A practical guide for humanitarian workers in the field

STRATEGIC PROGRAMMING FOR COMMUNITY NUTRITION INTERVENTIONS

FRANCE
4 rue Niepce
75014 Paris
Tel: +33 1 43 35 88 88
www.actioncontrelafaim.org

SPAIN
C/ Caracas, 6, 1º
28010, Madrid
Tel: +34 91 3915300
www.accioncontraelhambre.org

UNITED KINGDOM
First Floor, rear premises, 161-163 Greenwich High Road, London, SE10 8JA
Tel: +44 208 293 6190
www.aahuk.org

UNITED STATES
247 West 37th Street
Suite 1201
New York, NY 10018
Tel: +1 212 967 78 00
info@actionagainsthunger.org
www.actionagainsthunger.org

CANADA
Action Contre la Faim
7464 rue St Denis
Montreal, QC, H2R 2E4
Tel: +514 279-4876
www.actioncontrelafaim.ca
STRATEGIC PROGRAMMING FOR COMMUNITY NUTRITION INTERVENTIONS

A PRACTICAL GUIDE FOR HUMANITARIAN WORKERS IN THE FIELD

Technical Department of Health and Nutrition
ACF International Network
This document has been edited and written by Marta Ayats, nutritionist for Action Against Hunger.

The Technical Department of Health and Nutrition team from Action Against Hunger Spain (ACF-E) would like to thank all those who have given their support to the elaboration of this guide. In particular we would like to thank:

The personnel of the missions to Guinea, Malawi and Mali, who shared their experiences of the Community Workshop’s (CW) programme, and were instrumental in the development of this guide.

Amador Gómez, Technical Director of ACE, for his on-going coordination of the Health & Nutrition Department team, and for his support during the definition and execution phases of the different projects in the field, so that this guide could be elaborated as an on-site work tool.

Nuria Salse, Head of the Health & Nutrition Department of ACF-E, who supervised the structuring and content of this work, providing valuable advice and above all, her support, dedication and time.

The local organisations, institutions and associations, which permitted the development of the CW in their respective countries, for their close collaboration and dedication.

To the Water and Sewerage Department (W&S) of ACF-E, and particularly to Victor Arroyo and Pablo Alcalde, for their support and definition of the interventions through the CW in W&S.

To the Department of Food Security (FS) of ACF-E, and particularly to Carole Lambert, for her support and definition of interventions in FS.

It must be said that, without the help of the people who are on site implementing the programmes of the Community Workshops, it...
would not have been possible to write this guide. It is the result of: great dedication and devoted work by the personnel, a large mobilisation and awareness-raising in the communities, and good collaboration of key people within the community.

Poor communication lines, and tropical weather in most of the countries where the CWs were carried out, did not stop our personnel - loaded with the required material for the workshops - from continuing the programme in several communities and continuing the rehabilitation of children with acute moderate malnutrition.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>Community Agent</td>
</tr>
<tr>
<td>ACF-E</td>
<td>Action Against Hunger-Spain</td>
</tr>
<tr>
<td>ADAR</td>
<td>Adventist Agency for Development and Assisting Resources</td>
</tr>
<tr>
<td>IGAs</td>
<td>Income Generating Activities</td>
</tr>
<tr>
<td>W&amp;S</td>
<td>Water and Sewerage</td>
</tr>
<tr>
<td>OA</td>
<td>On site Agent</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitudes and Practice</td>
</tr>
<tr>
<td>NDC</td>
<td>Nutritionist-Doctor Coordinator</td>
</tr>
<tr>
<td>RNEC</td>
<td>Rehabilitation and Nutritional Education Centres</td>
</tr>
<tr>
<td>PD</td>
<td>Positive Deviation</td>
</tr>
<tr>
<td>HS</td>
<td>Home Survey</td>
</tr>
<tr>
<td>FADU</td>
<td>(in English) Frequency, Amount, Density and Use</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>PM</td>
<td>Project Manager</td>
</tr>
<tr>
<td>ML</td>
<td>Mother Light</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>PAK</td>
<td>Practice, Attitude and Knowledge</td>
</tr>
<tr>
<td>BP</td>
<td>Braquial Perimeter</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>NMP</td>
<td>Nutritional Minimum Package</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>S</td>
<td>Supervisor</td>
</tr>
<tr>
<td>FS</td>
<td>Food Security</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Rehydration Serum</td>
</tr>
<tr>
<td>CWs</td>
<td>Community Workshops</td>
</tr>
<tr>
<td>HVs</td>
<td>Home Visits</td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS

1. INTRODUCTION ........................................................................................................ 11

2. DEFINITION OF THE PROGRAMME ............................................................................ 13
   2.1. WHAT IS A COMMUNITY WORKSHOP (CW)? ..................................................... 13
   2.2. DEFINITION OF ESSENTIAL TERMS .................................................................... 14
   2.3. OBJECTIVES OF THE PROGRAMME ..................................................................... 15
   2.4. JUSTIFICATION FOR THE IMPLEMENTATION OF CWS ................................. 16
      2.4.1. CONTEXT .................................................................................................... 16
      2.4.2. AVAILABILITY OF LOCAL FOODS .............................................................. 17
      2.4.3. MOBILISATION OF THE COMMUNITY AND COMMUNITY COMMITMENT ................................................................. 17
      2.4.4. SANITARY AND HEALTH INTERVENTION STRUCTURES AT A COMMUNITY LEVEL ................................................................. 19
   2.5. ADMISSION AND SELECTION CRITERIA ........................................................... 19
   2.6. ADVANTAGES AND DISADVANTAGES OF COMMUNITY WORKSHOPS ............ 21

3. PLANIFICATION AND ORGANISATION OF THE PROGRAMME:
   PHASES OF INTERVENTION ......................................................................................... 22
   3.1. PREPARATION ..................................................................................................... 22
   3.2. SESSIONAL PHASE .............................................................................................. 44
   3.3. FOLLOW-UP ......................................................................................................... 48

4. ESSENTIAL COMPONENTS INTEGRATED INTO THE PROGRAMME ....................... 51
   4.1. NUTRITIONAL MINIMUM PACKAGE. IEC MESSAGES ........................................ 52
   4.2. INTEGRATION OF HEALTH INTERVENTIONS ..................................................... 58
   4.3. INTEGRATION OF WATER AND SEWERAGE INTERVENTIONS .............................. 60
   4.4. INTEGRATION OF FOOD SECURITY INTERVENTIONS ....................................... 63

5. PROGRAMME MANAGEMENT ..................................................................................... 67
   5.1. SUPERVISION ELEMENTS ................................................................................... 67
   5.2. PRESENTATION OF REPORTS .............................................................................. 68

6. RESULTS, MONITORING AND EVALUATION .......................................................... 70

7. THE EFFECTIVENESS OF THE INTERVENTION .................................................... 75
   7.1. QUANTITATIVE EVALUATION: WEIGHT GAIN AND W/H % .............................. 76
   7.2. QUALITATIVE EVALUATION: KAP SURVEYS ...................................................... 79

8. MATERIALS & UTENSILS ......................................................................................... 86

9. STRENGTHENING OF LOCAL STRUCTURES AND ORGANISATIONS ................... 88

10. TRAINING .................................................................................................................. 89

11. NEXT STEPS ............................................................................................................. 97
12. ANNEXES ........................................................................................................ 98

1 HOME SURVEY ................................................................................................. 98
2 OBSERVATION SHEET FOR A HOME VISIT (HV) ..................................... 103
3 24-HOUR REMINDER ....................................................................................... 104
4 TRAINING MODULE EXAMPLE .................................................................... 105
5 FORMS ................................................................................................................ 133
   a • Population register of the nutritional condition of 6 to 59 month-old children ........................................................................................................ 133
   b • Pre-selection of 6 to 59 month-old children ........................................... 135
   c • Final selection of 6 to 59 month-old children into a community workshop ...................................................................................................................... 136
   d • Referral sheet ............................................................................................. 137
   e • Growth evolution of children per workshop during sessional & follow-up phases .............................................................................................................. 138
   f • Attendance record for children & mothers carers at the workshop and for the circulation of IEC messages ............................................................ 139
   g • Mother´s daily contribution during the sessional phase ............................ 140
   h • Recipe preparation form ........................................................................... 141
   i • Control of the child´s diet consumption per day ....................................... 142
   j • IEC messages developed per day ............................................................... 143
   k • Abandonments & referrals follow up ....................................................... 144
6 THE CALCULATION OF PORTIONS FOR MEAL PREPARATION ................ 145
7 AN EXAMPLE OF CULINARY RECIPES ....................................................... 146
8 WEIGHT/AGE INDEX TABLE ........................................................................... 152
9 EXAMPLE OF AN AGRICULTURE CALENDAR ............................................. 153
10 CONTRACT NOTICE ......................................................................................... 154
11 WRITTEN TEST AND INTERVIEW ............................................................. 155
12 EXAMPLE: TEST FOR ON-SITE AGENTS .................................................. 155
13 SELECTED CANDIDATES FOR THE POST OF ON-SITE AGENTS ............ 156
14 NUTRITIONAL ANALYSIS FOR PD FAMILY SELECTION ........................ 156
15 MARKET SURVEY ............................................................................................ 157
16 GUIDE TO COMPILING A REPORT TO HQs ............................................... 158
17 BUDGET GUIDE LINES FOR THE FORMULATION OF A CW PROGRAM .... 160
18 CRITERIA FOR WEIGHT GAIN OF CHILDREN ADMITTED TO A WORKSHOP .................................................................................................................. 161
19 EXAMPLE OF AN AGREEMENT WITH A LOCAL COUNTERPART ................ 161
20 EXAMPLE OF PRE-TEST FOR OA ................................................................. 163
21 CERTIFICATE FOR TRAINING PARTICIPATION ........................................ 163
22 EXAMPLE OF AN AGREEMENT WITH A HEALTH MINISTRY ..................... 164
13. BIBLIOGRAPHY ........................................................................................................ 164

CHARTS

1. CAUSAL TREE OF MALNUTRITION ................................................................. 12
2. CW MAIN CONCEPTS/COMPONENTS ............................................................... 14
3. OBJECTIVES OF THE PROGRAMME ................................................................. 15
4. ASPECTS TO BEAR IN MIND IN ORDER TO HAVE A GOOD
   RELATIONSHIP WITH THE COMMUNITY ......................................................... 18
5. QUICK EVALUATION TECHNIQUES ................................................................. 22
6. SYSTEMATIC TREATMENT OF ACUTE MODERATE MALNUTRITION
   CASES IN THE CWS ...................................................................................... 45
7. INTERVENTION LEVELS ON NUTRITIONAL BEHAVIOURS ......................... 52
8. EXAMPLE OF REGIONAL OFFICE’S INFORMATION SHEETS ......................... 57
9. AN EXAMPLE OF THE PRESENTATION OF RESULTS
   OF THE KAPS IN A REPORT ........................................................................... 84
10. EXAMPLES OF TRAINING METHODOLOGY.................................................... 89

TABLES

1. ADVANTAGES AND DISADVANTAGES OF COMMUNITY WORKSHOPS .......... 21
2. GUIDE OF GOOD PRACTICES FOR THE SELECTION OF PD FAMILIES .......... 39
3. ACTIVITIES TO BE CARRIED OUT DURING THE PREPARATION PHASE ...... 43
4. RESULTS ON THE NUTRITIONAL CONDITION
   PER COMMUNITY DURING NUTRITIONAL CENSUS .................................. 72
5. RESULTS OF GROWTH EVOLUTION AND WEIGHT GAIN ............................. 73
6. RESULTS OBTAINED FROM GOOD BEHAVIOURS AMONG
   MOTHERS WITH WELL-NOURISHED CHILDREN............................................. 74
7. TRAINING REQUIRED ....................................................................................... 91
8. DESIRED CONTENT FOR THE ML TRAINING MODULE ............................... 92
9. DESIRED CONTENT FOR THE CA’S TRAINING MODULE ............................... 93
10. OA & HEALTH AGENT TRAINING MODULE’S DESIRED CONTENT ................. 94
11. DESIRED CONTENT FOR THE PROJECT MANAGER
    AND SUPERVISOR’S TRAINING MODULES .................................................... 95

RECORDS

1. INFORMATION ON THE COMMUNITY............................................................... 23
2. EVOLUTION OF CHILDREN’S WEIGHT GAIN FOR THE 10 WORKSHOPS ...... 77
3. W/H % EVOLUTION OF CHILDREN FROM 10 WORKSHOPS ........................... 78
1. INTRODUCTION

Malnutrition continues to be a serious public health problem in many countries, mainly affecting children through a high rate of infant mortality. Fifty six percent of infant deaths are associated with the effects of malnutrition, and of these 83% are not caused by severe, but by light and moderate malnutrition. This constitutes a silent emergency which puts children, women and families in danger and, ultimately, the general viability of the entire society. Its persistence has serious consequences for the future of the whole village. Children with malnutrition can suffer learning difficulties, which then have an impact on their whole development and upon their future capacity to earn a living, further reducing their productivity.

Because of its high prevalence and slow appearance of symptoms, the people in charge of children (their families, communities, and governments) often overlook malnutrition. It is a situation effected by: a lack of food, poor distribution of the available food, inadequate breastfeeding and complementary feeding practices, coupled with inadequate family care practices, a deficiency in early stimulation, as well as a deficiency in water and sewage, and the presence of illnesses.

Malnutrition has a greater impact on infant mortality than first thought. Strategies which only involve the identification and treatment of children with severe acute malnutrition will not suffice in reducing infant mortality. Therefore, it is imperative that community nutrition programmes are implemented where acute, moderate and light malnutrition can be treated. The prevention can be emphasised through a community nutrition programme called Community Workshop (CW). A programme which focuses on the indirect behavioural causes (habits and customs) of malnutrition at a household level - such as a mother’s inadequate infant care - in order to tackle the two direct causes of malnutrition (Table 1). The community must be involved so that its members can play an essential and active role, by accepting the responsibility for improving, in a sustainable manner, the nutritional condition of their own children, whose socio-economic conditions are precarious. A greater impact through interventions on Water and Sewerage and on Food Security is to be developed. Work is undertaken with ministries of health and their personnel in order to refer severe cases with complications to the health systems; and because of the need to integrate the programme within health structures, thereby favouring a greater sustainability.

The objective of the Community Workshop is the fast, accessible and sustainable nutritional recovery of those children with acute moderate malnutrition and those at risk of malnutrition, but without any associated pathology. The programme makes use of the methodology of Positive Deviation (PD) to identify the good habits and conducts of those mothers whose children are healthy and well nourished. The best of those mothers with the greater availability is chosen to collaborate in a voluntary manner. She is given the name Mother Light (ML). Through educational ses-
The good practices are transferred to those mothers in the community who have the same socio-economic conditions as ML, but whose children are undernourished or at risk of malnutrition. This also contributes to changing the child’s feeding, care and health habits, which will have a reverberating effect and benefit future generations.

This guide is a compilation of what has been learnt and experienced in different CWs given in Guinea, Malawi and Mali, with children experiencing different levels of malnutrition, and living in communities very different from one another. Our Aim with this guide is to improve the implementation, undertaking and follow-up procedures of the workshops. The guide provides the following:

### Causes of Malnutrition

1. Immediate causes: a connection between inadequate food consumption and illnesses
2. Indirect causes: have an influence on the immediate causes and which cover 3 areas: food security, public health and hygiene, and the social environment (habits and customs)
3. Basic causes referring to: institutional aspects; local priorities and resources; political, economic, social, and cultural contexts

---

**Chart 1. Causal tree of malnutrition**
1. Information on how to analyse the context in order to know if the implementation of a CW is justified.

2. The steps to follow for greater efficiency.

3. The essential elements to bear in mind, with the object of obtaining a higher quality intervention and follow-up.

4. The interaction with other interventions of W&S, Health and FS

5. Techniques for community participation.

In its elaboration, the following has been used:

1. Compilation and analysis of documents associated to CWs and to the PD methodology (See bibliography)

2. Compilation of experiences and results achieved in the previously mentioned countries.

Obviously knowledge is never complete. And perhaps this is the motive for continuous progress and updating. However, with our experience in different contexts, we consider its application is sufficiently justified.

2. DEFINITION OF THE PROGRAMME

2.1. WHAT IS A COMMUNITY WORKSHOP (CW)?

A Community Workshop is a community nutrition programme, and as such is based within the community and the home. It has been conceived in order to fight infant malnutrition, primarily among those with acute moderate malnutrition, or at risk of malnutrition. The methodology employed is that of the PD approach, which identifies the good practices and behaviours of mothers and people in charge of caring for the healthy and well nourished children of poor families. Those practices and behaviours are later transferred, through educational sessions and cooking demonstrations, to other community families who share the same socio-economic conditions and have malnourished children, or at risk of malnutrition.

This allows the community to learn how poor families can have well nourished children. By comparing malnourished children to healthy children from the same socio-economic background, the community learns how to find local solutions to fight malnutrition.

'Some solutions to the problems suffered by the communities already exist within the community -they need only be discovered'
The PD approach is the result of a series of studies carried out during the 1960s, '70s and '80s. The CWs originated in Haiti during the 1960s with the creation of the Rehabilitation and Nutritional Education Centres (RNECs which were established to rehabilitate severely undernourished children. The limitations of these centres were: their high cost ($6,000 per centre per year, in Haiti, in 1980), their dependence on imported animal proteins, and the three-month period needed for rehabilitation. To counteract these problems, other types of intervention were proposed, such as: child-growth follow-ups; periodical delousing; and lowering costs by reducing the three month period to two weeks. Interventions were being modified until 1991, when the PD approach was implemented in community nutrition, especially in Vietnam, where Save the Children/US applied PD to the CWs. With the implementation of PD in Vietnam, severe acute malnutrition was reduced from 15% to 2%. Later, the PD approach was successfully employed by other NGOs in seven other Asian countries: Bangladesh, Bhutan, Cambodia, Japan, Myanmar, Nepal and Pakistan; Haiti and Bolivia in Latin America; and in Africa: Egypt, Ethiopia, Guinea, Mali, Mozambique, Tanzania, and Senegal.

The PD approach is used in two phases during the implementation of CWs; its uses are determined as:

A method used to identify nutritional foods that mothers can give to their children, which are locally available within the community, and are also geographically and economically accessible.

A communication method used to convince the mothers of malnourished children that an approachable solution exists which can improve the nutritional condition of their children, and thus reduce morbidity and mortality rates.

Chart 2 summarises the CW main concepts/components:

<table>
<thead>
<tr>
<th>CHART 2. SUMMARISES THE CW MAIN CONCEPTS/COMPONENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Managed by the community</td>
</tr>
<tr>
<td>• Involves the participation of the community</td>
</tr>
<tr>
<td>• Empowers the community to discover its own solutions to malnutrition</td>
</tr>
<tr>
<td>• To use the proper practices identified during the home survey</td>
</tr>
<tr>
<td>• Regular nutritional follow-ups of child-beneficiaries</td>
</tr>
<tr>
<td>• Facilitates the integration of other components (i.e.: iron supplements, delousing, etc.) which contribute to the improved state of the children's health and nutrition</td>
</tr>
</tbody>
</table>

2.2. DEFINITION OF ESSENTIAL TERMS

Deviation. 'A person or conduct which deviates from the traditional method of doing things. Generally, the term ‘deviation’ possesses a negative connotation; however, it can be either positive or negative as it only implies a deviation from the norm'.

Positive Deviation / Positive Model. 'A person, whose behaviour or practices enable him or her to resolve a problem with greater success than his or her neighbours, who have access to the same resources and who also share the same risk factors. Within a malnutrition context, a PD child is a well nourished child who belongs to a family with scarce resources (following the village/community’s norm)’. Positive Deviation families have developed good culturally-appropriate practices which enable their children to have good health and nutrition, even though the risk factors exist.

Mother Light (ML). The most capable of the mothers from the positive model group; she is also the most readily available for volunteering.

Home. A setting where educational sessions on nutrition and nutritional rehabilitation are held. It is usually a public community space or the house of one of the volunteers.

Community Workshop (CW). Twelve days of sessions which are designed to facilitate the rehabilitation of children with acute moderate malnutrition, or at risk of malnutrition; and to teach PD behaviour and practices. Within the home and with the support of volunteers, supplementary recipes are prepared and given to the malnourished children.

The PD approach within the Community Workshop. This is a key concept. "This approach helps the individual members and the community as a whole to find existing and sustainable solutions to its problems, by understanding the behaviour of Positive Deviation people in that community'. Once these solutions are identified, the objective is to transmit these practices and habits to the other mothers with malnourished children in the community.

2.3. OBJECTIVES OF THE PROGRAMME

The purpose of the Community Workshop’s* programme is to determine the knowledge and local resources of poor communities so that they can quickly and independently rehabilitate their undernourished children in an accessible, sustainable and culturally appropriate manner. In Chart 3 the objectives of the CW’s programme are outlined:

<table>
<thead>
<tr>
<th>CHART 3. OBJECTIVES OF THE PROGRAMME</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To rehabilitate both the infant population (from 6 to 59-months-old) identified with acute-moderate malnutrition, and those at risk of malnutrition within the community, using available local products</td>
</tr>
<tr>
<td>• To empower families so that they themselves can sustain the rehabilitation of those children at home, thereby increasing their capacity and ability to take responsibility to resolve their own problems</td>
</tr>
<tr>
<td>• To prevent malnutrition in the community’s future infant population, through community positive behaviour in relation to the caring, feeding and health of their children</td>
</tr>
</tbody>
</table>
2.4. JUSTIFICATION FOR THE IMPLEMENTATION OF CWs

Before taking the decision to implement a CW programme, some criteria must be considered in order to know if the approach of the CWs is appropriate in a given situation. The effectiveness of the PD approach is directly connected to a community having the following characteristics:

- Unstable socio economic conditions
- A malnutrition rate of no less than 30% among children under the age of five - as defined by the Weight/Age Index
- Accessible food for the whole community
- The willingness of mothers to become volunteers
- The cooperation of both community leaders and those in positions of responsibility, being involved and active within the community.

2.4.1. CONTEXT

The Community Workshops can be implemented in post-emergency and developing situations, as well as in communities where negative community food practices have previously been associated as one of the immediate causes of infant malnutrition.

Also, in emergency situations where acute malnutrition rates surpass alarm thresholds, and where prevention already constitutes an essential component within the community, the CWs will be an additional component of the community’s response. Community members themselves will identify malnourished children in order to have them referred to health services where they can be treated.

Some general conditions will need to be taken into account as they are directly associated to the success of the Community Workshop’s programme.

The geographical proximity of homes: so that those in charge of the under aged can attend the sessions daily without having to walk great distances, and to facilitate the volunteers’ frequent visits to the homes of the beneficiary families.

The programme is more effective in those communities where at least 30% of the children are suffering from malnutrition, be it slight, moderate, or severe, as defined by the Weight/Age Index (W/A) and used by most of the Growth Monitoring Cards of Health Ministries. As it requires a high level of community participation, the programme would not constitute the best use of resources in areas where malnutrition is less than 30%. If your malnutrition rates seem to be low, please consider the possibility that not all children may have been registered.

A census and a nutritional registry (explanation following) will be carried out on community children in accordance with the Weight/Age Index (Annex 8).

Urban versus Rural settings. Though not through the direct experience of the ACF-E, success of CWs has been achieved in both urban and rural contexts by other insti-
tutions. In urban settings food is bought, while in rural areas the population grows its
own fruit and vegetables, and they can also fish or breed livestock. That urban areas
are more highly populated facilitates visits. Although the majority of programmes have
been implemented in rural areas, there are projects in semi-urban areas, such as the
one carried out in Guinea by ADAR.

Local displaced persons and refugees. CWs are not the best approach in these
cases, although they can constitute an effective tool to identify specific adaptation
strategies and skills, which would help certain families to better face their circum-
stances.

Populations whose land or communities have been illegally occupied. These are
unstable communities by nature, yet CWs can be considered on condition that an earn-
ings-generating component is included, to support the household food supply.

2.4.2. AVAILABILITY OF LOCAL FOODS

Local foods at reasonable prices should be available to the population so that the
community can sustain newly learnt behaviour associated with food. The foods can be
either bought or grown. It is more difficult to implement CWs in areas suffering from
droughts, long periods of food insecurity in the home (more than three months), and
in places where the main source of food comes from food support programmes.

The town’s markets and shops will be visited to determine the availability of food
at reasonable prices to the local population, and its nutritional values. A further in-
vestigation on the existence of seasonal foods, and an evaluation of the availability of
food grown in gardens, plots, as well as livestock or poultry will be carried out. This
quick market survey (Point 3.1) and other home surveys (Annex 1) will determine the
kinds of foods consumed by poor families.

It will allow us to design recipes based on locally available foods which are acces-
sible to the population.

2.4.3. MOBILISATION OF THE COMMUNITY AND COMMUNITY COMMITMENT

An indispensable prerequisite for the success of the CW’s programme is community
commitment, which plays a role as both agent and beneficiary. This indicates the level
of support the programme has, and is essential to achieve its goals.

As a first step (Chart 4), a meeting with the community leaders must be held in
order to inform them about the CW and its objectives; and negotiate with the moth-
ers their availability for the programme. The creation of a community dynamic facil-
itates the implementation of the programme. This dynamic is best achieved by clearly
defining the roles and responsibilities of each person involved in the project.

At the meeting with health personnel and community and religious leaders, an as-
essment may be carried out to discover if there is any concern about the health of
the community and a desire to reduce malnutrition. If the leaders do not recognise
malnutrition as a health problem, and do not commit to the CW’s programme, the
success of the strategy will be compromised. It is vital that they collaborate with the organisation of the programme's implementation.

<table>
<thead>
<tr>
<th>CHART 4. ASPECTS TO BEAR IN MIND IN ORDER TO HAVE A GOOD RELATIONSHIP WITH THE COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before each visit:</strong></td>
</tr>
<tr>
<td>• Share with the other members of the team the purpose of the visit</td>
</tr>
<tr>
<td>• Review with the team the information which attempts to be compiled as well as the tools employed</td>
</tr>
<tr>
<td>• Inform community leaders about the date and time of the visit to be able to talk about the programme</td>
</tr>
<tr>
<td><strong>During the visit:</strong></td>
</tr>
<tr>
<td>• Always attempt to seek out community leaders</td>
</tr>
<tr>
<td>• Inform them of the purpose of the visit, the activities we would like to undertake and why</td>
</tr>
<tr>
<td>• Draw a map of the community to identify the homes and which of them are located on the periphery</td>
</tr>
<tr>
<td>• The topics to be covered are:</td>
</tr>
<tr>
<td>- The health condition of the community, especially of those children under the age of five.</td>
</tr>
<tr>
<td>- The availability of a pair of volunteers to be community agents</td>
</tr>
<tr>
<td>- The availability of mothers willing to volunteer</td>
</tr>
<tr>
<td>- To describe the role/responsibility of each person</td>
</tr>
<tr>
<td>- To collaborate with the existing health personnel</td>
</tr>
<tr>
<td>• Fix the date and time for following visits, and specify with whom</td>
</tr>
</tbody>
</table>

The contributions volunteers and carers bring to the workshops include moral support and raw materials. These contributions finance the programme and determine its success or failure.

The responsibility to collect the basic materials for the development of the CW sessions will need to be shared among all community members, ACF-IN and those in charge of the children. At the beginning it may be necessary for ACF-IN to contribute more food for rehabilitation. However, once the community has witnessed the change from undernourished to healthy children and understands the value of the CWs, there will be an increase in the value they give to the programme and their willingness to meet its costs.

Those responsible for the children must comply with the requirement of bringing the PD foods (nutritional and accessible) to the sessions, and to practice other behaviours such as hygiene.
A PD woman from within the community will need to be voluntarily available to commit to the programme for a minimum period of two months. She will be the key human resource of the project and is called Mother Light (ML). The ML will be responsible for holding the educational sessions, transmitting simple messages to the other mothers, preparing food, carrying out cooking demonstrations, and supervising the mothers and others who are responsible for the children. If there are programmes other than the CWs underway in the community, ensure that MLs are not overloaded with work and responsibilities.

Individuals collaborating in the decision-making process are more likely to change attitudes and behaviours than those who only received information on the matter.

### 2.4.4 SANITARY AND HEALTH INTERVENTION STRUCTURES AT A COMMUNITY LEVEL

It is important to evaluate the existence and current state of complementary public health and development programmes, with the aim of improving the conditions of health and nutrition for the infant population.

The available public sanitary resources will need to be identified, firstly, because they are a necessary source of information, and secondly, because of their potential for integration into possible projects. It is important to know the individuals who make up the community’s health sector: local traditional healers, midwives, etc., as they are often the only health source available in the community.

It is important to ascertain the services and systems available to carry out nutritional follow-ups, to identify and select malnourished children, and to measure the capacity to collect information on vital events such as births, diseases and human migration. Malnourished children in need of CW can be identified through growth monitoring programmes. A community population register compiling the details of the nutritional condition for all children under the age of five will be needed.

### 2.5. ADMISSION AND SELECTION CRITERIA

All 6 to 59-month-old children with acute moderate malnutrition, or at risk of malnutrition (following the W/H Index) and their mothers or carers, are to be accepted into the workshops.

**Child admission criteria:**

- Firstly a register of the nutritional condition of all 6 to 59-month old children, following the Weight/Age Index (Table of Annex 8) should be carried out in the community. Children with severe malnutrition will be classified in red, and those with moderate malnutrition will be classified in yellow. Children having adequate weight for their age will be classified in green.

- Results are to be entered in the record of Annex 5.a.
- The children classified as yellow or red will again be weighed and measured in order to classify them in accordance with the W/H Index. This is a pre-selection and the results are to be entered in the record of Annex 5b.

- A final child selection will be made by observing the results of record 5b, registering the children with a W/H % = or <70% and < or = 85%. These final results will be reflected in the record of Annex 5c, and those children will be accepted for the workshop.

- A minimum of eight and a maximum of 12 children with a W/H % between 70% and not > 85% will be included in a workshop. If in a community the final number of children is fewer than eight, those belonging to a neighbouring village, and who fit the admission criteria, should be included. If there are more than 12 children, two workshops will need to be implemented within the same community.

**Selection criteria for 'Mother Light':**

- Of those classified in green at the beginning, during the registering of the children’s nutritional conditions, a total of four are to be selected to carry out the HSs. (Annex 1 & 2).

Selection criteria for the Mother Light are:

- that the mother does not have a child who had a low birth weight
- that the child is not currently losing weight
- that the child is not sick
- that the child is between six and 59 months old
- that the mother has at least two children
- that she is geographically representative (located in the core or periphery of the community)
- that she is both professionally and socially a part of the group of mothers.
- must not be related to a community leader
- must belong to a poor family according to the poverty indicators established by the community (i.e. the number of months per year without basic food in the home, family income, etc.)

The aim is to identify the positive behaviours of PD families, and from among them, select the mother with the best practices and knowledge of nutrition, hygiene and health, and with the greatest availability to volunteer to be Mother Light.
2.6. ADVANTAGES AND DISADVANTAGES OF COMMUNITY WORKSHOPS

### TABLE 1. ADVANTAGES AND DISADVANTAGES OF CWS

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defrayable: Low cost, and families are not dependent on external resources as it is based on locally available resources</td>
<td>A risk of becoming dependant on supplementary food distributed at the workshop</td>
</tr>
<tr>
<td>Community participation. Managed and evaluated by the community. Discovery of existing solutions within the community</td>
<td>Large amounts of time and effort are required by the supervisors</td>
</tr>
<tr>
<td>Fast, visible, and sustainable progress</td>
<td>Irregular participation of mothers at the sessions</td>
</tr>
<tr>
<td>NoBoth nutritional rehabilitation and prevention. Best use of health services</td>
<td>The home positive model surveys need to be repeated in each community</td>
</tr>
<tr>
<td>Both culturally acceptable and respectful of local knowledge. Increased value is given to local foods</td>
<td>On-going monitoring requiring a large number of records</td>
</tr>
<tr>
<td>Primarily based on behavioural change, rather than the acquisition of knowledge. Pre-existing positive behaviours and strengths are sort out and reinforced</td>
<td></td>
</tr>
</tbody>
</table>

### RECOMMENDATIONS

- Best results are obtained when there is a period of intense negotiation with the community before beginning any part of the programme. The CWs are a good learning opportunity for any member of the community.
- It is helpful to know when mothers, CAs, and MLs may not be available to volunteer so that none of the phases of the programme is hindered.
3. PLANIFICATION AND ORGANISATION OF THE PROGRAMME: PHASES OF INTERVENTION

3.1. PREPARATION (approximately six weeks)

1. Evaluation of the area. Carry out a quick analysis of the area in order to evaluate whether or not the implementation of a CW is justified (Point 2.4, above). With this analysis, the project manager (PM) and supervisors will collect all the additional useful information for the community. The project manager will be responsible of filling out the following form, plus all other required information, as detailed in Point 2.4.

Chart 5 below briefly indicates some of the methods most commonly employed for quick assessment. They are low cost and include informal methods such as conversations and short visits etc., and formal methods, such as surveys and studies. They allow for the systematic gathering of all information required through actions and/or representations.

<table>
<thead>
<tr>
<th>CHART 5. QUICK EVALUATION TECHNIQUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Interviews with key people. Usually a group of 15 to 20 people, selected according to their knowledge and different points of view. The interviews are qualitative and semi-structured. A topics’ guide is used.</td>
</tr>
<tr>
<td>• Focus group. Several homogenous groups of 8 to 12 people discuss a topic introduced by a moderator, who directs the discussion and ensures that all participate.</td>
</tr>
<tr>
<td>• Interviews with the community. They are held in an open, public space with any member of the community. The interaction between the interviewer and the participants follows a topics’ guide prepared prior to the interview.</td>
</tr>
<tr>
<td>• Direct observation. Observation teams note all they have observed and heard of the programme, by using an observation form. This is completed while undertaking other activities, such as interviews or discussions. In the CWs, this technique is employed during the HV (HS).</td>
</tr>
<tr>
<td>• Short surveys. Twenty five to 30 randomly selected individuals. Structured interviews are used where there are a number of closed questions. This provides quantitative data which can quickly be analysed.</td>
</tr>
</tbody>
</table>

2. Elaboration of agreements. To establish an agreement with the Health Ministry to both implement the project and secure its sustainability through a later integration of the programme.
**RECORD 1. INFORMATION ON THE COMMUNITY**

I. GENERAL INFORMATION (can be recorded during the meeting with community leaders)

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>&lt;5 year-olds</th>
<th>&lt;5 year-olds</th>
<th>6-16 year-olds</th>
<th>17-60 year-olds</th>
<th>&gt;60 year-olds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attach agricultural calendar & brief description of activities undertaken by other institutions (if any) within the area.

