GCPH Seminar Series 3
Paper 1

Transcript of Jerry Sternin's lecture:
Wednesday 8 November 2006

Andrew Lyon:
Good afternoon ladies and gentlemen, friends and colleagues. Thank you for coming and welcome to the first lecture in what is the third series of the Glasgow Centre for Population Health lecture and seminar series. My name is Andrew Lyon in case you don't know who I am and it's my great pleasure to help facilitate this series in collaboration with the International Futures Forum and the Glasgow Centre for Population Health. As you probably know, the Centre was established as a way of trying to find new and more effective ways to tackle the health challenges that remain persistent in Glasgow despite our best efforts over the past 50 or 60 years. It's really our hope and intension that the seminar series contributes to that effort by inviting a variety of people to the city and asking them to share a diverse range of perspectives and opinions with us, really to provoke us and to stimulate us towards fresh insight and action on wellbeing in the city and beyond.

The normal kind of format is a lecture followed by plenty of time for questions and then off to the left hand side out this door at the back we have time for drinks and snacks afterwards so there is plenty of time to mingle and continue the conversation. If you are able to do that you'd be very welcome. My experience of it is that the more people that stay the better fun it is so I would encourage you to do that because I have to stay anyway, so it would be great if some of you could join me.

A couple of comments before we go on. You may have seen one of these before. It's a mobile phone and if you've got one I would ask you to switch it off now or if you have to have it on if you could put it silent. I'm going to switch mine off, I hope. We have got the ritual switching off of the mobile phones, thank you very much for that. In terms of your safety, I'm assured that there are no fire drills planned for our time in the building and so if the fire alarm does go off it's for real and the fire exit signs are well marked – the three doors behind us, one in the corner over to my right here – and if we could reassemble in the street outside to the right hand side if we have to do that, but hopefully we wont have to, but just watch out for that in case it happens.

So in the vein of insight and towards provocation and thought, it is my great pleasure to introduce Jerry Sternin to Glasgow. Jerry as many of you I'm sure will know, is the director and co-founder of the Positive Deviance Initiative based at Tuffs University in Boston. Together with his wife Monique, who is also with us this evening and will be helping to lead our workshop tomorrow, they have lead or inspired a prodigious amount of positive deviance initiatives all over the planet. Go to the web site, the last count I saw 30 countries working on as many issues and literally helping to save and improve many thousands of lives: men, women and children. It's really quite an eye opener to have a look at it. In addition to that, Jerry has worked as the country director of Save the Children in the US, the US version of Save the Children, in Bangladesh, the Philippines, Vietnam, Egypt and, most recently, Burma which some of you might know as Myanmar, and he has also been a peace corp volunteer and country director in Rwanda, Mauritania, Nepal and the Philippines. And in addition to that he has seen active duty as the Assistant Dean and Student Advisor at Harvard Business School. During the course of an extensive interview about positive deviance for Fast Company Magazine in the year 2000, Jerry said (and he will be embarrassed to hear me say this) he said, amongst many other things, he said "Maybe the problem is with the whole model for how change can actually happen. Maybe the problem is that you can't import change from the outside in". That brings us to the theme for today's lecture which is 'Social Change from the Inside Out'. Will you please welcome Jerry Sternin.

[Applause]

Jerry Sternin:
Thank you very much Andrew. Good afternoon, or evening, to everybody. First thanks to the Centre for the invitation. This is Monique and my first time to be in Scotland and we are thrilled to begin in the nicest city or so the Glaswegians have all told us. I will begin talking about positive deviance with the same story I always tell when I introduce positive deviance because for me it captures what positive deviance is in a photograph. Nasirudin is a famous Sufi mystic and in every story he takes on a different guise. In this particular story Nasirudin is an acknowledged smuggler so every day when he comes to the customs house the customs people stop him with his donkeys, their baskets full of straw, take out every piece of straw to see what Nasirudin is smuggling. They can never find anything. Everyday the same routine. Here comes Nasirudin! We will catch him today – stop those donkeys. They inspect every strand of straw and again never find anything. Finally the years go on and Nasirudin retires and so does the customs man and one day they meet each other on the trail and the customs man says "Nasirudin, now that you are old and you've retired and I'm old and I'm retired and I can no longer harm you tell me what was it all those years that you were smuggling?" Nasirudin looks him in the eye and says: "Donkeys". [Laughter]

I tell the story because positive deviance, like Nasirudin's donkeys, suggests that the answers to very, very complicated problems very often lie before our very eyes. Positive deviance is based on the observation that in every community (the community can be a village, a school, a hospital when we work with HIV/AIDS risk reduction, a brothel) in any community there are certain individuals or groups whose special practices or behaviours enable them to find a better solution to a problem than their neighbour who has access to exactly the same resources. If I had a blackboard here what would be underlined is exactly the same resources. The positive deviant is then an individual, a group of people, who within the same constraints, the same barriers as their neighbours and with no special resources somehow or other is able to have a better outcome or find a better solution. The positive deviance approach, which we will be learning about this afternoon, has a very specific design, which enables the community to discover that solution. That's critical to the whole nature of positive deviance, it's the community, it's the very people whose behaviour will need to change to solve the problem who are the ones who have the 'a ha' to discover the solution which exists. In that sense positive deviance is very different from the normal best practice roll out. With best practices you are telling people here, dummy look at the smart guy who has found the answer out there. When that happens that really very often evokes the immune system rejection response. Just as there is a physical biological immune system rejection to a foreign body, there is also a social system rejection response when you are bringing solutions from the outside. In the States where I come from, in case you didn't tell from my accent, we say that best practices very often produces the 'yeah, but syndrome'… Yeah, but they're not us. Yeah, but they have these resources. Yeah, but this; yeah, but that. So it's that push back which you get. With positive deviance because the solution and the host, in a sense, share the same DNA, you don't get that push back.

