WV'S PROGRAM ADAPTATIONS FOR POSITIVE DEVIANCE HEARTH PLUS IN THE CONTEXT OF COVID-19

WV'S PROGRAM ADAPTATIONS FOR PDH+ IN THE CONTEXT OF COVID-19 (INCLUDING GMP, IYCF, PDH)

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WV's Program Adaptations for PDH+ in the Context of COVID-19 (Including IYCF, GMP, PDH)

Version: 28 May 2020

All Staff must seek out and follow COVID-19 guidance on legally permissible working and gatherings issued by their local government agencies. *Nothing in these guidelines should be interpreted as authorizing staff to ignore the law or put themselves or our beneficiaries in increased danger of contracting COVID-19. If legally permissible, these guidelines should be used by all WV staff and volunteers to conduct group meetings, other mass gatherings, home visits, or other contact with beneficiaries that are not prohibited under local laws and regulations. This includes CHWs and also Child Protection, Education, WaSH, Livelihoods, Health and Nutrition, Faith & Development, and Child Sponsorship staff and home visitors.* **Always follow local ministry of health or other government regulations on mass gatherings and group meetings. Where the Ministry of Health (MOH) or government regulations are more stringent, follow those regulations. Where government regulations are less stringent, then the following WV recommendations should be adhered to, as a minimum practice.** We encourage you to discuss and share these guidelines with other organizations and the MOH in your country.

Overview

Breastfeeding and complementary feeding with proper hygiene practices can help protect children from common infections and bring comfort to both the mother and child. In settings where diarrhea, respiratory infections and infectious morbidity are common in infants, any possible risk of transmission of COVID-19 through breastfeeding (not reported to date) is outweighed by the known risks associated with replacement feeding[1]. While available evidence on COVID-19 infections shows that children are generally seen with milder symptoms, we do not yet know how it will affect wasted children. It is reasonable to assume that severely wasted children are at a higher risk of COVID-19 related pneumonia,[2] and that nutrition service provision may be interrupted during COVID-19 outbreaks[3]. In addition, with the increase in food insecurity and number of people experiencing acute hunger expected to double due to the COVID-19 pandemic, it is anticipated that there will be an increase in the number of severely wasted children.[4]

Thus, it is even more essential to continue providing community-based nutrition services in times of COVID-19 while considering adaptations for specific contextual barriers and bottlenecks in each geographical area and/or country. World Vision's priorities for management of malnutrition in the context of COVID-19 is three-fold:

1. **Increase coverage of prevention interventions** such as decentralizing nutrition screening or growth monitoring and promotion (GMP) (early detection) and providing Infant Young Child Feeding (IYCF) counselling.
2. **Strengthen and adapt Positive Deviance/Hearth (PDH) for rehabilitation** of underweight children and in some settings, to rehabilitate wasted children without medical complications if management of wasting services are not available, yet food security exists on the most part.
3. **Sustain and adapt existing services for the early detection and treatment of child wasting** (refer to *WV Management of Wasting in context of COVID-19: Program Adaptations CMAM Programs).*

The following table and Annex are key adaptations and approaches to consider for different anticipated levels of disruptions and challenges (complete or some restriction in mobility) when implementing IYCF, GMP, and PDH, along with relevant resources and tools. Please refer to link for program adaptations for CMAM.

KEY ASSUMPTION: Follow the guidance of the Ministry of Health and Nutrition Cluster, where such guidance exists. For assistance in adapting this guidance to your context, please contact Disaster Management - **Getinet Amenu** (Getinet_Amenu@wvi.org) or the Technical Service Organization (TSO) for support.

[1] https://www.ibfan.org/wp-content/uploads/2020/03/IYCF-Programming-in-the-context-of-COVID-19-Brief-2_v1-30-March-2020_-for-distribution-1.pdf
[2] https://www.nutritioncluster.net/sites/default/files/2020-04/Joint%20statement%20on%20COVID%2019%20and%20Wasting.pdf
[3] https://reliefweb.int/report/yemen/covid-19-aftershocks-secondary-impacts-threaten-more-childrens-lives-disease-itself
[4] https://insight.wfp.org/covid-19-will-almost-double-people-in-acute-hunger-by-end-of-2020-59df0c4a8072

