Developing Food-Based Recommendations for Complementary Feeding Using Local Foods: Household Approach

A Workbook for Resilience Food Security Activity Partners

Household Pathway of the *Optimizing Diets by Using Local Foods for Improved Nutrition for Women and Children Guide*

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Introduction

The United States Agency for International Development’s (USAID) Bureau for Humanitarian Assistance funds multi-year non-emergency Resilience Food Security Activities (RFSAs) in highly vulnerable regions of low-income developing countries. These activities often focus on strengthening resilience and improving food security and nutrition among highly vulnerable populations. A majority of RFSAs emphasize improving women and children’s nutritional status, with a focus on the first 1,000 days from conception to the first two years of life. The first 1,000 days are considered a window of opportunity to reduce child mortality and morbidity, prevent malnutrition, and support optimal child growth and development.

**The Optimizing Diets Guide includes 7 components:**

1. Overview
2. Optimizing Local Diets Tool (OLDT)
3. Instruction Manual for OLDT
4. **Household Pathway Workbook**
5. Market Pathway Workbook
6. Business Model Calculator Tool (BMCT)
7. Instruction Manual for BMCT

RFSAs typically include resource transfers. A key benefit of resource transfers, whether cash or in-kind food assistance, is that they are often intended to support age-appropriate complementary feeding of children 6–23 months of age. However, these transfers are typically for a short duration and not sustainable after a RFSA concludes its activities. To sustain these benefits for this age group in the long-term, RFSAs often look to transition to local alternatives for complementary feeding. One option is to use a household food-based approach to develop food-based recommendations (FBRs) and related supportive behaviors for complementary feeding using locally available foods, taking into account market access, seasonality, food prices, etc. This workbook is a part of the *Optimizing Diets by Using Local Foods for Improved Nutrition for Women and Children Guide* (referred to hereafter as the Optimizing Diets Guide), developed to help RFSA implementing partners (IPs) use locally available, accessible, and affordable alternatives to sustain nutrition outcomes for children under age two.

A key challenge to implementing complementary feeding interventions is that they rarely specify which types of foods caregivers should include in a child’s diet, in terms of quantity, frequency, or consistency based on what is locally available, accessible, and affordable. The household food-based approach to develop FBRs addresses a number of these challenges. Using the steps in this process, RFSA IPs can identify locally available, accessible, and affordable foods that are most nutrient-dense and likely to fill gaps in diets and provide key nutrients of concern. In Step 4, RFSA IPs can use the Optimizing Local Diets Tool (OLDT) to develop one or two things:

Food-based recommendations (FBRs) are dietary recommendations to promote consumption of specific foods or food groups for members of a specified population. They may also include the recommended frequency of consumption of the foods or food groups in a 1-day or -week period (adapted from FAO/WHO 2001).

* A list of key foods for different segments of a vulnerable population, separated by food groups and prioritized by nutrient density and serving size
* FBRs for children 6–23 months for complementary feeding, again prioritized by food groups and, within each, by nutrient density and serving size. For these FBRs, RFSA IPs can develop a prioritized list of nutrient-dense foods based on the nutrient composition analysis in the OLDT.

Principles of the Workbook

This workbook is designed for RFSA implementing partners (IPs) specifically to engage a multi-disciplinary team led by staff with a nutrition background. This workbook describes a process to determine whether a household food-based approach to developing FBRs for complementary foods[[1]](#footnote-1) is operationally feasible, viable, and ultimately sustainable.[[2]](#footnote-2) It can be used to guide and coordinate inputs from multiple different technical teams within a RFSA program (e.g., private sector engagement, nutrition, agriculture and livelihoods development, social and behavior change [SBC] teams). It focuses on developing FBRs for children 6–23 months, but can be tailored for other age groups (e.g., pregnant and lactating women, adolescents). Engaging caregivers and community stakeholders through participatory exercises is a key component of developing context-specific FBRs. The workbook can also be used to document the decision-making process to identify local foods to promote. It draws on a number of tools that provide more detailed guidance for key steps in the process (e.g., the OLDT, which supports Step 4 of this household food-based approach) and provides practical templates for data collection for other steps in the process.

Timing and Time Requirements

A household food-based approach to develop FBRs should start during the first year of RFSA implementation (i.e., the refine and implement phase) to ensure sufficient time to identify and test FBRs to promote at the household level, as this will likely become an integral part of nutrition SBC activities. This would provide time to integrate key questions related to locally available foods and preferences into planned refine and implement studies. For example, if a market assessment including questions on key foods that are available and affordable by season is planned, it is important to have accurate information from which to develop FBRs. Starting early in the program implementation cycle would give households and communities adequate time to adopt improved complementary feeding practices and support a sustainable exit strategy. However, the approach can also be conducted throughout the life of the program as activities are established, phased in, or expanded to new areas (e.g., gardening activities) and situations change and new foods become available.

Steps one through six of developing a household food-based approach using this workbook should take about 10 months to complete. Step seven, which involves training program staff on this approach to scale it up, will likely require another three months to complete. Step 5 includes pilot testing using Trials of Improved Practices (TIPs) to ensure that the RFSA team accounts for the complexities of promoting FBRs that are feasible, affordable, and acceptable to households. An implementation calendar is provided at the end of this section to help the RFSA team plan all steps along a timeline, indicate progress, and adjust as needed.

Phased Approach

The process to determine whether and how to apply a household food-based approach to develop FBRs is designed to be rapid and iterative. Data collection is kept to a minimum and is phased—only relevant data are collected at every step in the process. The process starts with a careful review of existing secondary data and the results from the refine and implement studies. If information gaps are identified after this first review, the RFSA team may collect additional targeted data. This helps limit the time and resources RFSAs have to invest.

Process Outline

Two Stage with Seven Steps

Figure 1. Seven-Step Process

The process described and applied in this workbook includes two stages and seven distinct steps. Steps 1–4 under Stage A aim to gather all the information needed to develop the FBRs, and Step 5–7 under Stage B aim to test, modify, and scale up the use of the FBRs. The first step can be undertaken alongside the broader review of secondary data as part of the refine and implement process. A key decision is for the RFSA team to determine whether the household food-based approach is suitable for the program context. Table 1 shows the seven steps and their associated tasks.

|  |
| --- |
| **Stage A: Develop the Food-Based Recommendations (FBRs)** |
| 1.Review secondary data |
| 2.Enter list of key local foods into OLDT |
| 3.Observe common meal preparation |
| 4.Analyze and refine food combinations |
| **Stage B: Test, Modify, and Scale Up the FBRs** |
| 5.Test recommendations  6.Apply learning to program  7. Use the training guide for programming |

Stage A: Develop the FBRs

Stage A’s four steps are used to identify nutrient-dense and underutilized local foods, understand current infant and young child feeding (IYCF) practices, and develop FBRs based on this information.

Steps 2 and 3 use a rapid data collection approach to understand current feeding practices and perceptions. Step 4 uses the OLDT to develop and analyze up to four different FBRs (each FBR can include up to 10 foods).

Stage B: Test, Modify, and Scale-up the FBRs

This stage uses TIPs to determine if the FBRs are feasible, acceptable, and affordable. Once the FBRs have been tested, they may need to modified before they can be used in nutrition SBC activities.

Implementation Calendar

This calendar will help the RFSA team develop a more detailed timeline for the implementation of the different steps in the development of household food-based approach for complementary feeding, and make adjustments over time as needed. The ‘notes’ column can be used to indicate who is responsible for the step and hyperlink information that might be useful for others involved in the process.

Table 1. Implementation Calendar

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Stage A** | **Month 1** | **Month 2** | **Month 3** | **Month 4** | **Month 5** | **Month 6** | **Month 7** | **Month8** | **Month 9** | **Month 10** | **Month 11** | **Month 12** | **Month 13** | **Notes** |
| **Step 1. Review secondary data** | Not Started |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Step 2. Develop a key foods ID list** | Not Started |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Step 3. Observe common meal preparation** | Not Started | Not Started |  |  |  |  |  |  |  |  |  |  |  |  |
| **Step 4. Analyze and refine food combinations** |  |  | Not Started |  |  |  |  |  |  |  |  |  |  |  |
| **Stage B** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Step 5. Test recommended actions** |  |  | Not Started |  |  |  |  |  |  |  |  |  |  |  |
| **Step 6. Apply learning to the program** |  |  | Not Started |  |  |  |  |  |  |  |  |  |  |  |
| **Step 7. Use the training guide for programming** |  |  |  |  |  |  |  |  |  |  | Not Started |  |  |  |

Considerations for a Household Food-Based Approach

Potential Impact Pathways

The application of a household food-based approach for complementary feeding for children under age two includes the following impact pathways for the RFSA partners to consider:

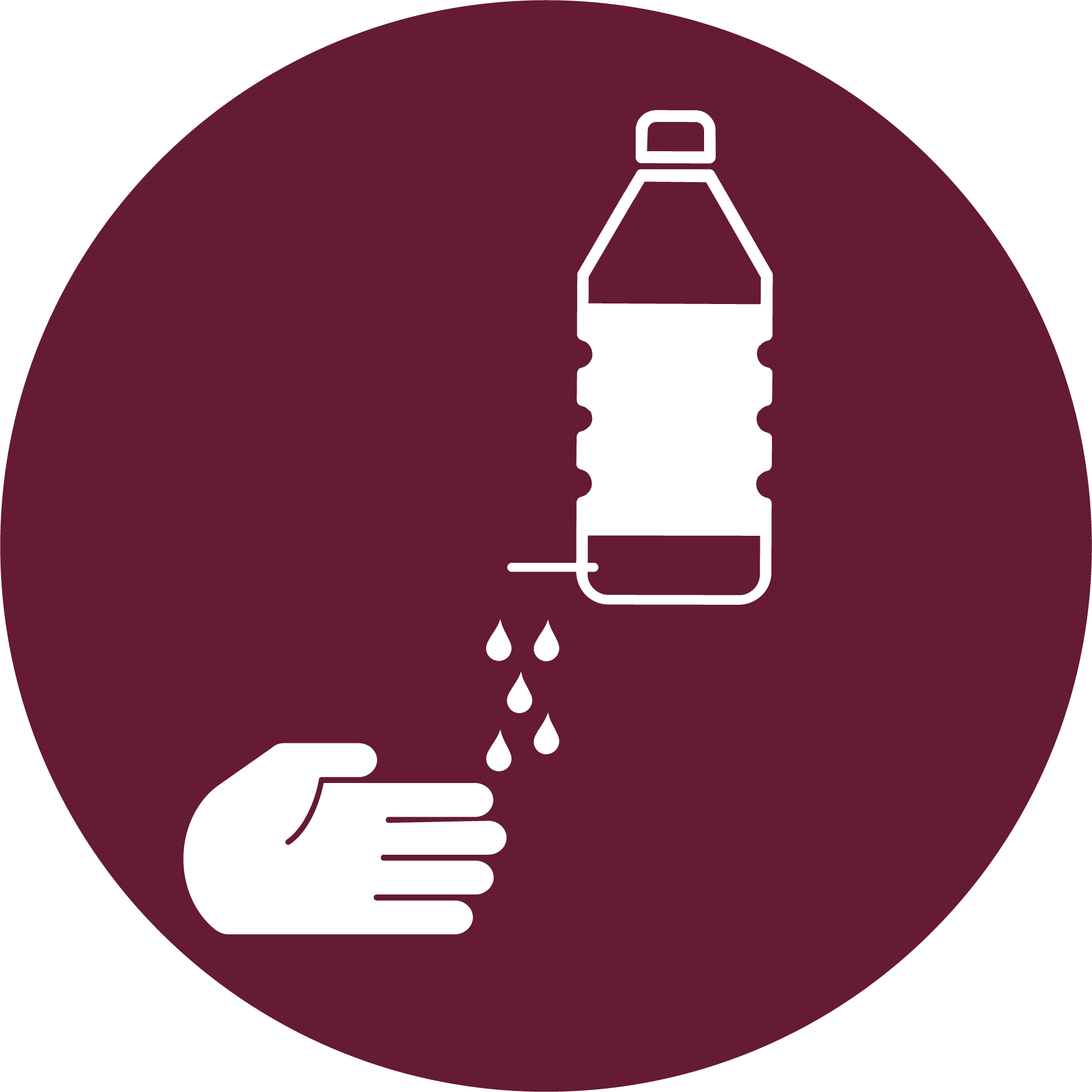
1. Improved nutrition for children under age two through the consumption of targeted and diverse nutrient-dense foods with greater frequency.
2. Increased caregiver skills and knowledge to prepare and integrate nutrient-dense foods in complementary feeding in appropriate quantities, consistency, and frequency.
3. Increased household dietary diversity through increased household income to purchase and/or increase household production and processing of specific nutrient-dense foods that are locally available and acceptable.

# As with any approach, the risks and potential benefits for the RFSA IP the households associated with each of these potential pathways must be considered. Food safety and hygiene in terms of how complementary foods are prepared, fed, and stored are important to consider given the vulnerable age group and the high risk of infection. The World Health Organization (WHO) identifies food safety and hygiene as one of the requirements of optimal complementary feeding.

Improperly stored food can pose serious health risks. It can result in the growth of harmful germs, including bacteria, mold, and yeasts. For example, crops stored in damp spaces are at risk of mycotoxin contamination (toxins released by mold fungi). Home-canned products, similarly, may contain botulinum toxin (a strong toxin released by the bacteria Clostridium botulinum) due to poor sanitation and improperly treated raw materials. Therefore, it is important to follow guidelines to ensure food is safe at the household level.

The WHO suggests 5 steps for keeping food safe:**[[3]](#footnote-3)**

1. Keep clean (surfaces, hands, cooking materials).
2. Separate raw and cooked foods.
3. Cook thoroughly to proper temperatures.
4. Keep food at safe temperatures (outside the danger zone).
5. Use safe water and raw materials.