So let's go from the abstract conceptual framework of positive deviance to talking about how it is actually been applied. I probably will tell four stories of four different applications of positive deviance to give you a sense of the breadth of the approach and then we will look at a PowerPoint which will give the conceptual framework and the specific 4 steps in the design and then leave lots of time for questions.

So, 1990 the government of Vietnam invited Save the Children (which was the organisation for which I was working) to come to Vietnam to help with the problem of childhood malnutrition. At that time, upwards of 65% of all children under the age of three were suffering from second and third degree malnutrition, which is moderate to severe malnutrition. So two out of every three Vietnamese children where at risk of being lost to the community; they would never reach their full intellectual and physical potential. The government said we will never have the resources to provide supplemental feeding programmes for 10,000 villages. What we are asking you for is to create a programme, which will enable the community to take responsibility for its own nutritional status. Now clearly you're not going to go in and wave a wand and malnutrition will go away. We understand there will have to be some initial input, but what we are really asking you for is a programme or model which, once the input has been made and there is an enhancement in nutritional status, the community will be able to sustain the enhanced nutritional status. So the invitation was for sustained improvement in childhood malnutrition.

In 1990 the US had an embargo against Vietnam and relations between the two countries were not very good and so in December 1990 Monique, our son Sam, who was 10 at the time, and I arrived as the 11th, 12th and 13th resident Americans to live in Hanoi. We arrived at the Hanoi airport with our suitcases hoping someone would pick us up so that we could solve childhood malnutrition. Talk about delusions of grandeur. Finally someone came up and said:
"Are you Americans?"
" Yes."
"Are you the Sternins?"
"Yes."
"Come this way."
And that began a six year, wonderful, wonderful voyage and journey in Vietnam. The first week I was there (this is all relative to how we got to positive deviance this background) the first week I was there I was summoned to the foreign ministry and Mr Nuou called me into his office and said "Sternin, I am very happy to see you, but there are many people here who are not at all happy to have a US non-governmental organisation here at the time when your government is really hurting us with this embargo. You have six months to show measurable impact on the problem of malnutrition or we will not be able to get you another visa and you're out." There was a seeming impossibility of the challenge which led us to positive deviance. Normally we would spend the first year learning the language, setting up in office, hiring people, going to villages and saying "What's your problem; what's wrong; what do you need; what are the gaps; what can we do to help you?". With six months we've got to find a new way of doing business. We've got to find something which is already working, something that is already there that we can build upon, and that led us to positive deviance which had been around for several decades as a research tool. People had done studies in many countries around the world looking at poor families whose children were well nourished and looking at the factors that enabled those poor families to have well nourished children. They then wrote up the research and that was basically the end of the process. We said if we can take that notion (but there is a bell curve and there are people at the end of it; the bell curve, the positive end) if we can translate that into action maybe we can meet this six month deadline.

So we began working with four communities in the northern part of Vietnam, 20,000 people and around 3,000 children under the age of three and, as I said earlier, malnutrition in these villages were 66-67%. We discovered that in the villages there were women's union members, members of a mass organisation all throughout Vietnam. These women were already there, they were a resource and their role was to help the villagers, but they didn't have very specific job descriptions and we thought, well, this is a great resource, we will work with them. We trained them to weigh the children, to get their nutritional status. It's a simple chart: the child's age on one axis, her weight on the other, you put the dot at the number of months and the number of kilos and it tells you whether she is well nourished, moderately malnourished or severely malnourished. We then asked the volunteers for each child they had weighed to give a socio-economic status rating to the family and in Vietnam 1990 the three categories the villages chose were 'poor', 'very poor' and 'very, very poor'. We then after all the children had been weighed by the volunteers we called the volunteers together and said may I see your list, are there any children on your list who come from very, very, very poor families who are well nourished. They looked at their lists and said yes, yes, yes. We said you mean it's possible right now for a very, very poor family to have a well nourished child. Yes, yes, yes. We said well lets go and see what they are doing which is different. We had asked the volunteers… I'm stopping the narrative for the moment to make a design point. We asked the volunteers to look at their list because, although we could have taken the data back to Hanoi and done probably a more accurate job on the analysis, then

turned to the village and said “We have great news for you, it is possible in your village for…” that would have been our discovery. By asking the volunteers to look at their list and to answer the question “Are there any very poor kids who are well nourished?” the volunteers were the ones who had the discovery. As we look at positive deviance in all its applications the first step and the critical issue is that the community has to be the ones to discover the solution which exists. It is the community who has the yes, yes, yes and in terms of behaviour change I think that is a very, very important point. It’s quite different to go into a community and to do exactly what I’d described and then to go back and tell the community this is what I have discovered, but I’m not the one whose behaviour needs to change to solve this issue. So as we listen to the other applications of positive deviance the first step is always a recognition by the community that the solution already exists and the data, this is very data driven, we are always finding a way, whether it’s a nutritional status of a child or some other measurable indicator which enables the community to look at their data, and based on data to discover that the solution is already there. And as we talk more about positive deviance in its simplest sense it is looking at what already is working within the constraints, the taboos of the community before you or I come in to do anything. It’s the solution which is already sitting there. One American poet, Robert Faw, said in one of his poems “We dance around in a circle and suppose, but the secret and truth sits in the middle and knows”. That’s positive deviance, it’s there before our very eyes.