II. WATER & SEWERAGE DATA

<table>
<thead>
<tr>
<th>WATER</th>
<th>NO</th>
<th>YES</th>
<th>Distance from the community</th>
<th>Access</th>
<th>Easy</th>
<th>Difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stream</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>River</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wells</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wells</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEWERAGE</th>
<th>WHO BUILT THEM?</th>
<th>CONDITION</th>
<th>Empty</th>
<th>Half full</th>
<th>Full</th>
</tr>
</thead>
<tbody>
<tr>
<td>N°. of community toilets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N°. of traditional toilets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOOD SECURITY</th>
<th>Period of year (indicate month) with</th>
<th>Main activities within the community</th>
<th>Is there enough food at the market?</th>
<th>Do you buy foods?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most food</td>
<td></td>
<td></td>
<td>YES / NO. What is lacking?</td>
<td>Yes. What?</td>
</tr>
<tr>
<td>Least food</td>
<td></td>
<td></td>
<td></td>
<td>NO</td>
</tr>
</tbody>
</table>

iii. DATA ON FOOD SECURITY

- Has the community received food support in the last month? YES /__/ NO /__/ 
- Market day is on /____________________/ 

<table>
<thead>
<tr>
<th>IV. DATA TO COLLECT FROM THE VILLAGE’S HEALTH CENTRE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and job position / _____________________________/</td>
<td>Opening hours: /____________________/</td>
</tr>
<tr>
<td>Are there any Nutritional Recovery Centres? YES/<em><strong>/ NO /</strong></em>/. If so, where? /_______________/</td>
<td></td>
</tr>
<tr>
<td>When did it open? /_______/ and which institution runs it? /________________________________/</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH &amp; NUTRITION</th>
<th>YES NO</th>
<th>Distance</th>
<th>Means of transport</th>
<th>Cost of consultation</th>
<th>Cost of hospital referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kind of Health Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Traditional Healers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available nutritional data</td>
<td>MUAC</td>
<td>W/H</td>
<td>W/A</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Four main causes of mortality</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>Main causes of morbidity</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>Vaccination data</td>
<td>Nº of vaccinated children</td>
<td>Date of vaccination (Jan04, Feb05...)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. To inform at a regional and district level. ACF-E will present itself to the regional and/or district representatives, giving information on the projects and the CW programme.

4. To identify other local and or international NGOs currently holding or interested in holding CWs, and invite them to the training which will be developed.

5. Meeting with community leaders: Information and negotiation.
   A meeting will also be held with the members of different committees, ie: religious and health leaders.

INFORMATION

a. Presentation of ACF-E and of the programmes being carried out in the area, and their progress. The beneficiary population will be specified for each of them.

b. Information on the CW Project: Definition, methodology, required activities, and an explanation as to why these activities need to be held (KAP surveys, nutritional census, market survey, HVs, etc.). Information regarding the beneficiary selection criteria, so that it is understood why not all the community’s children can join the programme. And that CWs are developed with a minimum of 8 and a maximum of 12 children per workshop.

c. To inform when the nutritional census will be taken in order to achieve better organisation and cooperation. And a calendar, listing all the activities to be carried out, will be provided to them.

d. To inform about the possibility that a CW would not be held in their community if the results obtained in the nutritional census are satisfactory\(^2\).

e. To produce a seasonal agricultural food calendar (Annex 9) giving information on the availability of foods according to the different seasons, which will then be used to develop the different menus. It will be compiled by the project manager, who will attach it to Form 1 (Information on the Community) as previously mentioned.

f. To find out the places where people of the community stock up on food (the market, shops, neighbours, neighbouring communities, etc.,) and later carry out the market survey in those places.

\(^2\) In that case, when knowing the results, we will give our thanks for their collaboration
g. **To identify where the CW will be given and select the place where training could take place.** The CW must be given in a place easily accessible by all participants. It must be able to accommodate up to 12 children and their mothers, and facilitate cooking. There must be a source of drinking water, and toilets nearby. If an appropriate community space does not exist, a house of one of the mothers could be used, or, indeed, the health centre. Regardless, all the sessions taking place during the sessional phase must be held there.

**NEGOTIATION**

A conversation must be held with community leaders and health agents, etc., expressing the need to carry out the activities and sessions in the following manner:

h. To mobilise the mothers on the day of the nutritional census; to inform them that there will be no provision of supplies or payment of taxes, but that the children will be weighed to measure their nutritional condition. It will be essential that they attend with their health card or equivalent, to verify their age.

i. To emphasise the ability CWs have to bring about positive behavioural change in the home, and in the condition of the children.

j. The possibility of nutritional rehabilitation through locally available foods.

k. Learning through repeated practice, good habits within a safe environment.

l. Precision in the duration of the workshops: twelve/12 days of sessions, given in the following manner: six workshop days followed by a rest day, followed by six workshop days.

m. Availability: mothers with malnourished children participate in the workshop, and confirm their attendance each day during the two weeks. The availability of the CAs for voluntarily carrying out the nutritional census, and the KAP and the HVs surveys, will be negotiated.

To evaluate the possibility of giving kitchen utensils to the ML, and a bicycle to the CA once the session phase has been concluded.

n. Four or five (4 or 5) hours per session. The last hour and a half will be reserved for the dissemination of IEC messages. On the first and last days, six-hour sessions will be needed as the children will be weighed and measured.

o. Daily food contributions from the mothers to the workshop.
6. **Human Resource Selection**

At the beginning it will be necessary to define the type of personnel who will be needed in the different phases of the programme, and for the development of the activities. A distinction between volunteer and remunerated personnel will be made. The needed personnel are:

**Volunteer personnel**

The person will be provided with a description of all the activities he or she will be committed to carry out in a voluntary manner. The following job positions will be required:

- One or two Community Agents (CAs) per CW.
- One ML per CW.
- A Health Agent responsible for the community where the CW will be given. It is possible that one agent may be responsible for ten communities, of which eight are holding CWs.
- A traditional healer, a local midwife, a religious leader, and a community leader or teacher of the community in which the CW is held.

**Remunerated personnel**

- A project manager
- An On-site agent (OA) for approximately each two to three workshops
- A supervisor for each five or six CWs. The number will depend on the geographical distance between CWs.

Subsequently job descriptions are to be carefully outlined. They define a role, and list responsibilities and activities to be completed by each agent. By providing this in writing, people know what is expected of them, and are also provided with a guide for the on-going development of the skills needed to carry out the job.

The examples of job descriptions may be modified according to locally available resources.
MOTHER LIGHT
(Positive Deviation)

Description: A volunteer selected according to the requisites listed below. She becomes the reference woman for the whole community because of the good ways she has herself developed.

Under the supervision of: On-site Agents (OAs)

Name and surname ___________________________________________ Starting date __ / __ / ______

Community in which she will work ____________________________________________

Times she is committed to work ____________________________________________

I. REQUISITES

• A willingness to work as a volunteer during the full period - from beginning to end - of the three phases of the CW, and full time, during the 12 days of the sessional phase.

• A mother with healthy and well nourished children.

• Who has the same socio-economic and socio-sanitary conditions as the other families with malnourished children, and who also shares the same risk factors.

• Who has acquired at least four good food, sanitary, caring and hygiene practices.

• Who has an interest in the food and health care of the child at a community level.

• Respected and trusted by the community.

• Dynamic, sociable, and from the village where the CWs will be carried out.

• Willing to learn and open to new ideas.

• Who knows how to read and/or write, at least.

II. TASKS TO CARRY OUT

(Please refer any doubt, problem or incident to the On-site Agent)

• To attend all the programme’s different training courses.

• To welcome the mothers at the beginning of the CW.

• To encourage the mothers to play with the children and keep them distracted during the sessions of the CW.

• To encourage and motivate the other mothers, ie: to collect the ingredients, and by visiting them during the follow-up phase.

• To keep, with the help of the other mothers, the location of the CW and the kitchen utensils clean.

• To share out the tasks among the other mothers.

With the help of the CAs:

• To weigh the children on the first and last days of the CW.

• To monitor the children’s rehabilitation, by the results obtained at the previous weighing, during home visits in the 1st, 2nd, 6th and 12th month after the 12-day CW.

• To elaborate on the details of the recipe with the help of two other mothers (cooking demonstrations), and later to serve the food.

• At the end of each session, and with the help of all mothers, choose a culinary recipe to be made on the following day. To manage and quantify the ingredients.

• To actively participate in spreading the IEC messages in a simple manner.

• To supervise the mothers and those others in charge of the children during the preparation of food and feeding.

• To be responsible for the hygiene of the mothers and children, before, during and after the CW.

• To detect any child with an illness, and with the help of a health carer, referred him or her to the health centre.

• To encourage mothers to maintain the new nutritional practices learnt during the CW sessions.

At (location) _____________________, On (date) ___ / ___ / ____________

Project Manager The Volunteer
THE COMMUNITY AGENT (CA)

Description: A volunteer selected on behalf of the community by the members of a community based committee. Will work closely with the ML.

Under the supervision of: the On-site Agents

Name and Surname __________________________________________ Starting Date __/__/____

Community in which he or she will work ________________________________

Committed to work for the following hours ______________________________

I. REQUISITES

• A willingness to work as a volunteer for the required period during the three phases of the CW: s/he will be available for the community and the CWs for as much as s/he is needed.

• To better develop trust and respect, s/he must be a member of the community - or from a very near-by community - where the CW will be held.

• To be interested in the food and health care of children at a community level.

• Able to encourage others, and to have experience with communities.

• To be calm, patient, organised, responsible, flexible and dynamic.

• Willing to learn from less-able people.

• Excellent interpersonal and communicative skills.

• Able to read and write.

II. TASKS TO CARRY OUT

(Please refer any doubt, problem or incident to the On-site Agent)

• To attend to all training courses for the duration of the programme.

• To carry out a child census whenever necessary and classify them according to their nutritional state. A pre-selection will be carried out by using the Weight/Age Index.

• To circulate the results of the children’s nutritional condition, and on the good/bad feeding, sanitary, health and care practices in the community.

• To weight and measure the children and to carry out a final selection according to the Weight/Height Index.

• To participate in the selection of the ML: home visits, HSs and 24-hour food reminder

• To be respectful and kind during a visit, and to clearly explain its purpose. To remind that s/he is there to learn, so avoid making criticisms or having disagreements, as well as giving any signs of approval.

• To help the OAs and ML to fill out the 24-hour Reminder form and the HS form.

• To know the extent of the mothers participation and their contribution to the sessions.

• To maintain a dynamic community: to support the fathers and community leaders as they mobilise and motivate the mothers who will participate in the CW.

• To be responsible for the anthropometric and CW material: Daily stocktaking and follow-up

• To maintain the register correctly and regularly update it: to complete the required sheets/forms and to hand them to the OA, who will pass them on to the supervisor.
With the ML:

- To weigh the children on the first and last day of the CW.
- To monitor the children’s rehabilitation, by the results obtained at the previous weighing, during home visits in the 1st, 2nd, 6th and 12th month after the 12-day CW.
- To make the recipe with the help of two other mothers (cooking demonstrations), and later to serve the food.
- With the help of all the mothers at the end of the session, choose a culinary recipe to be made on the following day. To manage and quantify the ingredients.
- To actively participate in the giving of the IEC messages in a simple manner.
- To supervise the mothers and those others in charge of the children during the preparation of food and feeding.
- To be responsible for the hygiene of the mothers and children, before, during and after the CWs.
- To encourage mothers to preserve the new nutritional practices learnt during the CW sessions.

With the assistance of the community health personnel:

- A nutritional follow-up of the community’s children to prevent future malnutrition cases.
- To delouse and distribute the vitamin A and iron supplements at the beginning of the first day of the CW, before weighing and measuring the children.
- In the event of illness, coordinate the referral of children to the health centre.
- To be responsible for the follow-up of the referral sheets, and to hand them to the OA, who will pass them on to the supervisor.

At (Location) _____________________ on (Date) ___ / ___ / ____________

Project Manager ___________________________ The Volunteer ___________________________
**COMMUNITY HEALTH AGENT**

**Description:** A voluntary or a paid position (by the country’s health department). Working in close cooperation with the CAs and MLs, and with the support of the OAs.

**Under the supervision of:** The Ministry of Health and the On-site Agents.

(To be filled out when a Health Officer covers different communities)

<table>
<thead>
<tr>
<th>Name and surname</th>
<th>Starting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community in which s/he works</td>
<td>Day of the week</td>
</tr>
<tr>
<td>The hours s/he works at health centre</td>
<td></td>
</tr>
<tr>
<td>Community in which s/he works</td>
<td>Day of the week</td>
</tr>
<tr>
<td>Hours s/he works at health centre</td>
<td></td>
</tr>
<tr>
<td>Community in which s/he works</td>
<td>Day of the week</td>
</tr>
<tr>
<td>Hours s/he works at health centre</td>
<td></td>
</tr>
<tr>
<td>Hours s/he is committed to work with the CW</td>
<td></td>
</tr>
</tbody>
</table>

**I. REQUISITES**

- A willingness to work for the required period during the three phases of the CW: s/he will be available for the community and the CWs for as much as s/he is needed.
- To better develop trust and respect s/he must be a member of the community - or from a very near-by community - in which the CW will be carried out.
- To be interested in the food and health care of the child at a community level.
- To be, calm, patient, organised, responsible, flexible and dynamic.
- Willing to learn from less-able people.
- Able to read and write.

**II. TASKS TO CARRY OUT**

*Please refer any doubt, problem or incident to the CA who will contact the OA.*

- To ensure that any child requiring medical treatment receives it.
- To participate in the review, analysis and circulation of results obtained through the CW programme.
- To participate in the negotiations with community leaders.
- To participate in the OA, CA, and ML training courses.
- Before distributing the vitamin A and iron supplements check the child’s health/vaccination card in order to verify that the child has been vaccinated. Give reminders about future visits, and the importance of following the vaccination calendar.
- Record the follow-up on children’s growth for the health centre.

*In coordination with the CA:*

- Nutritional follow-up of the community’s children in order to prevent possible cases of malnutrition.
- To delouse and distribute the vitamin A and iron supplements before weighing and measuring the children, at the beginning of the first day’s CW sessions, following the ACF-E protocol.
- To receive any child referred to the health centre due to illness. To complete the referral sheet, and give a copy to the CA. To file the referral sheets at the health centre.

At (Location) _____________________ On (Date) ___ / ___ / ____________

Project Manager The Volunteer
FATHERS, COMMUNITY LEADERS

Description: Imams, village chiefs or neighbourhood leaders, grandparents, etc. Their involvement is negotiated at the very beginning during the preparation phase, to obtain their consent and support.

In close cooperation with the CAs and the ML, and with the support of the OAs.

Fathers also play an important role in the rehabilitation of children. They are usually responsible for the financial contribution of the family, and must be involved in the follow-up of the child’s growth and the support of the mother’s participation for the monthly weighing. The grandparents also play an active role in the education and development of the children.

Under the supervision of: the On-site Agents.

Name 1 ____________________ Role (father, community leader, etc) _______________________
Name 2 ____________________ Role (father, community leader, etc) _______________________
Name 3 ____________________ Role (father, community leader, etc) _______________________
Name 4 ____________________ Role (father, community leader, etc) _______________________
Name 5 ____________________ Role (father, community leader, etc) _______________________
Name 6 ____________________ Role (father, community leader, etc) _______________________
Name 7 ____________________ Role (father, community leader, etc) _______________________
Name 8 ____________________ Role (father, community leader, etc) _______________________
Name 9 ____________________ Role (father, community leader, etc) _______________________
Name 10 ___________________ Role (father, community leader, etc) _______________________

Date of the meeting __/__/____
Community ________________________________________

I. REQUISITES
- It is essential to be motivated and to believe in the programme and its purposes.
- To be involved in the development of all activities during the different phases of the programme.
- To show interest in the food and health care of the child at a community level.

II. TASKS TO CARRY OUT
(Please refer any doubt, problem or incident to the CA who will contact the supervisor).

The activities to be carried out by the community leaders are:
- To raise the awareness of mothers with a malnourished child so that they participate in the CW
- To mobilise mothers to have their 6 to 59-month-old children weighed
- To contribute to the gathering of all the ingredients required for the CW: to give ingredients
- To give advice to their children
- To look after the children when the mother is absent or working.

The activities regarding the fathers:
- Contributions of finance and food during the CW
- To encourage mothers to systematically weigh their children, and to participate in the CW activities while the child is malnourished
- To give affection to the children, as their mothers would do
- To accompany the mothers to the health centre when needed
- To support in the home, the use of the recipes and the health of the breastfeeding mother.

At (Location) _____________________ On (Date) ___ / ___ / ____________

Project Manager The Volunteer
ON-SITE AGENT (OA)

Description: A paid position remunerated by the organisation and/or the country's health department.

Under the supervision of: the supervisors

Name and surname ________________________________  Contract's starting date ___/___/_____

Work place ______________________________________

(An availability to work extra hours depending on the activities. Depending on the week, Saturday could be a work day)

I. REQUISITES

• To be interested in the food and health care of the child at a community level.
• Having experience in working with communities. To develop trust and respect in the community.
• S/he might not necessarily belong to the health sector, but professional experience in nutrition would be valued.
• To be calm, patient, flexible, organised and responsible.
• Willing to learn from less-able people.
• Being a good listener and having excellent interpersonal skills.
• High level of the local language and communication skills.
• Able to read and write.

II. TASKS TO CARRY OUT

(Please refer any doubt, problem or incident to the supervisor.)

• To attend all training courses for the programme.
• To be responsible for preparing the CAs and ML during the preparation phase, under the supervision of the supervisor.
• To ensure the CAs and ML carry out all their tasks, as defined in the job descriptions, correctly.
• To support and give technical follow-up to the CAs, ML and health agents, and give regularly information updates to the supervisor.
• Responsible for the identification and registration of the beneficiaries.
• To supervise/help the CAs weigh the 6 to 59-month-old children to evaluate their nutritional condition. To fill in the pre-selection forms in accordance with the Weight/Age Index, and make the final selection of beneficiaries of the programme. To detect and immediately rectify any mistakes made during the measuring and weighing.
• To actively participate in the selection of the ML. HSs, 24-hour food reminder.
• To elaborate the IEC messages with the help of the CA and the ML. The circulation of these messages will be through the use of images and the active participation of the CA and ML. They will ensure that the IEC messages are correctly understood by the participating/interested mothers.
• To direct the selection of the menus by consensus with the CAs, ML and CW-participating mothers each day, at the end of workshop. This way, mothers can provide the ingredients required for the following cooking demonstration.
• To direct the market survey and accompany the CAs and ML as they carry it out.
• To organise a daily meeting with the CAS, ML and participant-mothers, to be held at the end of the session.
• To ensure all the utensils used for the preparation and eating of the meals are clean. To ensure hygiene norms are respected before and after the meals.
• To be responsible for the anthropometric and CW material.
• To support the CAs and health agents on the first day of the CW sessions, in the systematic treatment (Mebendazole/Albendazol, iron), following the ACF-E protocol.
• To raise the awareness of the CAs and ML of how important the nutritional follow-up phase is once the CW’s sessions have finished.
• To be responsible for carrying out a correct register and to systematically update it: to review all needed sheets/forms provided by the CA and ML and to hand them to the supervisor.
• To be responsible for the follow-up of the referral sheets provided by the CA. To give them to the supervisor, who will pass them on to the project manager.

### III. SERIOUS FAILURES WHICH MAY WARRANT A WARNING OR DISMISSAL

- Failure to comply with the internal rules of ACFIN
- Failure to complete working hours or unjustified absence
- Incorrect undertaking of the tasks entrusted with
- Lack of respect for the beneficiaries

At (Location) _____________________ On (Date) ___ / ___ / ____________

Project Manager _____________________ The employee _____________________

Depending on the development of the programme, the list of responsibilities may be modified.
**SUPERVISOR**

**Description:** A paid position remunerated by the organisation and/or the country's health department.

**Under the supervision of:** the project manager

Name and Surname_____________________________ Contract's starting date __/__/________
Number of OAs in charge of_________ Number of CAs in charge of__________
Work place __________________________________
Work hours ______________________ (An availability to work extra hours depending on the activities)

I. **REQUISITES**

- S/he might not necessarily belong to the health sector, but professional experience in nutrition will be valuable.
- Experience in personnel management
- A high level in the local language and communication skills.
- To be flexible, calm, patient, organised and responsible.
- To be a good listener with excellent interpersonal skills.
- To have a capacity for problem-solving at ground-level.
- To respect those s/he supervises, and their suggestions.

II. **TASKS TO CARRY OUT**

(If any doubt, or a problem or incident is greater than her/his authority, please refer it to the project manager).

- To attend all the programme’s training courses.
- To be responsible for preparing the OAs, health agents, etc.
- To give technical support to Human Resources, mainly during the execution phase of the workshop.
- To ensure that the OAs, the CAs, the ML and health agents correctly carry out all tasks contained in their job description.
- To invite the fathers, local authorities, and religious leaders to the opening of the workshop.
- To supervise:
  - The OAs when preparing the CAs and ML.
  - That the OAs, CAs, ML and health agents correctly carry out all the tasks contained in their job descriptions, and keep the project manager up-to-date.
  - The anthropometric taking and undertaking of the home visits.
- To help the project manager inform and mobilise the communities during the development of the programme.
- To distribute the work material and/or utensils to the OAs so they in turn can distribute them to the appropriate people.
- To ensure, through the OA, that the administering of medicines during the systematic treatment is rigorously respected by the CA and the health agents, in accordance with ACF-E protocol.
- To assist the OAs in the selection and training of the ML, and with making the recipes.
- To ensure that all hygiene norms are strictly respected by all in the workshop.
- To verify agreement between the OA’s reports and the follow-up form data.
- To control and ensure that the referral sheets are correctly filled out. To review the sheets/records provided by the OA - including the referral sheet (if that’s the case) and hand them to the project manager.
- At the close of the workshop, to make a programme evaluation with the community regarding its positive effects on the nutritional condition of the children. AND to share that which did not go so well.

III. **SERIOUS FAILURES WHICH MAY WARRANT A WARNING OR DISMISAL**

- Failure to comply with the internal rules of ACFIN
- Failure to complete working hours or unjustified absence
- Incorrect undertaking of the tasks entrusted with
- Lack of respect for the beneficiaries

At (Location) _____________________ On (Date) ___ / ___ / ____________
Project Manager The Employee

Depending on the development of the programme, the list of responsibilities may be modified.
**PROJECT MANAGER**

**Description:** a paid position remunerated by the organisation.

**Under the supervision of:** expatriate nutritionist-doctor coordinator (NDC).

**Name and surname** _______________________________ **Contract's starting Date** __/__/______

**Work place** (Based at the office, and frequently available to be on site to supervise the teams and functioning of the CWs)

**Work hours** _______________ (With an availability to work extra hours depending on the activities)

**I. REQUISITES**
- To have professional experience in nutrition, primarily community nutrition.
- Good pedagogue. Training experience will be of value.
- Experience in personnel management.
- To be calm, patient, flexible, motivated, dynamic, organised and responsible
- To be a good listener, and have excellent interpersonal skills.
- It is essential to have IT skills.

**II. TASKS TO CARRY OUT**
*(If any doubt, or when a problem or incident is greater than her/his authority, please refer it to the Nutritionist-Doctor Coordinator.)*

- To be responsible for the proper implementation and ongoing maintenance of the programme. To actively collaborate with the DNC with the aim of obtaining a high quality programme.
- To assist the NDC in his/her organising, administrative and logistic tasks needed to undertake the CWs activities, i.e.: personnel management, team organising, material preparation, orders, delivery of equipment to site, organising and supervision of activities, etc.
- To define the activities to be carried out in cooperation with the NDC, and to ensure the activities carried out by the teams are respected.
- To be a source of community information: with the support of supervisors to inform and mobilise the community, and contact community leaders and committee members - if any.
- To raise the awareness of, and to negotiate with the communities for their involvement in the programme.
- To coordinate with the community leaders, the Ministry of Health, and involved members.
- To manage both the final selection of the ML and the daily-menu recipes.
- To organise and direct a meeting - at least weekly - with the supervisor and the OAs, allowing them to carry out a follow-up, and the efficient management of the CW activities.
- To verify all records completed on-site, and to make all the required modifications before handing them to the NDC.
- To monitor and evaluate the results.
- To write a final report on the execution phase of each workshop, with statistical data, situation analysis and appropriate suggestions.
- To make suggestions to redirect the approach if need be.

**III. SERIOUS FAILURES WHICH MAY WARRANT A WARNING OR DISMISAL**
- Failure to comply with the internal rules of ACFIN
- Failure to complete working hours or unjustified absence
- Incorrect undertaking of the tasks entrusted with
- Lack of respect for the beneficiaries

At (Location) _____________________ on (Date) ___ / ___ / ____________

Project Manager ___________________________ The Employee

*Depending on the development of the programme, the list of responsibilities may be modified.*
Once the work positions have been described, the contraction of the personnel is to begin. The following steps are to be followed:

- **Give public notice of the contract**, listing the needed requisites and documentation for the post, and noting the time and date for lodging documentation.

- **To advertise the position**, including all requisites for the job. (See example in Annex 10)

- To publish the **candidate pre-selection**, inviting the three (or more) finalists to take a written test and attend an interview. (See example in Annex 11)

- **To give the written test**, and conduct the **interview**. (See test example for On-Site Agents, in Annex 12)

- After the test and interview are both completed, a **final selection** of the candidates will be made. This is to be published, and at the same time they are to be given information on the training and work to be undertaken. (See example, Annex 13)

7. **Team training** (CAs, OAs, supervisors, health personnel, etc.) (More details, Section 10)

   a. To evaluate training needs. To consider their aptitudes and which skills will need to be improved; this can be done through the pre-test.

   b. To select training contents and prepare training materials. An example of a training module has been attached to Annex 4.

   c. Post-training test as an evaluation method.

The training contents are to include an orientation guide on how to carry out the HVs and HSs.

8. **Adaptation of Home Survey (HS)** (Annex 1) Depending on the local context, the HS model is to be adapted, by assessing all those questions which may give useful information. The HSs consist of asking a series of questions to the members of the family, as well as making observations on the condition of the home, with the intention of noting any good nutritional, health, hygiene and child-care habits. There is an observation sheet at the end of the questionnaire (Annex 2) in order to confirm/contradict whatever the mothers say during the interviews.

9. **Revision of materials** for the taking of the census and the HVs (See Section 8)

10. **To take the Nutritional Census** of 6 to 59-month-old children, following Weight/Age Index (See Table in Annex 8). To classify them accordingly as well- or
mal-nourished: Green-coloured band for well-nourished children, Yellow for children with moderate malnutrition, and Red for children with severe malnutrition (the latter are to be referred to the nearest NDC, failing that, to the hospital). Those children suffering a congenital illness, or who have any physical or mental handicap will be excluded. Verification of a child’s age will be done by checking their health card or any other proof-of-age document.

The CAs will be responsible for filling in the population registers of the nutritional condition of the 6 to 59-month-old children (Annex 5.a). They will fill out as many forms as the number of children who participated in the census.

11. To plan the HVs with the families once the nutritional census results have been analysed. The homes of those children classified - according to the poverty criteria defined by the community - as well-nourished (green-coloured band) and belonging to poor families, will be selected. Bear in mind the distances of homes, and that the CAs will ask families if HVs can be carried out in their homes, thereby ensuring their presence on the programmed day.

Once the HV has been programmed and the CA has ensured the family’s presence at the selected home, proceed with the home visit, using the HSs (See Annex 1 & 2) and the 24-hour reminder (See Annex 3). The aim is to identify four PD families and, among them, identify the ML.

The 24-hour Reminder is useful for the food regime follow-up: it will indicate what foods and drinks the mother gave the child in the previous 24 hours. This information is collected by the CA. This reminder is based on the FADU principle:

i. Meal frequency: number of meals, access to food in the home, preparation time, means to cook and to keep cooked meals.

ii. Amount: the amount relative to the number of people sharing the meal; the consistency/viscosity and food variety in the child’s food intake; the way in which the food is given to the child - by spoon, hand; the flavour, colour, taste.

iii. Energy and Nutrient Density: to know the nutritional composition and caloric value; how the meal is prepared.

iv. Use of Energy and Nutrients: conditioned by an absence of parasite infection, illness; or by the degree of absorption and digestion; and by the temperature of the meals.

Attempt to carry out the HVs during meal times (the mother and the carer will have to
continue with the tasks s/he was carrying out before your arrival) and, with sufficient practice the team will not need more than a couple of hours to complete it.

The team comprises three people (two CAs and a ML is advisable): Each is to be assigned a task. The person asking the questions will direct them to the appropriate family members. Another will take notes, and the third will concentrate on observing aspects of child care, hygiene and health practices, meal preparation, as well as the availability of food and kitchen utensils. If the team is only two members strong, the person carrying out the observation will ask the questions. These roles will be jointly decided.

For the first HSs, the OAs and the supervisor are to accompany the team in order to guide them. On arrival explain the purpose of the visit, as well as that of the survey (to discover good food, health, hygiene and care practices, which ensure poor families have well-nourished children). Ask the family if it is possible to visit the house and carry out the survey. Establish an amicable atmosphere to put the family at ease, and facilitate the interview process.

The interview must be given on the house’s patio. However, it is advised that topics concerning hygiene during food preparation, be covered in the kitchen, and so observe what utensils are used, and check their cleanliness. This facilitates conversation and allows one to confirm the consistency between what is said and what is done.

Attempt to collect as detailed information as possible. For instance, if the question 'What food is the child given?' receives the answer 'Rice and vegetables', clarify with 'Which vegetables?' (spinach, etc.).

Other aspects to bear in mind during the survey are:

- Ensure all the survey questions have been asked to each family visited,
- If the answer has not been properly understood, ask again,
- Listen as carefully as possible.

13. Undertaking of a KAP Survey (Knowledge, Attitudes, and Practice). (For baseline, See point 7.2)

14. Qualitative Nutritional ‘Analysis’ of the Community (See Annex 14). It will be carried out according to the results obtained in the census and the HVs (surveys and 24-hour Reminder). A maximum of four key good practices - nutritional, health, hygiene or good care practices - will be classified per family (the family’s personal data to be included).

Take into account that the good-practice selection criteria must be replicable and accessible today by all carers of the community. Table 2 may be used to select the four good practices.
15. To share the results obtained with the community, by using a visual aid: A growth curve of the red, yellow, and green-coloured bands is reproduced on a blackboard or flip-chart to visualise the nutritional condition of the group of weighed children.
This way, the current nutritional and malnutrition situation in the community can be explained, as well as the causes, and consequences for the short and long term. This will entail adopting the concept of Positive Deviation as the solution, using illustrations based on culturally acceptable practices, such as proverbs, metaphors, etc.

Other possible tools: a poster to present good practices identified in the positive-model families, and if such practices may be applicable to other families. Displaying the posters at schools, in health centres, at the community’s meeting place, etc. Also show those negative practices which have been identified (insalubrious conditions, non-existent communication among members of the family, etc.) and compare those good and bad practices.

16. Identification of the Mother Light (ML). From all the surveys carried out, and among those presenting a positive model, the mother with the best practices and conducts is chosen as the Mother Light. She will also have to comply with the following requisites: to have a well-nourished child, to be available and accept to work as a volunteer (negotiate her participation depending on her availability), to be dynamic, able to transmit her knowledge to the other mothers, and to have their credibility, trust and recognition.

The ML constitutes a resource and reference point for her community. With the aim of improving the nutritional condition of malnourished children, she encourages other community members to learn from her and so acquire the positive behaviours already existing in the community.

17. Training of the Mother Light. Training will be given by the OAs together with the CAs (See Training Module, Annex 4). Its objectives are:

- To reinforce skills for the transfer of her competences and good practices to other mothers.
- To initiate her with the CW’s protocol.
- To teach her how to carry out a market survey to know the availability of food in the village for each of the year’s seasons and, hence:
  - To quantify the energy and protein intake per ingredient.
  - To draw up the menus according to the availability and nutritional value of the foods.
  - To determine the daily food contribution of the mothers.
• To know the local measures most commonly used for each ingredient within the community.

- To initiate her on the circulating of IEC messages during the CW.

It is recommended to give mothers a post-test at the end of the training, to see how much has been learnt.

18. To construct a market survey (See Annex 15) on the cost and nutritional value of foods, following local measures. A form will be filled out for each of the places where different products can be acquired (shop, market, etc.)

19. Result analysis and interpretation of the first KAP Survey. These results will help us create the IEC messages.

20. To programme the CW sessions (given during the execution phase).

   a. To draw up the plan and calendar of annual activities.

   b. To plan the daily menus for the 12-day CWs, and supplementary diets in order to ensure a fast recovery of the child. The diet shall contain between 800 & 1000Kcal. (Go to Annex 6 to calculate meals)

   c. To create the IEC messages (Point 4.1) according to the results obtained in the HVs and the first KAP.

   d. To establish the protocols throughout the CW sessions (See point 11.2).

21. Admission of children to the Community Workshops for their nutritional rehabilitation, following the Weight/Height Index.

Pre-selection

All the children registered in the nutritional census, those classified as yellow and red, according to the Weight/Age Index, are to be weighed and measured.

The results will be recorded by the CAs on the appropriate pre-selection form, following the W/H% (Annex 5.b.) This way, children will be classified according to the W/H% Index.

Final selection

Only those 6 to 59-month-old children who had a W/H% Index between 70% and not > 85% on the pre-selection sheet, mentioned earlier, and without illnesses, will be accepted for the workshop (See point 2.5: Admission and Se-
lection Criteria). Their names and data will be transferred to the Final Selection form (Annex 5.c).

In the event that there are more than 12 children fulfilling the CW admission criteria, more CWs will be opened as needed, for every 12 children.

The period of time between the last weighing (census carried out at the beginning of the programme) and the beginning of the CW sessions shall not exceed three/3 weeks.

During the pre- and final selection, when the nutritional condition has been identified, those children classified with acute severe malnutrition, according to the W/H % Index, are to be referred to the nearest therapeutic nutritional centre or, where there isn’t one, to the hospital (See Referral Form of Annex 5d). The referral criteria will be as follows:

- Severely ill children identified during any of the programmes’ phases.
- Children who have not put on any weight by the end of the CW sessions.
- Children who become ill during any of the CW sessions.
- Children without a complete vaccination calendar.

