



Positive Deviance/Hearth

An effective approach for treating children under six years of age with moderate malnutrition

PRIMARY TARGET GROUP

PD/Hearth is used for children aged six to 36 months experiencing moderate and severe underweight.

What is this approach?

Positive Deviance/Hearth (PD/Hearth) focuses on communities where 30% or more of young children are moderately and severely malnourished as measured by low weight-for-age (underweight). Beneficial practices by mothers or caregivers of well-nourished children from impoverished families (positive deviants) are carefully studied, so lessons can be learned from their practices. A hearth facilitator forms a committee to mobilise local partners and the community, and trains volunteers. Two weeks of practical home-based nutrition training is conducted and families use their own resources to feed malnourished children.

When would this project model be used?

When nutrition is identified as a priority area by WV in a relatively stable community with a high percentage of vulnerable and moderately malnourished children. The support of a nutritional advisor and provision of training and support for volunteer trainers are both essential.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
CWBO	Child Well-Being Outcome
DADD	Do, Assure, Don't Do
FGD	Focus Group Discussion
GMP	Growth Monitoring Promotion
HIV	Human Immunodeficiency Virus
IDPs	Internally Displaced Persons
IMCI	Integrated Management of Childhood Illness
IPM	Integrated Programming Model (now called World Vision's Development Programme Approach)
IYCF	Infant and Young Child Feeding
MoH	Ministry of Health
NERS	Health and Nutrition Education and Rehabilitation Sessions
NGO	Non-Government Organisation
ORT	Oral Rehydration Fix
PD	Positive Deviance
PDI	Positive Deviant Inquiry
PMTCT	Preventing Mother-to-Child Transmission
WAZ	Weight for Age Z-Scores
WV	World Vision
WVI	World Vision International

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Positive Deviance/Hearth project model

I. What is 'PD/Hearth' about?

Positive Deviance/Hearth (PD/Hearth) is an internationally proven community-based project model for rehabilitating malnourished children in their own homes. It targets moderately and severely malnourished children aged between six and 36 months.¹

From birth to three years of age, children experience very rapid growth and development. Children who are malnourished during this stage of life will not develop to their full potential. Early malnutrition affects a child's physical, mental and emotional capacity throughout their entire life. Malnourished children are one of the most vulnerable groups in any community.

'Positive deviance,' means 'different in a positive way from what is usual practice.' 'Hearth' refers to the place within a house where food is cooked and served. Despite limited resources, some parents find ways to raise well-nourished children. Understanding what these 'positive deviant families' are doing differently from the parents of malnourished children in the same community is the foundation for this project model. Volunteers share this knowledge and teach these practices to caregivers with malnourished children in practical lessons called 'Hearth' sessions.

PD/Hearth empowers communities to take responsibility for addressing the causes of malnutrition.

I.1. What are the issues/problems that the project was developed to address?

This project model is for communities with a high prevalence of underweight children, when either 30 per cent or more of the community's children or ≥ 90 children under five years of age are mildly, moderately or severely malnourished (low weight-for-age).

The *PD/Hearth* project model may have been identified through World Vision's Development Programme Approach (formerly called the integrated programming model (IPM)) community engagement processes, detailed within the Critical Path. For this project model to be considered, childhood malnutrition will have been identified either as a community priority or as a root cause of a related issue.

If no nutrition data is available for the programme impact area, the following issues and root causes of malnutrition may emerge during community discussions that indicate that a *PD/Hearth* project may be needed:

- poor access to energy-rich, nutrition-rich food
- lack of availability of energy-rich, nutrition-rich foods
- lack of knowledge as to how to prepare nutritious foods for children
- children lacking energy, prone to illness, slow to heal and lacking appetite
- children growing slowly or poorly
- children dying
- harmful cultural practices, myths and food taboos.

¹ Some projects expand this range to include children age six to 59 months, all children under five.

Root causes of the identified community's child well-being priorities are explored at Step 5.2.1 of the Critical Path. At this point, the *Health and Nutrition ADAPT* tool will have been referred to and used to help explore root causes related to health and nutrition priorities. *PD/Hearth* is one of several project models that may have been suggested as an appropriate means of addressing health and nutrition needs in the community. The project model's possible implementation should be considered and discussed with local level partners. Some additional primary data may have also been collected during Step 5, using the ADAPT for Health and Nutrition to assist in the analysis of the root causes and the identification of the most appropriate projects to consider.

In considering the most appropriate project models to implement within a community, it is important to ensure that the projects complement and support similar goals. For example, if the *PD/Hearth* project model is being adopted, consider implementing a supporting small-scale, household-level food security project as well.

1.2. What are the main components of the model?

The main features of the *Positive Deviance/Hearth (PD/Hearth)* project model are as follows:

- **Feasibility of PD/Hearth I – nutrition analysis:** Technical staff members identify locations with high levels of malnutrition by collating information from the programme baseline or other reports, secondary data, such as national demographic and health surveys, or reports from non-governmental organisations (NGOs). In this way, the target population is determined and the weight for age z-scores (WAZ) of all the children in the target population are measured to identify their nutritional status.
- **Feasibility of PD/Hearth II – situational analysis:** To further identify the feasibility of the project model for the target community, focus group discussions (FGD), interviews, market surveys and wealth ranking is conducted to gather specific information on the community's 'norm' in child feeding and caring practices in order to determine the underlying causes of malnutrition. More importantly, positive deviant households are also identified.
- **Community-based discovery:** Discover key practices that result in positive deviant households by conducting a Positive Deviance Inquiry (PDI), interviewing and observing hygiene, health-seeking and child caring practices, and most importantly identifying how food is obtained, prepared and fed. This information is used to develop a nutrient-dense menu that is easily accessible and affordable and to design the key messages to be shared during the Hearth session, messages specifically designed for the community.
- **Nutrition and health behaviour change communication:** Behaviour change theory suggests that repeating a behaviour encourages the new behaviour to become a habit.² Thus, 12-days of 'Hearth' sessions, which include sharing key health messages, hands-on experience practicing hygiene, food preparation and feeding practices, and two weeks of follow-up home visits, ensures behavioural change in caregivers. Positive behavioural changes increase caregivers' ability to rehabilitate their malnourished children.
- **Build local capacity to sustain and prevent future malnutrition:** From the beginning of the project model's implementation, mobilise the community and local community leaders to create a Hearth committee or working group. It is important to