**Food Hygiene**

* Keep clean:
* Set up a tippy tap hand washing station near latrine and cooking

areas; maintain with soap and water.

* Wash hands with soap before and during food preparation.
* Wash hands with soap after going to the toilet, and after cleaning baby and disposing of feces.
* Wash and sanitize all equipment and food preparation area.
* Protect kitchen area from animals, pests, and insects.
* Treat water if giving to baby or mixing with food.
* Regularly wash child’s hands with soap and water, particularly before feeding.
* Keep areas where baby sleeps, sits, plays, and eats clean of animal and human feces.
* Separate raw and cooked foods:
* Keep meat, poultry, and seafood separate from other foods.
* Use container to store cooked and raw foods separately.
* Use separate equipment, knives, and cooking utensils for cooked and raw foods.
* Cook foods thoroughly, especially eggs and other animal foods.
* Keep food at safe temperatures, serve food hot, and do not leave food out at room temperatures for longer than 2 hours.
* Use safe water and fresh foods.

Source: FANTA 2016

**Complementary Feeding**

Around six months of age, an infant’s need for energy and nutrients exceeds

what is provided for by breast milk, and complementary foods are necessary

to meet their nutritional needs along with continued breastfeeding up to two

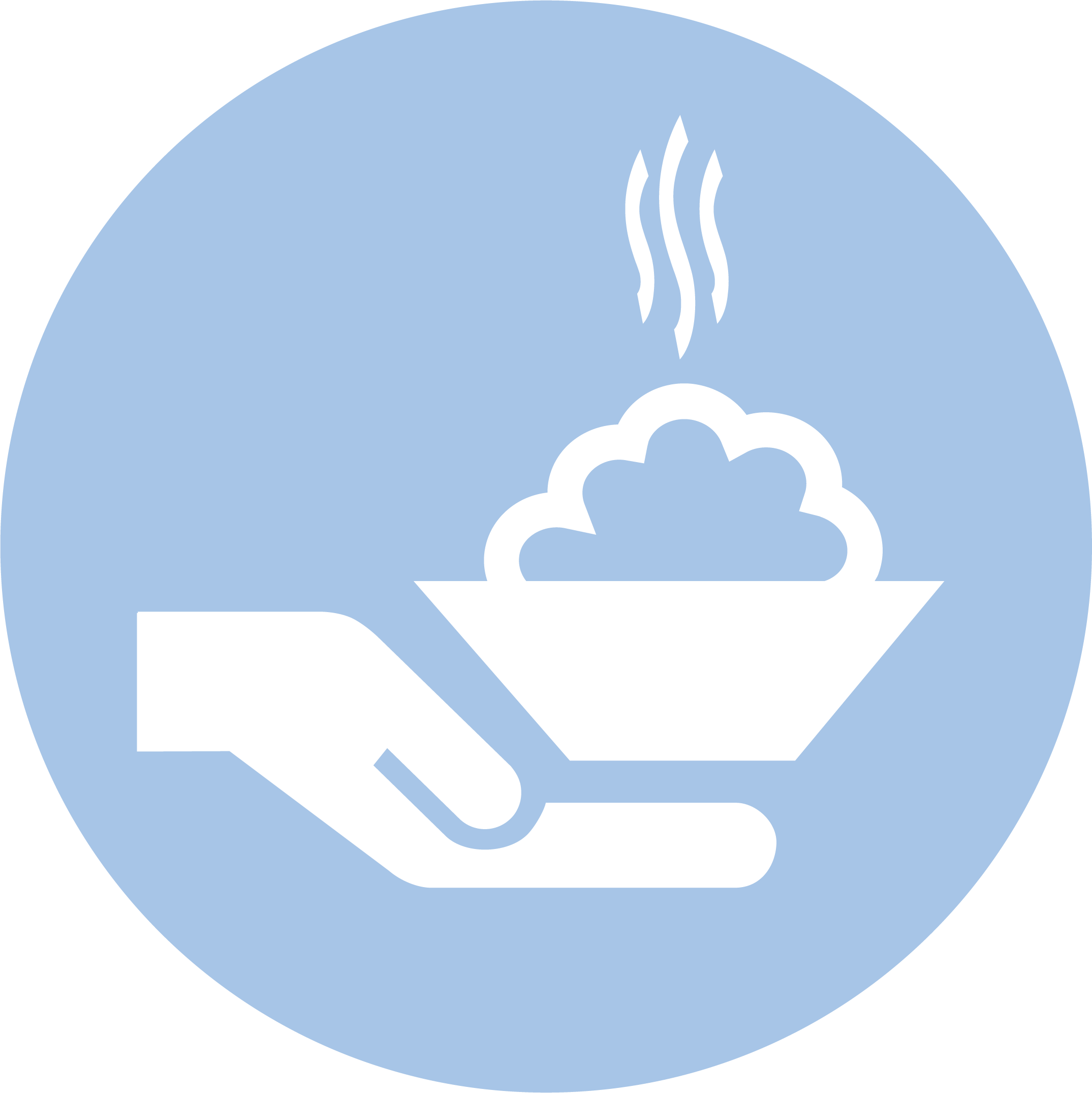
years of age. A six-month old infant is also developmentally ready for other foods.

This transition is referred to as complementary feeding. There is a high risk of growth faltering if complementary foods are not introduced around the age of 6 months, or if they are given inappropriately. Ensuring that infants nutritional needs are met requires that complementary foods be:

* **Timely:** Introduced when the need for energy and nutrients exceeds what can be provided through exclusive breastfeeding;
* **Adequate**: Provide sufficient energy, protein, and micronutrients to meet a growing child’s nutritional needs.
* **Safe**: Hygienically stored and prepared, and fed with clean hands using clean utensils and not bottles and teats.
* **Properly fed**: given consistent with a child’s signals of appetite and satiety, and meal frequency and feeding suitable for age.

Caregivers should respond to the child’s clues for hunger and encourage the child to eat.

Source: WHO [https://www.who.int/health-topics/complementary-feeding#tab=tab\_1https://www.who.int/health-topics/complementary-feeding#tab=tab\_1](https://www.who.int/health-topics/complementary-feeding#tab=tab_)



The UNICEF framework (UNICEF 2021) in figure 2 provides a clear overview of the interplay between consumption behaviors, access to income and care practices, and the pathways in which these influence nutrition outcomes.

Figure 2. UNICEF Nutrition Framework

**UNICEF Nutrition Framework depicts interplay among (bottom to top) Enabling determinants, Underlying determinants, Immediate determinants, and Outcomes for children and women on Maternal and Child Nutrition.

Enabling determinants:
Governance (political, financial, social and public and private sector actions.)
Resources (environmental, financial, social and human.)
Norms (positive social and cultural norms and actions.)

Underlying determinants:
Food (age-appropriate, nutrient-rich foods including breast milk in early childhood, safe and palatable drinking water, and household food security.)
Practices (age-appropriate feeding and dietary practices from early childhood, with adequate food preparation, food consumption and hygiene practices.)
Services (adequate nutrition, health, education, sanitation and social protection services, with healthy food environments that support good diets.)

Immediate determinants: Diets (adequate food and dietary practices for children and women). Care (driven by adequate services and practices for children and women.)

Outcomes for children and women: Maternal and Child Nutrition (improved survival, health, physical growth, cognitive development, school readiness and school performance in children and adolescents; improved survival, health, productivity and wages in women and adults; and improved prosperity and cohesion in societies.)**

1. Improved nutrition for children under age two through the consumption of targeted and diverse nutrient-dense foods with greater frequency

Nutrition interventions increasingly focus on improving age-appropriate complementary feeding practices for children under age two, given its importance for preventing malnutrition. The challenge is that age-appropriate complementary feeding consists of a complex set of transient behaviors. These behaviors, which change over time, can be difficult for providers to convey to caregivers, and are difficult for caregivers to master without adequate support. For this reason, it is important to tailor complementary feeding interventions and activities by the ages and stages of children within the 6–23-month age range. The WHO identifies these key ages and stages when transitions usually occur as 6–8 months, 9–11 months, and 12–23 months. The consistency, density, frequency, variety, and texture of foods change as children grow month-to-month. Complementary feeding complements continued breastfeeding up to the age of two. IPs and their staff need to consider these changes when proposing, planning for, and implementing complementary feeding activities.

The formative research on nutrition that a RFSA usually conducts as part of the program inception is an important resource for determining the relative balance of risks and benefits associated with a strategy of improving nutrition through a household food-based approach for complementary feeding. In the absence of formative research on nutrition, a simple analysis of the seasonality of malnutrition in comparison to the seasonality of food insecurity could indicate potential risks. In addition, the Integrated Food Security Phase Classification (IPC) produces the acute food insecurity and malnutrition snapshots that provide this type of overlaid information for areas of high vulnerability in which RFSAs implement activities. If, for example, areas are identified as IPC3 or higher, it may be challenging for households to improve complementary feeding with nutrient-dense local foods because they are unavailable. In particular, it will be important to consider the relative importance of **food, practices, and services** as underlying determinants of malnutrition (see figure 2). In contexts where practices and services are more important than food as underlying determinants of malnutrition, a household food-based approach for complementary feeding may enable households to produce, purchase, and consume nutrient-dense complementary foods. In contexts where lack of food is the primary underlying determinant of malnutrition, the RFSA IP should carefully consider whether the household food-based approach can be used to produce nutrient-dense foods, given the conditions for food production.

2. Increased caregiver skills and knowledge to prepare and integrate nutrient-dense foods in complementary feeding for young children in appropriate quantities, consistency, and frequency

While RFSA IPs regularly use cooking demonstrations to help mothers and caregivers acquire skills to prepare age-appropriate complementary feeding, the use of the household food-based approach has a few advantages. By identifying locally available and acceptable foods, and developing a prioritized list for FBRs by food groups with more precise serving sizes, caregivers may be able to integrate small quantities of specific nutrient-dense diverse foods in children’s diets. For example, in Zimbabwe, mopane worm is a culturally acceptable food that is locally available and a part of the usual diet, and as little as 10 grams can provide significant daily needs of key micronutrients and macronutrients such as iron and protein. This type of information can help caregivers integrate small but effective dietary changes. FBRs that provide these types of options with appropriate serving sizes give caregivers skills and knowledge to prepare more nutritious complementary foods, and tailors FBRs to the local context. Step 5, for example, uses TIPs to test the FBRs, but following testing, a RFSA can use TIPs more systematically over the life of their award to promote the adoption of improved practices in addition to community-based activities such as care groups.

3. Increased household dietary diversity through increased household income to purchase and/or household production and processing of specific nutrient-dense foods that are locally available and acceptable

Improving the diets of women and children often requires improving household dietary diversity. Often, RFSA IPs propose improving household dietary diversity as a supporting objective to improve child nutrition. A RFSA program has the opportunity to make a direct and explicit link between the interventions designed to improve income or crop production and household consumption of diverse foods. The household food-based approach can support RFSA IPs to strengthen these links, by not only identifying nutrient-dense foods that are locally acceptable and available, but by also promoting household production and consumption of these nutrient-dense foods; or by promoting income-generation activities that increase income and purchasing power to purchase local nutrient-dense foods. The key challenge to consider is whether vulnerable households have the capacity to either grow or purchase nutrient-dense foods that could be promoted using the household food-based approach process. If the conditions for food production are not conducive because of lack of access to land and related resources, poor soil conditions, or the program area is categorized as IPC3 or higher, the RFSA should reconsider the feasibility of implementing this approach.

For impact pathways 2 and 3 above, quality, food safety and hygiene and sustained access to nutrient-dense foods are a significant concern in the household approach. When certain nutrient-dense foods or ingredients are not available, accessible, or affordable during certain times of the year, it may be difficult to meet some of the FBRs promoted by a RFSA. Quality and food safety and hygiene are also important, particularly as they relate to how food is prepared, stored, and fed to children in the home, and may be compromised with poor post-harvest processing and storage. To mitigate these risks, a RFSA team should consider and integrate activities to support food hygiene and safety, particularly related to complementary feeding at the household level. If there is an effort to improve food production for households, it should integrate efforts to promote optimal post-harvest processing and storage to minimize risks such as aflatoxins and molds in food produced and stored. RFSAs should integrate appropriate post-harvest practices and technologies to ensure product quality (e.g., use of PICS[[4]](#footnote-4) bags for aflatoxin control, drying tarpaulin, other safe food storage construction techniques). RFSAs using this approach should also consider food safety and hygiene risks of foods purchased at local markets, particularly those that may be used as complementary, to assess how this could be mitigated. There are no set standards or regulations for food produced at the household level or that are available in local open markets. Water, sanitation, and hygiene practices may be poor at the household level, and RFSAs would have to address this to promote food safety and hygiene in the context of promoting complementary feeding.

Step 1. Review Secondary Data: Identify Secondary Data Sources and Sub-optimal Dietary Factors

Key Function of Step 1

The purpose of this step is to identify and review existing data relevant to your RFSA, related priority complementary feeding behaviors, and additional factors that influence nutrition behaviors. See box 1 for examples of secondary data sources.

Once your team has identified secondary data sources, review them to identify the sub-optimal dietary and caring practices that may hinder adoption of the priority complementary feeding behavior that the program will promote. This includes gaps that may need to be further studied through primary data collection and participatory community-based exercises, and will help focus the nutrient composition analysis and the proposed FBRs to be tested using TIPs. The tables below will help your team understand how the nutrition situation relates to infant and child feeding practices. Importantly, information that you identify and review in this step will be used in Steps 2 and 4 where you will develop a key foods ID list and the FBRs.[[5]](#footnote-5) Also consider the availability, accessibility, affordability, and consumption of fortified foods or multiple micronutrient supplements for children in your program area in this step. This information will help you identify which foods to include in your key foods ID list and FBRs[[6]](#footnote-6) in Steps 2 and 4.

