. 4, Qualis	Negative
Team no. 8	Health Quarters, Jamalpur	Nita	Dr. Mothabeer, Madhvi, Farheen	Car no. 5, Versa	Negative
Team no. 9	Dashrath mukhi ni chali, Danilimda	Shaheen	Suhrid, Maya, Dr. Ejaz	Car no. 6, Versa	Negative

- Car no. 7, Indica, Ashish for field coordination and Titi for Photographic documentation

Field plan for Hearth Observation

Afzalkhan no Tekro, Raipur		Abadnagar, Danilimda	
Sr. No.	Team Members: Team 1	**Sr. No.**	**Team Members: Team 2**
	Cars: 1, 2 (Qualis), 4 (Ambassador)		**Cars: 3 (Sumo), 5, 6 (Versa)**
1.	Jaydeep	1.	Heer
2.	Anupama	2.	Ashish
3.	Donna	3.	Rajeev
4.	Vanessa	4.	Pradeep
5.	Ramine	5.	Monique
6.	Nanang	6.	Azamath
7.	Manjushree	7.	Raymundo
8.	Deepak	8.	Orla
9.	Maryhelen	9.	Suhreed
10.	Dr. Mothabir	10.	Krishna
11.	Maya	11.	Vani
12.	Bradley	12.	Rupa
13.	Godfred	13.	Dr. Ejaz
14.	Farheen	14.	Madhvi
15.	Jasmine	15.	Kumud
16.	Raj	16.	Ruchi
17.	Dharmendra		

Attachment H:
Results of Market Survey India/Gujarat/Ahmedabad

$1 US = 50 Rupees

Sr.	Item	*Unit*	Price (Rs.)	*Seasonal*
	Go Group			
1.	Rice	100 gm	1.60	No
2.	Wheat	100 gm	1.00	No
3.	Oil – cotton seed	100 gm	5.00	No
4.	Vegetable oil	100 gm	6.00	No
5.	Desiccated Coconut	100 gm	6.00	No
6.	Flaked Rice	100 gm	2.50	No
7.	Sago	100 gm	3.00	No
8.	Semolina	100 gms	1.50	No
9.	Sugar	100 gms	1.50	No
10.	Jaggery	100 gms	2.00	No
11.	Dates	100 gm	2.00	No
12.	Peanuts	100 gm	3.50	No
	Grow Group			
13.	Buffalo Meat	100 gm	10.00	No
14.	Chicken - Broiler	100 gm	6.00	No
15.	Curd	100 gm	3.00	No
16.	Dals/ Lentils	100 gm	3.00-3.50	No
17.	Egg	100 gm	1.50	No
18.	Fish	100 gm	6.00	No
19.	Goat Meat	100 gm	4.00	No
20.	Milk (Cow)	100 gm	2.00	No
21.	Pulses	100 gm	3.00-3.50	No
	Glow Group			
22.	Apple	100 gm	3.00	No
23.	Banana	1 No.	1.50	No
24.	Brinjal/ Egg plant	100 gm	1.00	No
25.	Cabbage	100 gm	2.00	No
26.	Carrots	100 gm	3.00	Seasonal
27.	Cauliflower	100 gm	1.20	Seasonal
28.	Chili	100 gm	2.00	No
29.	Coriander	100 gm	2.00	No
30.	Cucumber	100 gm	2.00	No
31.	Fenugreek leaves	100 gm	2.00	Seasonal
32.	Garlic	100 gm	2.00	No
33.	Ginger	100 gm	4.00	No
34.	Green Onions	100 gm	2.00	Seasonal
35.	Green Tuver/ Green Lentils	100 gm	5.00	Seasonal
36.	Guava	100 gm	3.00	No
37.	Lady's finger/ Okra	100 gm	2.00	No
38.	Lemon	1 No.	1.00	No
39.	Local Beans	100 gm	2.00	No
40.	Mint	100 gm	2.00	No
41.	Onions	100 gm	0.60	No

42.	Peas	100 gm	4.00	Seasonal
43.	Potatoes	100 gm	0.90	No
44.	Pumpkin	100 gm	1.00	No
45.	Spinach	100 gm	1.00	No
46.	Tomatoes	100 gm	1.50	No

Indian Food Composition Tables

(Nutrients per 100 gms)