At the conclusion of the programme, the CAs, the ML and the health agents will be responsible for the continuity of referral when required.

22. **Community Selection.** Only when the results obtained in the Area Analysis have been received, and it is known which children are to be accepted for the CWs, can the communities be selected for development of the CWs.

23. **Informing the Communities.** Once the communities who participated in any of the previous activities have been chosen, all will be informed of the results, and of the reasons why they have or have not been selected.

The mothers of children accepted into the CW will be asked to take with them their children’s health or vaccination cards on the first day of the sessions. This is to note the W/H control, the supplement provision dates for vitamin A and iron, as well as the delousing treatment.

Those mothers whose children have not been accepted will be informed of the good health of their child, and will be encouraged to continue with their good attitudes and practices.

The unselected communities must be thanked for their participation.

Next, a summary of all the activities to be carried out during the preparation phase.
### TABLE 3. ACTIVITIES TO BE CARRIED OUT DURING THE PREPARATION PHASE

<table>
<thead>
<tr>
<th>ACTIVITIES / WEEK</th>
<th>1st Week</th>
<th>2nd Week</th>
<th>3rd Week</th>
<th>4th Week</th>
<th>5th Week</th>
<th>6th Week</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Week</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Analyse the area</td>
<td>S, PM</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Agreement with the Ministry of Health</td>
<td>DNC</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Inform at a regional and national level</td>
<td>DNC</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Identify other NGOs and local structures</td>
<td>DNC</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Meet with community leaders: information and negotiation</td>
<td>DNC y PM</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Select the Human Resources</td>
<td>DNC</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2nd Week</strong></td>
<td>Agent</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td><strong>3rd Week</strong></td>
<td>Agent</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>7. Train the teams</td>
<td>DNC, S, OA</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>8. Adapt the HSs</td>
<td>DNC, PM</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>9. Review the (HV and Census) materials</td>
<td>DNC</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>4th Week</strong></td>
<td>Agent</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>10. Undertaking of the nutritional census</td>
<td>CA, OA</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>11. Analyse the results and plan HVs</td>
<td>PM, DNC</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5th Week</strong></td>
<td>Agent</td>
<td>29</td>
<td>30</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Undertaking of HVs</td>
<td>CA, OA</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Undertaking of KAP survey</td>
<td>CA, OA, S</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>14. Nutritional analysis for selecting PD families</td>
<td>DNC, PM</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Share the results obtained in the HVs and nutritional census with the community</td>
<td>DNC, PM y S</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Select the ML</td>
<td>DNC, PM y S</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Train the ML</td>
<td>OA</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6th Week</strong></td>
<td>Agent</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>18. Elaborate a market survey</td>
<td>CA, ML</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Analyse and interpret KAP survey’s results</td>
<td>DNC, PM</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>20. Programme the CW sessions</td>
<td>DNC, PM, S</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>21. Admit the children: Pre-selection and final selections</td>
<td>CA, ML, OA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Select the communities for the CWs</td>
<td>DNC, PM, S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Inform communities which have, and have not been accepted for the undertaking of the CWs</td>
<td>OA, S</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Throughout the second week the personnel’s selection process is to be developed and all training materials required are to be prepared.
3.2. SESSIONAL PHASE (A total of 13 session days, the seventh being a rest day)

In order to know in detail who will be responsible for which activity during the sessional phase, please refer to Section 11.2.C.: Development of the 12 session days) of this manual.

The sessions are conceived to allow participant mothers to learn appropriate practices and behaviours which will improve the health and nutrition of their children. Once all the material has been gathered, sessions may be carried out by following these steps:

1. **Verification of Material.** The list of all the materials required (See Section 8) shall be verified by the CA before and after each session-day of the CW.

2. **CW Opening Day.**
   - To welcome and enrol the mothers and carers. The ML will be in charge of registering the name of the children and their mothers / child carers (See Record, Annex 5f). The ML will record whether or not the mother and/or carer has attended the workshop and present the IEC messages, described below.
   - All members of the community are to be invited to the Opening Day (first day) and to the Closing Day (last day) of the CW.

3. **To Weigh and Measure the Admitted Children.**
   The workshop beneficiary children will be weighed and measured on the first and last day of the session. The data will be recorded in the child’s growth-evolution register (Annex 5e).

   On the first and last day, the children will be weighed and measured, allowing the members of the community to follow the nutritional condition, and to directly see the impact of the programme on the nutritional condition of the children.
4. To administer supplements of vitamin A, iron, folic acid and to undertake the delousing, following the protocol shown in Chart 6. To record the dates on the child’s health cards.

The three supplements will be administered on the first day of the CW. If this is not possible, they are to be administered a couple of days before, so that the mothers will not associate any possible cases of diarrhoea with the new recipes.

<table>
<thead>
<tr>
<th>VITAMIN A</th>
<th>Age</th>
<th>Dose</th>
<th>Frequency of dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 to 11 month-olds</td>
<td>100,000 UI</td>
<td>Once a year</td>
</tr>
<tr>
<td></td>
<td>12 to 59 month-olds</td>
<td>200,000 UI</td>
<td>Every 6 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Iron / Folic Acid (FAF)</th>
<th>Weight</th>
<th>Dose</th>
<th>Frequency of dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(less than) &lt; 10 kg</td>
<td>½ cp</td>
<td>Once only</td>
</tr>
<tr>
<td></td>
<td>(more than) &gt; 10 kg</td>
<td>1 cp</td>
<td>Once only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mebendazol (100mg)</th>
<th>Age</th>
<th>Dose</th>
<th>Frequency of dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(under) &lt; 1 year of age</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between 1 and 2 years of age</td>
<td>2 + ½ cp</td>
<td>Once only</td>
</tr>
<tr>
<td></td>
<td>(over) &gt; 2 years</td>
<td>5 cp</td>
<td>Once only</td>
</tr>
</tbody>
</table>

5. Food Contribution. It shouldn’t be forgotten that these activities can be carried out thanks to the community participation and to a subsidy - although the community participation will be two or three times larger than the subsidy. These contributions can be of goods or money, made by the beneficiary mothers, or by the whole community. All these are to be previously negotiated.
The daily contribution of food is essential for the sustainability of the project. The focus is more on a 'change of conduct' than on a 'transfer of knowledge'. It should be kept in mind when developing the protocol of the CWs.

Each day when the mother or child carer arrives at the workshop, their daily contribution of materials and/or ingredients is to be recorded in the approaches described.

6. Preparation of the Diet. With the local food contribution and the help of the mothers, a diet will be chosen and prepared. This will take approximately two hours. The ML is the reference person. It must be made clear that this menu is a supplementary meal only, and that if the child does not receive food over and above this supplementary meal during several days, its recovery will be slow, and the mother may lose all motivation to continue. Each child will be given a dish of food, and some locally available fruit.

The OA will be responsible for registering the different prepared-diets, specifying their ingredients, local measures and nutrient values. (Annex 5.h)

7. Supervision of Hygiene at the Cooking Demonstration

8. Distribution of food. This will take half an hour.

The consumption of each child’s diet will be supervised every day - by using the form found in Annex 5.i - specifying whether or not the meal was fully eaten, or only a half, a quarter, etc.

9. Distributing IEC messages through the ML and the CAs, and under the supervision of the OAs. These are key messages which allow mothers to adopt new practises. The messages cover key topics such as: hygiene (body, food, clothing, but mainly about washing the child’s hands and kitchen utensils); promoting breastfeeding and weaning; to vary meals using locally available products; to fight diarrhoea; to prevent malaria; to promote vaccination and carry out a growth follow-up and control. Their design will be based on the results obtained in the HSs and the 24-hour food reminders. These messages are detailed in Section 4.1 and are distributed once the children have already eaten and washed their hands.

The IEC messages are recorded every day in the register by the OA (Annex 5.j).

10. Closure of the CW, together with the Opening Day constitutes one of the most interesting moments for the community leaders, and for all those involved in the CW. As mentioned earlier, the children are again weighed and measured, and the data is recorded in the child’s growth-evolution form.

Given the large number of forms required for an effective programme follow-up, we have included a summary of the daily tasks to be performed by those responsible during the sessional phase.
1. The ML welcomes the mothers of the beneficiary children. The ML will take attendance using an attendance form.

2. Collection of mothers’ contributions (food, utensils, etc.) by the ML while the OA fills in the form. If there isn’t an OA, the ML will do so.

3. Those mothers who do not contribute more than once should not be allowed to attend the session on that day. The CA will try to raise her awareness for the following day.

4. The ML and the CA are to verify the quantity of each ingredient given, according to the number of children for that day’s meal.

5. The CA will control all the CW materials and distribute what is needed. In the event of loss and/or damage, the CA will fill out the appropriate form and hand it to the OA.

6. The ML will assign the tasks to be carried out by the mothers during the day: cleaning of utensils, preparation of meals, etc.

7. With the help of two other mothers (different each day), the ML will prepare the food and cook it (cooking demonstration).

8. While the food is cooked (more or less half an hour) the programme’s objectives are to be reviewed, and the ML reads out the IEC message for that day.

9. Mothers are to be told to wash the children’s hands with water and soap before giving them the food.

10. The ML will distribute one meal (dish) per child and together with the CAs supervise how the mothers feed their children. They are not to do other activities while feeding their children - they can interact with their children once the meal has been eaten.

11. The CAs and ML ask mothers to wash their children’s hands with water and soap after having fed them, and to clean the kitchen utensils.

12. The CA is responsible for filling out the daily Consumption Control form of the children.

13. Distribution of IEC messages by the ML and the CA. The OA will fill out the IEC Message form of that day.

14. The OA will ensure that the kitchen utensils are washed with water and soap, and that the CW space is clean. Meanwhile, the CA will fill in the Material Control Record.

15. The CA, the ML and the OA will organise a game or song for the children.

16. The ML will designate the mothers who will help her prepare the food for the following day.
17. The CAs, with the help of the OAs if required, will remind mothers to bring
their contribution the following day, and explain to them why this contribution
is so essential.

Other activities will need to be undertaken only on the first and last day of the ses-
sional phase.

**On the first day**, including the daily activities mentioned above:
- The CA and OA are to weigh and measure the children. The CA will fill out the
  appropriate section of the Growth Evolution Form of the child during the ses-
sional and follow-up phases.
- The health agent, jointly with the CA, will administer the systematic treat-
  ment. They will supply the appropriate dose, verifying the child’s age and
  previous weight, by checking the child’s health card. The OA and the health
  agent are to fill out the Medical Follow-up Form.

**On the last day**, including the daily activities mentioned above:
- The CA and OA will weigh and measure the children. The CA will fill out the
  appropriate section of the Growth Evolution Form of the child during the ses-
sional and follow-up phases.
- The CA and OA will invite community, political, and religious leaders, official
  and unofficial health agents, parents, teachers, etc., to the closing session.
- The OA and the supervisor will show the results obtained during the 12-day
  workshop and will insist on the importance of the next step - the follow-up
  phase - reinforcing the figure of the ML and the CA.
- The OA will give a follow-up calendar to the CA and the ML, as well as the
  bicycle (if any) in order to facilitate the follow-up process. A copy of the
  calendar is also to be provided to the health agent and community
  leader/chief.
- This day is to be considered a day of celebration, so songs containing the IEC
  messages learnt during the sessions may be sung.

3.3. FOLLOW UP AT: One month/ Two months/ Six months/ One year after the closing
of the CW

During this phase, the behaviours acquired during the sessional phase of the com-
munity workshop, are to be supported through the HVs.

At least 21 days are required to change new behaviours into habits. Therefore the
follow-up HVs will not begin until a month after the conclusion of the CW sessions.

Thereafter, HVs are carried out two months, six months and 1 year after the exe-
cution phase of the workshop has concluded.
During these visits, apart from undertaking the HSs, much support must be given to the mothers so that they can put into practice the new knowledge acquired during the CW sessions. The CAs must also help mothers find solutions to difficulties. Special attention is to be given to children who did not recover their weight during the 12 sessions.

During this phase, periodical visits will be made, and the following is to be carried out at each of them:

- At one month after the close of the workshop
  - HVs: HSs
  - To weigh and measure the child. To calculate the W/H %
  - To register abandonments and referrals (See form of Annex 5.k)
- To register weight increase evolution and W/H % (See Annex 5.e and forms 2 and 3, Section 7)

- At two months after the close of the workshop
  - To weigh and measure the child. To calculate the W/H %
  - To register abandonments and referrals (see form of annex 5.k)
  - To register weight increase evolution and W/H % (See Annex 5.e and forms 2 and 3, Section 7)

- At six months after the close of the workshop
  - HVs: HSs
  - To weigh and measure the child. To calculate the W/H %
  - To register abandonments and referrals (See form of Annex 5.k)
  - To register weight increase evolution and W/H % (See Annex 5.e and forms 2 and 3, Section 7)

- At one year after the close of the workshop
  - HVs: HSs
  - To weigh and measure the child. To calculate the W/H %
  - To register abandonments and referrals (See form of Annex 5.k)
  - To register weight increase evolution and W/H % (See Annex 5.e and forms 2 and 3, Section 7)

The elaboration of an annual follow-up plan can be very useful. More than one CW session may be simultaneously carried out in different communities, although the following needs to be taken into account:

- Number of people on our team
- Distance between communities

These will affect the follow-up and monitoring of the CWs.

Ideally, there will be 2 OAs per CW, working alongside a CA in the community where the CW is developed. Depending on the number of personnel, it may be possible to give one or more CWs. They will be the ones travelling to the other communities to carry out the follow-up at one month/two months, etc., with the help of the community agents who are already there or near by.

The following is an example of where the implementation of 10 CWs has been considered, and where each month the sessional phase of two of them begins.
4. ESSENTIAL COMPONENTS INTEGRATED INTO THE PROGRAMME

Given that malnutrition can be the cause and effect of so many other public health problems, and that it cannot be treated separately, a variety of already existing pro-
programmes, such as food security, and water and sewerage safety, can be integrated in the CWs. Immunisation, micro-nutrient supplements, and delousing programmes, as well as a referral system for sick children to local health units, already form part of the CWs programme. Good implementation of the CWs can have an impact on other public health indicators, such as diarrhoea, and can contribute to an important reduction in malnutrition.

4.1. NUTRITIONAL MINIMUM PACKAGE. IEC MESSAGES

The Nutritional Minimum Package (NMP) is an intervention strategy, developed in order to promote six positive nutritional and health habits/behaviours at three different levels, as detailed in Chart 7:

<table>
<thead>
<tr>
<th>NUTRITIONAL BEHAVIOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breastfeeding only for the first 6 months</td>
</tr>
<tr>
<td>2. From 6 months on, introduce complementary food and continue breastfeeding until 2 years-of-age.</td>
</tr>
<tr>
<td>3. Consumption of foods rich in vitamin A and/or supplement intake of vitamin A.</td>
</tr>
<tr>
<td>4. To care for a sick child in an appropriate manner:</td>
</tr>
<tr>
<td>a. To continue feeding the child and increase the liquid intake during illness.</td>
</tr>
<tr>
<td>b. To increase the amount of food the child receives after illness</td>
</tr>
<tr>
<td>5. All pregnant women should take iron/folic acid</td>
</tr>
<tr>
<td>6. All families should regularly take iodised salt</td>
</tr>
</tbody>
</table>

**CHART 7. INTERVENTION LEVELS ON NUTRITIONAL BEHAVIOURS**

- **Improving behaviours in the home**
  - Nutritional education by health agents, CAs, midwives.
  - Breastfeeding support groups.
  - To give suggestions in the home on how to feed children.
  - Joint community planning

- **Improving support to the community**
  - Distribution of vitamin A and iron / folic acid.
  - Regular access to iodised salt.
  - Regular access to nutritional products

- **Improving basic health services**
  - Health agents receive training and equipment:
    - To give appropriate nutritional advice.
    - To give micro-nutrient supplements when needed.
    - To examine, diagnose and treat sick children.
  - That health services have enough micro-nutrient stocks, regular revisions and IEC materials

- Improving behaviours in the home
- Improving community support
- Improving the basic health services

This is an intervention strategy to reduce malnutrition and, as such, it must integrally form part of all primary health programmes, and be adapted to local habits. The impact on nutrition will be larger and more significant if it is linked to other health activities, such as prenatal consultations, vaccination, etc., and to community mobilisation strategies. All these activities are directed towards developing the local capacities to maintain the programme in the health structures.

These six nutritional behaviours, and no others, are to be selected due to their impact on morbidity and mortality rates; for their viability and sustainability; for their costs-effective intervention; and because they can be measured, permitting the monitoring and evaluation of the programme.

For each of the six nutritional conducts, the following will be promoted:

1. Breastfeeding only for the first 6 months
   a. The importance of breastfeeding the child immediately from birth.
   b. Child’s immunity thanks to the colostrum’s antibody content.
   c. Economic and always available.
   d. Strengthens the relationship between mother and child.
   e. Contains enough water. There is no need to give water to the baby before the age of six months.
   f. To breastfeed the child whenever he/she requires feeding.
   g. Ensures optimum nutrition of the child.

2. From the age of six months, introduce complementary food and continue breastfeeding the child until the age of two.
   a. Increase the quantity of food according to the child’s age and weight.
   b. Increase the frequency of meals according to age:
      i. 6 - 8 months: 2 - 3 meals daily.
      ii. 9 - 23 months: 3 - 4 meals daily. 1 or 2 snacks.
   c. Vary meals in order to ensure adequate intake of nutrients, including the following:
      i. Meat, poultry, fish or eggs daily, or as much as possible.
      ii. Fruits and vegetables containing vitamin A daily, and enough lipids.
iii. Avoid drinks with scarce nutrient content, such as coffee, tea, etc.

iv. Complementary meals are to be gradually introduced with small mashed or semi-solid quantities.

3. Food consumption rich in vitamin A (liver, fish, eggs, mango, papaya, carrots, etc.) and/or vitamin A supplement intake.

4. Look after a sick child appropriately:
   a. Continue feeding the child and increase the intake of liquids during sickness.
   b. Increase food intake after sickness until the child recovers the lost weight.
   c. If the child is breastfed, do not stop breastfeeding.
   d. Liquids shall be given regularly, using a spoon.

5. All pregnant women are to take iron/folic acid during pregnancy and up to six months after birth (except in malaria endemic zones). Promote consumption of iron-rich foods (liver, fish, meat, entrails, cereals, fruit, mandioca, spinach, etc.).

6. Families are to regularly take iodised salt to avoid any iodine deficiencies.

The promotion of these nutritional and health behaviours is to be developed by transmitting appropriate and culturally acceptable messages, by using the locally available communication channels. These messages are referred to as IEC MESSAGES. IEC Messages are a useful tool to reinforce the concepts linked to the change, and promotion of new behaviours in the carer of a malnourished-child.

A good understanding of healthy habits and practices at home and at the community level is essential to ensure the coverage, quality and impact of the programme.

The steps to follow for the development of the IEC messages are:

1) To identify any possible conducts which may need to be changed through the HSs, the 24h food reminder, market surveys and KAP studies.

2) To discover which are the most appropriate communication channels for the community. Messages could be transmitted orally or in writing, through children’s games or songs, the regional office’s information sheets (See Table 8), radio, etc. This will depend on the context.

3) Define objectives. Possible changes.

4) Develop and adapt the messages and suggestions we wish to communicate.

5) Train the health personnel, CAs and ML on how to transmit IEC messages.

6) Transmit the messages. Each day a new topic is introduced. Once the chosen topics have been covered, the remaining days will be used to review the messages.
Content of IEC messages:

The beneficial behaviours and practices promoted in the CWs through the IEC messages are divided into four main behavioural categories, which include 16 key practices, in order to cover the six nutritional conducts of the MNP.

1. The child’s growth and development: Feeding practices improvement.
   a. Promotion of breastfeeding. To exclusively breastfeed the unweaned baby at least until the age of four months and, if possible, until the age of six months. What is the colostrum and why give it to the baby?
   b. Complementary feeding from the age of six months. It must be freshly cooked and with a high nutrient and calorific content, and continue breastfeeding the baby until two years.
   c. Adequate consumption of micronutrients in the meal or through supplements (vitamin A and iron mainly).
   d. To promote the mental, emotional and psychological development of the child through improved care practices, by attending to their needs: frequent verbal interaction, giving them attention, and demonstrating; to share the child’s care in order to offer good supervision, mainly during the meals, with an active participation of the fathers (by playing with and speaking to him/her, and providing an stimulating environment).

2. Illness prevention
   a. To promote vaccination. To complete the total regime of immunisations before reaching one year-of-age, and growth follow-up.
   b. To promote food, body and clothing hygiene. Just one hygiene practice: to wash one’s hands with water and soap before eating and after defecating, is vital in the fight to reduce the incidence of diarrhoea illnesses.
   c. To promote the use of impregnated mosquito nets.
   d. To adopt and maintain appropriate behaviours in the prevention and treatment of HIV/AIDS, to treat those affected by the illness, including orphans.

3. Appropriate home-care visits
   a. Continue feeding and hydrating in the event of illness. Offer more liquids including the mother’s milk.
   b. Administer adequate treatment in the home whenever the child suffers any infection. Example on preparation and use of ORS in the event of diarrhoea.
c. Prevent child abuse and leaving the child unattended; and to take the appropriate measures when necessary.

d. Ensure men take an active part in the child’s care, and in the education of the family’s reproductive health.

4. Seeking care outside the home

a. Pre-natal visits (four visits before birth and antitetanic vaccination).

b. Follow suggestions from the health agent on the treatment, and to return for future consultations.

c. Recognise the serious signs of diarrhoea, temperature and cough, and know when the child needs treatment in order to seek appropriate medical attention.

d. The mother needs the support of her family and of the community when seeking appropriate medical attention at birth and immediately after.

All these practices and behaviours are to be reviewed within the cultural context of the community where the CW is implemented. The personnel of the programme are to collaborate with the local partners to select the priority key conducts for each community.

According to the results obtained in the market survey, agriculture calendar and HSs, a balanced and diversified diet will be taught in line with the nutrient food locally available.

---

**RECOMMENDATIONS to make communication more effective**

- Congratulate the mother for all she is doing well, and for being willing to learn new things.
- Identify barriers that the mother may find while adopting the new behaviours, seeking from her the solutions which may be within her reach.
- Show what the family should do in the home. In order to better do this, use real quantities and objects wherever possible.
- The message is to be repeated as many times as needed.
- The message is to be presented slowly, and the participants asked to repeat and explain the information learnt.
- Always allow some time to discuss and ask questions.
- Messages are to be short, simple, clear and understandable, and motivate the listener.
Regional Ministry’s information sheets. These sheets are support material to improve group focus on certain topics and to give individually advice to mothers. Some of the topics covered are breastfeeding, growth and weight control, diet for 6 to 11 months, diet from age one, care measures for child with diarrhoea or with acute respiratory infection, washing one’s hands, etc.

How to use them:
- The sheets of the information set are double-side, allowing the group to see the front displaying the drawing, while the facilitador can see the back with the text.
- Information is divided into 5 sections:
  - Introduction: a general sentence or question to initiate dialogue on the topic of the sheet.
  - Experience: questions to facilitate identifying what the mother does right or wrong, and to facilitate learning from the mother or child care’s experience.
  - Key Messages: short storytelling to help the mother memorise the most important key points and to bring the characters on the sheet alive.
  - Verification: simple questions to verify if the mother has clearly understood the advice provided, and clarify any doubts.
  - Commitment: questions aimed to motive mothers to commit to adopting the suggested actions.
- The symbol ö indicates a question that the mother or child-carer should be asked.
- The ‘pointing hand’ symbol is to prompt the facilitator to point out a particular drawing on the sheet to the group.
4.2. INTEGRATION OF HEALTH INTERVENTIONS

Formal and informal health resources are to be identified and coordinated in the CWs. The personnel of the health unit can identify the resources and services available to treat referred children.

There is to be a close relationship with the health services in the decision-making of delousing protocols, on the distribution of vitamin A, and on the unification of criteria for the appropriate content and reinforcement of the health messages for the CW sessions.

The tasks to be carried out by the health centre’s personnel are included in the job descriptions.

**Growth follow-up**

Monitoring growth allows early detection of infant malnutrition. This growth follow-up may be used as an educational tool to show mothers how to monitor the growth progress of the child, and to detect when growth begins to decline.

**Objectives**

- To allow families to both know the nutritional condition of their children and to follow their growth.
- To identify children at risk of malnutrition so that they can be admitted to the CW, or to carry out a follow-up at home to identify possible obstacles, which impede the adoption of good practices.

It is ideal that this programme be previously implemented in the health structures near the community where the CW will be held; otherwise, two people from the team are to be assigned to implement and monitor it. Those working close to the community’s health agent will train a couple of CAs (not those in charge of the CW programme) to carry out such activity as volunteers.

Training will mainly focus on how to weigh the children, interpret the growth curve, and give advice to the child’s carer. Carers are then informed of the results, which are to be interpreted through both gender and age groups. Annex 4 will be employed for the training module. Once trained, the required material is to be prepared (See details in training module), and a calendar created: who will carry out the follow-up, where and when.

As a CW programmed activity, it implies mobilising the community, for its participation will facilitate the children’s follow up. Firstly, a meeting with community leaders, teachers, and health personnel is to be held to explain the objectives of the CW programme and what has been done up to then; the objective and description of the growth follow-up; the human resources required to implement it; and when the personnel training will be given. Provide a calendar of activities so they will know when the growth follow-up of the 6 to 59-month-olds will be done, and be able to help mobilise mothers and child carers.
The place where the growth follow-up will be done is to be divided into three different areas: a waiting area for mothers and carers in which they will also be welcomed; a second area where the children will be weighed; and a third area where the mothers can be given advice. It is better not to weigh more than 100 children a day. If the number of 6 to 59-month-old children in the community is greater, the personnel will need to return the following day. Another possibility is for two distinct monitoring areas could be established with another team of two CAs, who will have been previously trained.

The CAs, jointly with a community leader, will weigh all the 6 to 59-month-old children once a month to ensure their growth is normal, and the mothers or child carers are to be informed of the results. It is to be taken into account that once the mother or carer has been told his/her child suffers malnutrition, there must be a follow-up programme, and/or the giving of advice for recovery or prevention. If the child suffers severe acute malnutrition, he/she will be given a referral sheet to the nearest therapeutic nutritional centre or. If none is available, they are to be referred to the nearest hospital. If the child suffers moderate acute malnutrition or is at risk of malnutrition, he/she will be admitted to the next CW. If the child grows normally, we will encourage mothers/carers to continue with their good practices.

Once a month (some days after the follow-up) the results are to be provided at a meeting with the community, and the current nutritional condition of the children will be evaluated. Community participation will strengthen through community growth follow-up, which will show the results of the evolution of the community’s children, particularly with regard to mothers. When the growth is not favourable, indicate possible causes, discuss possible solutions, and encourage when growth is adequate.

Apart from directly collaborating with the Health Ministry by training personnel, this type of intervention permits members of the community to learn techniques and skills for weighing the children in remote areas, and so, widening coverage of the growth follow-up programme. The CAs will also reinforce on an on-going basis, the use of health services by referring sick children.

**Fight Against a Micro-nutrient Deficiency**

Good nutrition, with a good micro-nutrient contribution, is the first defence against numerous child illnesses which may have life-long after-effects on the child, limiting his/her physical and intellectual performance, and diminishing his/her levels of productivity as an adult. Intestinal parasitism and nutritional problems (micronutrient deficiency) are considered the main causes of school absenteeism and desertion, and for the deterioration of a child’s learning capacity.

Due precisely to the relation between a deficiency of certain micro nutrients and some child illnesses, micro-nutrient supplement interventions will be used to
reduce the risk of illnesses such as: measles, acute respiratory infections and diarrhoea. Such micro-nutrients are vitamin A, iron and folic acid.

The following actions are to be carried out:

- The production (See point 4.4) and consumption of foods rich in vitamin A and iron.
- The distribution of vitamin A, iron/folic acid supplements, following ACF-E’s protocol. Vitamin A supplement can reduce child mortality by 23-34%.
- Delousing the children (following ACF-E’s protocol) on the first day of sessions to ensure a faster recovery.

Finally, intestinal parasitism directly affects the nutrition condition of the child, as it increases iron and vitamin A losses, provokes the loss of nutrients ingested, and increases anorexia levels. Malnutrition - a problem directly related to poverty factors - diminishes defences and favours infestations of helminths. Because of this, delousing of children must go beyond the mere administration of anti-parasites (as per the ACF-E’s protocol), to that of generating information and changing attitudes within the community. This way, ongoing and sustained low levels of parasitism can be reached, allowing a broader focus on the causes affecting a child’s health.

To administer the vitamin A and iron/folic acid supplements, and delousing, the following will be needed:

- A permit from the Health Ministry.
- To know where vitamin A capsules are available.
- To assess the quantity needed depending on the number of CWs to be held, with a maximum of 12 children per workshop.
- To train the CAs, with the support of the community’s health agent, on the administering protocol for the vitamin A supplement.
- To ask mothers to take the child’s health or vaccination card with them on the first day of the CW.
- The health agent will record the date the vitamin A supplement is administered on the child’s health card, and will complete the medical CW follow-up form. The OA will supervise the data once updated.

4.3. INTEGRATION OF WATER AND SEWERAGE INTERVENTIONS

The integration of water and sewerage interventions will bring focus to the indirect causes of malnutrition. This will be done by improving access to drinking water and basic sewerage. It is necessary to identify, through a sanitary technical evaluation, which of the communities selected for the CWs are the ones with unsecured water and whose living circumstances do not meet basic health standards (those with great-
RECOMMENDATIONS

Vitamin A is a liposoluble vitamin which is important for healthy vision (a classic vitamin A deficiency sign is night blindness), cellular differentiation, bone growth and, specially for resistance to infection and normal development of the child. Children under the age of five are more likely to suffer a deficiency in vitamin A as their nutritional demand is greater, consumption of vitamin A foods may be limited. In the event of infection, use all vitamin A reserves.

Deficiency occurs when the absorption and use of vitamin A is compromised. In many cases infections and/or a low consumption of lipids and proteins cause this deficiency. Those foods containing lipids are required for the body to adequately absorb vitamin A and proteins.

Found in foods of animal origin: milk, meat, eggs, fish, liver; and in fruit and vegetables of an intense yellow or dark green colour, such as carrots, spinach, lettuce, mango, chard, watercress, sweet potatoes, tomatoes, asparagus, pumpkins, oranges, melon, and papaya.

RECOMMENDATIONS

An iron deficiency and anaemia (especially due to an iron deficiency) continue to be one of the most significant and severe nutritional deficiencies. This deficit affects both physical development and that of the nervous system. Therefore, the children who had anaemia in their early years are at risk of slow growth, and may see their intellectual development and cognitive capacities diminished. Also, an iron deficiency damages the immune mechanisms, and is associated with an increase in morbidity rates.

Anaemia reduction strategies contribute to better life standards of the individuals and communities, and help break the circle of poverty, which is associated to a scarce iron content in the diet. Food rich in iron are: liver, red meat, fish, chicken, etc., and those foods containing vitamin C increase the absorption of iron, juices, potatoes and tubers, green leaves vegetables, cauliflower, cabbage and spices, such as soy sauce.

Iron supplements, usually given in the form of iron sulphates, is the current strategy most commonly used as a preventive public health measure to control anaemia caused by iron deficit. Generally it is better absorbed when taken on an empty stomach. Side effects with oral intake are not frequent in children. It is to be administered following ACF-E’s protocol.

RECOMMENDATIONS

• To know the nutritional situation it is very helpful to have a Nutritional Monitoring System in place for a long period. The prevention of malnutrition is essential, so the areas where CWs need to be implemented must be known.

• CWs allow access to more qualitative information, and could be called ‘Kitchen Observatories’. To be sitting with the women by the cooker and pot can facilitate the provision of other types of relevant information, in addition to that which comes via the Nutritional Monitoring System.

• Once again, to know and complete the area’s nutritional situation, communication and coordination with the area’s health services is of vital importance. In order to achieve this, it can be very useful to make an agreement with the region’s department of the Health Ministry. (See example, Annex 22)
est nutritional vulnerability). And if this has any direct relation on the high percentage of diarrhoea illnesses diagnosed among the community’s children under the age of five.

Once identified, and evaluated to select and define the adequate technical options, wells and water pumps will be built or rehabilitated; over and above the protection and rehabilitation of existing traditional water sources. The construction of wells and conditioning of pumps must be done in places traditionally recognised and used by the beneficiary communities. To maintain the sites and supervise the ancestral traditions, thereby improving the durability of water resources.

If a major stress on the water supply is found in the communities, and an absence of superficial and underground water resources is confirmed through hydro-geological and hydrographic studies, new perforations will need to be defined.

To improve water access in terms of quantity and quality, production and protection of captures will need to be improved, new water sources must be protected, and sanitary safety perimeters respected, diminishing access and waiting times.

A water management committee is to be created or strengthened in order to manage and maintain those improved sanitary structures: from the identification of possible members from the community, its creation, the training of its members, until its eventual recognition by local institutions; and with the final aim of integrating the communities into the maintenance and development institutional services. Material support will be given by providing maintenance and cleaning kits. The committee, jointly with the CA and the ML, will ensure community participation in the development of the different activities. Also, the ML, jointly with the committee, will manage the use of water.

The IEC messages of the CWs will include the spreading of good water hygiene practices: individual and collective practices, and the maintenance of the sanitary environment:
- Water-related illnesses and transmission channels
- Sanitary maintenance at a structural and housing environment level
- Waste management
- Water usage
- Use of toilets

Messages are to be given using visual didactic supports (pedagogical images and posters) showing colonies of faecal coliforms, which have been found in bacteriological analysis, having previously been ingested by the participants.

The CAs will be responsible for raising the awareness of the community regarding cleaning and clearance (clearing matter from rivers and marshes, maintaining and cleaning of surface-water drainage, protecting existing sanitary infrastructures, etc.), and will closely collaborate with the newly created and/or strengthened water committee. Mass awareness-raising of infrastructures and the environment has an immediate, demonstrable impact.

It is preferable that this awareness raising happens while the new sanitary structures are being built or rehabilitated, to maintain the basic cleaning of public community lavatories, washing areas, and tips. The access improvement of sanitary structures is through additional sanitary infrastructures adapted to collective needs. Population numbers, protection and awareness of waste management are to be taken into account.

