Care for Child Development

Regional Training of Trainers in Early Childhood Development in Response to the Sahel crisis

11 - 15 June 2012
Dakar, Senegal
UNICEF West and Central Africa Regional Office

Participating Organizations

UNICEF, WHO, Ministry of Education Senegal, Ecole nationale des travailleurs sociaux, Ministry of Health Botswana, NGO Enda-Tier Monde, NGO World Education, NGO Tostan and Hospital St. Martin de Rebeuss

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The Sahel Crisis and Its Impact on Children

The lean season from May to August is an extremely risky time for the residents of the Sahel region. No crops are in the fields, thus households rely on what has been produced the previous year. Unfortunately, scarce rains, increasing food prices, poor harvests and economic and political instability caused a critical food shortage in 2012. More than 18 million people, including one million children under age five, are expected to suffer from severe malnutrition in 2012 (UNICEF, 2012a).

This is the third time in less than 10 years that the Sahel region has been hit by severe drought. Droughts in 2005 and 2010 forced families to sell their livestock, borrow money and stop sending their children to school as they coped with the food crisis. In 2012, these families—and especially their children—are more vulnerable than ever. Even when no drought threatens the region, about 500,000 children die each year from causes related to food shortage. During droughts, that figure can be dramatically higher.

In West and Central Africa, eight countries are most affected: Senegal, Mauritania, Mali, Burkina Faso, Niger, Nigeria, Chad and Cameroon (Fig.1).

Main areas of food insecurity and malnutrition in the Sahel region

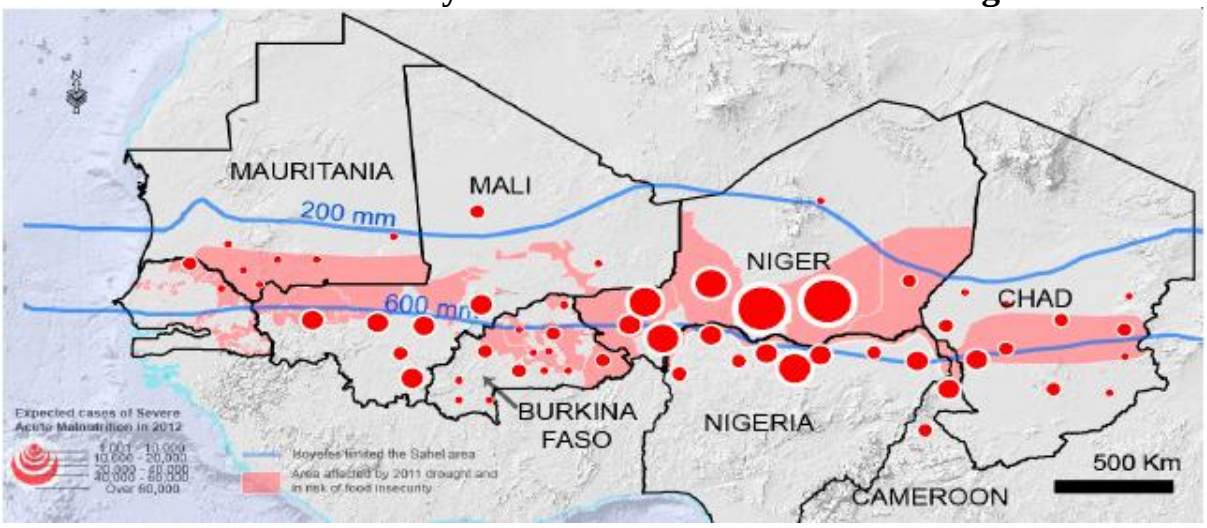

Fig. 1: Source: OCHA response plan addressing the food and nutrition crisis in the Sahel, 2012. Accessible online at http://ochanet.unocha.org/p/Documents/Sahel%20dashboard%20Feb%202012.pdf.

In addition, continuing conflict in Mali has forced 170,000 people to leave their homes and flee to neighbouring countries (UNICEF, 2012b). The displacement of children in dispersed locations makes it challenging to provide support and slows down emergency interventions such as food supplementation, school materials distribution and psychosocial support.

