Report on Positive Deviance/Hearth Workshop in Benin

“Formation Regionale des Formateurs sur le Modele Deviance Positive: Foyers d’Apprentissage et de rehabilitation Nutritionnelle (FARN)”

Sept 1 – 8, 2004
Porto Novo, Benin

Sponsored by CRS/Benin with participation with other CORE member organizations

23805 Currant Dr.
Golden Co., 80401

Context: CRS Benin has received USAID and other funding to work with local partners to implement, as the major nutrition component of a new project, “Foyers d’Apprentissage et de Rehabilitation en Nutrition” (FARNS) that use the Hearth/Positive Deviance approach. These FARNS (apprenticeship/rehabilitation workshops) will be distributed across the field areas implicated in a new project. Direct beneficiaries will include children under five and their parents, eventually covering a total population of nearly one million. The project, at the time of this consultation, had not yet realized a pilot project for FARNS, and sought advice and council and training.

This workshop was funded by The CORE Group to provide a regional W. African training opportunity for multiple NGOs. This was made possible by support from the Bureau for Global Health, USAID under Cooperative Agreement FAO-A-98-00030.

The CORE Group is a membership association of more than 35 U.S. nongovernmental organizations (NGOs) working together to improve the health and well being of children and women in developing countries through collaborative NGO action and learning. Collectively, its member organizations work in more than 140 countries, supporting health and development programs.

The Hearth/Positive Deviance approach is a resource-based rather than a “needs based” approach that depends on positive deviant inquiries (PDI’s) carried out as home visits. The objective of the PDI (positive deviance inquiry) is to empower villagers to discover their own resources by visiting poor families whose children are well-nourished. PDI’s are to be repeated in every village, as a prerequisite to the “apprenticeship” offered to mothers to rehabilitate their own children using local foods. If well carried out under the direction of the trained nutrition “educatrice”, villagers will discover that in the poor families whose children are well nourished, there are skills and behaviors that prevent malnutrition as well as healthy menus & useful snack-foods that pre-school children will eat. The educatrice will explain that for “skill transfe” an “apprenticeship” is needed: a safe place to try the new skills and see their result; hence involving the home of a volunteer mother who is willing to use her “hearth” to help rehabilitate children. She uses her kitchen («hearth») for two weeks to help participant mothers begin the rehabilitation process. The volunteer mother then follows up for two weeks with home visits. The malnourished child should be well on the road to recovery, and is then re-integrated into the ongoing growth monitoring program.
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**Purpose/Background (from Dr. Dubuisson)**

The purpose of this Scope of Work (SOW) is to describe the responsibilities of the consultant for the regional workshop on the Hearth model. CRS/Benin expects to have the event from August 1st to August 8th and is requesting that the consultant provide the participants with skills and tools for implementing and promoting the Hearth model in their respective country program. The consultant will organize the training and facilitate a seven-day PD/Hearth workshop in Benin for 25 individuals from CORE member organizations and select partners in the West African region. This workshop will prepare PVO’s and partners to develop and implement PD/Hearth programs in their intervention areas. The consultant will:

- Introduce participants to the Positive Deviance approach.
- Introduce participants to the potential benefits for addressing and sustaining nutritional improvements in resource poor communities.
- Introduce participant to the concept of adult learning.
- Equip participants with the skills needed to mobilize and support communities in the implementation of PD/Hearth activities.
- Equip participants with tools to monitor, evaluate and expand PD/Hearth interventions for addressing malnutrition among children.
- Provide participants with Technical Resources, Tools and Links to Networks for the support of implementing PD/Hearth activities.
- Provide participants with practical lessons learned on integrating PD/Hearth into existing programs.
- Provide participants with practical tools for Positive Deviance Inquiry, market survey.
- Organize field practice
- Provide participants with the skills to apply the steps for the implementation of the Hearth.
- Develop with participant mechanism for integrating PD/Hearth into existing programs.
Abbreviations & Definitions:

CRS: Catholic Relief Society
FARN: “Foyer d’Apprentissage et de Rehabilitation Nutritionnelle” (Hearth/Positive Deviance approach to nutrition education and rehabilitation) (see definition below)
NGO: Non governmental organization
USAID: United States Aid for International Development
PDI: Positive deviance inquiry (see definition below).
VHW’s: Village Health Workers (VHWs) are resident home-visitors who labor for their neighbors, the local health services and for Hearths by weighing 0-4 year-old children, issuing health cards, and referring persons to the nearest health services for vaccination or other care.

Key Definitions:

**Hearths (FARNs)** can be thought of as “itinerant workshops” for mothers of malnourished children to rehabilitate them through the services of a neighbor in her own home, using local foods. This trained and supervised volunteer mother invites a few neighbor mothers and their malnourished children to her kitchen (“foyer”) for a few hours daily, for two weeks to allow for an “apprenticeship” in nutrition rehabilitation. During this “hands on” training, participant mothers prepare and feed a nutritious meal and snack made from local foods, as discovered during the Positive Deviance Inquiry” (PDI). Participant mothers contribute part or all the ingredients, planned the day before. The **volunteer mother** not only teaches recipes and justifies the ingredients, she must model behaviors, such as hand washing and “active feeding”, also found in the local PDI. She also organizes with the participating mothers the daily menu to which the participating mothers contribute in kind. She then follows-up the child for two more weeks, assuring that the participant mother continues to give her child the meal and snack supplements learned in the HEARTH. All menus, recipes, and snacks are derived from several previous village level “positive deviant” inquiries (PDIs) in that village, and at the particular season of the year. The supplement that is offered must be calorie-dense and not bulky; it should contain 700 – 900 calories, 25 – 27 grams of protein, and adequate vitamins and minerals.

**Positive Deviance Inquiry (PDI) (for nutrition)**
The PDI is an inquiry into the child protective behaviors of poor families with well-nourished children. It takes place during a home visit by a small group of interviewers/observers, including some community members, and is based on the following theory:
In most poor villages and neighborhoods in developing countries, where 30% or more of pre-school children are malnourished, there are some children whose poor families have been able to keep them well nourished against all odds. These families and their children are known as “positive deviants”. That is, they are deviating from the “norm” of having malnourished children, despite their modest means. These families have adopted behaviors that are protective and prevent malnutrition. These behaviors fall into three categories:

- **Child-feeding behaviors**, including the number of times per day a child is fed, and what foods are used (simplified 24 hour diet recall)
- **Child caring behaviors** (who cares for the child? Is the child caressed and loved?)
- **Health seeking behaviors on behalf of the child** (immunization, ability to administer oral dehydration therapy, regular attendance at nutrition surveillance sessions).
Workshop Preparation:
Dr. Dubuisson, Elizabeth Zanou, CRS nutritionist, and Dr’s Warren and Gretchen Berggren met prior to the workshop to choose the themes appropriate for the workshop. Themes suggested included the following:

- History and background of the Hearth/Positive Deviance (FARN) Approach
- Definitions, Objectives for the workshop
- Hearth/Positive Deviance Approach: Introduction to steps for implementation
- Participatory Adult Education as underpinning for FARN approach
- Causes and Consequences of Malnutrition; micronutrients
- Malnutrition and infection, vicious cycle; implied actions
- Prerequisites for FARNs in Benin (in each field site)
- Details on roles of actors at each level (volunteer mothers, educators, etc.)
- The positive deviance inquiry; plan for application, use & teaching of it
- Who does what in FARNs; daily schedule for FARNs; messages & FARNs
- Monitoring and Evaluation: Information system implied Experience with the CRS information system; adapting it to FARN
- Plan for management of a series of FARNs to rehabilitate children targeted
- Training needs at each level for FARN implementation
- Curriculum development (planned as a Sunday session)
- Planning for adequate supervision and management.

Notes from planning discussions with Dr. Dubuisson
FORMATION REGIONALE DES FORMATEURS
SUR LE MODELE DEVIANCE POSITIVE (French/English)
FOYERS D’APPRENTISSAGE ET DE REHABILITATION NUTRITIONNELLE (FARN)

| Translated roughly from French original | Objectives for the PositiveDeviance/FARN (PD/F) Workshop :

- To understand: definition, justification & approach of PD/FARN in order to diminish malnutrition in a sustainable way at the community level.

- Understand the principles and advantages of adult participatory education.
- Understand, develop competence to teach the methodology of PD/F
- Master the steps necessary to implant FARNs in communities.
- Develop competence in planning a PD/F training program.
- Develop competence for developing and teaching a system of information and evaluation appropriate to FARNs
- Evaluation of workshop |
## PARTICIPANTS EXPECTATIONS

<table>
<thead>
<tr>
<th>Attentes (French)</th>
<th>Expectations (ENGLISH)</th>
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<tbody>
<tr>
<td>Mieux comprendre plus <em>Deviance Positive</em> et la notion de <strong>FARN</strong> en Réhabilitation Nutritionnelle</td>
<td>Better understanding of PD/F and its role in nutrition rehabilitation.</td>
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<tr>
<td>Partager nos connaissances avec les participants et facilitateurs</td>
<td>Sharing of knowledge between the facilitators and the participants about PD/F</td>
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<tr>
<td>Pouvoir partager Postérieurement les acquis avec les collaborateurs de terrain pour une mise en œuvre effective</td>
<td>Ability, after acquiring skills, to share them with collaborators in the field in a way that is effective (in application) of PDF.</td>
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<tr>
<td>Pouvoir appliquer ce modèle de <strong>FARN</strong> dans nos communautés ; pouvoir adapter cette approche dans le contexte Béninois à travers le PSA du Plan Béninois</td>
<td>Ability to apply PD/FARN in our communities ; adapting the approach to the context of the PSA of the plan for Benin (in primary heath care)</td>
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<tr>
<td>Développer des compétences pour mobiliser et encadrer les communautés dans la mise en œuvre de l’approche <em>Positive Deviance</em> /Hearth</td>
<td>Develop competence in community mobilisation and how to share it with communities in order to implement the PD/Hearth approach</td>
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<tr>
<td>M’approprier l’approche par l’acquisition des compétences nécessaires pour des interventions au niveau de la communauté</td>
<td>Internalize/appropriate the approach and develop related competencies in [implanting] community based PD/Hearth</td>
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<tr>
<td>Être capable de conduire un programme communautaire de Nutrition grâce aux outils de l’approche <em>Positive Deviance</em>/FARN.</td>
<td>Become capable to conduct a community based nutrition program thanks to the tools developed in the PD/Hearth approach</td>
</tr>
<tr>
<td>Maîtriser la méthodologie de l’approche <em>Positive Deviance</em>. Définitions / Mise en œuvre leçons apprises / Difficultés</td>
<td>Master the methodology of PD/Hearth ; understand its definitions/implantation and lessonbs learned/difficulties.</td>
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<tr>
<td>Identifier les avantages par rapport à d’autres méthodes notamment le VISA</td>
<td>Identify the advantages of the method compared to others, such as the VISA approach of MCDI.</td>
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<tr>
<td>Gestion de suivi post Récupération pour limiter les rechutes et d’incidence au niveau d’un Foyer</td>
<td>Management of the recuperation of a child in the FARN in such a way as to prevent recrudescence of malnutrition</td>
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<tr>
<td>Savoir comment maintenir de bons états pour les enfants après la mise en œuvre du programme</td>
<td>Learn how to maintain a good state of health for children after the start of the program</td>
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<tr>
<td>Connaitre les méthodes et outils d’intervention de l’EDP/FARN</td>
<td>Understand the methods and tools of PDI/FARN</td>
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<tr>
<td>Connaitre comment suivre un programme utilisant le <em>Positive Deviance</em>/Hearth.</td>
<td>Know how to monitor and follow up a program using PDI/FARN</td>
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<tr>
<td>Faisabilité sociologique du <strong>FARN</strong> et <em>Positive Deviance</em> comme instrument de lutte contre la malnutrition.</td>
<td>[Understand] Sociologique feasability of the FARN and Positive Deviance as instruments to combat malnutrition</td>
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<tr>
<td>Suivi Post Récupération pour éviter rechutes</td>
<td>Understand follow-up and monitoring after recuperation in order to prevent recrudescence of malnutrition</td>
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<tr>
<td>Critères d’identification des mères modèles /exemplaires</td>
<td>Understand criteria for identifying exemplary « model » mothers (Positive deviant mothers)</td>
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<tr>
<td>Comprendre Modele/DeviancePositive en Nutrition. Etapes de mise en œuvre / évaluation.</td>
<td>Understand the « Positive Deviance » model in nutrition, steps to utilize it, and evaluate it.</td>
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<td>Pouvoir identifier les avantages et inconvénients de l’approche.</td>
<td>Become able to identify the advantages and inconveniences of the [PDI/Hearth] approach</td>
</tr>
<tr>
<td>Comment régler les questions de ressources nécessaires à la réhabilitation Nutritionnelle en matière de <strong>Positive Deviance</strong> ?</td>
<td>Know how to come up with the resources necessary for nutrition rehabilitation using the PDI/Hearth approach</td>
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<tr>
<td>Comment assurer la pérennité de l’approche</td>
<td>Learn how to assure the sustainability of the approach</td>
</tr>
<tr>
<td>Comprendre l’approche de la <strong>Positive Deviance</strong> et pouvoir cerner ses aspects positifs</td>
<td>Understand the approach of Positive Deviance/Farn</td>
</tr>
<tr>
<td>Connaitre l’expérience des autres pays dans ce domaine… succès/difficultés ; approche de solution</td>
<td>Know about the experience of other countries with positive Deviance/Farn</td>
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Result of evaluation of the workshop by 15 participants:
(see list of participants in annex)

N.B.: This was accomplished before last review, the morning of the past day; therefore answers to some of the questions were answered before closing the workshop.