In washing areas, wells, and water points traditionally used for domestic purposes, a protected washing base and platform may be constructed and the evacuation of used water may be drained out through the bathing area. The women’s awareness of the use of water sources for domestic tasks should be raised.

For all this, the personnel required will be: water driller and assistant, drilling mechanics, work superintendent, hydraulic technicians, qualified plumbers, technicians on manual pumps, well-diggers, well technicians, chemists, unskilled labourers, hygiene educators, and community volunteers.

Finally, it must be noted that with improvement of access at water sources, the beneficiaries - especially women - waste less time, and therefore have more availability to carry out income-generating activities.

4.4. INTEGRATION OF FOOD SECURITY INTERVENTIONS

Integration of food security aspects to CWs will permit the development of a strategy in response to malnutrition. Insufficient agricultural yields and incomes are un-
favourable circumstances for food autonomy and,
consequently, nutritional problems cannot be
treated. We believe that through strengthening
agricultural sectors and improving the access to
income, the nutritional situation would become
more normal, and that trend be maintained.
Therefore, a food security programme, which in-
cludes community market gardens and IGAs (In-
come Generating Activities), is to be integrated
into the CWs.

- To improve the availability of foods rich in micro-nutrients throughout the whole
  year.
- To ensure access to those foods by those families whose children have been ad-
  mitted to the CWs.

These strategies would be reinforced through community awareness-raising using
the IEC messages developed during the sessional phase of the CW.

**Community Market Gardens**:

Iron deficiency. Efforts are to be directed towards the access to, availability and
promotion of, foods rich in iron, ie: (farm) meat, fish, and foods of non-animal ori-
gin, such as legumes, and green-leaf vegetables: cauliflower, cabbage, etc. Animal
origin foods which increase iron absorption, ie: red meats, liver and fish; and of veg-
etable origin: some fruits, vegetables, and tubers (which are good sources of vita-
min A & C and folic acid).

Vitamin A deficiency. Efforts are to be directed towards the promotion of animal-
origin foods, ie: milk, meat, eggs, fish, liver, etc., and of foods of vegetable origin:
intense-yellow or dark-green coloured fruits, and vegetables: carrots, squash,
spinach, lettuce, mango, chard, watercress, sweet potatoes, tomatoes, asparagus,
pumpkin, orange, melon, and papaya.

**Income generating activities** can help vulnerable people overcome food inse-
curity when financial access to food is its main cause, and where there is avail-
ability at the local markets. Within the CWs programme, where the context is much
more stable, and the population faces a chronic food shortage, where sustenance
strategies are weak, and there are important structural difficulties, IGAs can be
promoted and supported. That is, with the objective of improving, in a sustainable
manner, food security and the living conditions of those living in chronic-vulnera-

For more information on the implementation of the community market gardens, please refer to ACF-E’s Depart-
ment of Food Security.
Then, whenever there is sufficient food availability at local markets, the impact of IGAs on families’ food security will be positive. But this will be influenced by factors such as the intra-family income distribution.

ACF-IN’s aim is, through the IGAs support and promotion programmes, that vulnerable populations be able to cover their food and basic needs in a sustainable manner through the income they produce. That is, improving financial access by increasing the payment-capacity of family units.

To optimise the performance of current activities or to create new IGAs, interventions could include activities of a diverse kind. Below is a list with some of the steps to follow during the undertaking of this type of programme:

→ To present the programme to local authorities and to communities.
→ To identify the needs of each type of IGA developed by the population; to carry out a study of the value chain.
→ To study the possibility of developing new activities; analysis of comparative advantages (activities which generate aggregated value, primary production activities, etc.).
→ Specific-market studies.
→ Beneficiary selection process (point II contains essential details to define intervention level)
→ To diagnose training needs.
→ To develop plans for:
  • Technical training
  • Management training
  • Marketing training
  • Work-team training
→ To develop business plans (as an activity to be carried out by the beneficiaries during the training process).
→ In the event of working with groups, to define internal rules (as an activity to be carried out by the beneficiaries during the training process).
→ To introduce technical improvements to increase production quality and/or quantity, and its conservation or transformation.
→ Access improvements to goods and raw materials:
  • Free distribution of goods and raw materials.
i. Direct distributions
   ii. Vouchers
      • Creation of raw material stores

→ To support access to financial capital
   • Creation of revolving funds
   • Creation of rural banks.
   • Access support to micro-loans
      i. Strengthening of micro-financial institutions
      ii. Technical support to beneficiaries to apply for and manage micro-loans.

→ To support the management of activities.

→ Improvements in the marketing processes:
   • Construction of processing infrastructures for those products needing some treatment or processing to improve their commercialisation.
   • Market construction or rehabilitation.
   • Establishment of regular market information channels.
   • Contact with intermediaries.
   • Promotion of meetings and trade fairs

→ Programme’s follow-up and evaluation:
   • Monitoring of activities.
   • Monitoring of group or family performance.
   • Intermediate and impact evaluations.

→ Systematisation of experiences.

It is important to take into account that not all performance improvement programmes, and/or creation of IGAs, need to follow all of the above steps. The planning of projects will include consideration of: performance limiting aspects, market access, and the possibilities to develop new IGAs.

For more information on IGAs, please see manual Support to Sustenance Systems: Promotion of Income Generating Activities; From Definition to Establishment, by Action Against Hunger.
5. PROGRAMME MANAGEMENT

Management is in reality a relatively easy task. It all relates to the optimum use of the available resources. The better the tools and means we have at hand to achieve the goal, the better and easier their management will be. The resources available can be of any type: material, human, financial, etc.

5.1. SUPERVISION ELEMENTS

Supervision is a much needed tool for the effective control of the project, which implies observing and influencing the main activities and objectives to be carried out. To be efficient, it must be done in an organised manner, and be used to inform other people involved in the progress and problems of the project. Supervision mainly concentrates on activities surrounding the project and short-term fulfilment.

In fact, to supervise what we do is to maintain a record of the problems that arise in order to:

- Anticipate future similar problems
- Detect current problems and mistakes
- Correct problems and redesign some activities
- Generate feedback
- Encourage progress
- Provide motivation

To ensure good supervision:

- It must be clearly specified to each person what he/she must do, and who will supervise their work (Section 3.1 includes the job descriptions)
- It is not a task to be exclusively carried out by supervisors
- Supervision plans/calendars must be realistic about time, human resources, and distances
- If possible, a supervision guide shall be provided
- We must ensure the supervisor creates a tranquil and secure environment

Supervision training is essential and will indirectly form part of a personnel motivation strategy.
There are different direct supervision methods. These include directly observing the working personnel, interviewing the personnel, and analysing the information collected.

Useful tools include supervision calendar plans, monthly reports, etc. These must be included in the programme’s preparation.

Include below a number of questions which help to understand the quality of the programme’s supervision, and which cover many of the above mentioned activities:

- How to determine the quantity of ingredients in the menu and their nutritional value
- Mother’s attendance at the CW
- Which IEC messages to give and which communication tools to employ
- What can mothers contribute with, and how this has been determined
- If mothers are encouraged to breastfeed their children only
- That volunteers carry out their tasks, and who in the community is involved in the programme
- Check that the information collected in the HVs is available during the follow-up phase
- Check that records have been correctly compiled.
- (...)

The frequency of supervision visits will depend on the number of people the supervisor is in charge of, as well as on the number of communities he or she must visit, always trying to ensure that the number of visits is never less than one per week, per community.

5.2. PRESENTATION OF REPORTS

Reports are a very important and useful tool to monitor - among other things - the activities of the programme, reflect any difficulties found, monitor the progress made toward achieving objectives, register the results achieved, and note any suggestions. It is also very useful to include stories told by members of the community, thereby including some informal but no less important information.

The Report to the Head Office can be written monthly and is not be longer than three pages.
In Annex 16, a guide on how to write the report to the head office has been included. It contains: general aspects of the programme, the activities foreseen for that month, what has and has not been carried out and why, the results and main problems in the different departments linked to the programme, as well as their solutions. Some space will be given over to observations, and the objectives for the following month are to be set out. Meetings held are also to be noted, specifying who attended and the issues covered.

**Project Application**

Briefly speaking, project application must contain the following data:

- Name / Location / Country / Period of implementation (with the preparation period taken into account, it will be more than one year) / Title of the Project / Participants

Brief description of the context in which the CW activities will be implemented, justifying the need and commencement of the programme. Explain if it is to be an isolated programme or if it will form part of a current programme.

- Background
- Programme’s objective and contribution towards ACF-E’s strategy in the region.
- Intervention description
- Results
- Impact (measured) from initial indicators
- Project appropriateness
- Problems found and proposed solutions
- Suggestions
- Activity chronogram

- Include Budget Sheet (Annex 17). Amounts will depend on the number of workshops to be implemented. Food costs are minimal, as the project is based on low-cost, locally-available foods, provided by the community. The responsibility of gathering all the basic materials needed for the CW sessions are to be shared among all members of the community, the relevant institution (ACF-E in this instance) and the mothers of the enrolled children. At the beginning, ACF-E may need to contribute food, kitchen utensils and hygiene materials such as soap. Once the community has understood the value of the CW sessions, and has been witness to the change from malnourished children to healthy ones, they will value the programme and will be more willing to cover the costs.
6. RESULTS, MONITORING AND EVALUATION

To select from the project’s results, monitor the progress, and evaluate the effectiveness and scope of the programme are important aspects in each step and phase of the CW, and is to be carried out in an on-going manner. Sustainability must be incorporated from the very beginning of the programme, and not as an afterthought during the final stages of the project.

Given the large number of follow-up forms we have described for the different activities of the CW’s programme, it is difficult to synthesise results. In brief, during the different phases of the CW, the following activities are to be supervised, which will be reflected in the appropriate control forms:

**During the Preparation Phase**
- Information on the community
- Register of the nutritional condition of the population of 6 to 59-months-of-age. There are a total of three forms for a total of 60 children
- Pre-selection of 6 to 59-month-olds
- Final selection of 6 to 59-month-olds
- Referral sheets (if required)
- 24-hour reminder for feeding regime, and selection of ML
- HSs (home surveys)
- Market survey

**During the sessional phase**
- Children’s attendance at the workshop during the 12 days of the sessions
- Daily contribution of the mothers - they must learn and believe that they are the ones who can feed their children with nutritious food
- Ingredients used for recipes and their nutritional value
- Control of the child’s diet
- Medical follow-up of systematic treatment
- IEC messages developed day-by-day.
During the follow-up phase

- HVs to ensure mothers apply good care, feeding, health and hygiene practices learnt during the CW sessions; and to incite them to persevere with these practices
- Evolution on weight gain and W/H %.

During the sessional and follow-up phases

- Evolution of weight gain
- Evolution of W/H %
- Abandonments and referrals for the children of a total of 10 workshops
- Referral sheet, if required.

During the sessional and follow-up phases

- Evolution of weight gain
- Evolution of W/H % for the children of a total of 10 workshops
- Abandonments and referrals for all children at a total of 10 workshops
- Referral sheet, if required.

Taking into account the results of the forms completed during the different phases of the CW, only those results of greatest importance and which are not to be overlooked will be included in the report. The following is an explanation of how to present these results in a report. Special attention is to be paid to:

- The registering of data in the distinct forms, that it is correct and validated
- Analysis
- Presentation and interpretation.

For example:

CWs were implemented in XX communities of the region (name of the region), in (country) and began in the month of (month).

While taking the population census, XXX children from the age of 6 to 59-months were weighed and, following the Weight/Age Index, XX of them were found to be in the red-coloured band and XX in the yellow. The results on the nutritional condition per community, gender and age have been the following: (Presentation in a Table)
### TABLE 4. RESULTS ON THE NUTRITIONAL CONDITION PER COMMUNITY DURING NUTRITIONAL CENSUS OF 6 TO 59-MONTH-OLDS

<table>
<thead>
<tr>
<th>COMMUNITY</th>
<th>AGE OF THE CHILDREN in months</th>
<th>TOTAL NUMBER OF CHILDREN</th>
<th>TOTAL NUMBER OF BOYS</th>
<th>TOTAL NUMBER OF GIRLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>GREEN %</td>
<td>YELLOW %</td>
</tr>
<tr>
<td>A</td>
<td>6-11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>12-29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>30 -59</td>
<td>TOTAL</td>
<td>X1</td>
<td>Y1</td>
</tr>
<tr>
<td>B</td>
<td>6-11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>12-29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>30 -59</td>
<td>TOTAL</td>
<td>X1</td>
<td>Y1</td>
</tr>
<tr>
<td>C</td>
<td>6-11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>12-29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>30 -59</td>
<td>TOTAL</td>
<td>X1</td>
<td>Y1</td>
</tr>
</tbody>
</table>

X1+Y1 boys and X2+Y2 girls suffer malnourishment in a total of (A+B+C) communities. The communities B and C are those with a higher percentage of malnourished children.

---

**RESULTS OF THE NUTRITIONAL CENSUS IN X COMMUNITIES**

Of all the children suffering malnourishment, after carrying out the pre-selection, _____ % had a W/H % <80%, _____ % had a W/H % >= 80 and < 85%, XXX children had a W/H % >=85%<sup>4</sup>. Finally, a total of X boys and X girls were admitted to a total of XX CWs<sup>5</sup>.

Al finalizar la fase de ejecución de los TC y tras pesar a los niños constatamos en la tabla 5 lo siguiente:

• XX niños han sido rehabilitados con una ganancia de peso adecuada.
• XX niños tuvieron fracaso en el crecimiento ya que la ganancia de peso fue <= 200gr.
• XX niños perdieron peso.
• XX abandonaron. Resulta importante mencionar las causas del abandono.

<sup>4</sup> These percentages can be obtained from the Results Register of the Pre-selection Form.

<sup>5</sup> Bear in mind that if the number of beneficiaries is greater than 12, it must be indicated in the report how many more CW were opened in that same community. Likewise, if the community has a high percentage of children, yet they do not total eight, indicate why a CW was not opened.
The register is comprised of the results contained in record a) Evolution of W/H %, and record b) Evolution on weight gain for the children of a total of 10 workshops. Both are described in Section 1.7 of this manual.

<table>
<thead>
<tr>
<th>No. CWs</th>
<th>Admission (1st CW day)</th>
<th>Conclusion (12th CW day)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were X cases of transfers, all of them to the hospital as there wasn’t a therapeutic nutritional centre. During follow-up, X children died and X were discharged from hospital on XX/XXXX/XXXX.

Referring more to qualitative data, among the XX children of the green-coloured band, HVs were carried out and through the HSs and the 24-hour reminder 4 PD families and 1ML were selected. Complete the following table according to the behaviours identified in the first HSs, previous to the execution phase of the CW.
In view of the results obtained in the first KAP survey, showed below, and the negative behaviours of the HSs, it was decided that only specific IEC messages were going to be given during the sessional phase.

During the follow-up phase, the quantitative results to be highlighted are the evolution on the gain of weight, and the W/H % (See Section 7.1). These two records can be attached to the report’s annex whenever updated. Interpretation of the records can be done as follows: the evolution of nutritional rehabilitation can be observed a year after the CW. From XX % of children who rehabilitated at the conclusion of the CW’s sessional phase, a month later, XX % of them continued with adequate growth, XX % of them had accelerated growth and XX % failed to grow. Six months after the CW, XX % continued with an adequate growth, XX % continued with an accelerated, yet XX % failed to grow.

Qualitative results If we keep in mind that the CWs focus more on changing and promoting new behaviours than transferring knowledge, the programme’s success will be measured by what the most-able people do. Through them we can see the results of changes of behaviour identified in the HSs, carried out a month after the conclusion of the CW, and in those identified during the 2nd KAP, carried out 6 and 12 months after the CW was started. The KAP report (See Section 7.2 for guide on KAP elaboration), is to be attached to the report’s annex.

Finally, it is to be noted that most / many / few (XX %) mothers contributed ingredients (give examples) and their attendance to the CWs has been positive/negative (show results following records).

A supervision and evaluation plan is essential to determine the impact of the programme and to know if the population’s behaviour has changed. Regular supervision and use of that information allows for re-adaptation of the programme’s strategy and/or for a change of the key people, if required.

Evaluation is to be carried out through HSs, with structured interviews, and through KAP studies. KAP studies are the methodology most commonly used to discover the

---

**TABLE 6. RESULTS OBTAINED FROM GOOD BEHAVIOURS AMONG MOTHERS WITH WELL-NOURISHED CHILDREN.**

<table>
<thead>
<tr>
<th>Hygiene and Health Practices</th>
<th>Affection and caring behaviour</th>
<th>Nutritional practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding hygiene: use of clean utensils to feed the children</td>
<td>The father shows the child affection</td>
<td>Increase the frequency of meals</td>
</tr>
<tr>
<td>Children washed, and wearing clean clothes (personal and clothing hygiene)</td>
<td>The children are supervised and kept from danger by an experienced person</td>
<td>Variation in children’s menus</td>
</tr>
</tbody>
</table>
changes produced in feeding, health, hygiene and caring practices (see Section 7). Both HSs and KAP studies are carried out in some homes of the communities selected to implement the CW’s programme, or, in order to carry out a comparison, in some of the homes of the communities which have not been selected.

Some of the points for the programme’s evaluation are:

- Mothers continue giving their children the diets learnt in the CWs a month after execution of CW
- Children, with hospital referrals, who did not gain any weight during the workshop, are to receive medical assistance and treatment if necessary
- IEC messages reinforced by ML or community agents
- Regular ongoing weighing and measuring of the workshop’s children once the sessional phase has concluded.

RECOMMENDATIONS

- To supervise the activities as well as of the project’s management.
- Participation results must be measured following the agriculture calendar and implementation period of the project. Good participation results can be obtained during periods of abundance, where men and specially women have a greater availability and are under less stress, compared to periods of shortage, where men and women are busier.
- In order to know the impact of and improve the programme’s integral component, the water and sewage, food security, health and psycho-social interventions applied are to be evaluated.

7. THE EFFECTIVENESS OF THE INTERVENTION

In order to know the intervention’s effectiveness, it is essential to carry out an evaluation. This evaluation will allow us to check the results or consequences of the project, based on quantitative objectives. It can be carried out at the end of a programme’s phase, at the end of the whole programme or even two years after the programme’s conclusion. It is different from supervision and it focuses on the totality of aims and objectives of the programme, and on the long-term effects and impacts on the objective group; as well as on counterparts and other entities and organisations involved in the development of the project.

Evaluation is a critical tool for any programme, and not only for nutrition and health programmes. After evaluation, achievements can be highlighted, reasons for poor planning can be observed and understood, and chosen solutions analysed.
For example, it can be said that the CW’s programme has been effective when:

- It involves volunteer mothers from the community, defined as MLs, who direct the CW’s sessions and the follow-up HVs.
- Beneficiaries are deloused on the first day of the CW, and the required micronutrients are provided.
- Growth monitoring is used to identify newly malnourished children and monitor their nutritional progress.
- It ensures that those people responsible for children contribute with foods/utensils for the workshops on a daily basis.
- It designs the menus for the sessions, by using locally available foods which are within everyone’s reach.
- It demands attendance and participation from the parents and those responsible for the children, at all the sessions.
- Twelve days of CW sessions are completed within a 2-week period.
- The first follow-up HVs are carried out a month after the workshops conclusion, to ensure the 21 days of practice needed (on average) to transform the newly-acquire behaviour into a habit.
- It actively involves the whole community throughout the whole process.

However, the evaluation of the programme’s impact is to be carried out through precise indicators, which will enable us to know the nutritional condition of the children once they have finished the CW, and their newly acquired behaviours:

- **Quantitative Evaluation.** The taking of anthropometric (Weight and Height) measures on the first and last days of the CW, and over a period of a year, at intervals of one month, two months, six months and 12 months. Nutritional condition will be classified following the Weight/Height criteria. These results will show us the programme’s impact on the nutritional condition of the child. The indicators are Weight Gain, Adequate Growth, Accelerated Growth and Inadequate Growth. The child will be allowed to leave hospital once he/she has gained adequate weight, according to the table of Annex 18.

- **Qualitative Evaluation.** As mentioned, at least 21 days are needed to change a new behaviour into a habit, and so, HVs will begin a month after the workshop’s conclusion. Then again at six months, in order to compare results with first one. A third KAP survey will be taken 12 months from the workshop’s conclusion.

### 7.1. QUANTITATIVE EVALUATION: WEIGHT GAIN AND W/H %

The two records shown below are used for both the sessional and the follow-up phases. They provide a general overview of the programme’s weight gain, showing
### RECORD 2. EVOLUTION OF CHILDREN'S WEIGHT GAIN FOR THE 10 WORKSHOPS (TO BE FILLED IN BY THE AT)

<table>
<thead>
<tr>
<th>No. of workshops</th>
<th>No. of children/workshop</th>
<th>During workshop</th>
<th>Follow-up, at 1 month</th>
<th>Follow-up, at 2 months</th>
<th>Follow-up, at 6 months</th>
<th>Follow-up, at 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accelerated growth (&gt;400gr)</td>
<td>Accelerated growth (&gt;400gr)</td>
<td>Accelerated growth (&gt;700gr)</td>
<td>Accelerated growth (&gt;700gr)</td>
<td>Accelerated growth (&gt;700gr)</td>
<td>Accelerated growth (&gt;700gr)</td>
</tr>
<tr>
<td></td>
<td>Inadequate growth (&lt;200gr)</td>
<td>Inadequate growth (&lt;200gr)</td>
<td>Inadequate growth (&lt;200gr)</td>
<td>Inadequate growth (&lt;200gr)</td>
<td>Inadequate growth (&lt;200gr)</td>
<td>Inadequate growth (&lt;200gr)</td>
</tr>
<tr>
<td>Nº</td>
<td>Nº%</td>
<td>Nº%</td>
<td>Nº%</td>
<td>Nº%</td>
<td>Nº%</td>
<td>Nº%</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The evaluation of weight gain is to be calculated according to the difference in grams obtained after measuring the child on the first and last days of the CW and 2, 6 and 12 months after, and from the results recorded in Annex 5e (Growth evolution of the children per workshop during sessional and follow-up phases).

Another option is to register the % increase of weight, according to the Weight/Height Index, the weight and height gain criteria can be found in Annex 18.
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No: OF CHILDREN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL CHILDREN WITH A W/H % OF</strong></td>
<td>Nº</td>
<td>%</td>
<td>Nº</td>
<td>%</td>
<td>Nº</td>
<td>%</td>
<td>Nº</td>
<td>%</td>
<td>Nº</td>
<td>%</td>
</tr>
<tr>
<td><strong>AT BEGINNING OF WORKSHOP</strong></td>
<td>&lt;80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;=80% Y &lt;85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AT END OF WORKSHOP</strong></td>
<td>&lt;80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;=80% Y &lt;85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;= 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AT 1 MONTH</strong></td>
<td>&lt;80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;=80% Y &lt;85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;= 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AT 2 MONTHS</strong></td>
<td>&lt;80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;=80% Y &lt;85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;= 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AT 6 MONTHS</strong></td>
<td>&lt;80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;=80% Y &lt;85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;= 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AT 1 YEAR</strong></td>
<td>&lt;80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;=80% Y &lt;85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;= 85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
how many from the total number of children in each workshop have adequate and inade-quate growth. Record 1 (Evolution of nutritional condition following weight gain for all children from ten workshops) contains data in grams; Record 2 in W/H %.

7.2 QUALITATIVE EVALUATION: KAP SURVEYS

The KAP is one of the tools which provides the information required for behavioural change. Its objective is to identify and discover the community’s knowledge, attitudes and practices of nutrition, health, hygiene, affection and care of the communities identified with a high % of malnutrition. These can be positively influenced by a community nutrition programme. It also constitutes a follow-up and evaluation tool of the achievements of the workshop.

The following topics can be evaluated: Water and Sewage, Agriculture, Breastfeeding and Child’s Diet, Growth Monitoring, Vaccination, Care of Sick Children, Diarrhoea, ARI, Malaria, Pre-natal Care, Childbirth, Post-childbirth, Family Planning, and HIV/AIDS. Not all topics will be included in a CW’s programme; it is to be adapted to the community’s needs and local context. When adapting the questionnaire, it should be remembered that the KAP will give a concise and easy-to-use list of indicators to account for the results.

There are three implementation phases:

1. **Pre-implementation**: 15 to 20 days are required and it will be developed at the same time as the CW’s preparation phase (they share several points in common).

During this phase community leaders will be interviewed in order to gather any required additional information.

**We will design the sampling strategy.**

Communities were selected following the criteria listed in Section 2.4 of this manual. To select the sample (surveys to take) the following formula is used:

\[
n = \frac{N \cdot z^2 \cdot p \cdot (1-p)}{d^2 \cdot (N-1) + z^2 \cdot p \cdot (1-p)}
\]

Where,
- \(n\) = size of sample
- \(N\) = total population
- \(Z\) = statistical certainty chosen (corresponding to the levels of trust). When assigning the \(z\) value, most studies assume a 95% confidence interval. This indicates that there is a 95% probability that the true population rate lies...
within the value range defined by the estimated limits of trust of the survey. The value of $z$, corresponding to a level of trust of 95% is 1.96.

$p = \text{Expected proportion within the population.} \text{ Usually, the value of } p \text{ is unknown, in which case, a more conservative procedure may be used and } p=0.5. \text{ This will indicate the size of the largest possible sample for study.}$

$q = 1 - p$

$d = \text{desired accuracy.} \text{ Depends on the level of accuracy desired and must be chosen according to survey’s objectives and needs. Usually, the accuracy is within 5% (} d=0.5 \text{) or 10% (} d=0.1 \text{).}$

Bearing this formula in mind, in a community of 265 homes\(^6\) (1,590 inhabitants, at an average of 6 people per house), the size of the sample equates with 157 surveys to be carried out, with an accuracy of 5%; and 71 surveys if the accuracy is 10%. Ten percent accuracy is commonly accepted and used.

In order to identify the starting point - the first household to be surveyed - go to the central point of the community, spin a bottle - or ball-pen - and when it stops, the neck of the bottle or the ball of the pen will indicate the direction.

1. Go to the community’s central point, where the population is approximately equally distributed in all directions.
2. Find a flat and level place, put the bottle on its side and spin it.
3. When the bottle stops spinning, the direction to follow is determined by the neck of the bottle. A member of the team will walk in that direction until reaching the section’s limit, counting the number of houses along the way.
4. From all those houses, randomly choose the first house to begin: house number 1. Then, follow on in that direction.
5. The following houses will each be selected by choosing the house with its front door closest to the last visited house.
6. Surveys are then to be carried out, following that system, until the sample size for that community has been completed.

If, having arrived at the end of the section and the sample is incomplete, one must return to the village’s central point and randomly choose another direction by repeating all the above steps, until the sample has been completed.

If there were two teams taking surveys in the same area, they must go in opposite directions. That is, one team goes in the direction selected by the neck of the bottle, the other in the direction indicated by the bottle’s base.

The questionnaire is to be answered by those caring for children under the age

---

\(^6\) When only the number of inhabitants is known, divide this number by the average number of people per household.
of five, as they are the ones who better know aspects related to the home and
the children. If the carer is not at home, continue by going to the next house
on the right.

The required budget, the dates of the survey, and the report’s presentation
date are all to be determined. The needed human resource personnel and ma-
terial (as well as their training, 3 to 4 days) are to be chosen.

The questionnaire is to be adapted to local reality, and only those subjects we
need to know about are to be included. Validate the questionnaire by survey-
ing two mothers, one or two days before commencing the implementation
phase.

The use and process of the questionnaires is standardised through a two-day
training course, where all questions are detailed and the correct manner used
to fill in the questionnaires and interview people is explained.

2. Implementation (4 days): before sending surveyors to the community, it is help-
ful to meet with them:

- To solve any last minute problems
- To confirm the availability of all the required materials
- To confirm the availability of the locations assigned to each survey team for
  that day
- To review the protocol for arrival at the community - visit local leaders and
  health workers
- To review home-selection protocol.

Effective data collection will be achieved through the undertaking of surveys,
noting the average time spent for an interview, the number of days employed,
problems found, and measures taken to avoid mistakes.

It is recommended that all surveyors meet as a group on a daily basis to share
experiences and problems. The team must meet at the end of each day at the
very least, to hand over the questionnaires to the supervisor and examine any
problems or to receive follow-up training. It is also helpful that supervisors
meet as a group with the KAP coordinator to carry out a daily follow-up.

3. Post implementation (6 to 10 days)

Data tabulation and analysis. Bear in mind the personnel required for this task
(ie: three people for four days).

Before analysing the data, any mistakes made during data collection or entry -
if a computer is used - are to be corrected. The coordinating team as well as
project field-personnel must be involved in this activity. There is no need to
wait until all the interviews are finished before refining data. Checking for mis-
takes can be done during field implementation, while it is still possible to correct them. As interviews are completed, supervisors are to check that questionnaires have been correctly filled out. Supervisors then follow-up with interviewers to rectify any identified mistakes, visit interviewees again if necessary, and ensure that those same mistakes are not made again in the remaining questionnaires. Below are examples of mistakes which must be identified:

1. Blank questions
2. Wrong postcodes
3. Incorrect jump patterns (to skip a question after interviewee has given the answer)
4. To tick/write down the correct answer in the wrong place
5. Illegible marks.

Once data refining is concluded, the data is tabulated. It is useful to pair up data entry personnel, rather than have them work individually. With each completed questionnaire, one can read the interviewee’s answers while the other enters the correct codes in the computer.

Once the appropriate files have been created and the data entered, computer analysis can be quite fast and, depending on the type of analysis that can be done, give the projects greater flexibility. Most analyses are limited to frequencies (counts) on each question.

Dissemination of conclusions and writing of the report to be circulated with other organisations, agencies and/or institutions working in the area. The data will be used in taking decisions on health issues.

A KAP survey’s report is an important outcome of the PAK process. It must provide a detailed explanation of the study, present survey’s conclusions, and examine the programming implications of such conclusions. Individuals who were not involved in the study must be able to read the report and come away with a solid idea, not only of the main conclusions but also of the process and methods used. It must contain the following:

1. Front Page: title, date and OVP/country, co-participating organisations, other participating organisations and authors’ names
2. Thank-yous
3. Table of Contents
4. Introduction: Geographical situation (total population, number of children under the age of five, number of homes), the area’s nutritional and health information; type of ACFIN programme being developed and the specific objectives of the KAP.
5. Executive Summary

6. KAP Methodology: Questionnaire (topics assessed, survey duration, etc.), indicators (grouped by topics, definition of each indicator, etc.), sample design (calculation of the sample’s size, etc.), teams, training courses, number of days required for the implementation phase, problems found, measures taken to avoid mistakes, etc.

7. Results: analyse and present the assessed topics with each indicator. (For instance: Percentage of 12 to 23-month-old children who received a measles vaccine; Percentage of ill 6 to 23-month-old children who, in the last two weeks were given a larger quantity of liquids and food etc..) It is very helpful for readers as well as for report writers to present findings in charts and to refer to them in the text. Graphics and tables are used to present the results.

8. Conclusions and comparisons with results of previous KAPs.

9. Recommendations

10. Annexes: Questionnaire (the distinct modules in which the questionnaire is to be based and adapted can be found at ACF-E headquarters)

In the report’s final version, it is not necessary to include the frequencies of each survey question. Nonetheless, they may be included in the report’s appendix, if this is deemed necessary, so that the statistical differences on the results of the two KAPs (initial & final) can be considered. A cross-tabulation of the data is recommended, using key variables (ie: gender, mother’s age, etc.). It is not necessary to present a table for each cross-tabulation. However, it is useful to account for the findings of cross-tabulations, though it can only be stated that differences were not found in some of them.
Entre el 25 y 35% de las madres acuden a un centro de salud cuando su niño presenta fiebre y/o diarrea. Por otro lado, frente a un caso de desnutrición, el 91,4% de las madres dice que acudiría a un centro de salud, y se logró disminuir del 26,5% al 8,6% las madres que acudirían a la medicina tradicional en caso de desnutrición.

Between 25% and 35% of mothers visit a health centre whenever the child has a temperature and/or diarrhoea. In a malnutrition case, 91.4% of mothers visit a health centre, and it was possible to reduce from 26.5% to 8.6% the mothers who would turn to traditional medicine in the event of malnutrition.

Those mothers who now understand that a substantial loss of weight is a clear sign of malnutrition have increased by 30%. There is a decrease of approximately 52% (from 88.2% to 36.4%) of those not carrying out a nutritional follow-up of the child.

Breast-feeding: an increase from 2.9% to 9.1% of mothers who breastfed their children immediately after birth.

While 67.6% of mothers did not initially know about the advantages of exclusively breast-feeding, two months after, 66.7% of them mentioned at least one of the three advantages when asked. Also, 48.5% know that the child should be exclusively breastfed until he/she is four months old, still 82.4% gave the baby water before the age of four months.

It was also possible to decrease (from 85.3% to 66.7%) the number of mothers who gave complementary food to children under the age of four months.

Good eating habits: initially 94.1% of the mothers were unaware of the three food groups, and of what constitutes a balanced diet. With the second KAP, 60.6% of them knew the three groups, and half knew that one food from each must be used for a balanced diet.

Initially 50% of mothers were unaware of any health practices to follow during pregnancy. Yet, awareness that one must eat for two when pregnant increased by 60%. Likewise, where 94% did not initially know the causes of anaemia, and 85.3% could not identify foods rich in iron, after two months, 66.7% knew that a lack of iron causes anaemia, and that meat is the main source of iron.

One hundred percent of interviewees did not know what cretinism was, nor which foods contained iodine. In the second survey 63.6% identified an iodine deficiency as a cause for cretinism, and 69.7% knew that enriched salt is a food rich in iodine.

Night blindness could not be defined by 97.1%, neither did they know what foods are rich in vitamin A. Two months later and 84.8% noted the lack of vitamin A as the cause for night blindness, and 69.7% knew that fruit is a high-content source of vitamin A.

Immunisation remains more-or-less unchanged at 80% - the percentage of children holding a vaccination card.
To sum up, a very positive evolution in mother’s hygiene, health and nutrition knowledge can be seen. It is very important to remember these results during future implementations of CW programmes, and apply them accordingly. Educational sessions seem to be appropriate, and support with nutrition and the application of recipes must be increased in order to completely improve health habits and conditions in general.
8. MATERIALS & UTENSILS

Utensils are to be kept in a wooden or waterproof box for their good management and maintenance. All office material and follow-up records will be kept in a separate box.