² Wollinka, O., Keeley, E., Burkhalter, B.R., & Bashier, N. (1997) *Hearth Nutrition Model: Applications in Haiti, Vietnam, and Bangladesh*. Published for the U.S. Agency for International Development and World Relief Corporation by the Basic Support for Institutionalizing Child Survival (BASICS) project, Arlington, VA.

raise awareness and allow the community to know that overcoming malnutrition is affordable and the future of their children is in their hands. The Hearth committee becomes responsible for on-going monitoring of the programme and continues to spread positive deviant practices. Letting the community select the members of the committee or working group allows the community to take ownership of the project, making it sustainable.

1.3. What are the expected benefits or impacts of this model?

The goal of this project model is to increase the proportion of children in the community that are adequately nourished.

The benefits of such a project include:

- sustainable rehabilitation of malnourished (underweight) children
- families being able to sustain the improved nutritional status of their children through new feeding, cooking, hygiene and caring behaviours
- prevent future malnutrition among children born in the community
- raised awareness of malnutrition and that malnutrition can be affordably overcome
- easy integration with other interventions
- enabling the community to seek existing local solutions to address malnutrition.³

WV has implemented *Positive Deviance/Hearth (PD/Hearth)* in more than 20 countries since 1999, beginning in the Latin America and Caribbean region and expanding to the African and Asian regions. The results of World Vision's experience have recently been reviewed and a summary can be found in *Appendix A*.

1.4. How does the project model contribute to WV's ministry goal and CWB?

As a community-based, participatory project for addressing child malnutrition, *Positive Deviance/Hearth (PD/Hearth)* aligns with WV's ministry goal for the 'sustained well-being of children within families and communities, especially the most vulnerable' and with WV's strategic global focus on improved health and nutrition for children.

This project model contributes primarily and most directly to the aspiration of 'children enjoy good health' and the child well-being outcome of 'children are well nourished.' Because the child well-being outcomes (CWBOs) are interconnected, this approach has a secondary impact on the aspirations 'children are educated for life' and 'children are cared for, protected and participating.' The *PD/Hearth* project model is also aligned with WV's Health and Nutrition Do, Assure, Don't Do (DADD) framework in contributing directly to the Do of 'mobilise and build capacity of community-level maternal child health and nutrition stakeholders.'

2. Context considerations

2.1 In which contexts is the project model likely to work best?

Positive Deviance/Hearth (PD/Hearth) is likely to work best in the following situations:

³ Schroeder, Marsh, Pachon, et al. (2002). Food and Nutrition Bulletin Special Report. <http://www.positivedeviance.org/pdf/publications/marsh.pdf>

- where $\geq 30\%$ of the community's children OR ≥ 90 children under five years of age are mildly, moderately, or severely malnourished (low weight-for-age)
- in locations where families live close enough to be able to meet daily for two weeks
- in locations where community members are willing to take an active role and where the community is supportive of the project
- where food security or agriculture projects are on-going or planned (Availability of affordable nutritious food is important and projects such as household gardens, poultry and egg production, and raising small animals is important for the sustainability of the outcomes of this project.)
- where complementary health services are present (Being able to refer children that have underlying illnesses or medical conditions is important. It is also important to work with functioning health centres to provide important inputs, such as deworming, immunisations and micronutrient supplementations.)
- where growth monitoring is taking place so that malnourished children can be identified
- where there is a stable population who identify as belonging to the community
- organisational commitment of local level partners.

PD/Hearth can be implemented in rural and urban areas if the above criteria are met.

2.2 In which contexts should this model not be considered?

Positive Deviance/Hearth (PD/Hearth) is difficult to implement, or should not be considered, in the following situations:

- areas suffering from extended drought
- areas suffering from household food insecurity for periods of more than three months (However, aspects of the *PD/Hearth* approach may still be implemented with some adaptations in these areas.)
- where food aid activities are being conducted
- areas with internally displaced populations (IDPs) and refugees (However, using the positive deviance approach without the hearth component may be useful to identify effective coping strategies and skills for these areas.)
- where households are vastly scattered
- communities with landless populations or squatter communities (This is difficult unless the project model is combined with some type of income-generation project to support household food security.)
- where there is significant ongoing conflict
- in emergency settings.

2.3 What questions should field staff ask, and are there particular context factors relating specifically to this project model that they should consider when adapting this model?

Some of the questions that need to be considered are regarding the identification of children from the most vulnerable groups. When identifying malnourished children, extra care needs to be taken to ensure that children from vulnerable or marginalised groups are included. For example, disabled children may be hidden or children from ethnic minority groups may be excluded. The working group can review the work done by the starter group in earlier steps of the Critical Path. For example, in Step 3, the starter group defined

vulnerability for the area and created a map of the most vulnerable households. This information can be used to identify the most vulnerable children.

If this project model is being considered for an urban area where there is limited space for complementary projects, such as small animal keeping or household gardens, consider other innovative complementary projects that would still allow *Positive Deviance/Hearth (PD/Hearth)* to proceed. Likewise, if working with squatter populations, it may be possible to adapt the project model to fit the context but it would require some flexible, imaginative and innovative approaches. For example, pairing the Positive Deviant Inquiry (PDI) with a behaviour change methodology that is more contextually appropriate may be more suitable if the caregivers are unable to meet on a daily basis for the 12 days of 'Hearth' sessions.