**Attained objectives:** *(Atteinte des objectifs):*

Faible (poor): 0/15

Acceptable (acceptable): 6/15

Excellent: (excellent) 9/15

**Mastery of the approach** *(Maîtrise de l'Approche)*

Faible: (poor) 0/15

Acceptable: (acceptable) 9/15

Excellent: (excellent) 6/15

**Elements mentioned as being least well understood:**

-- Curriculum for the monitrice (trainer-supervisor). (N.B. This was planned for Sunday during the workshop but participants preferred not to work on Sunday; therefore the workshop organizers were hard pressed to include details of curriculum. Method of developing curriculum was presented. However, in response to this comment, copies of curriculum from other countries was distributed on last day)

-- Training plans for the above (Plan d’enseignement)

-- Number of monitrices and trainers that could be trained at once & training plan (This question was partially answered before dismissal of participants)

-- Budget for FARNS (Comment: a model budget was presented after this comment was made)

-- Duration of FARN activities for the individual child (presumably how often the FARN might need to be repeated and therefore how many total days child might be in a FARN). Comment: This was also discussed before dismissal).

**Elements best understood: Éléments bien compris.**

A- PDI (EDP) 13/15 87%

B- Steps to take to establish FARNS (Etapes de mise en œuvre d’un FARN) 13/15 87%

C- How to calculate the nutritive value of foods for FARN menus (Calcul de la valeur nutritive des aliments et composition des menus)

D- Evaluation and follow-up (Evaluation/Suivi)

E- Community Mobilization (Mobilisation communautaire)
Evaluation of materials distributed (included French copy of the manual plus CD of same): 
(Matériel distribute)

Not appropriate 1/15 7%
Appropriate 14/15 93%

Evaluation of Facilitation pf workshop:
Acceptable 3/15 20%
Good 8/15 53%
Excellent 4/15 27%

Logistics for workshop (Logistique):-
Acceptable 2/15 13%
Good 8/15 54%
Excellent 5/15 33%

Suggestions from participants:

-- That CRS should develop the FARN program for Benin and thus provides a “living university” for it. Comment: Many participants wanted to “see FARNS in action”, and indeed this would be the ideal way to hold workshops in the future.
-- Add to the workshop more opportunities for exchange of ideas between organizations. -- Lunch and food: should be free choice (“Déjeuner/hébergement libre”)
-- Better materials should be provided for curricula for training monitrices (“Matériel insuffisant surtout document de formation des monitrices”)

Comment: This was planned for Sunday, and participants opted not to meet on Sunday; Therefore model curricula were briefly discussed and distributed last day, after this evaluation). - - Better plan for recreation activities (Récration – Activités de détente – Etrangers) – -- Better verification of materials/methods for presentations (avoid breakdowns in equipment such as power-point equipment that did not always work) Vérifier le Matériel technique (2) à l’avance pour éviter les pannes
-- Per diem: CRS should not apply its own per diem but honor usual per diem of other organizations represented (Per diem: ne pas appliquer le per diem CRS au personne non CRS)
-- Number of days allowed for the workshop was insufficient (Nombre de jours insuffisants pour la formation)
-- Inform participants at an earlier date about the possibility of attending workshop (Informer plus tôt les participants. Plus de temps pour l’inscription pour la formation).
KEY FINDINGS especially as they apply to CRS Benin (from Pre and post-workshop discussion)

General Impressions/Comments:

- **Justification:**
  Because malnutrition is considered to be an underlying or directly contributing cause in 60% of deaths in under-fives in West Africa, this project is appropriate and needed in a number of exciting ways.
  - It recognizes the complexity of underlying causes of malnutrition; it will partner with CRS development work; fathers as well as mothers are expected to be involved in FARN preparation and evaluation.
  - It includes skill building and skill transfer (apprenticeships) as opposed to “passing messages” aimed at grass-roots level behavioral change that that will help combat malnutrition in families;
  - It will build on village level infrastructure already existing in many places and with which CRS/Benin has already had much experience.

- **Positive Findings for sustainability:**
  As nutrition consultants coming from a medical background with years of experience with the HEARTH/Positive Deviance (FARN) approach, it has been gratifying to work with skilled and experienced medical, agricultural and development workers that CRS has identified, recruited, and is now training. There is, for example,
  - Planned collaboration with the local Ministry of Health personnel to assure distribution of micronutrients (at least for Vitamin A thus far) and complete coverage with immunization.
  - Planned door-to-door registration of families, carried out by “promoteurs” and overseen by the Village Development Committees will provide a hedge against under-representation of the poorest, most vulnerable families.
  - Planned re-inforcement or implementation of growth monitoring/Counseling sessions both pre and post FARN implementation, so that the rehabilitated child will be re-integrated into these sessions, to be held at assembly points within village

-- Findings and a plan for CRS/Benin: IMPLEMENTING HEARTHS during the 2005 - 2009: results of consultation with Warren L. Berggren and Dr. Dubuisson:

A. **Introduction/Background:** --In order to get coverage with HEARTH (FARN) implementation across its target population during 2005-2009, CRS would need to organize 8,000 Hearths. Forty thousand (40,000) mothers will attend these Hearths and be enabled to: a) rehabilitate their own malnourished children in a sustainable manner, and to b) prevent new cases of malnutrition. Each Hearth will be managed by a volunteer mother, educated for her tasks by a nutrition educator. Nutrition educators (Monitrices) will each train and supervise thirty volunteer mothers per year. CRS will educate at least eighty-nine (89) Monitrices to educate 8,000 volunteer mothers during three years.
Village Health Workers (VHWs) are resident home-visitors who labor for their neighbors, the local health services and for Hearths by weighing 0-4 year-old children, issuing health cards, and referring persons to the nearest health services for vaccination or other care. CRS will educate 1,000 VHWs to establish and maintain a family registry and to support local health services, and especially, their local volunteers mothers and the Hearths.

**B. Education Strategy**

The above-mentioned 40,000 mothers of malnourished children are distributed over a vast geographic area divided administratively into eighteen communes that include one million inhabitants. The 8,000 volunteer mothers will be educated within their neighborhoods of residence where they will serve their neighbors. The 1,000 VHWs and 89 Monitrices will be recruited from the geographic areas in which they will serve. They will be educated in their respective communes of residence.

VHWs will assemble for two weeks of education in the main town of their commune of residence. By the end of the session, each will have demonstrated an acceptable level of competence in registering families, issuing health cards, weighing children, distributing vitamin A capsules, albendazol, antimalarials and oral rehydration salts, completing routine reports and motivating families to get their members vaccinated.

By the end of the session, each VHW will have registered, without error, at least 125 residents of the town or its surroundings, will have weighed all the 0-4 year-old children among them, will have issued any health cards needed by the residents and will have successfully referred those needing vaccination or care to the local health services.

Certificates of competence will be issued to all who complete, successfully, all the above tasks. Finally, CRS will send the certified VHWs back to work in their respective service areas.

CRS will educate Monitrices in the main town of their respective communes of residence. They will first learn to perform all the VHW activities mentioned above. Next, they will serve as teaching assistants in the two-week educational session for VHWs. They will then conduct a positive deviance inquiry (PDI), a market place survey and a one-day simulated Hearth. Next, they will each identify a volunteer mother and the neighborhood in which she lives.

With their respective recruited volunteer mothers, the Monitrices will repeat all the exercises of the five-day training for volunteer mothers. Each Monitrice – volunteer mother pair will then recruit mothers of malnourished children and together they will conduct a hearth, report its results and evaluate its effect on children’s weight gains and mother’s care and feeding behaviors.

Next, still under close supervision by CRS senior staff, Monitrices will each identify five neighborhoods with one volunteer mother per neighborhood. They will each train five volunteer mothers, help each of them recruit 4 to 7 mothers of malnourished children and conduct a Hearth. The Monitrices will submit reports and evaluations of the Hearths they supervise.
CRS will award certificates of competence to Monitrices who successfully complete all the above tasks. CRS will send certified Monitrices to their respective geographic service areas to conduct hearths.

**N.B.** FARNs may need to be repeated more than once; the number of educators will need to be doubled. There may be a need to repeat the FARN exercise in some communities in order to complete rehabilitation, and in some communities to accommodate variations in food availability at different seasons.
## REGIONAL TRAINING OF TRAINERS WORKSHOP FOR THE POSITIVE DEVIANCE/HEARTH (FARN) APPROACH

**Day 1 (Wed Sept 1, 2004)**

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<tr>
<th>Time</th>
<th>Topic/activity/presenter</th>
<th>Materials and methods:</th>
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<tbody>
<tr>
<td>8:30 – 9:30</td>
<td>Arrival, installation; Welcome; presentation of participants: Dr. Dubuisson, Gretchen Berggren, Elizabeth, others; Recognition and thanks to Ministry of Health and USAID participant</td>
<td>Registration forms; form for expectations, flip chart</td>
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<td>9:30 – 9:45</td>
<td>Objectives of TOT workshop: G. Berggren</td>
<td>Powerpoint presentation</td>
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<td>9:45 – 10:45</td>
<td><strong>Review of the agenda; Introduction to the PD/Heath methodology (GB)</strong> (Sternin’s)</td>
<td>Agenda distribution; power point presentation (Sternin’s)</td>
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<td>10:45</td>
<td>Coffee break</td>
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<tr>
<td>11:00 – 12:45</td>
<td><strong>Principal Objectives of PD/Heath:</strong> G. Berggren; Some results from PD/Heath; references; Participatory Adult education (Principals from Jane Vella’s books); preparation for role play</td>
<td>Flip chart presentation; small groups prepare role plays of “active” vs “passive” education</td>
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<td>13:00 – 14:00</td>
<td>Lunch</td>
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<td>14:00 – 15:00</td>
<td>Role plays of examples of adult participatory education</td>
<td>Group presentations; assisted by staff</td>
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<tr>
<td>15:00 – 15:30</td>
<td><strong>Introduction of Steps to PD/HEARTH implementation; Step one Determine if PD/Heath is right for you</strong>: Gretchen Berggren</td>
<td>Use of Manual to explore overall steps; flip chart to review prerequisites to PD/Heath, with participants</td>
</tr>
<tr>
<td>15:30</td>
<td>Coffee Break</td>
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<tr>
<td>15:45 – 17:00</td>
<td><strong>Step 2 a: Community Mobilization:</strong> Discussion from CRS experience in Benin (Emmanuel et al)</td>
<td>Flip chart; Emmanuel; review of CRS experience; other organizations</td>
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<tr>
<td>17:00 – 17:30</td>
<td><strong>Step 2 b: personnel, resources,</strong> from PD/Heath experience G Berggren leads discussion; Input from MCDI about “VISA mothers” (volunteer mothers &amp; their role).</td>
<td>Flip chart; reference to workbook; Discussion of resources necessary anecdotal examples from Vietnam; flip chart; Haiti example: the trainer-supervisor “monitrice” in nutrition</td>
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<tr>
<td>17:30 – 17:45</td>
<td>Review of key points of the day: Elizabeth Zanou</td>
<td>Flip chart</td>
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## Day 2 – Thursday

<table>
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<tr>
<th>Time</th>
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| 8:30 – 8:30 (30m) | Review of today’s plan  
Housekeeping matters; Questions & responses  
Elisabeth Zanou |
| 9:00 – 10:00 (1h30) | **Step 3:** Preparing a PDI: Definition of PDI and logistics  
G. Berggren  
3a. Situation Analysis: Members of the community are invited to join in discussion about their nutrition situation; crops; seasonal changes, opinions;  
**Key points:**  
- Discover and present to the community any data already available  
  - Using or creating map and census data (if available); notions about how to make a simple map.  
  - Identify and discuss health structure. If there are community agents of any sort, they are invited.  
  - Group discussion and or feedback: What are resources? (What is already available?) |
| 10:00-10:45 (45m) | Indicators and the PDI: Preparing the positive deviance inquiry (PDI continued): **How to identify poor families and use of local norms to identify children by nutritional status.**  
- Discussion about identifying poor families as opposed to better off families so that the «positive deviant» is a well nourished child from a poor family. Participants discussed socioeconomic indicators from studies done on the communities for working with villagers who often know if a family is «better off» or «not so well off».  
- The national home-based growth chart card; wt/age indicators, what they mean, why they were chosen; Other anthropometric indicators  
Discussion of question: Can we identify «positive deviant» families with the help of village health workers? What about «negative deviants» (malnourished child from better-off families)? |
| 10:45-11 (15m) | Coffee Break |
| 11 – 11:50 (50m) | Community diagnosis from point of view of nutrition: use of scales and one growth chart to do a neighborhood weigh-in, placing one point per child on the growth charts and then calculating % of children «in the red», «in the yellow» (in need of rehabilitation).  
Discussion of creation and use of Pie diagrams for community feedback. |
| 11:50 – 12:45 (55m) | Orientation to small group work utilizing wt/age registers from nearby village. Discussion of how Positive and Negative deviants could be identified with local health worker volunteers, their weight/age registers, and their knowledge of mothers in need. |
| 12:45 – 13:45 (1hr) | Lunch |
| 13:45 – 15:30 (1h 45m) | Work in small groups: each group works with local health workers and their weight/age registers by small groups tomorrow to conduct the PDI; |
| 15:30 – 15:45 (15m) | Pause |
| 15:45 – 16:30 (45m) | How to discover the «positive deviant» behaviors during a home visit (Discussion)  
**Step 4:** Conducting a PDI: Who does what, how when and where?  
- Discovering the «three goods» **Good health seeking behavior, good caring/hygiene behaviors**, and especially **good child feeding behaviors.**  
- Simplified 24 hour diet recall  
- Tools: Semi-structured interviews; Home visit for Observation, (p 101 in Manual)  
- «Restitution» of the PDI |
| 16:30-17:00 (30m) | How to **analyse and interpret results** from several PDI’s (at least seven) in order to give feedback; reach consensus and plan menus for daily sessions for HEARTH:  
- Basic menus using local recipes discovered during the PDI’s  
- How to «tweak» the recipes to make them calorie-dense |
| 17:00 – 17:30 (30m) | Preparation for **field visit and doing PDI’s** in small groups with local workers. Evening assignment: study PDI chapters in manual. Discussion: questions and answers. |
| 17:30 – 17:45 (30m) | Review of key points from the sessions (Participants) |
### Day 3 – Friday