Time Required

This should take 1–2 months. This review can also be completed at the same time as the secondary data review you undertake as you refine and implement your award.

**Box 1. Examples of Secondary Data Sources**

* Government:
* Food fortification and nutrition policies
* SBC strategy
* IYCF strategy
* Health and nutrition surveys
* Market surveys
* Diet and food groups policies
* Global databases with country trend data for nutrition and other key indicators:
* UNICEF
* WHO
* World Bank

Tasks

* RFSA refine and implement studies:
* SBC strategy
* IYCF-related behavior profiles
* Market assessments
* Nutrition and/or SBC studies
* RFSA population-based surveys:
* Current RFSA baseline survey
* Past or current RFSA midterm and endline surveys
* Routine monitoring data
* Other related NGO and stakeholder documents:
* Demographic and Health Surveys
* MICS
* SMART surveys
* FEWSNet assessments
* FAO surveys
* World Food Programme assessments/reports
* Any information on agro-ecologies or market

Fill the cells in table 2 below with quantitative data, stratifying by program geographic (districts, sub-districts) or other pertinent areas. Fill in the fields with data that related to the key practices relevant for your program, which will contribute to achieving programmatic indicators.

**Definition:** For the purposes of this work, nutrient-rich foods are defined as foods from 4 or more foods groups (breast milk; grains, roots, and tubers; legumes and nuts; dairy products; flesh foods; eggs; vitamin A-rich fruits and vegetables; other fruits and vegetables). These food groups are consistent with those in the children’s minimum dietary diversity (MDD) indicator.

Use table 3 to enter qualitative descriptions in the cells to analyze context-specific data related to the priority behavior identified in table 2. Table 3 presents examples and focuses on additional factors that influence nutrition behaviors based on key findings from the formative research you have undertaken. This exercise will help you identify factors that can improve uptake of the priority behavior. After entering data into the cells, shade them to inform possible programming recommendations/approaches, including barriers to be overcome (shaded in light red) and motivators to be leveraged throughout the program (in light green). The latter may be common community member perspectives; desire to use current program approaches/platforms to reach the specific population; and factors in the program theory of change that are critical to reaching an outcome. In addition to other secondary data, consider using behavioral profiles and refinement year research for this exercise. This will inform some of the sustainability factors in the nutrient composition analysis in Step 4.

**Why is a review of secondary data important and what can you learn from it?**

A review of existing secondary data is an important first step to help you understand:

* The prevalence of malnutrition in your program area, and examine how it differs from the national prevalence of malnutrition. Is the prevalence of malnutrition in your program area higher, lower, or about the same as the rest of the country? Are there any unique features about the prevalence of malnutrition in your program area that are important to consider?
* Trends in malnutrition among children 6–59 months are also important to examine. Understanding the prevalence of malnutrition at 6–23 months and 36–48 months helps you assess ***when*** children are becoming malnourished. Is it when they are infants? Or when they are older? At what age does an indicator like stunting peak? This can tell you how early you need to intervene to prevent malnutrition, and, along with other nutrition data, it can also help you understand which interventions to prioritize.
* The prevalence and trends in exclusive breastfeeding practices in your program area: Are mothers able to exclusively breastfeed up to six months? What proportion of mothers are able to do so? Does the trend in the prevalence of exclusive breastfeeding change from birth to six months? When are more mothers exclusively breastfeeding, and by when within the first six months does this decline? Low exclusive breastfeeding prevalence or declining exclusive breastfeeding as a child approaches the age of 6 months is important to identify, because children who are not exclusively breastfed are usually introduced early to other foods and liquids, increasing the risk of infections in infants. Importantly, this practice compromises age-appropriate complementary feeding.
* The prevalence and trends in complementary feedings in you program area: What proportion of children are receiving soft foods at 6–8 months of age? Is this high or low? What proportion of children receive the MDD and minimum feeding frequency? Is MMD better than minimum feeding frequency, or vice versa? What is the prevalence of the minimum acceptable diet? Is it high or low in your program area? How does it compare to the national prevalence? If minimum food frequency is relatively high, but MDD is low, this suggests that a programmatic focus on improving MDD could be a priority.
* The coverage and access to supplements such as vitamin A capsule supplementation, micronutrient sprinkles, and fortified foods in your program area. Do children receive any supplements or fortified foods that could improve their nutritional status? Are there any national policies on supplements or fortified foods? If yes, are they enforced, and how accessible are supplements or fortified foods?

Summary of Key Nutrition Indicators

**Priority behavior:**

**RFSA specific population: Children aged 6–23 months**

**Selected RFSA districts:**

**Other key characteristics/stratifying factors: (e.g., socioeconomic status, biological sex, livelihood, ethnicity/religion)**

**Table 2. National and RFSA Population-based Baseline Survey Data: Key Indicators Related to the Priority Behavior[[7]](#footnote-7)**

|  | **Stoplight**  **Assessment\*** | **Nationally Representative Population-Based Survey Data** | | | **Population-Based RFSA Baseline Survey** | | **Program Monitoring Indicators** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicator** |  | **National** | **District 1** | **District 2** | **District 1** | **District 2** | **District 1** | **District 2** |
| Stunting (children 6–59 mos)  Height-for-age (%) | Not a problem |  |  |  |  |  |  |  |
| Stunting (children 6–23 months)  Height-for-age (%) | Not a problem |  |  |  |  |  |  |  |
| Global acute malnutrition (wasting) (children 6–59 months)  Weight-for-height (%) | Not a problem |  |  |  |  |  |  |  |
| Exclusive breastfeeding under 6 months: proportion of infants 0–5 months who are fed exclusively with breast milk | Not a problem |  |  |  |  |  |  |  |
| Continued breastfeeding at 1 year: proportion of children 12–15 months who are fed breast milk | Not a problem |  |  |  |  |  |  |  |
| Continued breastfeeding at 2 years: proportion of children 20–23 months who are fed breast milk | Not a problem |  |  |  |  |  |  |  |
| Introduction of solid, semi-solid, or soft foods: proportion of infants 6–8 months who receive solid, semi-solid, or soft foods | Not a problem |  |  |  |  |  |  |  |
| Minimum dietary diversity: proportion of children 6–23 months who receive foods from 4 or more food groups | Not a problem |  |  |  |  |  |  |  |
| Minimum meal frequency: proportion of breastfed and non-breastfed children 6–23 months who receive solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more. | Not a problem |  |  |  |  |  |  |  |
| Minimum acceptable diet: proportion of children 6–23 months who receive a minimum acceptable diet (apart from breast milk). | Not a problem |  |  |  |  |  |  |  |
| Consumption of iron-rich or -fortified foods: proportion of children 6–23 months who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children, or that is fortified in the home. | Not a problem |  |  |  |  |  |  |  |
| Children 6–23 months who ate vitamin A-rich foods in the past 24 hours (%) | Not a problem |  |  |  |  |  |  |  |
| Vitamin A supplementation coverage rate (% of children 6–59 months) | Not a problem |  |  |  |  |  |  |  |

\*Stoplight assessment is like a traffic light assessment: green indicates no problem, yellow indicates a discrepancy, red indicates a problem. **Note:** This table includes active drop-down menus

Source: WHO/UNICEF 2021 [Indicators for Assessing Infant and Young Child Feeding Practices](https://www.who.int/publications-detail-redirect/9789240018389)

Additional Factors That Influence Nutrition Behaviors[[8]](#footnote-8)

Table 3. Additional Factors that Influence Nutrition Behaviors

|  |  |  |  |
| --- | --- | --- | --- |
| **Which factors make it easier or difficult to practice the priority behavior?** | **District 1** | **District 2** | **Cross-district or national level** |
| Structural examples | | | |
| Accessibility to nutrient-rich foods |  |  |  |
| Availabilityof nutrient-rich foods |  |  |  |
| Affordability of nutrient-rich foods |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Social examples | | | |
| Feeding practice norms |  |  |  |
| Women’s workload |  |  |  |
| Decision-making authority of caregivers related to food purchases, preparation, and intra-household distribution |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Internal examples | | | |
| Caregiver’s perceived self-efficacy to prepare nutrient-rich foods |  |  |  |
| Skills to prepare nutrient-rich foods |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Supporting actors and actions examples | | | |
| Institutional |  |  |  |
| Community (traditional and religious leaders) |  |  |  |
| Household (primary and secondary caregivers) |  |  |  |
|  |  |  |  |
|  |  |  |  |

How to Use This Information

Once you have completed this first step, take a close look at all the data you have identified, and summarize the nutrition situation in your program area and the key additional factors that influence nutrition behaviors. Analyzing, interpreting, and synthesizing this information can indicate important nutrition problems. For example, within the set of infant feeding behaviors for which you have gathered data, you may be able to pinpoint which are the most significant infant feeding problems and how they program might solve them. You are likely to find that women and children’s dietary diversity is poor, and this information helps you focus your program efforts. At the same time, be sure to note gaps in evidence so you can determine which additional primary data you need to collect starting from Step 2.

Step 2. Develop a Key Foods ID List

Based on the conclusions of the nutrition situation analysis completed in Step 1, you will need to identify and develop a key foods ID list,[[9]](#footnote-9) and this may require primary data collection.

Key Function of Step 2

The purpose of this step is to create a list of locally available highly nutritious foods that you will use to develop FBRs for your specific population. To do this, follow the steps for organizing an existing or new list of foods available in the community. Your output will be a list with 25–30 key foods grown in the wild, produced in the home, and available commercially and that include energy-rich and animal-source foods and sources of protein and/or micronutrients (iron, zinc, vitamins A and C, and calcium) that can help fill nutrient gaps identified in Step 1. Remember to identify any policies related to fortified foods or micronutrient supplements, and how commonly consumed these products are in your specific population. Use Tabs 1 and 2 in the OLDT to record information (availability, price, origin) about the fortified and key foods that you identify. The [Food Environment Assessment Package](https://www.advancingnutrition.org/spotlight/food-systems) can also help with this.

Time Required

This step will take about two months to complete. While you may have planned to complete a market mapping exercise and develop a seasonal calendar during the refine and implement phase, other IPs may have relevant market assessments and seasonal calendars that you could use to develop your key foods ID list.

Tasks

Work as a multi-disciplinary team to find and compile:

1. A list of locally available foods (to be compiled in Tabs 1 and 2 of the OLDT).
2. A seasonal calendar.
3. A market map.
4. An analysis of the community focus group discussions.

Foods List

Use the instructions and table 5 below to document foods available in the community. It may be useful to list one food per line as it relates to the respective food group, noting seasonal availability, cost, and district in which it is found. The following may help you draft the initial list:

* Globally recognized food groups, such as those in MDD guidelines.[[10]](#footnote-10)
* A [food composition table](https://www.fao.org/infoods/infoods/tables-and-databases/africa/en/) for your country or region.
* National Ministry of Health food groups.
* Seasonal food availability calendar (guidance below).
* Market survey data: if there is no information on market availability and cost, conduct the market mapping exercise. A detailed methodology is suggested below.
* For any new context, conduct a community focus group, which asks about neglected and underused foods. A detailed methodology is available below.

Organize the information from the various sources and exercises forming a list of 25–30 key foods. Consider adding foods that are being promoted through your program’s (nutrition-sensitive) agricultural activities. These key foods will populate the accompanying OLDT (Step 2).

Table 4. Instructions for Key Foods ID List

|  |  |
| --- | --- |
| **Availability** | Specify the months in which the food is available by: **high** (H)=max availability; **medium** (M)=moderate availability; **low** (L)= minimal availability; or **NA**=not available during the month |
| **Price per unit or level of effort** | Indicate the **price** of a **quantity** to be specified (based on recall from the previous year). This will allow the team to eventually estimate the cost of the proposed FBRs and review affordability considerations.  *Example: one 50 kg bag of maize was $50 in May, June, July but is $40 during the other months of the year.*  If the collection of price per unit data is not possible, consider indicating the level of effort (**low**, m**edium, high)** needed to produce or gather a certain food.  *Example: Baobab fruit is collected by the mother in a household. It sometimes takes her more than half-a-day to collect enough for the week (high level of effort). Other wild fruits are available in greater abundance and only require half-an-hour of the mother’s time for a week’s worth (low level of effort).* |
| **Origin** | * **Locally sourced:** within the community or district (e.g., immediate locality). * **Domestically sourced**: within the country, but another region/agro-ecological zone. * **Imported**: brought from a neighboring country or another continent. * **Mixed**: sometimes available locally/domestically, sometimes imported. |

Summary of Key Foods ID List

Table 5. Key Foods ID List: Food Availability, Acceptability, and Price Variation (based on the MDD for women)

| **Food** | **Acceptability in program area districts** | **Reasons it is or is not acceptable** | **Availability to households in program area districts** | **Seasonal variation in availability and access** | **Price by season** | **Overall evaluation based on all factors** |
| --- | --- | --- | --- | --- | --- | --- |
| Grains, roots, tubers (examples provided) | | | | | | |
| **White maize** |  |  |  |  |  |  |
| **Sorghum** |  |  |  |  |  |  |
| **Millet** |  |  |  |  |  |  |
| **Sweet potatoes** |  |  |  |  |  |  |
| Pulses | | | | | | |
| **Beans** |  |  |  |  |  |  |
| **Cowpeas** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Nuts and seeds (examples provided) | | | | | | |
| **Peanuts** |  |  |  |  |  |  |
| **Peanut butter** |  |  |  |  |  |  |
| **Sesame** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Dairy (examples provided) | | | | | | |
| **Milk** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Meat, poultry, fish (examples provided) | | | | | | |
| **Chicken** |  |  |  |  |  |  |
| **Fish** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Eggs | | | | | | |
|  |  |  |  |  |  |  |
| Dark green leafy vegetables (examples provided) | | | | | | |
| **Pumpkin leaves** |  |  |  |  |  |  |
| **Moringa leaves** |  |  |  |  |  |  |
| **Green leafy vegetables** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Other vitamin A-rich fruits and vegetables (examples provided) | | | | | | |
| **Mango** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Other vegetables | | | | | | |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Other fruit | | | | | | |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Seasonal Food Availability Calendar

A seasonal food availability calendar indicates when different foods are available in the community or particular program area. If a seasonal food availability calendar does not exist, use the table in the OLDT (Tab 2: Key Foods ID List) to collate the required information by quarter. Additional detailed guidance on developing seasonal calendars for any food groups are in this [guide](https://hdl.handle.net/10568/108914). Review results from the seasonal calendar exercise against the market mapping exercise (below) because availability, accessibility, and affordability (e.g., cost of a food or level of effort needed to obtain or gather it) are closely linked and should be considered when developing FBRs.