Other projects that may complement *PD/Hearth* and could be implemented simultaneously are projects that address the root causes of malnutrition and illness, such as food security or water and sanitation projects.

3. Who are the key target groups and beneficiaries of this model?

3.1 Primary target group(s)

The primary target group for *Positive Deviance/Hearth (PD/Hearth)* are the caregivers of children aged six to 36 months with moderate and severe under-nutrition. The caregivers are empowered to implement their new knowledge and skills, including those to improve the food security of their households.

3.2 Who are the intended primary beneficiaries?

The primary beneficiaries of the project are children aged between six and 36 months who are moderately or severely malnourished as defined by weight-for-age. They attend intensive caring and feeding sessions with their caregiver(s) and become well nourished.

Indirect beneficiaries include:

- Older and younger children in the family benefit, as caregivers practice new caring and feeding habits at home.
- Caregivers directly benefit by being empowered to implement their new knowledge and skills, including those to improve the food security of their households.
- Community volunteers and partners benefit from training and supervised implementation, contributing to improved delivery of health services and food security.
- Other children in the community benefit through the promotion of locally-developed and appropriate key messages about nutrition and health through behaviour change communication.

3.3 Life cycle stages to which the model contributes

Positive Deviance/Hearth (PD/Hearth) is aimed specifically at children aged six to 36 months of age and women during child-bearing years, but it also contributes to other stages of the life cycle.

Preventing and treating malnutrition in children less than two years of age benefits the child in all subsequent life cycle stages. A well-nourished child has a greater cognitive capacity to learn during school, better protection from infection and disease and adequate growth as

an adolescent. When well-nourished girls become women and have children, their children are more likely to be well-nourished as well. Good nutrition during pregnancy and during the first two years of life also lowers the risk of obesity, high blood pressure and cardiovascular disease in adults.⁴

3.4 How will the model include/impact the most vulnerable?

Children from vulnerable or marginalised groups often suffer from higher levels of malnutrition. Groups to be aware of, and ensure are included in the project, are disabled children, abandoned children, children in institutions, children suffering violence, children affected by HIV and AIDS, children from ethnic minorities, children affected by armed conflict and other marginalised populations such as girls.

Positive Deviance/Hearth (PD/Hearth) should identify all malnourished children. By recognising, including and involving children from traditionally marginalised groups *PD/Hearth* can change the community's perceptions and increase the involvement of marginalised groups within the community.

In contexts where males are culturally valued over females, girls and women are often given less care, less food or lower quality food. Therefore, they may be more susceptible to malnutrition. In these situations the project may address the negative cultural practices and provide peer support for the mothers or caregivers.

Building the capacity of community leaders, volunteers, healthcare providers and caregivers to recognise, treat and prevent malnutrition decreases children's vulnerability. Each participating child attends the 'Hearth' sessions with his/her caregiver. Children in child-headed households, or in households where the caregivers may be temporarily absent, attend the 'Hearth' sessions with an older sibling or another responsible person.

Through the community-wide nutrition analysis all children are weighed and the most vulnerable are identified for inclusion in the project.

In general, the key benefits of the *PD/Hearth* project model to the most vulnerable include:

- decreased risk of child illness and infection
- improved access to basic healthcare and nutrition support (Community mobilisation activities, including active-case finding of malnourished children, ensure that vulnerable groups who are often excluded, participate.)
- improved child nutritional status
- peer support for mothers and caregivers of vulnerable children
- honouring local practices and wisdom which support maternal and child health
- improved learning potential and future performance of children.
- addressing harmful, gender-biased cultural practices, such as preferential food provision.

⁴ Allen, L.H. & Gillespie, S.R. (2001) *What Works? A Review of the Efficacy and Effectiveness of Nutrition Interventions*. Asian Development Bank with the UN ACC Sub-Committee on Nutrition. http://www.adb.org/documents/books/nutrition/what_works/prelim.pdf.

4. How does the project model work?

4.1 Overview of approach/methodology

In general, once the *Positive Deviance/Hearth (PD/Hearth)* project model has been identified as being appropriate for the context, and has been agreed on by the local-level partners and the community, project implementation begins.

The suggested sequence for project implementation is as follows:

- Conduct a programme baseline and situational analysis to identify the feasibility of *PD/Hearth* in the target community. Identify positive deviant children and *PD/Hearth* participants and plan culturally acceptable and affordable menus.
- Mobilise and select and train working group members, community volunteers and staff.
- Prepare for and conduct a Positive Deviance Inquiry (PDI).
- Design 'Hearth' sessions.
- Conduct a 12-day *Hearth* session, ensuring that all participating children are fully immunised, dewormed and received Vitamin A supplementation on the first day.
- Support new behaviours through daily follow-up visits for two weeks after the completion of the 12-day 'Hearth' sessions. After two weeks, continue the follow-ups monthly.
- Repeat 'Hearth' sessions as needed.
- Expand *PD/Hearth* into other areas within the primary focus areas.

The community participates in a process to discover their own sustainable and contextually appropriate solutions for malnutrition. This investigation includes weighing children within the community and discovering those that are, or are not, malnourished. The investigation serves as a baseline for the project and also provides a way of identifying children who are not malnourished. These children are referred to as positive deviants. A Positive Deviance Inquiry (PDI) is conducted in the households of these children, enabling the community to discover for themselves the good health and nutrition practices in local families where children are well-malnourished. These practices may include identifying local foods to improve nutrient density, proactive child feeding techniques or positive hygiene practices.

Successful caring and feeding practices are taught to caregivers of underweight children in an intensive 12-day behaviour change activity ('Hearth' sessions). Recipes to provide 100-800 kcal, 25-27 grams of protein and adequate micronutrients are developed based on the PDI.