The Sahel crisis places many stresses on families. Parents relocate looking for better economic opportunities, and children are withdrawn from school. Early childhood programmes are not delivered

regularly. Nutrition interventions cannot meet the needs of all who require assistance. These conditions leave parents vulnerable and unable to provide adequate stimulation, attention and nurturance to their children. This starts a vicious cycle: Hungry children become apathetic and do not cry or crawl for food; this leads to neglect by parents; that neglect leads to children becoming sick.

Children are the first victims of the food crisis. But even those children who survive could face permanent health damage because the first years of life are fundamental for the healthy development of a child's body and brain. The child develops indispensable skills and knowledge that cannot be neglected or delayed without irreversible consequences, and it has become clear that simply providing food might not be enough to help malnourished children recover in a crisis and avoid permanent repercussions. Caregivers need to be aware that communication and play—parts of what is called "psychosocial stimulation"—are essential components of a child's healthy development.

Key Point

Psychosocial stimulation refers to care practices that help to establish a positive attachment between caregiver and child and are necessary for healthy child development.

The caretaker's sensitivity and responsiveness to the child are critical factors in how well children develop, and psychosocial stimulation represents a powerful tool. In fact, stunted children who are exclusively supplemented with food do not develop the same as children who are both supplemented and stimulated (Grantham-McGregor, et al., 1991). After two years of integrated psychosocial stimulation and food, stunted children achieve almost the same development quotient (practical reasoning, hand-eye coordination, hearing and speech, and performance) as non-stunted children.

Key Point

Responsiveness is the capacity of the caregiver to respond contingently and appropriately to the infant's signals. ***Sensitivity*** is the caregiver's awareness of the infant's acts and vocalizations that communicate needs and wants (Ainsworth et al., 1974).

In other words, communication and play are as useful as food in a sick child's recovery (Fig.2). In the Sahel crisis, a response that integrates psychosocial stimulation can maximize the impact of nutrition programmes and have a positive long-term effect on parental practices.

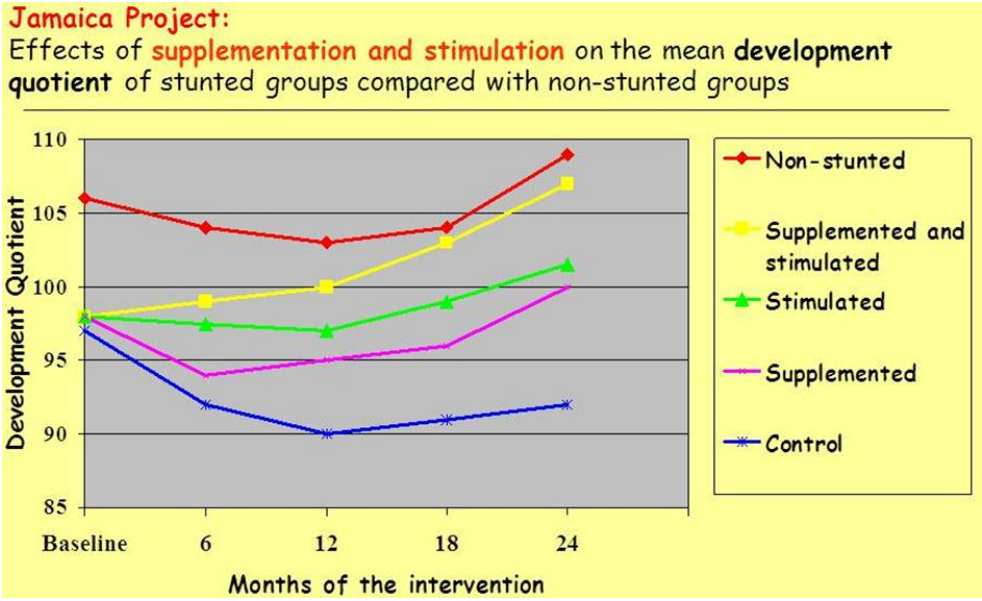

Fig.2: Effects on development quotient of providing either stimulation or food supplementation or both.