**Market Mapping Exercise**

Depending on the availability of secondary local market data and other assessments the RFSA program may have conducted as part of the refine and implement period, you may need to collect additional food market information. The purpose of a market mapping exercise is to identify the types of foods that are locally available, accessible, and affordable in the program area. Data concerning the seasonal availability and costs of foods that make up the different food groups and the consumer preferences and characteristics of food retailers help to determine which fruits, vegetables, and animal source and staple foods to consider when developing nutritious FBRs.

While there is a range of market survey and mapping methodologies,[[11]](#footnote-11) the program team can use the [Mapping of Territorial Markets](https://www.fao.org/3/cb9484en/cb9484en.pdf) for participatory data collection on food markets.[[12]](#footnote-12) The guide provides a detailed, step-by-step description of procedures and suggestions for data processing and analysis and includes data collection tools in the annexes. As with any market survey or mapping methodology, the program team will need to adapt questionnaires to the local context.

Depending on data previously collected by the RFSA team, some questions may not be needed and others may be added. While this methodology uses the 10 food groups as defined in the guide for measuring [MDD for women](https://www.fao.org/documents/card/en/c/cb3434en), it is easy to adjust it to the 7 [MDD](https://inddex.nutrition.tufts.edu/data4diets/indicator/minimum-dietary-diversity-mdd) food groups as appropriate. Note that these same food groups are used for the nutrient composition analysis in Step 4.

**Community Focus Group Discussions**

The objective of focus group discussions is to obtain perspectives from community members about available foods, including those produced or grown at home, raised, purchased, and gathered (neglected and underused foods). Plan to conduct about two focus group discussions, asking the questions in table 6 below, per area and including a cross-section of community members to get diverse perspectives. The key foods ID list (table 5 above) may be a helpful format for recording foods mentioned by community members in their respective food groups. Use table 7 to record your findings from each focus groups discussion and analyze the findings together.

Table 6. Community Focus Group Discussion Guide

|  |
| --- |
| **Household Livelihood Characteristics** |
| * Describe the socioeconomic status of households in your area. * Describe the family structure in this area. What types of households are common (e.g., monogamous, polygamous, female-/male-headed households). * What are typical livelihood activities in this area? (e.g., pastoral, agro-pastoral, migration). * Which ethnic groups live in this area * Which religions are common in this area? |
| **Food Production and Markets** |
| * What do people in this community grow or raise at home? * What do people in this community grow in the fields? * Where do you grow this food? * What do you grow in community or home gardens? * What do you buy at the market? |
| **Food Preservation and Gathering** |
| * Which foods can you preserve? * What foods do you preserve? * What preservation methods do you use? * How are these affected by the time of the year? * What foods can you collect from the wild? * Are there any traditional foods that are becoming less commonly consumed? * What do people in this community think about traditional foods? |

Table 7. Template for Summary of Community Focus Group Discussion Findings

|  |
| --- |
| **Household Livelihood Characteristics** |
|  |
| **Food Production and Markets** |
|  |
| **Food Preservation and Gathering** |
|  |

How to Use This Information

The information obtained by completing this step is key to developing FBRs. Combining information on locally available foods by season, undertaking a market mapping if needed, and talking with communities in focus group discussions allow you to learn what foods are available and when. In this step you also begin populating the OLDT that you will use more extensively to develop FBRs in Step 4. The information obtained in this step is also key for Step 3.

Step 3. Observe Common Meal Preparation

Key Function of Step 3

The purpose of this step is to observe how meals are prepared for the intended population; gather data for use in the nutrient composition analysis in Step 4; and identify potential modifications to current feeding practices. To do this, follow the directions for conducting a meal preparation exercise and combine it with a pile-sorting exercise. You will need the key foods ID list from Step 2 to set up the observation exercise and the pile-sorting exercise.

Your output will be new or modified dietary practices based on what is commonly eaten in specific population households. These dietary practices will be analyzed in Step 4, and refined according to facilitators and barriers indicated by the secondary data review and pile-sorting exercise to improve the nutrient content of diets for the specific population.[[13]](#footnote-13)

Time Required

This step will require about one month to complete.

Tasks

1. Meal preparation exercise.
2. Pile-sorting exercise.

Meal Preparation Exercise

Caregivers of the specific population will use selected locally available key foods that they usually use to demonstrate how they prepare meals for the specific population. This exercise can be conducted with 2–3 different types of local key foods to learn about a variety of meals that are typically prepared.[[14]](#footnote-14) Plan to conduct about two meal preparation exercises per program area. Use the meal preparation exercise form below to record data (use a separate form for each meal).

1. For each session, identify 8–10 caregivers with similar characteristics (e.g., from the same community, similar economic conditions). The RFSA team should try to form a group that is likely to work well together. Plan to have two or three people to care for young children so that caregivers are able to fully participate in the session. Bring toys to occupy the children).
2. Gather materials, including copies of the Meal Preparation Exercise Form, food scale, household measures for cooking, and ingredients (fresh and/or cooked foods selected from the key foods ID list prepared from a raw state in pre-weighed and recorded quantities appropriate for the number of participants). Bring materials for washing hands and sanitizing cooking utensils.
3. Conduct sessions in a relatively controlled atmosphere and either give caregivers the ingredients, utensils, and fuel—among other resources—for the meal preparation, or if feasible, ask caregivers to bring local ingredients. Hold sessions in a place where participants feel at ease cooking and tasting and feeding the commonly prepared meals or snacks to their children and discussing their impressions.
4. At the beginning of each session, clearly state the objectives of the exercise and follow the directions below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Meal Preparation Exercise Form**[[15]](#footnote-15) | | | | |
| **Introduction:** “Today we are here to make meals that are nutritious for young children. We are eager to learn what you typically prepare for young children and foods that you might be willing to try.”  **Ask:** “How do you cook for your children? Prepare an individual meal? A pot for children only? Does it differ by age? Or a household pot for everyone?” (*This determines if you prepare the meal once or twice, differing by age.*)  “Please create a typical meal that you serve your child with the foods or ingredients provided [mention what is available to them for this session]. We would like to know what is typically available. Please point out what you would to use if it was available.”  “You have up to 45 minutes to prepare the dish. After you prepare it, we will weigh the food and record the ingredients, and then you will have a chance to feed it to your child.”  “Once you have fed your child we will ask you some questions in a group.” | | | | |
| **Meeting date and place** | | |  | |
| **Meal name** | | |  | |
| **Age of meal recipient (in months or years, as appropriate):** | | |  | |
| **Name of dish and weight of container used to hold it** | | |  | |
| **Ingredient** | **Amount used in household measure** | **Amount used in grams** | **Edible portion[[16]](#footnote-16) (yes or no)** | **Cooked**  **(yes or no)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Cooking method (record all steps taken by caregiver to prepare the recipe)** | |  | | |
| **Observations during cooking and feeding (reactions, comments, etc.)** | | | | |
| * Are the ingredients washed? * Does the caregiver interact with the child while feeding the child? * Is the child fed on his/her own? * Does the child eat from a communal bowl? | |  | | |
| **Total preparation and cooking time** | |  | | |

**Summary of Meal Preparation Exercise**

|  |  |  |  |
| --- | --- | --- | --- |
| **Final amount of dish** | | | |
| **Weight (g)** | **Weight of container (g)** | **Net weight (g)** | **Total volume of food (number and type of household measure)** |
|  |  |  |  |
| **Amounts served and consumed** | | | |
| **Person served** | **Amount served (weight of container with portion, minus weight of container)** | **Leftover amount (g) of food only** | **Amount eaten (amount**  **served minus leftover**  **amount) (g)** |
|  |  |  |  |
|  |  |  |  |
| **Consistency of final dish (liquid, semi-liquid, thick, solid, other)** | | | |
| a) according to caregiver | |  | |
| b) according to staff/personnel | |  | |
| **Observations** | | | |
| Observations of acceptability of dish by specific population (observations made of tasting) | |  | |
| Observations made by caregiver about the recipe/meal | |  | |
| Is this typically what you prepare at home? | |  | |
| Always available (foods)? | |  | |
| Sometimes available (foods)? | |  | |
| What foods would you like to try adding to this recipe (something they didn’t select)? | |  | |

Pile-Sorting Exercise

Caregivers of the specific population or group of interest will use selected key foods or visual representations (pictures or picture cards) to answer the following questions on the Pile-Sorting Exercise Data Recording Form below.

1. The pile-sorting exercise can be conducted with the same participants as the meal preparation exercise.
2. Split caregivers into similar groups as those used for the meal preparation exercise. For example, group those with children 6–11 months of age together, and those with children 12–23 months.
3. The materials needed are either actual foods or pictures of foods of interest (such as potential foods that are taboo, beans, or eggs) or the most nutrient-rich foods available (animal- or plant-source foods that could fill a nutrient gap [e.g., iron, vitamin A]).
4. Arrange the key foods or the pictures by their food group to begin.
5. Use the form below to go through items and record data.

|  |  |
| --- | --- |
| **Pile-Sorting Exercise Data Recording Form** | |
| Meeting date and place |  |
| Main infant and child nutrition and feeding problems |  |
| Foods presented or food group to be discussed |  |
| **Ask:**   1. How do you cook for your child?    1. Prepare an individual meal, or a household pot for everyone?    2. A pot for children only? 2. Does it differ by age of child? 3. Does it differ for boys and girls?   Answers to these questions will determine if you can complete this exercise as group or divide into two by age group. | |
| Age of recipient of food (in months or years, as appropriate) |  |
| Show cards of the foods in the food groups. Ask the following questions per food group.  For [insert food group], show the cards that you are most likely to feed your child. Why?  For [insert food group], show the cards that you are least likely to feed your child. Why? | |
| Ask caregivers to:   * Sort the cards by most to least expensive. * Sort the cards by what is available all year to rarely available. * Sort the cards by what is easiest to hardest to purchase in the market. * Sort the cards by what is easiest to hardest to grow/cultivate/ or rear at home. * Sort the cards by what is easiest to collect in the community * Which foods can be preserved? * Which foods are associated with taboos? * Which of these foods could you feed your child every day? How much? * Which of these foods could you feed your child several times every week? How much? * Which of these foods could you feed your child only once a week? How much? * Which of these foods can you rarely feed your child? How much? * Which of these foods could you give your child as a snack? * Which of these foods would you be willing to add a small portion to your child’s own plate/bowl after ladling out food from the pot? * Which of these foods are preferred for boys? For girls? * Who in the household decides which foods are prepared for your child, and how frequently they are fed? * Who in the household decides how much to serve your child? And the order children are served? | |

Summary of Pile Sorting Exercise

|  |  |
| --- | --- |
| **Question** | **Response** |
| Main infant and child nutrition and feeding problems |  |
| Food groups most likely to feed your child |  |
| Food groups least likely to feed your child |  |
| Most to least expensive |  |
| Available all year to rarely available |  |
| Easiest to hardest to grow/cultivate/ rear at home |  |
| Food that can be fed to a child everyday |  |
| Food that can be fed to a child several times a week |  |
| Food that can be fed to a child once a week |  |
| Foods that can be added in small amounts to a child’s plate/bowl |  |
| Preferred foods for boys, for girls |  |
| Household decision about food preparation and frequency |  |
| Decision on how much to serve your child |  |

How to Use This Information

The information you obtain through this step will help you understand what and how families feed their young children and whether children have their own plate or eat from a common pot. This information is important to verify and validate the key foods ID list you have developed and, combined with information from Steps 1 and 2, will guide the development of the FBRs.

Step 4. Develop Food-Based Recommendations

Step 4 requires developing and analyzing FBR options. The OLDT allows the user to compose up to four different FBRs, using different locally available foods (e.g., ingredients that make up the FBR). This step is designed to ensure that the FBR meets the nutritional requirements of and appeals to children 6-23 months. Once you have developed potential FBRs, you will need to test their acceptability by undertaking household TIPs in Step 5 of this workbook. In Step 2, you would have used the information you gathered to develop a key foods ID list to populate Tab 2 of the OLDT. In Step 4, you will use Tabs 3b–4b in the OLDT to develop up to four tailored FBRs for children under age two for complementary feeding.

This step is designed to ensure that the FBRs meet the nutritional requirements of children aged 6–23 months. Once you have developed potential FBRs, you will need to test their acceptability by undertaking household TIPs in Step 5 of this workbook.

The OLDT breaks children aged 6–23 months into two sub-groups: 6–11 and 12–23 months. The rationale for this is two-fold: 1) global child development recommendations to “Gradually increase food consistency and variety as the infant gets older, adapting to the infant’s requirements and abilities,” and “Increase the number of times that the child is fed complementary foods as he/she gets older;”[[17]](#footnote-17) and 2) usually children in these age groups are fed differently in different contexts. Aligning how children in the two sub-groups are fed can increase the likelihood that improved feeding practices will be adopted.