Community volunteers invite a small group of caregivers (usually six to eight mothers) with malnourished children to their homes for 12 consecutive health and nutrition education and rehabilitation sessions (NERS). During each daily session, the caregivers prepare the local recipes together and the volunteer encourages them to learn and practice the recommended child feeding and care behaviours. The children are fed a nutritious meal and snack based on the local foods identified in the PDI. The *PD/Hearth* meal is an extra meal and is not meant to diminish to the number of meals the children consume at home. Each family contributes to the sessions by bringing a food item or another necessary input such as firewood or a cooking pot. Caregivers feed their children, learning how much food to feed them and how to encourage them to eat more.

Over the 12-day period, the children often visibly improve, showing more energy, and increased appetite and weight gain. After the sessions are over, the volunteers follow-up

with home visits to further encourage families to continue applying the learned behaviours. The weight of children is monitored for several months. Caregivers with children who do not gain weight are encouraged to complete the session again, bringing their child.

Experience shows that ‘Hearth’ sessions are most successful when limited to six to eight caregivers. The project works best when it is started in a small number of locations and then gradually expanded to rehabilitate all malnourished children in a primary focus area, and where the model is integrated with food security, agriculture and economic development activities.

4.2 What local level partners could be involved?

A working group is formed in Step 5 of the Critical Path. A list of potential partners (members of the working group) is provided below. Local government representatives are essential members of the working group.

TABLE I: Recommended local partners	
Partner(s)	Key partnership roles
<ul style="list-style-type: none"> ● Local Ministry of Health ● Health providers ● Ministry of Social Welfare ● Ministry of Agriculture ● Ministry of Education ● Health post staff ● Birth attendants ● Village doctors ● Village health workers ● Community health workers ● Agriculture extension workers ● Early education workers 	<ul style="list-style-type: none"> ● Provide health services (i.e. immunisations, deworming, micronutrient supplements) ● Train volunteers ● Conduct growth monitoring and promotion ● Aggregate growth monitoring results and communicate to district and national levels ● Communicate behaviour change messages ● Promote, train, support changes in agriculture and food security ● Promote healthy nutrition within day care, identify at risk children, ensure hygiene, and offer ways for women to continue breastfeeding ● Involve parents in early stimulation
<ul style="list-style-type: none"> ● Non-governmental organisations ● Community-based organisations ● Village development committee ● Village health committee ● Faith-based organisations ● Churches 	<ul style="list-style-type: none"> ● Facilitate community mapping and baseline assessments ● Facilitate community mobilisation and sensitisation ● Communicate and promote ‘Hearth’ sessions ● Assist in the selection of guide mothers and formation of groups ● Share and validate results with community members ● Provide training ● Implement complementary activities (e.g., water, sanitation, and hygiene activities) ● Implement ‘Hearth’ sessions as volunteers ● Participate as part of PDI team ● Monitor children
<ul style="list-style-type: none"> ● Community groups ● Women’s groups ● Farmers’ groups ● Volunteers 	<ul style="list-style-type: none"> ● Implement ‘Hearth’ sessions as volunteers ● Participate as part of the PDI team ● Monitor children

4.3 Partnering capacity context

TABLE 2: Partnering capacity context	
Context (Refer to Step 5 of the Critical Path)	Guidance on implementation
Few, or no, organisations	<ul style="list-style-type: none"> • Mobilise partner organisations
Weak organisations	<ul style="list-style-type: none"> • Build capacity in partner organisations
Strong organisations that are not child-focused or networked	<ul style="list-style-type: none"> • Catalyse a movement towards focussing on child well-being and protection and build understanding of the impacts of under-nutrition on children, adults and communities.
Established child-focused partnerships	<ul style="list-style-type: none"> • Join with child-focused partners to further expand and roll-out effective practices that positively impact child nutrition and child well-being.

4.4 How does the model promote the empowerment of partners and project participants?

Involving the community in the initial assessment and discovery of how to treat and prevent malnutrition using local foods and practices, builds ownership and increases the likelihood that community members will adopt *Positive Deviance/Hearth's (PD/Hearth)* good practices for fighting malnutrition. The project facilitator and the working group guide the community in finding solutions to the challenges of malnutrition, working with community members during design, implementation, monitoring and evaluation. Using local wisdom and resources increases the project's long-term goal of sustained child nutrition and decreases reliance on WV.

Aligning the project with government policies creates the potential for disseminating lessons learned more broadly and opens the possibility for advocating for policy change.