Food Items	% Edible	Calories	*Protein*	Calcium	Iron (mg)	Vit C (mg)	Vit A (mg)
Carbohydrates[1]							
Millets	100	361	11.6	42	8	0	132
Wheat	100	348	12.1	48	4.9	0	29
Semolina	100	348	10.4	16	1.6	0	0
Rice	100	345	6.8	10	0.7	0	0
Potatoes	100/90	97	1.6	10	0.48	17	24
Proteins[2]							
Peanuts	100	567	25.3	90	2.5	0	37
Lentils- Green Gram	100	348	24.5	75	3.9	0	49
Lentils- Green Gram	100	334	24	124	4.4	0	94
Roasted Bengal Gram	100	369	22.5	58	9.5	0	113
Lentils- Tur dal	100	335	22.3	73	2.7	0	132
Goat Meat		118	21.4	12			
Lentils- Bengal Gram	100	372	20.8	56	5.3	1	129
Buffalo Meat		194	18.5	0.15	2.5	0	9
Egg	90	173	13.3	0.06	2.1	0	360
Desiccated Coconut	100	662	6.8	400	7.8	7	0
Milk (Buffalo)	100	117	4.3	210	0.2	1	160
Milk (Cow)	100	67	3.2	120	0.2	2	174
Chicken - Broiler							
Fish							
Vegetables[3]							
Peas	60	109	7.2	0.02	1.5	9	83
Coriander	80	44	3.3	184	1.42	135	6918
Cauliflower	75	30	2.6	33	1.23	56	30
Spinach	80	26	2	73	1.14	28	5580
Local Beans	90	16	3.2	130	1.08	49	198
Carrots	80	48	0.9	80	1.03	3	1890
Tomato	100	35	1.5	12	1.0	27	351
Cabbage	80	27	1.8	3.9	0.8	124	120
French Beans	90	26	1.7	50	0.61	24	132
Onions	90	50	1.2	46.9	0.6	11	0

[1] In descending order based on caloric value and then protein content.
[2] In descending order based on protein content and then caloric value.
[3] In descending order based on Iron content, then Vit A and then protein content.

Cucumbers	90	2.5	0.4	13	0.6	7	0
Pumpkin	85	25	1.4	10	0.44	2	50
Fruits[3]							
Dates	80	144	1.2	22	0.96	0	0
Papaya	70	32	0.6	17	0.5	57	666
Banana	70	116	1.2	17	0.36	7	78
Guava	100	51	0.9	10	0.27	212	0
Fats[4]							
Oil – Groundnut	100	900	0	0	0	0	2500
Animal fat (Cow)	100	900	0	0	0	0	2000
Animal fat (Buffalo)	100	900	0	0	0	0	900
Sugars							
Jaggery	100	383	0.4	80	2.64	0	0
Sugar	100	398	0.1	12	0.155	0	0

[4] In descending order based on Vit A. content.

Attachment I:
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 time line 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…

Sr. NO.	Attachment J: NETWORKING LIST **Name, Organization & Designation of Participants**	**E-Mail & Phone Nos.**
1.	Krishna Soman **Assoc. Prof.** (Public Health) INSTITUTE OF DEVELOPMENT STUDIES KOLKATA (IDSK)	krishna_soman@rediffmail.com Phone No: ® 24165878
2.	Donna Sillan *Independent Consultant* PUBLIC HEALTH CONSULTANT	dmsillan@comcast.net 72 Hazel Ave. Mill Valley, CA 94941, USA phone No. 001-415-380-8913 Mobile No.: 001-415-559-6527
3.	Heer Chokshi *Health Education Specialist* COUNTERPART INDIA	heer@icenet.net Mobile No: 31002164 Phone No: (O) 079 – 7484567 079 – 30911593
4.	*Jaydeep Mashruwala* *MIS Manager* COUNTERPART INDIA	jmashruwala@indiatimes.com Phone No: (O) 079 – 7484567 079 – 30911593 Mobile No: 98250 – 58156
5.	Vanessa Dickey *Program Manager* MERCY CORPS	vdickey@mercycorps.or.id Phone No: 62-021-782-8611 Mobile No: 08120-8784317
6.	Monique Stemin *Visiting "Scallop"* **(Scholar)** TUFTS UNIVERSITY	monique_stemin@hotmail.com monique.stemin@tufts.edu
7.	Manjushree Guha Biswas *Program Manager* *S.P.C.O.*	mitishleis@com.net Phone No: (Head Office) 033 – 2650 – 1481 (District Office) 03521, 252086
8.	Farheen Khurshid *Co – ordinator PD* UNICEF KOLKATA	farheen_K123@rediffmail.com farheen51@hotmail.com Phone No: 22872477
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Attachment K: Final Evaluation Results

(# of participants in addition to initial comment)

What workshop activities did you find most useful?