Key Functions of Step 4

* Short lists 10 foods out of the key list of 30 foods identified and entered in Step 2 based on local contextual considerations (e.g., consumer desirability, cultural appropriateness, climate resilience, input requirements, ease of production and processing).
* Creates up to four unique FBRs to meet the nutritional needs of the specific population.

Time Required

Step 4 should take two days to one week, assuming a multi-sectoral team can engage and review the sustainability and food safety considerations for each of the proposed ingredients that make up the FBRs.

Tasks

**Important: The tasks described in Step 4 require the use of the OLDT (**<https://www.advancingnutrition.org/resources/optimizing-local-diets-tool>***).*** Comprehensive instructions and the Nutrition Composition Calculator spreadsheet (Tabs 3b–4b in the OLDT) are an integral component of the OLDT. The user must complete the application of this tool and calculations before starting Step 5.

The following five tasks will need to be completed:

1. In Tab 1 of the OLDT, in row 7, select the option for children 6–23 months.
2. From the list of 30 local foods you have added to Tab 2 of the OLDT, short-list up to 10 for use in the Nutrition Composition Calculator (Tab 3b-4b in the OLDT). Use the information you gathered in Steps 1–3 to guide you in the permutations of shortlisted foods to use to develop the FBRs.
3. Locate the nearest food composition data for each shortlisted ingredient, and add the hyperlink and data to the Nutrition Composition Calculator (step 4 in the OLDT).
4. Iterate formulations to produce a nutrient-rich FBR that meets the population’s unique nutritional needs
5. Enter the composition of FBRs that are selected for testing in table 8 below.

You will need to use an iterative process to test different permutations of FBRs. As such consider:

* Whether the foods differ by sociocultural practices or by geographic location, if so develop tailored FBRs for each location (e.g., by district).
* Including foods from the different food groups. For example, ensure at least 3 food groups in addition to any cereals or tubers.
* Meeting close to 30% of the key nutrients of concern in each serving.
* Using foods in the scenarios from the pile-sorting exercise that are considered most available, least expensive, most likely to give a child, and that caregivers said they would be willing to try adding to common meals.
* When creating new combinations, frequency of offering foods based on those that can be provided every day and those that can be fed several times to once a week.
* Modifications to improve quantity (amount per meal), frequency of meals, and variety of nutrient-rich foods for both meals and snacks.
* How your analysis aligns with national IYCF policies and global guidelines.

The modifications may include simply aiming to add one additional food (e.g., animal-source) to the typical staple in the morning. It may include aiming to increase the amount of a specific food that is offered. Or it may include feeding a child a snack from the list of vitamin A-rich foods in the area.

Summary of FBRs

**Important**: Copy data for table 8 below from Tab 3B–4B of the OLDT based on the blends you composed. Ensure that each food (e.g., ingredient) is listed where it indicates [insert foods], followed by the proposed volume (in grams) for each food per FBR, based on the number of FBRs (up to 4) that you composed.

Enter the composition of FBRs that are selected and considered for household TIPs in table 8 below.

Table 8. Food-based Recommendations Options

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **#** | **Product** | **1** | **2** | **3** | **4** |
| FBR name | |  |  |  |  |
| [insert preparation method] | |  |  |  |  |
| 1 | [insert food] |  |  |  |  |
| 2 | [insert food] |  |  |  |  |
| 3 | [insert food] |  |  |  |  |
| 4 | [insert food] |  |  |  |  |
| 5 | [insert food] |  |  |  |  |
| 6 | [insert food] |  |  |  |  |
| 7 | [insert food] |  |  |  |  |
| 8 | [insert food] |  |  |  |  |
| 9 | [insert food] |  |  |  |  |
| 10 | [insert food] |  |  |  |  |
| + | Added sugar (g) |  |  |  |  |
| + | Added salt (g) |  |  |  |  |
| + | Vitamin mix |  |  |  |  |
| **Total FBR weight [g]** | |  |  |  |  |
| *Average serving size for specific population* | | *50–140 grams/serving\** | | | |

\*50–140 grams/serving is the range per meal for children aged 6–23 months. Adjust depending on the actual age of the child. Further guidance on this is provided in the OLDT.

How to Use This Information

The composition of the four FBRs developed in this step will be used as inputs for the TIPs among households with children under age two. Based on the results of the household TIPs, the FBRs will be refined for use in program implementation as a part of SBC activities. Steps 6 and 7 in this workbook provide more details on how to adapt the FBRs and train providers and care group leaders on their use. Tables 9 and 10 provide examples of the FBR outputs for testing.

Table 9. Illustrative Example of Food-based Recommendations Output, Amalima Loko RFSA: Children 6*–*11 months

|  |  |  |  |
| --- | --- | --- | --- |
| Household measurement: 1 tablespoon = 15g; 1 teaspoon =5 g; 1 cup=250g | | | |
| **Animal-Sourced Foods** | | **Fruits/Vegetables** | |
| Mopani worm powder  Goat’s or cow’s milk  Egg  Kapenta  Chicken | - 15 grams  - 50 grams (¼ cup)  - 1 egg  - 15 grams  - 15 grams | Monkey orange (umkhemeswane)  Tamarind  Moringa powder  Pumpkin leaves  Watermelon (yellow)  Baobab fruit  Pumpkin | - 10 grams  - 10 grams  - 5 grams  - 10 grams  - 10 grams  - 10 grams  - 15 grams |
| **Staple Grains** | | **Legumes/Seeds** | |
| Maize  Millet  Sorghum  Sweet potato | - 50 grams  - 50 grams  - 50 grams  - 50 grams | Cowpea  Groundnut  Pumpkin seed | - 10 grams  - 10 grams  - 5 grams |
| **Snacks** | | | |
| Cowpea  Groundnut  Pumpkin  Sweet potato  Amahewu  Snot apple (xakuxaku)  Pawpaw  Mango | Donkey berry (umbhunzu)  Watermelon  Kale (umbhida)  Gourd (amakhomane)  Monkey Orange | - 15 grams |  |

Table 10. Illustrative Example of Food-Based Recommendations Output, Amalima Loko RFSA: Children 12*–*23 months

|  |  |  |  |
| --- | --- | --- | --- |
| Household measurement: 1 tablespoon = 15g; 1 teaspoon =5 g; 1 cup=250g | | | |
| **Animal-Sourced Foods** | | **Fruits/Vegetables** | |
| Mopani worm powder  Goat’s or cow’s milk  Egg  Kapenta  Chicken | - 30 grams  - 75 grams (⅓ cup)  - 1 egg  - 30 grams  - 30 grams | Monkey orange  Tamarind  Moringa powder  Pumpkin leaves  Watermelon (yellow)  Baobab fruit  Pumpkin | - 20 grams  - 20 grams  - 5 grams  - 20 grams  - 20 grams  - 20 grams  - 30 grams |
| **Staple Grains** | | **Legumes/Seeds** | |
| Maize  Millet  Sorghum  Sweet potato | - 80 grams  - 80 grams  - 80 grams  - 80 grams | Cowpea  Groundnut  Pumpkin seed | - 20 grams  - 20 grams  - 10 grams |
| **Snacks** | | | |
| Cowpea  Groundnut  Pumpkin  Sweet potato  Amahewu  Snot apple  Donkey berry | Pawpaw  Mango  Watermelon  Kale  Gourd  Orange monkey | - 30 grams | |

Step 5. Test Food-Based Recommendations

Context-specific FBRs have the potential to improve the nutritional status of infants and young children but require the caregiver(s) or supporting actors to change behaviors. After completing Steps 1–4, test potential FBRs to enhance traditional meal nutritional quality with commonly-used foods.

Key Functions of Step 5

The purpose of this step is to test participants’ responses to FBRs for improving feeding behaviors (e.g., inclusion of new ingredients, altered preparation) and determine which are most feasible and acceptable; and to investigate the constraints on participants’ willingness and ability to change behaviors and motivations for trying and sustaining the new practices​. Once barriers and/or facilitators to adopt the FBRs are identified, the FBRs need to be modified before promoting them through designated program activities. Test FBRs to observe how caregivers and supporting actors implement the them under typical conditions. TIPs[[18]](#footnote-18),[[19]](#footnote-19) use a consultative and bi-directional approach that involves participants in decisions about the behaviors to promote. TIPs are conducted in the homes of selected participants. Results from TIPs are used to modify the proposed FBRs to increase the likelihood that households adopt them.

Time Required

This step will take 4–5 months. The RFSA team will identify participant households in the selected program areas and will need three weeks to assess households’ ability to put the proposed FBRs and supporting feeding behaviors into practice.

Tasks

Your team will need to complete the five tasks shown in table 11 below. The household interview guide (for Tasks 3 and 4) is provided in **annex 1.** The last section of the interview guide has a tabulation form that must be completed after all the three interviews are completed. This form is important because it collates all the information obtained from the three interviews with each participant. These data can be collated, tabulated, analyzed, and synthesized across all the interviews completed in Task 5.

Table 11. TIPs Tasks

|  |  |  |
| --- | --- | --- |
| **1** | **Set the stage** | 1. Understand country context based on existing information​. 2. Draft initial TIPs menu. |
| **2** | **Establish needed background** | 1. Gather information through interviews and observations to understand household problems and current practices​. 2. Refine list of problems​. 3. Tailor TIPs menu recommendations. |
| **3** | **Try the behaviors** | 1. Counsel on possible behaviors to try.​ 2. Negotiate 1–2 new practices that the participant is willing to try.​ 3. Track distribution of practices. |
| **4** | **Assess outcomes** | 1. Understand what the participant was and was not able to do​. 2. Learn about important barriers, supports, and perceived benefits​. 3. Solicit suggestions from the participant about how to modify, promote, and ensure adoption. |
| **5** | **Analyze and make recommendations** | 1. Summarize critical information​. 2. Determine strategies and interventions.​ 3. Determine measures and milestones. |

Task 1. Set the Stage

About 1–3 weeks before planning field visits for data collection, review and synthesize all your findings from Steps 1–4 to identify and understand the key country context as it relates to your program area. Use table 12 to:

* Detail essential information on the households.
* Summarize specifics on the overarching nutrition problem that you hope to mitigate.
* Summarize specifics about solutions that have been tried previously for this overarching nutrition problem.
* Specify what households want that you can address in your planned SBC activities designed to create demand for the foods a program is promoting.

Table 12. Set the Stage: Information Collection

|  |  |  |  |
| --- | --- | --- | --- |
| **Household Characteristics** | **Child Feeding Problems** | **Solutions Tried and Outcomes** | **Reported Demand for and Use of Information Desired by Households** |
| **6–11 months** |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **12–23 months** | | | |
|  |  |  |  |
|  |  |  |  |

For each common child feeding problem by age group, identify behavioral recommendations that build on solutions tried and how they went. Identify information about motivations and challenges to practice each recommended behavior. This becomes your “menu” of options for TIPs.

Review the information available: does it provide what you need to know? If not, will TIPs fill all the gaps? If not, what other research might you need to conduct to understand your context and the problems? Detail what other method(s) you will use, with whom you will use it and why you think it is needed. Table 13 lists other possible methods, and why and with whom you may use them.

Table 13. Methods to Explore Food-Based Recommendations in Addition to TIPs

|  |  |  |
| --- | --- | --- |
| **Method** | **Use to Understand** | **With Whom** |
| **In-depth interview** | Beliefs, motivations, and constraints related to current practices | * Primary caregivers who will try the TIPs and their household members * Health workers * Leaders * Community influencers |
| **Observations** | Actual behavior, situation, and what is needed to practice the ideal behaviors | * Primary caregivers who will try TIPs, secondary caregivers, and other household members * Communities in which TIPs participants live |
| **24-hour dietary recall** | Practices that one can recall from the day before | Primary caregivers who will try TIPs |
| **Focus group discussion** | Issues affecting a household’s ability to adopt behaviors | * Health workers * Leaders * Community influencers |
| **Collective action trial** | Community beliefs, motivations, decisions | Entire community |
| **Community walk** | Community situation and access | * Leaders * Community influencers |

**Sampling Frame**

It is best to identify a small number of sites and use purposive sampling for testing FBRs. Table 14 below provides an example of a sample size per study site. Also consider:

* Selecting sites that reflect the various sociocultural and/or socioeconomic characteristics of the program areas. Selecting the sample for testing FBRs begins with choosing population segments, or groups of people defined by characteristics that affect young child feeding and reflect significant differences in child feeding practices and related beliefs. Find these characteristics by asking about the context in your program area, such as what types of feeding challenges are common, where these problems are the greatest, and which characteristics (e.g., ecological zones, ethnicity, proximity to markets, household structure) may result in significant differences.
* Avoiding more than four population segments; too many increase the complexity, duration, and cost of the exercise. Collect detailed information on participant groups that the program can address with tailored actions (e.g., religious affiliation, marriage practices, etc.).
* Choosing categories (e.g., maternal age, household structure, work status) of primary caregivers that may influence ability or willingness to change young child feeding practices.
* Selecting age groupings for children of participants. Determine these groupings by the local nutritional status, and feeding and relevant cultural practices. For example, if there is a local ceremony at 10 months to mark a milestone in children's lives, that may be a more appropriate break point than an 11 months cut-off (Dickin et al. 1997).

There are no definitive rules for calculating sample size, but including at least two or three individuals per participant category is recommended. Include 10–15 children from each site, or 2–3 in each age group per site. If there is another characteristic of particular interest, such as whether children are growing well or are ill, the sample size is increased (Dickin et al. 1997).

