Implementation guidelines for Nutrition Impact and Positive Practice (NIPP) approach
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Acknowledgments

The NIPP approach was conceived, designed and authored by Hatty Barthorp, GOAL Global Nutrition Advisor.

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ANC/PNC</td>
<td>Ante-natal care/Post-natal care</td>
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<tr>
<td>BA</td>
<td>Barrier Analysis</td>
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<tr>
<td>BC/BCC</td>
<td>Behaviour Change / Behaviour Change Communication</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
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<tr>
<td>CI</td>
<td>Chronically Ill</td>
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<td>CMAM</td>
<td>Community Management of Acute Malnutrition</td>
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<tr>
<td>DALY</td>
<td>Disability Adjusted Life Year</td>
</tr>
<tr>
<td>EBF</td>
<td>Exclusive Breastfeeding</td>
</tr>
<tr>
<td>FES</td>
<td>Fuel Efficient Stove also sometimes referred to as Energy Saving Stoves (ESS)</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>GMP</td>
<td>Growth Monitoring Programme</td>
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<tr>
<td>HFIAS</td>
<td>Household Food Insecurity Access Scale</td>
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<tr>
<td>HH</td>
<td>Household</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>IGA</td>
<td>Income Generating Activity</td>
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<tr>
<td>IUGR</td>
<td>Intra-Uterine Growth Restriction</td>
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<tr>
<td>IYCF</td>
<td>Infant and Young Children Feeding</td>
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<tr>
<td>MEAL</td>
<td>Monitoring Evaluation Accountability and Learning</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<tr>
<td>NIPP</td>
<td>Nutrition Impact and Positive Practice</td>
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<td>OTP</td>
<td>Outpatient Therapeutic Programme</td>
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<td>PD</td>
<td>Positive Deviance</td>
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<tr>
<td>PLW</td>
<td>Pregnant and Lactating Women</td>
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<tr>
<td>RAM-FSNS</td>
<td>Rapid Assessment Methodology for Food Security and Nutrition Survey</td>
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<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>SFP</td>
<td>Supplementary Feeding Programme</td>
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Introduction

GOAL works in 19 countries across the world to bring humanitarian assistance to people in crisis and to support those recovering from crisis towards sustainable development. First operational in the late 1970’s, GOAL has now worked in more than 50 countries across the globe. GOAL uses a mixture of direct implementation and partnerships with local government, national and international civil society organizations, the private sector, and communities, to support socio-economic development. GOAL implements nutrition programmes in eight countries and aims to improve equitable access to and use of nutrition support services, in conjunction with improved community and home-based nutrition, to protect high-risk groups, with a particular focus on infants, young children, women of reproductive age and people living with chronic illnesses. GOAL’s nutrition programme is implemented as part of an integrated model including Health and Water-Sanitation-Hygiene.

The aim of the implementation guidelines for the NIPP approach is to provide public access to NIPP guidelines and tools developed by GOAL. GOAL will strive to disseminate information that is accurate and up-to-date on the day it was initiated. Every effort will be made to correct any errors that are brought to our attention. The implementation toolkit for NIPP has been designed to promote the lessons learnt from and the best practices of NIPP implementation within and outside GOAL. The toolkit aims to meet the needs of nutrition programme managers, coordinators, and advisors willing to implement the NIPP approach. In addition to tools supporting roll out and monitoring of NIPP circles, the toolkit contains planning, costing and communication tools.

In countries with existing national protocols for the treatment of acute malnutrition and the prevention of chronic malnutrition, this toolkit should be adapted to be aligned with and to support the existing nutrition policies.

There is a need to continue to build a robust evidence-base upon which the effectiveness of the NIPP approach can be evaluated. Therefore, your inputs, lessons learnt and best practices will be welcome by GOAL in order to ensure this toolkit is kept updated with useful and practical information.

Please send us your comments at nipp@goal.ie.
Rationale for the Nutrition Impact and Positive Practice (NIPP) Approach

The 2016 edition of the Global Nutrition Report estimates that 159 million children are stunted (1 out of every 4 children) and 50 million are wasted, of which 16 million are severely wasted globally. According to the 2008 and 2013 Lancet Series on Maternal and Child Undernutrition, the risks related to undernutrition and suboptimum breastfeeding practices on mortality and disease are huge. Indeed, 45% of deaths among children aged under five years are attributable to undernutrition. Combined, it is estimated that stunting, wasting and intra-uterine growth restriction and deficiencies in key micronutrients, are responsible for ~3.1 million deaths and 21% of disability-adjusted life years (DALYs) for children under five years of age, every year. Sub-optimal breastfeeding was estimated to be responsible for 1.4 million child deaths and 10% of DALYs in children under five.

Severe wasting during the first 24 months of life leads to a loss of up to 18 points of an individual’s expected intelligence quotient score and thus reduced income generating potential due to an impeded ability to learn. Episodic bouts of wasting or prolonged undernutrition also result in stunting, subsequently reducing an individual’s ability to perform physical labour. This negative impact on the physical and mental potential have long lasting consequences for survivors, trapping them in an inter-generational cycle of poverty, whereby undernutrition is estimated to reduce an adult’s annual income by an average of 22%\(^2\), national economic advancement by at least 8%\(^3\) and diminish national productivity, costing countries as much as 3% of their gross domestic product.

Currently, many nutritional programmes focus solely on the curative element of malnutrition. However, the above findings make a compelling case for the implementation of interventions that, as well as improving the nutritional status of those already malnourished, also focus more holistically on attempting to ‘prevent’ the occurrence of malnutrition in the first instance, through changes in behaviour and practice.

Thus, where malnutrition is an identified problem within a community, working with communities and individual families (both men and women) to identify key causes of malnutrition and subsequently find viable solutions, are essential tools in the battle against such an ever present illness.
What are NIPP circles?

Nutrition Impact and Positive Practice (NIPP) circles are male and female gatherings of community members who meet on a regular basis for a recommended period of 12 weeks to share and practice positive behaviours. NIPP circles aim to improve the nutrition security and care practices of households (HH) either affected by, or at risk of suffering from malnutrition, through participatory nutrition/health learning (including hygiene-sanitation) and diet diversity promotion (including small-scale agricultural production). The circles aim to facilitate knowledge and skills sharing of both men and women using locally available resources with discussion, practical exercises and positive reinforcement to help families adopt sustainable, positive behaviours. The concept is focused around there being easy and viable solutions accessible to all participating families.

To ensure a holistic approach, the circles provide participants with knowledge and skills through 3 main components, including a package of ‘must-have’ or ‘non-negotiable’ extras:

1. **Practical behaviour change sessions**
   - focused on key causes of malnutrition for improved awareness and practice. These sessions also include ‘non-negotiable’ activities which sessions must cover if they are absent from communities:
     - fabrication and use of local hand-washing facilities with soap or ash,
     - fabrication and use of simple latrines using local materials only,
     - fabrication and use of fuel efficient stoves (FES),
     - practical demonstration on food processing, preservation and storage,
     - plus any other feasible and useful initiatives, such as drying racks, rubbish pits, etc.
   - Lastly, all participants are requested to bring Health/Vaccination-Growth Monitoring Cards (children and mothers), to enable NIPP volunteers to promote and support timely health seeking behaviours.

2. **Micro-gardening**
   - For improved HH nutrition security

3. **Participatory cooking demonstrations**
   - For improved nutritional status, feeding and care practices
What is Positive Deviance?

The term ‘Positive Deviance’ (PD) was first coined in the mid-1980’s by Gretchen Berggren in light of numerous studies throughout the 60’s and 70’s that focused on individuals who were apparently healthy, whilst consuming diets which seemed to be restricted. PD in nutrition describes children who grow and develop adequately in poor families and communities, where a high number of children are malnourished and frequently ill. The well-nourished children are positive deviant children, in positive deviant families. The theory is that these families have developed culturally appropriate positive practices that enable them to succeed in spite of their poverty. The idea is based on the premise that solutions to problems either already exist within the community or can be introduced with relative ease. Using indigenous knowledge also guarantees that the intervention is culturally acceptable.

Objectives and framework of the NIPP approach

Aim
To reduce rates of malnutrition with a primary focus on acute malnutrition and/or chronic malnutrition in target communities, concentrating on women, infants and young children and other at risk groups.

Note: As the initiative looks to tackle a package of the underlying causes of malnutrition, a reduction in rates of malnutrition may be achieved through the community-based treatment of Moderate Acute Malnutrition (MAM), community-based prevention of MAM, potential community-based prevention and rehabilitation (over a longer timeframe) of stunting, and potential prevention of Low Birthweight (due to Intra-Uterine Growth Restriction) and/or micronutrient issues.

Specific objectives
Through positive and sustained behaviour change we hope to:

1. Improve the nutritional status of targeted individuals with confirmed malnutrition.
2. Improve families’ understanding of why malnutrition occurs in high risk individuals and what can be done to prevent future episodes.
3. Improve diet diversity, and thus nutritional repleteness, of participating HHs.
4. Sustain improvements in HH care practices (including hygiene-sanitation), feeding practices and health-seeking behaviours for infants, children, pregnant or lactating women (PLW) and the chronically ill (CI).

Outputs
1. Establishment of volunteer peer-led NIPP Circles within the target community for as long as support is required.
2. Improved familial knowledge (men and women) of optimal breastfeeding, complementary feeding, appropriate maternal and CI feeding practices.
3. Circle participants demonstrating practical ways to improve the nutritional status of family members using local knowledge and resources i.e. establishment of micro-gardens, hand-washing and latrine facilities, use of FES.
4. Increased HH use of high energy, nutrient-rich and diverse foods for complementary feeding (for children below 2 years) and supplementary feeding (for PLW, CI, and children above 2 years), using affordable, available and accessible local ingredients.
Methodology

The NIPP circle model identifies key causes of malnutrition within the community. The PD approach is then used to identify parents or caretakers from well-nourished, but equally poor households. Their knowledge of successful behaviours and practices are then harnessed and honed, reinforced, and transferred to HHs with ‘at-risk’ members through the forum provided by the NIPP circle. To promote sustainability, NIPP circles are led by trained volunteers from positive deviant HHs in the communities. NIPP volunteers facilitate a series of fun, interactive and engaging sessions using peer-led education; not only inducing and reinforcing positive behaviour change but also replacing negative practices.

It is understood in many cultural settings, that women are often not the sole decision makers regarding family food, HH sanitation and hygiene, child care, family feeding practices, etc.; although they are often the primary implementers. Men, mothers-in-law, elders, traditional healers, community leaders, religious heads and others, all play a role in determining what are deemed acceptable practices within a community. Consequently, NIPP circles not only address women (as primary carers), but also engage others who play influential roles in their day-to-day life. Each "macro circle" is broken down into three separate tailored circles: females, male representatives from the same targeted HHs, and key community figures. By maximising transparency, we can try to ensure understanding and acceptance of new behaviours and/or changes to HH routines. This will help sustain positive behaviour change.