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>8:00-8:30 (30m)</td>
<td>Departure for nearby village and home visits, accompanied by local workers.</td>
</tr>
<tr>
<td></td>
<td>N.B. : »coffee break » available in vehicles that transport teams.</td>
</tr>
<tr>
<td>9 – 13:00 (4h)</td>
<td>Small groups conduct one or more PDI’s with families selected (both well nourished and poorly nourished) in selected neighborhoods; plan is for each group to make at least four home visits with village health workers. Return to car for lunch; to complete field notes; commence analysis of findings</td>
</tr>
<tr>
<td>13:00-14:30 (1h30)</td>
<td><strong>Lunch at Bimynx village</strong></td>
</tr>
<tr>
<td>14:30-16:30 (2h)</td>
<td>« Restitution of the PDI’s » in small groups. Reach consensus on food frequencies; foods most often mentioned, and number of times per day child is fed, &amp; most often used menus/recipes including snacks; caring and health seeking behaviors from real findings. Group work: Prepare menus for HEARTH based on PDI findings; prepare shopping list for market survey. Assignment: Study chapter on daily schedule at a FARN.</td>
</tr>
<tr>
<td>16:30-17:30</td>
<td>Group presentations on PDI results: analysis and interpretation</td>
</tr>
<tr>
<td>17:30-17:45 (45m)</td>
<td>Distribution of food values tables; Plan for Distribution of money &amp; explanation to each group for marketplace exercise; questions and answers. Review of key points from the day</td>
</tr>
</tbody>
</table>

### Day 4 – Saturday

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 – 8:15 (15m)</td>
<td>Review of Daily calendar Logistic Distribution of money for marketplace activities</td>
</tr>
<tr>
<td>8:15 – 11:15 (3h)</td>
<td>4b) Market place survey (coffee available en route)</td>
</tr>
<tr>
<td>11:15 – 12:45 (30m)</td>
<td>Return to conference room for small group exercise to weigh foods bought for one daily menu requirement; calculate food values (weighing scales, calculators, and food value tables available) Analysis by each group of results &amp; discussions (quantity/cost; quality/cost; cost per child for the « example » daily menu</td>
</tr>
<tr>
<td>12:45 – 13:45 (1hr)</td>
<td><strong>Lunch</strong></td>
</tr>
<tr>
<td>13:45 – 14:30 (45m)</td>
<td>Small group exercise; each group prepares flip chart presentation to display results and justification; display foods showing food values for items purchased; discuss preparation of foods so they are appropriate for toddlers.</td>
</tr>
<tr>
<td>14:30 – 16:00 (1h30)</td>
<td>Presentation by each group of their menu and marketplace results; discussion menu vs food values: « is the menu calorie dense? » questions and answers. One menu chosen to be prepared by a health worker so that group can taste the food prepared</td>
</tr>
<tr>
<td>15:30 – 15:45 (15m)</td>
<td>Coffee break; NB participants chose not to work on Sunday</td>
</tr>
</tbody>
</table>

### Day 5 Sunday

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>All day</td>
<td>Free time; participants urged to read manual;</td>
</tr>
<tr>
<td>Time</td>
<td>Activities</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8:00-8:30</td>
<td>Review of Daily calendar, Logistics, Questions &amp; answers</td>
</tr>
<tr>
<td>8:30-9:30</td>
<td>Steps 5 &amp; 6 from manual: Conceptualization of daily Hearth/positive deviance (FARN) sessions as « apprentissage » for mothers; how they are conducted; daily protocol. Introduction to information system so that indicators can be found. Introduction to supervision: Who does what, how when and where.</td>
</tr>
<tr>
<td>9:30-10:30</td>
<td>Step 7: Small group work: Behaviors and how to model them in the FARN sessions: child feeding behaviors; health seeking behaviors; caring behaviors</td>
</tr>
<tr>
<td>10:30-10:45</td>
<td>Coffee break</td>
</tr>
<tr>
<td>10:45-11:30</td>
<td>- Looking at results: Discussion Step 8: Alternatives for the participant child who still has growth faltering during the FARN</td>
</tr>
<tr>
<td></td>
<td>a) Home visit (by whom?) and planned medical referral (If mother has no money, how to arrange for this?)</td>
</tr>
<tr>
<td></td>
<td>b) Repeating the FARN sessions if necessary for those children still not growing well: how, when, where.</td>
</tr>
<tr>
<td></td>
<td>Importance of Snacks in the FARN: Presentation by Dr Dubuisson</td>
</tr>
<tr>
<td>12:00</td>
<td>12:30-13:30 Lunch</td>
</tr>
<tr>
<td>13:30-14:00</td>
<td>Summary and Review: Key elements of the FARN Discussion with flip chart note as: according to participants, list “non-negotiables”; Révision</td>
</tr>
</tbody>
</table>
| 14:00-14:45| Personnel and required resources; training plan | - (Job Task Analysis)  
         | - Training plan (réf Vanderschmidt et al Boston University; Manual available)  
<pre><code>     | - Budget (example from CRS Bénin &amp; partners) |
</code></pre>
<p>| 14:45-15:00| Pause                                                                      |
| 15:00-15:30| Supervision of FARNs; « everyone deserves supervision » in FARN (DP/Foyers); Ratio of « monitrices » to volunteer mothers/FARNS |
| -15:30-16:00| Monitoring and evaluation: Frequency of measurement during FARN and follow-up |
| 16:00-16:45| Small group work: Tools needed for supervision, monitoring and evaluation Each group prepares outline of needed tools at GFARNs, Farn register, benchmarks: at entry, at one month, at two months, at six months, at one year |
| 16:45-17:15| Review of key points of the day; participants express expectations of what to cover tomorrow |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 8:45</td>
<td>Review of Day’s plan in light of expectations (attentes)</td>
</tr>
<tr>
<td>8:45 – 9:45</td>
<td>Logistique</td>
</tr>
<tr>
<td></td>
<td>Presentation by teams on their envisioned tools and plans for monitoring and evaluation based on chosen indicators</td>
</tr>
<tr>
<td>9:45 – 10:30</td>
<td>Micronutrient deficiencies and their role (see power pint presentation in Annex)</td>
</tr>
<tr>
<td><strong>Etape 9:</strong></td>
<td>Expansion</td>
</tr>
<tr>
<td></td>
<td>How, when and where to expand: Example of Vietnam</td>
</tr>
<tr>
<td>10:30 – 10:45</td>
<td>Coffee break</td>
</tr>
<tr>
<td>10:45 – 11:30</td>
<td>Resources for PD/Hearth (web sites, references)</td>
</tr>
<tr>
<td></td>
<td>- Questions &amp; Answers; clarification on implementation</td>
</tr>
<tr>
<td></td>
<td>- Planning for covering a defined population with HEARTH activities planning for more community or many communities; planning personnel needs.</td>
</tr>
<tr>
<td></td>
<td>- Re-integrating children in routine Growth monitoring and counseling sessions</td>
</tr>
<tr>
<td>12:30-14:00</td>
<td>Lunch</td>
</tr>
<tr>
<td>14:00-15:00</td>
<td>General overview of what has been covered; unmet needs; participants request more information on training « monitrices » using Boston University Training plan; powerpoint presentation on training plan</td>
</tr>
<tr>
<td>15:00-17:30</td>
<td>Small group work: Planning for one year; notions of plan for HEARTH coverage FARN (each participating organization forms a group)</td>
</tr>
<tr>
<td></td>
<td>Presentation of notions of planning and possible use of HEARTH by participating organizations: (CRS, PLAN, AFRICARE, CARE, DANA, CPAN, MCDI)</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
</tr>
<tr>
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<td>----------------------------------------------------------------------</td>
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</tbody>
</table>
| 8:30-9:00 (30m) | Revised plan for the closing day  
Logistics for check-out  
**Evaluation of Workshop by participants** |
| 9:00-9:45 (1h) | CRS/CPAN/DANA : Examples of budgets to implement Hearth/Positive  
Deviance Approach |
| 9:45-10:00 | **Available Resources** : Web sites; disks of Manual distributed ; Boston  
University Workbook for task oriented, competency based  
curriculum planning ; powerpoint presentation (see Annex) |
| 10:05-10:30 (30m) | **General Synthesis ; Powerpoint presentation and Review ;  
Distribution of model curricula and workbook materials to develop a  
curricula.** |
| 10:30-10:45 (15m) | Coffee break |
| 10:45-12:00- (1h) | Establishing a referral center ; discussion of a « living university »  
training ground for francophone Africa |
| 12:30 | **Distribution of Certificates and congratulations to all** |
Workshop Notes: Participative Adult education: how adults learn (notes from Dr. G Berggren)

The FARN exercise in nutrition education and rehabilitation is mean to accomplish behavioral change. It is based on sound theory of principles in adult education, especially that of learning by doing. Ref: Jane Vella et al.

Insert File Elmer Learning Cycle:--- powerpoint (see attachment)

From Day 1: Powerpoint presentation (“Madagascar bleu”, translated from “Blue” presentation by Jerry and Monique Sternin) was followed by discussion.

- Need for Nutrition Surveillance (Growth monitoring/counseling) to achieve equity in coverage before FARN program is established. Discussion covered principle that no child (or his/her family) should be left out of the nutrition surveillance that leads up to and follows FARN implementation. Hence, workshop presentation emphasized the need for door-to-door registration (may be preceded by village and hamlet mapping, house-numbering), so that eventually there could be under-fives’ registers. Personnel (perhaps volunteers) or “promoteurs de sante” will update them monthly or bi-monthly. And, because malnutrition often begins in utero, it is hoped that surveillance could also be considered necessary for pregnant women, in cooperation with Ministry of Health (MOH) installations.

Comment: Nutrition surveillance in keeping with norms of the Ministry of Health was discussed during the workshop. However, using the present village level infrastructure, much will depend on a volunteer worker, or some kind of “promoteur de sante” (1:20 families) whose motivation must be determined, especially if he or she received some small compensation in the past, during activities related to nutrition surveillance or dry ration distribution. Our field exercise and information revealed that although CRS made the instruments available, it is doubtful that nutrition surveillance activities, a necessary prerequisite to the FARN, will continue unless CRS and its partners deal with this issue.

- Related points:
  - The necessity of removing barriers to coverage and reaching the poorest of the poor: Surveillance as described at the workshop would address under-representation of the poorest of the poor and remove some barriers to coverage. In addition, workshop participants felt that some services related to the FARN exercise should be cost-free. This includes immunization, micro-nutrient distribution and parasite control, including malaria. Vitamin A supplementation and de-worming, and, in the instance of a child with fever, access to chloroquine treatment are examples of necessary “free” service.

  - Methodology for including the whole community, especially fathers, in the combat against malnutrition, and in “feedback” sessions with their own communities is essential.
    In Benin, as discussed in the workshop, CRS and its partners could train both fathers and agricultural “moniteurs” to prepare “pie diagrams” to share with the community the extent of the problem, and how it is disappearing. As an ongoing participatory activity,
the whole village can be updated using a pie diagram that shows the proportion of children malnourished, and still in need of rehabilitation.

Following the example in Vietnam, in Guinea, and in Mali, one would expect that the fathers of FARN children as well as members of the “Village Development Committee” or some similar entity, to participate in weighing children to detect the numbers of malnourished in the beginning of the program, and to participate in community feedback sessions.

Points that needed reinforcement:
The identification, role and characteristics of the volunteer mother and the “positive deviant” mother needs to be clearly understood.
- The volunteer mother in the FARN program who takes on the responsibility of rehabilitating malnourished pre-schoolers in her neighborhood may or may not be a “mere modele” (positive deviant mother). The best are good communicators, able to exhibit caring behaviors. All need training, supervision and positive reinforcement.
- The positive deviant mother or “mere modele” is simply the resource for understanding the best local alimentation and child caring practices. In the FARN program, the “mere modele” is our teacher in the sense that her recipes, child-feeding behaviors, caring practices and health seeking practices, once documented, are what we need to teach and especially to model in daily FARN activities.