Table 1. Table of Intervention Adaptations for IYCF, GMP, and PDH

Interventions	Anticipated Disruption/Challenge	Alternative Approach	Relevant Resources/Tools
Infant and Young Child Feeding[5] *(including but not limited to breastfeeding promotion, complementary feeding support and age-appropriate nutrition support)*	**Complete restriction in mobility:** 1. Mobility restrictions by community 2. Mobility restrictions by staff, community/village health workers/counsellors/volunteers 3. No community gatherings/meetings/sessions [groups]	1. Radio/media/social media messages/printed visible images and messages in local languages shared in food shops, retailers and places of worship 2. Announcements 3. Phone counselling and SMS promotion messages 4. Members of groups to support neighbors [maintaining social distancing and hygiene practices] 5. CHWs/VHWs support home visit according to social distancing and hygiene practices and in line with the WHO/UNICEF CCM Guide 6. Use of social platforms where applicable like WhatsApp groups and WV staff should use WV's priority digital partners: Dimagi/CommCare and Viamo, when possible	1. **IYCF in the context of COVID-19 Brief** 2. **Articles on digital projects (media/phone/SMS) in IYCF promotion/support** 3. **Nutrition Radio messages (ANNEX A)** 4. **Nutrition SMS messaging (Risk Communication for Community Engagement (RCCE) Training Guide)** 5. **WHO's IYCF Interim Guidance** 6. **WHO/UNICEF CCM Guide in context of COVID19 Pandemic**
	Some restricted mobility at the Community Level: 1. Some mobility restrictions by community 2. Some mobility restrictions by staff, community/village health workers/counsellors/volunteers 3. Fear to access health facilities and or nutrition centers	1. Promoting accessible support services where possible using phone/SMS 2. Adapt spaces where possible to provide non COVID-19 services 3. Communicate to women caregivers, pregnant women a "self-support guide and" how to contract for help and support	1. **IYCF in the context of COVID-19 Brief** 2. **Articles on digital projects (media/phone/SMS) in IYCF promotion/support** 3. **Nutrition Radio messages (ANNEX A)** 4. **Nutrition SMS messaging (Risk Communication for Community Engagement (RCCE) Training Guide)** 5. **WHO's IYCF Interim Guidance**

[5] Adapted from UNICEF/GTAM/GNC brief 'Management of child wasting in the context of COVID-19' available at: https://www.nutritioncluster.net/sites/default/files/2020-04/IYCF%20Programming%20in%20the%20context%20of%20COVID-19%20Brief%202_v1%2030%20March%202020_%20corrected%20for%20distribution.pdf

Interventions	Anticipated Disruption/Challenge	Alternative Approach	Relevant Resources/Tools
Infant and Young Child Feeding[6] (Continued)	**Some restricted mobility and Deprioritized IYCF:** 1. Health staff deprioritize IYCF counselling and support	1. Include IYCF counseling/breastfeeding support as part of the COVID-19 guidelines at the community and health facility levels [home-based support and clinical support]	1. **IYCF in the context of COVID-19 Brief** 2. **WHO's IYCF Interim Guidance**
	Some restricted mobility and Random BMS Donations: 1. Random donations of BMS and commercial complementary foods	1. Issue Joint statements at all levels 2. Sensitize and remind health workers, decision makers, politicians, donors of the importance of supporting recommended IYCF practices 3. Ensure reporting and enforcement of the national law/regular or relevant international mechanisms [online reporting and SMS reporting]	1. **IYCF in the context of COVID-19 Brief** 2. National regulations 3. **WHO's IYCF Interim Guidance**
Growth Monitoring and Promotion (GMP)	**Complete restriction in mobility:** 1. Complete lockdown and mobility restrictions by community and staff, CHWs/volunteers 2. Cessation of all GMP sessions	1. Use mobile phone call screening questions to identify and refer growth faltering children **(ANNEX B)** 2. Intensify efforts to strengthen the capacity of caregivers to detect and monitor their children's wasting status and for kwashiorkor using low-literacy/numeracy tools including Mid-Upper Arm Circumference (MUAC) tapes and videos on how to assess for bipedal oedema • Use tablets to show MUAC and how to assess for bipedal oedema training videos to caregivers. Tablets can be placed outside of the caregivers home, with the Health Worker standing 2 meters away from caregiver and proper PPE. Ensure tablets are sanitized afterwards (refer to ***MUAC and Oedema Training Video***). 3. Advocate for innovative decentralized GMP to be done at community-level (refer to #1-9 for GMP in some restricted mobility contexts below and **ANNEX C**)	1. **Management of child wasting in the context of COVID-19** 2. **Mothers Understand and Can do it (MUAC): a comparison of mothers and community health workers determining mid-upper arm circumference in 103 children aged from 6 months to 5 years.** 3. **Family MUAC Community of Practice** 4. **MUAC and Odema Training Video** 5. **Risk Communication for Community Engagement (RCCE) Training Guide** 6. **WHO's IYCF Interim Guidance**