Table 14. Illustrative Example of Sample Size per District or Study Site

|  |  |  |
| --- | --- | --- |
| **Participant** | **Population Segments in One District** | |
| **Close to a Market** | **Far from a Market** |
| **Caregivers of children 6–11 months** | 3 | 3 |
| **Caregivers of children 12–23 months** | 3 | 3 |
| **Sub-total** | 12 | |

Task 2. Establish Needed Background

Conduct the first TIPs visits to–

* Gather information to understand household problems and current practices through interviews and observations​. This will include learning more about the caregiver, his/her household, how s/he solves problems, and encouraging caregivers to identify what they can do to solve a problem.
* Refine list of child feeding problems​.
* Tailor TIPs menu recommendations.
* Develop interview guides for the first, second, and third interviews. A Household Trial Interview Guide for the three TIPs visits is provided in **annex 1.**

Table 15. Key Content for Interview Guides

|  |  |
| --- | --- |
| **First interview** | * Health and breastfeeding history, breastfeeding and feeding behaviors. * Dietary assessment. |
| **Second interview** | * Feedback on behaviors and recommendations based on the dietary assessment. * Appeals and motivations. * Information to overcome practical barriers or challenges. * Guidelines for reaching an agreement with the caregiver /household to try the new behavior for a certain period of time (usually about one week). * Space to record reactions to each recommendation. * Space to note recommendations that the caregiver /household agrees to implement. |
| **Third interview** | * Change since last visit. * Questions and a format to record the caregiver/household comments after trying recommendation. * Space to record any modifications to original recommendation. * Assessment of whether the caregiver/household plans to continue the new behavior. |

At the start of initial visit:

1. Explain that TIPs provide a way to learn about how people make decisions about healthy practices for themselves, their children, and their households, and how this can help them find practical ways to solve problems.
2. Ask the participant about: 1) him/herself and family; and 2) health in the home and community in general.

Complete the dietary assessment after the initial visit and compare with recommendations on the menu to identify child feeding behaviors that need improvement. Ask about the child’s health status and appetite at this time because a child's illness often influences feeding decisions. Plan the recommendations for child in the second (counseling) visit based on the dietary assessment.

Task 3. Try the Behaviors

Conduct the second counseling visit to each household to:

* Counsel on possible behaviors to try​.
* Negotiate 1–2 new behaviors that the caregiver/household is willing to try. ​
* Track distribution of behaviors that caregiver/household is trying.

Discuss the positive feeding behaviors and challenges and ask the caregiver to select recommended behaviors from the menu to mitigate each challenge. If s/he is willing, through a process of negotiation, agree on those that s/he will try over the next several days until the scheduled follow-up visit.

Whenever possible, practice the recommendation together. If, for example, a new or modified food is agreed on, prepare it together during the visit. Ask what s/he thinks may be challenges to trying the behavior and suggest ways to overcome them. Also ask if anyone else in the household may want to be informed or engaged and plan how to do that together.

Record the caregiver’s reaction to the recommendations and the stated reasons for accepting or not accepting each. ***Negative reactions and unsuccessful adoption are as important as positive reactions and successful adoption to guide program decisions.***

Complete a tabulation form for each household. At each of the three visits, fill in the corresponding columns at the end of the Household Trial Interview Guide (Annex 1).

Task 4. Assess the Outcomes

During this third and final visit, aim to understand if there have been any significant changes in the home or in the child's health since the previous visit (table 16). If possible, conduct a second 24-hour diet recall to compare the difference.

**Table 16. Summary of What to Focus on and How to Conduct the Follow-Up Visit**

|  |  |
| --- | --- |
| **WHAT to do at the follow-up visit** | 1. Conduct the dietary assessment again (if possible). 2. Reconfirm practices agreed upon (recall of trial from participant). 3. Gather detailed information **on each behavior tried**:    1. Difficulties.    2. Benefits.    3. Adjustments made to be able to continue to practice (make manageable) the behavior.    4. Motivations to continue, regardless the ease or difficulty of behavior.    5. Advice participants would give to friends, family, and others. |
| **HOW to conduct this visit** | 1. Greet participant politely and warmly 2. Re-explain that TIPs provide a way to learn about how people make decisions to improve their children’s nutrition and finding ways that practices can be improved. 3. Ask participant to confirm the behaviors they thought they could try. 4. Explain that the behaviors you will discuss today are based on information the participant gave at during the initial visit. 5. Ask the participant if s/he understands or has any questions that require further explanation. |
| **What should you document to assess the overall outcomes?** | * Verify which behaviors were tried, adopted, and modified during trial. * Which behaviors the caregiver/household intends to continue. * Acceptance, trial, adoption, and rejection reasons. * Common problems. * New positive behaviors * Similarities and differences across the priority behaviors tried. |

Task 5. Analyze and Make Recommendations

* Summarize critical information uncovered through the field research.
* Make recommendations for the program.

**What are the components in TIPs analysis and interpretation?**

A. Summarize and analyze findings

1. Summarize the major child feeding practice problems when the work started.
2. Summarize dietary assessments (highlighting common problems and positive practices).
3. Analyze qualitative information (highlighting similarities and differences).
4. Complete each household tabulation table.
5. Describe household member reasons for accepting, trying, adopting, or rejecting recommendations.
6. Summarize critical information that can be used by programs:
   1. How to reach households.
   2. Positive practices that mothers and household members can teach the community.
   3. How to motivate household members to change behavior.
   4. How to overcome major barriers to behavior change.
   5. Specific language and words to convey concepts.

B. Compare and contrast the findings in different communities, age groups, and types of households by sorting the summaries into piles by various criteria.

C. Highlight significant contrasts (by rural or urban, first-time or experienced, etc.) and include specific participants' perspectives or quotes that illustrate the conclusions.

1. Summarize the results of testing the specific behaviors in table 17. Tally the number of times each recommendation was suggested, agreed to, tried, and adopted. Describe adaptations made.
2. Interpret these numbers based on the reasons for acceptance or rejections (motivations or barriers).

Table 17. Summary of TIPs Findings

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Priority Behavior** | **Complete from Second Counseling Visits (Task 3)** | | **Complete from Third and Final Follow-Up Visits (Task 4)** | | | |
| **Recommended behavior for each age (FBR options)** | **No. of people asked** | **No. of people willing to try** | **No. of people who tried** | **No. of people who were able to carry out agreed practice** | **No. of people able to do the practice through the trial period** | **No. of people who plan to continue** |
| FBR options for children 6–11 months | | | | | | |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| FBR options for children 12–23 months | | | | | | |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Table 18. Detailed Summary of Priority Behaviors Tried by TIPs Participants by Location/Study Site

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **LOCATION/STUDY SITE** | | | | | | | | | |
| **Priority Behavior** | **Tried**  **(yes/no)** | **Adopted (yes/no)** | **Modified (yes/no) (explain how)** | **Reasons for agreeing to try and/or adopt priority behavior** | **Reasons for refusing to try and/or adopt priority behavior** | **Most common problems** | **New positive practices emerging (if none write N/A)** | **Similarities**  **(what and with which other priority behaviors)** | **Differences**  **(what and with which other priority behaviors)** |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

How to Use This Information

D. Use the analysis to make program-specific recommendations

The program can promote specific modified behaviors by the age of the child from the tally in the tabulated Summary of TIPs Findings (table 17 above) that caregivers and households intend to continue. These have been shown to be feasible for people in program communities, even if they are not the ideal recommendation.[[20]](#footnote-20)

The observations and qualitative data collected will also provide insights into the challenges and barriers that caregivers and households face in practicing the behaviors. The benefits that caregivers and households experience as a result of trying the behaviors are also important to consider in the program recommendations. The perceived benefits of adopting improved behaviors can be integrated and added to SBC efforts and group activities that your RFSA team has planned to help people adopt the FBR.[[21]](#footnote-21) Include the specific benefits and terms and language that households use to describe what they find good about the behaviors in promotion efforts.

Step 6. Apply Learning to Your Program

Once the FBRs have been tested, review what you have learned as a team. At this point, you should have enough information to determine which FBRs worked and which to promote through the program. Deciding which FBRs to use will depend on the objectives of the program and sectors through which interventions are implemented. However, FBRs should be drawn from the learning generated in each step of the development approach. This includes the review of secondary data and collection of primary data at community and household levels. When promoting FBRs, consider and address barriers to and facilitators of improving the key behavior. The FBRs can be promoted through various program platforms such as care, farmers,’ and men’s groups and household and/or community dialogue, and through key influencers such as community volunteers and leaders.

Key Function of Step 6

This step will ensure that your team take the time to review and assess the findings from testing FBRs and decide those that you will promote and scale through your planned activities. The FBRs that were tested in one or two areas during development may need to be pre-tested and adapted to other areas. If you have a broad set of FBRs that are relevant for your entire program area, you can proceed with promoting these.

Time Required

The review of FBR findings may take 2–3 three weeks to complete. More time will be required to promote these FBRs, which may include training change agents.

Tasks

1. Integrate the FBRs to be promoted within your SBC approaches, thinking through which participant groups to engage and through which platforms or channels.
2. Determine which frontline workers will promote the FBRs and the materials they will need to promote them, taking into consideration their and caregivers’ literacy levels. The materials could be print or bowls, spoons, measuring cups to communicate which foods to promote and in what quantities.
3. Develop materials to train health workers and/or change agents. Step 7 provides a training guide for group leaders to promote the FBRs. This is only one approach; there may be many other trainings you have planned with other frontline workers where the session plans in annex 2 could be integrated.

Tailor FBRs by the age group of children under age two (i.e., 6–11 and 12–23 months) including:

* quantity (amount per meal and frequency)
* variety of nutrient-rich foods
* meals and snacks
* other factors (determinants) as outlined in earlier steps (e.g., helping with household chores, food purchase and preservation).

Tables 9 and 10 in Step 4 provide examples of which nutrient-dense foods can be promoted and in what quantities. Table 19 provides an example of recommendations for the amount and variety of food at and frequency of each meal. Use tables 20 and 21 to develop something similar based on your FBRs.

Table 19. Example of FBR Recommendations, Amalima Loko RFSA

|  |  |  |
| --- | --- | --- |
|  | **Children 6–11 Months** | **Children 12–23 Months** |
| **Amount per meal** | * Feed your child 2 to 3 tablespoonfuls per meal starting at 6 months and gradually increase to half (½) 250 ml cup/bowl (provide a local bowl with marking to indicate amount). | * Feed child ¾ to one 250 ml cup/bowl at each meal (provide a local bowl with marking to indicate amount). * As child gets older, increase amount of food offered. Give as much as the child will eat, with active encouragement. |
| **Frequency of feeding** | * Feed child 2-4 meals a day. * Offer 1**–**2 snacks between meals [select from nutrient-rich list]. * Continue to breastfeed your child throughout the day and night, on demand. | * Feed child 3**–**4 meals a day. * Offer 1**–**2 snacks in between meals [select from nutrient-rich list]. * Continue to breastfeed your child throughout the day and night, on demand. |
| **Variety of foods** | * Feed child 2**–**3 different foods groups at each meal, aiming to eat foods from each food group each day. * Add 1 animal-source food (insert measurement) and 1 fruit/vegetable (insert measurement) to their porridge in the morning. * Add 1 legume and 1 vegetable/fruit to their sadza in the afternoon. * Add 1 animal-source food and 1 vegetable/fruit to their sadza in the evening. | * Feed child 2**–**3 different foods groups at each meal, aiming to eat foods from each food group each day. * Add 1 animal-source food (insert measurement) and 1 fruit/vegetable (insert measurement) to their porridge in the morning. * Add 1 legume and 1 vegetable/fruit to their sadza in the afternoon. * Add 1 animal-source food and 1 vegetable/fruit to their sadza in the evening. |

Summary of FBRs and Supporting Behaviors

Table 20. Food-Based Recommendations Output: (Specify children’s age group 6–11 months or 12–23 months)

|  |  |  |  |
| --- | --- | --- | --- |
| Household measurement: 1 tablespoon = 15g; 1 teaspoon =5 g; 1 cup=250g | | | |
| **Animal-Sourced Foods** | | **Fruits/Vegetables** | |
| Food option | Quantity (g) | Food Option | Quantity (g) |
|  |  |  |  |
| **Staple Grains** | | **Legumes/Seeds** | |
| Food option | Quantity (g) | Food option | Quantity (g) |
|  |  |  |  |
| **Snacks** | | | |
| Food option | | Quantity (g) | |
|  |  |  |  |

Table 21. Recommendations to Improve the Quantity of Food and Dietary Diversity

|  |  |  |
| --- | --- | --- |
|  | **Children 6–11 Months** | **Children 12–23 Months** |
| **Amount per meal** |  |  |
| **Frequency of feeding** |  |  |
| **Variety of foods** |  |  |

How to Use This Information

All of the efforts from Steps 1 to 5 should have allowed you to develop a set of FBRs tailored to the age of the child and context. Collating the final FBRs and supporting behaviors in Step 6 will allow you to develop materials that clarify which FBRs and supporting behaviors to promote through the program.

Step 7. Use the Training Guide for Programming

The next step in the process is training frontline workers and providers, specifically group leaders, on the RFSA team and those who may serve as volunteers.

Key Function of Step 7

This step provides initial guidance on training group leaders in your RFSA. The purpose of this brief training guide is to prepare leaders of groups such as care groups and male champions to conduct peer group sessions using locally available nutritious foods.

Time Required

Depending on the scale and scope of your RFSA, the timing to complete trainings with group leaders may take up to three months to complete. This training session is designed as a one-day session.

Tasks

1. Use the training guide below to prepare a training for group leaders using the program materials developed in Step 6.
2. Use the group activities provided in annex 2 to help trainees learn how and what to communicate in each session they plan to conduct.
3. Conduct trainings as required with group leaders in different RFSA program areas to scale up these activities gradually.

