

Answers To Commonly Asked Questions About PD/Hearth

As part of a recent CORE Member Survey, PVO field and headquarters staff presented the following series of concerns and questions about PD/Hearth implementation. This section provides answers based on the guidance of the PD/Hearth Technical Advisory Committee, a group of practitioners and researchers that meets every two years to share lessons learned and to refine the approach.

Concern: *Many children do not graduate after participating in three or more Hearth sessions.*

Response: First, consider whether your menus each day contain the amount of nutrients specified in the CORE PD/Hearth Resource Guide? Secondly, are the caregivers bringing the child every day to consume the meal on site and practicing active feeding? Was the child dewormed and given micronutrients prior to the Hearth session? If the answers to the above questions are “yes”, then, the children may have underlying illnesses that need to be treated. Any child who does not gain weight after regular participation in two Hearth sessions where the menus are adequate should be referred for medical evaluation. Children who do not gain may be suffering from tuberculosis, repeated malaria, or another serious health problem, which must be treated before they will gain weight. Social issues at home, such as domestic violence, alcoholism, or depression, may also interfere with the caregiver’s ability to care for the child. If volunteers become aware of such issues, they may need to refer these families to appropriate services.

Consider whether you have set your graduation criteria too high. Perhaps many children are achieving catch-up growth of 400g, and/or are now steadily maintaining an upward trend on the growth curve, but have not achieved “normal” weight for age status. It may be more practical to graduate such children, giving them continued follow-up during home visits, rather than discouraging the caregiver by asking her to repeat yet another session.

Concern: *The mothers are too poor to contribute the PD food or any food to the Hearth session.*

Response: If the families are too poor to purchase the PD food, then, the program must evaluate whether the PD families were indeed as poor as those with malnourished children. If the families cannot bring any food, perhaps some days, they can bring water, firewood, cooking pots, or devote additional time to clean up after each session. At some point during the session, each participant should bring the PD food, if one has been identified, so that they have an opportunity to see how much it costs or where to obtain it. Having the Hearth participants discuss amongst themselves where they are obtaining the PD food and how much it costs can enable all the caregivers to learn where they can get it affordably. Carefully planning menus to serve only the malnourished children will minimize the amount of food that each participant must bring. Mothers and accompanying siblings can be offered a cheap snack instead of the meal, perhaps provided by the implementing agency. Families with extreme food insecurity will need to be referred to companion programs of micro-enterprise, home gardening and small livestock production, and/or improved agriculture production and marketing.

Concern: *The houses of the malnourished children are some distance apart, making it difficult for the caregivers to come every day; therefore, we are only holding Hearth sessions twice a week.*

Response: Caregivers and children must attend 10-12 days within a two-week period. Consuming the nutrient-dense menu in this concentrated fashion will bring about rapid recovery, with visible signs such as improved appetite, increased alertness and activity, and less irritability and crying. It is the recognition of these signs which motivates families to continue the new practices. If houses are very far apart, this is probably not an appropriate setting to implement PD/Hearth. An alternative would be to hold weekly or monthly meetings with caregivers to demonstrate preparation of PD foods, active feeding, appropriate breastfeeding, etc. Good quality, individualized counseling at monthly growth monitoring sessions is another option.

Question: *We felt that we learned enough from our first PDI that we didn't need to repeat the exercise in the other communities. Why does the CORE PD/Hearth Resource Guide say to do it in every community?*

Response: The Positive Deviance Inquiry (PDI) is a learning opportunity for the community, not just fact-finding for the project staff. It is meant to provide an opportunity for community members (Hearth volunteers, health staff, community leaders, etc.) to “discover” that very poor families have certain good practices that enable them to prevent malnutrition and these can be done by any family with similarly scarce resources. The PDI should be conducted relying on observation as much or more than on discussion with family members. It is not meant to be a structured interview. The participating community members will need some training on how to conduct the discussions and make thorough observations. Role-plays are good training for this. Project staff will have to help community members analyze the findings and draw conclusions.