The duration of NIPP circle cycles and session lengths are based on flexible timeframes to best suit the context and the participants and to ensure attendance is maintained. It is possible for the NIPP approach to be run as a short cycle project (i.e. 2wks) with daily sessions when linked to facility-based nutrition programs with a rapid turnover, i.e. Community Management of Acute Malnutrition (CMAM). Conversely where the influx of beneficiaries can be drip fed at a slower rate, NIPP can be run as a longer cycle (i.e. 12 weeks) with sessions 3 times a week (this is the most common design used). Irrespective of the form, the aim of the initiative is to elicit positive behaviour change.
between 10-15 female primary carers and/or elders from target HHs should be invited to each circle. They should be hosted by a female PD trained volunteer from the community, at a time that is most suitable to all (in rural settings this may vary during the planting and harvest seasons). Each session will cover all of the 3 main components: 1) Behaviour change communication and counselling, 2) Micro-gardening, 3) Cooking demonstrations PLUS the non-negotiables.

between 10-15 fathers, brothers and/or other influential male family members who play a role in determining what practices can and/or cannot be employed within the targeted homesteads should be invited to each circle. They should be led by dynamic and trained male volunteers and cover the same major topics the women will focus on, using tailored gender-sensitive ‘hooks’ to stimulate interest and support. Male participants will not necessarily ‘have’ to undertake cooking demonstration or micro-gardening practical, although it is completely feasible that men may want to become involved in either or both elements, and this should be actively encouraged. The sessions will focus on ensuring that male HH members understand and support female HH members to make positive changes for their families.

these might include traditional healers, key community representatives and community leaders, influential religious figures, respected elders, etc. Strong candidates of either sex should be selected to conduct circle sessions attended by key community figures. These sessions should introduce core topics included in both women’s and men’s circle sessions and discuss key practices that will be reinforced for both men and women in the homestead. They should also include education and practical demonstrations on simple nutritional screening techniques, signs used to help identify malnutrition, and the responsibilities of key individuals (including those participating) to refer at-risk members of the community to either CMAM programme or NIPP circles.
The number of NIPP circles per community is dependent on both its size and the number of positive and negative deviant HHs identified. The more negative deviant HHs identified, the greater the need for more circles. However, the number of circles being formed is dependent on there being a positive deviant HH available and willing to host the sessions.

Note: As with all educational programmes, limiting the number of participants, provides a “safe” environment in which relationships can be built and ensures that individuals have an equal opportunity to participate in all activities. Experience has shown that the female sessions are most successful when limited to fifteen caregivers, with ten to fifteen being an ideal number. If the beneficiary case-load is high, there can be more than one circle at one time in a community.

Note: The timings and timeframes for circles are flexible and should be adapted to individual settings as appropriate. Participants themselves can help guide the length and duration of sessions to ensure attendance is maintained.

Criteria for implementation: Assessing the suitability of NIPP for the context

NIPP circles may not be appropriate in all settings: You must be able to answer ‘Yes’ to boxes 1-7 below in order for NIPP to be deemed suitable for implementation:

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<tbody>
<tr>
<td>1</td>
<td>Are causes of malnutrition centred on either use of negative practices or a lack of positive practices?</td>
<td>Yes/No</td>
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<td>2</td>
<td>Is there basic food security, meaning access to and availability of an adequate, basic HH food-basket? As the NIPP project only addresses smaller scale HH diet diversity and thus ‘nutrition security’, if a community suffers from wider ‘food insecurity’ some degree of malnutrition will inevitably persist.</td>
<td>Yes/No</td>
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<td>3</td>
<td>Is there basic water access to ensure that simple hygiene and sanitation can be practiced?</td>
<td>Yes/No</td>
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<td>4</td>
<td>Is there physical security and access to ensure that groups can meet on a regular basis? If displacement is common due to insecurity or access is poor i.e. during rainy seasons, NIPP circles should not be planned for implementation during periods when interruptions are likely to occur.</td>
<td>Yes/No</td>
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<td>5</td>
<td>It is advised for the implementing body to have conducted a capacity assessment to determine the following: a) Are there adequate staff numbers to support the project? b) Do staff have the requisite capability to train and support volunteers and their participants, collect the requisite Monitoring Evaluation Accountability and Learning (MEAL) data and act on MEAL data to modify the initiative as necessary?</td>
<td>Yes/No</td>
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<td>6</td>
<td>Have positive deviance HHs been identified within target communities?</td>
<td>Yes/No</td>
<td></td>
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<td>7</td>
<td>Is there suitable community cohesion, whereby positive deviant volunteers will be willing to act as circle leaders to promote positive, peer-led behaviour change?</td>
<td>Yes/No</td>
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Note: Although not a pre-requisite, basic literacy/numeracy of the target population is a huge advantage, as sessions can be more detailed with higher levels of education.

Note: Prior to implementation, information should be collated from all the organisations running or supporting community-based programmes in the target area, to ascertain what ‘incentives’ are currently being provided or are planned for provision. Organisations distributing hand-outs have the potential to completely undermine voluntary participation. Therefore the assessment of whether this is a significant risk that cannot be overcome, needs careful review.

Note: To date, GOAL have found that NIPP circle cycles work best with around a three month gap between cycles, to enable teams sufficient time to collect post-implementation data and undertake the preparatory work required to establish new circles. In addition, if target communities have periods during the year where IGAs become particularly labour intensive, it is best to schedule NIPP circle cycles outside of these times, otherwise attendance will likely be poor and outcomes difficult to achieve.

Behaviour change to address the core components

Behaviour change is notoriously hard to elicit.

Added to which, many target beneficiaries may be innumerate and/or illiterate, with limited memory retention for large amounts of verbal information. As such, circles aim to reinforce positive practices through practical demonstrations and active participation. Circles replace the more staid and commonly used approach of ‘preach and we expect beneficiaries to practice’, which does not yield good results. People learn better by doing, compared to listening and reading. Therefore, positive behaviours will be practiced, reinforced, discussed and repeated to maximise chances of the desired behaviour being adopted at home. Repetitive, practical sessions are deemed essential to the success of the NIPP approach.

Methods used to elicit behaviour change

Numerous studies have been conducted, looking at the outcomes of different methods of education. In 1994 one such study by Dr J. Vella discovered learners remember more when visuals are used to support the verbal presentation, but best when they practice the new skill. She noted, ‘We remember 20% of what we hear, 40% of what we hear and see and 80% of what we hear, see and do’. As such, sessions should always include interactive techniques and methods to help participants remember the desired positive behaviour such as:

a. Group discussions: provide a platform for exchanging opinions, and increase tolerance and understanding.

b. Peer led sessions: sharing of knowledge and experience within the community, leads to greater chance of peers adopting the positive practices and skills.

c. Practical demonstrations: people learn best by doing, therefore physically practicing and repeating positive behaviours serves to (i) positively reinforce the behaviour by giving the participants confidence that they are able to carry it out at home and (ii) provides a longer lasting memory of the
behaviour, so the participants are more likely to remember it when they return home.
d. Role plays: facts and opinions can be presented from different viewpoints on diverse issues.
e. Posters / flash cards: these are simple to produce, can be prepared locally and can be used as visual aids to help people identify positive/negative behaviours, or can be used in games to facilitate learning. They can also be produced as take home cards (if a sustainable funding source is identified), to help people remember core topics.
f. Songs: clear and simple messages can be conveyed, whereby repetition helps to reinforce newly introduced messages and practices.
g. Puppets / marionettes: they are sometimes a good way for people to express their feelings indirectly about a topic. They allow people to talk about subjects that they are usually less comfortable discussing and work through possible ways to tackle more sensitive issues. GOAL has done work in Niger using this method of communication and behaviour change with great success.
h. Games: they make sessions fun and engaging. They create a relaxed learning environment and make learning enjoyable. GOAL have used games in behaviour change programmes with very positive outcomes, including examples such as picture flash-cards and snakes and ladders in both Malawi and North Sudan.
i. Site visits: group visits may be conducted to the market to illustrate to both male and female participants the variety of different foods available for consumption within the region. Similarly, home visits to different homesteads may be conducted to view progress of different initiatives. This will help to positively encourage adoption and maintenance of various positive practices.
j. Drawing: using drawing enables people (particularly those who are illiterate and/or innumerate) to illustrate different ways of remembering things. This is particularly useful when both men and women participants are being taught different types of high energy, micro-nutrient rich recipes. Instead of detailing a list of ingredients, they can draw images of the different types of foods that have gone into the recipe and provide indications of the quantities using simple techniques.
k. Testimonials: testimonials from respected individuals have proven to be a highly impactful way of sharing experiences and thus motivating people across many diverse cultures.

Note: For the provision of inputs such as pencils and paper (in the case of drawing), which would need replenishment after each circle cycle, the local administration, key community figures or relevant associated ministry departments should be contacted to try to provide this type of low cost input, to ensure sustainability.
Design and Implementation of Nutrition Impact and Positive Practice Approach

Reference note: For this section refer to “Annex 0 - Programme planning tools” which includes:
- Annex 0.0 Activity plan: guide
- Annex 0.1 Costing tool: guide

The “NIPP activity plan” template has been elaborated to help programme officers plan and monitor the implementation of the main NIPP activities. This is found within Annex 0.0. Additionally, a costing tool guiding the elaboration of a budget for the implementation of the NIPP approach can be found in Annex 0.1.

Establishment of NIPP circles should follow these key stages:

1. Identify suitable implementing partner(s) to work with and communities to work in
   a. Assess whether NIPP circles are suited to the context - as per the outline under part 1.
   b. Strive to identify a long term partner prior to commencing, who can implement the NIPP approach prospectively and continue to actively support and encourage circles after funding ceases. This may be the Ministry of Health (MoH) Community Outreach Department (or equivalent) and/or an appropriate local based NGO/CBO/volunteer group etc. This will add an additional element of sustainability to the project, safeguarding longer term support for HHs in tackling malnutrition and thus will continue to improve coverage. If however there are no viable partners identified, the implementing bodies may support the implementation of peer-led NIPP circles themselves. As one of the main direct objectives is to try to achieve ‘sustainable improvements in HH care and feeding practices’, at least the impacts in those HHs already targeted should be durable.
   c. Identify with the partner (if applicable), target communities where malnutrition is an identified persistent problem. This may include communities with high rates of either acute or chronic malnutrition, or both.
   d. Assess whether NIPP circles (trying to elicit positive BC) could work in the target community, through discussions with the MoH, key community figures and lay-representatives from the selected community. If it is deemed to be a viable initiative, it is essential to ensure that the community are actively engaged. In order to set the right tone within target villages, appropriate community sensitization at the outset of the project is critically important. The project is reliant on people’s desire to change, so if there is little community buy-in, the team should look to work in another village. First off, any assumed need for inputs such as refreshments, cash, food or other such tangible ‘incentives’ should be conveyed as unnecessary and negative, rather pride and self-reliance should be promoted. The implementing body must then identify ‘hooks’ in order to capture people’s interest through perceived benefits to the family or reduction in negative consequences. These will likely differ between men and women, i.e. men may be more interested in financial gains, such as a reduced loss of earnings from malnutrition induced illness, or well-nourished children having increased earning potential when older. For the women, motivation may be derived from a reduced risk of infant or child illness/death, fewer sick-days off school, increased intellectual capacity etc. The team should plan...
to revisit community discussions on a periodic basis, to maintain the right attitude, whereby future sessions can start to use the likes of positive testimonies.

e. Request the support of community leaders and a village health committee (if established) to facilitate screening, recruitment of NIPP volunteers, conducting market price assessments, possibly contributing materials and utensils to NIPP volunteer hosts (where necessary), assuring that eligible men/women attend the circle sessions regularly, and encouraging other community members to support families in adopting new practices.

f. With the help of village leaders during planning, if there is to be more than 1 circle/village, ensure different locations are identified within the community, to allow access to as wide a number of HHs as possible. Teams should start by focusing on areas thought to be most notably affected by malnutrition. These may be decided upon with the help of community health workers, using outpatient therapeutic programme (OTP) admission records (assuming coverage is known to be good) - highlighting areas with high severe acute malnutrition (SAM) rates, GMP records from health facilities - showing areas with high rates of undernutrition and/or stunting, or using screening results - showing either depending on type of screening.

g. Establish whether it is feasible for female circles to be run from the NIPP volunteer’s home, where cooking demonstrations can be conducted easily. If the homestead does not lend itself to gatherings, find alternative locations i.e. under a nearby tree. Male circles should be organised in a similar fashion. Community circles may be carried out in a school, administrative building, health centre or village leader’s homestead.

h. Ensure all involved parties are absolutely clear that the NIPP project does NOT provide any incentives or materials that might need replenishing and the reasons why this is so. The only material provisions deemed acceptable are information, education and communication (IEC) materials or/and behaviour change communication (BCC) materials, memory aids especially in contexts with poor literacy levels and starter-seed packs (see section 7). If ‘exceptional’ cases are encountered, where NIPP participants/communities show a real commitment to the project, but cannot access basic materials such as floor mats or large cooking pots and it is deemed the circles will fail as a result, it may be necessary to intervene. In such cases, it is suggested that the implementing body requests support from the village committees or community leaders, to try to source the necessary tools or materials themselves, further promoting community ownership.