[6] Adapted from UNICEF/GTAM/GNC brief 'Management of child wasting in the context of COVID-19' available at: https://www.nutritioncluster.net/sites/default/files/2020-04/IYCF%20Programming%20in%20the%20context%20of%20COVID-19%20Brief%202_v1%2030%20March%202020_%20corrected%20for%20distribution.pdf

Interventions	Anticipated Disruption/Challenge	Alternative Approach	Relevant Resources/Tools
Growth Monitoring and Promotion (GMP) ***(Continued)***	**Some restricted mobility:** 1. Reduced number of caregivers bringing children U5 to GMP sessions due to: • Some mobility restrictions by community, staff, community/village health workers/counsellor/volunteers • Limited community gatherings/meetings/sessions [groups] • Fear of attending GMP sessions • Need to minimize the risk of COVID-19 transmission and to protect health workers, by promoting a "no touch" approach in settings in which communities have localized clusters of COVID-19 (e.g. urban centers or regional transportation hubs) or community transmission	**DECENTRALIZED GMP** 1. Decentralize GMP sessions to community level and designate multiple posts per village 2. Increase number of days allotted for GMP in community per month (e.g. conduct GMP at community-level 1 week per month at multiple locations) 3. Adapt decentralized GMP posts to ensure social distancing and proper hygiene standards are maintained and practiced (e.g. handwashing station with soap, marks on ground 2m apart to guide standing positions for waiting) 4. Mobilize and train additional volunteers and existing CHWs in proper COVID-19 prevention behaviours and PPE use for frontline workers and volunteers using limited/no touch approach, and in decentralized GMP curriculum (select volunteers such as local shop keepers who have to stay in one spot for long periods of time already and who are used to record keeping). 5. Use radios/SMS/megaphones and/or other media platforms to communicate the new GMP locations and to mobilize community. Ensure messages are given to NOT attend GMP sessions if child or another family member is feeling unwell and to go directly to the health centre. 6. Record phone numbers of caregivers with children U2 to provide IYCF and COVID19 messaging through interactive calling/SMS. 7. Use low-literacy/numeracy tools to keep record of weight and MUAC records. Use of PDH-GMP app is highly recommended for CHWs and volunteers taking weight and MUAC measurements (app is already developed within WV and can easily be translated for local contexts). 8. Provide proper referral of children who are underweight (to PDH) and who have severe acute malnutrition or bipedal oedema (to wasting treatment programs or CMAM where available).	1. **Nutrition SMS Messaging - Risk Communication for Community Engagement (RCCE) Training Guide (including PPE guidance)** 2. **National regulations/protocols** (if any) 3. **GMP-PDH mHealth app presentation** 4. **Nutrition Radio messages (ANNEX A)** 5. **WHO's IYCF Interim Guidance** 6. **How to make soap water**