Comment: Worldwide experience has shown that poor mothers (meres modeles) whose children are well nourished may or may not be good communicators, an essential quality of the volunteer mothers. Indeed, in many countries volunteer mothers who conduct FARNS may be grandmothers or others who have the time, motivation and dedication for completing the training and follow-up.

Questions from Day 1:
- Question: How many children are in a FARN and how many FARNS can go on simultaneously in a village, and who supervises them?
Several small “FARNS” in a given village are usually going on simultaneously, each reaching about 5 children (for example, five FARNS would reach 25 children over a one month cycle in a given small village). Children come from and go back to their homes daily, accompanied by their mothers or a secondary caretaker who has helped prepare food and fed their child under supervision. The village-chosen volunteer mothers conduct the FARNS; each has had brief training (five days or so) from a full time supervisor-educator (“educatrice”) who is present and acts as a problem-solve/formative supervisor in the village while FARNS are going on. She can then move on to another village or another set of neighborhoods to prepare them for the FARN exercise.

- Question: What is the participating mother’s commitment? Ans:— Mothers must promise not to deny the child her/his part from the family pot, so that the supplement is truly an “extra meal and snack” and not a replacement. Most children have
participated in village level nutrition monitoring/counseling programs in their village, and are expected to be followed-up in these as part of their mother’s commitment.

Day 2 continued:
Notes from flip chart presentation

**FARN Cycle:**
N.B. FARNS must be supervised by full-time trained “educatrices” (many of whom may already have been recruited as “educateurs”). Part of their responsibility will be to train the volunteer mothers. The 6 week FARN cycle includes much community preparation and follow-up.

- **Weeks 1&2 (or more) :-- Community Mobilization** (may be more time than this if community is totally unprepared; maybe less if community is ready) Discussed were:
  - Multiple meetings with village leaders; participatory assessment of the village and its resources including agricultural and medical; methods of food storage, marketing.
  - Weighing all children if that has not previously been done; determination of number and % of children malnourished and in need of FARN participation; feedback sessions to community, especially the “Comite de Sante et Developpement” or similar entity.
  - Work with community leaders to assure that FARN prerequisites are in order, such as door-to-door census&/or update of registers for under-fives;
  - Identification and recruitment of volunteer mothers;
  - If the educatrice will live in the village for several weeks, there must be an accord about the community role in helping her find a place to live.

- **Week 3: -- training of volunteer mothers (daily, few hours per day)**
- **Week 3 & 4 – conduct and supervision of FARNS at home of volunteer mother**
- **Weeks 5 & 6 Follow up weeks; homes visits by volunteer mother to home of Hearth participants**
- **Week 7: Follow-up, write up**

Workshop notes from Day 2: (continued)

- **Overview: -- Understanding “positive deviance”, FARNS, the Positive deviance Inquiry and its role**

Trainees discussed how Hearths (FARNs) work and where the PDI fits. FARNS can be thought of as “itinerant workshops” for mothers of malnourished children to rehabilitate them through the services of a neighbor in her own home. This trained and supervised volunteer mother loans her kitchen for a few hours daily, for two weeks to allow for this “apprenticeship” during which participant mothers prepare and feed a nutritious meal and snack made from local foods, as discovered during the **Positive Deviance inquiry** (PDI). Participant mothers contribute part or all the ingredients, planned the day before. The volunteer mother not only teaches recipes and justifies the ingredients, she must model behaviors, such as handwashing and “active feeding”. She also organizes with the participating mothers the daily menu to which the participating mothers contribute in kind. She then follows-up the child for two more weeks, assuring that the participant mother
continues to give her child the meal and snack supplements learned in the HEARTH. *All menus, recipes, and snacks are derived from several previous village level “positive deviant” inquiries (PDIs) in that village, and at the particular season of the year.*

The supplement that is offered must be calorie-dense and not too bulky; it should contain 700 – 900 calories, 25 – 27 grams of protein, and adequate vitamins and minerals. *This would approach about half the child’s daily requirement. The mother is expected not to deny the child his/her portion from the family pot to complete the requirement.* Children may not eat all they are offered at first, but over the two-week period, they usually eat more and more. *N.B.* *Malnutrition Prevalence Rate in the village chosen was too low for a FARN application* (it should have been at least 30%). However, participants were able to find both well nourished children in some relatively modest families, and some malnourished children whose parents could be interviewed.

**Questions and answers :**

**Q. Explain HEARTH eligibility and numbers**

*Ans :--* Hearth children usually are between the ages of 6 and 35.9 months. The recommended hearth capacity is 5 mother-child pairs per hearth.

*Discussion :* A nutrition educator (« monitrice ») can organize, supervise and follow-up only 5 or 6 hearths (around 30 mother-child pairs) during a seven-week period, provided the « Hearths » are nearby each other. For example in a neighborhood with 60 malnourished children (30% of under threes) one educator (monitrice) would need seven weeks to implant and supervise the six or seven hearths needed to begin with. Some may need to be repeated.
Notes from Days 2 & 3: Applying a Positive Deviance Inquiry (PDI):

Activity: Participants prepared and then « tried out » an application of the PDI in a nearby village (BIMYNX) that turned out to be relatively well-off according to Elizabeth Zanou, nutritionist with CRS/Benin. In addition to learning the positive deviant families’ caring behaviors and feeding habits, workshop participants recorded the recipes and food products fed to children by the positive deviant families, and the number of times per day the « positive deviant » child was fed. During the following day participants purchased a list of foods for selected menus discovered by the PDI that might be considered ideal to be used in FARNs. They went to a local market, learned their prices, bought the foods that they imagined might be cooked for 4 – 5 children, and returned to the workshop site to weigh the foods and calculate their food values. A volunteer mother then prepared one model meal from the purchased foods and participants judged the appropriateness as a hearth meal.

Output from day 2 & 3 of Workshop:

- Getting Ready for the PDI; Plans:
  1. Review characteristics of the village: relatively well off rural community; many residents are farmers and rice growers
  2. Characteristics of the health services and growth monitoring
  3. All the children under five are registered, neighborhood by neighborhood, by community health workers
     Equipment used: Registry books, weighing scales, Growth monitoring cards with growth charts
  4. Identification of poor mothers of well nourished children (“Positive deviants”) who are willing to be interviewed
     - Participants prepared to go in small groups with community workers to make home visits and look for the “three good” behaviors:
       - Good child feeding behaviors (involves simplified 24 hour diet recall)
       - Good health-seeking behaviors (involves checking child’s immunization record and how mother handled last illness)
       - Good child caring behaviors (involves observing family norms of how child is taken care of, hygienic practices, attitude toward child, secondary care giver)
     - Participants were urged to read manual on PDI (“Enquete sur le Modele (Deviance) Positive” or EDP).
Results of Group exercise for the PDI:

Each group enlarged upon what they would look for during the PDI and how to record it (recording later rather than while interviewing) They decided:--

1. For the child (sur l’enfant) groups will need to look for child caring behaviors, child feeding behaviors, and health-seeking behaviors. They mentioned: psychological state; hygiene; immunization status; growth monitoring card; child’s interaction with caretakers.

2. For other family members; especially the mother, the father, and the secondary guardian, they would ask the questions:-- Who looks after child? What is family dynamic in caring for the child that is apparent to the interviewer? Who prepares food?

3. Obvious hygienic practices: participants would observe during the home visit:-- a place to wash hands, hygiene of the kitchen or cooking area, presence of latrine, water source, and farm animals well separated from cooking area (“Pratiques d’hygiene”)

4. Child feeding practices: each group would interview one or more mtoers/caretakers to create a simplified 24 hour diet recall. What did the child eat when yesterday? Number of times per day child was fed; what exactly were the contents of the recipes; was cooking oil added?

5. Food availability and storage: What does family produce? How is it stored, where?

6. General health practices: Use of mosquito nets; clean water storage, presence of soap, presence of oral rehydration therapy packets, and presence of chloroquine in the home.

Preparation to go to given village for PDI exercise:

- Because all the children had been weighed recently by CHW’s, weighing of all under-fives and classification by nutrition status was unnecessary
- Identification of well nourished under threes and their mothers was carried out with help of CHW’s and use of their growth monitoring registry.
- Identification of “positive deviant” mothers (“meres modeles”) who were willing to be interviewed at home was carried out by CHW’s ahead of time

Implementation of the PDI:

- Carrying out of home visits to accomplish the PDI was carried out on Day 3
- Restitution of the PDI to summarize findings was carried oput immediately afterward.
- each group prepared a presentation on their findings.
Restitution of the PDI:

Findings about child caring and health seeking behaviors:
Positive findings:
General:
1. Body cleanliness (Hygiène corporelle)
2. Abundant water for washing and drinking (Présence de l’eau abondante)
3. Both mother and child wash hands (La mere et l’enfant lavent les mains)
4. Soap available (presence du savon)
5. Continued breast feeding during and after diarrhea
6. Supervised feeding: (Someone in the family feeds the child or sees that the child is eating)
7. Secondary caretaker, especially the maternal grandmother plays an important role in supervising menu and feeding (5 fois).

Health seeking behaviors:
1. Complete immunization
2. Mother knows when to go to the clinic

Negative behaviors:
1. Having no soap available at the home for handwashing
2. Having no latrine available
3. Having pigpen near the home

Facilitator’s Note: Step of community feedback on the above was not included. It is important, after restitution, to share with the community the findings before going on with the FARN exercise.

** Lessons learned from this day: include community feedback step
Field exercise did not include this community feedback step. Output, using the national growth chart, would be:
- Total number of children weighed (denominator)
- The number in the « normal » (green) channel (calculate proportion or %)
- The number in the « moderately malnourished » (yellow) channel (calculate %)
- The number in the « severely malnourished » (red) channel (calculate %)

Note from Vietnam: Fathers of children in the neighborhoods served and village leaders enjoyed making the above calculation and making a « pie diagram » to present results.

Benin: Dépouillement de l’EDP: Fréquence de l’utilisation Des aliments selon le rappel de 24 heures chez les mères “DP”
Exemple de l’exercice réalisé en Benin, Sept 2004, par une équipe pendant les visites à domicile:

<table>
<thead>
<tr>
<th>Nom de l’aliment</th>
<th>Fréquence (Nombre de fois l’aliment était mentioné par des mères enquêtées)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lait maternel</td>
<td>Bien nourris: 6</td>
</tr>
<tr>
<td>Huile de palm</td>
<td>Bien nourris: 3</td>
</tr>
<tr>
<td>Produit</td>
<td>Groupe 1</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Pâte de maïs</td>
<td>3</td>
</tr>
<tr>
<td>Avec eau, sel</td>
<td></td>
</tr>
<tr>
<td>Sauce tomate</td>
<td>2</td>
</tr>
<tr>
<td>Souvent avec oignons</td>
<td></td>
</tr>
<tr>
<td>Feuilles vertes</td>
<td>1</td>
</tr>
<tr>
<td>Poisson</td>
<td>2</td>
</tr>
<tr>
<td>Viande boeuf</td>
<td>3</td>
</tr>
<tr>
<td>Haricots</td>
<td>1</td>
</tr>
<tr>
<td>Oignons</td>
<td>1</td>
</tr>
<tr>
<td>Crevettes</td>
<td>1</td>
</tr>
<tr>
<td>Sorgho (bouilli)</td>
<td>5</td>
</tr>
<tr>
<td>Mais (bouilli)</td>
<td></td>
</tr>
<tr>
<td>Sucre</td>
<td>1</td>
</tr>
<tr>
<td>Soja (farine)</td>
<td>1</td>
</tr>
<tr>
<td>Canne sorgho</td>
<td>0</td>
</tr>
<tr>
<td>Jus des fruits</td>
<td>0</td>
</tr>
<tr>
<td>Lait cocotier</td>
<td>1</td>
</tr>
<tr>
<td>Pain</td>
<td>1</td>
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Le groupe qui a trouvé les résultats a remarqué une nourriture peu diverse chez l’enfant malnourri. Pendant la présentation par les autres groupes, on a trouvé la même différence.

Les autres groupes ont remarqué aussi l’utilisation des feuilles vertes beaucoup plus souvent chez les mères “DP”. Les feuilles ne coûtent pas chères. On a mentionné:
Feuilles manioc; feuilles de baobab; feuilles de niebé; “crin-crin”; bissab; vernonia; grasset/talinum.