Conduct formative research and subsequent actions

As part of the inception phase, formative research should be carried out to explore the behaviours of the local population in terms of care, feeding and sanitation practices, access to foods, food use and storage, livelihoods and other relevant topics. This can then be used to tailor the ‘core’ topics covered in the NIPP circle sessions (see below).

2.1 Situational analysis

Most countries periodically carry out Multiple Indicator Cluster Survey (MICS) or Knowledge, Attitude, Practice and Behaviour (KAPB) surveys. Findings from these surveys can be used to help identify key nutrition and health ‘problems’ in the target communities, such as poor adherence to exclusive breastfeeding (EBF) in infants under six months, early introduction of complementary foods, inappropriate hygiene and sanitation practices or poor ante-natal care/post-natal care (ANC/PNC) attendance, etc. To supplement this information, or in cases where this information is not available, focus group discussions (FGDs) should be carried out to help identify actual current practices being employed. This includes
infant and young children feeding (IYCF) and PLW feeding practices, CI feeding practices, male feeding practices, HH health seeking behaviour practices including ANC/PNC visits, use of mosquito nets, HH hygiene and sanitation practices, cooking practices, food use and storage practices, use of FES, income generating activity (IGA) practices, farming methods and types of crop production, crop use (sale or home consumption), market access, types and cost of foods bought/sold, etc. FGDs should ideally continue to run until a pattern emerges from the responses, but 3 to 4 sessions per district or county should be sufficient. There should ideally be between 6 to 10 participants per FGD, with similar characteristics in terms of gender, socio-economic background and age range to facilitate discussion and analysis. FGDs should last between 1 to 2 hours. Information from the FGDs can be categorized into themes and used to decide on the key behaviours that will be investigated by a barrier analysis (BA) and later addressed in the NIPP circles. BA will only be conducted on a limited number of what are perceived to be the prioritised ‘significant’ behaviours.

2.2 Barrier analysis and Designing for behaviour change frameworks

Only a limited number of what are perceived to be the prioritised ‘significant’ behaviours will be selected for further investigation by a BA. Each behaviour will be inserted into a designing for behaviour change (DBC) framework.

The frameworks use a systematic process of:

a. Identifying the positive behaviour you want to promote
b. Detailing the priority and influencing groups
c. Identifying the determinants of the behaviour
d. Listing what it is we want to achieve
e. Brainstorming what needs to be done to accomplish these achievements and design activities that might deliver these achievements.

BA is a type of rapid assessment tool used for step c) to identity the range of behavioural determinants associated with a particular behaviour. BA compare two groups of people: those who currently do the behaviour (doers) and those who do not (non-doers). It focuses on up to twelve determinants including perceived susceptibility, perceived severity, perceived action efficacy, perceived social acceptability, perceived self-efficacy, cues for action, perception of divine will, perceived cultural taboos, and positive and negative attributes of the action or behaviour. The differences in the two groups can tell us the main barriers to carrying out a particular behaviour. Once we understand this, the messages and associated activities can be tailored to have a maximum impact on reinforcing positive behaviour change.

Note: If you have not conducted a BA before, please request assistance from GOAL’s technical team or engage a consultant for training. Further information on BA can be found at: http://barrieranalysis.fhi.net/.

In the final step of each DBC framework, where activities to be undertaken during NIPP circle sessions are designed, be they in the form of a demonstration, role play, game etc., teams must think outside of the box. If the same activities that have been used time and again are churned out, the project will have limited impact. If however, innovative, interesting, engaging and fun activities are designed; the ability to effect positive behaviour change will be enormously elevated. Do not rush this process. The activities designed for the NIPP volunteers to carry out with their participants during the sessions underpin the success of the project.
2.3 Subsequent actions

Once malnutrition causes and viable solutions have been discussed and designed, the implementing body will need to:

a. List priority topics to be covered in male and female NIPP circles and insert these into the volunteer training plan (see section 4.0). Note: if target communities are not homogeneous, topics may vary depending on causes of malnutrition and local resources available to tackle them.
b. Create a detailed NIPP volunteer sessions guide for the duration of the full NIPP cycle (usually 12 weeks)
c. Adapt or commission the design of appropriate IEC/BCC materials or memory aids to be used by NIPP volunteers. Materials should be engaging. They must involve participatory methods and should help to reinforce the desired behaviour. Please ensure that as a minimum ‘food flash cards’ are prepared (see section 7 for photo examples).
d. Field test all IEC/BCC materials and memory aids. Once they have been successful tested, place the full order.
e. Conduct a market survey and observation visits to local homesteads to determine the full range of foods available, accessible and affordable – either grown or purchased.
f. Using this information gathered in step e), pilot a variety of high energy nutrient rich recipes, check compositions and select an assortment for the NIPP circle sessions (see section 7.3).

Identify NIPP Circle Volunteers

Reference note: For this section refer to “Annex 1 - NIPP volunteer information” which includes:

- Annex 1.0 (a/b/c) NIPP volunteer Terms of reference (female/ male/ community)
- Annex 1.1 NIPP volunteer agreement

The implementing body should work with key community figures to identify positive deviant HHs with individuals willing to act as NIPP volunteers. The community themselves with the aid of community leaders will be able to identify HHs with well-nourished individuals practising good behaviours, such as hand-washing, clean HH environment, good health seeking behaviour practices, etc. It is important that the positive deviant HHs selected are not any more affluent than the negative deviants in the community (who will be admitted to the NIPP circles). From experience, GOAL have found that if the community members themselves are given the responsibility of selecting the most popular positive deviant volunteers, participation significantly improves and defaulting reduces. The implementing body should visit the identified HHs to verify that they are positive deviant HHs and verify that members are willing to become NIPP volunteers.

Note: both the female and male member of the positive deviant HH may be suitable and willing to volunteer, or indeed only one party, this will depend on individual HHs.

NIPP volunteer hosts do not receive any remuneration for their work, and as such should only be expected to lead one, possibly two full NIPP circles in their community, unless they are actively willing to undertake more. For budgeting purpose, it is advised that enough funds are allocated to conduct trainings for new male and female NIPP volunteers after each cycle, as we cannot guarantee they will be willing or able to support subsequent cycles.
It is also recommended that at least two volunteers are recruited and trained for each of the male and female NIPP circles to mitigate potential drop-outs and to help with workload sharing if necessary. You may have a situation where the two volunteers choose to undertake the first cycle together and then take it in turns thereafter to undertake a subsequent cycle each – this will be very context specific. Selection of suitable candidates as NIPP volunteers should be based on the following:

Characteristics of NIPP volunteers

1. The household should display positive deviance characteristics i.e. having well-nourished children (can be grown up) who are clean and predominantly healthy despite being affected by the same socio-economic conditions as their neighbours, employing good hygiene and sanitation practices and employ active health seeking practices.
2. The candidates selected should have a thorough understanding of what they are agreeing to undertake and a willingness and commitment to continue running NIPP circles within their community for the duration of at least one full cycle.
3. Candidates with previous volunteering and/or community work should be considered favourably, as this indicates the right frame-of-mind and hopefully a commitment to development work.
4. Candidates should have an ability to communicate and engage with village members. The more dynamic, interesting and fun an individual is, the better the chance of eliciting positive behaviour change in their peers.
5. Volunteers should be selected by the community as this is likely to significantly increase participation and reduce drop out.

- Female volunteers should be selected to host circles for mothers / carers / influential females in target HHs.
- Male volunteers should be selected to lead circles for the males from the same target HHs as female participants.
- Strong candidates of either sex should be selected to conduct circle sessions attended by key community figures.

Once volunteers are selected, they should be provided with locally adapted terms of reference and sign the volunteer agreement. Examples of these can be found in Annex 1.0, which should be adapted with country specific information.

3.1 Issues surrounding volunteer incentivisation

Sadly, many communities in Africa who previously prided themselves on having excellent community volunteering systems, now no longer have these structures, in many cases as a direct result of international organisations employing a ‘pay for a quick fix’ philosophy. As such, although this is a harder route to take and this requires much more dialogue, planning and initial support, the implementing body should always strive to secure true volunteers. The exchange of money or incentives would undermine any sense of real community ownership, the potential sustainability of learned actions and the ethos of communities being able to help themselves and each other to improve their quality of life that the project strives to build.
NIPP circle volunteers should however receive payment from the implementing body for training days, by way of remuneration for loss of earnings. The implementing body may however advocate for the use of these dedicated, community spirited individuals in other remunerated activities, such as government health campaigns which would provide a small form of repetitive income. Other motivators might include
recognition within the community (volunteer open days or recognition days), or small inducements through sustainable means such as soap through local administration/ministry departments. In some contexts, communities themselves have chosen to remunerate volunteers, e.g. in Niger for example, locally collected taxes have been used by the district mayor to provide a small financial incentive and in Malawi, the volunteers were given “labour days”, when the community worked for free on the volunteers’ land. Other incentives might include donations of flour, grain or small livestock through a collective community mechanism driven by local leaders.

4 Train NIPP Circle Volunteers

Reference note: For this section refer to “Annex 2 - Training and pre-implementation materials” which includes:

- Annex 2.0 Training agenda
- Annex 2.1 Volunteer certificates
- Annex 2.2 Materials needed for NIPP circles
- Annex 2.3 Instructions for NIPP volunteers training on the admission of infants under six months
- Annex 2.4 Instructions for NIPP volunteers training on nutritional assessment
- Annex 2.5 Important pre-implementation issues

Training plans should be designed for both male and female NIPP volunteers. In recognition of the fact that there are different gender roles within the HH and the wider community, the majority of the volunteer training should be split into two separate, concurrent groups following the same syllabus. Males and females should be taught/engaged separately, using messages and activities that appeal to their respective genders. However, many of the practical sessions (i.e. the building and maintenance of micro-gardens, FES, food processing, preservation and storage, hand-washing facilities, HH latrines, etc.) can be undertaken jointly in the interest of time, resources, skill-sharing, etc. Again, if separate messages want to be given in conjunction with these practical sessions, the men can be corralled together at intervals to discuss specific motivational issues and the same with the females.

It is advised that the overall training workshop is split into two phases: a preliminary phase whereby all the NIPP volunteers assume the role of the circle participants and are trained by the implementing body in collaboration with MoH support staff, then a second phase whereby the volunteers become the circle lead and practice leading sessions themselves.

Both male and female NIPP volunteers, assisted by the implementing body, will work through a training agenda of approximately 2 weeks. Annex 2.0 provides an example of a template that can be adapted as appropriate. It is advised however that the training includes:

- an outline of the project objectives and the desired impacts the participants should be able to achieve
- the role of the NIPP volunteer
- an introduction to malnutrition and the various problems and key causes in their communities
- discussion of positive and negative practices within their community
- identification of key positive practices that should be promoted
- role play of all of the circle sessions to be conducted by NIPP volunteers, practicing use of any of the IEC/BCC materials and memory aids developed
- conduct sessions on how to role play with participants and work on negotiation skills.
Try using the following communication and counselling steps: Ask, Listen, Identify problem, Discuss, Recommend and Agree (ALIDRA), then practice with NIPP circle volunteers on the basis of possible situations that might arise.

NIPP volunteers should also be trained on completing the attendance sheet (see section 9), on measuring mid-upper arm circumference (MUAC) for children under five years and PLW, on understanding ‘Road to Health’ growth charts and how to enter information into the attendance sheet. The importance of referrals should be highlighted, especially through MUAC measurements in children.

Further information related to behaviour change methods and key messages which could be used in the training session is found in Annex 3.0.