Interventions	Anticipated Disruption/Challenge	Alternative Approach	Relevant Resources/Tools
Growth Monitoring and Promotion (GMP) ***(Continued)***	**Some restricted mobility (continued):**	9. Conduct GMP sessions monthly (if possible) to detect growth faltering children early and refer underweight children to PDH or other rehabilitation services before they become wasted. 10. Follow-up with growth faltering children through phone calls (if possible) or household visits using 'no touch' and social distancing approach (**ANNEX C**)	
Positive Deviance/Hearth (PDH)	**Complete restriction in mobility:** 1. Complete lockdown and mobility restrictions by community and staff, CHWs/volunteers 2. Cessation of all GMP sessions	1. If Hearth messages have not been designed and situational analysis and PDI cannot be conducted due to lockdown, use pre-selected Hearth messages and pre-designed Hearth menus (contextual) (**ANNEX D**) 2. Stop all group Hearth sessions 3. Encourage PDH volunteers to follow-up with existing PDH participant households through: i. Home visits (if allowed), following proper COVID-19 prevention behaviours for frontline workers and volunteers using limited/no touch approach and PPE (refer to RCCE Training Guide) OR ii. Mobile phone calls to replace household visits (refer to PDH+ COVID-19 guidance for details on follow-up phone call guideline). 4. Conduct GMP through mobile phone calls using the screening questions (**ANNEX B**) or decentralized GMP (see above) 5. Underweight children should be referred to the COVID19-adapted PDH program. Explore use of simple mobile phones to share: i. Hearth messages through voice calling and ii. Hearth menus through SMS with PDH participant caregivers.	1. **Risk Communication for Community Engagement (RCCE) Training Guide** – Infection prevention and control guidance for WV Staff and Frontline Workers & Volunteers (especially CHWs), including PPE usage **2. Pre-selected Hearth messages, Hearth menu ingredients, Hearth and follow-up phone call guides (ANNEX D)** **3. GMP-PDH mHealth app presentation** **4. How to make soap water**

Interventions	Anticipated Disruption/Challenge	Alternative Approach	Relevant Resources/Tools
Positive Deviance/Hearth (PDH) ***(Continued)***	**Complete restriction in mobility (continued):**	6. If caregivers do not already possess a phone, WV should provide simple phones that can receive calls and SMS (refer to PDH+ COVID-19 guidance for details on key messages to share and phone call guideline for Hearth sessions and follow-up). 7. For COVID19-adapted PDH program, if possible, pair PDH participant caregivers living in close proximity and provide COVID19 prevention messages as a checklist to caregivers so prevention practices are adhered to (***RCCE Training Guideline – Module 4: How to prevent the spread of COVID19***), but use a 'buddy system' to keep caregivers accountable to cooking Hearth meals according to recipes,sharing ingredients to keep Hearth meal costs low, and feeding the Hearth meals to the underweight children as an extra meal for 12 consecutive days. Depending on the food security situation, the more expensive ingredients could be provided by WV (e.g. oil or groundnut) to the PDH participant caregiver pairs so it could be shared and added to the Hearth meals during this food insecure time period where it may also be difficult to access. If majority of households are experiencing food insecurity, please consider implementing a Blanket Supplementary Food Program (BSFP) and integrating with PDH. Please refer to **ANNEX D** for examples of micronutrient-rich foods (contextual – can use food composition tables to identify micronutrient-rich foods for country context). 8. Follow-up of Hearth participant caregivers will need to be done by volunteers during the 12 days either through home visits or mobile phone calls (whichever is feasible).	

Interventions	Anticipated Disruption/Challenge	Alternative Approach	Relevant Resources/Tools
Positive Deviance/Hearth (PDH) ***(Continued)***	**Some restricted mobility:** 1. Increase in food insecurity and limited health services available that may result in increased prevalence of underweight and wasting in U5 children 2. Mobility restrictions by community, staff, community/village health workers/counsellor/volunteers 3. Limited/restricted community gatherings/meetings/sessions [groups] to <10 adults 4. Fear of attending Hearth sessions	1. Use radios/SMS/megaphones and/or other media platforms to communicate that all Hearth participants with children or family members that are feeling unwell should inform PDH volunteers (provide volunteer phone number to caregivers) and self-isolate or go directly to the health centre and do NOT attend Hearth sessions. 2. For Hearth sessions, participant caregivers are highly encouraged to leave all children at home with a responsible caregiver (father/mother/grandparent), if/when possible. If no other caregiver is available at home, all children must be kept on the back of the caregiver (piggy back) or children must remain close to the primary caregiver during the Hearth session. 3. Keep Hearth session numbers to maximum 4 caregivers and 1 volunteer (or follow national COVID19 response guidelines/protocols). 4. Register all caregivers and record their mobile phone numbers, safely storing the numbers and not sharing with others without the person's consent. 5. Limit Hearth session to 6 days and replace remaining 6 days with phone calls (refer to **ANNEX D** for details on Hearth session phone call guidance). 6. Conduct 1st household visit face-to-face using proper physical distancing and then conduct follow-ups through interactive voice calling (2 phone calls per week for 2 weeks to replace face-to-face household visits (refer **ANNEX D** for Follow-up phone call guidance). 7. Use WV's already developed PDH-GMP mHealth app (if possible) to monitor programs. PDH Online database is harmonized with the mHealth app so data entry can be entered just once and summary reports can be easily generated.	1. **Risk Communication for Community Engagement (RCCE) Training Guide** – Infection prevention and control guidance for WV Staff and Frontline Workers & Volunteers (especially CHWs) 2. **National COVID19 response guidelines/protocols** (if any) 3. **Pre-selected Hearth messages, Hearth menu ingredients, Hearth and follow-up phone call guides (ANNEX D)** 4. **GMP-PDH mHealth app presentation** 5. **How to make soapy water**

