USAID'S REGIONAL HEALTH INTEGRATION TO ENHANCE SERVICES IN EAST CENTRAL UGANDA (USAID RHITES-EC)

CASE STUDY

Implementing an Effective Community-Based Rehabilitation Program for Children with Moderate Acute Malnutrition in Namutumba, East Central Uganda

Background

In March 2018, the average global acute malnutrition (GAM) rate in children in Nsinze and Magada subcounties in Namutumba district in East Central Uganda was 39.5%, which is above the national threshold of 30%. To address the nutritional status of children and improve the GAM rate in these two subcounties, the USAID Regional Health Integration to Enhance Services in East Central Uganda (USAID RHITES-EC) worked with Namutumba District Local Government to pilot the Positive Deviance/Hearth (PD/Hearth) Approach.[1]

Caregivers preparing nutrient-dense foods for their children during a PD/Hearth session.

Interventions

USAID RHITES-EC piloted the PD/Hearth Approach in 10 villages over a 26-day period from March to April 2018. The pilot consisted of nutrition rehabilitation sessions targeting families with moderately malnourished children aged six to 59 months old. The PD/Hearth pilot aimed to achieve a 75% cure rate for these children by implementing the following detailed steps:

1. **Mobilized and oriented community gatekeepers, caregivers, and health workers:** The project identified and sensitized key community gatekeepers, including village health teams (VHTs), local village leaders (LCs), and opinion/cultural/religious leaders, and caregivers about the negative impact of malnutrition on children, malnutrition myths and misconceptions, and community practices to improve nutrition and health. USAID RHITES-EC also oriented health care workers and VHTs on the PD/Hearth Approach.
2. **Conducted Positive Deviance Inquiry (PDI):** The project used PDI, a community-specific survey, to identify demonstrable, successful, and desired practices

[1] The Positive Deviance/Hearth Approach is a home-based and neighborhood-based nutrition program for children who are at risk for malnutrition

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and behaviors of positive deviant caregivers that could be replicated by others in the communities. The survey involved:

a. A rapid baseline nutrition assessment, including mid-upper arm circumference (MUAC) or Weight-for-Age to identify malnourished children;

b. Community-specific wealth ranking to determine poor and wealthier households. The project used the rankings to identify 'potential positive deviants', or model households (e.g., households with well-nourished children who practice good nutrition practices); and,

c. Sessions to discuss community feedback on the rapid baseline nutrition assessment findings. The sessions also included community dialogues to address myths and causes of malnutrition, create community action plans, and discuss caregivers' roles in addressing malnutrition with an emphasis on male involvement. USAID RHITES-EC also used the nutrition status of children <5 years as a proxy for the overall nutrition status of the children in their communities. By sharing this information, the project aimed to help community members understand the nutrition status of their children and encourage them to participate in the PD/Hearth sessions and address malnutrition.

3. **Designed and conducted hearth sessions:** USAID RHITES-EC invited caregivers of children with moderately acute malnourished to participate in the hearth sessions. Each hearth consisted of six to 10 moderately malnourished children. The project worked with VHTs to identify model mothers (positive deviants) to facilitate hearth sessions that focused on practical nutrition rehabilitation. These mothers were already practicing appropriate health behaviors[2] and had a compound capable to host other mothers. Facility-based health care workers trained these model mothers to conduct the 12 sessions (three hours every day) for households with moderately malnourished children. The model mothers taught the caregivers how to recognize signs of malnutrition and how to treat them with locally available nutrient-dense foods, such as dark green leafy vegetables, groundnuts/simsim, orange-fleshed sweet potatoes, and eggs. They also led cooking demonstrations. As part of these activities, it was important for the caregivers to contribute locally available foods to enable them to easily take up the newly learnt practices. The hearth sessions also included information on childcare, health care seeking, child feeding, hygiene, and food preparation practices. During the sessions, facility staff also immunized children based on national guidelines and weighed them on specific days (1, 4, 8, 12) to monitor their growth/weight gain. Facility staff also managed any illnesses among the children.