An integrated approach, including psychosocial stimulation, nutrition and health care, is the optimal solution. The Care for Child Development training promotes this approach and offers a comprehensive response to the Sahel crisis. The integration of support for child stimulation and caregiver skills with a nutrition programme can help save many children's lives and assure the full development of their potential.

In an emergency of this nature, psychosocial support to caregivers is another component of a comprehensive child protection response. Psychosocial support to caregivers very often must address issues of violence within and outside homes. Addressing these issues requires strong linkages with child protection actors and systems. Parents and caregivers should also be informed of means to prevent and protect children from violence, including positive parenting. It is important to remember that some children are at greater risk of malnutrition and lack of adequate stimulation than others: children separated from caregivers, children unaccompanied or in custodial care, and children whose caregivers have physical or mental disabilities or are dependant on drugs or alcohol are at increased risk.

Key Point

Positive parenting refers to interventions by parents or caregivers that aim to reduce risks and promote protective factors for the social, physical and emotional wellbeing of children.

Overview of the Care for Child Development Training

A Care for Child Development training (training of trainers) was held in Dakar at the UNICEF West and Central Africa Regional Office (WCARO) from 11 June to 15 June 2012. Participants were invited from Burkina Faso, Mali, Niger and Senegal, which are countries that have been directly affected by the crisis. In addition, the WHO Regional Office for Africa sent two observers. Most participants were UNICEF officers coming from education, nutrition and child protection sections. Also included were officers from the ministries of education and other state institutions, as well are representatives from non-governmental organizations (NGOs) (Annex 1: List of Participants). Theory lessons, technical seminars and planning activities were held at UNICEF WCARO, and several clinical sessions took place in inpatient and outpatient health facilities. Two clinical sessions were held at St. Martin de Rebeuss, a public pediatric hospital with a nutrition rehabilitation centre in Dakar. Another session took place at Maison Rose in Guédiawaye, a centre that provides shelter and rehabilitation to mothers who are victims of physical and psychological violence.

Training Objectives

- To familiarize participants with the joint UNICEF-WHO note on the integration of ECD into nutrition programmes in food-crisis settings.
- To help participants adapt the proposed framework to ongoing interventions and field requirements.

Key Concepts

- Child development: The process of change in which the child masters more and more complex levels.
- Early childhood: The period between birth and eight years of age. In this programme, the focus is on children attending emergency feeding programs.
- Growth: The change in weight, height and circumference of the head.
- Responsiveness: Parenting that is prompt and appropriate to the child's immediate behaviour, needs and developmental state.
- Care: Attention to body, health, nutrition and emotional, social, language and intellectual development.

— Vijaya Singh, ECD Unit, UNICEF New York

The course was based on the Care for Child Development training package developed by UNICEF and WHO. It also included a tailored component planned by UNICEF HQ and WCARO to provide an early childhood development (ECD) response to the on-going Sahel crisis. The standard package teaches participants how to counsel family and train other counsellors. The new module enables participants to design a country-based emergency response using an integrated approach that includes psychosocial stimulation, nutrition, health and child protection.

Participants also achieved these learning outcomes:

- Observe and understand the responses of children and caregivers to recommended play and communication activities.

- Help caregivers recognize children's cues and respond appropriately.
- Advise the family on appropriate play and communication activities to stimulate growth.
- Gain skills to adopt and implement the package in local contexts.
- Gain knowledge and skills to conduct the training in the respective countries.
- Develop critical reflection on ECD and the Sahel crisis and link it to policy and practice.

Key Point

Surveys show that only 10 to 41 percent of parents in developing countries have materials to stimulate their children psychosocially. Only 11 to 33 percent involve their children in learning activities (Walker et al., 2007).

- Identify and respond to the main ethical issues of being a first-line worker in emergency contexts.
- Explore debates in ECD and emergency response actions focusing on how to integrate ECD in nutrition programmes.
- Train local staff and volunteers to deliver counselling on psychosocial stimulation.
- Plan an integrated intervention with nutrition programmes to cope with country-specific emergencies.