This list of utensils is to be verified by the CA before and after each session. In the event of damage or loss, he or she will be held responsible.

<table>
<thead>
<tr>
<th>KITCHEN UTENSILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utensils</td>
</tr>
<tr>
<td>Plate</td>
</tr>
<tr>
<td>Dish</td>
</tr>
<tr>
<td>Scissors</td>
</tr>
<tr>
<td>Knife</td>
</tr>
<tr>
<td>Tea spoon</td>
</tr>
<tr>
<td>Soup spoon</td>
</tr>
<tr>
<td>Ladle G</td>
</tr>
<tr>
<td>Cup</td>
</tr>
<tr>
<td>Drum</td>
</tr>
<tr>
<td>Colander</td>
</tr>
<tr>
<td>Dried-out Pumpkin used as a pot</td>
</tr>
<tr>
<td>Cooking pot with lid</td>
</tr>
<tr>
<td>Bucket with lid</td>
</tr>
<tr>
<td>Spatula</td>
</tr>
<tr>
<td>Empty tins and containers</td>
</tr>
<tr>
<td>Measuring jugs</td>
</tr>
<tr>
<td>Pestle &amp; Mortar</td>
</tr>
<tr>
<td>Measuring scales to 50kg</td>
</tr>
<tr>
<td>Precision scales</td>
</tr>
</tbody>
</table>
### REGISTER AND FOLLOW-UP MATERIAL

<table>
<thead>
<tr>
<th>Material</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marker, black/blue/red pens, pencil, rubber, sharpener, ruler</td>
<td>1 of each</td>
</tr>
<tr>
<td>Calculator</td>
<td>1</td>
</tr>
<tr>
<td>Folder</td>
<td>1</td>
</tr>
<tr>
<td>Waterproof folder</td>
<td>4</td>
</tr>
<tr>
<td>Small notebook</td>
<td>1</td>
</tr>
<tr>
<td>Laminated Child Weight/Height Measure</td>
<td>1</td>
</tr>
<tr>
<td>Laminated Child Weight/Age Measure</td>
<td>1</td>
</tr>
<tr>
<td>Protocol Poster of systematic treatment – laminated</td>
<td>1</td>
</tr>
</tbody>
</table>

### FURNITURE

<table>
<thead>
<tr>
<th>Material</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benches</td>
<td>4</td>
</tr>
<tr>
<td>Small table</td>
<td>1</td>
</tr>
<tr>
<td>Wooden box for utensil storage</td>
<td>1</td>
</tr>
<tr>
<td>Small mats</td>
<td>5</td>
</tr>
</tbody>
</table>

### HYGIENE MATERIAL & EQUIPMENT

<table>
<thead>
<tr>
<th>Material</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bar of hand soap</td>
<td>2</td>
</tr>
<tr>
<td>Washing up detergent</td>
<td>2</td>
</tr>
<tr>
<td>Broom</td>
<td>1</td>
</tr>
<tr>
<td>Sponge</td>
<td>2</td>
</tr>
<tr>
<td>Serviettes</td>
<td>2</td>
</tr>
<tr>
<td>Chamber-pot</td>
<td>4</td>
</tr>
</tbody>
</table>

### ANTHROPOMETRIC MATERIAL

<table>
<thead>
<tr>
<th>Material</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby scale</td>
<td>1</td>
</tr>
<tr>
<td>Scale to 25kg</td>
<td>1</td>
</tr>
<tr>
<td>Weight wedges</td>
<td>2</td>
</tr>
<tr>
<td>Nylon string</td>
<td>5m</td>
</tr>
<tr>
<td>Verification weights</td>
<td>1 de 2Kg I 1 de 5Kg</td>
</tr>
<tr>
<td>Strip to measure the braquial perimeter</td>
<td>2</td>
</tr>
<tr>
<td>Table for measuring children</td>
<td>1</td>
</tr>
<tr>
<td>Adhesive Metric band</td>
<td>1</td>
</tr>
</tbody>
</table>

### OTHERS

<table>
<thead>
<tr>
<th>Material</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Megaphone and batteries</td>
<td>1</td>
</tr>
<tr>
<td>Regional Office’s information sheets</td>
<td>1</td>
</tr>
<tr>
<td>Radio cassette player and batteries</td>
<td>1</td>
</tr>
<tr>
<td>T-shirts</td>
<td>5</td>
</tr>
<tr>
<td>Rucksack</td>
<td>4</td>
</tr>
</tbody>
</table>

*This material will depend on the capacity of the project’s design and acquisition’s budget.

ACF-E will deliver this material if CAs commit to:
- Comply with the undertaking of tasks they are entrusted with.
- Not to use the delivered equipment & material for private purposes.
- Only wear the shirts when home visits are being made.

In the event of failing to comply with the above, ACF-E will suspend its help, and the CA must return all the delivered equipment, material, and T-shirts.

Date: __________________________

Community Agent (CA)
Do not forget medicines: *Mebendazol (100mg), iron/folic acid and vitamin A of 100,000 UI y 200,000 UI*

At the end of the sessional phase, a bicycle may be given to the CA in order to motivate him/her to continue activities during the follow-up phase.

In the event of damage or loss, the following form must be filled out and handed over to the OA, who will give it to the supervisor. In each case replacement will be assessed.

<table>
<thead>
<tr>
<th>Description of Item</th>
<th>Unit</th>
<th>Damaged or Lost</th>
<th>What happened?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. STRENGTHENING OF LOCAL STRUCTURES AND ORGANISATIONS

Different agents are involved within a CW programme. Often, the international NGO or Ministry of Health takes the lead to direct and train the village’s health personnel so that they can implement the CW at a community level. In order to ensure a quality implementation, the leading organisation must provide sufficient support for monitoring, and for the mobilisation, training and supervision carried out by the executing institution, ensuring that they adhere to the programme’s fundamental principles.

If there is collaboration with a local institution, it can help strengthen that institution and promote an improvement of its response capacities, guaranteeing intervention sustainability. This way ACF-IN will be able to begin withdrawing from the area by relying on the developed capacities of local institutions.

The first step when defining possible counterparts is to identify all organisations working in the area. Difficulties can be found when initiating stable professional contact with them. As both organisations must contribute to one another’s interest, create trust, and define clear communication and coordination methods, the signing of understanding agreements or memoranda is essential.

Partnerships are not restricted to the subcontracting of activities; and if it is desired to strengthen specific organisations, it will be necessary to design a work plan and have the required funds. It is also important to take into account that ACF-IN counterparts will need to endorse the organisation’s principles. Annex 19 shows an example of an agreement between ACF-IN and a chosen local counterpart.
10. TRAINING

‘If I hear it, I forget it. If I look at it, I remember it. If I do it, I learn it. If I discover it, I apply it.’

Training based on the Positive Deviation approach is the focus of the CWs. In order to carry out the CW process, personnel, MLs and key community members must be trained so that a substantial impact on child malnutrition can be made.

Compared to the traditional methodology employed for the undertaking of KAP home visits, the CWs’ learning methodology is based on Practice, Attitude and Knowledge (AKP). This approach focuses on changing behaviours in order to change ideas and ways of thinking, compared to the method of changing the ways of thinking, in order to later change behaviours. It is only after practice (when child carers see that children start to ‘wake up’) that they start changing their attitudes. When seeing the change their child is undergoing, they begin to understand the reasons behind it and to recognise other changes needed for the rehabilitation.

After each training course, it is essential to carry out an evaluation of participants to find out how much they have learnt. This evaluation is done with a Pre-test (Annex

---

**CHART 10. EXAMPLES OF TRAINING METHODOLOGY**

**Interactive discussion.** This is a methodology to involve participants in the gathering of information. It can be employed for a wide range of topics.

Q: Who are the people in charge of keeping children in a healthy condition?
A: Parents

Q: What else can be done independently by poor families?
A: To use the PD practices.

Q: How can families learn to keep their children in a healthy condition?
A: By changing their habits; learning new ones and which are accessible-to-all (…)

**Survey questions.** Posters are used to show correct/incorrect practices and/or situations. Discussion is begun with a general question about the poster, followed by deeper questioning of the participant’s impressions of what the posters illustrate. For instance:

Poster 1: A woman washing her hands.
Opening question: Why is she washing her hands?
Survey question: When do you wash your hands?

Poster 2: A woman washing vegetables
Opening question: Why is she washing the vegetables?
Survey question: Do you usually wash the vegetables before cooking them? Why / Why not?
20), before the training on the first day and a Post-test on the last training day. Of course tests are not the only evaluation tool: observation during participation in the different training methodologies is part of an informal evaluation technique.

Format example for training attendance sheets

<table>
<thead>
<tr>
<th>TRAINING ATTENDANCE FORM</th>
<th>(To be completed by trainer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; surname</td>
<td>Position to take</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Given the variety of people required for the different roles, the contents to be developed will vary for each group. Follow Table 7 in order to achieve the following training objectives:

Before undertaking any training, the participants’ current skills and knowledge are to be identified in order to establish the gaps which require filling. The above table is for orientation purposes only, and is to be adapted according to the characteristics of each group. The person to undertake each training module must be chosen.

The following tables summarise the training modules’ content for each group.
<table>
<thead>
<tr>
<th>Directed to</th>
<th>Facilitator</th>
<th>Time required</th>
<th>When?</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager, Supervisor</td>
<td>DNC</td>
<td>5 days</td>
<td>Before deciding to implement the CWs</td>
<td>To organise and manage the CWs’ programme. To analyse and interpret the results obtained during the different phases of the CWs. To inform the community on the results achieved during the sessions.</td>
</tr>
<tr>
<td>OA, Health Agents</td>
<td>Supervisor</td>
<td>5 days</td>
<td>After having negotiated with the community</td>
<td>Supervision, monitoring and evaluation skills. Information System Use of food-composition charts and menu planning. Interpretation of the CW’s results. Understanding of nutrition and infection cycle. Vaccination programmes. To inform the community on the results achieved during the sessions. To evaluate the progress made by children and, at the end of sessions, to provide adequate advice to child carers.</td>
</tr>
<tr>
<td>ML</td>
<td>OAs</td>
<td>4 days</td>
<td>During the preparation phase</td>
<td>Growth monitoring and promotion. Basic nutrition, nutrients and use of food-content chart. Market study. Home-visit skills. The value of food - three or four groups Principles of treating malnutrition at home. Prevention and treatment of dehydration in the event of diarrhoea. How to recognise signs of acute illness which require hospitalisation, including pneumonia, malaria and serious diarrhoea. Early-age stimulation techniques. To explain the programme’s two aims to mothers and other people in charge of the children’s care. To convince mothers and family members of the need to bring their daily contribution of food. To organise and give the different IEC messages during the daily sessions of the CWs. To effectively use training modules and visual aids.</td>
</tr>
</tbody>
</table>
**TABLA 8. CONTENIDO DESEADO DEL MODULO DE CAPACITACIÓN DE LA ML**

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>3hr &amp; 30min</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presentation</strong></td>
<td>To review the previous day</td>
<td>To review the previous day</td>
<td>To review the previous day</td>
<td>15mins</td>
</tr>
<tr>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
<td></td>
</tr>
<tr>
<td>To review HSs’ findings and show results of the nutritional census</td>
<td>Food groups and their functions (energetic, constructive and protective substances)</td>
<td>How to fill in the sheets: - The Market Survey Form - Child Attendance Record</td>
<td>Illness prevention and treatment</td>
<td>1hr</td>
</tr>
<tr>
<td>30mins</td>
<td>30mins</td>
<td>30mins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Context: When can a CW be given? Description: What is a session and what is it comprised of? And admission criteria.</td>
<td>Diet calendar: - breastfeeding exclusively - complementary feeding</td>
<td>Complementary food</td>
<td>How to prepare a ORS in the home</td>
<td>30mins</td>
</tr>
<tr>
<td>45mins</td>
<td>45mins</td>
<td>1hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td>Break</td>
<td>Break</td>
<td>Break</td>
<td>15mins</td>
</tr>
<tr>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
<td></td>
</tr>
<tr>
<td>Objectives of the programme Who will be working together to rehabilitate the children and what their roles will be?</td>
<td>Preparation of CW’s first session (first day of CW): tasks and proceedings</td>
<td>How to use the Regional Office’s Information Sheets</td>
<td>Why, and how to carry out the HSs</td>
<td>30mins</td>
</tr>
<tr>
<td>30mins</td>
<td>30mins</td>
<td>15mins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ML’s role during the sessional and follow-up phases of the CWs</td>
<td>Protocols</td>
<td>Messages included in the Regional Office’s Information Sheets (NMP)</td>
<td>Preparation of last session (day 12) of the CW - Tasks and Proceedings</td>
<td>30mins</td>
</tr>
<tr>
<td>30mins</td>
<td>1hr</td>
<td>30mins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To find out local availability of the foods, materials and utensils required for CWs</td>
<td>Diet and Personal hygiene</td>
<td>Practice explaining a Regional Office’s Information Sheet</td>
<td>Training evaluation</td>
<td>30mins</td>
</tr>
<tr>
<td>15mins</td>
<td>1hr</td>
<td>15mins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch*</td>
<td>Lunch*</td>
<td>Lunch*</td>
<td>Lunch*</td>
<td>Closing</td>
</tr>
<tr>
<td>90mins</td>
<td>90mins</td>
<td>90mins</td>
<td>90mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Family’s daily contribution mins Breastfeeding 1hr Child care 1hr</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To prepare, according to local availability, diverse and nutritive menus for the 12 days of the CW To write a song for the CW 15mins General review of topics 30mins</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90mins</td>
<td>15mins</td>
<td>15mins</td>
<td>30mins</td>
<td></td>
</tr>
<tr>
<td>Evaluation of the day Evaluation of the day Evaluation of the days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*During lunch, diverse menus will be prepared and a local name will be given to each recipe. The child’s portion will be calculated by using local measures. Menus are to be prepared for the 12 days of the CW.*
### TABLE 9. DESIRED CONTENT FOR THE CA’S TRAINING MODULE

<table>
<thead>
<tr>
<th>Day</th>
<th>5hr &amp; 30mins</th>
<th>Day 2</th>
<th>5hr &amp; 45mins</th>
<th>Day 3</th>
<th>5hr &amp; 30mins</th>
<th>Day 4</th>
<th>6hr &amp; 45mins</th>
<th>Day 5</th>
<th>2hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>Presentation</td>
<td>15mins</td>
<td>Review of the previous day</td>
<td>30mins</td>
<td>Review of the previous day</td>
<td>30mins</td>
<td>Review of the previous day</td>
<td>30mins</td>
<td>2hrs</td>
</tr>
<tr>
<td></td>
<td>Objectives and training introduction</td>
<td>15mins</td>
<td>Each person’s role in a CW</td>
<td>30mins</td>
<td>How to carry out the Nutritional Census</td>
<td>1hr</td>
<td>IEC Messages: (definition, objectives, transmitting</td>
<td>30mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 2</td>
<td>1hr</td>
<td>Pre-test</td>
<td>Role of the CA</td>
<td>30mins</td>
<td>Practical exercise with the children of the community</td>
<td>30mins</td>
<td>How to use the Regional Office’s Information Sheets</td>
<td>15mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 3</td>
<td>Break</td>
<td>15mins</td>
<td>Break</td>
<td>15mins</td>
<td>Break</td>
<td>15mins</td>
<td>Break</td>
<td>15mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 4</td>
<td>Malnutrition concepts: types, signs, causal tree, consequences, etc.</td>
<td>1hr</td>
<td>Anthropometric measures: objectives, material, etc.</td>
<td>30mins</td>
<td>How to complete: - The Population’s Nutritional Situation Register, Pre-se-lection and Final Selection records</td>
<td>45mins</td>
<td>Messages included in the Regional Office’s Information Sheets (PMN)</td>
<td>2hrs</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 5</td>
<td>State of malnutrition in the country, region &amp; community</td>
<td>15mins</td>
<td>Taking anthropometric measures: weight, height, PB</td>
<td>1hr</td>
<td>How to fill in: - Child Growth Evolution Record - HS Records and 24-hour Diet Reminder - Market Survey - Child’s Diet Consumption Control Record - Referral Sheet</td>
<td>90mins</td>
<td>Practice on how to explain a Regional Office’s Information Sheet</td>
<td>15mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 6</td>
<td>Description of a CW</td>
<td>30mins</td>
<td>Nutritional Indexes</td>
<td>45mins</td>
<td>Lunch</td>
<td>90mins</td>
<td>How &amp; why to carry out a Market Survey</td>
<td>1hr</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 7</td>
<td>Lunch</td>
<td>90mins</td>
<td>Lunch</td>
<td>90mins</td>
<td>How to find out the local availability of foods and tools/utensils required during CW</td>
<td>15mins</td>
<td>Lunch</td>
<td>90mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 8</td>
<td>CW’s phases</td>
<td>2hrs</td>
<td>Practical exercises in the taking of anthropometric measures</td>
<td>1hr</td>
<td>To prepare diverse and nutritious menus according to food availability and recipe examples</td>
<td>30mins</td>
<td>How to do the HSs</td>
<td>90mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 9</td>
<td>Evaluation of the day</td>
<td>15mins</td>
<td>Interpretation of growth evolution curve and child’s referral</td>
<td>45mins</td>
<td>Family’s daily contribution during the CW’s rehabilitation phase</td>
<td>15mins</td>
<td>Evaluation of the previous days</td>
<td>30mins</td>
<td>15mins</td>
</tr>
<tr>
<td>Day 10</td>
<td>Evaluation of the day</td>
<td>15mins</td>
<td>Evaluation of the day</td>
<td>15mins</td>
<td>Evaluation of the day</td>
<td>15mins</td>
<td>Evaluation of the day</td>
<td>15mins</td>
<td>15mins</td>
</tr>
</tbody>
</table>
### TABLE 10. OA & HEALTH AGENT TRAINING MODULE’S DESIRED CONTENT

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>5hr &amp; 30min</td>
<td>7hrs</td>
<td>7hrs</td>
<td>6hr &amp; 30min</td>
<td>4hr &amp; 45min</td>
</tr>
<tr>
<td><strong>Objective &amp; training introduction</strong></td>
<td>30mins</td>
<td><strong>Installation &amp; presentation</strong></td>
<td>30mins</td>
<td><strong>Review of the previous day</strong></td>
</tr>
<tr>
<td><strong>Objectives &amp; training introduction</strong></td>
<td>30mins</td>
<td><strong>Review of the previous day</strong></td>
<td>30mins</td>
<td><strong>Review of the previous day</strong></td>
</tr>
<tr>
<td>1hr</td>
<td><strong>Definition, objectives, and the importance on taking anthropometric measures, and on growth follow-up</strong></td>
<td>1hr</td>
<td><strong>Referral system. Filling in and follow-up of:</strong></td>
<td>90mins</td>
</tr>
<tr>
<td>1hr</td>
<td><strong>Protocols</strong></td>
<td>1hr &amp; 45mins</td>
<td><strong>- Evolution on growth gain for the total number of children from ten workshops</strong></td>
<td>90mins</td>
</tr>
<tr>
<td>1hr</td>
<td><strong>Implementation of CWs and phases</strong></td>
<td>1hr</td>
<td><strong>- W/H% (Weight/Height) evolution for the total number of children from ten workshops</strong></td>
<td>90mins</td>
</tr>
<tr>
<td>1hr</td>
<td><strong>Descriptions of tasks to be carried out by the CA and ML</strong></td>
<td>1hr</td>
<td><strong>- Abandonment and referrals</strong></td>
<td>90mins</td>
</tr>
<tr>
<td>1hr</td>
<td><strong>Analysis of the community situation. How to take a Nutritional Census and a KAP</strong></td>
<td>90mins</td>
<td><strong>- Medical follow-up</strong></td>
<td>90mins</td>
</tr>
<tr>
<td><strong>State of Malnutrition in the country, region and community</strong></td>
<td><strong>Lunch</strong></td>
<td><strong>Lunch</strong></td>
<td><strong>Lunch</strong></td>
<td><strong>Closing</strong></td>
</tr>
<tr>
<td>45mins</td>
<td>90mins</td>
<td>90mins</td>
<td>90mins</td>
<td>15mins</td>
</tr>
<tr>
<td><strong>Context, description, general objective, admission definition and criteria</strong></td>
<td><strong>Study</strong></td>
<td><strong>Diet during pregnancy &amp; breastfeeding</strong></td>
<td><strong>Messages included in the Regional Office’s Information Sheets (NMP)</strong></td>
<td><strong>Evaluation of the day</strong></td>
</tr>
<tr>
<td>45mins</td>
<td>1hr</td>
<td>15mins</td>
<td>90mins</td>
<td>30mins</td>
</tr>
<tr>
<td><strong>Agriculture Calendar / food groups</strong></td>
<td><strong>How to carry out the HSs</strong></td>
<td><strong>Market Survey</strong></td>
<td><strong>Evaluation of the day</strong></td>
<td><strong>Evaluation of the day</strong></td>
</tr>
<tr>
<td>30mins</td>
<td>30mins</td>
<td>30mins</td>
<td>30mins</td>
<td>30mins</td>
</tr>
<tr>
<td><strong>Pre-test</strong></td>
<td><strong>Break</strong></td>
<td><strong>Break</strong></td>
<td><strong>Break</strong></td>
<td><strong>Break</strong></td>
</tr>
<tr>
<td>1hr</td>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
</tr>
<tr>
<td><strong>Break</strong></td>
<td><strong>How to fill in the anthropometric data records</strong></td>
<td><strong>Other nutritional deficiencies: (Fe, vitamins, etc.)</strong></td>
<td><strong>Descriptions of tasks to be carried out by OAs and health agents</strong></td>
<td><strong>Undertaking a Synthesis Analysis</strong></td>
</tr>
<tr>
<td>15mins</td>
<td>1hr</td>
<td>1hr</td>
<td>1hr</td>
<td>2hrs</td>
</tr>
<tr>
<td><strong>Malnutrition concepts : types, signs, consequences, etc.</strong></td>
<td><strong>Diet diversification and recipes</strong></td>
<td><strong>Implementation of CWs and phases</strong></td>
<td><strong>Description of tasks to be carried out by the CA and ML</strong></td>
<td><strong>Presentation of reports</strong></td>
</tr>
<tr>
<td>1hr</td>
<td>90mins</td>
<td>1hr &amp; 45mins</td>
<td>1hr</td>
<td>1hr</td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td><strong>Evaluation of the day</strong></td>
<td><strong>Evaluation of the day</strong></td>
<td><strong>Evaluation of the day</strong></td>
<td><strong>Evaluation of the day</strong></td>
</tr>
</tbody>
</table>
**TABLE 11. DESIRED CONTENT FOR THE PROJECT MANAGER AND SUPERVISOR’S TRAINING MODULES**

<table>
<thead>
<tr>
<th>Day 1</th>
<th>7hrs &amp; 30mins</th>
<th>Day 2</th>
<th>6hrs &amp; 30mins</th>
<th>Day 3</th>
<th>7hrs</th>
<th>Day 4</th>
<th>6hrs &amp; 30mins</th>
<th>Day 5</th>
<th>4hrs &amp; 45mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Installation &amp; presentation</td>
<td>15mins</td>
<td>Review of the previous day</td>
<td>30mins</td>
<td>Review of the previous day</td>
<td>30mins</td>
<td>Review of the previous day</td>
<td>30mins</td>
<td>Review of the previous day</td>
<td>30mins</td>
</tr>
<tr>
<td>Objectives &amp; training introduction</td>
<td>15mins</td>
<td>Taking of anthropometric measures and nutritional indexes: interpretation of Nutritional Census</td>
<td>90mins</td>
<td>Organisation and diffusion of IEC messages</td>
<td>90mins</td>
<td>How to monitor activities, Follow-up Calendar, etc.</td>
<td>1hr</td>
<td>Post-test</td>
<td>1hr</td>
</tr>
<tr>
<td>Pre-test</td>
<td>1hr</td>
<td>Break</td>
<td>15mins</td>
<td>Break</td>
<td>15mins</td>
<td>Break</td>
<td>15mins</td>
<td>Break</td>
<td>15mins</td>
</tr>
<tr>
<td>Break</td>
<td>15mins</td>
<td>Referral system protocols</td>
<td>1hr</td>
<td>HSs</td>
<td>1hr</td>
<td>Exercises on how CW records must be filled in</td>
<td>2hrs</td>
<td>Undertaking a Synthesis Report</td>
<td>2hrs</td>
</tr>
<tr>
<td>Context, description, general objective, admission, definition, criteria</td>
<td>45mins</td>
<td>Agriculture Calendar and Market Survey</td>
<td>30mins</td>
<td>Organisation and management of beneficiaries’ food contributions</td>
<td>30mins</td>
<td>Practice exercise on record’s data entry in the computer</td>
<td>30mins</td>
<td>Presentation of reports</td>
<td>1hr</td>
</tr>
<tr>
<td>CW Implementation &amp; Phases</td>
<td>90mins</td>
<td>Nutritional value of locally available foods according to local measures</td>
<td>30mins</td>
<td>Lunch</td>
<td>90mins</td>
<td>Lunch</td>
<td>90mins</td>
<td>Closing</td>
<td>15mins</td>
</tr>
<tr>
<td>Description of each person’s role in the CW</td>
<td>1hr</td>
<td>Calculation of nutritional rehabilitation recipes</td>
<td>1hr</td>
<td>Strategies on: -Health -Nutrition -Water &amp; Sewage -Food Security</td>
<td>1hr</td>
<td>Elements of supervision to bear in mind</td>
<td>1hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td>90mins</td>
<td>Lunch</td>
<td>90mins</td>
<td>KAP Study</td>
<td>1hr</td>
<td>How to present the reports: -results -interpretation -suggestions, etc.</td>
<td>1hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malnutrition concepts: Types, Signs, Causal Tree, Consequences, etc.</td>
<td>1hr</td>
<td>Community participation techniques</td>
<td>1hr</td>
<td>Evaluation of the day</td>
<td>30mins</td>
<td>Evaluation of the day</td>
<td>30mins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State of malnutrition in the country, region, &amp; community</td>
<td>45mins</td>
<td>Evaluation of the day</td>
<td>30mins</td>
<td>Evaluation of the day</td>
<td>30mins</td>
<td>Evaluation of the day</td>
<td>30mins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation of the day</td>
<td>30mins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Project managers and supervisors are required to have professional experience on nutrition. And so, training will focus on other programme’s supervision and management aspects. Nutritional aspects will only be superficially covered.
CW sessions can be seen as training modules themselves. Attending mothers can be involved on the rehabilitation of their children and can learn new behaviours to keep them healthy. Each CW constitutes a 'Training Workshop' where adult learning techniques are incorporated. The process begins by extracting the training messages required through the HSs and the 24-hour meal reminders, and follows with the design of the training contents and logistic planning.

Health education cannot be taught simply by lecturing. But by taking mothers through a series of experiences over several weeks, they learn how to feed their children in an ideal and supportive environment. Afterwards, a follow-up is carried out through home-visits where they practice, in their own kitchen, the new food preparation techniques and child feeding behaviours.

Learning is primarily a social process. People learn through observation and interaction. Learning comes through making and discovering.

At the end of the training modules, each participant should receive a Participation Certificate. (Annex 21)

RECOMMENDATIONS for carrying out training modules

- Time management is to be followed in order to avoid overwhelming participants and ensuring that skills are directly and appropriately applied.
- To prepare the appropriate materials in advance: IEC messages in Regional Office's information sheets, visual aids, paper, markers, PD-foods drawings and/or illustrations, food charts, local measuring tools (spoons, tins, local measures, scales, etc.), menu visual aid, and menu card, etc.
- It is very tempting, especially for those who are health professionals, to impose one's own messages, menus and nutritional theories. During the workshop personnel should consider the participant's position. After the workshop, continue to teach the ML, but by example.
- Participation experiences where participants discover the concepts and apply their own experiences are much more effective.
- It is important to train personnel in the same manner in which we wish them to train.
- To present the new information step by step. To repeat and reinforce information.
- To promote a supportive and guided learning-environment where beneficiaries feel their participation is successful.
- To ask participants to repeat or explain information.
- To always leave time for questions and discussion.
- To interact with all, not just with those who actively participate.
- To keep sessions short and simple.
- To initiate the session by reviewing what was learnt and discussed the previous day.
- To use visual aids and demonstrations as much as possible so that all senses can be used during the learning process.
- The more training materials, the more interesting and fun it will be.
11. NEXT STEPS

To adapt a CW guide so that it can be used by the community and not only by co-operators. So that key community people will have a consultation tool, to execute the programme and prevent malnutrition in children once they have been rehabilitated through the CWs. The most appropriate information channels are to be considered: images of specific actions, plenty of practical examples adapted to their local customs, translated to the native languages of the community where the workshops will be held, etc.

The involvement of community members to adapt this guide may be useful.

Through the CW programme, the community discovers its problems and finds their own solutions as they are based on their own resources. From the beginning active participation is achieved. They learn how to manage and supervise the project. Those programmes having a community component, such as home malnutrition treatment, could be carried out using methods which awaken the community's interest, such as those used by the CW. The sections of this manual on involvement, motivation and mobilisation of the community, may be useful for and applicable to other programmes.

It would also be rather useful to develop a standardised evaluation check-list, based on an analysis of the programme’s weaknesses and strengths. This tool would have a double function: to evaluate the programme’s results, and with which to begin the updating of processes, based on acquired experience.

To develop and integrate an intervention on mental health of psychological care practices as an essential example for the good development of the child. This could be done during the sessional or the follow-up phases. Such interventions have been successfully carried out in several projects within therapeutic nutritional centres. To give greater dimension to psycho-social issues - not only psychological illness but also other elements found within the community - as it is an event or problem which involves the whole population, as well as the social environment in which the affected people or group lives. Integration of mental health interventions can have an important impact at a community level.

To complete water and sewerage, food security, and psycho-social interventions so that the impact of the CW’s programme is integral. A more regular and rigorous evaluation will efficiently achieve the integration of such components.

Although the implementation of all the programme’s phases, and the support of a local counterpart will take 14 months, at least one additional year must be taken into consideration, to ensure that the local personnel can carry out a complete follow-up of the programme, which ACFIN will train them for. During the third year of intervention, the institution should independently continue the programme and identify behaviours that are detrimental to the health of the community’s children.
12. ANNEXES

ANNEX 1. HOME SURVEY (HS)

HOME SURVEY FAMILY QUESTIONNAIRE
Workshop No: /___/ Date/___/___/_______/
Starting time /____hr.____min./ Finishing time /____hr.____min./
District/________________________/ Community/________________________/
Home/________________________/
Child’s name/_____________________________________________________/  
Child’s age (in months) /___/
Mother’s name/____________________________________________________________________/
Father’s name/____________________________________________________________________/
CA’s name/____________________________________________________________________/
OA’s name/____________________________________________________________________/

A. GENERAL INFORMATION (To be answered by the mother)
A.1. How many children do you have? /__/___/
A.2. Gender (In decreasing order of age order: M= male, F=female): /__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__: 

B. AVAILABILITY OF FOOD IN THE AREA
B.1. How many people live in this house? /__/___/
B.2. How much money do you spend on food each day? /___/___/___/___/
B.3. What food products do you buy each week?

<table>
<thead>
<tr>
<th></th>
<th>Food</th>
<th>Quantity (in local measurements)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B.4 Where did you buy/get food in the last 30 days? /_______________________________________/

B.5. a. How much time do you spend on going to and returning from the place where you usually buy/get food? /____/min.
   b. What type of transport do you use? Car /___/ horse /___/ urban/rural transport /___/ on foot /___/ other /___/

B.6 Have you had any problems acquiring/getting the food you consumed in the past 30 days?   Yes /___/ Give details /__________________________________________________________/ No /___/

B.7 How many meals do you eat per day, at home? /___/ How many snacks? /___/

B.8 What foods are available on your street (at easy access)? In which season are they produced?

<table>
<thead>
<tr>
<th>FOODS</th>
<th>SEASON (MONTH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

WARNING:
The following questions refer only to the child enrolled in the Community Workshop

C. FEEDING HABITS (To be answered by the mother)

C.1 Do you breastfeed your child? YES /__/ NO /__/ (if not, go to question C.5)

C.2 How many times do you breastfeed the child each day? /__/__/ And during the night? /__/__/

C.3. Do you give the child supplementary food & drinks? YES /__/ NO /__/

C.4. a. If yes, what? /___________________________________________________/
   b. If it is baby food, what are the ingredients? /__________________________/


C.6. What did the child eat this morning? /________________________________/ And last night? /__________________________________________/

C.7. Does the child eat from the family plate? YES /__/ NO /__/ How? (spoon, fingers, etc.) /____________________/

C.8. What quantity does he/she eat per meal? (in local measurements)
/__________________________________________________/

C.9. In your family, who is served first (men, women, children)? /______________/

C.10. Are there any foods that are prohibited for your child? YES /__/ NO /__/
If yes, fill in the table below with which ones, indicating why.
C.11. What’s your child’s favourite food? /___________________________________/
C.12. What type of food do you give to your child when he/she is sick? /_________/
And to drink? /______________________________________/ More or less than usual? More
/___/ Less /___/ The same /___/
C.13. What do you do when the child is not hungry or does not want to eat?
/_______________________________________/

D. AFFECTION PRACTICES (To be answered by the mother)
D.1. What else do you do with the child when feeding him/her? /_______________/
D.2. Who looks after the child when his/her mother is out? /___________________/
D.3.a What do you do when your child cries? /________________________________/
D.3.b And when he/she shouts? /_________________________________________
D.4. Does your child play with the other children? YES /___/ NO /___/ What games?
/__________________________________________/
D.5. What do you do with your child when you (the parents) have to go to work (in
the field, etc.)/_______________________/
D.6. In your opinion, are girls treated the same way as boys? YES /___/ NO /___/
How are the girls treated? /_______________________________________/
Why? /_____________________________________________________________
D.7. How much time do you spend with your child?  /___//___/ hours
D.8. What activity do you prefer to do with your child? /_______________________/
D.9. What does the elder brother/sister do with the younger one? /______________/
D.10. What advice would you give to the eldest brother/sister if looking after your
other children? /_______________________________________________________/
D.11. What tasks does your husband do in order to help you at home? /__________/
D.12. What do you believe is your child’s greatest need? /______________________/

E. CARE AND HYGIENE PRACTICES (To be answered by the mother)
E.1. How many times do you bath your child per day? /___/ And per week? /___/
E.2. When do you wash your hands? /_______________________________________/

<table>
<thead>
<tr>
<th>What food is prohibited?</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

STRATEGIC PROGRAMMING FOR COMMUNITY NUTRITION INTERVENTIONS
Why? /____________________________________________________________/

When do you wash your child’s hands? /________________________________

Why? /_____________________________________________________________

E.3. Have you vaccinated your child? YES /___/ NO /___/ (If yes, ask to see the child’s health/vaccination card)

E.4. Has the child received vitamin A? YES /___/ NO /___/

When? (dd/mm/yyyy) /_____//_____/ Why? /_______________________/

E.5. Has your child suffered diarrhoea in the last 15 days? YES /___/ NO /___/

E.6. What did you do? / __________________________________________________/

And after? / ________________________________________________________/

E.7. In the event of diarrhea in the family, what do you do? /___________________/

Do you have ORS sachets at home? YES /___/ (Ask to see sachets or ingredients to prepare them) NO /____/

E.8. What do you do when the child has:

a- An eye infection/_____________________________________________________

b- An earache /_________________________________________________________

c- A toothache /_________________________________________________________

d- A headache /_________________________________________________________

e- A skin infection /_____________________________________________________

f- Difficulty breathing / ________________________________________________/

g- A temperature/_____________________________________________________

E.9. With what symptoms would you visit a:

a- Traditional healer? /__________________________________________________/

b- Health Centre? /_____________________________________________________

E.10. Within your family, who takes the decisions on health? /_________________

Why? /_____________________________________________________________

Note: Ask to go to the toilet in order to wash your hands with soap.