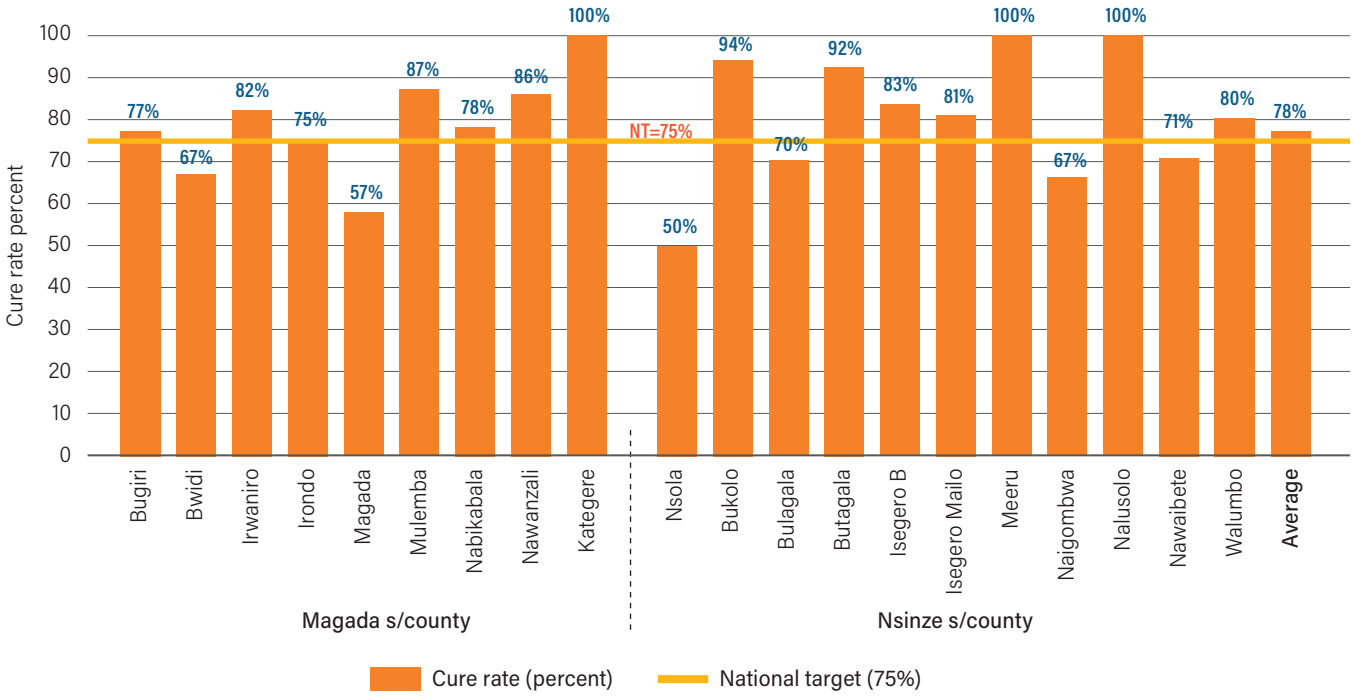
There is plenty of nutritious food at this well attended PD/Hearth session.

4. **Supported caregivers to sustain good nutrition practices:** Following the 12 rehabilitation sessions, VHTs and community model mothers followed up with the caregivers for 14 days to support them in maintaining the newly learned good nutrition practices at the household level.

5. **Evaluated success of hearths on Day 26:** USAID RHITES-EC conducted a rapid post nutrition assessment at the end of the pilot for all children who had participated in the hearth sessions. The assessment helped to determine their weight gain, assess the adoption of practices for each participating household, and collect feedback from the hearth attendants on the program.

[2] Healthy behaviors include healthy child feeding, practicing exclusive breastfeeding of newborns until six months, breastfeeding up to 2 years, and having a bathing shelter, pit latrine, drying rack and rubbish pit.

Figure 1. Cure rate for children enrolled in the 26-day PD Hearth program



Results

A total of 247 caregivers and their children participated in the hearth sessions at 20 different sites within Nsinze and Magada subcounties in Namutumba district. A total of 263 children who were assessed at baseline and identified with GAM were invited to participate in the hearth sessions. At the end of the 12-day period, a post nutrition assessment revealed that 73.4% (193/263) of the children had gained at least 0.2 kg. Attaining an increase in weight of 0.2 kg was a pre-requisite for graduating from the community-based rehabilitation program. At the end of the pilot, including the 14-day follow-up period, 78% (205/263) of the children gaining an average weight of 1.2 kg and were deemed to be cured of malnutrition.[3] On average, the cure rate of 78% for the 20 hearths session sites was above the 75% minimum national standard cure rate for malnutrition programs. Only six hearth session sites performed below the national target. This sub-optimal performance at these sites was largely attributed to inconsistent attendance at the hearth sessions during the 26 days and illnesses among the participating children.

Lesson learnt and conclusion

Implementing a community-based malnutrition rehabilitation approach, such as the PD/Hearth Approach, can influence appropriate child-feeding practices and improve nutrition outcomes for malnourished children within 26 days. The PD/Hearth Approach engages positive deviant caregivers (model caregivers of well-nourished children) to transfer their positive practices to peer caregivers who have malnourished children in the community. This type of strategy can be effectively scaled up to other communities and districts where malnutrition levels are above 30%. Success hinges on the ability of community members to contribute locally available foods during the hearth sessions and the caregivers' consistent attendance at the PD/Hearth sessions. Other malnutrition prevention interventions can also easily be integrated into the PD/Hearth sessions to comprehensively address the childhood malnutrition challenge.

[3] Children were considered to have been cured of malnutrition if they gained at least a total 0.4 kg after the 14th follow-up visit during the 26-day program period.