- Calculating menus (11)
- Informal networking/sharing of experiences (1)
- Sharing of experiences (111)
- Visit to slum area (1111111111)
- Group exercises (111)
- Vibrant partic ipation approach of every aspect (1)
- Panel discussion
- Applying PD in other programs (newborn care, pregnancy) (11)
- All
- Hands on exercise
- Presentation from Indonesia
- PDI (1)
- Introduction to concept, definition (1)
- Evening sessions
- Monitoring and Evaluation and tools (1)
- Living University concept and scaling up (11)
- Community mobilization (1)
- 6 Ds
- Role-playing
- Starting Hearth and making it sustainable
- Brainstorming sessions (1)
- Presentations
- Means to make Hearth interesting
- Warming exercises

- ***<u>What activities did you find least useful?</u>***
  Evening sessions
- Applying PD to other problems
- Discussion in large groups
- Presentations (11)
- Games
- Limited time to discuss
- Discussion of PDs
- Community mobilization
- Detailed discussion on tips for community mobilization

<u>What PD/Hearth content area would you like to spend more time discussing?</u>

- Monitoring and Evaluation (111111)
- Cost benefit analysis
- Motivation
- Expansion
- Budgeting
- Proposal
- Compare PD to other interventions

- Menu calculate (1)
- Striking right balance
- Cost
- Loss of micronutrient
- Preferred method of cooking, preparing food
- Living University
- How to make Hearth successful
- Designing Hearth
- PDI in field
- Community Mobilization
- Situational analysis

<u>What areas are still unclear?</u>

- Field visits
- Selection of children on wealth ranking in urban areas
- Learn from others who are running PD Hearth
- Calculating calories and protein
- Sustainability issue in Hearth (1)
- How to prepare TOT for anganwadi workers
- Liaising with others in PD/Hearth
- Expanding Hearth (1)
- Selection of target area
- Dealing with relapsers
- Cost effectiveness
- Feasibility

Recommendations for future trainings

- More field visits (111)
- Prevent repetitions
- Good process
- More field-oriented, learning and observing community
- Punctuality
- Continue evening brainstorming sessions
- Less ambitious program
- Have field in rural areas
- Include research done on PD Hearth
- Facilitators need to be more focused
- More case studies (1)
- More group exercises
- More on Hearth failures
- Carry on good work
- Make it more localized
- Smaller groups going to field (1)
- Longer time in field
- More discussion on cost effectiveness
- More role-plays
- Focus Group Discussions (1)
- A lot of discussion

- Shorter training (1)
- Not longer than 8 hour days
- Additional 2-3 days for more small group interactions
- Evening sessions shouldn't end too late
- Format for sharing field visits

How will you use this training in your work?

- New inputs and ideas in the existing ongoing program
- Overview to staff (1111)
- Propose training at organizational level (1)
- Include PD in CS proposal
- As we have Health and Sanitation program we will implement next year
- Share other experiences with my colleagues and use what is appropriate
- Implement pilot (1111)
- Make research more feasible and practical
- Will decide if hearth is appropriate to culture
- PDI as pilot
- Can be used in my work (111)
- Promotion of hygiene and sanitation
- Adopt step-by-step (1)
- Share ideas with community
- Use in newborn care and nutrition
- Design a Hearth component
- Share PD with Non Health team to stimulate ideas
- New areas
- Continue in existing Hearth
- Vitamin A, adolescent reproductive health

What additional technical support would you or your organization require to increase quality and scale of PD/Hearth programming activities?

- Networking with others who implemented
- TOT manual and lessons learned
- Technical support to design and implement Hearth in new environments
- More supervision from CORE in field
- Micro-enterprise program to be linked with Hearth
- Visit to more Hearth areas
- More technical training on nutrition and guidelines
- Bring Donna to come over to train team and stakeholders and partners simultaneously and initiate Hearth
- More Journals, books on PD in different countries
- Simple means of analyzing data by organization and community
- Assistance to evaluate
- Training field office staff on PD/Hearth

Additional comments:

- I am overall satisfied with this training. Some concerns: 1) too long duration-5 days; 2) too many facilitators – one international and 1 local is all you need maximum; 3) poor time keeping.
- Notes should be circulated in a timely fashion the following day.
- Issues with the rate fixed for boarding – told includes breakfast but charged Rs. 125 afterwards. Also, receipts issued for the fees received are not acceptable in any USAID auditable organization.
- Overall, training is very informative and few points, which were not clear became clear by reading PD/Hearth guide.
- As the program is entirely for the community, with the community and by the community, participation of some community leaders (at district level) would be more helpful for the entire process.
- As health intervention plays a very important role for the program Health officials from government post would have been more helpful for the training program
- The field visit area/time requires more time.
- The training was simply brilliant. I really wish I had this training before, probably I could have done better.
- It was great to learn from the experiences of others esp. Vietnam, Indonesia, Ahmedabad.
- I would sincerely like to thank all facilitators – Donna, Monique, Vanessa and Krishna, for this wonderful cooperation and facilitation. Thanks to my organization "CINI" for sending me.
- Because I had training in PD/Hearth before, so I will implement while I train. Excellent!
- Pace, style, experience of facilitators all made this workshop extremely enjoyable and enlightening. Being able to have time for discussion and sharing was really appreciated.
- Thanks for the wonderful workshop (6)
- Logistical arrangements need to be better – A.C. during trainings needs regulation. Need to inform in prior the cost of room, breakfast complementary or not. Otherwise the stay was comfortable.
- Big thanks to Counterpart, colleagues and all facilitators. State-wise trainings with all like-minded NGOs are appreciated. Networking should be ensured for faster learning focus. May God bless you all.
- I like the teaching process and methodology of the facilitator, especially Donna.
- It is very much participatory that is why it is more effective.
- Organize reinforcement training for TOT, which will help in solving actual problem faced by all of us.
- The hotel was a bad bargain with the breakfast not being complimentary. The hotel folks told us "your buffet will be laid out at 7:30am". Which did not have the option of eating a breakfast of our choice. We were taken for a ride.
- Counterpart staff are very polite, generous, caring, helpful. Had very clear conceptual and practical understanding of the project.

Attachment L: PRESS RELEASE

4th December 2003

Dear Ms. ,

Times of India.

Counterpart India and your organization have had an encouraging relationship till date owing to your interest in developmental news. We would be appreciative of your interest in the following event and invite you to attend the inauguration ceremony of the International PD/Hearth

INVITATION

Dear Friends from the Press,

Counterpart India and CORE Group (Child Survival Collaborations and Resources Group) cordially invites you to the inaugural ceremony of the

Asian Regional Positive Deviance/Hearth Training of Trainers Workshop
Ahmedabad, India (December 8-12, 2003)

On: 8 December 2003 **Time:** 9 am – 9.30 am
Venue: Centre for Environment Education, Thaltej Tekra, **Ahmedabad 380052**

Chief Guest: Mr. D N Pandey, IAS
Secretary and Commissioner, Family Welfare, Government of Gujarat

Trainers: Donna Sillan, Vanessa Dickey, Monique Sternin, Krishna Soman
Participants: Members of PVOs/NGOs, representatives from the Ministry of Health, USAID, World Bank, and UNICEF

Please find attached herewith a brief about PD/Hearth
RSVP: Ramesh K Singh, Counterpart India Ph: 7484567, 30911593

workshop.

Please Note: Mr. Harry Dorcus, Vice President of Counterpart International and Ms. Darshana Vyas, Director Health Programs, Counterpart International will be joining the program from our headquarters at Washington D.C.

For more details please feel free to call Ramesh K Singh: 9825025653, Heer Chokshi: 31002164

Thanking You.

With regards,

Ramesh K Singh,
Program Director

Counterpart India

Training of Trainers Workshop on Positive Deviance/Hearth: Mechanisms for Community-Based Management of Malnutrition

December 8-12, 2003

Ahmedabad, Gujarat, India

Sponsored by The CORE Group and USAID, in conjunction with Counterpart India

The Nutrition Working Group of the CORE Group (Child Survival Collaborations and Resources Group) USA will be hosting a Positive Deviance/Hearth Training of Trainers Workshop in Ahmedabad, Gujarat, India from December 8-12, 2003 in conjunction with Counterpart International. The goal of the workshop is to equip field staff with the skills needed to design, implement and evaluate PD/Hearth interventions.

The CORE Group is a membership association of more than 35 US Private Voluntary Organization (PVO) that work together to promote and improve primary heath care programs. Its mission is to strengthen local capacity on a global scale to improve health of women and children through collaborative NGO action and learning. Collectively its member organizations work in over 140 countries, supporting health and development programs.