4.1 Traits of a good NIPP circle volunteer to be developed during the training

People will learn best from a peer, with whom they feel comfortable and who understands local customs. The following skills will also help volunteers when supporting sessions and should be encouraged during the second phase of the training session:

- Ability to welcome all who are attending and to invite each participant to introduce themselves in order to create a comfortable atmosphere for experience sharing
- Ability to briefly introduce the session topic and to explain the objective of the session
- Ability to present new information slowly and to ask questions in order to generate discussions
- Ability to encourage quieter participants to talk and give their opinions
- Ability to make sure that all sessions are fun, engaging, interesting and most important, participatory
- Ability to ensure at the end of the session that everyone understands the positive behaviour to be employed at home and ensures that each participant can describe how to make the high energy recipe for the day.

Identify NIPP Circle Participants

Key community members within the village should be invited to join the introductory community circles. These might include traditional healers, key community representatives and leaders, influential religious figures, respected elderly, etc. Amongst other things, they will discuss ways in which they can support families to improve HH health and nutrition.

In order to identify priority HHs, a nutritional screening exercise will need to be undertaken in the community. This can be conducted either through a local health facility (whereby all children under five years and PLW can be called to attend GMP/screening), or a mass screening can be undertaken. Mass screenings are often undertaken at the same time as child health or expanded programme on immunization (EPI) days, during which vaccination, de-worming and micronutrient supplementation also occurs. However, if these are not viable, one-off screenings can also be arranged at minimal cost in the target catchment area, but it is important to ensure good community participation through widespread information dissemination. The purpose of the screening is to identify HHs with family members suffering from malnutrition. In order to assess wasting, MUAC tapes should be provided where possible by the MoH, if not available the implementing body will need to provide these. The child’s ‘Road to Health’ cards (or equivalent health/growth records) can also be used during screening – these are particularly useful in settings with low rates of acute malnutrition but high rates of stunting. If the Weight-for-Age (WFA) or Height-for-Age (HFA) index on the card shows <80% of the median or z-scores <-2 standard deviation (SD), or if the growth chart indicates
that the child has had static weight for three or more consecutive recordings over the last two months, they should be recommended for participation in the nearest NIPP circle. Note: most countries conducting growth monitoring use WFA (undernutrition), but some countries with high rates of chronic malnutrition have also now started including HFA to assess stunting and others may collect Weight-for-Height (WFH) to assess wasting. Thus, all these anthropometric indexes have been included as viable admission criteria into NIPP circles (see below).

OTP discharges are also classified as ‘high risk’ individuals, therefore, to identify OTP discharges, consult with health facilities and request referrals of cured OTP discharges to NIPP circles operating in the area. To identify other categories of NIPP circle participants (CI, multiple births) conduct community sensitisation so key community figures can help to actively identify HHs who qualify based on this criteria.

To identify OTP discharges, consult with health facilities and request referrals of cured OTP discharges to NIPP circles operating in the area. To identify other categories of NIPP circle participants (CI, multiple births) conduct community sensitisation so key community figures can help to actively identify HHs who qualify based on this criteria.

**5.1 Prioritisation of targets**

In order to ensure the highest risk cases are selected for inclusion, targets should be prioritised (where possible) according to the following criteria in order of descending priority:

1. HHs with children <24 months with identified MAM: HH with infants <2 months who are visibly thin but still have an appetite for breastmilk; children 2-5 months with MUAC <110mm; children 6-23 months with MUAC >115mm and <125mm and or referrals from health facilities with MAM
2. HHs with older children 24-59 months with identified MAM: MUAC > 115mm and <125mm or referrals from health facilities with MAM (WFH) or static weight for more than 3 consecutive recordings.
3. HHs with PLW with identified MAM: MUAC <230mm. Note: cut offs may alter slightly from country to country (MUAC <210mm), use the appropriate cut offs for your setting.
4. HHs with children who have recently been discharged from OTP: regardless of age or anthropometric status, clearly there has been a serious issue with malnutrition where cause(s) need to be identified and tackled.
5. HHs with children <24 months with identified chronic malnutrition: HFA z-scores <-2SD based on road to health charts.
6. HH with children 24-59 months with identified chronic malnutrition: HFA z-scores <-2SD based on road to health charts.
7. HHs with children undernourished: WFA z-scores <-2SD or static weight for more than 3 consecutive recordings.
8. HHs with CI who are susceptible to malnutrition and would benefit from NIPP, including those with HIV.
9. HHs with twins or multiple births.
10. HHs with PLW who are non-MAM but keen to learn in order to try to prevent prospective malnutrition in their HH.
11. HHs who display a real interest in participating, in order to learn how best to care for their infants and children.

Upon completion of the screening exercise, the implementing body and NIPP volunteers should select and prioritise 10-15 negative deviant HHs from the target criteria outlined above and invite the primary female carer(s) to join a female circle and male members from the same HH to join parallel sessions in the male circle.
Rationale for prioritisation: adequate and appropriate nutrition from conception until 24 months (first 1000 days of life) is absolutely critical to ensure a child’s health, growth and neurological development. Conversely, poor nutrition associated with poor hygiene and sanitation, in addition to episodes of common illness such as diarrhoea, can result in growth faltering (wasting and stunting), micronutrient deficiencies (with a range of individual problems) and reduced intellectual capacity. Luckily however, we have a therapeutic window, termed the ‘window of opportunity’ from conception until 24 months, whereby the provision of adequate and sustained nutrition can completely reverse the deleterious effects of prolonged or episodic post-partum malnutrition. Therefore small children and PLW are given ultimate priority, followed by those at greatest risk in descending order.

Enrolment to the programme must be voluntary, and the participants must know what enrolment entails and must agree to all aspects prior to admission. This includes the number of sessions they should attend, length of sessions, contributions to cooking demonstrations and expected project outcomes and timeline. Detailed admission and discharge criteria are outlined below.

### 5.2 Admission and discharge criteria for NIPP circles

<table>
<thead>
<tr>
<th>Admission criteria into female circles</th>
<th>Discharge criteria from female circles</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHs with children with identified moderate malnutrition:</td>
<td>Improved anthropometric status at the end of the NIPP circle cycle AND their career passes the post-test assessment (includes theory &gt;70% post-test result):</td>
</tr>
<tr>
<td>- Infants &lt;2 months visibly thin but with appetite i.e. taking breastmilk</td>
<td>- Infants &lt;2 months no longer visibly thin or with improved status on road to health chart (verified at health facility);</td>
</tr>
<tr>
<td>- Infants 2-6 months with MUAC &lt;110mm with appetite</td>
<td>- MUAC ≥110mm for infants 2-5 months admitted on MUAC;</td>
</tr>
<tr>
<td>- Children 6-59 months with MUAC &gt;115mm and &lt;125mm = MAM</td>
<td>- MUAC ≥125mm for children 6-59 months admitted based on MUAC;</td>
</tr>
<tr>
<td>- Children with WFH &gt;70% and &lt;80% or WFH z-scores &gt;-3SD and &lt;-2SD and referred from a health facility = MAM</td>
<td>- WFH &gt;80% or z-scores &gt;-2SD on the road to health charts for children admitted based on WFH</td>
</tr>
<tr>
<td>- Children with WFA &lt;80%, WFA z-scores &lt;-2SD or growth faltering (static weight for more than 3 consecutive recordings) on their road to health chart (WFA) = Undernourished</td>
<td>Note: For those children admitted based on either WFA (undernutrition) or HFA (stunting), we cannot use anthropometric criteria for successful discharge, only carers passing post-test, as there is likely to be insufficient time for us to potentially reverse the effects of the malnutrition that has manifested itself during a NIPP circle cycle. We should, however, observe some improvement through a positive growth trajectory shown on their road to health chart.</td>
</tr>
<tr>
<td>- Children with HFA &lt;80%, HFA z-scores &lt;-2 or growth faltering (static weight for more than 3 consecutive recordings) on their road to health chart (HFA) = Stunted</td>
<td>- MUAC ≥125mm at the end of the NIPP circle cycle AND</td>
</tr>
<tr>
<td>PLW with MUAC &lt;230mm = MAM.</td>
<td>- Carers pass the post-test assessment (includes theory &gt;70% post-test result)</td>
</tr>
<tr>
<td>Note: check your country’s guidelines as the cut off may differ i.e. MUAC &lt;210mm</td>
<td>Note: if cut-off is 210mm in your country, amend the above discharge criteria accordingly.</td>
</tr>
<tr>
<td>All children recently discharged cured from OTP</td>
<td>- MUAC &gt;230mm for PLW admitted based on MUAC AND</td>
</tr>
<tr>
<td>HHs with CI (including people living with HIV), families with twins or multiple births, families with healthy PLW (non-MAM), families where the primary carers show a keenness to participate to improve their public health nutrition education (PHNE) knowledge</td>
<td>- They pass post-test assessment (includes &gt;70% post-test result)</td>
</tr>
<tr>
<td>- Carers pass the pass post-test assessment (includes theory &gt;70% post-test result)</td>
<td>- MUAC ≥125mm at the end of the NIPP circle cycle AND</td>
</tr>
<tr>
<td>- Carers pass the pass post-test assessment (includes theory &gt;70% post-test result)</td>
<td>- Carers pass the post-test assessment (includes theory &gt;70% post-test result)</td>
</tr>
</tbody>
</table>
5.3 Direct/Indirect beneficiaries

- **Direct beneficiaries**: Female NIPP participants (mothers, carers, grandmothers, PLW, etc.) and male NIPP participants (fathers, uncles, etc.) plus the children enrolled, all of whom are registered in NIPP database. Therefore, the information collected in both the circle monitoring tools (see chapter 9) and subsequently entered into the database should relate to the direct beneficiaries based on admission.

- **Indirect beneficiaries**: any additional children or other members of the HH not registered in the database, other community members involved in the circles including participants of the community NIPP circle, and all volunteers.
Develop timetable and establish NIPP circle sessions

NIPP circle sessions will need to be planned around the normal daily routines of both men and women participating. Timings and duration should be scheduled where compliance is possible and the beneficiaries are happy. Due to the different environments in which circles may be rolled out, timeframes, frequency of meetings and duration of meetings are all flexible and should be adapted to individual settings to maximise attendance and outcomes. The most commonly applied timetable is a cycle of 12 weeks with participants meeting for 2-3 hours, 3 or more times a week. For subsistence farmers, sometimes the frequency and duration of meetings is reduced during planting or harvest periods, or the frequency of meetings is reduced but duration extended during rainy seasons when access is more difficult. If access is projected to be really problematic, or families cannot commit to the requisite time due to other activities, it is advised that NIPP circles are not rolled out, rather scheduled for a more suitable time. Currently, it is advised that each female/male circle should try to achieve at least 72 hours during 36 sessions. Anywhere below 30 sessions and it is projected that problems will occur, both in terms of covering the requisite compliment of topics (given the multi-causal nature of malnutrition), eliciting positive and sustainable BC and subsequently improving nutritional status of those admitted with MAM.

NIPP circles could possibly be used as a stepping stone between emergency and development interventions, whereby there might be a continuous and steady supply of beneficiaries identified for support (i.e. linked to a programme with weekly discharges), it may then be appropriate to reduce the overall duration of the circle cycle to ~2 weeks. In such a scenario, only 2-3 positive/negative behaviours should be selected for address during such a short cycle.

6.1 Female NIPP circles

- Female sessions should be held with the primary female carer and any key female influencers in the HH i.e. grandmothers.
- If doing 2-hour sessions, they should be divided roughly into three 40-minute parts to cover each of the three NIPP components:

  **Part 1**
  Behaviour change communication and counselling:
  circle sessions focus on one of the identified key causes of malnutrition, plus other relevant ‘non-negotiable’ positive behaviours to be replicated at home such as hand-washing, use of latrines, etc.