ANNEX A: COVID-19 Nutrition Radio Messages

Topic	Content	Word Count
Breastfeeding and COVID-19 – should I breastfeed?	Can women with COVID-19 breastfeed? Yes. Breastfeeding can continue even if you have COVID19 or suspect that you may have it, according to the World Health Organization. Some advice if you are feeling unwell: wash your hands with soap before and after touching your baby; wear a mask, is possible, during breastfeeding, and regularly clean surfaces around the home that the mother has been in contact with, using soap and water	**71**
Skin to Skin contact and COVID-19	Can I touch and hold my newborn baby if I have COVID-19? Yes. Close contact and breastfeeding helps a baby to thrive. Spend as much time as possible skin to skin in the early hours, days and weeks. Skin to skin means baby in a diaper (nappy) only and adult with no clothing on their front. In the first hours of life, focus on skin-to-skin with the birthing parent - after this, the other parent or caregiver can share the skin-to-skin time.	**84**
Breastfeeding During COVID-19 – for protection	Breastfeeding protects you and your baby in many ways - and keeping babies and young children healthy is more important now than ever. Breastfed babies are less likely to be sick from common infections. Breastfeeding comforts both mother and baby, even when the household is very stressed. Frequent handwashing by caregivers also helps babies to avoid respiratory infections and diarrhea. Some parents may be feeding a combination of expressed milk and infant formula along with direct breastfeeding. Breastfeed directly as much as possible to maximize the germ-fighting power of your milk.	**91**
Feeding non-breastfed infants & COVID-19	For non-breastfed infants, caregivers should wash their hands with soap and water before preparing infant formula. It is recommended to use a cup, instead of a bottle to feed your baby, as cups are easier to clean. Cups or bottles (if used) should be sterilized before use.	**47**
Food preparation in the context of COVID-19	Before preparing or eating food, wash your hands with soap and water, and make sure food preparation areas are regularly cleaned and disinfected. If your household normally eats from a common bowl, or if feeding children by hand is common, consider switching to separate bowls. It is better to use the child's own plate and spoon for feeding to avoid transmission of COVID-19.	**63**

ANNEX B: Remote identification of growth faltering children under 5 years of age that require intervention

Table 1.0 - Screening questions for children aged 59 months and younger:

Screening Questions	Concerning Answer	Reason for Concern	Next Step/Referral
1. Do you have child(ren) 5 years and younger? If so, what age is your child(ren)?	Yes	*Children under 2 years are more at risk. However as long as household has child(ren) under 5 years of age, continue with the screening questions.*	Continue with screening questions.
2. Are any of your children unusually less active, unusually sleepy or have had any loss of consciousness, had seizures, difficulty or rapid breathing, a stiff neck or is not feeding at all or vomits everything?	Yes	*If yes to this question, the child has an underlying danger sign during child illness or is severely wasted. Caregiver needs to seek medical attention for this child immediately*	Refer to hospital or CMAM services immediately. Next day, follow-up with caregiver to ensure child was taken.
***3. Since the emergency, has your household lost their primary source of income to meet basic needs?**	Yes	*If a family is struggling with having adequate income, this can compromise access of food and intake of children*	***See note below.**
***4. Since the emergency, has your family been struggling more to have access to enough food everyday for all the household members?**	Yes	*If a family is struggling to have enough food, this will compromise intake of the children.*	If 3 or more of the answers for Questions #4-8 are 'concerning answers', child is most likely growth faltering and may already be underweight or wasted. ***1. Use weekly follow-up phone calls to provide close IYCF counselling and share 6 key Hearth messages from ANNEX D*** ***2. Advise caregiver to access available health/nutrition services.***
5. Has your child been identified as malnourished or admitted to a nutrition treatment programme in the past 3 months (e.g. PDH or CMAM)?	Yes	*A child who previously was underweight or wasted is at higher risk.*	
6. Is your child showing loss of appetite or eating very little in the past 2 weeks?	Yes	*Poor appetite for food indicates a child who is unwell.*	
7. Do you think your child is too thin or is becoming thinner than before?	Yes	*A child who has recently lost weight or has faltered in growth is at increased risk*	
8. [Ask this question only if there is a child under 2 years of age]: **a) Have you ever breastfed your child?** **b) If no longer breastfeeding, when and why did you stop?**	a) No b) Stopped breastfeeding recently because child has poorer appetite or child stopped latching	a) *A child not breastfeeding is at higher risk, especially if under 1 year of age. If not breastfed and child is under six months of age, child requires immediate further investigation as to how this infant is being fed.* *b) It is important to identify children who have stopped breastfeeding due to reduced appetite/ willingness or ability to breastfeed.*	
***NOTE: If many households answer Questions #3 and 4 with 'yes', consider starting a Blanket Supplementary Food Program (BSFP) to then be integrated with GMP and PDH (depending on context)**			

In complete lockdown contexts where access to growth monitoring and promotion (GMP) or other in-person clinical anthropometric assessments are limited, the following eight possible questions (Table 1.0) can be asked through mobile phone calls to screen remotely for risk of growth faltering children under 5 years of age. Supporting questions are provided as follow up questions where possible/appropriate.

ANNEX C: Decentralized Growth Monitoring and Promotion (GMP)

See the preparation required for setting up decentralized GMP post and additional guidance below.

1. Checklist for preparation required for decentralized GMP (by local shops) post:

- ❑ Follow WV's Guidance on staff and volunteer protection during COVID-19
- ❑ Setup different stations (handwashing station where caregivers are guided to wash hands – one where caregivers with children can wash hands one at a time; station for checking MUAC and checking for palmar pallor and bipedal oedema; and Weighing station; Registration Station and weight/MUAC recording station if not done on tablet/phone at the stations)
- ❑ Handwashing station (running water – tippy tap if water pumps not available and soap; refer to **How to make soapy water**
- ❑ Clear markings on the ground 2m apart to identify standing spots while waiting in line or while sitting waiting
- ❑ No more than 15 caregivers with children per decentralized GMP post
- ❑ Properly functioning weighing scales (hanging or standing) – ensure adequate batteries available
- ❑ MUAC tapes (If adequate MUAC tapes exist, prepare MUAC tapes for caregivers to take home with them after GMP session)
- ❑ Sanitizing equipment/supplies for weighing scales, weighing pants/sling (but preferable to ask caregivers to bring own kitenge, skirt wraps, or thin blankets to use in place of weighing pants and sling for child) and MUAC tape (after every use)
- ❑ Adequate PPEs for all volunteers measuring weight and MUAC and checking for bipedal odema and palmar pallor
- ❑ Someone (with PPE) directing the caregivers and children standing in line
- ❑ Monitoring tools for recording weight and MUAC of children and registration (Have a separate registration station from the weighing and MUAC/bipedal oedema/palmar pallor station)
- ❑ Make sure to have a column to record household's mobile phone number in registration book or tablet if using GMP mHealth application (Please contact Health@wvi.org for more info on WV's GMP mHealth application use)

2. Additional Guidance for Decentralized GMP:

- Conduct GMP for 1-2 weeks per month near local shops since caregivers are still accessing local shops for essentials and to purchase food and local shop keepers stay in shop all day
- Use 'no touch' approach and volunteers with proper PPE should:
    - Direct caregivers in how to weigh child, take MUAC measurements, check for bipedal odema, and look for palmar pallor at the GMP post;
    - Read the scales/MUAC tapes, record data and sanitize equipment
- Explain to caregivers that while this is a teaching opportunity for them to learn how to take proper MUAC of children at home and MUAC tapes can be distributed to them during this time, it is still highly recommended to bring their children to GMP sessions even if MUAC can be taken at home (refer to **MUAC and Oedema Training Video**)
    - Follow-up children for growth faltering with **weekly** phone calls to assess appetite, feeding, meal frequency, danger signs, etc. Provide IYCF counselling over mobile phone calls for children identified as growth faltering to discuss growth faltering solutions (Refer to **Risk Communication for Community Engagement (RCCE) Training Guide and WHO's IYCF Interim Guidance) and share pre-selected 6 key Hearth messages (ANNEX D - Section A of this document)**
    - Assure caregivers understand the basics of COVID-19 prevention (using the RCCE)