Counterpart International's India Jeevan Daan Child Survival program is located in the urban slums of Ahmedabad, reaching a population of over 1.8 lakh in 6 AMC wards together with AMC and NGO Partner Sanchetana. Under Jeevan Daan Program 7 Hearths have been set up till date and has become a model in implementing urban PD/Hearth and will serve as a "living university" for the trainees, providing an operational field example of the Hearth in action.

What is Hearth?

Hearth is a community-managed program designed to reduce the incidences of malnutrition in children and to sustain their improved nutritional status. The program's three-dimensional approach rehabilitates malnourished children, teaches families how to sustain their children's enhanced nutritional status and dramatically reduces malnutrition among children born in the community in the future. In doing this, Hearth simultaneously raises community awareness of malnutrition, empowers the community to seek existing local solutions, and teaches families healthy behaviors.

Developed by private voluntary organizations, Hearth has been successfully applied in some of the poorest countries in the world: Haiti, Vietnam, Nepal, Bangladesh, India and Mozambique. The organizations know that solving the root causes of malnutrition such as poverty and lack of access to health care can take several generations. Meanwhile, malnourished children are dying or surviving, but never reaching their full potential.

Surprisingly, not all children in a targeted community are malnourished. Despite stark poverty and food scarcity, some parents find ways to feed their children well and raise well-nourished children. What are these "positive deviant families" doing differently than the parents of malnourished children in the same community? Identifying the strategies of these positive deviant families is key to a successful Positive Deviant Hearth program.

The Nutrition Education and Rehabilitation Session (NERS)

Hearth trainers identify positive deviant caregivers and gives them basic nutrition training. These volunteers invite participating families to their homes for the Nutrition Education and Rehabilitation Sessions (NERS) and engage the families in helping to prepare food practicing good hygiene, and helping with clean up. The children are fed a meal based on the foods identified in the positive deviant inquiry. **Each meal contains 700 calories and 24 grams of protein.** Each family brings **a daily contribution of a handful** of the kind of food used by the positive deviant families in their community, thereby practicing and acquiring a new habit. Families **actively feed** their children, learning how much food to feed them and how to coax them to eat. As they cook and clean up, the volunteer shares information with the families about beneficial health practices gleaned from the positive deviance inquiry.

Preliminary data shows that the Positive Deviant Hearth program has produced dramatic results. **Severe malnutrition has been reduced by 80% in participating communities.** Sixty to ninety percent of children weighed 1-3 months after participating in Hearth have at least adequate growth. Many of the children even have catch-up growth. Because families continue to practice the behaviors they learned in Hearth, the younger siblings of Hearth participants enjoy significantly better nutrition than their older siblings did before the Hearth program.

Why Does Hearth Work?

- Community members and volunteers learn from the **PDI that solutions accessible to the poorest** exist right in their community. By bringing their daily contribution of food, families practice and acquire new habits that they continue at home when the NERS sessions are over.

- Families see children "perk up" after 10-12 days rehabilitative feedings in the NERS and are motivated to continue the new feeding and care behaviors. **All inputs needed for NERS come from the community, including food, water, fuel, and volunteers**.

- The **NERS creates a support group** where caregivers can try new practices in a safe environment. **Families are not passive recipients but are active learners** at the NERS and at home with the volunteer's support.

- NERS continues in the community long enough (up to 6 months) for community members to experience and witness the impact of good feeding, caring and health seeking behaviors on their children. As a result of this prolonged involvement, **the community's conventional wisdom about these behaviors is changed.** This ensures the **sustainability of the new behaviors** and the dramatic reduction of malnutrition in future generations in the community.

Facilitators: The workshop facilitator will be **Ms. Donna Sillan**, who was the lead writer for the CORE PD/Hearth Resource Guide. Ms. Sillan has extensive experience in designing PD/Hearth programs for CORE members around the world, as well as an in-depth understanding of PD/Hearth resource materials and case studies.

Joining Ms. Sillan will be Vanessa Dickey, who is currently working on a PD/Hearth program fro Mercy Corps-Indonesia, and Krishna Soman, who has worked with the Child in Need Institute/UNICEF PD/Hearth program in West Bengal. Monique Sternin, world-renowned Hearth expert, who championed the process in Vietnam with Save the Children, will be the main resource person.

Participants: Potential participants include members of PVOs /NGOs, as well as representatives from the Ministry of Health, USAID, World Bank, and UNICEF who are engaged in community-based strategies.

Training: The training will be conducted in English over a period of 5 days in Ahmedabad, Gujarat, India. The curriculum includes the introduction of the concept and methodology of Hearth and field-based exercises in the community.