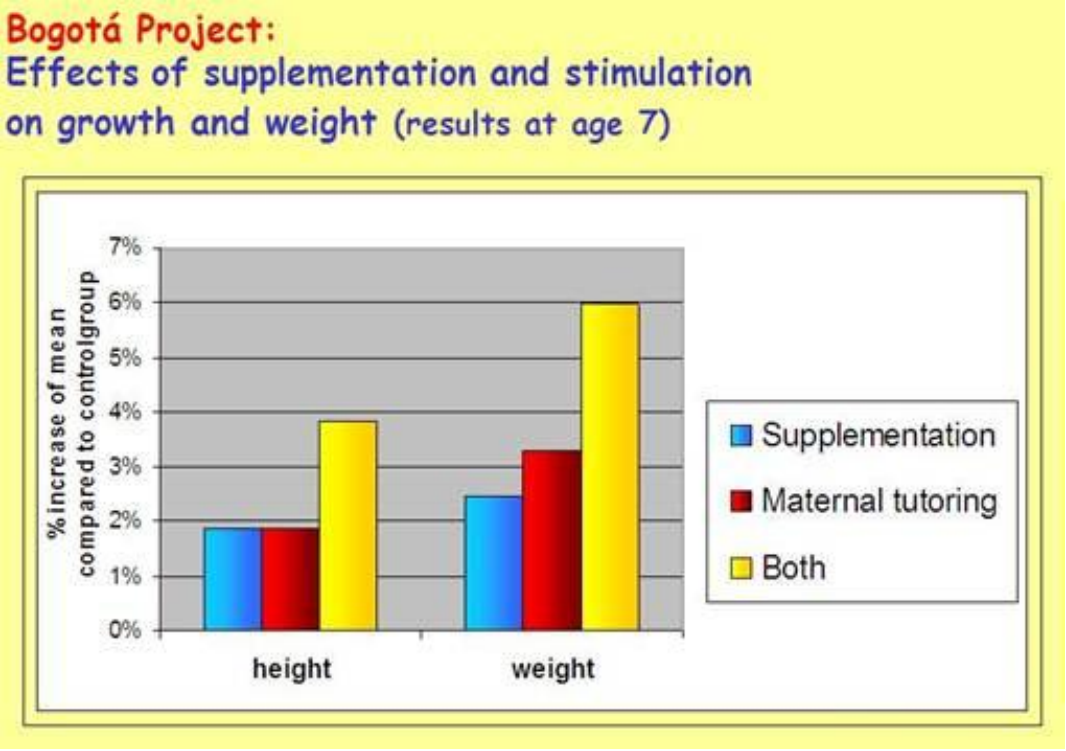

Fig 3: Source: Van der Gaag, J. School Performance and Physical Growth of Underprivileged Children: Results of the Bogotá Project at Seven Years (1983). World Bank, Washington, D.C. (The mothers who participated in the Bogotá project were taught directly at home how to play and communicate with their children.)

During clinical practice, participants who were not familiar with hospital settings had the chance to identify and experience the value of psychosocial stimulation. Participants were asked to interview parents, observe interaction between children and parents, and counsel caregivers on recommended play and communication activities. Working in groups and pairs, participants observed and coached each other. The facilitator and the clinical instructor took video and photos to be used as learning material during the debriefing session.

Three assessment questions to understand a caregiver's behavior toward a child:

- How does the caregiver play with the child?
- How does the caregiver talk to the child?
- How does the caregiver prompt a smile from the child?

The planning session, which covered a day and a half, was mainly based on the UNICEF and WHO document *Integrating Early Childhood Development Activities into Nutrition Programmes in Emergencies: Why, What and How*.

Reflections From a Course Facilitator

Jane E. Lucas, PhD, course facilitator and consultant in child health and development

Background

Caption: Outpatient training session at the NGO La Maison Rose in the suburbs of Dakar.

According to a 2011 series on child development in the medical journal *The Lancet*, more than 200 million children suffer from conditions that limit their chance of achieving their full potential: They are stunted, poor or both, and thus are likely to be developmentally disadvantaged.

No children are more at risk than those who start life in families that face extraordinary challenges to their basic survival. In the Sahel, the full focus of the caregivers of young children is on seeking shelter and security, finding food and connecting with basic health services. The result is a generation of poorly nourished children often separated from their parents, poor health conditions and delayed opportunities for education in the home and through failing community resources. These children often live under impoverished, unsafe and low-stimulating conditions, while families wait for help in camps or migrate long distances.