Training Guide

Table 22. Train-the-Trainers Session

|  |  |
| --- | --- |
| **Title** | A Train-the-Trainers Session on Interactive Approaches to Promote FBRs for Complementary Feeding |
| **Purpose** | Prepare group leaders to conduct group sessions that will improve children’s diets through locally available nutritious foods. |
| **Objectives** | * Support group leaders to use the program materials on young children’s diets with locally available food. * Demonstrate how group leaders can conduct group sessions (discuss, practice, reflect, plan for action). * Give and receive feedback on the effectiveness of activities. |
| **Participants** | Care group lead mothers and promoters, male champion and other leaders as relevant. Each training may have approximately 20 participants. |
| **Duration** | 1 day |
| **Expected outputs and outcomes** | * Group leaders will demonstrate an effective approach for conducting group sessions on locally available food for young children * Group leaders will be able to identify the specific needs of group members and articulate strategies for adapting content to meet those needs. * Group leaders will have strategies to overcome barriers to group members to take actions they prioritize. |

Training Agenda and Outline

* Welcome and introductions [30 min].
* State your name, role, how long you have been a group leader, and one thing that a child does to make you smile or laugh.
* Review the purpose and objectives for the training.
* Describe the types of sessions that group leaders will conduct.
* Discussion: think of a good learning experience. What was the situation? How did the person teach you? What made it easy to learn?
* Explain importance of tailoring content to audience and context. The best learning takes place when facilitators make content relevant to the learner’s context and challenges.
* Skills for conducting effective group sessions [90 min]
* Be open yourself.
* As group members talk, share your experience too. This will build trust and connection with your group members.
* Explain clearly.
* Break down the session into small, clear steps. Facilitators often skip steps or make incorrect assumptions about what participants know.
* Give the rationale for each step. People often learn better when they understand why they are learning something.
* Do not simply give information or tell group members facts. Set up the activity and ask participants to discuss and solve problems together. This is the facilitator’s role. Peer exchange and hands-on practice is the most effective way for the participants to learn.
* Ask questions and listen more than you talk. Your groups want you to hear and appreciate their ideas and contributions.
* Prepare content in advance.
* This 1-day training includes several session plans with different activities each for a 1.5–2-hour session. Select an activity or two for group leaders to practice during this 1-day training, and encourage them to use these activities with their groups based on the interest of their groups. Encourage them to try to use all of the activities over time, as their groups meet.

● Introduce the program materials. [60 min]

* Ask participants to read the program materials. Ask questions and allow participants to discuss with each other.

● Conduct teach-back session [180 min]

* Divide participants into 2 groups.
* Ask each to select and practice one activity (below).
* Ask each to facilitate its activity with the larger group.
* Peers observe and give feedback.
* Repeat process with the second group.

● Plan how to use in groups [60 min]

* Each group leader can prepare an action plan to use with his/her groups and present to plenary.
* Evaluate the training
* Ask participants to complete an evaluation to provide you with feedback on how to improve this training.

How to Use This Information

Use the information from the training evaluations to review and assess participant feedback and modify the training scope and duration accordingly.

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Annex 1. Trials of Improved Practices Three-Household Visit Interview Guide

**HOUSEHOLD TRIALS: INITIAL VISIT[[22]](#footnote-22)**

**BACKGROUND INFORMATION**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ START TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| COMMUNITY |  | CODE |  |
| INTERVIEWER |  | CODE |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Child name |  | Sex |  |
| Age in months |  | Birthdate |  |
| Caregiver name |  | Occupation |  |
| Relationship to child |  | Address |  |

Explain to the caregiver that we want to learn about child's health and feeding.

**HEALTH HISTORY**

1. How is the child's overall illness? Any problems? (Probe for frequent illnesses and caregiver’s general impression of the child's health.)
2. If possible, check the growth chart and note how well the child is growing. Also, note your own observations about how the child looks.
3. 3. Generally, how is the child eating? Any problems? How is the appetite?

**BREASTFEEDING HISTORY**

1. Is the child breastfed? \_\_\_\_\_ (Y/N)
2. If yes: frequency? day \_\_\_ \_\_\_ night \_\_\_ \_\_\_

(estimate number of times)

On demand? day \_\_\_ night \_\_\_\_ (Y/N)

Until when does she plan to continue? \_\_\_\_ \_\_\_ (child's age in months)

1. If no: Ever breastfed? \_\_\_ (Y/N)
2. If yes: When did she stop? \_\_\_ \_\_\_ months. Why?
3. If never breastfed: Why?

**BREASTFEEDING OBSERVATION**

If mother breastfeeds during the interview, observe her and the child and make notes on breastfeeding style. For example, include points such as the following:

* Does the mother seem relaxed about breastfeeding?
* Does she feed from both breasts?
* Does she begin the next breastfeed with the other breast?
* Who initiates and ends the feeding: the mother or the child?
* Does the child breastfeed frequently?
* For long periods?

**FEEDING OBSERVATION**

As part of the dietary assessment, observe any feedings that take place during the interview, noting issues such as type of food, consistency, amount served and consumed, method of feeding, and attitude of both the caregiver and the child. Make notes to supplement the 24-hour recall.

**DIETARY ASSESSMENT**

1. Conduct 24-hour recall for all foods and liquids (including water) other than breast milk.

Ask caregiver to tell you everything the child has taken by mouth in the previous day and night. Start in the morning and for each food, ask what the ingredients were, the amount and the mode of feeding (hand, cup, bottle, etc.)

Probe for snacks or pieces of fruit between meals, bites of family meals shared with the caregiver, foods purchased from vendors, drinks of tea, water or other liquids. Be patient and allow the caregiver to recall everything s/he can.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hour** | **Food or drink** | **Ingredients** | **Amount** | **Mode** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Conduct a food frequency assessment about other foods, drinks, or snacks that child commonly receives (other than those listed above). Ask about foods that caregiver sometimes gives the child, but not yesterday. The idea is to learn about foods that were not included in the 24-hour recall, but that the child might eat at least once a week.

Probe for foods eaten only once in a while, such as when away from the house, on weekends, or just when available. Ask caregiver to estimate how much the child usually eats of this food, and about how often. Also ask about purchased foods and snacks.

|  |  |  |  |
| --- | --- | --- | --- |
| **Food or drink** | **Ingredients** | **Amount** | **Times per week** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Ask the questions below that apply to the child's age and diet. Probe and take detailed notes.

For all children 0–5.9 months:

1. What was the first thing given by mouth to the child after delivery? Why? Who recommended it?
2. When was breastfeeding started? Was colostrum given? Why or why not? Would you be willing to start breastfeeding within one hour after birth? Why or why not?
3. What is the next new food or drink you are planning to add to the child's diet? Why? When? How will you know the child is ready?

For all children aged 0–11.9 months, if ever breastfed:

1. Have you had any problems breastfeeding?

Probe insufficient milk, soreness, child crying, child refusing, being away from the child, etc. What problems? [If none, skip to question11.]

What did you do to resolve these problems?

Who do you ask/where can you go for help with breastfeeding problems?

For all children aged 6–23.9 months

1. Is there any change in the child's appetite or feeding during illness?

Probe: diarrhea and respiratory infection.

Does the child take less, the same, or more of breast milk? Of water and other fluids? Of pap and soft foods? Of solid foods?

If less, is it due to child refusing or you not offering?

Is appetite a problem? What do you do about it?

For all children

1. Where do you learn new information about child feeding? who is a good (trusted) source of information or help with child feeding problems? Why? Probe: for VFW, TBA, CBD

Do you listen to the radio? If yes, how often? What do you like to listen to? Have you heard any information about child health on radio? What messages? What did you think about it? What about television (or other media)? Same probes as for radio.

By the end of the interview, try to carefully/indirectly find out the level of education of the caregiver, the number of children, and the birth order of this child (3rd, 5th, etc.)

Caregiver's level of education (check one)

None \_\_\_\_ Primary incomplete \_\_\_\_\_\_ Primary completed \_\_\_\_\_\_ Secondary incomplete \_\_\_\_ Secondary completed \_\_\_\_\_ post-secondary \_\_\_\_\_

No. of children \_\_\_\_\_\_\_ Birth order of child in study \_\_\_\_\_\_\_\_

**CLOSURE: Thank the caregiver for answering your questions and explain that you will return tomorrow to discuss the child's diet with her. Arrange a time to visit.**

Counseling visit arranged for : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time finished : \_\_\_ \_\_\_ : \_\_\_ \_\_\_

**ANALYSIS OF DIET** (TO BE COMPLETED AFTER FIRST VISIT)

14. Analyze the dietary information and identify any feeding problems listed on the Assessment and Counseling Guide. Write a brief summary of the following aspects of the diet and indicate whether or not current feeding is adequate.

Breastfeeding practices (including frequency):

Feeding frequency: (other than breastfeeding):

Amount given:

Quality/variety:

Consistency/thickness:

15. Problems identified : \_\_\_ \_\_\_\_ \_\_\_\_\_

List numbers from Assessment and Counseling Guide

Possible recommendations: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_\_

**HOUSEHOLD TRIALS: SECOND COUNSELING VISIT**

**BACKGROUND INFORMATION**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ START TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| COMMUNITY |  | CODE |  |
| INTERVIEWER |  | CODE |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Child name |  | Caregiver name |  |
| Same person as interviewed on visit 1 and 2? [Y/N] |  | If no, relationship to child |  |

**DISCUSSION OF DIETARY ASSESSMENT**

Explain your assessment of the child's diet to the mother, remembering to praise her for any positive practices.

For example: "Your child has/has not been receiving breast milk..." [If receiving, note frequency and any problems.]

"In addition, your child is getting... \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(milk/drinks) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (foods)."

[Note frequency, quantity, thickness for the caregiver.]

"Your child takes this from a bottle/cup/by hand/or from a common plate with the rest of the family, etc." "As you have told me, your child seems to be healthy /ill in the past /frequently ill/ill today..."

[Add any other important information the mother has mentioned. Ask if she agrees with your summary.]

**Problem-solving:**

[See discussion guide for ideas on how to begin talking about the child's diet and possible recommendations.]

* Ask the caregiver if s/he would be willing to try something new to improve the diet for the child's health and strength.
* Ask if s/he has any ideas—make general suggestions and try to get her to come up with some possible improvements.
* Discuss the appropriate recommendations for the child's age and current feeding patterns, based on the Assessment and Counselling Guide. On the following forms, record as much detail as possible about the caregiver's responses to the recommendations (how does s/he react, why is s/he willing or unwilling to try?)
* Negotiate with the mother so that she chooses one new practice she would be willing to try for a few days.

Explain that you will be coming back to get her opinion on the new practice.

RECOMMENDATION: Recommendation # \_\_\_\_\_\_\_ :

|  |  |
| --- | --- |
| Specific food options suggested? |  |
| Caregiver's initial response. Willing to try? |  |
| Why or why not? |  |
| Any other circumstances under which s/he would try the recommendations? When?  What modifications? |  |

[Insert additional sheets for as many recommendations as are planned for this counselling.

Ask caregiver to explain to you the new practice s/he will try. Make sure s/he understands and agree.

Summarize (in his/her own words) what the caregiver has agreed to try: Ask if s/he has any questions or comments (record them). Make sure that all the details of preparation are clear.

Write what s/he is going to try on a "Child Feeding Reminder" slip and give it to them to keep. Arrange a date for follow-up in about 5 days (see schedule). Ask the caregiver when a convenient time of day is to meet and try to arrange that s/he will be home when you come.

Follow-up visit arranged for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank him/her for spending time answering your questions and encourage him/her to try the new practice.**

Time finished : \_\_\_ \_\_\_ : \_\_\_ \_\_\_

**HOUSEHOLD TRIALS: THIRD FOLLOW-UP VISIT**

**BACKGROUND INFORMATION**

DATE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ START TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| COMMUNITY |  | CODE |  |
| INTERVIEWER |  | CODE |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Child name |  | Caregiver name |  |
| Same person as interviewed on visits 1 and 2? [Y/N] |  | If no, relationship to child |  |

**DIETARY ASSESSMENT**

1. Begin with a 24-hour recall, following the same approach as during the first visit. Probe for all foods, beverages, and snacks consumed by the child in the previous day and night. [Insert 24-hour recall table, as in form for initial interview.]
2. Analyze the dietary information and note any differences since the first visit. Is there any indication that the caregiver has added the new practices that were recommended?

* How is the adequacy of the diet now?
* Breastfeeding practices (including frequency):
* Feeding frequency (other than breastfeeding):
* Amount given: quality/variety:
* Consistency/thickness:

**OUTCOME OF TRIAL**

Refer to summary of the agreement made with the caregiver during the second visit (after counseling). Using the following forms, note each practice s/he agreed to try, and ask the questions listed. Probe for reasons why and make detailed notes.

Fill in separate forms for each practice s/he agreed to try, or for what s/he tried instead.

RECOMMENDATION: Recommendation # \_\_\_\_\_\_\_ :

1. Has the caregiver tried it? \_\_\_ Y/N
2. If no, what are his/her reasons? Probe why not
3. If yes, did s/he like it? \_\_\_\_ Y/N
4. What did s/he like about it?
5. What didn't s/he like about it?
6. How did the child respond?
7. Did s/he modify the recommendation? How? Why?
8. Did other people say anything about it? Who? (husband, in-laws, friends?) What did they say?
9. Will s/he continue the recommended practice? Why or why not? Will it be every day?
10. Would s/he recommend it to others? How would s/he convince them to try it? (in his/her own words) [Insert additional sheets as needed].