So the volunteers have their yes, yes, yes there are poor families and we decide that we will go and visit them. The we, I know without looking at Monique she’s saying say who ‘we’ is because the we is not us. The ‘we’ are the community members, these village volunteers that I mentioned, the health services and the local communist party. So you’ve got the political wing, the health wing, the community who are all a part of this. Everybody who potentially impacts on the problem with positive deviance is the solution, so you need to involve all of the stakeholders.

A decision was made before we went to visit the positive deviants to go out and talk to everybody in the community to establish the common practices. Positive deviance is only deviant in the context of normal practices. So, we went out and talked to mothers, fathers, grandmothers, older siblings who take care of the kids, teachers… Again with PD you want to go out and reach the entire network. We always talk about going beyond the usual suspects. Nutrition is not an issue of mums and children, it involves the father who decides what resources will be spent, it involves the grandmother who decides what her grandchild will or won’t eat, etc. So we went out, talked to them to discover what the common practices where around feeding, caring, health seeking and hygiene practices then, with that in mind, the common practices, the health volunteers and members of the health staff went to visit the positive deviants, those poor families with well nourished kids. What they discovered in the first four villages some of the positive deviant practices were, in every case where there was a well nourished kid, despite poverty, somebody was going out to the rice paddies and collecting tiny shrimps and crabs the size of one joint of one finger, adding those to the child’s diet as well as the top of sweet potato greens. The convention of wisdom was these are inappropriate foods for a young child, but in every case that is what was being fed to the child. Of course, as this programme has expanded now to 41 countries it’s not about shrimps, crabs or greens: it’s about whatever is working today in that community to enable a poor family to have a well nourished child.

Other practices were washing hands with soap and water. That was not a common practice at all, but the positive deviant mums were washing their children's hands with soap and water. Common practice was to feed children twice a day. People were very busy and they went out to the rice paddy so they would feed the child in the morning and then when they came back from the rice paddies. These were under three year old kids and they have quite small stomachs. So, here we have two neighbours with exactly the same bowl of rice; exactly the same resource. Common practice was to feed the children once, twice and this is what the kid got. The next door neighbour, the positive deviant, with exactly the same resource was feeding her child four times a day: one, two, three, four. So with exactly the same resource the positive deviant family, the positive deviant child was getting twice the nutrition. This is really critical because as we look at other positive deviant strategies they're always exquisitely simple and very often it's not what somebody does, but how they do it. But again the point that I would like to make here is always with the same resources. If somebody solves a problem with additional resources that's great, but that's not what positive deviance is about. With positive deviance you are looking at the people who are least likely to succeed, the people who within the context of this problem are at the highest risk and it's within that cohort that you are finding the people who have succeeded. So if they can do it, anybody can.

So, after the community had discovered the positive deviant strategies – the shrimps, the crabs, hand washing, frequency of feeding etc – Monique and I, were about to do our normal roll out. We had discovered, the community had discovered the solution so it was time to educate people to tell them and fortunately we took a breath and realised that in the past when we had had failures, which of course we did in our development work, it was exactly at that juncture, at the juncture where you discover a solution – if it's in medicine, where you've got your evidence based protocol – when you discover the answer you go and you educate people, you tell people what to do. So I need everybody's help just for a second. Anyone who knows in this room that stress is bad for you please raise your hands. Oh great, so I'm talking to a room full of people who are never stressed, right? The point is knowledge does not change behaviour. Knowledge simply doesn't change behaviour. Is knowledge important? Of course it is. Does knowledge occur when behaviour occurs? Of course it does, but knowledge alone simply does not change behaviour and so we realise that it wouldn't work if we went back to the community and said: "Eat shrimps, crabs and greens. Wash your hair with soap and water". That wasn't going to work. We needed to find a way to enable the community to begin to practice the new behaviours. Not to know about them, not to learn about them, but to actually acquire a new habit and to begin to practice the new behaviours. And so we sat and we worked with the community for a couple of weeks. Monique, myself, and Mrs Shan, our Vietnamese counterpart, could have easily designed a programme in one day to enable the community to practice these new behaviours, but again that would have been our programme. So instead of taking one day to do that we sat for two weeks with lots of different stakeholders and basically said: "Look, this is what we've learned from you. We need your help in designing a programme that will enable you and your neighbours to begin to practice these new practices. Help us with the design. You are the worlds greatest experts on how people in this village learn, so you need to help us". And over those two weeks the community came up with a programme where for two weeks every month mums of malnourished kids would bring their child – mums or caretakers – would bring their child to a neighbour's house, eight or ten kids to a house. So, if there were fifteen malnourished children there would be five houses in the community where for two weeks they would get a nutritious meal that was provided by the community in order to rehabilitate the children. If you're malnourished you need additional food.

Since the objective was to sustain the enhanced nutritional status after the children were rehabilitated, the issue was to get them to change their behaviour and so every day each family, kind of as a price of admission, was required to bring a handful of shrimps and crabs to the session. And they cooked the shrimps and crabs with the health volunteers with the other food, learned new recipes, they washed their hands with soap and water at the beginning of every session (there was a bowl with clean water and soap and towels) and the focus was on acquiring new habits and practices. Not lectures about washing your hands with soap and water, but a bowl of water and soap and a towel. Not lectures on shrimps and crabs, but having you go out to the rice paddy and actually getting them so you had acquired a new habit.

For two weeks then the children participated in this programme and kids, you know, even kids who are very, very poor eaters, when you have eight or ten of them together in the same room there is a lot of competition and children who normally don't eat will eat. The mums are with other mums just like themselves so they have the social comfort of learning from peers. The children were weighed on the first and last days of the programme. If they had gained enough weight to be 'normal' they didn't participate in the session the following month, if they were still malnourished they came back the next month to go through another two week session.