  **Part 2**
  Micro-gardening:
  for improved nutrition security.

  **Part 3**
  Cooking demonstrations:
  interactive peer guided practical cooking demonstration sessions, conducted at the end of the session. Ideally, 5 different recipes should be selected, and subsequently repeated on a rotational basis i.e. Recipe A is demonstrated every Monday, Recipe B is demonstrated every Wednesday, etc.
6.2 Male NIPP circles

- Male sessions should be held with fathers, brothers and/or other influential male family members who will play a role in determining what practices can or cannot be employed within the homestead.
- Sessions should ideally run in parallel to female sessions and use a similar 3-part agenda, although the duration of each gathering ‘may’ be shorter as some of the practical exercises might only need to be covered in theory, whereas the women (as the primary carers) will need to practice and master new positive behaviours. Note: where males express a desire to be more involved in various practical elements, such as micro-gardens, fuel efficient stove construction or even cooking demonstrations, this should be actively encouraged as job-share activities.
- They should cover the same core topics as the women, but using gender-tailored topics and gender-sensitive information communication tools. Gender-tailored NIPP sessions for male circles may also include topics relevant to routine male activities and interests, as a way of ‘incentivising’ participation e.g. IGA or livestock rearing, messaging focusing on the economic benefits of the new behaviours for the household, and, potentially football game or similar social activity.

6.3 Community members NIPP circles

- Community circles might include community leaders, traditional healers, key community representatives, influential religious figures, respected elders, etc.
- As with the female and male circles, the community circle sessions should be arranged according to the suitability for the circle members, be that a couple of hours a day over 1 week, or a couple of full days.
- The meetings should be used to introduce core topics and practices that will be reinforced in both female and male circles. They should also include education/practical demonstrations on simple nutritional screening techniques, signs used to help identify malnutrition and the responsibilities of key individuals (including those participating) to refer at risk patients to either OTP or NIPP circles.

Main components of the circle sessions

As described above in the formative research section, the compliment of ‘core’ topics selected for NIPP circle sessions will depend on the context in which they are rolled out, the key causes of malnutrition and health issues in the community and viable solutions. The number of topics selected will depend in part on the number and duration of the circles and thus the total number of sessions that will be attended. As outlined above, the Community Member circles will only run for a few days and should comprise of a synopsis of the male/female NIPP circle sessions.

Male and female NIPP circles

Each individual session should be broken down into three parts of around 40 minutes each. The total session should last no longer than 3 hours, ~2 hours is recommended. The length of the session may be influenced by the number of sessions feasible per week. Every session should include ‘practical elements’, no sessions should be entirely theory focused.
7.1 Part one of every session: Behaviour change communication and counselling

Reference note: For this section refer to “Annex 3 - Part 1: Behaviour change communication and counselling” which includes:

- Annex 3.0 Methods for eliciting behaviour change
- Annex 3.1 Nutrition, health and hygiene-sanitation key messages
- Annex 3.2 Fuel efficient stoves
- Annex 3.3 Water-Sanitation-Hygiene (WASH)
- Annex 3.4 Food processing, preservation and storage

During each session, the circle should focus on one ‘core’ topic, (identified through the formative research process) for approximately 40mins. Each session should cover a different topic whereby the list of topics is repeated two or more times over the course of the 12 week (or alternative) circle cycle. The number of topics selected should be determined by the ability of the NIPP volunteers to deliver sessions effectively and the timeframe of the full circle cycle – do not overburden volunteers! For example, 12 topics may be selected; where participants are gathering 3 time per week. This means topics are repeated three times over the 12 week duration of the cycle. Core topics will vary from community to community and will be determined by crucial gaps in participant knowledge and the subsequent behaviour change that needs to be elicited to improve or safeguard nutritional status.

Examples include:

- awareness and signs of malnutrition (acute and chronic);
- availability of foods through markets, the benefits of home gardens and the role of local foods in addressing nutritional needs;
- appropriate maternal nutrition and health during pregnancy and lactation including advocacy to access micro-nutrient supplementation from health facilities, including elimination of cultural practices that limit consumption of a nutritionally adequate diet, reduced risk of low birth weight babies and as such the risk of inter-generational effects of malnutrition;
- EBF during the first 6 months, with practical sessions on infant positioning and promotion of continuing breastfeeding for up to 2 years;
- IYCF including timely introduction of appropriate complimentary foods, adequate number of feeds and active feeding;
- knowledge on how to best spend HH money on healthier more nutritious foods;
- the multiple roles of men in facilitating positive behaviour change etc.

In addition to the ‘core’ topics all NIPP circles must include the following ‘non-negotiables’ unless already in place:

- Fabrication and use of a simple hand-washing point i.e. tippy- tap with ash or soap
- Fabrication and use of local latrines and rubbish pits using indigenous materials only
- Fabrication and use of FES
- Practical demonstrations on food processing, preservation and storage
7.2 Part two of every session: Micro-gardening

Reference note: For this section refer to “Annex 4 - Part 2: Micro-gardening guidance notes” which includes:
- Annex 4.0 Micro-garden guidance and crop input package

This part of the session is dedicated to practical learning around the construction and maintenance of a micro-garden, and lasts around 40 minutes. Participants should be walked through a step-by-step process of how to construct and then maintain a small scale garden, using a model garden at the volunteer HH. They should then be encouraged to replicate what they have learned at home. There are different options for HH micro-gardens, including key-hole gardens, bag gardens, kitchen gardens, etc. You should choose the most appropriate design of garden for the context in which you are working.

Note: for those with limited land available, GOAL can access DVDs from the NGO “Send A Cow”, demonstrating how to make bag gardens [www.vimeo.com/7264277](http://www.vimeo.com/7264277) or key-hole gardens [www.vimeo.com/7262464](http://www.vimeo.com/7262464).

In order to incentivise participants, the circle should plan to visit each other’s gardens on a rotational basis, to provide encouragement and help problem solve if necessary. Please see Annex 4.0 for guidance notes on micro-gardening.

7.3 Part three of every session: Cooking demonstrations

Reference note: For this section refer to “Annex 5 - Part 3: Cooking Demonstration” which includes:
- Annex 5.0 Food selection chart (to aid recipe selection)
- Annex 5.1 Cooking demonstration: recipes template

In order for circle participants to identify the complete range of foods available and accessible in their community, including home grown, market or wild foods, use Food Flash Cards (photo cards showing different locally available and accessible food types). Participants will naturally focus on foods ‘most commonly eaten’, but as diet diversification is often poor, they should be encouraged to identify ‘other’ foods, including available wild foods. Added to which, it should be pointed out, once micro-gardens start
to yield, HHs will also be able to use these foods to diversify meals further. Once all foods are identified, get participants to put foods into appropriate food groups. This way, participants can: a) see the complete range of food types available/accessible to them, b) use the images to make up different recipes (using the Recipe Guide below for reference), and c) identify the different ingredients they will need to contribute as a group, to make each of the selected recipes. In this way carers are taught how to diversify family diets, both between meals and from day-to-day. Each participant should be asked to contribute a different food and quantity each session to facilitate the group recipe demonstration. The NIPP volunteer will need to coordinate this within the group.

During every session, together the participants should prepare high-energy, micronutrient-rich complimentary /supplementary food, taking no longer than 40 minutes. Up to six recipes should be taught in total, then repeatedly demonstrated on a cyclical basis. To maximise chances of participants using recipes at home, the volunteer should evoke discussions around recipes trialled with feedback from the family, etc. They should encourage picture drawing by participants to help them remember the recipe. The volunteer must ensure everyone participates during food preparation, cooking and subsequently feeding of children, PLW and CI. The purpose of this activity is to show carers that they really can afford to feed their families nutritious foods, consequently improving the nutritional status of their family, maintaining it and also helping to prevent future malnutrition. Active involvement promotes ownership and builds self-confidence. Obtaining and bringing foods is practice to reinforce this idea.

Note: in advance of rolling out NIPP circles you should develop multiple sets of country-specific flash-cards as illustrated above. Each NIPP circle will require 3-4 packs of food flash cards so that multiple copies of certain foods are represented.

Please stress that for children with mild or moderate malnutrition and all PLWs, this is a ‘supplementary’ meal to be eaten in addition to their usual daily diets. This ‘extra’ meal is needed in order to improve their nutritional status – in practice, it acts as a sustainable community alternative to a Supplementary Feeding Programme (SFP). Note: infants under six months should NOT be given any supplementary foods promoted in NIPP circles. If they are malnourished, EBF should be advocated and if they are suffering complications they should be referred to the closest health facility for appropriate care according to the national nutrition policies. If specific counselling is required for mothers having breastfeeding problems, they should be referred to the implementing body or to the closest health facility for adequate support. Although the male circles are unlikely to conduct cooking demonstrations, the ingredients necessary should be discussed during their sessions. This is important, as in some cultures/tribes it is the men who access markets and buy weekly HH provisions.
Recipe guide

To help NIPP volunteers select appropriate recipes, one of two methods can be used. The simplest method (as there is more control here) is to develop and field test a number of different recipes (10 for example) during the project inception phase (as noted in section 2.8 ‘Formative Research and Subsequent Actions’). Then NIPP volunteers can present the 10 options to their circle and participants can select preferred recipes to be taught and repeated during the course of the cycle. If however it’s thought this approach will not work, it may be deemed more appropriate for each NIPP circle to design their own recipes using the Food selection chart in Annex 5.0. The chart will need to be adapted to the context to illustrate the full range of foods available and accessible in the immediate environment. If circles come up with their own recipe ideas, the implementing body should check the nutrient content of recipes to ensure they are appropriate. All recipes promoted (using either method) should be documented by the implementing body using the Recipe templates that can be found in Annex 5.1.

Any recipes developed should aim to provide a nutrient-dense meal, sufficient for rapid growth and healthy weight gain. Different countries will suffer from different micronutrient deficiencies. These micronutrients deficiencies should be recognised and addressed through ingredient selection in recipes. It is advised that pureed, mashed or semi-solid foods are prepared, as these will be most easily consumed by all family members in need, including children. The amounts illustrated below are based on WHO estimates for nutrient needs for complementary foods in children 12-23 months (still breastfed). The same may be used for pregnant / lactating women.

<table>
<thead>
<tr>
<th>Calories</th>
<th>Protein</th>
<th>Vitamin A</th>
</tr>
</thead>
<tbody>
<tr>
<td>550 kcal (20-30% from fat)</td>
<td>5 g</td>
<td>126 RAE (RAE = Retinol Activity Equivalent)</td>
</tr>
</tbody>
</table>

Note: it will not be possible to ensure all nutrients are represented in every meal. However, the implementing body can provide guidance on recipe content by using NutVal v.4 or an alternative software package, to ascertain macro and micronutrient compositions of different recipes and the package of recipes selected as a whole. If context-specific foods are not included in the NutVal Food and nutrient database, values can be inserted manually into NutVal using National food composition tables for the country. See: [http://www.nutval.net/2007/05/downloads-page.html](http://www.nutval.net/2007/05/downloads-page.html)

Note: where possible, cooking should be done on FES and carers actively encouraged to use them at home.
Timetable for NIPP circle sessions

Reference note: For this section refer to “Annex 6 - Monitoring, Evaluation, Accountability and Learning” which includes:

- Annex 6.1 (a/b/c) Attendance sheet (Female/ Male/ Illiterate)
- Annex 6.2 (a/b) Data collection booklet (Female/ Male)

As outlined above, NIPP female and male sessions should ideally be split into three parts and follow the same pattern each time. The very first session however will be slightly different from the others. A field support staff of the implementing body should always be present at the first and last session for the specific purpose of collecting data.

8.1 Activities to be Conducted Pre-Implementation - Prior to the first session

a. Home visits: the implementing body will carry out home visits to each participant HH, along with the female or/and male NIPP volunteer. Collect all requisite information outlined in the booklets: see Annex 6.2a-female, 6.2b-male, including a pre-test at the homestead with the targeted HH participants - males and females. Where physical observation is possible to verify some of the indicators, this should be used e.g. presence of a hand-washing point, evidence of latrine in use etc.

b. Health documentation checks: check all HH members’ health documents. These may include: health passports, health cards, children’s road to health charts, vaccination booklets, ANC/PNC cards etc. - whatever documentation is used in your setting. Refer to their appropriate health facility if routine visits have not been undertaken. Ask participants to bring their documents to each NIPP circle session. Note: if stunting is a particular issue in-country and the MoH have started to collect height as well as weight and age data, request that all children are taken for GMP, so that the implementing body can assess and monitor stunting.