On est à la recherche toujours des collations ou “casse-croutes” employés par des mères “Deviants positives”. Parmi ces mères, on a trouvé aussi que leurs enfants mangent plus souvent, au moins 5 fois/jour. Par contrast, si ce nest pas pour le lait maternel, les enfants malnourris mangent moins souvent.
| Aliment | Mesure local | grammes | Prix par 100 gms | Prix par 100 gms | Kilocalorie Total | Protein par 100 gms | Protein Total | Fer par 100 gms | Fer Total | Vitamine A par 100 gms | Vitamine A Total | Zinc par 100 gms | Zinc Total | Acide folique par 100 gms | Acide folique Total |
Suggested Indicators of realization of FARNS

In a given village or neighborhood

1) % of under-threes malnourished and eligible for FARNS
2) % of under-threes eligible and enrolled in the FARNS
3) % of malnourished under-threes enrolled and who participate in FARNS
   a. % enrolled and who participate less than 12 days (séances) = “Drop-out rate”
   b. % enrolled who complete 12 days = Rate of completion of FARNS workshop
      “apprenticeship” activities
   c. % enrolled and who complete FARNS and who receive follow-up home visits for 4 weeks
      after day 12 = percent completing FARNS with one month follow-up
   d. % of mothers or caretakers in the FARNS who attend 12 days, classified according to
      whether they are:
      1. Mothers
      2. Grand-parents
      3. Older siblings (12 years or more and noted to be caretakers)
      4. Fathers
      5. Others
   e. Number of children in a FARNS:
      Average
      Median
      Spread (extremes)
   f. Number of FARNS per 1000 total population
   g. Ratio of children rehabilitated per volunteer mother and per educatrice

INDICATORS OF RESULTS: Immediate indicators:

2.1 % of children who were successfully rehabilitated; that is, they gained 400 grams from Day 1 –
   Day 30 of FARNS activities
2.2 % of children who had satisfactory weight gain, that is, they gained between 200 and 400
   grammes in the month after Day 1
2.3 % of children who had unsatisfactory weight gain (“failed” FARNS activities) in month of
   FARNS activities less than 100 grams during the month after FARNS Day 1.
2.4 % of children who gained nothing in the month after Day 1
2.5 % of children who lost weight from day 1 – Day 30 of FARNS activities.

N.B. All children with unsatisfactory weight gain should be seen at clinic or by physicians to determine if
underlying illness is the problem.

3. Morbidity Indicators

3.1 % of children in FARNS (during Day 1-30) who showed signs of:
   - malaria
   - IRA
   - Diarrhea
   - Measles
   - other diseases (identify)
3.2 % of children in FARNS treated by qualified personnel for
   3.2.1.1 malaria
   3.2.1.2 Respiratory infection
   3.2.1.3 Diarrhea
   3.2.1.4 Measles
   3.2.1.5 Others (identify)
4. Mortality indicators

4.1 % of children in FARN deceased during the 4 weeks

4.2 % of children in FARN deceased due to
   - Malaria (Paludisme)
   - Acute respiratory infection (IRA)
   - Diarrhea
   - Measles (Rougeole)
   - Autres maladies à identifier

5. Immunization/deworming indicators

5.1 % of children aged 12 – 36 months in FARN who completed all antigens before their first birthdays (see vaccination card of child)

5.2 % of children aged 12 – 36 months in FARN who “dropped out” between dose 1 and dose 3 for DPT vaccination

5.3 % of children in FARN aged 12 to 36 months having received ROUVAX

5.4 % of children in FARN having received “capsule de VITAMINE A” during or in the 6 months preceding the FARN

5.5 % of children in FARN having received one dose of MEBENDAZOLE in the six months preceding the FARN

6. Village level nutrition indicators of children 0 to 59 months of age

6.1 % of children 0 – 59 months with “normal” nutritional status (“VERT”)

6.2 % of children 0 – 59 months with moderate malnutrition (“JAUNE”)

6.3 % of children 0 – 59 mo. with severe malnutrition (“ROUGE”)

6.4 % of children 0 – 59 mo. Enrolled and weighed

6.5 % des enfants de 0 – 59 mo. Enrolled, weighed, and having their names properly listed in the registry of under-fives for nutrition surveillance.

6.5.1.1 Number of weighings at posts planned

6.5.1.2 Number accomplished

6.6 Indicator of mother’s ability to prevent malnutrition: # and % of younger siblings of malnourished children who never fell into malnutrition
Workshop notes continued: Roles of persons involved with FARN programs:

1) Role of administrator of Farn program:
   1- Recruitment & assistance in training of health educators ("educatrices") along with technical assistance
   2- Identification recruitment and training of promoteurs de sante (PS), and volunteer mothers who conduct FARNs
   3- Assist in planning of menus based on PDIs along with team

- Training of technicians and other agents at the periphery:
  1- Educatrice (ES)
  2- Health promoters (PS)
  3- Volunteer mothers (along with educatrice) (MV)
  4- Volunteer community development committee (CVD)

- Collection and analysis and interpretation of data gathered to evaluate results:
  1- Assure the collection of data coming from zones
  2- Cleaning of data and verification of it
  3- Analysis of data and findings
  4- Provide feedback to villagers and others concerned

- Reporting:
  1- Verification of data; organizing of it
  2- Forwarding
  3- Assists in analysis and interpretation

Profile:
- Physician or nutritionist with experience &/or public health training
- Experienced/trained in nutrition rehabilitation activities
- Able to communicate to all levels
- Trained to be a trainer/supervisor (formative supervision)
2) Health educators (“Monitrices” or “EDUCATEURS en nutrition”)

Roles et responsabilities:
- Assures education and supervision of volunteers « promoteurs » and assists training of meres volontaires
- Technical assistance to vol. health promoters (appuyer techniquement les promoteurs)
- Carries out, along with other community members, the PDI,
- « Classifies » MOTHERS ; IDENTIFIES RECRUITS AND TRAINS VOLUNTEER MOTHERS WHO CONDUCT farns ; ASSURES THEIR SUPERVISION ; ASSURES FARN IMPLEMENTATION (reclassification, enquête, sensibilisation des MV, mise en place et execution du FARN)
- supervises, reports on FARNs for the Diocese (etablir le rapport des activites du FARN pour le diocese)
- assure collaboration nwith local authorities (collaboration avec les autorites locales et les CSB)
- Assures door-to-door registration (recensement)
- Helps create map and house-numbering to assure the above

Profile:
- High school ed
- Notions of basic health/nutrition
- Knowledge and possibly experience in community development/health [Connaissance en developpement communautaire (en sante communautaire)]
- Knows and has lived in local environment (Bonne connaissance du milieu) Lives in district
- Available and willing to live elsewhere in district for weeks at a time
- In general, is probably a woman with some experience with children

Relevant notes in french on Expected performance from educatrices : Consensus statement from physicians who worked in the Madagascar pilot project

[PERFORMANCE ATTENDUE DES CANDIDATES AU POSTE D'EDUCATRICE EN NUTRITION (CAPEN)]
1. Avoir une écriture lisible.
2. Etre compétente aux opérations mathématiques de base: l’addition, la soustraction, la division, la calcule des pourcentages, et le maintien des courbes des poids
3. Etre compétente a remplir les cartes, registres et les formulaires employés dans le programme des FARNs.
4. Etre habile de s’exprimer clairement en écrit comme en parlant
5. Avoir une compréhension adéquate de la théorie, ainsi que de toutes les gestes enseignées dans l’atelier de formation
6. Etre compétente a conduire un PDI, y-compris l’exploitation des données
7. Etre compétente a engager les mères participantes dans un dialogue et de les faire découvrir les conduites qui favorisent la santé des enfants
8. Etre d’accord a vivre pendant 6 semaines de suite dans les villages des FARNs afin de démontrer à tous les habitants de la localise que les enfants malnutris sont réhabilites par une alimentation adéquate et peu chère, ainsi que par les bonnes habitudes de soins familiaux.

3) Positive Deviant Mother: Roles et responsibilities:
Role:
- Shares information on her child rearing, child care-taking, and health seeking behaviors; especially her child feeding behaviors.

Profile:
- Modest income; not rich
- Has well nourished child
- Willing to have home visits by staff
- Displays “three good” type behaviors during home visits

4) Role and Responsibilities of participating mothers of malnourished children (MERES PARTICIPANTES)

Roles et responsibilities:
a. Brings ingredients assigned daily (Apport des ingredients)
a. Assists in preparation of meals & learns about food value (Preparation des repas FARN)
b. Cares for and watches over children during FARN exercise (Soins et éveil des enfants au FARN)
c. Helps feed children; active feeding (Donner à manger aux enfants pendant les séances de FARN)
d. Learns messages related to nutrition; justification of ingredients and behaviors
e. Continues new practices in her own home & shares with others (Continuer les acquis du FARN et partager)

Profile:
✓ Comes from very modest or poor family; mother has at least one malnourished child (mere pauvre ayant au moin un enfant MN)
✓ Long time resident of village or one who has moved in with intent to stay (residente dans le village)
✓ Agrees to give her time for daily activities (disponible)
✓ Desires and is willing to commit to participation (ayant la volonté de participer)

5) Community health workers or health promoters:

Roles et responsabilities:
- Helps identify and motivate volunteer mothers who will conduct FARNs
- Weighs children at weighing posts; interprets growth card and counsels mothers
- Maintains register for under-fives and other report forms (FARN + SCN)
- Reports on births and deaths; maintains death register on children
- Follows up on activities of “Meres volontaires”
- Provides counsel for volunteer mothers
- Promotes FARN with village development committee and provides feedback to community

Profile:
- Primary school education
- Trained in animation and capable of mobilization
- Elected by community
- Resides in village/neighborhood he or she serves
- Male or female
- Motivated, dynamic personality

6) Village Development Committee

Roles:
- Pleads with authorities for FARN activities (plaider aupres des autorites pour le FARN)
- Participates in « community diagnosis » and making a crude map of village in preparation for door-to-door registration (participer a l’élaboration du carte du village)
- Participates in identification and classification of children and families; helps with census and door to door registration (participer a l’identification et a la classification des enfants et familles + recensement)
- Helps fix criteria for volunteer mothers, and with identification and recruitment (fixer les criteres et selectionner les MV)
- Collaborates with and encourages volunteer mothers (collaborer et encourager les meres volontaires)
- Helps assure that there is one volunteer mother for every 20 or so families, distributed across the village.
- Collaborates with NGO and govt organizations involved with or peripheral to the FARN activities (collaborer avec ONG et OG)
- Promotes FARN participation (promouvoir la participation au FARN)
- Facilitates family access to FARN (faciliter l’accès des familles aux appuis necessaires)
- Aids in resolving problems (aider a resoudre les problemes relatifs au FARN)
- Organizes weighing sessions and helps interpret results to community (organizer les séances de pesée pendant la surveillance de la croissance mensuelle)
- Helps with evaluation for improvement of programme (réfléchir sur les possibilités d’amélioration)

Profile:
- Voluntary and available (volontaires et disponibles)
- Elected by the community (élus par la communauté)
- Ready to work as a team and with team (apte à travailler en équipe)
- Able to read and write if possible (lettres si possible)

7) Coordinator of FARN and other programmes (if such exists for a zone) « RESPONSABLE DU DISTRICT/SUPERVISEUR » of a zone

Roles and responsibilities and Profile: (to be developed by organization as this person probably has responsibilities for more than one programme in his/her area)

8. TECHNICAL ADVISOR

Roles and responsibilities:
- Develops and applies tools;
- Helps with curriculum development and training
- Is responsible for quality control
- Helps with national and international relations
- Provides technical supervision
- Assures coherence of activity with other activities in the zone
- Helps with monitoring and evaluation and data analysis and interpretation
  - Helps with interpretation and diffusion of results

Day 4; Notes from Group exercise: Getting Ready for a FARN in a village: Below is a synthesis of exercise, from group results based on international experience:

TEN Preliminary Steps groups mentioned for a FARN (ref: Hearth/positive Deviance Manual)

1) Answer the question: Is the FARN/Deviance positive approach right for you? To make the decision if FARNs are appropriate, ask the following questions:

- Are 30% or more of the children malnourished?
- Can you make the community aware of the problem and are they willing to volunteer some time?
- Is there already a nutrition surveillance system, or can one be re-installed?
- Do you have the capability and resources for identification, recruitment, training and supervision of « nutrition educatrices » or « monitrices » (N.B. for a total population of 200,000, one would need 20–30 « educatrices » to be trained in order to cover the needs of mothers of malnourished under-threes in a three year cycle).
- Will FARNs fit within the MOH structure and be accepted as a complementary method?
- Is there a « back-up » primary health care referral services to which very severely malnourished children would be referred?

2) Assure receptivity on the part of local authorities: Can you « plead your cause » with them and keep them informed?

3) Identify, recruit and train « educatrices » (6 week training course); in the meantime:

4) Identify the village or villages where FARNS can be established.

5) Visit local authorities

6) Organize meetings with leaders for social mobilization purposes; discuss the importance of malnutrition. If data is available, make « pie diagrams » to illustrate problem.
7) Explore the environment with village leaders and informants in order to establish a rough « community diagnosis ». Make a crude map of the village, showing all the « hameaux ». Discuss the nutrition situation : what is grown here ? how is food stored ? Is there a « saison de soudure »? Is breastfeeding universal ? At what age are children weaned completely from the breast?

8) Identify village volunteers « promoteurs » de sante and establish or re-establish them in their roles to carry out nutrition surveillance.

9) Collection of basic information ; door to door census if possible (N.B. not necessary but desirable)
   ✓ Map, house numbering
   ✓ Census : plan to derive registers :Plan includes Under-fives register. Register of heads of households (for the agricultural-FARM School program) register of women in the reproductive age group (to keep track of pregnancy and pregnancy outcome)

10) Establishment of registers from door-to-door exercise so that « no child is left out »
Notes from Discussion:
Underlying Causes of Malnutrition

- mentioned by participants: cataclysmic events, disease, and poverty, ignorance in food utilization, improper feeding behaviors, and food shortages at the household level.
- Related participatory exercise: Categorization of these causes by participants and discussion about which could be addressed by the FARN implementation. Conclusion of this exercise: Many underlying causes cannot be addressed immediately; however, the FARN could be applied almost immediately, while the underlying causes, like poverty, are being more slowly addressed. Great optimism in that CRS has an accompanying agricultural program that would be complimentary.