Under these emergency conditions, many would ask why UNICEF and its partners in the region would introduce Care for Child Development, an intervention to improve the psychosocial development of children. In the face of meeting these children's needs for safety, shelter, nutrition and health, efforts to ensure that the children thrive and are productive in the future could assume a lower priority.

We now know, however, that adding support for the child's development and the parent's sensitive and responsive care can be life-saving for the most vulnerable young children. Simple play and communication activities, designed to stimulate the child's development, also stimulate the development of the child's physical strength, coordination and neurological responses.[1] Weak and sick babies grow stronger and more controlled when their parents massage their under-developed muscles. Stimulating activities for undernourished children increase the effectiveness of nutrition interventions. Low-weight, stunted children can catch up to healthy children in height and weight, as well as in

[1] Holt, R. L. and Mikati, M. A. (2011). Care for Child Development: Basic science rationale and effects of interventions. *Pediatric Neurology* 44(4):239-253.

psychosocial development, by combining nutritional supplementation and stimulation through simple play and communication activities.[2] These same interventions have been linked to a reduced severity and duration of illness in sick children.[3]

Children living in crises need strong social support for their emerging skills and, under adverse conditions, are in special need of caring adults. The Care for Child Development intervention also develops the skills of adults who learn, through the same recommended activities, more effective ways to help a child learn from birth. Counsellors use the activities to help caregivers become more responsive by coaching them to recognize and interpret the child's way of communicating needs and then responding appropriately. By responding well to the child, the caregiver helps the child attach to them and look to the adult for appropriate attention, protection, affection and daily care. This process is essential for all children but can be critical to the child's resiliency in crisis conditions. Furthermore, counsellors can use these activities to help adults meet the needs of children who have been separated from their parents temporarily or permanently.

The Course

The objectives of the course on Care for Child Development are that participants are able to:

- Identify the interaction between a child and the primary caregiver.
- Counsel the family on activities to strengthen the relationship between the child and caregiver.
- Advise the family on appropriate play and communication activities to stimulate the child's healthy growth and development.

These objectives, content and exercises from the generic course were adapted for a five-day course specifically to address children in the emergency conditions in the Sahel. Training materials were translated into French, and printed materials were produced in both French and English. Simultaneous translation was secured for classroom and clinic sessions in French, English and Wolof. Common household items (e.g. plates, cups, spoons and plastic storage and water containers) were collected into sets of "toys" for participants to use in classroom exercises and with families during the clinical practice. From the point of view of this facilitator, the local preparations and consistent support throughout the week were superb and enabled the course to be very effective.

[2] Grantham-McGregor, S.M., Powell, C.A., Walker, S.P., and Hines, J.H. (1991). Nutritional supplementation, psychosocial stimulation, and mental development of stunted children: the Jamaica Study. *Lancet* (338): 1-5.
[3] Ertem, I.O. Atay, G., Bigoler, B.E. Dogan, D.G., Bayhan, A., and Srica, D. (2006). *Pediatrics* 118(1):124-113.

Building a Regional Prototype For the Development of a National ECD System in WCARO

Nicolas Reuge, education specialist, UNICEF WCARO

ECD has shown little progress in the West and Central Africa region, despite the fact that it was part of the Dakar framework in 2000. Based on experiences in Madagascar and Mauritania, WCARO decided to develop a prototype for supporting development of a national ECD system. This prototype includes three dedicated tools:

- A simulation model to help national authorities organize an ECD system from parental education activities to preschool. This model will strengthen visibility of ECD within the education sector.
- A dedicated household survey to gather evidence on parental practices regarding young child development and care. The survey results will support the design and implementation of parental education activities in an integrated strategy.
- An assessment of the competencies of young children at the beginning of the primary education cycle to provide information on child readiness and to support parenting and preschool curricula definition or revision.

In the West and Central Africa region, Mauritania completed the two first steps and has started to implement a competency assessment for young children at the beginning of the 2012-13 school year. In 2012, Cape Verde, Sao Tome and Principe and Togo will also start the process.