8.2 Activities to be conducted during session one – Important inclusions

a. Welcome: NIPP volunteers should introduce themselves and outline what they hope the group will achieve by the end of the cycle. Ask each of the participants to introduce themselves and give a brief outline of their family, no. of children, where they live and how they make a living.

b. Attendance: NIPP volunteer to complete attendance sheet (Annex 6.1). Note there are separate sheets for females (Annex 6.1a) and males (Annex 6.1b). There is also an attendance sheet adapted for illiterate volunteers (Annex 6.1c).

c. MUAC: all circles led by literate female NIPP volunteers should also check the participants MUAC on this first session and at least every fortnight thereafter to check for any deterioration in nutritional status - refer children if necessary. Illiterate volunteers should also measure MUAC and refer, although this will not be recorded on the attendance sheet.

d. Health documentation: participants should have brought their health documents. Together as a group they should check whether routine visits have been undertaken by the participating families:
   i. All children should be referred to their local clinic for GMP (if available), de-worming, vaccination and vitamin A supplementation (as appropriate).
   ii. PLW should be referred for ANC/PNC visits and appropriate micronutrient supplementation (in line with country campaigns).
   iii. In HIV prevalent countries, anyone in the group who does not know their status and has suffered from a series of repeated bouts of illness should be sent for voluntary counselling and testing if appropriate and accessible.
By ensuring these simple health checks/interventions are sought, it will help to maximise chances of a speedy recovery and eliminate these issues as possible causes of malnutrition.

**Note:** As circles often run for longer than a month, as some vaccinations require repeating after one month, children’s cards should be checked and referred on week 5 of the cycle.

**Note:** advocacy for referral of women and children to health facilities should also be re-enforced during Male circles, so that husbands/fathers can also actively encourage women/ HH members to undertake health facility visits.

e. Market visit: NIPP volunteers should lead a market visit with the group (if possible) to identify the complete variety of different foods available and their cost (which will determine access to HH members).

f. Food flash card use: these cards can be used in a number of different ways during sessions. During session 1, they should be used in the following ways:

i. Identify all foods available and accessible: as referenced in section 7.3, volunteers should ask participants to lay out photo cards and select every single type of food that is available and accessible for consumption from the whole pile of different food pictures, irrespective of whether they usually eat it. This should include home grown, market and/or wild foods. Point out that once micro-gardens start to yield, they will be able to add these foods to recipes. Assess diet diversity and feed frequency: from the full variety of foods identified as available and accessible, volunteers should then ask each participant in turn, to select cards and put into piles what they ate for breakfast, lunch and dinner (if 3 meals a day are consumed). So for example, in the morning if they ate bread and tea, they would put these ingredients in one pile. For lunch, maybe they had maize and beans, so they would put the ingredients in a different pile. Then if they had dinner and ate bread and milk, they would put these ingredients in a third pile. Then ask them to repeat the exercise in new piles, showing what they ate yesterday for each meal and again in different piles for the day before. This should be repeated for 3 or more days’ worth of meals. If the participant is shown to have poor dietary diversity (using the same food types over and over again), the NIPP volunteer can demonstrate this, by pointing out all the unused foods from flash cards that have not been selected. The NIPP volunteer should also take this opportunity to point out that if participants have shown they are only eating 2 times per day i.e. poor feeding frequency, this is not sufficient for children, who need a minimum of 3 meals per day. They should explain that children cannot physically eat enough food in two sittings. Remember, this exercise should be repeated for different members of the group, so participants understand this relates to all of them.

ii. Food groups: in order to start teaching the group about the importance of diet diversity, the NIPP volunteer should ask participants to use the full variety of foods identified as available and accessible and put the cards into appropriate food groups. If participants are not familiar with their country food groups, the volunteer can teach them.

iii. Recipe selection: NIPP volunteer can then help the group to use the food flash cards from foods identified as available, to start making up different recipes, using either of the methods outlined in the ‘Recipe Guide’, under section 7.3.

Group contributions for cooking demonstrations: once a selection of recipes has been decided upon, the NIPP volunteer should discuss with the group how they will be asked to each bring a different ingredient each session. This will allow the group to practice making the recipes and then children, PLWs and CI will eat the meal to help improve or maintain their nutritional status.
Note: during the development of IEC materials, it is highly advisable to produce a picture reference card for NIPP volunteers to use as a memory aid and help them to walk through each of these 5 exercises with their participants.

8.3 Activities to be conducted during all subsequent sessions

a. Welcome: NIPP volunteer should welcome each of the participants
b. Attendance: NIPP volunteer to complete attendance sheet
c. Objectives of the session: introduction to what they are going to achieve during the session
d. Health assessment: conduct simple health assessments of participating individuals including MUAC of children and PLW, plus verification whether appropriate health facility visits have been undertaken for GMP, de-worming, vaccinations, micronutrient supplementations and ANC/PNC visits.
e. Behaviour change communication and counselling: participants will discuss causes of malnutrition and a ‘core’ topic will be covered as per the session guide.
f. Micro-gardening: a practical session should be led for women at the NIPP volunteer homestead, around the construction and management of a small scale micro-garden. Male groups can either conduct practical or theoretical sessions as deemed appropriate.
g. Cooking demonstration: preparation of a high-energy, micronutrient-rich supplementary food and consumption during female circles. A theoretical version should be introduced during the male circles.
h. Group recipe ingredients: female circle members should discuss what ingredients they will each be able to bring to the next session for the complimentary/supplementary meal. Males should be informed of the types of foods the women will be asked to contribute. Ensure that no undue pressure is placed on any one individual to bring a particular food. Allow participants to discretely discuss food access problems they might have with the NIPP circle volunteer outside the session if necessary.
i. Group HH visits: either during the session or at the end of each session, it is suggested that the group try to visit a different member of the circle, to view their progress in establishing micro-gardens, hand-washing facilities, latrines, drying racks, rubbish pits, FES and adopting positive practices within the homestead. This will serve to encourage replication of positive initiatives at home, help the group bond and also serve as a further educational

The implementing body and the NIPP volunteer should carry out at least one follow-up home visit for each participant during the NIPP cycle. Participating families will need continued support to implement
the new practices in their own homes. During home visits, the NIPP volunteers or the implementing body should spend time with caregivers on a one-to-one basis to help them think of solutions to any difficulties they are encountering or respond to concerns about the progress of a child or PLW admitted with malnutrition. Use as a guide the “Home visit checklist” in the female booklet (see Annex 6.2).

Absentees, defaulter and minimum attendance
If absentees are noted from circles, they should be traced by the NIPP volunteers and in conjunction with the implementing body, provided with counselling to identify why they defaulted and discuss viable solutions. Default is defined as missing two consecutive sessions. However, as defaulting may have been unavoidable i.e. due to an illness/death in the family, assuming the participant wants to resume attendance, if the circle volunteer and participant are happy to come to an arrangement whereby the missed sessions can be covered one-to-one, the defaulter criteria can be waved. If however NIPP volunteer/participant decides they cannot commit to covering missed sessions, the participant(s) may be discharged and readmitted to the next cycle, if they are motivated to do so. It is also recommended that participants attend a minimum of 80% of the circle sessions, as the effectiveness of the behaviour change will likely be compromised if they attend less. However, even though attendance data will be collected for each circle, those not attending the recommended minimum number of sessions will not be defaulted from the programme, as they may still successfully graduate.

8.4 Post-Implementation - After the last session

After graduation, the implementing body should carry out a home visit for the following purposes:

- Conduct post-test with the primary carer at the homestead (see Annex 6.2)
- Document various pieces of graduation data as outlined in Annex 6.2
- To provide feedback to the HH on the ‘graduation status’ of participants

Successful graduation is reported (and documented in the database) based on the following criteria:

- Graduation from male circles: successfully completed post-test (>70%)
- Graduation from female circles: successfully completed post-test (>70%) AND successfully attained the necessary anthropometric criteria if admitted based on anthropometric measures

It is also strongly advised that after the end of each cycle, a ‘Volunteer recognition and participant achievement day’ is held in the local community. This provides a forum in which NIPP volunteers are able to relay to the community, including participants, key community figures and members of the wider community, what the NIPP circles have managed to achieve through results provided to them by the implementing body. The circles can show-case what they have built by holding the day at or near a participant HH (i.e. hand-washing points, drying racks, rubbish pits, latrines, compost heaps, micro-gardens, FES, etc.) and practices they’ve started using (i.e. harvesting from micro-gardens, food preserving and storage, cooking demonstrations, etc.). In conjunction with the initial ‘sensitisation days’ (outlined in section 1d), this will further promote awareness, strengthen acceptance of practices and reinforce community ownership of the initiative.
Monitoring, evaluation, accountability and learning

Reference note: For this section refer to “Annex 6 - Monitoring, Evaluation, Accountability and Learning” which includes:

- Annex 6.1 (a/b/c) Attendance sheet (Female/ Male/ Illiterate)
- Annex 6.2 (a/b) Data collection booklet (Female/ Male)
- Annex 6.3 Database - two versions one for the field and one for the MEAL coordinator
- Annex 6.4 NIPP volunteer/worker review meeting Form: guide
- Annex 6.5 Monthly report: guide
- Annex 6.6 Database reference and quality guide
- Annex 6.7 Rapid assessment methodology for food security and nutrition survey (RAM-FSN) for the NIPP approach
- Annex 6.8 Learning review template

Monitoring, Evaluation, Accountability and Learning (MEAL) is a joint responsibility between the NIPP volunteer, the implementing, the NIPP programme manager and the MEAL team. In order to ensure high standards of MEAL, various ‘process’ indicators will need to be collected (such as number of circles established, numbers of beneficiaries participating, number of sessions held, attendance etc.), as well as ‘outcome’ indicators which are used to monitor both immediate and sustained progress. A booklet found in Annex 6.2 has been designed for data collection and is explained in more detail below. Data will be collected from all participants in female circles at baseline and graduation, with a sample follow-up at 2, 6 and 12 months. Only pre/post-test and project summary data will be collected for the male circles. This data should be collected by the implementing body. All the information collected should be entered into the NIPP database for analysis (see Annex 6.3).

Currently, NIPP data collection is quite ‘heavy’, as we need to build a robust evidence base upon which the effectiveness of the project can be evaluated. As such, we collect information on a whole host of outcome indicators including anthropometry, care practices, feeding practices, micro-gardening and LLH practices, hygiene and sanitation practices and HIV. All this information is collected at predetermined time points through longitudinal monitoring and provides us with information on the outcomes of different programme elements.

9.1 Monitoring and data collection

Attendance forms

NIPP volunteers should maintain NIPP circle registers and record details of individual attendance at each session. They will need to enter the date of each NIPP circle meeting into a new column and then mark each participant’s attendance on their individual rows, by ticking or marking the box under the day’s respective date. Attendance of each participant must be recorded for every NIPP circle meeting. The attendance form has been adapted for female (Annex 6.1a), male (Annex 6.1b) and illiterate (Annex 6.1c) NIPP volunteers.

The attendance form is also where literate volunteers are required to record the MUAC of children and PLW. At present the attendance form has a space marked for MUAC recordings every 5th session. If for some reason there are two or less sessions occurring per week, MUAC should be recorded at least once every fortnight (2 weeks) and always on the last session. NIPP volunteers will be trained to take these readings correctly and shown how to record data in the attendance form (Annex 6.1) by indicating with...
a tick if the MUAC strip is red, green or yellow for children and then either recording PLW MUACs in cm, or indicating whether they are below or above the cut-off line of 23cm (or alternative). The MUAC colour coding for children will be used for the volunteer to make referrals if appropriate i.e. if the MUAC is red, the child should be referred to a nearby OTP.

The attendance form for illiterate volunteers is a ‘template’ and should be modified or adapted based on how the NIPP volunteers themselves will best be able to record attendance. If it is known in advance that there will be a number of illiterate volunteers, the adaptation of this form, or design of an alternative means to record attendance, should be piloted during the project’s inception phase. For example, NIPP volunteers could be shown how to give each of their participants a ‘symbol’ rather than a written name so that they can mark their attendance on the form. Or, if each participant is asked to sit in the same place each week, a different form could be generated showing the seating arrangement with lines radiating from each placing. The attendance can then be marked sequentially on the line. It is important for MEAL purposes that defaulters and attendance rates for each participant can be measured even by illiterate NIPP volunteers.