Is there a toilet? YES /___/ NO /___/ Is there soap? YES /___/ NO /___/

F. QUESTIONS TO BE ASKED TO OTHER MEMBERS OF THE FAMILY

TO BE ANSWERED BY THE GRANDMOTHER, MOTHER-IN-LAW, STEP MOTHER, ETC.

F.1. In your opinion, at what age should the mother begin feeding the child with other food apart from breastfeeding? /_______/

F.2. a How long does the mother breastfeed the child? /______________________

STRATEGIC PROGRAMMING FOR COMMUNITY NUTRITION INTERVENTIONS
F.2.b Do you think that breastfeeding alone is beneficial for the child? YES /_/ NO /_/ Why? /__________________________________________________________/

F.3. In your opinion, which foods are not recommendable for a child:
   A- Under the age of three months? /_________________________________/
   B- Under the age of six months? /__________________________________/
   C- Under the age of one year? /____________________________________/
   D- Under the age of two years? /___________________________________/
   E- Under the age of three years? /___________________________________/

TO BE ANSWERED BY THE FATHER
F.4. In your opinion, is your child in good health? YES /___/ NO /___/
   Why? /________________________________________________________________/

F.5. How much time do you spend with the child? /__/__/ hours

F.6. What do you do when one of your children becomes ill? /___________________/

F.7. In your opinion, how can the child be kept healthy?
   /____________________________________________________________________/

F.8. In your opinion, what does your child need most of all? /___________________/

F.9. Who do you look after the most within your family? Classify by preference order
   (1 being the most):
   Your girl/s /___/; your boy/s /___/; your wife /___/; your brother /___/;
   your mother /___/; your father /___/

TO BE ANSWERED BY THE SIBLING OR THE PERSON WHO LOOKS AFTER THE CHILD
F.10. How old are you? /______/ in years

F.11. Do you go to school? YES /___/ NO /___/

F.12. What responsibilities do you have for your younger sibling? /___________________/

F.13. How much time do you spend with him/her? /__/__/ hours

F.14. What activities do you do during the day? /_______________________________/

F.15. a What do you do if the child cries? /____________________________________/
   b And, if the child is hungry? /___________________________________________/

F.16. What things do you like doing with your sibling? /___________________________/
   Why? /__________________________________________________________________/

F.17. What DON'T you like doing with your sibling? /___________________________/
   Why? /__________________________________________________________________/

F.18. What food do you give to the child? /___________________________________/
### ANNEX 2. OBSERVATION SHEET FOR A HOME VISIT (HV)

**OBSERVATION SHEET TO BE FILLED IN DURING HOME VISITS**

<table>
<thead>
<tr>
<th>1. OBSERVATIONS ON THE CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASPECTOS FÍSICOS</strong></td>
</tr>
<tr>
<td>Solid body, eyes, skin, body hygiene, hands &amp; nails.</td>
</tr>
<tr>
<td><strong>PSYCHOLOGICAL ASPECTS</strong></td>
</tr>
<tr>
<td>curious / angry / cheerful / active / inactive / sociable / reserved / trusting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. OBSERVATIONS ON OTHER FAMILY MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MOTHER</strong></td>
</tr>
<tr>
<td>Physical aspects (hygiene, if pregnant, breastfeeding, etc.) and psychological (kind, attitude towards the child and towards strangers, etc.)</td>
</tr>
<tr>
<td>Second person looking after the child. Status in the family. Physical and psychological aspects. Quality of interaction with the child</td>
</tr>
<tr>
<td><strong>FATHER</strong></td>
</tr>
<tr>
<td>Quality of interaction with the child (verbal and non-verbal)</td>
</tr>
<tr>
<td><strong>OTHER FAMILY MEMBERS</strong></td>
</tr>
<tr>
<td>Type of interaction: games, stimulation, etc.</td>
</tr>
<tr>
<td><strong>OTHER OBSERVATIONS</strong></td>
</tr>
<tr>
<td>Toys, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. OBSERVATIONS ON HYGIENE PRACTICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>In relation to eating and water</td>
</tr>
<tr>
<td>Wash their hands before and after eating, &amp; before preparing food</td>
</tr>
<tr>
<td>Washing kitchen utensils. Food is covered</td>
</tr>
<tr>
<td>In relation to the body</td>
</tr>
<tr>
<td>Soap: do they wash their hands after using the toilet?</td>
</tr>
<tr>
<td>In relation to the surroundings</td>
</tr>
<tr>
<td>Toilet, water source, if there are animals, if there are flies, where the food is prepared, cleanliness</td>
</tr>
<tr>
<td><strong>OTHER OBSERVATIONS</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. OBSERVATIONS ON FEEDING PRACTICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does the child eat with (hand, spoon, etc.). If he/she shares the dish with more people. Who he/she eats with</td>
</tr>
<tr>
<td>Ingredients seen in the dish: quantity</td>
</tr>
<tr>
<td><strong>OTHER OBSERVATIONS</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. OBSERVATIONS ON FOOD AVAILABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alimentos que provienen de animales, del campo, de la huerta. Almacenamiento y conservación de los alimentos.</td>
</tr>
<tr>
<td><strong>OTRAS OBSERVACIONES</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. OBSERVATIONS ON CARE AND HYGIENE PRACTICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccination marks, health card, use of iodised salt, presence of ORS or corresponding ingredients</td>
</tr>
<tr>
<td><strong>OTHER OBSERVATIONS</strong></td>
</tr>
</tbody>
</table>
# ANNEX 3. 24-HOUR REMINDER

## 24-HOUR REMINDER FOR FOOD REGIME
(To be filled by the CA)

<table>
<thead>
<tr>
<th>Feeding Time</th>
<th>Quality – Ingredients (Food / Drink)</th>
<th>Frequency: how many times in the last 24 hours</th>
<th>Quantity: local measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Does the child eat all the food you give him/her?
   - Yes (go to question 4)
   - No

2. Which foods does your child reject?

3. Why does he/she not want to eat them?

4. Does your child drink a lot of water each day?
   - Yes
   - No
   - How often?

5. Do you prohibit certain foods from your child?
   - Yes
   - What?
   - Why?
   - No
## ANNEX 4. TRAINING MODULE EXAMPLE

<table>
<thead>
<tr>
<th>COMMUNITY WORKSHOPS (CW) TRAINING MODULE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENEFICIARIES:</strong></td>
</tr>
<tr>
<td><strong>FACILITATOR</strong></td>
</tr>
<tr>
<td><strong>DURATION</strong></td>
</tr>
<tr>
<td><strong>TIMETABLE</strong></td>
</tr>
<tr>
<td><strong>TRAINING LOCATION</strong></td>
</tr>
<tr>
<td><strong>ORGANISED BY:</strong></td>
</tr>
<tr>
<td>Technical Department of Health and Nutrition. ACF-E</td>
</tr>
</tbody>
</table>
INDEX. More topics may be added, if necessary

1. Training objectives
2. Anthropometric measurements
   2.1. Brachial perimeter
   2.2. Weight
   2.3. Height
   2.4. Nutritional Indexes
   2.5. Exercises
3. Nutritional Census
4. Project of Communitarian Workshops (CWs)
   4.1 Description of the Project
   4.2 Admission Criteria
5. Organisation of IEC Strategy
6. IEC messages developed during the CWs
7. Description of foods and their role in the body.

1. TRAINING OBJECTIVES

- To provide the training beneficiaries with:
- The knowledge and skills required to correctly take the anthropometric measurements of the 6 to 59-month-old children, as part of the nutritional census.
- The basic knowledge required by the community to be able to carry out the nutritional follow-up of the 6 to 59-month-old children.
- Basic knowledge of the CW’s (Communitarian Workshop’s) program.
- The information required to correctly understand the IEC (Information, Education, Communication) messages.
- The information and skills needed to transmit this knowledge to the groups of mothers and children selected for the workshops.
- The information required to understand the formulation of recipes which will be developed as a part of the CW activities.
- The knowledge and skills needed to transmit this information to the groups of mothers, ensuring that they make the recipes during the workshops. (1 recipe per day for 12 days)
The basic knowledge needed to raise the community’s awareness about a healthy and balanced diet.

2. ANTHROPOMETRIC MEASUREMENTS

Specific objectives
1. At the end of this training, training beneficiaries shall be able to:
2. Weigh a child according to the different stages described in the technical form.
3. Weigh a child lying-down/standing with a maximum error of 0.5 cm.
4. Reliably weigh the brachial perimeter with a maximum error of 0.1 cm.
5. Identify malnutrition oedemas and classify them according to the criteria’s seriousness.
6. Record these data on the child’s Follow-up Form.
7. To be convinced of the importance of taking anthropometric measurements for the identification of malnutrition.

Material & Preparation
- 25-kilogram scale
- Measuring table or wall measurer
- Braquial perimeter (MUAC or BP)
- Weight/Height % Tables
- Weight wedges
- Calculator
- Child’s Observation Forms.

Taking anthropometric measurements

The anthropometric measurements used to evaluate the nutritional condition of an individual are the following:
- Braquial perimeter
- Weight
- Height
- Oedemas
- All these related to age and gender.
2.1. **THE BRACHIAL PERIMETER (BP)**

The brachial perimeter (BP) (also referred to as MUAC) does not give a representative indication of a child’s malnutrition condition, rather it indicates the risk of death. The smaller the BP is, the higher the risk of mortality.

It is used to identify 6 (>=65 cm) to 59-month-old children at highest risk of mortality.

Because of its easy use and good correlation of the risks of mortality, it is usually used for quick assessments.

According to MUAC results, children can be classified into three categories:

<table>
<thead>
<tr>
<th>Child / BP</th>
<th>&lt; 110 mm</th>
<th>110-120mm</th>
<th>120-135mm</th>
<th>&gt;135 mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate acute malnutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malnutrition with risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe acute malnutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Children whose BP is less than 110mm are to be admitted to the therapeutic nutritional centres (TNCs).*

*Children whose BP is between 110 and 119mm are to be admitted to the supplement administering centres and included in the CWs.*

**Presentation of material and techniques for taking measurements:**

- The BP is measured from the left arm, at the middle point between the shoulder and elbow, with the help of a special BP meter which is placed around the arm
- The arm must be relaxed
- The reading appears on the BP metre window, by smoothly adjusting the BP metre around the arm
- The measurement is registered with an accuracy of 0.1cm.

**Practical Exercises**

- Practice taking measurements until they are reliable. The evaluation by agents will be made among themselves, under the supervision of the trainer. An agent takes the measurement while another observes, criticises and corrects.
- Observation of possible error sources.
- How to record the BP on the child’s form.
2.2. **WEIGHING**

**Material & technique:**
- Use a 25-kg mechanical scale, hung in such a way that its face is in the direct sight of the operator
- Hang the weighing wedge on the hook and adjust the scale to read zero
- Each and every morning the scale’s reliability is to be verified with the help of a fixed, known weight
- Undress the child and place him/her in the weighing wedge
- Once it has stabilised, take the reading at the nearest 100g weight mark (Ensure the child is hanging freely, without touching anything)
- Call out the measurement to the second person, who will record it on the child’s form, repeating it aloud as he or she does so

**Practical Exercise:** Verify the reliability of the scales, and adjust to zero.

2.3. **HEIGHT**

- A child over 85cm in height is to be measured while standing.
- Children less than 85cm are to be lying down for measuring. In this case the height is always measured by two people.

**Measuring a child while laying-down:**
- Place the board on the floor.
- Lay the child down on the centre of the board, so that the feet rest flat against the indicator.
- With the child looking straight up, a person holds the head at the ears, maintaining the head against the fixed end of the board.
- The other person places one hand under the child’s ankles or over the knees, keeping the legs straight while, with the other hand, moving the indicator until it rests flat against the soles of the feet.
- The reading is made to the nearest millimetre and then called out.
- The measurement is recorded on the child’s form by an assistant who in turn calls it out by way of confirmation.

**Measuring in an upright position:**
- Place the wall measurer against a flat surface
- Having removed the child’s shoes, stand him/her on the base, with the back of the heels touching the back of the board
- The head, shoulders and buttocks must touch the measure
- A person should hold the child’s ankles and knees, as the other, while keeping the child’s head straight, moves the indicator down to read the measurement
  - The child must be looking straight ahead at the moment when the measurement is taken
  - The reading is made to the nearest mm, the measurer calls it out and the assistant repeats it aloud and records it on the child’s form

**Practical exercise:**
To measure the community’s children in a standing or lying-down position. It will not be possible to do this exercise if there aren’t any children where the training is taking place.

2.4. **NUTRITIONAL INDICES**

The parameters described independently and considered earlier on, do not assess the nutritional condition of a child, so **nutritional indices** are used:

- **Weight/Height Index:** allows the detection of acute or recent malnutrition.
- **Weight/Age Index:** allows the detection of global (protein-energetic) malnutrition; it is a very sensitive index.
- **Height/Age Index:** allows the detection of chronic or long-term malnutrition.

In all cases, the presence of oedemas indicates severe acute malnutrition - or Kwashiorkor.

2.4.1. **Weight/Height Index (W/H %)**

The Weight/Height Index is the most appropriate means to quantify malnutrition in urgent contexts, where severe malnutrition cases are the most common kind of malnutrition. In a healthy child, height and weight increase in a parallel manner. It is therefore possible to know the average values from which weight-height tables are established. In relation to his or her height, a malnourished child will weigh less than the ‘normal’ weight of a healthy child.
In the Table:
- Weights appear in kg in columns, below the percentages.
- Heights appear in cm, at intervals of 0.5 cm.
- For a particular height, the lower the weight, the more reliable the percentage will be.
  - Average weight = 100% Well-nourished child
  - Objective weight = 85% To be assisted in nutritional centres
  - 70 to 79% Moderate malnutrition
  - < 70% Severe malnutrition

Ensure that all agents clearly understand the notions of percentages, intervals, etc.

2.4.2 Weight-Age Index (W/A)

The simple measurement of weight related to age does not determine if a child is suffering acute malnutrition (a thin child), or a chronic malnutrition (a child with low height), but it is used in growth follow-up.

In the medical card of the mother and child, and in the child’s Follow-up Form, the Weight/Age Index is used to supervise the child’s growth.

Completing the Growth Form:

The Follow-up Form is commonly called the infant’s Growth Form and comprises two parts:

1. General Information:
   - Name
   - Weight of the newborn in grams
   - Date of Birth
   - Risk factors: premature birth, low birth weight, congenital malformations, multiple births, sequential pregnancies, number of older siblings, type of food, recurrent illnesses.

2. Graph:

The growth of the child is represented in a graph found on the form. A curve indicates the differences in the child’s weight at different ages. This curve must be compared with a reference curve to know if the growth is normal or not. There are many reference curves, the most commonly used is the WHO. This curve is also in the medical card of the mother and child (infant’s Growth Form).
It can be seen in the graphic:

- Vertical lines represent the age of the child in months
- Horizontal lines represent the weight of the child in kilograms

- A box on the left represents the child’s birth month, and is where the newborn’s weight is to be recorded

- Reference curves:
  - Upper curve (U)
  - Middle curve (M)
  - Lower curve (L)

  The space between two curves is commonly called ‘strip’. The growth curve is therefore divided into four strips:

  The strip located between the upper curve and the middle curve is the area of normal growth - referred to as the green strip.

  The strip located between the middle and lower curves is the area of moderate malnutrition - yellow strip. The children who appear in this strip are to be included in the CW’s pre-selection.

  The strip located below the lower curve is the area of severe malnutrition - red strip.

  The strip located above the upper curve corresponds to the area of malnutrition due to excess weight or overweight. However, not all children appearing to this strip are necessarily overweight.

**Growth Form Completing Techniques:**

The graphic allows the following:

A) To find:

- The line corresponding to the actual age - in months - of the child
- The horizontal line corresponds to the weight of the child in kilos, as taken at the last measurement
B) Find the intersection between the two lines, corresponding to the child's weight at the current age, which is obtained from the weighing undertaken at the current session. This same exercise is to be carried out each month.

C) To join the points of different monthly measurements. With the data taken from several monthly weighings the child’s growth curve becomes apparent.

If the child has not been weighed in the previous months, it is advisable not to fill in the corresponding boxes, rather leave them blank.

If the weight does not equal a whole number - for example, 6.5kg - it is to be noted in the centre of the corresponding box. If the age does not correspond to whole numbers - for example, 1 month and ten days - it too is to be noted in the centre of the corresponding box.

If the child is weighed a second time within a month, it is not to be recorded on the child’s form if he/she is healthy. However, if the child is ill, his/her weight is to be recorded on the form in order that a decision can be taken. In this case, the position of the point will be determined by whether the child is weighed in the first or second half of the month.

**Curve Interpretation:**

A single point cannot provide all the information. It is the relation between the trend of the growth curve, and the reference curves which is of prime importance.

The curve may present several aspects:

- An **ascending and regular** curve is a sign of good growth
- A **stationary** curve indicates a need for alertness
- A **descending** curve is a sign of danger.

In the CWs, we will use W/A Indices to follow growth and make the first selection. The W/H Index is used for the final selection of children for the CWs.
Depending on the curve’s trend, the person in charge will be:

*Less than six months-of-age:*

<table>
<thead>
<tr>
<th>Curve’s Trend</th>
<th>Green Strip</th>
<th>Yellow Strip</th>
<th>Red Strip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascending curve</td>
<td>The health centre:</td>
<td>The health centre:</td>
<td>The hospital:</td>
</tr>
<tr>
<td></td>
<td>- Encourages the mother to continue breastfeeding the child</td>
<td>- Encourages the mother to continue breastfeeding the child</td>
<td>- Evaluation</td>
</tr>
<tr>
<td></td>
<td>- Raises awareness and educates the parents</td>
<td>- Raises awareness and educates the parents</td>
<td>- Nutritional rehabilitation</td>
</tr>
<tr>
<td></td>
<td>- Seeks other possible illnesses (diarrhea, malaria, etc.)</td>
<td>- Seeks other possible illnesses (diarrhea, malaria, etc.)</td>
<td>- Treats inter-recurring illnesses</td>
</tr>
<tr>
<td></td>
<td>- Refers the child to hospital if the child’s weight remains in this strip</td>
<td>- Refers the child to hospital if the child’s weight remains in this strip</td>
<td>- Refers the child to the health centre for a follow-up</td>
</tr>
<tr>
<td></td>
<td>for a period longer than three months</td>
<td>for a period longer than three months</td>
<td></td>
</tr>
<tr>
<td>Curve stationary</td>
<td>The health centre:</td>
<td>The health centre:</td>
<td>The hospital:</td>
</tr>
<tr>
<td>for three months</td>
<td>- seeks the cause (diarrhoea, malaria, etc.)</td>
<td>- Seeks the cause (diarrhoea, malaria, etc.).</td>
<td>- Evaluation</td>
</tr>
<tr>
<td></td>
<td>- Refers the child to a hospital, or wherever possible</td>
<td>- Refers the child to a hospital, or wherever possible</td>
<td>- Nutritional rehabilitation</td>
</tr>
<tr>
<td>Descending curve</td>
<td>The health centre:</td>
<td>The health centre:</td>
<td>- Treats inter-recurring illnesses</td>
</tr>
<tr>
<td></td>
<td>- seeks the cause (diarrhoea, malaria, etc.)</td>
<td>- Refers the child to a hospital, or wherever possible</td>
<td>- Refers the child to the health centre for a follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
More than six months-of-age:

2.5. EXERCISES

Exercise 1
List admission criteria to CWs.

Exercise 2
1) Find out the exact W/H % of the following:
   51cm & 2.8kg
   63.5cm & 6.6kg
   76.5cm & 7.5kg
125cm & 16.9kg
2) Round height to the nearest 0.5cm and find the exact W/H % of:
   91.2cm & 11.3kg
   109.7cm & 12.8kg
   69.8cm & 6.4kg
3) Find the approximate W/H %, expressed in intervals (i.e.: 70-75%) or by < than
   (i.e.: < 75%):
   51.1cm & 2.4kg
   65.7cm & 5.5kg
   79.3cm & 6.3kg
   113.8cm & 15.5kg
Repeat the exercises until percentages are obtained without errors.
Show how to write down the weight-height % on the child’s form.

Exercise 3
You have just carried out a nutritional survey in the village/town. You have weighed twenty (20) 0-5 year-olds and have obtained the following results:

<table>
<thead>
<tr>
<th>Child No.</th>
<th>Gender</th>
<th>Age (in months)</th>
<th>Weight (in kg.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>16</td>
<td>6,5</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>3</td>
<td>4,0</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>24</td>
<td>8,2</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>18</td>
<td>9,0</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>6</td>
<td>5,0</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>10</td>
<td>5,2</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>42</td>
<td>11,0</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>28</td>
<td>8,2</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>33</td>
<td>12,0</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>25</td>
<td>7,0</td>
</tr>
<tr>
<td>11</td>
<td>M</td>
<td>8</td>
<td>5,2</td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>9</td>
<td>7,0</td>
</tr>
<tr>
<td>13</td>
<td>F</td>
<td>12</td>
<td>6,9</td>
</tr>
<tr>
<td>14</td>
<td>M</td>
<td>24</td>
<td>7,8</td>
</tr>
<tr>
<td>15</td>
<td>F</td>
<td>54</td>
<td>15,0</td>
</tr>
<tr>
<td>16</td>
<td>M</td>
<td>35</td>
<td>8,5</td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>20</td>
<td>8,0</td>
</tr>
<tr>
<td>18</td>
<td>M</td>
<td>15</td>
<td>8,8</td>
</tr>
<tr>
<td>19</td>
<td>M</td>
<td>5</td>
<td>8,0</td>
</tr>
<tr>
<td>20</td>
<td>F</td>
<td>9</td>
<td>7,5</td>
</tr>
</tbody>
</table>
Exercises:
- Record the weights on the growth form
- Record the survey’s results in the following table

<table>
<thead>
<tr>
<th>Results</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal nutrition or overweight</td>
<td></td>
</tr>
<tr>
<td>Moderate malnutrition</td>
<td></td>
</tr>
<tr>
<td>Serious or severe malnutrition</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

3. NUTRITIONAL CENSUS

The objective of the Nutritional Census is to find out the nutritional condition of 6 to 59-month-old children from a specific region. This age group is considered the most vulnerable to malnutrition and associated illnesses.

These are the steps to follow in order to correctly take the census and fulfil its objective:
- To raise the awareness of the people where the census is to be carried out
- The mothers of the 6 to 59-month-old children are to be at the place (village/town) on the day when the census will be taken
- Mothers are to bring the child and the child’s health card (and not that belonging to a sibling), or any other document which verifies the child’s age
- Material preparation: mechanical scale, forms for data compilation, etc.
- Ensure there is adequate space between the weighing and waiting areas
- Call a mother and ask for the child’s health card. Age verification is to be done according to the following table:
The children who are not in the table are not to be included in the census. Children under the age of six months must be breastfed only.

Once the child’s age has been verified, he/she is to be weighed following the technique detailed above.

All information is to be correctly recorded in the Census Register without neglecting to write down the name of the village/town and district. The following is an example of the register to be completed during the census:

<table>
<thead>
<tr>
<th>Mes de nacimiento</th>
<th>Año de nacimiento</th>
<th>Edad actual en meses</th>
<th>Mes de nacimiento</th>
<th>Año de nacimiento</th>
<th>Edad actual en meses</th>
<th>Mes de nacimiento</th>
<th>Año de nacimiento</th>
<th>Edad actual en meses</th>
</tr>
</thead>
<tbody>
<tr>
<td>julio</td>
<td>2006</td>
<td>6</td>
<td>enero</td>
<td>2005</td>
<td>24</td>
<td>julio</td>
<td>2003</td>
<td>42</td>
</tr>
<tr>
<td>junio</td>
<td>2006</td>
<td>7</td>
<td>diciembre</td>
<td>2004</td>
<td>25</td>
<td>junio</td>
<td>2003</td>
<td>43</td>
</tr>
<tr>
<td>mayo</td>
<td>2006</td>
<td>8</td>
<td>noviembre</td>
<td>2004</td>
<td>26</td>
<td>mayo</td>
<td>2003</td>
<td>44</td>
</tr>
<tr>
<td>abril</td>
<td>2006</td>
<td>9</td>
<td>octubre</td>
<td>2004</td>
<td>27</td>
<td>abril</td>
<td>2003</td>
<td>45</td>
</tr>
<tr>
<td>marzo</td>
<td>2006</td>
<td>10</td>
<td>septiembre</td>
<td>2004</td>
<td>28</td>
<td>marzo</td>
<td>2003</td>
<td>46</td>
</tr>
<tr>
<td>febrero</td>
<td>2006</td>
<td>11</td>
<td>agosto</td>
<td>2004</td>
<td>29</td>
<td>febrero</td>
<td>2003</td>
<td>47</td>
</tr>
<tr>
<td>enero</td>
<td>2006</td>
<td>12</td>
<td>julio</td>
<td>2004</td>
<td>30</td>
<td>enero</td>
<td>2003</td>
<td>48</td>
</tr>
<tr>
<td>diciembre</td>
<td>2005</td>
<td>13</td>
<td>junio</td>
<td>2004</td>
<td>31</td>
<td>diciembre</td>
<td>2002</td>
<td>49</td>
</tr>
<tr>
<td>noviembre</td>
<td>2005</td>
<td>14</td>
<td>mayo</td>
<td>2004</td>
<td>32</td>
<td>noviembre</td>
<td>2002</td>
<td>50</td>
</tr>
<tr>
<td>octubre</td>
<td>2005</td>
<td>15</td>
<td>abril</td>
<td>2004</td>
<td>33</td>
<td>octubre</td>
<td>2002</td>
<td>51</td>
</tr>
<tr>
<td>septiembre</td>
<td>2005</td>
<td>16</td>
<td>marzo</td>
<td>2004</td>
<td>34</td>
<td>septiembre</td>
<td>2002</td>
<td>52</td>
</tr>
<tr>
<td>agosto</td>
<td>2005</td>
<td>17</td>
<td>febrero</td>
<td>2004</td>
<td>35</td>
<td>agosto</td>
<td>2002</td>
<td>53</td>
</tr>
<tr>
<td>julio</td>
<td>2005</td>
<td>18</td>
<td>enero</td>
<td>2004</td>
<td>36</td>
<td>julio</td>
<td>2002</td>
<td>54</td>
</tr>
<tr>
<td>junio</td>
<td>2005</td>
<td>19</td>
<td>diciembre</td>
<td>2003</td>
<td>37</td>
<td>junio</td>
<td>2002</td>
<td>55</td>
</tr>
<tr>
<td>mayo</td>
<td>2005</td>
<td>20</td>
<td>noviembre</td>
<td>2003</td>
<td>38</td>
<td>mayo</td>
<td>2002</td>
<td>56</td>
</tr>
<tr>
<td>abril</td>
<td>2005</td>
<td>21</td>
<td>octubre</td>
<td>2003</td>
<td>39</td>
<td>abril</td>
<td>2002</td>
<td>57</td>
</tr>
<tr>
<td>marzo</td>
<td>2005</td>
<td>22</td>
<td>septiembre</td>
<td>2003</td>
<td>40</td>
<td>marzo</td>
<td>2002</td>
<td>58</td>
</tr>
<tr>
<td>febrero</td>
<td>2005</td>
<td>23</td>
<td>agosto</td>
<td>2003</td>
<td>41</td>
<td>febrero</td>
<td>2002</td>
<td>59</td>
</tr>
</tbody>
</table>
- **Date**: date when census is taken
- **No**: Census Number assigned to the child who has been weighed
- **Gender**: Write ‘F’ for female, ‘M’ for male
- **Child’s name and surname & Mother’s name and surname**
- **Town or location**: Where the chid lives
- **Date of Birth**: According to the child’s health card. If he or she does not have one, it will be recorded according to the nearest, most-important event which occurred then.
- **Age (MONTHS)**: It is very important to record the age following the above table. It is to be completed in figures
- **Weight (kg.)**: The weight is to be recorded in kg. and with a decimal figure (i.e.: 4.5kg)
- **Classification**: according to the Nutritional Condition Form. G stands for green strip; Y for yellow strip; and R for red strip.

The child is to be referred by using the appropriate referral sheets.

Organisation of personnel during census-taking:

CA: weighs and measures the child’s BP, etc.

Health Centre’s Agent: verifies the child’s age and records the result. If there isn’t an agent, a registered nurse is to do the job.

Once the village/town census has been taken, the forms are to be returned to ACF-E’s on-site agent for that area.

4. **COMMUNITY WORKSHOPS**

4.1. **PROJECT’S DESCRIPTION**

A means to connect with the community, conceived for the nutritional rehabilitation of children. Its aim is to establish the cognitive mechanisms needed to fight infant malnutrition - particularly that of a moderate type - which allows the community to find local solutions to fight it.

This approximation seems to be one of the safest of current methods, to ensure the improvement of a child’s nutritional condition through a community nutritional programme. It not only allows families to be responsible for the rehabilitation and treatment of simple cases of malnutrition within the community, but it also provides women with good feeding practices.

It is carried out during 12 workshop days, and followed by an eleven-month follow-up, close to the home of each beneficiary.
Mothers with malnourished children are invited to take part in the workshop's nutritional demonstrations by providing seasonally-available local foods, or by contributing with the preparation of the recipe for the day.

General Objective: the recuperation of malnourished children, and knowledge acquisition by mothers, with a view to long-term positive change.

Description:

CWs are a nutritional intervention designed to rehabilitate malnourished (6 to 59-month-old) children - not by health professionals, but by their own mothers. This is done in the home of a 'model-mother' volunteer neighbour (Mother Light), using locally available products, accessible to all poor families. Small well-nourished children (from poor families) and their families are referred to as 'positive deviators' or 'positive models', because good and culturally-appropriate practices have been carried out within the family, correctly educating and nourishing their children, in spite of their poverty and the great risks surrounding them.

The method is based on the concept of *positive deviation*: that the solutions to a community’s problems be found within the heart of the community, so that they do not have to resort to external remedies. Positive deviation is also used in the community workshops:

To identify the most nutritious, local foods which are financially and geographically accessible, with which mothers can easily feed their children

As supportive communication to convince the mothers of malnourished children (negative models) that feasible solutions exist, and can improve the nutritional condition of their children and contribute to a reduction of infant morbidity and mortality.

EXECUTION

The undertaking of Communitarian Workshops is divided into three different stages:

1) **Stage 1: Preparation of Community Workshops.**

2) **Awareness and negotiation with parents and community leaders**, so that they become involved in the project and in the construction of a shelter per community.

3) **Census and weighing of the town’s 6 to 59-month-old children.** This is carried out by registering all the town’s children: their age in months, weight, and the colour strip of their nutritional condition. This census is to be taken by the Community Agent, using the Weight/Age Index. Having weighed the children, proceed to identify eight children, four of them being well-nourished (positive deviation) and four being mal-nourished (negative deviation). This selection is to be carried out in a discreet manner to avoid exposing those mothers with mal-nourished children.
4) **24-hour Reminder.** This is a survey given to eight mothers previously selected by the Community Agent. For this activity, the On-site Agent has a form containing all food-regime information of the child. (See 24-hour Reminder Form).

5) **Home Survey** (See Home Survey Form). It enables the recording of all the child’s problems related to hygiene, health, feeding, etc.

6) **Market Survey:** It shows the availability and cost of food according to seasonality. The survey is taken by the On-site Agent, two Community Agents and Mother Light (See Home Survey Form).

7) **Choosing recipes:** Selection will depend on the results obtained during the 24-hour visit, and on the market and home surveys.

8) **Creation of Messages:** These will be created according to the problems detected during the 24-hour visit and in the home survey.

9) **Negotiation with participant mothers and their husbands:** Before initiating the negotiation, it is necessary to proceed to the final selection of those children who are in the red and yellow strips, according to the last weighings.

The equipment and material used for this final selection is the following:

- Census & Weight Registers for Children
- 25-kg scale
- Wall mounted measurer
- Weight wedges
- Weight/Height Table
- Growth Follow-up Form
- Calculator

An example of children finally selected to participate in the workshop:

<table>
<thead>
<tr>
<th>No.</th>
<th>Child’s Name</th>
<th>Mother’s Name</th>
<th>Age (in months)</th>
<th>Weight (in kg.)</th>
<th>Height (in cm.)</th>
<th>Adjusted Deficit in %</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Saa Millimouno</td>
<td>Fanta Leno</td>
<td>15</td>
<td>7.2</td>
<td>71</td>
<td>17%</td>
<td>Moderate malnutrition</td>
</tr>
<tr>
<td>2</td>
<td>Clarisse Kamano</td>
<td>Agathe Ouéndéno</td>
<td>24</td>
<td>8.5</td>
<td>75</td>
<td>16%</td>
<td>Moderate malnutrition</td>
</tr>
<tr>
<td>3</td>
<td>Bintou Wambouno</td>
<td>Finda Sitta Téédouno</td>
<td>16</td>
<td>7.0</td>
<td>71</td>
<td>20%</td>
<td>Moderate malnutrition</td>
</tr>
<tr>
<td>4</td>
<td>Oumou Tonguino</td>
<td>Koumba Sandouno</td>
<td>22</td>
<td>11.0</td>
<td>81</td>
<td>0%</td>
<td>Mother Light’s child</td>
</tr>
</tbody>
</table>

This is a very delicate stage. It can be the workshop’s source of success or failure because during this stage the parents are told about: the nutritional condition of their children.
child and his or her need to be enrolled in the workshop; their obligation to contribute, morally or materially; the duration of the workshop and its daily timetable; and of the need to delouse the child.