5. Project DME

5.1 What are the goal and outcomes that will be sustained as a result of this project model?

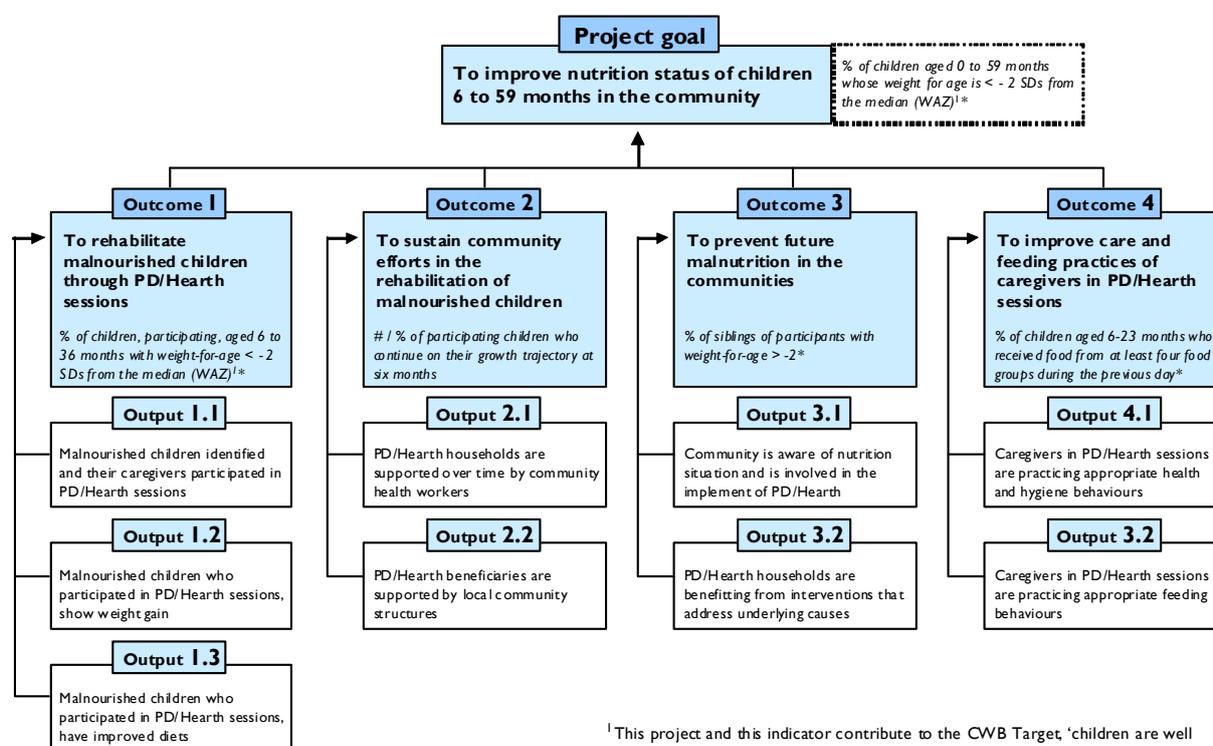
The goal of this project is to increase the proportion of children in the community that are adequately nourished.

The desired outcomes are as follows:

- malnourished children are rehabilitated through *PD/Hearth* sessions
- families are able to sustain the rehabilitation of children
- future malnutrition in the community is prevented
- local partners have the capacity to monitor children and provide 'Hearth' sessions (as needed).

5.2 Sample logframe

The diagram below shows the logic of this project model. The indicators shown below illustrate the types of indicators that can be used. An illustrative logframe including a range of potential indicators is provided in *Appendix D*.



5.3 Recommended monitoring methods

Regular meetings are held with the working group and key stakeholders to discuss the project's progress, reflect on improvements and discuss challenges. These meetings create space for reflection and for making necessary adjustments, ensuring the project stays on target and reaches its goals.

Method	Characteristic
Hearth monitoring	<ul style="list-style-type: none"> The working group supports and supervises community volunteers and stakeholders to ensure children are regularly monitored.
Project supervision	<ul style="list-style-type: none"> The working group, including WV and the local Ministry of Health supervise implementation. Regular meetings are conducted with the working group and other key stakeholders. The working group advocates with local or district leaders or government agencies for changing policy where needed.
Project monitoring and	<ul style="list-style-type: none"> The working group facilitates the collection of data by community

evaluation	<p>workers, including local MoH staff.</p> <ul style="list-style-type: none"> • The working group consolidates data and helps community to analyse and interpret the data. • A technical nutritionist is required to analyse the anthropometric data. • The working group facilitates reporting back to communities and to donors. • The working group conducts an end-of-project evaluation.
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5.4 Advocacy component(s)

Within the scope of this project, advocacy activities may focus on improving access to local health services, including advocating for the integration of growth monitoring protocols within the local government health infrastructure, and for access to adequate health services to reduce illnesses which aggravate malnutrition.

Citizen Voice and Action (CVA) is a local level advocacy methodology that aims to improve essential services (like health) by improving the relationship between communities and government. Sometimes WV staff will have identified shortfalls in government services during the LEAP Programme Assessment or during Steps 2, 3, and 4 of the Critical Path. Once these shortfalls are identified, CVA can be used to advocate for change in these areas.

CVA is an ‘enabling’ project model and is usually used as a component of another project model. For example, WV staff could implement the *PD/Hearth* project model while working with the government, through CVA, to address shortfalls in government health services.

Prior to adopting CVA, the initial ‘organisational and staff preparation’ phase must have been completed by the national office. Communities should be ready to engage government officials in a constructive, productive and well-informed manner. It is also essential that programme staff are trained in CVA and have excellent facilitation skills. For more information, see the *Citizen Voice and Action* project model on the Guidance for Development Programmes website: (www.wvdevelopment.org).

5.5 Critical assumptions and risk management

TABLE 4: Risk mitigation		
Critical assumptions	Importance (high, medium)	Management response
Lack of community commitment	High	<ul style="list-style-type: none"> • Consistently enable and facilitate local participation.
Stigmatisation of families with malnourished children	Medium	<ul style="list-style-type: none"> • Care must be taken throughout planning and implementation so families are not marked as being ‘better’ or ‘worse’ than others. (This issue is addressed during training with those who will carry out these inquiries with families.) • Make sure all community members understand why the mothers with malnourished children are participating, and others are not, thus facilitating strong community ownership of the problems and solutions of malnutrition.

Lack of commitment by WV at international, national, district or local levels to hire appropriate and adequately trained staff	High	<ul style="list-style-type: none"> Adequate numbers of staff and volunteers, including sufficient quality of nutrition technical support, is essential.
Turn-over of trained staff will negatively affect this project	High	<ul style="list-style-type: none"> The national office must make a commitment to maintain trained staff in position until the project is well established.
The quality and appropriateness of the training volunteers receive	High	<ul style="list-style-type: none"> Training must be thorough and contextualised to the appropriate learning level. Simple language must be used to describe technical issues.

5.6 Sustainability

The *PD/Hearth* project model enables local level partners, including the Ministries of Health and Agriculture, to work together and build their capacity for successful project implementation. This fosters ownership and ensures sustainability.