When the six months was up, we waited and the government officials arrived in three black cars, came out in their doctor suits with their pads and their scales, weighed all the children as we, you know, nervously awaited the results and in fact more than 65% had reached normal nutritional status. We got our visa and stayed on for six years. The programme began to expand to other villages. Within the first three to four years it was named a national nutrition model and by five years it had reached 2.2 million people within Vietnam. Of greater significance for us was, at the five year point the Harvard School of Public Health sent a team to look at the issue of sustained ability. They went and they weighed the cohort of children who had been in the first programme (at that point three years earlier) and found that they had sustained their nutritional status but, of greater significance, the younger siblings who had not even been born at the time that Save The Children moved on to new villages were also at that same enhanced nutritional status. The conventional way of taking care of children had changed and once the new behaviour was acquired there was no need for reinforcement there.

The programme, as I mentioned, has reached 2.2 million in Vietnam. It is now being used in 41 countries around the world and the countries are Christian, Muslim, Hindu, Buddhist. The point that I would like to make is with positive deviance it is always appropriate. Usually if you've got a successful programme in Glasgow and you are trying to do it in Edinburgh it doesn't work or even within the same city, it's very hard to take a successful model and move it some place else, but with positive deviance it is always culturally appropriate because you are discovering the solution from within your culture and your community. When we are doing it here, the solution will come from within your taboos, your language, your culture, your resources. When it's done here, again in this new community, the solution comes from within and for that reason positive deviance which is an approach, it's not a model, is quite effective because it's always based on demonstrably successful existing solutions.

I want to move now from the nutrition story which is by far the easiest application of positive deviance. Why is it easy? It's easy because everybody in the world wants a well nourished child. It's easy because the measures are so simple: you weigh a child then you see her nutritional status on the scale, you weigh her two weeks later and you see the improvement. So you've not only got data, but the behaviour change happens quite quickly and that's a great re-enforcer for behaviour change, when you can see the impact of your behaviour. So nutrition was and is the simplest application. I want to briefly talk about the most difficult to date (and probably what will always be the most difficult) and that is the story of the application of positive deviance to female genital cutting, or female circumcision, in Egypt.

After Vietnam we moved onto Egypt and Monique was contacted by a group of Egyptian leaders, mostly women, the anti-female genital mutilation committee. This was a group of people who were advocating against the practice in all Egyptians and they had heard about positive deviance and came to Monique and said: "Can you help us with this problem? We are extremely committed to doing away with this practice, but frankly we are very, very, very demoralised as are the eight local non-governmental organisations, Christian, Coptic and Muslim, who are advocating against this practice". Female genital cutting goes back 4,000 years in Egypt so has nothing to do with Islam: it's definitely pre Islamic, it is practiced by Christians, comes from the time of the Pharaohs and the prevalence was 92%. So can you imagine waking up in the morning as an advocacy group saying well I'm going out to work today to address a problem that's 4 000 years old with 92% prevalence?

Positive deviance turns that upside down and says wait a minute: at this very moment there are between 300 and 500 thousand women, the other 8%, who are not circumcised. What had been the extraordinary strategies of their families to resist this very, very deeply ingrained cultural practice? At the very beginning people said this is going to be impossible, nobody will talk to you. The first meetings with the International NGO that Monique was working with and with the female genital mutilation group was held in a convent with monastery, with closed windows, the curtains drawn and actually with guards outside. It was such a taboo subject that people said, you know, you have to be very careful even talking about it and it's going to be impossible. But very gradually trying to find just the very first few positive deviants… In this case, a positive deviant wasn't the uncircumcised girl because she hadn't necessarily done anything. It was her mother who had decided not to circumcise her daughter; it was the father who decided not to circumcise his daughter; it was the Muslim Sheik, the Christian priest who said this is not in the Koran, it's not in the Bible, I'm against the practice. They were positive deviants. It was a married man whose wife was uncircumcised; he was a deviant because that was not what you did in that culture. So they began to find the first few positive deviants and when they met… these are Egyptians… when they met with the positive deviants they asked them several questions, but among them was "do you know anybody else just like you?" and people said "yes, I do, but I need to get her permission to reveal that" because you would not want to out somebody unless they were comfortable having that happen. So they began to identify a group of positive deviants within the village and began to talk to them to find out what was the turning point: what was the moment at which you decided not to circumcise your daughter? What were the words used? What was the strategy?

Now the common practice to advocate against this had been to tell people circumcision is bad for your health and it's not in the Koran and it's not in the Bible. Well, those had been spectacularly unsuccessful arguments because in every village there were some women who were circumcised who did not have a physical problem and there was some sheik or some priest who said it is in the Koran or it is in the Bible. So that was not very powerful, but as they talked to the actual positive deviants they discovered that the compelling issue for most people who decided not to do it was a sense of almost betrayal. Betrayal means a women who had been circumcised and said: "I remember when I was a young girl and my grandmother, who is the person who had always instructed me on the purity of my body and the sacredness and how nobody could ever look at me, took me out one day and said we are going to visit somebody, took me out, spread my legs and they did this horrible thing to me and I will never forget the horror of that". It was a father who said: "I circumcised my first daughter and from that moment on she will not look me in the eye so I will not circumcise my other daughters". It really had to do with that dimension. In Egypt unlike many places in North Africa where circumcision is a right of passage, you know, where the girl is celebrated she knows what's going to happen and although the physical thing may be the same, it's very different emotionally. In Egypt it's not talked about, it's really a taboo and the girl has no idea what is happening until it happens.