- Notes from Dr. G. Berggren presentation: Malnutrition and infection:

Malnutrition is an underlying cause of death in 60% of cases in developing countries. According to the representative from the provincial health authority who was present at the workshop, studies in Madagascar show it to be an underlying cause of death in 54% of childhood deaths. Infectious disease is emerging as an important deterrent to recovery and survival of children in FARNs in results of the CRS project in Madagascar. There was discussion of how the weight curve of a child is visibly affected when a child has diarrhea or another infectious disease, measles during the FARN being an example.

Special note on «catch-up growth»: Children with infections are often anorectic and do not want to eat; mothers may not know how to re-establish appetite and «reef the» them. This is one role of the FARN. The consequence of this inadequate calorie and protein intake is growth faltering, often visible on the child’s weight/age growth chart. Recovering children who are not well fed (100-150 cals/K/day) do not show «catch-up growth» or «rattrapage». Their growth is impeded and may remain that way, dropping them down even further with the next infection.

Discussion of above by participants:--

✔ Lessons from the pilot project: No deaths during the FARN exercise occurred, but two children died in the subsequent six months, one of fever (suspected malaria), and one of a respiratory infection, possibly pneumonia. In both cases, one would have hoped that the child would have gotten early enough treatment to prevent death.

✔ Both curative and preventative activities are needed to combat malnutrition in Madagascar, and these need to begin at the outset when preparing for a FARN activity. Treatment should be before the FARN so that emphasis is on child feeding/caring behavior and not on medication during the FARN. For example, preceding a FARN one needs to assure immunization and “deparasitage”. The later would include distribution of vermifuge and anti-scabies lotion. In addition, it is already planned at national policy level to have chloroquine available through “distributeurs” to combat malaria at village level. Physicians working with the program may have to assure chloroquine availability. And because respiratory illness is a frequent killer, there must be FARN capability for early referral and treatment. Cotrimoxazole may also become available at a village level to combat pneumonia. Physicians associated with the project may have special responsibilities especially where there are barriers to early referral at government health centers.
Recommendations for FARN activities from key findings:

That community mobilization and feedback, including fathers, be emphasized by:

- Involving community development committee and fathers in:
  - preliminary meetings with community;
  - interpretation of weighing all children (or at least under-threes) in the community; teach them how to make findings understood; for example making “pie diagrams” showing proportion of children malnourished before and several months after the FARN.
- Involving community in preparation for the FARN: for example, assisting the “mere volontaire”, providing housing for the educatrice when must remain for days at a time in the village;
- Involving the agriculture trainers and local agricultural committees: for example preparation for FARN can involve fathers in planning for better planting well)

2) Information system & activities:

- Create village or neighborhood-level registers derived from door to door enrollment of all under-fives (with help of the health workers such as Promoteurs de Sante). If possible, include all women in the reproductive age group and create women’s register, with columns to indicate pregnancy and pregnancy outcome. N.B. :- This would allow for cross check to see if every newborn is registered in the under-fives register. A family register would, of course, include father and/or and all heads of households.

- Continually update registration of children based on door to door enrollment, assigning a “family number” as well as child’s number so that child can be linked to family number, so that no child is left out.
- Link child to family through family number so that investigation can be carried out for children doing poorly or who die (this will help us characterize families who cannot achieve “well child” status for their child, and thus help us to identify risk factors.
- Create FARN register with key info (see examples in manual). Continue to follow FARN children for up to one year with monthly weight/age status (previous GMP system worked well); Children should gain 200 – 400 grams per month, or be growing as fast or faster than the international std median rate weight/age). Investigate all children with growth faltering to rule out disease.
- Calculate if possible, the under-fives death rates, infant mortality rates (IMR), and “Deaths by cause” to indicator system. To do this:
  - Add pregnancy outcome/birth register and
  - under-fives death register to information system (small notebooks in each hamlet) that can be updated in women’s meetings and/or by promoteurs de sante.
- Aggregate data from above at village level; coordonateurs de sante could supervise this and investigate deaths in simple way, the objective being to
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document under-fives death rates and deaths-by-cause. These data, compared to regional or national data, can speak very well to the impact of the overall in targeted program.

3) Take Infectious Disease into Account and combat it as a cause of malnutrition:

- Assure that child is completely immunized before FARN participation, or as soon as possible (link with provincial health authorities for special plan);
- Assure rapid treatment and preventive measures for diarrhea and malaria;
- Continue deworming as a prerequisite for FARN activities.

4) Take micronutrients into account and provide to the fullest extent possible (see Annex):

- Use of iodized salt should be demonstrated daily in preparation of menus for FARNs; mother’s attention should be called to it.

- Given the fact that most children identified for the FARN will be anemic, it is recommended that daily iron supplementation for mothers and under-threes should precede and follow the implementation of FARNs. The supplement should be given at home, and should not be a part of the activities in the FARN.

5) Assure to the extent possible adequate medical supervision and referral services:

- Hospital services (CRENI’s) for children too ill to eat, in need of gavage feeding

- On site evaluation and treatment for children falling ill during FARN (CRS physician-coordinator or nurses can accomplish this and decide if child can continue in FARN). Example: bacterial conjunctivitis or scabies that can be treated so it doesn’t contaminate others.

- Clinical evaluation and treatment for children with growth faltering after FARN intervention (some may have hidden TB);
## ANNEX I – Participant List

<table>
<thead>
<tr>
<th>Noms et Prénoms</th>
<th>Institution/Provenance</th>
<th>Titre</th>
<th>Tél.</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urbain M. AMEGBEDJI</td>
<td>MCDI PARAKOU</td>
<td>COORDONNATEUR PSE/MCDI</td>
<td>61-06-41</td>
<td><a href="mailto:mcdipkou@intnet.bj">mcdipkou@intnet.bj</a></td>
</tr>
<tr>
<td>Issifou MOUSSA YARI</td>
<td>MCDI PARAKOU</td>
<td>Responsable Suivi Evaluation PSE</td>
<td>01-40-36</td>
<td><a href="mailto:mcdipkou@intnet.bj">mcdipkou@intnet.bj</a></td>
</tr>
<tr>
<td>Medoune DIOP</td>
<td>Counterpart International</td>
<td>Responsable Prog. Nutrition/Santé</td>
<td>(221) 6574338</td>
<td><a href="mailto:mediopmac@yahoo.fr">mediopmac@yahoo.fr</a></td>
</tr>
<tr>
<td>Félicien Agossou SAGBADJA</td>
<td>PLAN BENIN (AZOVE)</td>
<td>Nutrition Officer</td>
<td>384773/9123</td>
<td><a href="mailto:agsagbadja@yahoo.com">agsagbadja@yahoo.com</a></td>
</tr>
<tr>
<td>Bernard GNAHOUI-David</td>
<td>PLAN BENIN / COTONOU</td>
<td>Conseiller en Santé</td>
<td>38-21-99 / 24-03-20</td>
<td><a href="mailto:bernard.gnahoui-david@plan-international.org">bernard.gnahoui-david@plan-international.org</a></td>
</tr>
<tr>
<td>Victoire GOMEZ GNANGUENON</td>
<td>PLAN BENIN / Klouékanmè</td>
<td>Coordonnateur Santé (Klouékanmè)</td>
<td>92-60-18</td>
<td><a href="mailto:govimon@yahoo.fr">govimon@yahoo.fr</a></td>
</tr>
<tr>
<td>Kosi Agbéwonou DAVO</td>
<td>IFAD-ONG / Klouékanmè</td>
<td>Coordonnateur PSA/Plan Benin</td>
<td>08 - 17 - 70</td>
<td><a href="mailto:davokosi@yahoo.fr">davokosi@yahoo.fr</a></td>
</tr>
<tr>
<td>Thierry Abdou Rahmanou JOSSE</td>
<td>REPFed-ONG / Klouékanmè</td>
<td>Coordonnateur PSA/Plan Benin</td>
<td>45-41-77</td>
<td><a href="mailto:jostar12002@yahoo.fr">jostar12002@yahoo.fr</a></td>
</tr>
<tr>
<td>Ange MEIZOU</td>
<td>AFRICARE PROLIPO P/NOVO</td>
<td>Chargé des Activités communautaire</td>
<td>56-63-67</td>
<td><a href="mailto:ameizou@yahoo.fr">ameizou@yahoo.fr</a></td>
</tr>
<tr>
<td>Roger ADOUNKPE</td>
<td>CREDESA/PAHOU</td>
<td>Directeur des Activités intersectorielles</td>
<td>95-70-44</td>
<td><a href="mailto:credesa@leland.bj">credesa@leland.bj</a></td>
</tr>
<tr>
<td>Abibou MAMADOU</td>
<td>IRSP/UIDAH</td>
<td>Assistant de Recherche</td>
<td>95-54-57</td>
<td><a href="mailto:mamabibfr@yahoo.fr">mamabibfr@yahoo.fr</a></td>
</tr>
<tr>
<td>Andréa HOUINDOTE</td>
<td>DSF/MSP COTONOU</td>
<td>Chef Division de lutte contre la carence en micronutriments</td>
<td>33-20-21</td>
<td><a href="mailto:houindote@yahoo.fr">houindote@yahoo.fr</a></td>
</tr>
<tr>
<td>Marie Claude ADISSIN</td>
<td>DANA PORTO-NOVO</td>
<td>Chef Service Education Nutritonelle</td>
<td>21-26-70</td>
<td><a href="mailto:danamdr@leland.bj">danamdr@leland.bj</a></td>
</tr>
<tr>
<td>Yacoubou ABDOULAYE ALFA</td>
<td>C/SANA BORGOU</td>
<td>Chef Service Alimentation et Nutrition</td>
<td>56-37-77</td>
<td></td>
</tr>
<tr>
<td>Augustin BODJRENOU</td>
<td>C/PAN COTONOU</td>
<td>Superviseur Chef</td>
<td>30-32-95</td>
<td><a href="mailto:cpan@intnet.bj">cpan@intnet.bj</a></td>
</tr>
<tr>
<td>Zénabou Y. YESSOUFOU</td>
<td>C/PAN COTONOU</td>
<td>Directrice Cellule PAN</td>
<td>30-32-95</td>
<td><a href="mailto:cpan@intnet.bj">cpan@intnet.bj</a></td>
</tr>
<tr>
<td>Emmanuel BOKOSSA</td>
<td>CRS BENIN</td>
<td>Chef Service Qualité du Programme</td>
<td>30-32-95</td>
<td><a href="mailto:ebokossa@crsbenin.org">ebokossa@crsbenin.org</a></td>
</tr>
<tr>
<td>Edouard BALOGOUN</td>
<td>CRS BENIN</td>
<td>Analyste</td>
<td>30-39-45</td>
<td><a href="mailto:ebalogoun@crsbenin.org">ebalogoun@crsbenin.org</a></td>
</tr>
<tr>
<td>Elisabeth ZANOU</td>
<td>CRS BENIN</td>
<td>Assistant Program</td>
<td>30-39-45</td>
<td><a href="mailto:ezanou@crsbenin.org">ezanou@crsbenin.org</a></td>
</tr>
<tr>
<td>Name</td>
<td>Title/Location</td>
<td>Contact Information</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Saintely DUBUISSON</td>
<td>Manager HEALTH CRS BENIN</td>
<td>Chef Section Sante/Nutrition 30-36-73 <a href="mailto:sdubuisson@crsbenin.org">sdubuisson@crsbenin.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gretchen BERGGREN</td>
<td>CONSULTANT/USA</td>
<td>International Health Consultant Nutritionist 720 746 1172 <a href="mailto:gberggren@aol.com">gberggren@aol.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warren BERGGREN</td>
<td>CONSULTANT/USA</td>
<td>Adjunct professor of Public Health 720 746 1172 <a href="mailto:wiberggren2@comcast.net">wiberggren2@comcast.net</a></td>
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Annex II

Training Needs (BESOINS EN FORMATION)

BESOINS EN FORMATION:

Village Development Committees (COMITE VILLAGEOIS DE DEVELOPPEMENT):

- Community Development in general (Développement communautaire)
- How when why and where to carry our door-to-door enrollment (census) Pratique de recensement
- Orientation to FARN
- Communication (Communication/plaidoyrie)

Volunteer mothers (MERES VOLONTAIRES):

- Orientation in nutrition, and animation/comunication (Orientation concernant la conduite d'une petite réunion d'animation et de sensibilisation)
- Training in conduct of PDI (Formation en PDI)
- Orientation to FARNs (sur la conduite du FARN):
  - Must have in mind: conduct, daily agenda, nutrition messages implied from activities, 4 recipes derived from PDI (Conduite: messages importants (bonnes, pratiques), 4 recettes mesures locales, pesée)
  - How to communicate (Communication avec les meres)
  - How to accomplish follow-up (Suivie des meres participantes après les 12 jours du FARN)

HEALTH COORDINATOR or supervisor of village health workers (COORDONNATEUR DE SANTE):

- Qualified in TOT
- Training in supervision (Formation en supervision)
- Training in methods and use of tools associated with FARN (Formation sur les outils de surveillance et méthodes)
- Training in how to train others in home visits and the PDI (Visites à domicile)
- Training in how to support monitoring and evaluation system, all reports, etc. (Supports: remplissage registres, fiche de croissance, carnet de santé, rapports d'activité)
- Training in public health/hygiene, preventive medicine (Formation en hygiène, assainissement)
- Training in integrated management of child health and primary health care (Formation en PCIME-C)
- Training in motivation and animation (Formation en moto)
- Training in message development and dissimulation (Formation sur les messages d'éducation sanitaires)
- Training in MARP
- Training in follow-up and evaluation (en suivi et évaluation)
  - Logistics (Logiciels)
  - data gathering, analysis (Traitement de données)
Data analysis and interpretation and feedback (Analyse/feed-back)
Data Utilisation

• Needs to be able to travel for further training (Voyages d’échanges a l’exterieur et interdiocese)

Community health workers: (PROMOTEURS de sante)

• Communication (Technique d’animation/communication)
• Anthropometry (weighing, measuring…)Anthropometrie
• Filling out growth charts, and registers (Mode de remplissage de register)
• Training in FARN, including PDI (formation en FARN)

Monitrices

• Understand communication and training of trainers (TOT).
• Notions of basic nutrition (Formation en matiere de nutrition)
• Animation, communication techniques (Technique d’animation)
• Training in FARN Approach and implementation (Formation en Approche FARN)
• Follow-up & evaluation (Technique de suiviet evaluation)
• Mode of completing registers, reports, and follow-up information to get indicators (Mode de remplissage et anthropometrie)
• Child development milestones ; anthropometry
• Formative Supervision
• Importance of indicators and how to get the data for them
• Filling out forms and reports
Special Report : RECRUITEMENT ET FORMATION DES EDUCATRICES

Note from Dr Warren Berggren

Les formateurs des educatrices sont les participants dans l'atelier actuel et elles (ils) ont tous achevé leur formation en ce qui concerne les FARNs en seulement deux semaines. Ils sont certainement compétents de former les Educatrices dans la matière couverte pendant l'atelier.