PD/Hearth is built on the principles of empowerment and sustainability. It does not rely on outside resources such as food aid. Instead, the model identifies and employs existing community knowledge and local resources to treat and prevent malnutrition. The project model builds the capacity of local level partners, communities and caregivers to monitor, improve and maintain the nutritional status of their children, and to prevent future malnutrition. Community members are empowered and enabled to take responsibility for their children's well-being.

Factors that contribute to sustainability include:

- use of locally available and affordable nutrient rich foods, without reliance on outside inputs
- key messages and practices developed from local knowledge and practice
- improved capacity of local level partners, including local government entities
- use of existing structures and local volunteers as peer educators
- improved knowledge and skills among health care providers, such as the Ministries of Health, Agriculture, and Education, in preventing and treating malnutrition
- improved capacity of community volunteers to mentor and monitor caregivers in sustaining behaviour changes
- community mobilisation and sensitisation to malnutrition
- locally-generated solutions to malnutrition, leading to a long-term local commitment.

6. Protection and equity considerations

6.1 How can child protection be promoted in the implementation of this project model?

PD/Hearth is designed to sensitise participants about children who are particularly vulnerable to malnutrition. Community members, volunteers and caregivers also grow in their awareness of how family violence, gender discrimination or alcohol abuse can negatively affect child well-being. The project model builds community members' capacity to address these issues and protect their children.

As with any World Vision (WV) intervention, it is critical that project staff identify possible child protection issues that could arise from implementing *PD/Hearth*. For example, there may be a risk that community volunteers conducting 'Hearth' sessions and doing home-visits, could abuse or exploit the children they come into contact with. To mitigate against this risk, staff must follow WV's standard child protection protocol.

- Develop criteria for selecting and screening volunteers, including those with partner organisations, especially in regards to protection issues.
- Develop preparedness plans for serious abuse or exploitation of children in target communities (WV level I child protection incidents).
- Train volunteers on the basics of child protection, such as what are child abuse, exploitation and neglect, and discuss how these issues are seen in the community.
- Train volunteers how to recognise signs of abuse, neglect and exploitation, and train them how to respond. Report and refer effectively and in timely manner under the WVI Child Protection Definitions and Response Protocol available [here](#).
- Communicate to community members (including children) what are inappropriate and appropriate behaviours towards children by WV staff and volunteers.
- Establish a reporting and response mechanism with communities (including children) for concerned parties to report inappropriate behaviour towards children by WV staff, volunteers or community health workers.
- Establish child safe partnerships with healthcare providers and services (for referrals of child protection incidents).

6.2 How can the model promote equitable access to and control of resources, opportunities, and benefits from a gender perspective as well as other perspectives, such as disability, ethnicity, faith and more?

The *PD/Hearth* approach observes Do No Harm principles and provides tools for identifying and treating children suffering from malnutrition, a very vulnerable population that is often overlooked or ignored. It also uses adult education methods that empower caregivers. By finding local solutions to existing malnutrition problems, the approach does not compete with local producers and vendors through the introduction of external products. Rather, the model empowers local communities, improves community independence and reduces the possibility of conflict within the community around the use of external resources.

Gender considerations for child beneficiaries include ensuring that boys and girls are included in the project and that the gender balance is monitored. The project can also record gender in the baseline survey, and monitor and evaluate gender biases in project participation.

PD/Hearth promotes gender equity by challenging community member's to re-evaluate traditional and cultural practices that negatively affect female nutrition. Community mobilisation is an essential element. Both women and men should be included in this process as well as in trainings and implementation. Some projects have purposely used male volunteers to conduct the 'Hearth' sessions. This encourages involvement from men and increases their interest in preventing malnutrition. Discussions on the roles of men and women, family relationships and gender issues can be included as part of the 'Hearth' sessions. These discussions challenge both men and women on issues such as the distribution of resources within the home.

Improved self-esteem and confidence of women contributes to improved outcomes for children. As women are empowered they have an increased voice and place in community leadership.

Sensitising men about the importance of nutrition for their children, and increasing men's ability and capacity to produce a wider variety of quality foods for their children, has a positive influence on the community and the children's nutritional status.

7. Project Management

7.1 National office support required for project implementation and success

Success requires a commitment by support offices and national offices to provide funding, adequate technical support, organisational strengthening of local level partners, and adequate preparation and training.

Elements that need to be in place at the national office level before the *PD/Hearth* project model can proceed include the following:

- Nutrition is identified in the national office strategy as a priority area for WV
- A strategy is clearly communicated to the support office and the support office commits to the project's full implementation, including requisite competency development for *PD/Hearth*.
- Protocols are identified for health and nutrition, including infant and young child feeding practices.
- Ensure adequate technical assistance (See Section 7.2).
 - availability of a nutrition adviser with the required technical skills and competencies
 - training of trainers, weighing techniques and growth monitoring
 - analysis of menus, nutrient analysis of local foods, seasonality and affordability of local foods, application of PDI findings, calculation and approval of menu ensuring adequate energy (using best available food composition tables), iron and other nutrients for children of various ages.

7.2 Technical assistance needed

PD/Hearth, like many nutrition interventions, sounds deceptively simple. Programmes may be tempted to try to implement the project model without adequate technical support. It is important to note that specific technical expertise, especially in nutrition, is required at various points throughout planning and implementation for the project to be successful. *Appendix C* outlines the basic nutrition-related technical competencies required for successful implementation of *PD/Hearth*.

A nutrition adviser is required. This person should have the technical skills and competencies to use the *PD/Hearth* approach, training in anthropometric measurement, Positive Deviance Inquiry, calculation of energy and nutrients from local foods, and *Hearth* training and adult education skills.

During project planning, support from other technical specialists will strengthen the project and improve sustainability.