3) **Mother Light training on:** breastfeeding the child immediately after birth; breastfeeding exclusively; vaccination; growth promotion; fight against diarrhea illnesses; food diversification; vitamin A promotion, etc.

### Stage 2: Undertaking of Community Workshops

The opening will be held very early in the morning. Midwives, local and health authorities, fathers of participating children, and other volunteering mothers should be invited.

The mothers, taking the necessary ingredients for the recipes, are to meet at the shelter constructed by the community.

**Remember that:**

- For a child to recover normal weight during the workshop’s 12 days he or she must consume between 800 & 1000Kcal, and between 20 and 30 grams of proteins each day. All measures used for the preparation for the recipe should be in ‘local measures’, such as: an empty tomato can, a medium-sized bottle of Gloria milk, a ladle, a teaspoon, a dessertspoon, etc.

- Each workshop day, a new recipe will be prepared according the children’s taste and the participant mothers’ demand (See Recipe Form).

- All those invited to the Opening are to be invited again to the Closing Day so they can hear about the problems that were found, and ask them to continue carrying out the activities in the families and surrounding areas. They will also be informed about the follow-up to be done during the months after the workshop.

- To favour intestinal delousing, all children will receive a dose of Mebendazol, as per the protocol, on the Opening Day. They will also be administered FAF (Iron and Folic Acid).

### Stage 3: The Follow-up After the Workshop

This is the most important stage for the community agent and Mother Light. During this stage, after the workshop, the child’s follow-up is carried out in their home, and mothers are encouraged to persevere with the nutritional practices acquired at the CW.

This follow-up is divided into four parts (See Follow-up Forms). In the first two the Weight/Height % of the participant children is evaluated while, in the last two their Weight/Age Index is evaluated (in order to know if the children are in the green strip):
1 month after the workshop
2 months after the workshop
6 months after the workshop
and 12 months after the workshop

4.2. CHILD ADMISSION CRITERIA TO THE CW

A CW is comprised of 8 to 12 families, represented by their mothers and mal-nourished children. The selection of families depends on the adjusted deficit that the 6 to 59-month-old malnourished children have, and the extent of their vulnerability.

The pre-selection is made from among all the children who do not - in accordance with the Weight/Age Index - fall within the reference health path (yellow strip/Band), and whose braquial perimeter (BP) is between 110 & 119 cm. The final selection is made of those whose Weight/Height Index is between the > 70 percent - < 80 percent interval.

There is no obstacle preventing mothers excluded from the workshop attending the cooking demonstrations. They are voluntary and free.

The Community Agents’ Tasks

The Community Agents are chosen by members of the community, and their tasks will be supervised by ACF-E’s On-site Agents to whom they will be directly accountable. They are volunteers who will work closely with Mother Light. Their tasks are the following:

- To attend to all training courses held for the development of the program's activities
- To participate in the 24-hour visit, to choose the Mother Light, and to create the IEC messages
- To update the monthly Weight Registers (Growth Follow-up), by correctly recording the information.
- To support the committee, fathers and community leaders in their mobilisation and encouragement of participant mothers to attend the workshop
- To transmit simple messages
- To supervise mothers and/or child carers during the preparation of food and feeding
- To refer the children to the Health Centre in the event of an illness or severe malnutrition
- To help on-site agents to fill out the 24-hour Reminder Forms
- To watch over mothers’ and children's hygiene during and after the workshop
- To be available for the community at all times
- To record the monthly weighing of the community’s 6 to 59-month-old children
- To select the mothers for a 24-hour reminder and home visit
- To raise the awareness of the community on good nutritional practices
- To manage the CW’s equipment & material
The filling out of forms used in the CWs:
- Child’s Follow-up Form from the 1st to 12th day of the CW
- Child’s Follow-up Form at one, two, six and 12 months from the conclusion of the CW
- Growth Follow-up Form

TASKS TO BE CARRIED OUT BY MOTHER LIGHT:
- To welcome mothers
- To organise the workshop
- To quantify foods
- To manage the ingredients and recipes (choosing recipes)
- To prepare the food
- To assign the tasks among all participating women
- To give educational messages
- To visit participant mothers at their homes
- To participate in the undertaking of a market survey by Community Agents, with the help of On-site Agents
- To keep the equipment and material used for the preparation of food and feeding the children hygenically, both before and after meals
- To ensure mothers and children wash their hands before and after the meals
5. TUTORIAL SESSION ORGANISATION

Advice to be followed before each tutorial:

- Do not forget it is better to do nothing, than to do something badly
- Put yourself in the women’s shoes
- Speak in a simple and direct manner, repeating points as and when required
- Do not act self importantly, or show moody behaviour in front of the women
- Be punctual
- Be informed about any prohibitions and habits surrounding eating
- Study the local diet and the way in which foods are prepared
- Be informed about when children begin to be fed, and take this into account
- Work with common sense and a lot of courage

How to give the Nutritional Tutorial:

- Request the women to sit themselves in a circle/s, then place yourself in the middle
- Greet the women and take an interest in the children’s health and so gain the mothers’ trust
- Then ask questions on the topic to be introduced to get a sense of their knowledge on it.

For instance, if the topic is on a well-balanced diet for children, you could ask:

- What did your child eat yesterday?
- How did you prepare the food?
- What effect does milk have on your child?
- Introduce your topic, i.e.: the three food types, and ask mothers to repeat it and ask questions
6. **MESSAGES DEVELOPED IN THE CWs**

NB: this is not an exhaustive list and any newly identified message should be included

1. **Pregnant Women at the Health Centre for Pre-natal Consultation (PNC)**
   
   **Key message:**
   Each pregnant woman must go to the health centre at least three times during her pregnancy to be vaccinated, to receive the supplements (FAF; Chloroquine), and advice on her diet.

   **Additional information:**
   Pregnant women go to the health centre to receive: a tetanus vaccination, advice on (exclusively) breastfeeding, her diet during pregnancy, follic acid supplement to combat anaemia, and chloroquine supplement against malaria.

   It is very important that pregnant woman go to the health centre for a PNC to avoid malnutrition and other illnesses during pregnancy, labour and after having given birth.

2. **The Diet for Pregnant Women**

   **Key message:**
   A pregnant woman must eat more than normally, must vary her diet, and must eat foods rich in: iron (green-coloured leaves, meats), vitamin A (mango, liver), proteins (meat, milk, eggs, beans), and in iodine (sea fish, sea food, and iodised salt).

   **Additional information:**
   A pregnant woman must eat three times a day, or more than normally (100 to 300Kcal more a day), both for her good health and her child’s who will have greater weight. If a pregnant woman eats well, her child will be healthy at birth, and labour will be easier.

   Pre-natal Consultation: preparation for breastfeeding only.

   **Key message:**
   Breastfeeding is very positive for the child, regardless of the size of the mother’s breasts. A pregnant woman must eat well so that her milk is rich in nutrients. Pregnant women receive advice on breastfeeding at the health centre, so it is advisable to go regularly.

   **Additional information:**
   A pregnant woman’s husband can accompany her to the health centre so that both learn about the advantages of exclusively breastfeeding the child.

   • Just after birth, the child must be breastfed as the first milk (colostrum) is
especially rich in defences and vitamins for the new born

- Apart from being the first vaccine for the baby, the more milk the baby takes, the more will be produced
- The baby must be exclusively fed mother’s milk until the age of six months, without any other foods or liquids, such as water or tea
- The mother and child must be together so when the baby cries for food, she can feed him/her
- The mother must eat and rest well in order to produce milk
- Mother’s milk does not sour in the breast, and it cannot cause illness.

At birth: breastfeed the child after birth

**Key message:**
After birth, within the first half hour, the baby must be breastfed.

**Additional information:**
The baby has the automatic suckling reflex. He or she can take the first milk (colostrum) which is rich in defences and vitamins.

Breastfeeding also helps the mother after giving birth: the placenta is expelled more easily and haemorrhage is cut faster.

Breastfeeding only: this is the parent’s choice.

**Key message:**
Until approximately six months of age the child must only be fed mother’s milk. After sixth months it is necessary to introduce other foods, while continuing to breastfeed until, at least, two years of age.

**Additional information:**
The parents will be happy if their child develops well and rarely gets sick.

The husband must ensure the child is breastfed exclusively until the age of six months. He must ensure that the mother’s diet is rich. He will have already been informed that a breastfeeding woman must have foods such as vegetables, rice, beans, fruit, fish, meat, etc. The husband must also ensure that she rests each day, as the maternity and breastfeeding periods tax the mother’s body.

**The Nutrition for Breastfeeding Women**

**Key message:**
A breastfeeding woman must eat as much as a man. She must eat foods rich in iron and vitamin A, at least four times a week.

**Additional information:**
A breastfeeding woman must eat for two - for herself and her baby - so she must eat as much as a man. She must eat varied meals. Show recipe examples.
Growth Follow-up

Key message:
A 0 to 59-month-old child must be weighed each month to carry out his/her follow-up.

Additional information:
Weighing the children allows early identification of possible health problems: a stable weight implies a risk to malnutrition and a decrease in weight implies that the child is in danger of malnutrition.

Growth follow-up in the community

Key message:
A child up to the age of 59 months must be weighed monthly to see the evolution of growth.

Additional information:
The Community Agent must weigh children aged to 59 months monthly, and must analyse the results with the mothers. Depending on the results, the agent can then advice mothers of where to go.

Nutritional Tutorial

Key message:
The cooking demonstration and nutritional tutorial teach how to prepare high-quality meals using locally available foods.

Additional information:
It is important to teach mothers how to introduce complementary foods to their children from around six months-of-age. They must learn how to prepare new recipes, such as enriched baby food (mush) and other liquid or semi-liquid preparations.

Cooking Demonstrations

Key message:
Attend the cooking demonstrations and hear advice on nutritional feeding.

Additional information:
The women learn how to prepare enriched baby food, such as fish flour, palm oil, dried green leaves. And also about hygiene.

Using Local Foods

Key message:
In your local supermarket, you will be able to find all the foods necessary to prepare your child’s, indeed all the family’s meals.

Additional information:
It is not necessary to buy imported products for cooking. With locally available
foods mothers can prepare a good-quality meal. What matters are: the frequency of the meals (as a child must eat more often than an adult) feeding hygiene (meal preparation and consumption) and variation of ingredients.

**Feeding From the Age of Six Months**

**Key message:**
From the age of six months, foods complementary to mother’s milk must be introduced. Breastfeed the child first and then give the other foods.

**Additional information:**
It is necessary to avoid infections with strict hygiene. Ensure the child takes enough rich food (at least five times a day) and continue breastfeeding the child, at least until two years of age.

**Feeding from the Age of Nine Months**

**Key message:**
Do not stop breastfeeding the child. Ensure that he or she eats five times a day. Wash your hands before feeding the child.

**Additional information:**
Supplementary food and regular eating are to complement breastfeeding.

**Initiating the Child into the Family’s Meal**

**Key message:**
Wash your hands before feeding the child. A child under the age of three years must have his own bowl or dish to eat from. Individual portions are very important.

**Additional information:**
A small child will eat slower than older siblings. Having an individual dish will ensure enough food is eaten, and at the child’s rhythm. He or she can be given the same meal as the others, but will have to do it frequently and separately.

**A Healthy Family**

**Key message:**
To invest in the family’s nutrition is to invest in its development. A well-nourished family will be a healthy and happy family.

**Additional information:**
The good development of children is a reason for their parents to be happy. Birth must be controlled to correctly look after the children. All families should consume iodised salt.

**Problematic Family**

**Key message:**
Not to invest in the family’s nutrition is to encourage health problems. A mal-
nourished and badly-planned family will not be a happy family.

Additional information:
A too numerous family without the financial means is exposed to mal-nutrition, as there are more mouths to feed and more medical costs to cover as children often become sick.

A Sick Child

Key message:
When a child is sick it is important to manage the illness properly from the very first day. Encourage the child to eat, even if he or she does not want to. A sick child must be fed more often than a healthy child.

Feeding a Sick Child

Key message:
A sick child must eat more frequently than a healthy child. It is necessary to continue breastfeeding the child.

Additional information:
Continue breastfeeding the child. Offer food more frequently than the child’s usual meals. Insist on the child’s need to eat but do not use force. Choose the foods that the child likes, and ensure the child eats foods rich in nutrients. Chop the food up very well, and add a little bit of sauce or juice to facilitate the child’s swallowing. Continue to follow the child’s growth evolution. Once the child is cured, give more food than usual until the lost weight has been recovered.

Feeding Adolescents

Key message:
As the body of an adolescent develops, it must be fed three meals and snacks each day. A healthy adolescent is active, a good student and plays.

Additional information:
Due to menstruation girls must eat foods richer in iron. Parents know their children are developing and healthy when: clothes no longer fit, their weight and height increase, and they have a good appetite. A well-nourished child has more opportunities to develop normally than a mal-nourished child.

Feeding Adolescents

Key message:
An adolescent needs to eat often: breakfast, lunch and dinner, and locally available snacks in between meals.

Additional information:
Children must eat before going to school, otherwise they cannot concentrate in class.
**Anaemia due to a Deficiency Iron**

**Key message:**
Main signs of anemia are: fatigue, and paleness of lips, palms and nails.

**Additional information:**
Anemia is a condition where a person lacks haemoglobin - a substance which gives the red colour to blood. It is an illness which mainly affects women and children.

The risk groups are the following:
- Babies with low birth weight, under 2kg 500 grams, have a low iron reserve
- Babies who are not breastfed (iron from artificial milk is not absorbed as much as mother’s milk)
- Mal-nourished children
- Adolescent girls who lose blood during menstruations
- Pregnant women and who have recently given birth

Anemia reduces productivity (more fatigue), reduces the child’s development, and increases the mother’s risk of death while giving birth.

**Key messages:**
Have foods rich in iron, such as: mother’s milk, green leaves, meat, liver, fish, etc. Iron in foods of animal origin is more readily absorbed by the body than those of vegetable origin.

**Additional information:**
To avoid anemia:
- Breastfeed the child
- Eat foods rich in iron
- Eat raw foods rich in vitamin C (lemon, tomato, orange, etc.) to improve the absorption of iron. Avoid drinking tea or coffee with the meals
- Pregnant women must take iron supplements each day, which they will receive at pre-natal consultations

**Foods Rich in Vitamin A**

**Key message:**
Vitamin A protects us against infections and night blindness. Consume foods rich in vitamin A: mother’s milk, palm oil, carrots, mango, papaya, eggs, green leaves, liver, and dried fish.

**Additional information:**
A vitamin A deficiency is indicated by:
• A higher risk of infections (diarrhea illnesses and respiratory infections)
• Night blindness (the child cannot see properly after dusk, or in dimly lit places)
• ‘Dry eyes’ (the eyes lose their brightness), and blindness.

An Iodine Deficiency

Key message:
To avoid problems associated to an iodine deficiency, iodised salt and sea products must be consumed.

Additional information:
The consequences of an iodine deficiency are illnesses directly related to insufficient iodine-rich foods: cretinism (hypothyroidism), delayed growth, spontaneous abortion, premature births, reduction in intellectual coefficient, infertility in women, tiredness and cretinism (mentally retarded and often deaf-mute children).

To avoid an iodine deficiency, iodine-enriched sea salt (iodised salt) must be consumed in the same way as ordinary kitchen salt.

7. FOOD DESCRIPTION AND ITS ROLE IN THE BODY

Food is any nutrient that a human-being uses to satisfy its being or hunger. The role of food in the body is: thanks to the energy provided by the foods consumed, body organs (heart, liver, lungs, kidneys and other organs) work. Some foods, due to their composition, will have positive effects in the event of nutritional deficiencies. Others can help fight against certain illnesses and infections.
### ANNEX 5. FORMS

**TO BE FILLED OUT DURING THE PREPARATION PHASE**

#### 5.a POPULATION REGISTER OF THE NUTRITIONAL CONDITION OF 6 TO 59-MONTH-OLD CHILDREN (To be filled in by the CA)

<table>
<thead>
<tr>
<th>No.</th>
<th>Gender (M/F)</th>
<th>Child's given name</th>
<th>Child's surname</th>
<th>Mother's given name</th>
<th>Mother's surname</th>
<th>Town</th>
<th>Date of birth</th>
<th>Age (in months)</th>
<th>Weight (in kg.)</th>
<th>W/A %</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.4 Population Register of the Nutritional Condition of 6 to 59-Month Old Children

### Summary of the Register by Age, Gender, and Nutritional Condition According to Weight/Age

<table>
<thead>
<tr>
<th>Classification</th>
<th>6 to 11-Month-Olds</th>
<th>12 to 29-Month-Olds</th>
<th>30 to 59-Month-Olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Total No. of Boys

<table>
<thead>
<tr>
<th>Age of the Children</th>
<th>Total No. of Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 to 11-Month-Olds</td>
<td></td>
</tr>
<tr>
<td>12 to 29-Month-Olds</td>
<td></td>
</tr>
<tr>
<td>30 to 59-Month-Olds</td>
<td></td>
</tr>
</tbody>
</table>

#### Total No. of Girls

<table>
<thead>
<tr>
<th>Age of the Children</th>
<th>Total No. of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 to 11-Month-Olds</td>
<td></td>
</tr>
<tr>
<td>12 to 29-Month-Olds</td>
<td></td>
</tr>
<tr>
<td>30 to 59-Month-Olds</td>
<td></td>
</tr>
</tbody>
</table>
### Pre-Selection of 6 to 59-Month-Old Children

<table>
<thead>
<tr>
<th>No.</th>
<th>Child's Name</th>
<th>Name of Mother or Carer</th>
<th>Town</th>
<th>Gender (m/f)</th>
<th>Age (months)</th>
<th>Weight (kg)</th>
<th>Height (cm)</th>
<th>BP (mm)</th>
<th>W/H (%)</th>
<th>Current Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total No. of Children with a W/H % < 70%:**

**Total No. of Children with a W/H % < 80%:**

**Total No. of Children with a W/H % ≥ 80% & < 85%:**

**Total No. of Children with a W/H % ≥ 85%:**

---

**Workshop No.:**

**Starting Date:**

**Community:**

**District/Prefecture:**

**Name of the Community Agent:**

**Name of the On-Site Agent:**

---

**Strategic Programming for Community Nutrition Interventions**
### 5.c FINAL SELECTION OF 6 TO 59-MONTH-OLD CHILDREN INTO A COMMUNITY WORKSHOP (CW) (To be filled out by the CA)

<table>
<thead>
<tr>
<th>No.</th>
<th>Child's name</th>
<th>Name of mother or carer</th>
<th>Town</th>
<th>Gender (m/f)</th>
<th>Age (months)</th>
<th>Clasificación en el censo</th>
<th>Clasificación en la Pre-Selección</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The CA is to fill out the Referral Sheet in triplicate. Include the ‘reason for referral’, sign and date it. The three sheets are to be given to the mother, who will be responsible for sending the child to the indicated place of referral. The mother should be reminded to give the three referral sheets to the doctor. At the place of referral the medical personnel will ask the mother for the three referral sheets, sign them and attach the diagnosis, writing in the consultation date (these are the black fonts of the referral sheet). A copy will be kept by the centre for the CA to collect and hand to the OA. The following day, the CA will collect the referral sheet from where the child was referred. At the end of the execution phase (after the workshop) the OA will visit the referral centres to verify admissions and follow-up the cases. The OA is to write a report and give it to the supervisor.

<table>
<thead>
<tr>
<th>WORKSHOP No./Name</th>
<th>COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY AGENT (CA)</td>
<td>NAME OF THE CHILD</td>
</tr>
<tr>
<td></td>
<td>AGE</td>
</tr>
<tr>
<td></td>
<td>WEIGHT</td>
</tr>
<tr>
<td></td>
<td>HEIGHT</td>
</tr>
<tr>
<td></td>
<td>W/H %</td>
</tr>
<tr>
<td></td>
<td>BP</td>
</tr>
<tr>
<td></td>
<td>Green/Yellow/Red</td>
</tr>
<tr>
<td>NAME OF CARER</td>
<td>KINSHIP (mother, grand-mother, etc.)</td>
</tr>
<tr>
<td>CENTER of REFERRAL</td>
<td>HEALTH CENTRE</td>
</tr>
<tr>
<td></td>
<td>SUPPLEMENTARY NUTRITIONAL CENTRE</td>
</tr>
<tr>
<td></td>
<td>THERAPEUTIC NUTRITIONAL CENTRE</td>
</tr>
<tr>
<td></td>
<td>HOSPITAL</td>
</tr>
<tr>
<td>REASON FOR REFERRAL</td>
<td>MEDICAL DIAGNOSIS FROM THE CENTRE WHERE THE CHILD HAS BEEN REFERRED TO (to be filled out by the doctor at the centre)</td>
</tr>
<tr>
<td>SIGNATURES</td>
<td>COMMUNITY AGENT</td>
</tr>
<tr>
<td></td>
<td>HEALTH AGENT/DOCTOR/NURSE/…</td>
</tr>
<tr>
<td>Date:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

STRATEGIC PROGRAMMING FOR COMMUNITY NUTRITION INTERVENTIONS
5.e. GROWTH EVOLUTION OF CHILDREN PER WORKSHOP DURING SESSIONAL & FOLLOW-UP PHASES (To be filled out by the CA)

<table>
<thead>
<tr>
<th>WORKSHOP No.</th>
<th>COMMUNITY</th>
<th>Age in months</th>
</tr>
</thead>
<tbody>
<tr>
<td>STARTING DATE</td>
<td>DISTRICT / PREFECTURE</td>
<td>W (Weight) in Kg.</td>
</tr>
<tr>
<td>FINAL DATE OF WORKSHOP</td>
<td>NAME OF THE COMMUNITY AGENT</td>
<td>H (Height) in cm.</td>
</tr>
<tr>
<td>(To be filled out by the CA)</td>
<td>NAME OF THE ON-SITE AGENT</td>
<td></td>
</tr>
</tbody>
</table>

### During the workshop

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Surname</th>
<th>Gender (M/F)</th>
<th>Date of Birth</th>
<th>AGE</th>
<th>W (Weight) in Kg.</th>
<th>H (Height) in cm.</th>
<th>W/H%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admission (1st day)</th>
<th>Exit (12th day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>H</td>
</tr>
<tr>
<td>W</td>
<td>H/H%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At 1 month</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>H</td>
</tr>
<tr>
<td>W/H%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At 2 months</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>H</td>
</tr>
<tr>
<td>W/H%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At 6 months</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>H</td>
</tr>
<tr>
<td>W/H%</td>
<td>%P/T</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At 12 months</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>H</td>
</tr>
<tr>
<td>W/H%</td>
<td></td>
</tr>
</tbody>
</table>
### 5.f ATTENDANCE RECORD FOR CHILDREN & MOTHERS/CARERS AT THE WORKSHOP AND FOR THE CIRCULATION OF IEC MESSAGES

**ATTENDANCE OF CHILDREN & MOTHERS**

*(To be filled out by the ML)*

**WORKSHOP No.:**

**STARTING DATE:** /___/ /____/ /___________/

**FINAL DATE:** /___/ /____/ /___________/

**COMMUNITY:**

**DISTRICT / PREFECTURE:**

**NAME OF MOTHER LIGHT:**

**NAME OF COMMUNITY AGENT:**

**NAME OF ON-SITE AGENT:**

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Surname</th>
<th>CHILDREN’S ATTENDANCE</th>
<th>No. of Absentees</th>
<th>WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>D1</td>
<td>D2</td>
<td>D3</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No. of mothers who attended IEC message sessions and workshop (non-beneficiary children’s mothers)

Nº padres presentes en las sesiones IEC, y en el taller
<table>
<thead>
<tr>
<th>Child No:</th>
<th>Ingredient/material (May be more than one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOTHER'S</td>
<td>D1</td>
</tr>
<tr>
<td></td>
<td>D2</td>
</tr>
<tr>
<td></td>
<td>D3</td>
</tr>
<tr>
<td></td>
<td>D4</td>
</tr>
<tr>
<td></td>
<td>D5</td>
</tr>
<tr>
<td></td>
<td>D6</td>
</tr>
<tr>
<td></td>
<td>D7</td>
</tr>
<tr>
<td></td>
<td>D8</td>
</tr>
<tr>
<td></td>
<td>D9</td>
</tr>
<tr>
<td></td>
<td>D10</td>
</tr>
<tr>
<td></td>
<td>D11</td>
</tr>
<tr>
<td></td>
<td>D12</td>
</tr>
</tbody>
</table>

**5. g MOTHER'S DAILY CONTRIBUTION DURING THE SESSIONAL PHASE**

(To be filled out by the OA, if absent, by the ML)
### 5. h. RECIPE PREPARATION FORM

(To be filled out by the OA with the help of the ML and the CA)

<table>
<thead>
<tr>
<th>Name of the Recipe</th>
<th>Ingredients</th>
<th>Quantity (in local measurements)</th>
<th>Quantity (in grams)</th>
<th>Total No. of Kcal per food</th>
<th>Proteins (gr.)</th>
<th>Total %</th>
<th>Carbohydrates (gr.)</th>
<th>Total %</th>
<th>Lipids (gr.)</th>
<th>Total %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Technical Department of Health and Nutrition of ACF-E**
## 5.1 CONTROL OF THE CHILD’S DIET CONSUMPTION PER DAY
(To be filled out by the CA)

<table>
<thead>
<tr>
<th>Dia</th>
<th>Quantity/child</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>ML</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D10</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D11</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D12</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 5j IEC Messages Developed Per Day (To be filled out by the OA)

**Workshop No.:** /_____/
**Starting Date:** /___/ /___/ /__________/
**Final Day:** /___/ /___/ /__________/
**Community:** /___________________________________________/
**District / Prefecture:** /___________________________________________/
**Name of Mother Light:** /____________________/
**Name of the CA:** /_________________________/ 
**Name of the OA:** /_________________________/ 

<table>
<thead>
<tr>
<th>Topics</th>
<th>Session days</th>
<th>Observations (possible cause of any absenteeism, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>D1 D2 D3 D4 D5 D6 D7 D8 D9 D10 D11 D12</td>
<td></td>
</tr>
<tr>
<td>Complementary feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food diversity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child's diet during illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment and care of ill child (ARI, diarrhoea, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care practices (Stimulation, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene practices (personal, surroundings, food)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**No. of mothers** who attended IEC message sessions and workshop (non-beneficiary children's mothers)

**No. of fathers** who attended IEC messages sessions and workshop

**Total No. of attendees**
TO BE FILLED OUT DURING THE FOLLOW-UP PHASE

In the process of registering with the form of Annex 5.d, the following forms also require completion during the follow-up phase:

<table>
<thead>
<tr>
<th>No. of CW</th>
<th>No. of Children</th>
<th>ABANDONMENTS</th>
<th>REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DURING THE WORKSHOP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AT 1 MONTH</td>
<td>AT 2 MONTH</td>
<td>AT 6 MONTH</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 6. THE CALCULATION OF PORTIONS FOR MEAL PREPARATION

The prepared recipes are to be identified as supplementary to the normal food regime of the children, having a calorie content between 800 and 1000 Kcal, and protein content from 25 to 27 grams, accounting for 10-15%. Although the menus first identified in the home of the ML can serve as a basis for their elaboration in the workshops, the preparation of other meals based on locally available ingredients is preferable and advisable.

Each child is to have his/her own plate, thereby helping the mother understand the child’s nutritional needs.

Criteria for the development of the menus:
- Create at least five menus
- Each menu is to contribute between 800 and 1000 Kcal and between 11% - 15% proteins, 30%-35% lipids, and 50%-55% carbohydrates
- Use locally available and accessible-to-all foods
- Consumption of fruit and vegetable containing vitamin A and other micronutrients
- Use of animal products and fats, if available and accessible

There are different programs which allow the calculation of food portions, such as the NUTCALC, developed by Action Against Hunger, which compare food portions to the need of different nutrients. Or the computer programme PLANUT which estimates the best purchase of foods by taking into account the price and nutritional value. It also reduces the calculation error in the planning of menus at an individual and a collective level. The user manuals of both can be found at ACF-E HQ, Madrid. Keep in mind that although PLANUT is very effective for the CW programme, it mainly refers to ingredients found in Latin American culture, not African or Asian.

When calculating portions manually, use the following:

1. Given the nutritional composition of the foods, one can calculate the nutritional value per 100 grams of the ingredients for the recipes.

For example:

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Proteins g/100g</th>
<th>Lipids g/100g</th>
<th>Energy Kcal/100g</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corn (whole grain)</td>
<td>8,5</td>
<td>3,8</td>
<td>333</td>
</tr>
<tr>
<td>Lentils (green, raw)</td>
<td>24,3</td>
<td>1,9</td>
<td>298</td>
</tr>
<tr>
<td>Oil</td>
<td>0</td>
<td>100</td>
<td>900</td>
</tr>
<tr>
<td>Sugar</td>
<td>0</td>
<td>0</td>
<td>394</td>
</tr>
</tbody>
</table>
2. According to the nutritional value per 100 grams, the energy, lipid, protein and carbohydrate contributions of each food can be calculated to obtain a portion of food providing 800-1000 Kcal, of which 10-15% will be proteins, 30-35% lipids, and 50-55% carbohydrates.

The details of the calculation are shown below:

The energy of each food is calculated:

Example: 110g of corn = 333Kcal, 450g (275g of corn yields:

\[ 450 \times 333 / 10 = 1498 \text{ Kcal} \]

The sum of each food’s energy value gives the total energy of the portion.

The contribution of lipids and proteins of each food is calculated:

Example: 110g of corn yields 8.5g of protein, 3.8g lipids; 450g of corn yields:

\[ 450 \times 8.5 / 100 = 38.3 \text{g of proteins} \]
\[ 450 \times 3.8 / 100 = 17.1 \text{g of lipids} \]

The sum of the yield of proteins and lipids of each food corresponds to the total contribution of proteins and lipids of the portion.

Total percentage of energy provided by proteins and lipids:

Proteins (as with carbohydrates) provide 4Kcal per gram, and lipids 9Kcal per gram. The quantity of proteins and lipids in the portion is 53g and 43g respectively, being:

\[ 53 \times 4 = 212 \text{ Kcal} \]
\[ 43 \times 9 = 387 \text{ Kcal} \]

Representing respectively:

\[ 212 \times 100 / 1960 = 10.8\% \]
\[ 387 \times 100 / 1960 = 19.8\% \]

of the energy per portion

ANNEX 7. AN EXAMPLE OF CULINARY RECIPES

Examples of recipes according to their preparation

A) Simple baby food:

- 2 dessert spoons of millet or sorghum
- 2 teaspoons of sugar (10g)
- a pinch of salt
- ½ a cup of water (125ml)
**Preparation mode:**
- In a clean container, wet the flour with a little bit of water
- Bring the rest of the water to boil, then in order add the watered flour, sugar and salt, stirring until an oily baby food is obtained
- Simmer 10 to 15 minutes

**B) Enriched baby food:**

- **B1- Corn-flour baby food:**
  - 3 dessert spoons of corn flour, of rice or millet (30g)
  - the mashed yolk of a boiled egg, or a soup spoon of fresh fish, or a soup spoon of peanut paste
  - 2 pieces of sugar (10 g)
  - a pinch of salt
  - 1 cup of water (250 ml)

**Preparation mode:**
- In a clean container, wet the flour with a little water
- Bring the rest of the water to boil, adding in order the watered flour, egg yolk or fish, or the peanut paste, stirring until an oily baby food is obtained
- Add sugar or salt and let simmer for 10 to 15 minutes.