ANNEX D: PDH in COVID-19 context

Use pre-selected 6 Key Hearth messages if it is difficult to conduct situational analysis and PDI due to limited mobility (Section A). Share examples of foods high in calories, protein and vitamins/minerals if existing Hearth menus do not exist (Section B). When there are restrictions in mobility, consider using mobile phone calls to conduct partial or full Hearth sessions and household follow-ups (Phone guides available in Section C and D).

A. Pre-selected 6 COVID-19 Key Hearth Messages *(Give 1 message per day or phone call):*

1. **Handwashing:** Make a place for handwashing near the toilet, the kitchen, and/or the entrance to the house (e.g. tippy tap). Keep soap and water, soapy water, or alcohol-based hand rub present. Make washing hands for 20 seconds a habit for adults and children immediately after returning home, before preparing meals, before feeding, and before/after using the toilet or handling child faeces.

2. **Breastfeeding:** If a mother or child has suspected or confirmed COVID-19, it is safe for the mother to continue breastfeeding. Breastfeeding helps the child to fight disease and brings comfort to both. Wash hands before and after the feed for hygiene precautions. Continue to breastfeed up to 2 years of age.

3. **Active/Responsive feeding:**

   a) For children still breastfeeding: Look for early hunger signs in your infant, such as sucking on hands, lips, toes, and other objects, opening and closing the mouth, sticking the tongue out, and feed child as soon as they are showing these signs. You could sing or talk softly to comfort child while breastfeeding.

   b) For children eating food: Create a non-distracting environment for meal times. Feed or supervise your feeding child and adopt different strategies to encourage the child to eat such as assisting child when self-feeding, feeding slowly and patiently and not forcing child to eat, engaging through eye-contact and talking to child during feeding. If child refuses many foods, experiment with different combinations, taste, textures, and encouragement methods.

4. **Food handling:** Food handling is important to reduce food contamination, resulting in diarrhea and sometimes COVID19 transmission. Food should be eaten within 2 hours of preparation in hot weather. If food is kept at safe temperature (refrigerator), keep it covered to avoid contamination by insects and reheat before feeding the child. Separate raw from cooked foods and keep kitchen, bowls, and utensils clean. Wash all foods eaten raw with soap and water for at least 20 seconds.

5. **Complementary feeding:** Young children need frequent small meals throughout the day. A young child should have 3 meals and 1 to 2 snacks between meals. These meals should consist of ingredients that are: **1) high in energy**; **2) body building**; and **3) protective**. *(Ask mothers to repeat the 3 food groups and give mothers examples of country context-appropriate Hearth menu ingredients in Section B).*

6. **Separate bowls:** If your household normally eats from a common bowl, or if feeding children by hand is common, consider switching and using the child's own bowl and appropriate-sized utensil (spoon) to avoid transmission of COVID-19. It also helps caregiver to know if the child is getting enough food.

B. Examples of Hearth menu ingredients *(see country or regional food composition table for more):*

- **High Energy:** Oil, nuts (groundnut/peanut), maize/cassava/rice porridge, jaggery (unrefined cane sugar)
- **High Protein:** Nuts, soya, beans, lentils, shrimp/prawns, small dried fish, eggs, fish
- **High Vitamin:** Sweet potato, pumpkin, carrot, green leafy vegetables (amaranth, morning glory, spinach, taro leaves, etc.), mango, orange, guava, papaya, moringa leaves
- **High in Zinc (good for children having diarrhea):** Meat, shellfish, legumes (lentils, beans), seeds, nuts (groundnut/peanuts), dairy products, eggs, small dried fish, whole grains, and pineapples