Booklets for male and female circles
Section 5 of these guidelines ‘Identify NIPP Circle Participants’ explains how individuals will be selected and prioritised for inclusion. Once the participating HH’s have been identified, the process of collecting baseline data starts. There are 13 different categories for admission into female circles (listed in demographic groupings rather than in order of severity):

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Infants &lt;2 months visibly thin</td>
</tr>
<tr>
<td>B.</td>
<td>Infants 2-5 months with MUAC &lt;110mm</td>
</tr>
<tr>
<td>C.</td>
<td>Children 6-59 months MAM with MUAC &gt;115mm and &lt;125mm</td>
</tr>
<tr>
<td>D.</td>
<td>Children 6-59 months MAM WFH (% or z-scores) referred from HF</td>
</tr>
<tr>
<td>E.</td>
<td>Children 6-59 months Under-nourished &lt;80% on RtH chart (WFA)</td>
</tr>
<tr>
<td>F.</td>
<td>Children 6-59 months Stunted &lt;80% on RtH chart (HFA)</td>
</tr>
<tr>
<td>G.</td>
<td>Children any age referred from OTP (non-MAM)</td>
</tr>
<tr>
<td>H.</td>
<td>PLW MAM with MUAC &lt;230mm</td>
</tr>
<tr>
<td>I.</td>
<td>Others – PLW non-MAM (MUAC ≥230mm)</td>
</tr>
<tr>
<td>J.</td>
<td>Others – Chronically ill (non-malnutrition)</td>
</tr>
<tr>
<td>K.</td>
<td>Others – Non-malnutrition twins/triplets</td>
</tr>
<tr>
<td>L.</td>
<td>Others – Interested carers (with no children &lt;60 months)</td>
</tr>
<tr>
<td>M.</td>
<td>Others – All non-malnutrition children &lt;60 months with interested carer</td>
</tr>
</tbody>
</table>
To clarify who should have data collected and where to enter data for each participant/admission:

- All children in a NIPP HH meeting any of the above admission criteria should be included in the female booklet and have an individual row in the database. For example, if a PLW meets the admission criteria and also has one or more children meeting the admission criteria, each ‘admission’ should be entered into a different row in the database.
- If there is a child meeting the admission criteria, then there is no need to also include the mother or carer’s information as a separate admission unless the mother/carer also meets PLW/CI admission criteria. In that case, the mother or carer will be entered as another separate beneficiary in the female booklet and will have a separate row in the database.
- Female booklets include a mix of mothers and children, each admission should be recorded separately.
- If the HH are included because they have a family member who qualifies under the ‘Chronically Ill’ criteria, then data for the patient with the illness should be entered. As baseline and graduation data is collected during home visits by the Implementing body and the NIPP volunteer, even if the person with the CI is not able to participate on a regular basis, they can still be assessed for data collection and another family member can attend the female circle on their behalf.
- If the HH were included based on multiple births, all infants (e.g. both twins) should be included in the database. In this case there is no need to enter data for the mother or primary carer (unless they also meet admission criteria).
- If a HH is included based on “interest alone”, if there are children <60 months, only the youngest child should be included in the database. Make sure the age of each child is recorded. If there are no children in the HH, then the female participant should be entered. Only enter data for one individual in this case.

Note: as a general guideline for female circles, always enter data for children meeting admission criteria first and only enter data for the mother/primary carer if they also meet PLW or CI admission criteria or if there are no children in the HH.

Baseline information
As already outlined under section 8.1, prior to the first NIPP circle session, the implementing body and the NIPP volunteer, must carry out home visits to every HH with family members identified for participation (in lieu of the screening exercise). During the visit, baseline data (outlined in the booklets) needs to be collected for each individual who will be ‘admitted’ from the HH. There are separate booklets for female (Annex 6.2a) and male (Annex 6.2b) NIPP circles. Both children and female carers who meet the admission criteria should be entered as separate admissions into booklet ‘6.2a-Female NIPP Data Collection Booklet’ and males entered into ‘6.2b-Male NIPP Data Collection Booklet’ (one booklet per circle). The pre-test also needs to be completed by female/male adults who will be attending NIPP circle sessions, with test scores and “pass/fail” status also recorded in the booklets.

Graduation information
During the last circle session of each cycle, summary information from each NIPP circle should be completed by the implementing body. This is found on the last page of Annex 6.2a and Annex 6.2b. After the last session, the implementing body and the volunteer, will again conduct a home visit for each of the participants to complete the required information in Annex 6.2 under the ‘graduation’ column, including administering and scoring of the post-test. Feedback should be given to the participant on their post-test and congratulations given if they have passed.

Selected participant follow-up
A minimum of 82 participants from each area will be randomly selected and followed-up at 2, 6 and 12 months after graduation to monitor longer-term impact of the NIPP circle intervention. This information is also recorded in Annex 6.2a for those selected. For instructions on selection please see below ‘Performing the Selection’.
Database
At each of the five time points (baseline, graduation, 2, 6 and 12 months follow-up after graduation) the Annex 6.2a should be filled out. Information recorded in all grey cells in both the female and male booklets should be copied directly into the database (Annex 6.3). There are only two tabs for data entry in the database ‘FEMALE’ and ‘MALE’. All other tabs contain analysis information which is auto-generating. It is recommended that the following two auto-generating worksheets, ‘Outcome Indicators’ and ‘Beneficiaries Summary’, are copied and pasted into a word document upon completion of each NIPP cycle and shared with the team, to enable all support staff to review achievements and progress. **A simple summary of the results should also be shared with NIPP volunteers, key community figures and the wider community in advance of any ‘Recognition Days’**.

For data management, NIPP circles will be divided into geographical or cultural areas with relative homogeneity. One database will be maintained per geographical or cultural area. For advice on areas GOAL can be consulted. Therefore, one database will capture the information for all NIPP circles in that area. Information from both male and female circles is entered into the same database but on different worksheets. Each database will capture all participants in an area who start a NIPP circle and a selection will be followed up over a total of 15 months, assuming a typical circle cycle of 12 weeks is undertaken (baseline, graduation, 2 month, 6 month and 12 month post-graduation).

Statistical analysis
All ‘analyses’ will be automatically generated in the database. Although these are not visible on the database, statistically significant tests have been applied and can be produced upon request. Analysis of this data should be the responsibility of the in-country MEAL Coordinator.

**Analysis assistance available: if you require assistance with analysis of this data or any preparatory step associated with it, GOAL can be consulted.**

9.2 Measuring Impact

NIPP approach outcomes and impact are measured using longitudinal follow-up and cross sectional chronic and acute malnutrition prevalence surveys. In order to show the impact of the NIPP approach on chronic and acute malnutrition, it is favourable to anthropometrically measure both wasting and stunting for all NIPP participants aged below 24 months at baseline, endline and follow up; and compare this with a cross sectional survey of the target population as a whole, using the Rapid Assessment Methodology for Food Security and Nutrition Survey (RAM-FSNS) methodology. However, if it is not possible to collect height data for all programme participants, a RAM-FSNS survey can be conducted for NIPP participants aged below 24 months at baseline and annually thereafter to show attribution of NIPP through improved anthropometry.
**NIPP outcomes and impact**

<table>
<thead>
<tr>
<th><strong>Longitudinal follow-up</strong> (Exclusively NIPP cohort)</th>
<th><strong>RAM- FSNS</strong> (Cross-sectional survey on general population)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>K&amp;P</strong></td>
<td><strong>Wasting</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Stunting</strong> (Optional for longitudinal follow-up)</td>
</tr>
</tbody>
</table>

NIPP impact indicators - aim to collect as a minimum the following indicators:
- Height-for-age z-scores (prevalence of global and severe stunting)
- Mid-Upper Arm Circumference (prevalence of global and severe wasting)
- The following other indicators can also be collected:
  - Weight-for-height z-scores (prevalence of global and severe wasting)
  - Weight-for-age z-scores (prevalence of underweight)
  - The household food insecurity access prevalence (taken from the Household Food Insecurity Access Scale or HFIAS).

When evaluating potential impacts on stunting, the RAM-FSNS data generated allows us to answer the following questions:

**The curative effect of NIPP on stunting i.e. of young children admitted stunted. Were we able to reverse their status over time?**

**MEASURED VIA NIPP DATABASE AND LONGITUDINAL FOLLOW UP**

**The preventative effect of NIPP on stunting i.e. of young children admitted non-stunted. Were we able to maintain their status over time, preventing a deterioration (as would be expected in a certain % without any intervention)?**

**MEASURED VIA NIPP DATABASE AND LONGITUDINAL FOLLOW UP**

**The possible attribution of NIPP impact on the reduced rates of stunting in NIPP targeted households. This will enable us to see the impact in the direct intervention group.**

**MEASURED VIA NIPP DATABASE AND LONGITUDINAL FOLLOW UP AND COMPARING WITH AVAILABLE GEOGRAPHICAL AREA STUNTING DATA or RAM-FSNS**

**The possible attribution of NIPP impact on the reduced rates of stunting in the localised but slightly wider area of the targeted NIPP villages. This will give us an idea of both the direct intervention group and the spill over effect into the localised, wider area.**

**THIS WILL BE MEASURED VIA THE BASELINE AND ENDLINE RAM-FSNS**
Rapid Assessment Methodology for Food security and Nutrition Survey (RAM-FSNS)

The RAM-FSNS is a 16x12 cluster survey using a two-stage spatial sample with a small number of spatially even Primary Sampling Units or PSUs (e.g. 16 clusters), a small number of secondary sampling units (e.g. 12 HHs with children aged 0-23 months), resulting in a small overall sample of 192 (i.e. < 200). It is conducted separately to the NIPP approach monitoring at baseline and graduation. The aim is to assess the rates of chronic malnutrition and acute malnutrition prior to NIPP circle roll out, and annually thereafter to assess whether there is an effect on stunting rates in villages or communities where the NIPP approach was implemented. For this purpose, children 0-23 months are randomly selected using RAM-FSNS (see Annex 6.7) allowing the measurement of HFA z-scores and MUAC, but also food security using the HFIAS. The RAM-FSNS method comes with an open-source toolkit including a programme which generates survey findings once data is entered. Data can be entered manually into the programme or transferred from digital data gathering software. Modern computer-intensive data analysis procedures, referred to as PROBIT, are used as they enable the small survey sample size to be generalized to the wider survey geographical area. GOAL worked with an epidemiologist who originally designed this survey methodology as a rapid assessment methodology for acute malnutrition, but has adapted it to measure chronic malnutrition in children 0-23 months and household food security. GOAL believes this is a simple and low cost methodology for chronic malnutrition measurement and surveillance.

Longitudinal follow-up
A minimum of 82 participants from each area will be randomly selected and followed-up at 2, 6 and 12 months after graduation to monitor longer-term impact of the NIPP approach. This information is also recorded in Annex 6.2a for those selected. For instructions on selection please see below ‘Performing the Selection’.

Rationale for calculating the sample size for follow-up at 2, 6 and 12 months after discharge

**Hypothesis 1 - NIPP improves nutritional status:** based on an analysis of the characteristics of NIPP data observed from 2013 – 2015 and considering a level of significance of 5%, a power of 80%, and using online calculator of sample size calculation of paired t-test, the minimum sample size required to test no difference in measurement between two time points is 31.

**Hypothesis 2 - NIPP improves nutrition knowledge and practice (K&P):** minimum sample size required to test no difference in proportion between two time points is 59. In this case “Having a micro-garden” was used as reference. Based on a proportion of NIPP participants with a micro-garden at baseline of 30%, a proportion of NIPP participants with a micro-garden at 12-month follow-up of 65%, a level of significance of 5% and a power of 80% and using online calculator of sample size calculation of paired t-test, the minimum sample size required to test no difference in measurement between two time points is 59.