Conclusions and Recommendations

The Care for Child Development package was delivered for the first time in West and Central Africa. The decision to provide training in West and Central Africa comes as a response to the high demand of francophone countries for ECD tools to deal with the Sahel crisis. There is no doubt that the overall objectives were achieved through a broad, didactic approach. The majority of participants have assimilated the integrated approach that must be applied during food and nutrition emergencies. This methodological approach allowed participants to develop their expertise through inductive reasoning. Nonetheless, a punctual follow-up by UNICEF WCARO is needed to assure that country offices will actively include the acquired knowledge and skills in their programmes targeting children ages 0 to 8 years. For this reason, UNICEF WCARO will undertake the following measures:

- Nominate Care for Child Development focal points for each participating country.
- Promote and assist package delivery at the country level in the region.
- Supervise and provide technical assistance to the country response plan drawn by country teams participating in the training.
- Continue to support a comprehensive approach (including child protection, health and education) toward childhood development and survival issues within WCARO and in the country offices.
- Provide the French translation of the publication *Integrating Early Childhood Development (ECD) Activities Into Nutrition Programmes in Emergencies: Why, What and How.*
- Continue to liaise between the UNICEF HQ ECD Unit and West and Central Africa country offices on ECD in emergency issues.

The following recommendations will help improve future training in West and Central Africa:

- To avoid duplication, the planning session should be included in the standard training package and aligned to existing response plans to the Sahel crisis. In addition, the planning session should not be a theoretical activity. It should be a workshop in which professionals use their background and knowledge of their country to create an intervention plan with realistic goals and timelines.
- The training fulfills needs at both country and regional levels. However, some adjustments are necessary. At the country level, the training should be addressed to direct implementers (NGOs, community workers and volunteers) but still retain a teaching method based on practical sessions in health facilities. When delivered at the regional level, more sessions should focus on strategic planning.

- Participants to the training must not come exclusively from the education sector. Participation from the health, nutrition and social protection arenas must be highly incentivized.

Caption: Outpatient training session at the NGO La Maison Rose.

Participants' Evaluation of the Training

The following conclusions are drawn from feedback forms administered at the end of the Care for Child Development training. The evaluation was conducted anonymously with an open section for free comments and suggestions. Fourteen feedback forms were collected (Annex 2: Evaluation Form).

An overall assessment indicates that participants were satisfied and appreciated the training. Participants valued the learn-by-doing and collaborative learning approach. They came to the training with adequate prerequisites and skills and believed that the programme will positively affect their work. For example, participants were asked how useful the training has been. In a range from 1 to 5 (1=not satisfied; 3=satisfied; 5=very satisfied), 65 percent of the participants answered 5 and 35 percent answered 4. Concerning the teaching method, 57 percent indicated 5; 8 percent indicated 4; and 35 percent indicated 3. Organization was scored 5 from 65 percent of the participants; 14 percent scored it at 4; and 21 percent scored it at 3.

The clinical practice, role-playing, classroom discussions and group work were the most-appreciated activities. Participants highlighted the importance of first-hand experience in the health centres and hospitals. Counselling caregivers in real settings allowed participants to directly assess parental practices and listen to parents' needs and constraints during informal discussions. Participants said their confidence in the benefits of psychosocial stimulation increased significantly after they saw parents' positive reactions and interest. Among their comments:

"*In the clinics, I understood what psychosocial stimulation means in reality.*"

"*When we were about to leave the clinic, a mother came to me asking if I could give her the toy I used during the counselling with her child. It was a homemade shaker rattle: a small plastic bottle with some stones to make noise inside.*"

Participants said they were confident that they can use the skills and knowledge acquired during the training, and that they envisioned implementation of the package in their countries.

- COGES (Comité de Gestion des Etablissements Scolaires) can be an effective partner for counselling and training a high number of parents.
- Intensive Nutritional Rehabilitation Centres (CRENI) can be optimal partners to ensure an integrated approach of ECD issues. Caregivers can be counselled regularly and while a child is in the hospital for long periods of time.
- Care for Child Development programmes should be integrated in the response plan to the war in Mali.