Closure: Encourage caregiver to continue practice and ask if s/he has any questions or comments. Provide counseling or information as needed. Thank him/her for her participating.

Time finished : \_\_\_\_ \_\_\_\_ : \_\_\_\_ \_\_\_\_

**HOUSEHOLD TRIAL TABULATION FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Age group |  | Community |  | Interviewers |  |
| Interviewed First visit [Y/N] |  | Interviewed Second visit [Y/N] |  | Interviewed Third visit [Y/N] |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ID** | **Age** | **Feeding problems** | **Recs offered** | **Reasons/ reactions** | **Recs agreed** | **Tried** | **Outcome reactions/ changes** | **Intend to continue** |
|  |  |  |  |  |  |  |  |  |

Annex 2. Session Plans for Group Leaders for Group Activities to Improve Young Children’s Diets

| **Session plan** | **Activity 1: Seeing is Believing** | **Activity 2: Reaching for the Stars** | **Activity 3: Gifts for our Children** | **Activity 4: Champions of Children’s Diets** | **Activity 5: Role models in the community** |
| --- | --- | --- | --- | --- | --- |
| **Preparation** | [Using the program material] Select and prepare 1 or 2 FBRs. Ask participants to bring cooking materials and foods, in addition to a bowl to the session. Bring measurement tools. |  |  |  |  |
| **Part 1. Discussing our Children** | Facilitate a discussion including yourself by asking questions such as:   * What is special about children in the first two years of life? * What is the role of nutritious foods in children from 6 months growing well and staying healthy? * What are some nutritious foods available in this community for most families? | Facilitate a discussion, including yourself by asking questions such as:   * What is special about the first two years of life, especially 6–23 months? * How do you as a parent or grandparent feel when the child eats different types of foods each day? Do you notice differences when this happens? * What nutritious local foods are available to most families? | Facilitate a discussion, including yourself by asking questions such as:   * What are the best gifts we can give to children as parents and grandparents? * What colors of food do young children like? * Which nutritious local foods are available to most families in this community? | Facilitate a discussion, including yourself by asking:   * What would you like families to know about feeding children from 6 months? | Facilitate a discussion including yourself by asking:   * How many children in our community are under 2 years of age? * What nutritious local foods are available for these children? |
| **Part 2. Practicing Skills** | **Explain** that today you will prepare recipes using very nutritious food that is available in our community. Ask participants to decide who will prepare the food, cook, etc.  **Give** recipe instructions: in each bowl, add sadza or millet. Add 1–2 of the other foods selected [from the program material] (animal source, legumes, fruits or vegetables). Follow the amounts needed for the age of the child.  **Taste** the food. Thank the cooks!  If children are present, **feed** each using the amounts in the bowl needed for the his/her age.   * Encourage caregivers to talk with the child while feeding. * Observe how the child likes the food.   (Note, if a child has low appetite, do not force him/her to eat. When possible, encourage small tastes: every bite counts). | **Explain** that today you will discuss healthy locally available foods for children to eat each day. Children up to age 2 have special needs for growth and development. But their stomachs are very small so they cannot eat much at each time. [Show your hand as a fist.] They need a mix of different foods each day to get the nutrition necessary to grow well and stay healthy.   1. **Divide** participants into groups of 3–5 people. 2. **Ask** each group to make a menu for one day [using the foods in the program material] for a child 6–11 months. Each food will have 1 star. Be sure to select 1–2 foods from each of the 4 types that are realistic to feed the child *this season*. Count the stars in each group’s menu. 3. **Ask** each group to make a menu for one day [using the foods in the program material] for a child 12–23 months. Select 1–2 foods from each type that are realistic to feed the child this season. Count the stars in each menu. 4. If time permits, practice preparing one of the FBRs in the program material. | **Explain** that today you will discuss healthy foods for children to eat between meals: snacks. Young children until the age of 2 have special needs for growth and development. But their stomachs are very small and they cannot eat much at each time. Healthy snacks help children get nutrition that they need to grow well and stay healthy. Healthy snacks are a gift to show your love to the child and please the child. It is also a way to give children an opportunity to show their motor skills by feeding themselves. You might be surprised to learn how many locally available nutritious snacks can be fed to young children!   * **Divide** participants into groups of 3–5 people. * **Ask** each group to list all of the locally available foods that families could give to children 6–11 and 12–23 months. Ask each group to note which are available at different times of the year. * **Compare** lists and seasonal availability between the groups. Add foods not mentioned. * **Ask** each group to consider how each family member can help to prepare and feed children a healthy snack. One group could select grandmothers, one fathers, and one older siblings, for example. Or groups could discuss all family members. | **Divide** participants into groups of 3–5 people.  **Give** each one of the four scenarios below and 30 minutes to prepare:  **1. Home visit** to a family with a 16-month-old child. During the visit, ask about what the child usually eats. The family says that the child eats what others eat. You learn that the child eats from the same dish as others. *How could you help this family (the mother and others in the household) feed the child from his/her own bowl? How would you help this family add healthy foods to the child’s meal?*  **2. Home visit** to a family with an 8-month-old child. During the visit, ask about what the child usually eats. The family says that the child eats porridge. If there is other food available, it might add that. The family says that the child has low appetite. *How could you help this family (the mother and others in the household) find nutritious foods from the other 3 types and feed them to the child with patience?*  **3. Meeting a friend** who has an 11-month-old child. You see that the child often eats packaged sweets and then eats very little of the meal. *How could you encourage this friend and his/her family members to feed the child healthy snacks?*  **4.** Hearing that a village savings and loan group wants an income-generating activity. You see the potential of having local groups make nutrient-dense foods. *How could you encourage a group or a market vendor to try making nutritious foods for young children that could be available all year?*   * **Ask** each group to present its role play to the full group. * **Congratulate** all participants for showing that they can be champions of children’s diets. | **Explain** that today you will be role models to help the community improve young children’s diets by preparing and performing something.  **Ask** the group to select a drama, song, or other community event. The full group can opt to prepare one large activity together, or small groups could prepare different ones.  Ask that they convey the following key points, in addition to others they choose, in a creative way:   * Nutritious foods for children from 6 months are available in the community. * It is good for children to be fed 4 types of food a day from 6 months. * Add these nutritious foods to the child’s meal in a separate bowl. * Track how much of the foods children eat by using a separate bowl, even for children over 1 year. * Offer healthy snacks twice a day. * Good nutrition prevents worry and health care costs.   **Give** the group(s) time to prepare.  **Ask** the group(s) to present their drama, song, or event.  **Congratulate** all performers |
| **Part 3. Reflecting** | * How did the food taste? * Are you surprised that all these foods are here in the community? * [If children are present] Did you observe how much the child can eat from his/her own bowl? * What can family members do so that children eat like this from the age of 6 months, all year? * What can fathers do to help their children eat like this from the age of 6 months, all year? | * How did it feel to identify so many good foods for young children? * What should others in your community know about feeding children 6–23 months? | * How would you feel now about giving a child a healthy snack? * What should others in your community know about healthy snacks for children 6–23 months? * Is it surprising to see how many healthy snacks are locally available for children? | * How did it feel to see your group members be champions for children? * What techniques did you see in the role plays that can support a positive change? * What other issues on children’s diets could you share with our community? | * What would you like community members to learn from your presentation? * What would you like parents to feel after watching it? * How can we gather all family members of a 6–23 month-old child, a special time of life, together for the drama? |
| **Part 4. Making Plans** | * What specific actions will you try to help families improve the diets of children 6-23 months each day? * What challenges to preparing food like this each day might families have? * What challenges to giving young children healthy snacks twice a day might families have? * How can we help families to overcome the challenges to prepare these foods every day? * How can we encourage each other, as nutrition champions, to promote the use of nutrient-dense local foods to improve the diets of children 6-23 months? | | | | |

1. Simply called FBRs for the purpose of this workbook and the Optimizing Diets Using Local Foods for Improved Nutrition for Women and Children Guide. [↑](#footnote-ref-1)
2. A similar workbook is available to support a market-driven approach for the production of enriched blended complementary foods. [↑](#footnote-ref-2)
3. World Health Organization. (2006). *Five keys to safer food manual*. Available at: <https://www.who.int/foodsafety/publications/consumer/manual_keys.pdf> [↑](#footnote-ref-3)
4. Purdue Improved Crop Storage [↑](#footnote-ref-4)
5. Analyze information considering factors such as socioeconomic status, biological sex, livelihood, ethnicity, and religion. Information that you identify and review in this step will be used in Steps 2 and 4 where you will develop a key foods ID list and the FBRs. For example, coverage of vitamin A supplementation nationally and in your program area can help you assess if vitamin A is likely to be a problem nutrient and whether to prioritize dietary sources of it. While vitamin A foods are always important, if coverage is high in your area, it may not be as concerning as other key nutrients such as iron. Similarly, prevalence data for anemia in children under age five or on the consumption of iron-rich foods can help you assess if iron is a nutrient that should be prioritized. [↑](#footnote-ref-5)
6. If the consumption of fortified foods or multiple micronutrient supplements is high, you can focus on different nutrients that may be concerning. But if the consumption of these foods and supplements is low, consider optimal local dietary sources for these nutrients. [↑](#footnote-ref-6)
7. If you would like to add additional districts, you can copy this table into Excel and do so. [↑](#footnote-ref-7)
8. Adapted from USAID Advancing Nutrition’s Factors That Influence Multi-Sectoral Nutrition Behaviors <https://www.advancingnutrition.org/sites/default/files/2020-08/factors_multi-sectoral_nutrition_behaviors_tool.pdf> [↑](#footnote-ref-8)
9. Adapted from ProPAN Process for the Promotion of Child Feeding field guide, PAHO/WHO 2013 <https://www.paho.org/hq/dmdocuments/2013/Propan2-Eng.pdf>, and Recipe Development Guide, Catholic Relief Services 2020 <https://www.crs.org/sites/default/files/crs_recipe_development_guide_fillable_final.pdf> [↑](#footnote-ref-9)
10. MDD for children 6–23 months old. <https://inddex.nutrition.tufts.edu/data4diets/indicator/minimum-dietary-diversity-mdd> [↑](#footnote-ref-10)
11. USAID Advancing Nutrition’s assessments suitable for food environments in low- and middle-income countries resulted in a report that presents findings from three activities—a landscape assessment, a ranking exercise, and a survey—that led to a priority list of [methods, tools, and metrics for evaluating informal and formal market food environments](https://www.advancingnutrition.org/resources/methods-tools-and-metrics-evaluating-market-food-environments-low-and-middle-income). This resource has links and references to additional tools and methodologies the program team can explore. [↑](#footnote-ref-11)
12. The open-source [KoboToolbox](https://www.kobotoolbox.org/) is a data collection platform. [↑](#footnote-ref-12)
13. This step adapted from ProPAN Process for the Promotion of Child Feeding field guide, PAHO/WHO 2013 <https://www.paho.org/hq/dmdocuments/2013/Propan2-Eng.pdf> , and Recipe Development Guide, Catholic Relief Services 2020 <https://www.crs.org/sites/default/files/crs_recipe_development_guide_fillable_final.pdf> [↑](#footnote-ref-13)
14. How common foods are prepared, how ingredients are measured, and what quantities are offered to the specific population. [↑](#footnote-ref-14)
15. Adapted from ProPAN. Process for the Promotion of Child Feeding, 2nd Edition. Washington, DC: PAHO, 2013. [↑](#footnote-ref-15)
16. Parts that may be edible but that you do not consume, such as chicken bones. [↑](#footnote-ref-16)
17. Guiding Principles for Complementary Feeding of the Breastfed Child: For the average healthy breastfed infant, meals of complementary foods should be provided 2–3 times per day at 6–8 months of age and 3–4 times per day at 9–11 and 12–23 months of age. Additional nutritious snacks (such as a piece of fruit or bread or chapatti with nut paste) may be offered 1–2 times per day, as desired. Infants with low intakes of breast milk require the higher meal frequencies (3 at 6–8 months and 4 thereafter). <https://iris.paho.org/handle/10665.2/752>. [↑](#footnote-ref-17)
18. 10 videos for step-by-step review of using TIPs methodology and training workbook**-** [**https://drive.google.com/drive/folders/1wGnDHYOr8CjGyn8yWUxi9ZlkdgG\_-OQS**](https://drive.google.com/drive/folders/1wGnDHYOr8CjGyn8yWUxi9ZlkdgG_-OQS) [↑](#footnote-ref-18)
19. Dickin, Kate, Marcia Griffiths, and Ellen Piwoz. 1997. *Designing by Dialogue: A Program Planner’s Guide to Consultative Research for Young Child Feeding.* Washington, DC: for USAID.<https://www.manoffgroup.com/wp-content/uploads/Designing-by-Dialogue.pdf> [↑](#footnote-ref-19)
20. For example, a program may start with the intention to increase dietary diversity for children 6–23 months based on a review of nutrition needs. During research, including TIPs, it is found that households are able to add dried moringa and small fish to the porridge of children 6–11 months. Households are also willing and able to give fruit to children as snacks between meals. These two specific behaviors become those that the program promotes to increase dietary diversity. [↑](#footnote-ref-20)
21. For example, caregivers may need more family support to have time to prepare and feed children. [↑](#footnote-ref-21)
22. Dickin, Kate, Marcia Griffiths, and Ellen Piwoz. 1997. *Designing by Dialogue: A Program Planners’ Guide to Consultative Research for Improving Young Child Feeding.* Washington, DC: USAID Bureau for Africa’s Health and Human Resources Analysis for Africa (HHRAA) Project through the Support for Analysis and Research in Africa (SARA). [Designing by Dialogue.pdf (manoffgroup.com)](https://www.manoffgroup.com/wp-content/uploads/Designing-by-Dialogue.pdf) [↑](#footnote-ref-22)