Il faut remarquer que l'atelier a considéré la conduite pratique d'un FARN dans un cadre théorique. Heureusement Dr Dubuisson, participant de l'atelier, a déjà installé, supervisé, et évalué des FARNs et il est en mesure de faire toute la formation nécessaire pour habiliter une éducatrice à implanter et superviser les FARNs.

Je conseille à former les educatrices en les exigeant à conduire, chaque une, une ou plusieurs FARNs. Ainsi, l'Educatrice jouera, pendant sa formation, (de au moins six semaines), le rôle d'une mère volontaire dans un FARN. Elle aura la responsabilité de former 5 – 6 mères participants, de réhabiliter leur enfant et d'apprendre les habitudes et conduites qu'elle a découvert lors d'une enquête PDI.

Pendant les sept semaines de la cycle du FARN, l'Educatrice (« monitrice ») sera appuyée et supervisée par le Coordonnateur Sanitaire de sa diocèse et par les formateurs de CRS. Il sera souhaitable, alors, de regrouper tous ces premiers FARNs dans un seul grand village pour faciliter la formation du groupe des Educatrices.

Je conseille que les educatrices en formation reçoivent un contrat de “Candidat au Post d'Educatrice en Nutrition”. Le contrat précisera la performance attendue de la Candidate pour qu'elle puisse atteindre son Diplôme et, éventuellement, son contrat d'Educatrice en Nutrition.

Training of Coordinators, (if such are available) COORDONNATEUR DE DEVELOPPEMENT:

- Reminder sessions about management (Recyclage en gestion de projet)
- FARN approach (Formation sur l’approche FARN)
- Negotiation with community: techniques (Technique de negociation)
- Training in TOT (Formation en TOT)

COORDONNATEURS AGRICULTEURS:

- FARN training
- Training or review about nutritive values in foods and how to find them (Formation sur les valeurs nutritives des aliments)
- Review in food growing, ag. problems, and storage (Formation en stochage des produits agricoles)
Annex III
Review Notes from Presentation: Establishing a series of FARNs after preparatory steps are met:
Steps (from International experience) Ref: Health/Positive Deviance Manual and from experience of Dr’s Warren and Gretchen Berggren.

1) Make sure prerequisites have been met.
   ✓ Community mobilization carried out; door to door registration of at least under-fives
   ✓ Technical staff trained and in place
   ✓ Trained « educatrices » who carry out the following under supervision of technical staff.

2) Identify and recruit volunteer mothers (use map to be sure they are distributed across the village)

3) Weigh all under three’s. (Volunteer mothers help and use register to assure that no child is left out).

4) Classify nutritional status of all children according to wt/age criteria, using national growth chart.

5) Give feedback to community: Proportion of children in need of rehabilitation illustrated with pie diagram.

6) Identify, with community leaders/volunteers, from above exercise after weighing, those « well nourished » from poor homes. Arrange for positive deviant inquiries.

7) Give volunteer mothers five day training course. Includes PDI inquiry, restitution of PDI, and market survey.

8) Carry out PDI’s with villagers; interpret and give feedback

9) Implement FARNS: 12 days of daily « apprenticeship » for mothers of malnourished children, (« Deroulement » of the daily exercise and follow-up to be considered later).

10) 12 days of home-visit follow-up

Planning for FARNS: Presentation (see next page)
Planning for FARNs (French) Faire une CARTE: Using a map describes the distribution of personnel

Etapes dans la mobilization communautaires et preparation pour le FARN avec les leaders et les meres volontaires; preparation pour la première series de “pesées”:

1. Après une orientation pour la mobilization communautires, faire une carte du village et étudier la distribution des familles par grandes voisinage.
2. Décider avec la communauté le nombre de petite voisinages qu’il faut développer dans “grande voisinages” pour l’exercice FARN:
   Par exemple: Village d’Odombo: 5000 habitants;
   900 familles noyau; 200 se trouvent à l’autre côte d’une petite ravine.
   Alors, les leaders décident qu’il ya logiquement 4 grandes voisinages (A,B,C) dans une cote d’une ravine, et une (1) grande voisinage à l’autre côte de la ravine (Voisinage D). Dans l’exercice d’une recensement, on a trouvé que voisinage A contient 150 familles; voisinage B contient 200 contient familles, et C contient 300 familles. Dans chaque grand voisinage, avec les leaders, on explique encore qu’chaque FARN peut travailler avec une petite groupement de 10 – 20 familles.
3. Identifier, sélectionner et orienter une mère volontaire par voisinage de 10 – 20 familles [au moins 45 - 90 mères volontaires pour cette village].
4. Diviser les mères volontaires dans les groupes de 5 ou 6 mères volontaires qui habitent dans les voisinages très proches les uns les autres.
5. Planifier avec chaque groupe de 5 ou 6 mères volontaires comment on peut réaliser une station de peser tous les enfants 6 – 36 mois d’âge. Idéalement, on doit les enregistrer avant la station de peser, pour qu’il y’a aucun enfant laisse en dehors de la pesée pour le FARN. La mère volontaire garderait le registre.
   Cela doit être planifier avec une collaboration communautiare, pour que tous les peres peuvent participer dans un “feedback” immediate.
Special question: How to involve fathers in all this?:
Pourquoi et comment assurer la participation active des hommes (pères) des leaders, des grands parents etc… dans le FARN ?

Ans : WHY (Pourquoi) ?

la survie de l’enfant est l’affaire de tous ; plus l’enfant bénéficie de l’attention et des bons soins de tous les parents (pères, mères, grands parents etc), plus il connaît un développement harmonieux et grandit en bonne santé.

L’enfant constitue une richesse sociale au sein de la communauté. Les membres ont alors le devoir social de veiller à sa bonne santé et à son bon développement social

How ? (Comment) ?

Par : Le Diagnostic Participatif Communautaire (EDP)
Il doit être conduit avec la communauté en commençant d’abord par les leaders et toutes les personnes influentes surtout les pères qui sont les décideurs au niveau des ménages

Le plaidoyer pour une participation effective suivi du processus au niveau du FARN et à domicile ) des pères, des grands parents etc) pour ainsi soutenir la mère et contribuer à une bonne récupération de l’enfant.
Message à véhiculer lors des cultes sur la participation active des hommes

L’Identification avec les pères et autres personnes ressources des responsabilités qu’ils accepteraient d’assumer.

Le Suivi de la mise en œuvre de ces responsabilités par les pères, les grands parents et des personnes ressources
Annex IV. Need to address micronutrient coverage for treatment and prevention of anemia, Vitamin A and iodine deficiency disease:

**Background:** Anemia as well as Vitamin A and iodine deficiency diseases affect both mothers and children. National programs are expected to address these problems. It is expected that Vitamin A distribution, twice yearly will be provided. But neither mothers nor children are routinely getting iron unless it is prescribed, and then they must pay for it. International studies (MICS and others) showed that more anemic mothers tended to have under-threes with moderate or severe anemia. Recent studies have shown that if anemia is not corrected by 24 months of age, the IQ of the child will be permanently affected.

Rice has relatively small amounts of iron; under-three year olds will get only a couple of milligrams per day from rice. It will be necessary to include dried small fish and shrimp, eaten in their entirety, in their food; indeed these were found in the menus of the “meres modeles” at this season of the year. They may be key important “positive deviant” foods. Note that there is only 2.5 mg of iron in 100 g of dried fish, and a child would eat less than half that amount in the usual recipe.

**Iron supplementation** is recognized as a need in Benin. Iron supplements are prescribed for pregnant and lactating mothers, and for under-fives, but these must be paid for by the mother. Another alternative that of fortification of wheat flour with iron should be considered at a national level, but is beyond the scope of this project.

**Comment on Micronutrients and the FARN activities:**

1) **Vitamin A:** In cooperation with the Ministry of Health, it is hoped that Vitamin A should be available free of charge in all villages; educatrices (monitrices) should assure that this has been carried out.
2) If **iodinization** of salt is also a national program. All FARN recipes should demonstrate its use.

3) Anemia prevention: **Anemia and its underlying causes will be more difficult to address.** One suspects that heavy parasite loads (perhaps hookworm disease as well as malaria) are contributory. The present CRS plan **to insist on deworming with mebendazole as a preparatory step to nutrition rehabilitation is essential; mothers may also be included!** In addition, the plan to assure treatment for malaria during the FARN exercise is important. Malaria destroys red blood cells and is an underlying cause of anemia.
Annex V Analysis comparing FARN and Hospital rehabilitation (CRENI) Services

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<th>Strengths</th>
<th>Weaknesses</th>
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<td><strong>CRENI</strong></td>
<td>Complete integrated disease management for severely malnourished child; Medically developed protocol; curative oriented; Recognized by government authorities as a hospital-based approach; offers Emergency Rx for life treatment in malnutrition including tube-feeding child not dismissed until rehabilitated. Resources are usually available at the hospital level but must be paid for an outside NGO. Pre-established “Kit” and protocol for treatment</td>
<td>Costly and dependent on exterior financing; child doesn’t enter for rehab until seriously ill; Reaches only self-selected cases who decide to come Requires prolonged absence of the mother from her home Implementation may be affected by personnel limitations Individual, unique participation; community not involved; Education given to mother very limited level; Cannot function outside hospital setting; strict admission criteria Not effective without village level follow-up</td>
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<td><strong>FARN</strong></td>
<td>Close by and accessible; leaves out no child: all are invited to weigh-in through village-level invitations; every child in a defined population is “eligible”; Is both preventative and curative; protocol is flexible and depends on positive deviance inquiry with menu tailored to each ecologic setting; rehab is with local foods; Requires active community participation; appropriate to village needs and environment; ambiance pleasant for mothers who feel supported. Sustainable rehabilitation at family level; mother’s participate continually in the rehab process; Facile a mettre en oeuvre Peu couteux Valorise les resources et experiences locales Medicalisation non obligatoire</td>
<td>Does not emphasize medical RX, which should precede FARN Village preparation is long and intensive Approach is new and must be negotiated Relatively small numbers of children reached per 6 week cycle (5 FARNs = 25 children &amp; mothers in a given neighborhood) High risk of lack of good follow-up unless well organized Risk of abandonment of follow-up on children Limited duration in a given area.</td>
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SUPERVISION

DEFINITION:
Action continue d’information, d’orientation, d’instruction et de correction des erreurs. Certains: Arts de guider, d’instruire, d’encourager

BUT:
- Aider quelqu’un (collaborateur) a améliorer sa performance et ses compétences
- Pour assurer que les objectifs poursuivis sont adéquats
- Aider à développer la motivation du personnel

OUTILS:
- Description de poste
- Calendrier d’exécution
- Fiche ou cahier de supervision
- Règles de jeux: chacun doit savoir avec précision ce qu’on attend de lui:
  - Manuel de procédures
  - Description de poste: rôles et responsabilités
  - Objectifs quantitatifs, réalistes par rapport à la situation de départ
- Planification d’une supervision
- Préparation technique: élaboration fiche et méthodologie
- Préparation administrative: les données disponibles, le cibles de la supervision

EXECUTION:
- Contact avec le premier responsable (objet, méthode, cible)
- Contact avec le supervise (le mettre à l’aise, expliquer la réalisation)
- Rapports, recommendations (formation)
- Techniques: observation, entretien, interview, analyse documentaire (indirect)

FICHE OU CAHIER DE SUPERVISION:

Elements:
- Domaine à superviser:
  - Préalable du FARN
  - Mise en œuvre de la pesée (Village) (Service de surveillance Nutritionnelle, SNC)
- Indices: register SNC
- Technique: observation pesée
- Échelle d’appréciation : oui/non ou 1/2
• Criteres: reponse souhaitée= oui
• Observations: remarques eventuelles “donner au supervise la chance d’expliquer ses
problèmes “
NB: savoir feliciter et maitriser le feed-back

- Verifier les derniers recommendations
- Determiner la date de la prochaine supervision

ANALYSE DES DONNES:

- Rapportage: trimestriel/semestriel/annuel
- Trois niveaux:
  - District: programme simplifie
  - Excel diagramme des resultats, villages: feed-back
  - CRS: traitements des 4 dioceses: dioceses(feed-back)
- En general:
  - Analyse/quantitative
  - Feed-back
  - Pourquoi les resultats? Enquete qualitative
  - Partager les lessons apprises

EVALUATION DES CHANGEMENTS DE COMPORTEMENTS

• DAP: KPC, LQAS
• Periodicite: a determiner
• Avantages:
  - Cout abordable
  - Couvre la survie des enfants
  - Comparable ailleurs
  - rapide
• reviser le Questionnaire
Annex VII  Midterm evaluation (suggestions from Madagascar workshop)

EVALUATION A MIS PARCOURS

- Buts:
  - Evaluer l’effet du programme
  - Savoir si les objectifs fixes seront atteints pendant le reste de la période
  - Justifier l’existence et l’importance du projet vis à vis des bailleurs et les autres partenaires
- Assurer par:
  - Les réalisateurs (CRS, diocese…)
  - Ou selon bailleur: évaluateur externe
- Questions à poser:
  - La couverture est-elle adequate?
  - Existe-t-il des deviations dans la mise en œuvre du projet, si oui: limitent-elles la possibilité d’atteindre les objectifs?
  - Quelles sont les contraintes et quelles sont les mesures correctives
Evaluation des Etapes FARN et resultats au niveaux d’une village:
Presentation

Objectifs de la presentation:
But: rehabilitation de tous les enfants dans tous les communes, commençant avec tous les villages d’une ou plusieurs communes

1 Est-ce le choix des communautés étaient bon?

N.B.: Critères pour le FARN
• 30% malnourris ou plus
• receptivite de la communautè

2. Est-ce qu’on a accompli les activités necessaires pour la preparation communautaire?
N.B. Revoir chaque etape qu’il a fallu respecter: -- par exemple:
2.1 Faire plusieurs visites pour la mobilisation communautaire
2.2 Faire une carte du village pour etudier avec les leaders les quartiers et les voisinages. 
2.3 Identifier avec les leaders dans chaque voisinage, les meres volontaires; 1:20-30 familles
2.4 Avec les leaders et les MV’s, enregistrar tous les enfants 6 – 36 mois avant le pesee.
2.5 Peser tous les enfants dans une ou plusieurs voisinages (5 meres volontaires se reunissent avec les enfants de leurs voisinage pour faire le pesee); faire le “diagnostique communautaire” avec une carte poids/age, sur laquelle chaque enfant est represente; faire le pie-chart (“camembert”) pour feedback avec la communautè.
2.6 Identifier les families pauvres qui sont les “Deviants Positifs” parce-que ils ont des enfants 12 – 36 mois bien nourris)
2.7 Identifier et former les members d’une equipe popur accomplir les visites a domicile chez les meres pauvres qui ont les enfants malnourris, pour determiner les comportments importantes en alimentation, soins et eveil, soins medicale
Compilation des resultats et “feedback” a la communautè
Developpement des menus, recettes volontaires Rehabilitation des enfants en FARN

3. Planifier l’evaluation avec les indicateurs:
3.1 Indicateurs: Comment les choisir et utiliser?
N.B.:-- Il faut concevoir les outils de collecte des donnees avant le commencement des exercices FARN.... Considérer comment:
✓ Faire l’analyse de donnees quantitative et l’interpretation correspondante;
✓ Analyser et interpreter les resultats qualitatifs aprè analyse quantitative;
✓ Faire une evaluation des changements de comportments des responsables des enfants après l’exercice FARN.
3.2 Indicateurs (exemples de CRS Madagascar)

3.2.1 % des enfants éligibles pour le FARN

3.2.2 % malnutris éligibles et inscrits “

3.2.3 % malnut. Eligible et qui ont participés au FARN

3.2.4 % malnut. éligibles, participent au FARN, et qui achève les 12 jours (taux d’abandon)

3.2.5 % des enfants assidus aux séances de 12 j et et qui recoivent au moins une visite a domicile (VAD) hebdomadaire pendant 4 semaines après jour 12

3.2.6 % des reponsables d’enfants presents au FARN pend 12 j et qui sont
a) Mere b) grand parent c) frere et/ou soeur, d) pere e) autres

3.2.7. Nombre et % d’enfants dans un FARN qui sont rehabilite comme: moyenne; fourchette; mediane

3.2.8 % des freres et soeurs cadets de l’enfant malnutrit qui ont participes au FARN qui ne sont pas tombes dans la malnutrition

4. Choisir les indicateurs communautaires:
4.1 Resultats de le peser communautaire au commencement et 1 annee après l’implementation des FARNS

5. Choisir des indicateurs des resultats FARN.
5.1 pour les enfants qui ont terminez 12 j du FARN:--
✓ % des enfants qui ont “reussit” au FARN; rehabilites (plus que 400 grammes) (“ratrappage”).
✓ % des enfant qui ont gagne entre 200 – 400 grammes dans le mois pendant et apres FARN
✓ % des enfants qui ont gagne seulement 100 g
✓ % des enfants qui n’ont pas gagne du poids dans le mois après
✓ % des enfants de FARN qui n’ont pas gagner du poids

5.2 Indicateurs de Morbidite
✓ # et % des des enfants du FARN atteints, après le FARN, de
-- paludisme
-- IRA
-- Diarrhees
-- Rugoelle
% des enfants du FARN pris en charge par un personnel qualifie pendant la maladie de;
  o IRA
  o Paludisme
  o Diarrhee
  o Rugoelle

6. Indicateurs de Moralite
No. et % des enfants morts, pendant le FARN; dans les 6 mois après, et pendant 1 année après.

7. Immunisation

7.1 % des enfants (FARN) 12-36 mois qui ont reçu tous les antigènes vaccinaux avant le 1er anniversaire (confirmé carnet de santé)
7.2 % de déperdition entre DTC1-DTC3
7.3 % des 12-36 mois recu le Rouvax (confirmé avec carnet de santé)
7.4 % des enfants ayant reçu la capsule de Vit A
7.5 % ayant reçu une dose de mebendazole dans les 6 mois précédant le FARN

8. Surveillance de la croissance des enfants 0-59 mois

8.1 % des enfants 0-59 mois état nutritive “Vert”
8.2 % des enfants “jaune”
8.3 “rouge”

8.4 % des enfants recensés et pesés
8.5 % des enfants inscrits dans le registre
8.6 Nombre de séances de Pese
-- planifiée
-- réalisée
Key findings from study of Madagascar-FARN pilot project and its results, based on experience in CRS Madagascar and from key workshop exercises:

1) Pilot HEARTHS/key findings from Madagascar:

CRS’s pilot hearths, Workshop Participants’ field observations and population information in the FELANA project description all provide streams of information that is valuable for planning, staffing, training and implementation of hearths by CRS’s diocesan partners. The most salient discoveries are briefly reviewed below.

Parent’s Opinions of the Pilot Hearths

Background: CRS inaugurated 14 hearths in the Mananjary Diocese in order to measure their impact on malnutrition and to assess their requirements for skilled personnel and financial support. An Evaluator’s recent report of these hearths is encouraging and contains several recommendations for their improvement. CRS staff organized parent’s meetings during our consulting visit and were able to assess their opinions of the pilot hearths with the help of interpreters.

- Mothers and caretakers were pleased with the hearth methods, appreciated being led in their learning by one of their own neighbors and were happy with the changes that they observed in their children. They were doubtful of their capacity to maintain the weight gains now that the season had changed and, with it, the availability of some of the foods used in the hearths.
- Mothers wanted the hearths re-opened during a season when different foods are available. Most of them did not understand that the menus used in the hearths were all gathered from their neighbors who have well-nourished children.
- Fathers said that their children became healthier during and following participation in a hearth. They said they were raising more of the foods used in the hearth and that they gather more leafy green plants now in order to better nourish their families.

Pilot Hearths’ Information System

Background: Pilot hearth staff recorded children’s weights manually and electronically at monthly intervals for six to twelve months after hearth participation.

- Illnesses and Deaths in FARN Children: System tracked illness and deaths; a commendable innovation. The records included mention of illnesses and of two deaths. It was not clear how the children’s records were linked to information on their parent’s. Such a link would be very helpful since parents, too, are subjects of the hearth and are the persons whose behaviors determine success or failure for the hearth and whether or not their child’s nutritional status will be maintained over the years of childhood.
- Pilot Hearths’ Outcomes; indicators
CRS staff monitored two quantitative indicators of success:

- Individual child’s weight gain of at least 1,200 grams during six months of follow-up after participating in a hearth.
- Individual hearth’s record of at least half of their children gaining 1,200 grams between hearth entry and their six month’s follow-up.

Major findings from study of outcomes/indicators for Pilot Project:

- **Good hearth outcomes were associated with smaller numbers of children in the hearth.** Fourteen Pilot hearths cared for 74 mother-child pairs. Twenty-seven of the 74 succeeded in gaining at least 1,200 grams during 6 months of observation. Seven of the 14 hearths achieved success as defined above. In order to learn how successful hearths differed from the others, we looked for comparison indicators. This search will continue but one indicator, immediately available from routine records, was the number of child participants per hearth. **The successful hearths cared for an average of 4.9 children, whereas the average number of children in the other hearths was 6.9 (medians were 5 and 7, respectively.**

Comment: As our examination of means and medians suggested that good hearth outcomes were associated with smaller numbers of children in the hearth, we examined the entire distribution. The result shows a clear association: the fewer children in the hearth, the higher the proportion of children that had made adequate weight gains after six months (Table 1). Clearly, good weight gains, in this trial, depended on having fewer children in the hearth. **Further observations may teach us why the association is so close. There may be ways in which volunteer mothers can overcome the deleterious effects of admitting more than five children to a hearth.**

Performance of Fourteen Pilot Hearths by Number of Children per Hearth

- **Infectious Diseases’ Impact: Lessons from pilot project:**

  - **Deaths:**
    Two of the seventy-seven hearth children died of pneumonia and a “febrile illness”. As their deaths occurred more than five months after hearth participation, they are not hearth case-fatality. They illustrate, however, that hearth gains can be cancelled, decisively, by infectious disease if children do not have adequate medical care and preventive services.

  - **Vaccine Preventable Illness**
    Two hearth children contracted measles but survived through a year of observation. Complete immunization may not have been a requirement for hearth admission but that lesson is now learned.

CRS and Diocesan staff protest that they are not empowered to improve Madagascar’s dangerously low immunization coverage rates. Government services are the sole providers of vaccines and vaccinators. Vaccinations are performed in the Basic Health Centers to which all families have access if they can pay the modest fees. Access to Basic Health
Centers is severely impeded by geographic barriers to many populations served by CRS and its Partners.

The Health Ministry’s “advanced strategy” can assure delivery of vaccination services to villages isolated by distance from Basic Health Centers if parents pay the costs. It is not clear how the advanced strategy is activated in any particular village. CRS may wish to clarify means of activating the advanced strategy in time to keep their schedule for opening hearths.

✓ **Diarrheal Disease**

Diarrhea is mentioned frequently in the Hearth records and its negative impact on children’s growth is well known. Pilot hearths taught use of home-available fluids and increased breast-feeding during diarrhea. The importance of very active re-feeding after diarrhea also needs to be taught.

✓ **Malaria**

Malaria was recorded among adults during hearth follow up and it is likely that children were infected also. Since then chloroquine, under the trade-name “Palustop” has become available in Madagascar pharmacies. It is also available to distributors who are authorized to sell it in villages where there is no pharmacy. CRS may wish to assure that all the families they serve know how to access Palustop at a fair price and how to administer it, both to adults and to children. Antimalarials are very effective in preventing deaths due to malaria if they are immediately available.

CRS is also engaged in distributing insecticide impregnated bed nets. There may be ways of coordinating hearth activities and bed net distribution that could enhance the effectiveness of both programs.

✓ **Worm Infections**

CRS and its partners de-worm children with Mebendazol. It is not clear if this important service is done before entry in the hearth or is offered to all children that present for weighing nor if the procedure is ever repeated. Apparently mothers are not de-wormed although it is likely that they harbor hookworms which can seriously deplete their hemoglobin levels.

CRS will soon begin a program to promote and build ventilated improved pit latrines. Latrines are an important method of reducing Ascaris, Trichyuris and Hookworm infection levels over time. The VIP model is an excellent latrines if it is constructed with meticulous attention to the construction specifications. However, if the ventilator stack has a smaller diameter than the latrine’s slab hole, or if its outlet is not covered by a tight screen, or if light enters by other ways than through the ventilator, such flawed latrines will smell as bad and produce as many flies as any other pit latrine.