Concern: *The PD mothers don't want to volunteer to lead the Hearth sessions.*

Response: PD mothers are rarely asked to be volunteers. Any willing, respected woman who does not currently have malnourished children can be the volunteer. When identifying positive deviants, we are not looking for model families or model mothers. In fact, the PDI usually identifies a composite of practices from various families. No one family or one caregiver has all the desired behaviors. The PDI mother may be doing a good job of caring for her children, but the community knows that she is not a model citizen in other respects; therefore, it is risky to expect her to be the PD/Hearth volunteer. In some cultures, elevating one woman or one family as models, may result in social rejection by their peers. Only those who participate in the PDI know who the PD families are.

Concern: *We want to implement PD/Hearth but feel our community health volunteers already have too much to do.*

Response: It's usually necessary to recruit new volunteers for PD/Hearth rather than burdening community health volunteers with another responsibility. Existing volunteers can make a significant contribution during the initial community mobilization phase, and perhaps participate

in the PDI. After that, the designated PD/Hearth volunteers will be more able to devote the necessary time to conduct the sessions and follow-up home visits. The community health volunteers may be instrumental in promoting daily participation, and in organizing a community growth-monitoring system if one does not already exist. They should also be involved in presenting the PD/Hearth results to community leaders or the health committee. Since PD/Hearth is self-limiting, ending within a year or so after all malnourished children have participated, the PD/Hearth volunteers will not need to be maintained. However, many programs have found that these women are so motivated by their success with PD/Hearth that they wish to become regular community health volunteers.

Concern: *We've heard that some agencies simply give the participating caregivers cash to go buy the food in the market.*

Response: There may be some confusion on this point. During the training phase, the PD/Hearth volunteers are given money to go buy the foods for the menus so that they can see for themselves that the foods are affordable and to learn to judge the quantity needed. This is a one-time learning experience. Some agencies do subsidize the staple foods either through having the volunteers purchase them or using food aid commodities. Sometimes, community leaders purchase, or give cash to the volunteers to purchase, staples such as cooking oil. To avoid paternalism, promote sustainability, and enable caregivers to learn, the participants should be expected to bring the PD foods (if one is identified) and/or other nutritious menu components.

Question: *In all our PDIs, we never found any particular PD foods. How should we plan our menus?*

Response: Often, there are no obvious PD foods found. In this case, the menus must be planned around any affordable, locally available foods that can be combined to achieve the recommended nutrient density. After the menus are developed, it might be beneficial to have the volunteers ask relatives or neighbors to prepare and taste them to assess their affordability and acceptability. The focus of the Hearth sessions will then be on the active feeding, caring and/or health behaviors that were identified in the PDI.

Question: *The CORE PD/Hearth Resource Guide states that PD/Hearth is most effective in communities where at least 30% of children are malnourished. Why is this?*

Response: PD/Hearth is cost-efficient only where there is a sizeable concentration of malnourished children. The thirty percent cut-off may include mild, moderate and severe levels of malnutrition, but programs concerned with cost efficiency may want to focus PD/Hearth activities on those who are moderately or severely malnourished while using less intensive methods to address the children with mild malnutrition. In large communities, an alternative criterion may be the presence of at least 100 moderately or severely malnourished children in the 6- to 36-month age range. Since it is unlikely that an implementing agency will have done a census-based nutritional assessment prior to deciding whether to implement the program, the decision can be based on existing growth monitoring data, data from surveys of a representative sample of the population, or other existing data.

Question: *Why do I need to use weight-for-age in PD/Hearth programming? What about weight-for-height of MUAC?*

Response: PD/Hearth uses weight-for-age because that is the indicator most sensitive to change and does not require quality height measurements, which are difficult to collect. While Mid-Upper Arm Circumference (MUAC) is useful in screening for malnutrition in emergencies, it is not specific enough to identify all children who are also below weight for their age.