So they began talking to these positive deviants, they began hearing the actual words in Arabic that had been successful in convincing other people to stop the practice and before the organisations could do anything, there was a mergence in the communities; for the first time people were beginning to talk about this taboo subject. One young girl of 18 who had been interviewed and for the first time had admitted that she was against the practice, she then gathered all of her friends who were circumcised at the same time she was, gathered them together had them sit down and relive the horror of that situation. And she said: "Do you want this to happen to your younger sisters? The barber is coming next week". In many communities it's a barber who does it. It's either a barber or sometimes a doctor. "Go back and talk to your mothers." So people began to talk about this and what had been a totally taboo subject began to be something that people started talking about.

I need to point out that Egyptians just like everyone sitting here love their daughters. They are doing this not because they don't love their daughters they're doing this because that is the custom, they have no choice, there is no option. "Yes I, as an Egyptian doctor, am against it, but I'm not going to sacrifice my daughter so that she is unmarriageable or what have you, you know, we have no choice." But as people began to identify that there were people in their community who were virtuous women, that was the word they used, who were not circumcised the beginning of the possibility that there were options began to present itself. The notion that somebody just like me, what we call social proof, who I respect and who I know is not circumcised leaves, for the first time, the beginning option that this may be a possibility. Monique and I went back last March after five years to see how this programme was going and it was quite thrilling for both of us because instead of the closed curtains at the monastery we met with hundreds and hundreds and hundreds of new village committees of people who were doing anti-female genital cutting advocacy. There were school teachers, there were sheiks in the room, there was a Coptic priest and people eager to tell their stories about how they now go around in their community talk about this and advocate against it and the stories were very, very powerful.

I think the one that sticks most with me was about an old, old fellaheen, an old farmer. He was probably younger than me, but he looked very, very old and wrinkled and he was very quiet. This was at a meeting where people were saying: "We want to tell what we do in our village; we want to tell our story" and finally he said: "I'd like to tell my story. I have three daughters and when the first one was born we circumcised her; we are Egyptian. When the second girl was born, we circumcised here, but she began to bleed and they couldn't staunch the bleeding and it went on for weeks and weeks and finally I said to the doctor "kill her or cure her" and to this day she is not right in the head. So when our third daughter came I couldn't circumcise her, but when I made that decision I stopped sleeping because I felt I had done a terrible thing. But when these people *(meaning some local anti-FGM groups that had developed in this positive deviance programme)* came to the village and showed me other people in the village who also were not circumcised I realised I had done the right thing. Now I go around to every man in the village and I tell them my story and I say: "You know my three daughters? They are all virtuous. I'll tell you the difference between them: two of them I hurt and one I did not"".

So very, very powerful stories. But the point that I want to make in this particular application of positive deviance is as social proof. When you have an issue or a problem which seems totally intractable and you have to accept that there is nothing we can do about crime, poverty whatever it is; if you can identify a few individuals who are just like me, as a member of the community, who have the same constraints, the same barriers who have no special resources who have been able to solve the problem, that's the first step in opening the solution space.

What I would like to do, because I want to do the PowerPoint then have lots of time for questions, is to talk about two other applications quite quickly to give you an idea again of different possibilities. One of them is work that we are doing in Indonesia with very, very poor communities which traffic their girls for the sex trade. So, here again in those communities the conventional wisdom is we are very, very, very poor unless we let our girls go out, is what they call it, and earn a living to send back to the family we can't survive. So it's an issue… don't even talk about it it's an issue we can't do anything about. I was invited in with some colleagues to work with these people in the community and with a group of cotters, they call them, local volunteers and we began with a PD (a positive deviance) workshop, which during the first few days, even though the invitation was about coming to help us with trafficking of girls using positive deviance, the first two days of the workshop nobody could even say the word. And they talked about, yes well we can use positive deviance for better roads and better schools and… and on day three one of the braver volunteers said: "Maybe we can use this for the problem of girls going out". That was the best he could do. So: "Okay, say a little bit more about that" and the other volunteers agreed: "Yes, we can use it for the real issue of girls leaving the community". But it was such a taboo subject that even though that was what we were there to do, it took two days before people could even say the word. We began then in a positive deviance way saying: "So, if I understand correctly, every poor family in this community has to let their girls go out right?".
"No."
"Do you mean there are some very, very poor families today whose girls are not going out of the community?"
"Yes."
"Well, let's go and find out what they are doing to enable them within the same constraints that you have, the same poverty, to keep their girls at home."

This programme started two years ago and it's been wildly successful. It's success has nothing at all to do with me: I'm there at the beginning, I introduce PD work, train some local folks, but the local volunteers have been able to go into the community, identify those positive deviants, also identify some policies which are on the books but have never been enacted, for example there is currently a law in Indonesia that when you leave the village you need to fill out a travel paper, but nobody every enforces that. Well, as this positive deviance initiative began the community members went to the leaders and were able to get them to enforce a policy that was there but has never been in practice so that when a girl is leaving the community a community group that is developed, a watch group, goes and talks to the family. The volunteers have mapped the community for high risk households. They now know that if a girl is between the age of 13 and 18 and is out of school that's the highest risk. So they have mapped the community; they go and talk to those households; they have discovered some of the special practices of the positive deviants (those poor families who keep their girls within the community). They have to do with income, small income generating schemes that those families use, parenting skills that are different among the positive deviants, but again everything is in the design. It's not somebody who comes and does a lecture. The design is such that the community is able to identify on their own what are those solutions that somebody again just like me is using to keep their girls at home. This programme is expanding quite considerably now within Surabaya and in Java in Indonesia. So that's another use. I forgot to mention, I can get a mental note from my wife who is saying you forgot to tell them with the female genital mutilation that's now being done in Sudan as well. Okay.