7.3 Guidelines for staffing

Having a project coordinator at the programme level is recommended. This person must have a solid and comprehensive understanding of the project's concepts and principles in order to provide adequate oversight. Having an adequate number of Hearth facilitators is also recommended. The number of facilitators is based on the number of volunteers and groups that are planned. Ideally there should be one Hearth facilitator to every 20 volunteers. The facilitators should have a background in nutrition and health and the ability to work with communities and mothers' groups.

Project staff must have the following competencies and skills:

- weighing and measuring children
- training community members in proper weighing techniques
- identifying cases of severe malnutrition with medical complications or oedema for referral
- participatory training skills for leading community volunteers through 'Hearth' sessions
- understanding of infant and young child feeding and nutritious foods
- working with community health workers and health centre staff
- training and coordinating community volunteers.

The project relies on community volunteers working directly with participant families. The volunteers are trained by and work with the Hearth facilitator. They are essential to *PD/Hearth* projects. The two minimum requirements for all volunteers is a commitment to the project's goals and each volunteer must be nominated by the community. One volunteer is required for every six to ten caregivers or every six to ten malnourished children. Several 'Hearth' sessions can take place in a community at the same time if there are an adequate number of trained and available volunteers.

Women, typically mothers, are the most common volunteers. However, other community members are also encouraged to participate.

- **Fathers:** Including fathers can encourage male participation in childcare responsibilities. Several countries are using 'father-guides.'
- **Adolescents:** The aim of including adolescents is to prevent future malnutrition. Adolescent volunteers may be introduced to develop the skills of younger women, before they have their own children, or to support an illiterate mother or grandmother in her role as caregiver.
- **Grandmothers:** WV Senegal and WV Mauritania recognise the participation of grandmothers in the 'Hearth' sessions as a critical component for success.

7.4 Guidelines for resources needed for project implementation

While the 'Hearth' sessions are inexpensive to implement, the project requires funds for the early stages of implementation, including trainings and human resource development. Typically, these two areas account for approximately 90% of project costs. A greater economy of scale is seen where the total cost per child per year decreases as more children are included in the project. World Vision's (WV) experience so far shows that the average yearly cost per child decreased from \$17 per child when 750 malnourished children were targeted to \$8 per child when the number of beneficiaries was doubled to

approximately 1,400. Some projects, particularly those that integrate food security, may have a higher cost of \$100 per child per year.

In the past, *PD/Hearth* projects have been implemented as specially funded non-sponsorship projects or as components of grant projects. However, programmes are increasingly implementing *PD/Hearth* using only their core budget. It is important to note that the project is designed to include all malnourished children in the community who meet the *PD/Hearth* criteria, not just registered children.

Recommended timeline:

- It takes approximately two years to affect malnutrition levels with the *PD/Hearth* project.
- If there are high numbers of malnourished children and few staff or volunteers for training and implementing the project, *PD/Hearth* will require more than two years. Considerable scaling-up of the model to cover many groups requires a longer project timeline. It is also possible that nutrition will improve, but that only some behaviours will change within the first two years.
- The actual implementation of ‘Hearth’ sessions to rehabilitate malnourished children is relatively short, generally from one to three months. However, prior to this, initial project implementation and preparation for these sessions requires about six months.
- A simple review may be undertaken within a year of project implementation. This includes measuring weight-for-age of all the children in the community and comparing the per cent malnourished at the beginning of the project with the per cent malnourished at the end of one year. The results will help determine whether *PD/Hearth* should be considered for other groups within the primary focus or programme impact areas. The process from community mobilisation through the ‘Hearth’ sessions and follow-up visits will take nine months to one year.
- Technical support is helpful in developing a scale-up plan, once the initial ‘Hearth’ sessions have demonstrated success. In practice, many programmes begin *PD/Hearth* in a limited number of communities and scale-up to other areas over a period of years.

7.5 Critical success factors for the model

Six factors are critical to the success of this project:

- **Community commitment and ownership:** The community must take ownership of the challenges related to malnutrition and the solutions that are already present in the community. This helps build positive behaviour change and sustainability. It also ensures community-based monitoring of the project.
- **Partnerships:** Engaging local partners including the Ministry of Health (MoH), the Ministry of Agriculture and community-based organisations and facilitating community leadership, builds sustainability. Partners are also able to communicate results more broadly and are instrumental in influencing policy change that can affect nutrition.
- **Understanding positive deviant concepts and principles:** Success is dependent on understanding how and why implementation decisions are made. For example, if WV decides to purchase and contribute all the food for ‘Hearth’ sessions, caregivers do not realise what foods are locally available, affordable and contribute to child growth. By allowing caregivers to contribute a small quantity of food each day, caregivers learn and remember to include those foods at home.

- **Adequate human resource:** *PD/Hearth* is labour-intensive and requires commitment from volunteers in the community, local level partners who are members of the working group, and WV.
- **Adequate training:** The success of the project depends on caregiver's changing their behaviours to incorporate what they have been taught by the volunteers. The volunteers learn what to teach caregivers through training received from facilitators. The facilitators are equipped during training-of-trainers events. This form of cascading training is very dependent on thorough and excellent quality training at each level. Partners and key stakeholders should also participate to better understand and support the project.
- **Integration:** *PD/Hearth* is not a stand-alone project. It works best when it is integrated with other sectors, especially food security, nutrition, health and water and sanitation.

8. Any necessary tools

Resource materials and manuals are available to guide the planning, implementation, and monitoring of *PD/Hearth*. The principal manual is called *Positive Deviance/Hearth: A Resource Guide for Sustainable Rehabilitating Malnourished Children*. Published by CORE (February 2003), this manual is available in several languages. The manual as well as other resources are available at the following website:

http://207.226.255.123/working_groups/pd_hearth.cfm.