- The training is a good opportunity to discuss partnerships between government, UNICEF and NGOs.
- Ethnographic studies are fundamental to understanding and assessing child-rearing practices. It is important to understand how parental practices can differ from one country to another and their physical and psychological impacts on child development.

Participants also indicated some entry points for integration of ECD into nutrition activities such as:

- Growth monitoring and promotion
- Management of malnutrition
- Training of parents in schools
- A cluster approach
- Thematic groups
- Integrated Management of Childhood Illness (IMCI)
- Newborn care
- Parental education
- Community health workers
- Community-based programs

Participants also offered these comments and suggestions:

- **French translation of all the didactic materials.** PowerPoint presentations of the technical seminars were in English, and participants wanted to read evidence and data from scientific literature in their own language. Also, participants asked whether the document provided by UNICEF HQ *Integrating Early Childhood Development Activities into Nutrition Programmes in Emergencies: Why, What and How* can be translated. "Data were so interesting. It might be useful to read the slides in French," wrote one participant.
- **Increased participation from health and nutrition sectors.** Although UNICEF country offices were allowed to send participants from education, nutrition and child protection sections, participants mainly came from the education sector. Many comments underlined the necessity to set quotas for nutrition, health and child protection officers for future trainings. It might have enriched the debate. "My colleagues from nutrition should be here to understand that it is not only food [that] we need to provide!" wrote one participant.

The Way Forward for Participating Country Teams

During the last two days of training, country teams brainstormed on country-based interventions to operationalize the integration of ECD activities in nutrition practices in emergency situations. The rollout of the training at the country level has been identified as one of the most urgent activities to strengthen capacities of nutrition, health and social workers on the front lines of emergency response. Other initiatives include:

- The realization of an ethnographic study
- Adaptation of training to cultural practices
- Identification of volunteers or other staff to conduct psychosocial support and stimulation activities
- Capacity-building
- Monitoring and evaluation

Participants discussed specific activities to be included in on-going national responses to the emergency and are currently implementing their plans. For example, in Mali, NGO and nutrition workers are already being trained on early psychosocial stimulation.

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Annex 1

Care for Child Development Training

UNICEF WCARO, Dakar
11 – 15 June 2012

List of participants

COUNTRY	NAME	ORGANIZATION/SECTOR	EMAIL
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ANNEX 2

Care for Child Development Training, UNICEF WCARO, Dakar, 11 – 15 June 2012

Feedback form

1. How useful has this training been for you?

1	2	3	4	5
Not useful		Useful		Very useful

2. Name two likely entry points for integration of ECD into nutrition activities in your context.
3. Which topic was the most useful to your work in the nutritional crisis?

4. What methods of learning were the most useful to you? Tick all that apply.

□ Demonstration □ Clinical practice □PowerPoint presentations □ Videos
□ Classroom exercises/discussion □ Group work □Planning exercises

5. Were the training materials sufficient to study the topic? □ Yes □ No

6. Was your previous knowledge or background sufficient to understand the subject?
□ Yes □ No

7. How satisfied were you with the overall organization (sites, hours, etc.)?

1	2	3	4	5
Not satisfied		Satisfied		Very satisfied

8. How satisfied were you with the method of teaching?

1	2	3	4	5
Not satisfied		Satisfied		Very satisfied

9. Identify two recommendations for improving the workshop.

If you would like to add any comments, please feel free to write them on the reverse page.