The last one I want to mention before we look at the PowerPoint is in hospitals in the United States (because that's a very different setting) there is a huge problem which I think exists here, I don't know the data, with hospital borne infections. They're called methicillin resistant Staph aureus, MRSA. In the United States these killer bugs kill over 100,000 people every year, that's what we know about, that's the tip of the iceberg and the cause of MRSA, the major cause is hand washing, it's hand hygiene. Yet 100,000 people go into the hospital for a knee replacement or some sort of surgery and die in the hospital or have an amputation or spend four or five months in the hospital. It's a horrible, horrible problem. And it's a problem where everybody knows the solution, but they don't act on it. It's an issue of bridging the gap between knowledge and practice. So, we were invited about little over a year ago… Dr John Lloyd is a retired surgeon, he had been a surgeon for over 35 years, eminent surgeon in the state of Pittsburgh, Pennsylvania and he had been sent by the American CDC (Centre for Disease Control) to Pittsburgh because there was one hospital with two units who had done away with MRSA, but it hadn't spread to the other units of the hospital, nor had it spread to the other 42 hospitals in Western Pennsylvania who are part of a consortium. And so John was sent there four years ago to try and bring people to look at the answer which is right there. The solution was sitting right in these two units. Again spectacularly unsuccessful. John would bring people, they would come and visit and do the 'Yeah, but…', 'Yeah, but…', go back and nothing would happen. He read about positive deviance, got on the phone and said: "Can you come and help? We have this horrible problem and it's not a problem about knowledge, it's a problem about behaviour and social change". So we have been working for the last year with now 17 US hospitals in Bogotá and Majeen and Columbia on the problem of MRSA. The work has been to take a seemingly intractable problem where people think this is a hospital, you have hospital acquired infections but to help people see that at this moment there are some nurses, for example, who have the same number of patients, you know: "We can't comply with hand hygiene all the time, we have too many patients, we have to write reports, we have to do this, we have to do that". Positive deviance enables them to identify that

at this very moment there are some nurses who have the same number of patients, have the same reports, etcetera, who are always able to comply with hand hygiene.

It also does something which is quite thrilling from a behaviour change perspective. The first step was for the infections control people to go out and listen to 400 people in the hospital, not to talk to them and give them lectures, but to listen to them. And they listened to the day shift, the night shift to two o'clock, three o'clock in the morning; they listened to the people who work in the kitchen (they are part of the problem, they are part of the solution); they listened to people who clean the rooms; they listened to the entire community. Basically they asked them what do you know about MRSA? What do you personally do to make sure that people under your care don't get this disease? What are your barriers from doing it all the time? Obviously if you are not doing it there are barriers, and then switching to PD. Do you know of anybody who is doing it better, who, despite the barriers, is able to take the appropriate behaviour and do you have any ideas of how we could do this? So going out and listening, paying the respect to the whole hospital community has resulted in less than a year with 75% reduction of MRSA infections and a real change in the hospital culture. It's another aspect of PD. You don't go in, you don't do culture change. Just like you don't do gender. Gender is a part of any sensible development programme. Culture change happens when relationships change, when networks change within the hospital and within this changing network in the hospital they had been able to come up with a 75% reduction.

Some of the changes have come from the least likely people. Dr John Lloyd, our surgeon friend, calls Monique and me every week and says: "You won't believe what happened today. I was walking through the hall and the guy from the kitchen, who puts out the tongs and the utensils, grabbed me and said: "Dr Lloyd. I just noticed that when people come in to the cafeteria although we have tongs to pick up the fried chicken, people use their hands and then they put it down and I'm really concerned and so I've called a meeting of all the kitchen people, we are working on solving that problem"". Next week somebody who drives the van from one unit of the hospital to another said: "Dr Lloyd, we've got a problem. I take people from one place to another and there is no hand dispenser in the van. We need to have a hand dispenser in the van". The last anecdote from this particular story which is the most thrilling to me was every three to four weeks there is a stand up visit in each unit where the head of the hospital, the chief medical officer, the head of infection control goes to the unit to see how they are doing around compliance to hand hygiene, infections, etcetera. In the past these meetings were run by, of course, the important people by the chief medical officer who would go and give people their report card: "Here's your report for this unit. This week only 68% hand hygiene compliance, you've had three infections" etcetera. They have now switched that so it is the people in the unit who own the data and sit and tell the head of the hospital and the head of infection control how they have done this week. Say well we had one infection, but this was the reason and this is how we solved it and John Lloyd called and said you will not believe that in Unit 4 West, last week that briefing was done by the janitor. So the janitor in the unit who has been part of this and they're critical, they clean the rooms and the infections are all over the rooms, was so involved in this and so much a stakeholder that he was the one who presented to the chief of the hospital. So it's been a real cultural transformation. So I'm going to stop with those anecdotes take about 18-20 minutes, I promise it will not be death by PowerPoint, it's a brief one and then we will take questions after that. Is that okay?

We talked about the solutions before your very eyes, the positive deviance approach. What is it that enables certain individuals to have a better solution than their neighbours within the same resource base? The positive deviance enquiry is the tool which enables the community (and remember that's critical) to discover those uncommon behaviours and strategies. We then take the positive deviance findings and pass them through kind of a sieve of accessibility. Only those behaviours or strategies that are accessible to everybody are kept, the others we call TBU (true but useless) and they don't come through the sieve.