- **B2- Baby food of corn flour with green leaves:**
  - 2 handfuls of green leaves (manioc, pumpkin, potato) (80g)
  - 2 tablespoons of corn flour (20g)
  - A pinch of salt
  - 1 cup of water (250 ml)

**Preparation mode:**
- Wash then mash up the green leaves
- Cook them in a covered pot, over a low heat for 10 minutes
- Dilute the corn flour in a little water and add it to the pot
- Leave to boil for 15 minutes

- **B3- Baby food: Rice pudding**
  - 2 tablespoons of local uncooked rice (20g)
- 2 cans of tomato, fresh milk or curd cheese (150 ml)
- 1 cup of water (250 ml)

**Preparation mode:**
- Boil the rice until completely soft
- Add fresh milk and simmer for 10 to 15 minutes
- If it is curd cheese, let the baby food cool before adding the milk

- **B4- Baby food: Corn with eggs**
  - 1 egg (50g)
  - 2 tablespoons of corn flour (20g)
  - 1 dessertspoon of vegetable oil (13ml)
  - 1 cup of water
  - A pinch of salt and 2 teaspoons of sugar (10g)

**Preparation mode:**
- Boil the egg for 5 minutes and shell it
- Wet the corn flour with a little water
- In a saucepan bring the remaining water to a boil, then add the flour, stir from time to time
- Mash the egg and add the baby food and oil together
- Salt or sugar to taste

C) **Compound Meals:**

- **C1. Pulse dish:**
  - 1 medium sized potato (140 – 150 g)
  - 1 medium sized tomato (50 g)
  - 1 medium sized fish (100g)
  - 1 dessert spoon of peanut or palm oil, or other (13ml)
  - 1 cup of water (250ml)

**Preparation mode:**
- Boil the peeled potato, tomato and fish over a low heat
- Remove the fish from the flame then take out the bones
- Mash up the fish, tomato and potato
- Return it to the flame, add the oil and the water from the boiled fish and potatoes to soften the mixture
- Serve

**C2. Puree of 'macho' banana with eggs:**

- 1 small 'macho' banana (90g)
- 1 handful of spinach leaves or raw potato (40g) or other
- 1 fresh egg (50g)
- 1 cup of water (250ml)
- 1 dessert spoon of palm or peanut oil or other (13ml)
- A pinch of salt

**Preparation mode:**

- Boil the peeled banana, green leaves and egg together
- Mash the banana up with the leaves and ¼ of the egg yolk
- Add oil and the remaining water from boiling the banana, in order to soften the preparation
- Salt and serve
- The 'macho' banana can be replaced by manioc, potato, 'taro' or ñame. And the egg can be replaced by fresh or dried fish, insects or molluscs, or milk, depending on availability

**C3. Pulse baby food:**

- 1 medium size vegetable (sweet potato, or 50gs of tomato, 1 handful of potato leaves or other fresh or dried leaves)
- 1 small fresh fish (50 g)
- 1 dessert spoon of peanut paste (13g)
- A pinch of salt
- ½ litre of water

**Preparation mode:**

- Boil the water, and add potato, tomato and fish
- Remove the fish to take out the bones
- Mash up the potato, tomato and leaves
- Soften the preparation with the water remaining from boiling the fish
- Add salt, peanut paste, fish and leaves
- Cook for 5 to 10 minutes

• **C4. Fish rice:**

- 1 small fresh fish (50g)
- 1 handful of rice
- 1 medium size fresh tomato
- 1 medium size potato (60 g)
- 1 dessert spoon of ‘Karité’ butter, palm, peanut or other type of oil
- ¼ litre of water or a cup of water
- 1 handful of raw potato leaves (40g), or other types

**Preparation mode:**

- Boil the potato, tomato, and the fish
- Remove the boiled fish from the heat and add the previously rinsed rice
- Boil until soft
- Add the oil and mashed up fish - without bones - and the finely cut green leaves
## MANIOC MASH

<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Quantity (local measures)</th>
<th>Quantity (in grams)</th>
<th>Proteins</th>
<th>Lipids</th>
<th>Carbohydrates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manioc</td>
<td>1 piece</td>
<td>150</td>
<td>1,5</td>
<td>0,3</td>
<td>48,1</td>
</tr>
<tr>
<td>Taro (vegetable)</td>
<td>1 medium size</td>
<td>150</td>
<td>3,3</td>
<td>0,6</td>
<td>33,1</td>
</tr>
<tr>
<td>Peanut paste</td>
<td>1 saucepan</td>
<td>20</td>
<td>5</td>
<td>10,6</td>
<td>1,5</td>
</tr>
<tr>
<td>Ground fish</td>
<td>2 saucepans</td>
<td>40</td>
<td>24,1</td>
<td>2,6</td>
<td>1,8</td>
</tr>
<tr>
<td>Soumbara*</td>
<td>1 small piece</td>
<td>5</td>
<td>0,2</td>
<td>0,1</td>
<td>3,3</td>
</tr>
<tr>
<td>Red oil</td>
<td>1/2 teaspoon</td>
<td>15</td>
<td>0</td>
<td>15,0</td>
<td>0,0</td>
</tr>
<tr>
<td>Tomato</td>
<td>3 small</td>
<td>20</td>
<td>0,1</td>
<td>0,1</td>
<td>0,5</td>
</tr>
<tr>
<td>Manioc leaves</td>
<td>4 leaves</td>
<td>15</td>
<td>1,1</td>
<td>0,2</td>
<td>1,9</td>
</tr>
<tr>
<td>Onion</td>
<td>1 medium size</td>
<td>20</td>
<td>0,2</td>
<td>0</td>
<td>1,6</td>
</tr>
<tr>
<td>Water</td>
<td>500 ml</td>
<td>500 ml</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL in grams**

- 435
- 35,5
- 29,5
- 91,7

**Kcal**

- 142
- 261,8
- 366,7

**%**

- 18,4
- 34
- 47,6

**Total energy (Kcal)**

- 770,5

---

## RICE with PEANUT PASTE

<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Quantity (local measures)</th>
<th>Quantity (in grams)</th>
<th>Proteins</th>
<th>Lipids</th>
<th>Carbohydrates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>2½ packets</td>
<td>125</td>
<td>8,1</td>
<td>1,3</td>
<td>101,8</td>
</tr>
<tr>
<td>Peanut paste</td>
<td>1 spoonful</td>
<td>20</td>
<td>5</td>
<td>10,6</td>
<td>1,5</td>
</tr>
<tr>
<td>Vegetable oil</td>
<td>1 spoonful</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>0,0</td>
</tr>
<tr>
<td>Soumbara*</td>
<td>1 small piece</td>
<td>5</td>
<td>0,2</td>
<td>0,1</td>
<td>3,3</td>
</tr>
<tr>
<td>Ground fish</td>
<td>2 spoonfuls</td>
<td>40</td>
<td>24,1</td>
<td>2,6</td>
<td>1,8</td>
</tr>
<tr>
<td>Onion</td>
<td>1 medium size one</td>
<td>20</td>
<td>0,2</td>
<td>0,0</td>
<td>1,6</td>
</tr>
<tr>
<td>Tomato</td>
<td>3 small ones</td>
<td>20</td>
<td>0,1</td>
<td>0,1</td>
<td>0,5</td>
</tr>
<tr>
<td>Water</td>
<td>500 ml</td>
<td>500 ml</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL in grams**

- 240
- 37,7
- 34,7
- 110,4

**Kcal**

- 150,8
- 312,1
- 441,7

**%**

- 16,7
- 34,5
- 48,8

**Total energy (Kcal)**

- 904,6

---

## FISH MILK

<table>
<thead>
<tr>
<th>Ingrediente</th>
<th>Cantidad (medidas locales)</th>
<th>Cantidad (en gramos)</th>
<th>Proteínas</th>
<th>Lípidos</th>
<th>Glúcidos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harina de cereales</td>
<td>5 dessertspoons</td>
<td>100</td>
<td>9,7</td>
<td>1,7</td>
<td>74,7</td>
</tr>
<tr>
<td>Pescado molido</td>
<td>3 teaspoons</td>
<td>30</td>
<td>18,1</td>
<td>2</td>
<td>1,2</td>
</tr>
<tr>
<td>Aceite vegetal</td>
<td>2 teaspoons</td>
<td>20</td>
<td></td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Azúcar</td>
<td>16 teaspoons</td>
<td>80</td>
<td></td>
<td></td>
<td>80,0</td>
</tr>
<tr>
<td>Agua</td>
<td>1 litre</td>
<td>1 litro</td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

**TOTAL in grams**

- 230
- 27,8
- 23,7
- 155,9

**Kcal**

- 112,2
- 213,1
- 618,8

**%**

- 11,8
- 22,6
- 65,6

**Total energy (Kcal)**

- 943,1
## ANNEX 8. WEIGHT/AGE INDEX TABLE

Index weight/age in z-core for children between 0 and 59 months according to NCHS standards (WHO, 1983)

<table>
<thead>
<tr>
<th>Edad (meses)</th>
<th>NRAS</th>
<th>0-3</th>
<th>-2</th>
<th>-1</th>
<th>Mediana</th>
<th>+1</th>
<th>+2</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.6</td>
<td>2.2</td>
<td>2.7</td>
<td>3.2</td>
<td>3.5</td>
<td>4.0</td>
<td>4.5</td>
</tr>
<tr>
<td>1</td>
<td>2.2</td>
<td>2.9</td>
<td>3.4</td>
<td>3.8</td>
<td>4.0</td>
<td>4.5</td>
<td>5.1</td>
</tr>
<tr>
<td>2</td>
<td>2.7</td>
<td>3.3</td>
<td>3.7</td>
<td>4.1</td>
<td>4.5</td>
<td>4.9</td>
<td>5.5</td>
</tr>
<tr>
<td>3</td>
<td>3.2</td>
<td>3.9</td>
<td>4.3</td>
<td>4.7</td>
<td>5.0</td>
<td>5.4</td>
<td>5.9</td>
</tr>
<tr>
<td>4</td>
<td>3.7</td>
<td>4.5</td>
<td>4.9</td>
<td>5.3</td>
<td>5.6</td>
<td>5.9</td>
<td>6.3</td>
</tr>
<tr>
<td>5</td>
<td>4.2</td>
<td>5.0</td>
<td>5.4</td>
<td>5.8</td>
<td>6.0</td>
<td>6.3</td>
<td>6.7</td>
</tr>
<tr>
<td>6</td>
<td>4.7</td>
<td>5.5</td>
<td>5.9</td>
<td>6.3</td>
<td>6.6</td>
<td>6.9</td>
<td>7.3</td>
</tr>
<tr>
<td>7</td>
<td>5.2</td>
<td>6.0</td>
<td>6.4</td>
<td>6.8</td>
<td>7.0</td>
<td>7.3</td>
<td>7.6</td>
</tr>
<tr>
<td>8</td>
<td>5.7</td>
<td>6.5</td>
<td>6.9</td>
<td>7.3</td>
<td>7.6</td>
<td>7.9</td>
<td>8.2</td>
</tr>
<tr>
<td>9</td>
<td>6.2</td>
<td>7.0</td>
<td>7.4</td>
<td>7.8</td>
<td>8.0</td>
<td>8.3</td>
<td>8.6</td>
</tr>
<tr>
<td>10</td>
<td>6.7</td>
<td>7.5</td>
<td>7.9</td>
<td>8.3</td>
<td>8.5</td>
<td>8.8</td>
<td>9.1</td>
</tr>
<tr>
<td>11</td>
<td>7.2</td>
<td>8.0</td>
<td>8.4</td>
<td>8.8</td>
<td>9.0</td>
<td>9.3</td>
<td>9.6</td>
</tr>
<tr>
<td>12</td>
<td>7.7</td>
<td>8.5</td>
<td>8.9</td>
<td>9.3</td>
<td>9.5</td>
<td>9.8</td>
<td>10.1</td>
</tr>
<tr>
<td>13</td>
<td>8.2</td>
<td>9.0</td>
<td>9.4</td>
<td>9.8</td>
<td>10.0</td>
<td>10.3</td>
<td>10.6</td>
</tr>
<tr>
<td>14</td>
<td>8.7</td>
<td>9.5</td>
<td>9.9</td>
<td>10.3</td>
<td>10.6</td>
<td>10.9</td>
<td>11.2</td>
</tr>
<tr>
<td>15</td>
<td>9.2</td>
<td>10.0</td>
<td>10.4</td>
<td>10.8</td>
<td>11.1</td>
<td>11.4</td>
<td>11.7</td>
</tr>
<tr>
<td>16</td>
<td>9.7</td>
<td>10.5</td>
<td>10.9</td>
<td>11.3</td>
<td>11.6</td>
<td>11.9</td>
<td>12.2</td>
</tr>
<tr>
<td>17</td>
<td>10.2</td>
<td>10.9</td>
<td>11.3</td>
<td>11.7</td>
<td>12.0</td>
<td>12.3</td>
<td>12.6</td>
</tr>
<tr>
<td>18</td>
<td>10.7</td>
<td>11.5</td>
<td>11.9</td>
<td>12.3</td>
<td>12.6</td>
<td>12.9</td>
<td>13.2</td>
</tr>
<tr>
<td>19</td>
<td>11.2</td>
<td>11.9</td>
<td>12.3</td>
<td>12.7</td>
<td>13.0</td>
<td>13.3</td>
<td>13.6</td>
</tr>
<tr>
<td>20</td>
<td>11.7</td>
<td>12.3</td>
<td>12.7</td>
<td>13.1</td>
<td>13.4</td>
<td>13.7</td>
<td>14.0</td>
</tr>
<tr>
<td>21</td>
<td>12.2</td>
<td>12.7</td>
<td>13.1</td>
<td>13.5</td>
<td>13.8</td>
<td>14.1</td>
<td>14.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Edad (meses)</th>
<th>NINOS</th>
<th>0-3</th>
<th>-2</th>
<th>-1</th>
<th>Mediana</th>
<th>+1</th>
<th>+2</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.5</td>
<td>2.1</td>
<td>2.6</td>
<td>3.1</td>
<td>3.5</td>
<td>4.0</td>
<td>4.5</td>
</tr>
<tr>
<td>1</td>
<td>2.1</td>
<td>2.7</td>
<td>3.2</td>
<td>3.7</td>
<td>4.0</td>
<td>4.5</td>
<td>5.0</td>
</tr>
<tr>
<td>2</td>
<td>2.6</td>
<td>3.2</td>
<td>3.7</td>
<td>4.1</td>
<td>4.5</td>
<td>4.9</td>
<td>5.5</td>
</tr>
<tr>
<td>3</td>
<td>3.1</td>
<td>3.6</td>
<td>4.0</td>
<td>4.4</td>
<td>4.7</td>
<td>5.0</td>
<td>5.5</td>
</tr>
<tr>
<td>4</td>
<td>3.6</td>
<td>4.2</td>
<td>4.6</td>
<td>5.0</td>
<td>5.3</td>
<td>5.6</td>
<td>6.0</td>
</tr>
<tr>
<td>5</td>
<td>4.1</td>
<td>4.7</td>
<td>5.1</td>
<td>5.5</td>
<td>5.8</td>
<td>6.0</td>
<td>6.4</td>
</tr>
<tr>
<td>6</td>
<td>4.6</td>
<td>5.2</td>
<td>5.6</td>
<td>6.0</td>
<td>6.3</td>
<td>6.6</td>
<td>6.9</td>
</tr>
<tr>
<td>7</td>
<td>5.1</td>
<td>5.7</td>
<td>6.1</td>
<td>6.5</td>
<td>6.8</td>
<td>7.0</td>
<td>7.3</td>
</tr>
<tr>
<td>8</td>
<td>5.6</td>
<td>6.2</td>
<td>6.6</td>
<td>7.0</td>
<td>7.3</td>
<td>7.5</td>
<td>7.8</td>
</tr>
<tr>
<td>9</td>
<td>6.1</td>
<td>6.7</td>
<td>7.1</td>
<td>7.5</td>
<td>7.8</td>
<td>8.0</td>
<td>8.3</td>
</tr>
<tr>
<td>10</td>
<td>6.6</td>
<td>7.2</td>
<td>7.6</td>
<td>8.0</td>
<td>8.3</td>
<td>8.5</td>
<td>8.8</td>
</tr>
<tr>
<td>11</td>
<td>7.1</td>
<td>7.7</td>
<td>8.1</td>
<td>8.5</td>
<td>8.8</td>
<td>9.0</td>
<td>9.3</td>
</tr>
<tr>
<td>12</td>
<td>7.6</td>
<td>8.2</td>
<td>8.6</td>
<td>9.0</td>
<td>9.3</td>
<td>9.5</td>
<td>9.8</td>
</tr>
<tr>
<td>13</td>
<td>8.1</td>
<td>8.7</td>
<td>9.1</td>
<td>9.5</td>
<td>9.8</td>
<td>10.0</td>
<td>10.3</td>
</tr>
<tr>
<td>14</td>
<td>8.6</td>
<td>9.2</td>
<td>9.6</td>
<td>10.0</td>
<td>10.3</td>
<td>10.5</td>
<td>10.8</td>
</tr>
<tr>
<td>15</td>
<td>9.1</td>
<td>9.7</td>
<td>10.1</td>
<td>10.5</td>
<td>10.8</td>
<td>11.0</td>
<td>11.3</td>
</tr>
<tr>
<td>16</td>
<td>9.6</td>
<td>10.2</td>
<td>10.6</td>
<td>11.0</td>
<td>11.3</td>
<td>11.5</td>
<td>11.8</td>
</tr>
<tr>
<td>17</td>
<td>10.1</td>
<td>10.7</td>
<td>11.1</td>
<td>11.5</td>
<td>11.8</td>
<td>12.0</td>
<td>12.3</td>
</tr>
<tr>
<td>18</td>
<td>10.6</td>
<td>11.2</td>
<td>11.6</td>
<td>12.0</td>
<td>12.3</td>
<td>12.5</td>
<td>12.8</td>
</tr>
<tr>
<td>19</td>
<td>11.1</td>
<td>11.7</td>
<td>12.1</td>
<td>12.5</td>
<td>12.8</td>
<td>13.0</td>
<td>13.3</td>
</tr>
<tr>
<td>20</td>
<td>11.6</td>
<td>12.2</td>
<td>12.6</td>
<td>13.0</td>
<td>13.3</td>
<td>13.5</td>
<td>13.8</td>
</tr>
<tr>
<td>21</td>
<td>12.1</td>
<td>12.7</td>
<td>13.1</td>
<td>13.5</td>
<td>13.8</td>
<td>14.0</td>
<td>14.3</td>
</tr>
</tbody>
</table>

NB: los datos para los niños/a en que meses de 24 meses (medidos mundiales) y para los mayores de 24 meses (medidos por el recuento de las poblaciones de niños diferentes. Esto explica la falta de concordancia de los datos entre el a 24 meses.
### ANNEX 9.

#### EXAMPLE OF AN AGRICULTURE CALENDAR

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dry Season</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rainy season</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Temperature</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cool nights, moderate daytime temperatures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooler nights, higher temperatures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild temperatures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher temperatures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intense storms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abundant and regular rains</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peak</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peak</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Highlands</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remove bad weed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ or – late harvest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peanuts</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corn</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manioc</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BoH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweet potato</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legumes</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phased harvest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WET LANDS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice</td>
<td>H</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice 2 cycles</td>
<td>R</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harvest</td>
<td>H</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corn</td>
<td>H</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweet potato</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Plant</td>
<td>H</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legumes</td>
<td>H</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phased harvest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COMMERCIAL FARMING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palm (oil)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BoH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EoH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuts and oil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harvest of nuts and transformation to oil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocoa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EoH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BoH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee plantations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WILD FRUITS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bread tree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bananas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phased harvest during the whole year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wild fruits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wild tubers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phased harvest during the whole year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FISHERY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scarcie</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beginning of season</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HUNTING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less significant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less significant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

S: sowing time; H: harvest; BoH, EoH: beginning and end of harvest; N: nursery; R: replacement
### ANNEX 10. Contract notice

<table>
<thead>
<tr>
<th>Job title:</th>
<th>On-site Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration:</td>
<td>x months</td>
</tr>
<tr>
<td>Location:</td>
<td>Of the intervention</td>
</tr>
<tr>
<td>Organisation:</td>
<td>ACF-E</td>
</tr>
<tr>
<td>Required:</td>
<td>an OA for community nutritional program</td>
</tr>
</tbody>
</table>

#### Requisites:
- Nationality ___________
- Not currently working for any other NGO or public entity
- Speak the local language correctly
- Speaks and writes the country’s second official language
- Willing to live in the community for long periods of time, and in hard conditions
- Two years' experience in nutrition is desirable

#### Lodging documents:
- Resume
- Letter of objectives
- CV
- Photocopy of National Identity Card
- Copy of education certificate or equivalent
- Work certificate

The **deadline for the lodging of documents** is: 12noon on __/__/ of ______________/ of __________/

#### Place to lodge documents:
Headquarters of ACF-E (specify address), addressed to: The Manager, ACF-E Nutritional Programme

The list of candidates, pre-selected from the documentation provided, will be issued on __/__/ (Day of the Week), __/__/ of ______________/ of __________/ from 12noon at the ACF-E office, in the Health Centre.

...Those pre-selected from the provided documentation, will take a written test and be interviewed two days after the list has been issued, from 10am, __/__/ day of ______________/ of __________/ at the ACF-E offices.

Final selection of the OAs, through a written test and interview, will be issued on __/__/ day of ______________/ of __________/ from 4pm at the ACF office, at the Health Centre, ... ACF-E, Action Against Hunger. Nutrition Department.
ANNEX 11. WRITTEN TEST AND INTERVIEW

Those listed below have been pre-selected for the position of /______________________. We invite you to take the written test, and to be interviewed at /____________/ on /___/ of /__________________/ of /______/.

Mr/Mrs/Ms ________________
Mr/Mrs/Ms ________________
Mr/Mrs/Ms ________________

____________, on ___ of ___________ of _________

Person in charge - ACF–E Nutrition Program

ANNEX 12. EXAMPLE: TEST FOR ON-SITE AGENTS (OA)

1) List and define the various types of malnutrition. (1.5p)
2) Briefly explain what you understand by a Community Workshop (1.5p)
3) What are the admission criteria for a child to a CW? (1p)
4) What are the criteria to refer a child to a health centre? (1p)
5) What do you understand by ‘Mother Light’ (ML)? What are the tasks she is to undertake in a CW? (0.5p)
6) What do you understand by ‘Community Agent’ (CA)? (0.5p)
7) What tasks must a Community Agent undertake during a CW? (1p)
8) What importance does a CW have in a community? (1p)
9) What role must an OA play once the CW is finished? (1p)
10) What dosage of Mebendazol, Iron, and Folic acid, and vitamin A is to be administered? (1p)
11) What observations are to be made during a HS (home survey) (1p)
12) At what age is breastfeeding be initiated and concluded? (1.5p)
13) What’s the importance of breastfeeding? (1p)
14) At what age is complementary feeding to be introduced? (1p)
15) What actions are to be taken for a child with diarrhoea (1p)
16) What are the signs of dehydration (1p)
17) According to you, what are the responsibilities of an OA? (1.5p)
ANNEX 13. SELECTED CANDIDATES for the POST of ON-SITE AGENTS

Following the interview and written test, completed on /__/ of /__________/ of /______/, the selected person is:

Mr/Mrs/Ms ______________

The successful candidate is invited to contact the administration department of ACF-E, located at ________________, on/__/ of /__________/ of /______/ at /______/ time / for administrative formalities.

The following week, on /__/ of /___/ of /_________/ the /________________________/ training will be given. For this we request your assistance on /__/ of /__________/ of /______/ at /______/ time /.

Thank you for your collaboration

Person-in-charge, ACF-E Nutrition

ANNEX 14. Nutritional Analysis for PD Family Selection

<table>
<thead>
<tr>
<th>NUTRITION</th>
<th>HEALTH &amp; HYGIENE</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Family’s data

Child’s name

Gender

Date of birth

Nutritional condition

Mother’s name

Mother’s occupation

Description of the home
## Annex 15. Market Survey

<table>
<thead>
<tr>
<th>Product</th>
<th>Quantity (local measure)</th>
<th>Equivalent in grams</th>
<th>Total Proteins (g)</th>
<th>Total Lipids (g)</th>
<th>Total Kcal.</th>
<th>Available in</th>
<th>Seasonal availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Shop</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Price</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>market</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>precios</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Home Market garden</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>/run/pen</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 16. GUIDE TO COMPILING A REPORT TO HEADQUARTERS

1. General aspects: Programme, Month/Year. Written by, Objectives for the month, and note why any objectives were not met, if indeed that were the case.

2. Activities foreseen for the month (keeping in mind the dates of activities in the formulation of the project).

<table>
<thead>
<tr>
<th>Calendar Week</th>
<th>January</th>
<th>February</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td>X X X</td>
<td>X</td>
</tr>
</tbody>
</table>

3. Activities carried out during the month

4. Presentation of results (In accordance with Section 6 of this manual)

<table>
<thead>
<tr>
<th>ACTIVITY CARRIED OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

5. Problems & Solutions

<table>
<thead>
<tr>
<th>Department</th>
<th>Problem or difficulty</th>
<th>Proposed solutions</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Logistic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some examples of difficulties: mobilising the mothers, ingredient contributions, poor comprehension of the messages, etc.

6. Cultural specifics. Briefly describe the beliefs held about nutrition and food, and any health taboos existing in the community.
7. Observations. All that one believes is relevant, and that which has not been considered as a cultural problem and/or specific to that culture.

8. Internal coordination of meetings, or meetings with other local/international structures and or organisations

<table>
<thead>
<tr>
<th>With whom</th>
<th>Reason</th>
<th>Conclusions</th>
<th>Timing</th>
<th>Person in charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Following month’s objectives

10. Recommendations
### ANNEX 17. BUDGET GUIDE LINES FOR THE FORMULATION OF THE CW PROGRAM

<table>
<thead>
<tr>
<th>BUDGET SHEET</th>
<th>Quantity</th>
<th>Duration (In months)</th>
<th>Unit price (Local currency)</th>
<th>Total (Local currency)</th>
<th>Total in (in euro)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. HUMAN RESOURCES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1 Expatriate personnel</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify professional degree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.2 Local personnel</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-site Agent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. MATERIAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.1 Anthropometric material</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed wall measurer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.2 Training material</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.3 For sessions &amp; follow-up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitchen/workshop utensils</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albendazol/Mebendazol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision forms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.4 Office material</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials &amp; equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Printer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. LOGISTICS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication (radios, telephones, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petrol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House/office let</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TRANSPORT (according to needs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motorbike</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bicycle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VISIBILITY</strong> (shirts, caps, etc., with identification)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SUB-TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 18. CRITERIA FOR WEIGHT GAIN OF CHILDREN ADMITTED TO A WORKSHOP

<table>
<thead>
<tr>
<th>CRITERIA FOR WEIGHT GAIN OF CHILDREN ADMITTED TO A WORKSHOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child with acute malnutrition (Inadequate growth)</td>
</tr>
<tr>
<td>Grams</td>
</tr>
<tr>
<td>W/H %</td>
</tr>
<tr>
<td>&lt;200gr in all cases</td>
</tr>
<tr>
<td>&lt; 80%</td>
</tr>
<tr>
<td>Child with adequate nutritional recovery</td>
</tr>
<tr>
<td>Grams</td>
</tr>
<tr>
<td>W/H %</td>
</tr>
<tr>
<td>200 - 300g during workshop and that month</td>
</tr>
<tr>
<td>&gt;=80 y &lt; 85%</td>
</tr>
<tr>
<td>200 - 699g 2, 6 &amp; 12 months after workshop</td>
</tr>
</tbody>
</table>

Those children with a W/H% ≥ 85% are considered not to have acute malnutrition, and are to be discharged from the program.

ANNEX 19. EXAMPLE OF AN AGREEMENT WITH A LOCAL COUNTERPART

AGREEMENT Between
Action Against Hunger (ACF-E)
AND ____________________ (_______)

From /__/_/_____/_____/ To /__/_/_____/_____/  

Within the support program on community nutrition in the local towns of the region of ___________, where the main operator is ACF-E, represented by the office of ____________, the following has jointly been agreed with _________________ (Person in charge of the local Institution):

Article 1. Reason for Agreement
The result sort by ACF-E and ______________ is an intervention within the programs of CWs which support community nutrition in the local towns of the region of ____________. To achieve this, the following is required: Awareness-raising of health agents, and of the community. The mobilising of the community, and the selecting and training of community agents.
Detection of malnourished children, selecting and training of the ML, assessing beliefs and practices on health, nutrition and hygiene. Undertaking a market survey, selecting recipes, systematic treatment, and the CWs themselves. The follow-up at one, two, six and 12 months post workshop. Assessment through the use of indicators on the children's nutritional condition and change of behaviours.
It has been agreed that the local institution _______________ will be in charge of the follow-up of the children one, two, six and 12 months after the workshop, and of the assessment on behavioural change.

**Article 2. Collaboration Modes & Resources**

*Commitments of the Local Institution*

_________ commits to comply with the following responsibilities in close collaboration with ACF-E. For this ___________ will be in charge of Project Follow-up – evaluation through a supervisor, with the contract’s beginning on / / / _____/ and expiring on / / / _____/.

**Responsibilities**

- To contact the communities and carry out the Follow-up on the good functioning of the project
- To organise meetings with the ACF-E team as the follow up is developed, for the exchange and comparison of information on the results achieved
- The supervisor is to participate in the coordination of meetings for the general planning of activities and the development of a supervision calendar – and to generally enrich the meetings by contributing knowledge and experiences.
- Will provide an office in ____________, at the full disposal of the programme
- Write a monthly activity report which will include the number of workshops, number of children enrolled in the CWs, change detected, etc. And will ensure the provision of all useful information whenever required.

*Commitments of ACF-E*

As the main operator of the project ACF-E will ensure the results for beneficiaries and donors. Even if the involvement of the local institutions is strengthened, ACF-E reserves the right to take all final decisions.

**Responsibilities**

- To provide all required administration material and furniture for the office (one table, four chairs, etc.)
- To provide the facilitator with all forms and materials required to carry out the follow-up activities
- To provide a motorbike and car to be shared with the rest of the ACF-E team
- To supply petrol and maintenance of the transport used during the follow-up activities.

**Article 3. Conflict solution**

All conflicts between the distinct parties are to be solved in a friendly manner. Failing this, the present agreement will be cancelled.

**Article 4: Modifications**

Any modification affecting the administrative provisions of the present agreement will be subject to the agreement of both parties.

**Article 5 Duration**

This agreement covers the period between__________ & __________. It will take effect immediately upon signing this agreement, and will terminate when each part has complied with its obligations.

It may be extended in accordance with new funding.
Article 6. Special Provision
ACF-E reserves the right to demand the replacement of personnel in the event that his or her work or behaviour is not satisfactory.

Signed & approved by all involved parties

Signature of the Local Institution’s Representative

Signature of ACF-E’s Representative

Date

Date:

ANNEX 20. EXAMPLE OF PRE-TEST FOR OA

1) What is Positive Deviation?
2) What are the child admission criteria to a CW?
3) What are the reasons for transferring a child to a health centre?
4) What do you understand by a CW? Give a brief explanation.
5) What is the importance of a CW within a community?
6) What role must a CA play at the end of the CW?
7) Systematic treatment of CW children: explain its worth and detail the doses according to age and/or weight
8) What observations are to be made during a HS?
9) List some of the IEC messages for the CW sessions
10) When during the CW is hygiene most required?

ANNEX 21. CERTIFICATE FOR TRAINING PARTICIPATION

CERTIFICATE of TRAINING PARTICIPATION
for COMMUNITY WORKSHOPS (CWs)

Mr/Mrs/Ms ________________________ has participated in the training provided by ACF-E at the implementation of the CW’s program at _____________________, from /__/__/______ to /__/__/______

All topics related to the CW’s program were developed: Positive Deviation, the program’s phases, systematic treatment, the IEC messages, the taking of anthropometric measures, growth follow-up, etc.

Coordinator Nutritional Doctor
Action Against Hunger (ACF-E)
AGREEMENT between

Action Against Hunger (ACF-E)

and the Ministry of Health for the region of ____________

__________, on /__/ of /__________/ of 20___.

On one side, Mr/Mrs/Ms ____________________, Director of the Ministry of Health of the region ______________ (______________),

And on the other, Mr/Mrs/Ms _________________, ACF-E Mission Manager (___),

Recognise the need of this joint agreement in order to carry out the following:

Main Objective:

Within this community nutrition-support program of the local populations in the region of ____________, the two concerned sides establish, by mutual agreement, to work jointly on the different phases of the program, with the aim of treating and of carrying out the follow-up on the children with acute malnutrition of the region, and so strengthen a nutritional surveillance system.

Article 1. Duration of the Agreement

The present agreement will be in force from the date of its signing until /__/ of /______/ of 20___.

It may be reviewed by mutual agreement of the two signatories.

Article 2. Commitments of the Ministry of Health

The Ministry of Health commits to comply with the following responsibilities, in close collaboration with ACF-E.

Responsibilities

- A small committee will be created, defining the responsibilities of each of its members for the implementation, development and follow-up of the Community Workshop’s programmes. Each of those in charge will actively participate in the corresponding phases of the program.

The committee will meet once a week.

- Assign a person to develop the monthly ‘in situ’ follow-up of the region’s various health structures, to report the various communities’ malnutrition data to ACF-E, as well as the weaknesses and strengths of the services of each sanitary structure.

- To organise meetings to exchange and share the results with the ACF-E team.

- To inform the area’s health services, and announce to the communities and ACF-E, with adequate time, when vaccination, delousing, the administering of the iron supplement, etc., will be done.

- To grant ACF-E sufficient physical space to develop the training modules, whenever needed.

- To provide opinions and required to permit the program’s follow-up each time ACF-E terminates its action.

- (...)
Article 3. ACF-E’s Commitments

- ACF-E, as main operator of the project, will ensure the results for beneficiaries and donors.
- Even if the involvement of the Health Ministry is increased, ACF-E reserves the right to take all final decisions.
- A person will be appointed to participate in the meetings of the established committee on the CW program.
- ACF-E reserves the right to demand the replacement of personnel in the event that his or her work and/or behaviour is not satisfactory.
- To facilitate the required training modules for the community nutrition programmes with the Ministry’s personnel and the involved communities.
- (...)

Article 4. Conflict Resolution

Any conflict arising between the two parties will be resolved in an amicable manner; otherwise the present agreement will be suspended.

Approved and made in duplicate for both involved parties

Signature of the Ministry of Health’s Representative  Signature of ACF-E’s Representative

Date:  Date:
13. BIBLIOGRAPHY


- **Review of Health and Agriculture Monitoring Tools for Title II Funded PVOs** Prepared for Food Aid Management (FAM) by Thomas P. Davis Jr., MPH, and Julie Mobley, MSPH, 200.

- **The Effects of Malnutrition on Child Mortality in Developing Countries.** D.L.Pelletier, E.A. Frongillo, Jr, D.G. Schroeder, & L-P. Habicht

- **Laminas de orientación a madres. Programa de comunicación en Salud Infantil.** Comsain. Secretaria de Salud de Honduras. Basics II. USAID.

- **PD/Hearth Nutrition TAG meeting.** Academy for Educational Development, Washington, D.C. December 2004


• *Performance Monitoring and Evaluation. TIPS. USAID Center for Development Information and Evaluation. USING RAPID APPRAISAL METHODS. 1996, Number 5.*

• *Habilidades directivas y competencias profesionales en ONGs. RESPECT refugiados (Refugee Education Sponsorship Program Enhancing Communities Together).*

• *El apoyo a los sistemas de sustento: Promoción de actividades generadoras de ingresos: desde su definición a su puesta en marcha. Acción Contra el Hambre.*

A practical guide for humanitarian workers in the field

STRATEGIC PROGRAMMING FOR COMMUNITY NUTRITION INTERVENTIONS

FRANCE
4 rue Niepce
75014 Paris
Tel: +33 1 43 35 88 88
www.actioncontrelafaim.org

SPAIN
C/Caracas, 6, 1º
28010, Madrid
Tel: +34 91 3915300
www.accioncontraelhambre.org

UNITED KINGDOM
First Floor, rear premises,
161-163 Greenwich High Road,
London, SE10 8JA
Tel: +44 208 293 6190
www.aahuk.org

UNITED STATES
247 West 37th Street
Suite 1201
New York, NY 10018
Tel: +1 212 967 78 00
info@actionagainsthunger.org
www.actionagainsthunger.org

CANADA
Action Contre la Faim
7464 rue St Denis
Montreal, QC, H2R 2E4
Tel: +514 279-4876
www.actioncontrelafaim.ca