C. Hearth message phone call guidance for PDH volunteers/community health workers (CHWs)

(Frequency of Hearth session phone calls: Approximately 15-20 mins; 1 call per day for 5-12 consecutive days – Depends on approach: i) 12 days of Hearth message phone calls or ii) 5-6 days of Face-to-Face Hearth session and 5-6 days of Hearth message phone calls**) Please feel free to contextualize the phone guidance** *(italicized writing is a note to the interviewer)***.**

- Hi, my name is (*volunteer's name*) and I am a PDH volunteer. I am calling you today because (*Child's name*) was identified as malnourished and losing weight from the GMP session you attended (or phone call you received for GMP screening). Is this a good time for us to talk on the phone? It will take approximately 20 mins today. I will be calling you for the next 10-12 days to provide a key message and one of two menus that will help you to improve the health of (*child's name*), which will take approximately 15 mins after today. *(call back another time if caregiver says that she is not able to talk right now and ask for another time where she would be available to talk today).*
- **(For Day 1 only)** Your child is being admitted into the PDH program as of today so may I ask you some questions that are needed for registration? *Ask all relevant questions to register the child in the monitoring format.*
- Is your husband and/or child's grandmother also home? If so, would they be available to join the call right now with you? Let's put the phone on 'speaker phone'. *(If her husband or child's grandmother joins the call, repeat the introduction and purpose of the call)*
- **(For Day 2 & onwards)** Did you try any of the practices we discussed yesterday? (*repeat the key message shared the day before*)
    - If so, what was experience like? Have you seen any positive changes in your child (e.g. increase in appetite, more active, less clingy to mother)? (*Provide positive reinforcement).*
    - If not, why not? (*Encourage caregiver to try today).*
- **(For Day 2 & onwards)** Did you try cooking the Hearth meal at home and include the ingredients from the SMS I sent you yesterday?
    - If yes, did the child enjoy the meal? How much did (*child's name*) eat? Did you give the meal to the child as an extra meal?
    - If not, why did you not try cooking the Hearth meal for the child? (*Discuss solution and encourage caregiver to try give it a try today).*
- Today's key Hearth message is: (*Share 1 key Hearth message per phone call*).
- Are you doing any of these positive practices already? Do you have any questions regarding the positive practices I mentioned?
- Do you see any challenges in practice (*mention the key practice again*) at home? (*If challenges are identified, brainstorm or advise caregiver(s) with solutions they could try to overcome the challenges).*

- Can you repeat today's key message back to me please? Would you like me to repeat the message? Can you try repeating it back to me now? (*Provide positive reinforcement or encouragement)*
- **(For Day 1 only)** Now, I will be talking about something called a "medicine meal", which is also called a "Hearth meal". This meal is important because it will be used to help (*child's name*) to gain weight, improve in appetite and overall health. You need to cook this meal at least once a day and it must be an **additional** meal to what (*child's name*) would normally eat at home.

- I will send you a list of ingredients and amounts of each ingredient for the Hearth menu after this call through SMS. I challenge you to try cooking this medicine meal with these ingredients, which are low in cost but very nutritious. Please give me a call if you face any difficulty with cooking the meal. My phone number is (*Provide your phone number*).
- *Agree on a time for the next day's call and thank the caregiver(s) for their time.*
- *Send SMS with Hearth menu and another SMS with the key Hearth message of the day.*

D. Hearth follow-up phone call guidance for PDH volunteers/CHWs

(**Frequency of follow-up:** Approximately 10 mins; 2 times a week for 2 weeks after the last day of Hearth session or phone call)**:**

- *Greet the caregiver and inform them that you will only be taking a maximum of 10 mins of their time to check-up on them and see how they are doing.*
- *Go through the PDH home visit form and fill in the form. Use 1 form per household.*
- Have you seen any positive changes in your child's behavior or feeding?
- What are the 6 key messages that we have been discussing over the past 2 weeks? Can you recall any of them for me please?
- What are some practices that you have changed since the 1st day I gave you a call?
- What are some practices that you have not changed amongst the 6 key practices? What are some barriers that are preventing you from changing and adopting the new practices? (*Brainstorm solutions to overcome the barriers together.)*
- When can I call you again this week to follow-up and see how you and (*child's name*) are doing? (*Setup another time to call within the next 7 days.*)
- Thank you for your time! We'll talk again soon. God bless you!

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