So with, again, positive deviance when we use it to enable communities to make change, it's not a research tool. What we are concerned about is those capturing those practices and behaviours which are absolutely accessible to everybody because you can't build a programme on something which is special. It may be successful, but if people don't have access to it, it is not usable in developing a programme. For example if we thought that Carol was a positive deviant because she is very poor, but her child is well nourished and we discover that she has an uncle who has a pharmacy in the next village and when her child is sick he provides medicine, she's got a positive deviant. It's true that that medicine has contributed to her child's good nutritional status, but it's useless in designing a programme among poor people.

So, the focus with positive deviance is on the behaviour. We can't yet clone people, (this is an old slide, we can clone them now) but we can adopt their successful behaviours and strategies. So with PD you are not looking at the person, you're looking at her behaviours. You can't say, you know, be like Carol – you're not Carol and Carol may have certain attributes that enable her to do things that you can't. Carol or Mary or John may have a very supportive spouse who lets them work many long hours, but you don't. Carol may be somebody who is very charismatic and can convince crowds, but you can't. So you're looking at those practices or behaviours that the positive deviant has and some of those you cross out and say they are not accessible to me, but some of them are totally do-able whether you are Carol or not. Those are the behaviours that we are looking for and again the focus is on the practise not on the individual. In many cultures you can't point to a positive deviant because someone will put the evil eye on them or they will get into a lot of trouble so it isn't really looking at the person so much as her practices. There are exceptions, of course, when you're doing advocacy, for example, in the Egypt story. If the community says it's okay, you may use an individual who will give testimony which happened in Egypt, but again the community decides whether it's appropriate or not to actually identify who the positive deviant is, but we are looking at her behaviours.

PD focus, as we've mentioned, is on practice not on knowledge. In the United States there is a development paradigm called KAP. If you want to bring about change you first change people's knowledge that then changes their attitudes and then that changes their practice. With positive deviance it's flipped upside down you begin by changing people or enabling people to change their practice, which changes their attitudes and that changes ultimately their knowledge. If there is any mantra at all with positive deviance it's this: it's easier to act your way into a new way of thinking than to think your way into a new way of acting. If focus is always on getting people to begin to do something different, disturbing the equilibrium; not going in and thinking about it, but finding some juncture, some place at which people can begin to practice a new behaviour.

Positive deviance enables us to act today from many, many problems. If you are talking about crime in the city or you are talking about malnutrition in Vietnam, there are so many underlying causes that people are often immobilised to act. If you're looking at malnutrition you say it's a result of class, the status of women, illiteracy, disempowerment, poverty, lack of water, lack of sanitation, but at this very moment in those villages there are some people with exactly the same constraints, the same lack of water, sanitation, same illiteracy, same, same, same who have found a solution and so positive deviance enables us to begin to act today before all of the underlying causes are addressed. It is not at all a substitute for addressing those underlying causes, we must address those causes, but for the child who is dying of malnutrition or HIV/AIDS or MRSA infection in a hospital they don't have the weeks, the months, the years to wait until we address all of the underlying conditions. Their problem is today and the solution has to be today.

Here are the four steps in the positive deviance approach. I need to say before I show them that we have problem with the next four slides because they are presented 1, 2, 3, 4 in a linear fashion because we don't have four machines to do all four at the same time. In reality the four steps I'm about to share with you are not at all 1, 2, 3, 4. It's a very iterative process and you keep going from one step back to the next etcetera. So there's nothing linear about positive deviance it's very messy, it's all over the place and it's exquisitely simple, but not easy.

The first step is: you define the problem and you view the community to find the desired outcome. The example we had in Vietnam was defining the problem: kids from poor families are malnourished. Desired outcome: kids from poor families will be well nourished. We say to find the desired outcome either as a behaviour or as status income. Exclusive breast feeding, cessation of smoking are behaviours; good nutrition is an outcome. After we have defined the problem we determine are there any people or groups in the community now, today, who already exhibit that desired behaviour? Are there any very poor families with well nourished children today? If the answer to this question is no, you don't use positive deviance. If 100% of the people are suffering from 'it', whatever the issues is, you can't use positive deviance. If there are some people again within the community who have no special resources who have solved the problem, you determine that then you proceed with the positive deviance approach.

The next step is: discover through a positive deviance enquiry – where you go and visit the person at her home, in her work place, wherever the problem happens – what are the concrete positive deviance practices which enable the person to have a better outcome? I want to hold this one just for a moment because it's really important when you discover the PD practices the more concrete they are, the more successful you will be. For example we worked in Argentina with kids dropping out of school in a very poor region of Argentina. The issue was retention of kids and when the teachers and headmasters and parents from low performing schools went to visit the positive deviants, those schools rather who had high retention rates, they came back all excited from the first positive deviance enquiry and one of the group said: "Oh one of the things that we noticed at the PD school was the teachers showed much more respect for the kids". Useless because you cannot build a programme on be respectful, be respectful, be respectful; that's an attitude. I'm not saying attitudes are not important, but you cannot build a programme, I believe, around an attitude and so we said: "Go back tomorrow and say what you concretely saw that made you feel that those teachers respect the children". So they actually went back and then came back and said: "Oh, what we mean by respect is when the child makes a mistake instead of saying that was pretty dumb Andrew, the teacher says interesting you said that Andrew, lets look at why you said it" and, in other words, takes a

mistake, honours the child and makes that something the class can learn from; that was a specific practice that they translated into respect. When the teacher passes the child she puts her hand on his shoulder. Concrete verifiable practices are something that one can build into a programme; attitudes are not. Okay? So you are trying to discover the very concrete practices and behaviours that enable the person to succeed.