Tools for training on weighing and measuring ages of children can be found in *World Vision's Nutrition Toolkit*. This is available from the Nutrition Centre of Expertise. The World Health Organisation's (WHO) Anthro software can also be downloaded free of cost, from the WHO's growth website: <http://www.who.int/childgrowth/software/en/>.

9. Linkages and integration

9.1 Child Sponsorship

PD/Hearth projects include, but are not limited to, malnourished children who are either registered children or come from families who have registered children. The intervention is aimed at children under three years of age who are too young to be registered in some countries. The presence of one malnourished child in a household may signal that nutrition and food security issues are a priority for that family. The criterion for inclusion in the project is simply nutrition level.

PD/Hearth provides a response for the referral of registered and non-registered children, six to 36 months who are moderately malnourished.

Monitoring for *PD/Hearth* can be linked with sponsorship monitoring, however, weighing needs to be done by someone who has been trained using standard training protocols, such as the *Measuring and Promoting Child Growth* tool. Contact with children through *PD/Hearth* activities can be recorded as part of sponsorship monitoring. During follow-up visits with participant families *Hearth* volunteers can reinforce messages about child sponsorship, as well as key messages from other shared projects.

Regular contacts with children and families during child sponsorship monitoring or group gatherings can be used to reinforce key messages identified in *PD/Hearth*. Child sponsorship

can be a platform to raise awareness about childhood nutrition, its importance, and how the community can prevent malnutrition in the future.

Even if there are no registered children under five years of age, treating and preventing malnutrition among a registered child's siblings who are under two years of age can create a social safety net for that registered child.

9.2 Enabling project models

There are many possible points of intersection, collaboration and integration between *PD/Hearth* and other projects.

- **Health and nutrition projects:** *PD/Hearth* is included in the Health and Nutrition ADAPT as one of the possible projects available for adoption by local level partners. *Hearth* not only provides a way to rehabilitate malnourished children identified through either growth monitoring promotion or home visits by community health workers, but it also identifies positive infant and young child feeding practices, hygiene and other health-promoting behaviours that are culturally specific and appropriate. These health promoting practices can be scaled-up by training community health workers and volunteers to use them while doing home visits or timed and targeted counselling.
- **Integration across sectors:** Within WV, the *PD/Hearth* project model is not a stand-alone project. The PDI may identify positive local agricultural, water and sanitation or income generation practices that could contribute to a child's health.
- **Agriculture and food security:** When the PDI indicates that agriculture practices are a key difference between families of well and malnourished children, the *PD/Hearth* project can complement food security and agriculture projects. For example, if the practice of eating caterpillars is found in the PDI, but caterpillars are not easily accessible, then agriculture specialists may help develop projects such as planting more trees in the area that the particular caterpillars feed on for the families with malnourished children. In addition, families with malnourished children should be intentionally linked to agriculture or food security projects to increase their access to a variety of nutritious foods for household consumption. Typically, these projects focus on developing a source of animal-based foods (eggs, chickens, fish, and rabbits) and kitchen gardens. The projects might also include methods of food preservation such as solar drying to ensure consistent food supply throughout various seasons.

The integration of *PD/Hearth* with food security projects usually happens in parallel with the 'Hearth' sessions. It is important that a food security specialist is involved in the *PD/Hearth* orientation and training sessions. This will help them understand the importance of food security projects for rehabilitating malnourished children. The food security specialist should be involved in the initial Positive Deviant Inquiry (PDI). The PDI provides information on what foods families grow or gather that are beneficial and feasible for other families to grow. Careful decisions are made and projects are designed that promote the most contextually appropriate foods for fighting malnutrition. Families learn to produce foods that are promoted in the 'Hearth' sessions, while learning why these foods are important and how to prepare and feed them to their children.

Food security projects should involve fathers, mothers and other caregivers. It is important for women to be involved in decisions related to gardens and small animals. Sometimes caregivers can use the 'Hearth' sessions to explain the challenges they are having with their gardens or small animals. If food security project foods are available they can be included in *Hearth* menus. If the food security project foods are not available until after the 'Hearth' sessions, conduct additional 'Hearth' sessions six

months to a year after the original 'Hearth' sessions. Hold a session once a month and teach the women how to use the new food security project foods. These sessions are referred to as 'booster sessions.'

- **Early childhood development (ECD):** Culturally-appropriate infant and young child feeding and care messages developed by ECD can be incorporated into 'Hearth' sessions. Value is added as these messages are not only discussed but practiced daily during 'Hearth' sessions. Support from the Hearth volunteer during the sessions and during follow-up, increases the possibility that these messages transform behaviour.
- **Water and sanitation:** In one context where hygiene and latrines were identified in the PDI as a major gap, *PD/Hearth* participants were taught how to construct a temporary latrine at minimal cost. *PD/Hearth* then taught proper hygiene practices and promoted the use of latrines. Families who regularly used the latrine for six months received support to construct a more permanent latrine. This promoted behaviour change in *PD/Hearth* participants, and the *PD/Hearth* project provided endorsement and support for the water and sanitation project.
- **Gender:** In several projects, *PD/Hearth* has incorporated gender-related components into key messages. A gender specialist supported the development of messages and methods of delivery. This has been a bridge to initiatives around family relations, domestic violence, early marriage and the delay of the first pregnancy.
- **Collaboration with MoH:** *PD/Hearth* volunteers reinforce the continued use of local government health services through referrals and counselling. Before entering the Hearth session, families are required to take their children to the health facility for deworming, micronutrient supplementation and immunisations. Volunteers and project staff can also advocate to improve the services provided by health centres, such as growth monitoring.

Appendices

Appendix A - Summary of WVI PD/Hearth Review

Appendix B - Commitment required at various levels

Appendix C - List of basic nutrition competencies

Appendix D - Illustrative logframe

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