Annex 3

Care for Child Development Training

11 – 15 June 2012

Dakar, Senegal

Agenda

11 June Day 1	Topic	Method	Pages in Manual
9:00 – 10:15	**Opening** Registration Opening Remarks Introduction of participants Administrative announcements	Introductions PowerPoint presentation	
	Introduction **Who is the caregiver?** **Caring for the child's development** *Discussion: Care for child development*	Reading Discussion	1-10
10:15 – 10:30	**COFFEE BREAK**		
10:30 – 12:00	**Recommendations for caring for the child's development** *Video demonstration: Recommendations for pla and communication* *Discussion: Using the counselling card*	Reading Discussion	11-25
12:00 – 13:00	**LUNCH**		
13:00 – 13:30	Transfer to the inpatient ward		
13:30 – 15:30	**Clinical practice at St. Martin de Rebeuss, Intensive Nutritional Rehabilitation Centre, Dakar: Playing and communicating with children**	Clinical practice (inpatient ward)	
15:30 – 16.00	Transfer to UNICEF WCARO		
16:00 – 16:15	**COFFEE BREAK**		
16:15 – 17:00	**Debriefing: Play and communicate with children**	Discussion	
17:00 – 17.15	**Counsel the family** *Exercise: Identify the child and caregiver*	Reading Exercise	28-30
17:15 – 18:00	**Look, Ask, and Listen: Identify care practice** **Praise and Advise:** **Improve care practices** *Role Play Exercise: Advise the caregiver*	Reading Discussion	31-41

12 June Day 2	Topic	Method	Pages in Manual
9:00 – 9:30	Transfer to the health facility		
9:30 – 11:30	**Clinical practice at St. Martin de Rebeuss Outpatient Nutritional Rehabilitation Centre, Dakar:** **Counsel the family**	Clinical practice (community or outpatient setting)	
11:30 – 11:45	**COFFEE BREAK**		
11:45 – 12:30	**Clinical practice** (continued)		
12:30 – 13:00	Transfer to UNICEF WCARO		

13:00 – 14:00	**LUNCH**		
14:00 – 15:00	**Debriefing: Counsel the family**	Discussion, videos and pictures	
15:00 – 16:00	**Help solve problems** *Role Play Exercise: Help solve problems* *Video exercise: Identify and help solve problems*	Reading, discussion, role plays, videos	42-49
16:00 – 16:15	**COFFEE BREAK**		
16:15 – 18:00	Technical seminar 1	PowerPoint presentation Discussion	

13 June Day 3	**Topic**	**Method**	**Pages in Manual**
9:00 – 10:00	**Follow up the caregiver and child**	Reading, videos	50-51
10:00 – 11:00	Classroom training practice**:** Counsel the family and help solve problems	Classroom role plays Review videos	
11:00 – 11:15	**COFFEE BREAK**		
11:15 – 13:00	Classroom training practice (continued)	Classroom role plays Review videos	
13:00 – 14:00	**LUNCH**		
14:00 – 15:30	Classroom training practice (continued)		
15:30 – 15:45	**COFFEE BREAK**		
15:45 – 17:00	Technical seminar 2	PowerPoint presentation Discussion	

14 June Day 4	**Topic**	**Method**	**Pages in Manual**
8:45 – 9:30	Transfer to the community centre		
9:30 – 11:30	**Clinical practice at Maison Rose, Child protection centre, Guédiawaye: Counsel the family and help solve problems**	Clinical practice (outpatient or community setting)	
11:30 – 11:45	**COFFEE BREAK**	At outpatient or community setting, if possible	
11:45 – 12:30	**Clinical practice** (continued)	Clinical practice (outpatient or community setting)	
12:30 – 13:15	Transfer to UNICEF WCARO		
13:15 – 14:15	**LUNCH**		
14:15 – 16:00	**Debriefing: Counsel the family and help solve problems**	Discussion, videos and pictures	
16:00 – 16:15	**COFFEE BREAK**		
16:15 – 17:00	**Adaptation, planning workshop** Delivery opportunities and needs	PowerPoint Presentation, Discussion	
17:00 – 18:00	Adapting Care for Child Development for cultural sensitivities, marginal families in need, and delivery channel	Discussion Exercises	

15 June Day 5	Topic	Method	Pages in Manual
9:00 – 10:00	**Adaptation, planning workshop** (continued) Application to sample delivery channel (e.g. feeding programme, health system, or community health worker)	Discussion Exercises	
10:00 – 11:00	Application to country	Small group exercise	
11:00 – 11:15	**COFFEE BREAK**		
11:00 – 12:00	Application to country	Small group exercise	
12:00 – 13:00	Country plans and needs		
13:00 – 14:00	**LUNCH**		
13:00 – 15:00	Country plans and needs (continued)	Reports	
15:00 – 15:15	**COFFEE BREAK**		
15:15 – 17:00	Regional plans Closing	Discussion	