**Attrition rate:** In order to address high attrition, the sample size needs to be increased by the rate of attrition. Since the attrition rate is different in each country, the adjustment needs to be contextualized. The highest attrition rate reported in NIPP country programme was 40% and an average attrition rate of 30% was used for calculating overall sample size.

**Conclusion:** The minimum sample size required to test hypothesis 1 for each sub groups is 41 (31 + 31X0.3). The minimum sample size required to test hypothesis 2 is 77 (59+59X0.3). So if we select 41 children under four years old from random households and 41 PLWs from different random households for measurement of both their nutritional status and K&P, the total sample size would be 82.

**Note:** K&P information from the ‘children sample’ should be collected from their primary carer.
Performing the selection
Each geographical or cultural area should randomly select 41 participants from children aged 0-47 months and 41 PLW totalling 82 households for follow-up during 12 months after graduation.

Each year, 82 participants should be selected from the first cycle for follow-up if possible. If there are not 82 participants at this stage, a number of participants as close to this number should be selected from the first cycle and then the difference from the second cycle. This is to ensure that data can be collected and analysed within a reasonable time frame.

Further information on the sample size calculation or on the selection of participants for follow-up after graduation can be requested from GOAL. Also, if the rates of stunting are high in the area of intervention and the rates of wasting are low, but the implementing body wants to collect statistically significant data on wasting, given the fact that the sample of 82 randomly selected HHs will yield too few ‘cases’ of wasting, it may be necessary to select a parallel sample of children who were admitted based on MUAC (MAM) for follow-up. Contact GOAL for advice regarding the sample size required in such cases.

Note: if it is thought that there will be a higher degree of ‘fall out’ from the follow-up sample group, due to people moving, defaulting or any other reason, it is advisable to INCREASE THE FOLLOW-UP SAMPLE FROM 82, so that the statistical significance of results will be maintained. Support can be request from GOAL to establish the appropriate number of participants needed for follow-up to still allow for observation of a significant finding.

9.3 Human resource requirements for MEAL

The NIPP circles need to have a strong oversight, to ensure that the requisite technical support to the NIPP volunteers is provided. The management/MEAL team is also responsible for the overall monitoring and evaluation of the programme and documentation of lessons learnt. With regards to MEAL responsibilities, all NIPP volunteers are supervised by the implementing body. The implementing body is responsible for direct supervision and data collection, and in turn, they are managed by a programme manager, who is responsible for collecting together annexes 6.2 and for subsequent data entry into the database. Finally, the overall Nutrition/Health Coordinator and MEAL Coordinator are responsible for ensuring data is accurately collected, entered, analysed, presented and shared with all key stakeholders including participating communities.
Table 1: Illustration over time of quality assurance and the supervision schedule from the start point to the final monitoring exercise

<table>
<thead>
<tr>
<th>DATA REQUIRED</th>
<th>PERSON RESPONSIBLE</th>
<th>FORM USED (ANNEX)</th>
<th>WHEN DATA SHOULD BE COLLECTED</th>
<th>FROM INFO CAPTURED IN</th>
<th>REPORTED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Information</td>
<td>Implementing body</td>
<td>Assess stunting through RAM-FSNS &amp; 6.2 a / b Baseline column in booklet</td>
<td>Before First NIPP Meeting in target villages / During Home Visit</td>
<td>6.3 Monitoring DB</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Registration</td>
<td>Implementing body</td>
<td>6.1 a/b/c Attendance Form (female and male)</td>
<td>First NIPP meeting</td>
<td>n/a</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Attendance Sheet</td>
<td>Volunteer</td>
<td>6.1 a/b/c Attendance Form (female and male)</td>
<td>Every NIPP circle Session. MUAC taken every 5 sessions</td>
<td>6.3 Monitoring DB</td>
<td>Implementing body</td>
</tr>
<tr>
<td>Quality Assurance</td>
<td>Implementing body</td>
<td>6.2 a/b Home Supervision Checklist in booklet (female only)</td>
<td>During all Home Visits</td>
<td>n/a</td>
<td>Project Officer</td>
</tr>
<tr>
<td></td>
<td>Implementing body</td>
<td>6.2 a/b Circle Supervision Form in booklet (female and male)</td>
<td>All Circle Supervision Sessions</td>
<td>n/a</td>
<td>Project Officer</td>
</tr>
<tr>
<td></td>
<td>Implementing body</td>
<td>6.4 Volunteer Review Form (female and male)</td>
<td>Minimum Every Quarter at the Volunteer Review Meeting</td>
<td>6.5 Monthly report form</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Monthly reporting</td>
<td>Project Officer</td>
<td>6.5 Monthly Report Form</td>
<td>End of every month</td>
<td>HQ Monthly report</td>
<td>Programme Coordinator</td>
</tr>
<tr>
<td>Graduation Information</td>
<td>Implementing body</td>
<td>6.2 a/b Graduation column in booklet (female and male)</td>
<td>During Last NIPP Circle Meeting and Home Visit</td>
<td>6.3 Monitoring DB</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Impact Monitoring at 2 months</td>
<td>Implementing body</td>
<td>6.2 a - 2 month column in booklet (female only)</td>
<td>During home visit</td>
<td>6.3 Monitoring DB</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Impact Monitoring at 6 months</td>
<td>Implementing body</td>
<td>6.2 a - 6 month column in booklet (female only)</td>
<td>During home visit</td>
<td>6.3 Monitoring DB</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Impact Monitoring at 12 months</td>
<td>Implementing body</td>
<td>Repeat RAM-FSNS for stunting &amp; 6.2 a 12 month column in booklet (female only)</td>
<td>In target villages/During home visit</td>
<td>6.3 Monitoring DB</td>
<td>Project Officer</td>
</tr>
</tbody>
</table>

Note: if stunting data is available through country GMP programmes, then the RAM-FSNS will not be required.
9.4 Quality assurance

Circle supervision checklist
It is advised that the implementing body uses the ‘Supervision Checklist’ when undertaking supervision visits of the NIPP circle sessions. This will help lead the supervisor through this process, identifying areas where the volunteer would benefit from more support. This is found within Annex 6.2. Supervisory visits should ideally take place for both male and female circles at a minimum on the 1st and 2nd sessions during the first week, and then at least once during the 2nd, 3rd, 4th, 6th, 8th, 10th and 12th week. The shaded cells below indicate the points at which a supervisory visit should be made.

<table>
<thead>
<tr>
<th>Prior to start up</th>
<th>Home visits with Volunteer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Week 2</td>
</tr>
<tr>
<td>Week 3</td>
<td>Week 4</td>
</tr>
<tr>
<td>Month 1</td>
<td>At least the first 2 days, longer if necessary</td>
</tr>
<tr>
<td>Week 5</td>
<td>Week 6</td>
</tr>
<tr>
<td>Month 2</td>
<td>1 day during the 2nd week</td>
</tr>
<tr>
<td>Week 7</td>
<td>1 day during the 3rd week</td>
</tr>
<tr>
<td>Month 3</td>
<td>1 day during the 4th week</td>
</tr>
<tr>
<td>Week 9</td>
<td>1 day during the 6th week</td>
</tr>
<tr>
<td>Week 10</td>
<td>1 day during the 10th week</td>
</tr>
<tr>
<td>Week 11</td>
<td>1 day during the 8th week</td>
</tr>
<tr>
<td>Week 12</td>
<td>1 day during the 12th week</td>
</tr>
<tr>
<td>Post - graduation</td>
<td>Home visits with Volunteer</td>
</tr>
</tbody>
</table>

Plus at least one home visit per HH during the course of the circle cycle

NIPP volunteer review meeting form
NIPP volunteers should be encouraged to meet with each other on a regular basis, and with the implementing body where possible. Monthly meetings are preferable, but as a minimum, meetings should be scheduled at least once every 3 months. Incentivisation should be avoided (unless provided by the community or another sustainable source), as community ownership is actively encouraged, and it will likely negatively affect the long-term sustainability and possibility for further roll out of the project. Incentivisation provided from the community itself however is an excellent form of volunteer motivation and recognition for the services they’re providing. These review meetings should focus on feedback from the NIPP volunteers, whereby positive achievements, problems and viable solutions should be openly discussed. Findings from these sessions should be documented in Annex 6.4.
9.5 Reporting

Circle monthly report template
The monthly report should be completed by the implementing body programme manager or other senior staff member every month using data from the booklets and information gathered from the NIPP volunteers at the review meetings. This information is submitted to the nutrition programme manager and coordinator, and should feed into the monthly headquarters report.

Other reporting tools
A learning review form (see Annex 6.8) should be completed by the programme manager or their line manager as appropriate on an annual basis and circulated both within country, to the headquarters, and to the relevant technical team staff.

The implementing body is encouraged to document each implementation step and variations thereof, to enable learning. All programmes are encouraged to document at least one story of change from their programmes.

9.6 Fictional example scenario for MEAL

Zimbabwe
In Zimbabwe, 64 circles are planned for roll out per 3 districts over a 3 year time period, with the high risk areas prioritised. The roll out plan is for 16 circles/district in year one, increasing to 24 circles/district in years 2 and the same again for year 3. As each district is geographically and culturally different, a separate database is used for EACH DISTRICT, PER YEAR i.e.:

<table>
<thead>
<tr>
<th>District</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1</td>
<td>1 x DB for all 16 circles</td>
<td>1 x DB for all 24 circles</td>
<td>1 x DB for all 24 circles</td>
</tr>
<tr>
<td>District 2</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td>District 3</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
</tr>
</tbody>
</table>

Therefore the programme would have a total of 9 x Databases at the end of the project.

- 82 participants per district from year one would be followed-up for data collection for a further 12 months post-graduation (follow-up leading into year 2).
- A further 82 participants per district from year two intake would also be followed up (follow-up leading into year 3)
- And finally, as a total of 15 months is required from admission to end of follow-up, from year three initial intake, only admission, graduation data and follow-up 2 months after graduation would be collected, as there would be insufficient time to collect data from the subsequent two measurement points. However, if additional funding were secured, allowing the project to continue, follow-up data collection could resume for the full series.
A number of communication materials including NIPP brochure, poster and presentation have been developed to help the programme team in communications about the NIPP approach. These tools are available in Annex 7.

To request support on the NIPP approach, please contact NIPP technical support at: nipp@goal.ie
Diagram of key components to illustrate the initiative as a whole

Designed to Address:
- Community based TREATMENT of mild or moderate acute malnutrition (MAM)
- Community based PREVENTION of mild or moderate acute malnutrition (MAM)
- Potential community based REHABILITATION AND PREVENTION of STUNTING
- Potential community based PREVENTION of LBW (due to inter-uterine growth restriction)

Key principles include:

**Community based approach:** Aiming to build village capacity to address undernutrition at home using local resources/knowledge.

**Multi-sectoral approach:** Addressing malnutrition comprehensively requires a holistic, multi-sectoral approach.

**Formative research and designing for behaviour change (DBC):** The key to positive practice is evidence-based identification, and subsequently the addressing of, barriers that prevent the use of positive behaviours.

**Positive deviance:** NIPP circles are based on identifying households (HH) who are healthy despite facing the same challenges as other HHs in the community who are not thriving. People from these HHs are used as role-model volunteers who use a peer-led approach to teach positive practices.

**Reinforce positive behaviours:** Participatory practical sessions, positive reinforcement and repetition are used to habituate participants to the use of positive practices.

**Addressing key gate keepers to change:** Men are often gatekeepers to change, in that they play a part in decision-making in the HH. By addressing men in addition to women i.e. mother-in-law, we have the best chance of successful behaviour change in the HH.

**Long-term follow up:** Often project follow-ups finish upon beneficiary graduation. NIPP circles focus on following-up on beneficiaries 2, 6 and 12 months post-graduation, to determine the sustainability of positive behaviour change over time.

**Sustainability:** The goal is for MoH, local community based organisations (CBO) or national NGOs to support NIPP circles going forward. So that this might become a reality, expenses have been minimised as far as possible, thus project costs are low.