Then the last step is to develop… the subject in all of this is the community, that's critical; not you as an expert or as a facilitator, but the community then develops and implements a local initiative and an opportunity for others in the community to practice the new behaviours as well as create new solutions. So what we talked about in the Vietnam story about bringing the shrimps, crabs and greens, practicing the hand washing, once you discover those positive deviance strategies we're not going to sit down and e-mail everyone in hospital, in the community and tell them this is what you need to do. We are going to design an opportunity where people can actually begin to practice those behaviours.

I want to spend a little time on this one because for me this is a critical concept. We are looking at traditional problem solving and positive deviance. Traditionally when you have a problem you think you know the parameters of the problem and you try and solve the problem within those parameters. The problem is caused by A, B, C and D and in order to solve the problem we need to solve it within those parameters and that gives you a fixed solution space. No matter how big the parameters are, it still has to be solved within those parameters. With positive deviance you don't begin by looking at the problem; you start by looking at the successful solution to the problem and work your way back to the actual problem and in that way you will have a greatly expanded solution space. I usually get a blank dazed look when I say this so I give you a specific example of what this means because this one is really important.

Monique and I were invited in Indonesia to work with transvestite commercial sex workers; a rather exotic group. Neither of us have worked with transvestite commercial sex workers before, we didn't know them, we didn't know the culture and we said that before we work with them we need to really get to know the community a little bit. The International Health Organisation who invited us to work said: "Look the problem is between the waria *(which is the Bahasa Indonesian word for transvestite made up of the work pria for men and wanita is a woman)* and her client; you need to solve the problem of HIV/AIDS risk reduction within those parameters and the answer is condom use". Monique and I said: "Well, okay. But before we do that we need to know them a little bit". I mean, we didn't know how you talked to that group, spatial, you know, distance, we knew nothing and we said: "Before we start the workshop *(it was a two week workshop which would end with them actually implementing a programme)* we have to hang out at least for one evening". So we spent the Sunday night before the Monday morning of the workshop in a very dark depressing hovel in Jakarta with 17 or 18 of the waria. These are biological men who live as women and this group are commercial sex workers. So we spent a couple of hours just listening to them, we were on the ground there were not seats, listening to them talk about their lives, their aspirations and within the first half hour of talking one of the girls said, "Of course I'm lucky because I have a good mammy" and I said "What's a mammy?"
"Oh for every 20 or 25 of us we select an elder woman as our mammy and if we get in trouble with the police she helps us out, she kind of is our support system". So all of a sudden now there were the waria, her client and mammies and we said: "Well, are all mammies the same?"

“No, no, no. There are three mammies in Jakarta who are much better than the others.”
“Well what makes a good mammy good? What does she do that’s different?”
“She can always get her girls to wear condoms and she can always get her girls to the clinic.”
“Well, why is it so hard to go to the clinic?”
“Well, because when we go we humiliated. We go in, we are dressed as women, we’re called in, we have a physical examination, doctor sees a penis and we’re out in one minute and we’re humiliated so we don’t like to go, we won’t go to the clinic.”
he PD question then was: “Are there no clinics that you can go to in Jakarta?”
“Oh yes, there are two of the eight clinics where you are not treated that way.”
So all of a sudden you had the waria, her client, PD mammies, PD doctors. That is what this is about. By looking at the successful solution you discover that there are so many more data points, there are so many more people who can contribute to solving the problem and so many more issues. That’s the difference between a traditional and PD problem solving.

Positive deviant process uncovers existing PD practices, but it also creates a climate where new solutions emerge. So you’re not only discovering those solutions which exist at this moment, but by creating a climate in the hospital, in the village, in the school, wherever you are, where people really feel they are being listened to and their ideas are being acted on, all kinds of new ideas come up from the guy who puts the tongs at the fried chicken to the janitor. So you’re creating a climate where new ideas emerge as well.

The last one that I think we will look at is bridging the knowing, doing gap. For many of our problems, complex problems, behaviour, social change, a great part of it is bridging the gap between what people know and what they do. Whether you are talking about drug use among youths, talking about condom use, talking about exercise, you’re talking about stress it’s not that people haven’t heard about that, it’s their knowledge doesn’t really impact on their practice. With positive deviance and trying to bridge that gap, the first step is what we’ve talked about which is the “yes, yes, yes”; the self discovery has to come from within the community. The second step is social proof which I talked about; the proof that somebody just like me with the same constraints, the same barriers has been able to solve the problem is a very, very powerful motivator for behaviour change. And the last step is once those behaviours or practices are uncovered, the ability for people to begin to actually practice the new behaviours.

This one is looking at innovation and the speed at which innovation occurs and one of the seminal thinkers, Everett Rogers, wrote a book on the speed of innovation and he looks at five attributes which determine the speed at which any new idea will be adopted. They are the relative advantage of the new innovation. With positive deviance it’s identified as advantageous by nature of saying that’s a positive deviant solution. What we are looking at here are those five attributes and how positive deviance relates to them. The second is the compatibility of the innovation with the culture. Again, by definition with positive deviance it’s always compatible with the culture because it’s identified from within the culture. The next one is the complexity of the innovation: the more complex the slower the adoption; conversely the less complex the quicker. With positive deviance the behaviours require no special resources and tend not to be complex at all. Fourth is try-ability. Rogers says if a new innovation can be tried on a small scale it will be adopted more quickly than something where you would have to invest everything. If its low risk and you can try it then it will be adopted more quickly than if it is high risk.

The last is observe-ability and that is can you see the impact of the innovation and, of course, with positive deviance you are able to observe the impact of your behaviour.

If you are interested in learning more about positive deviance here is our website which is brilliantly called positivedeviance.org. It only took ten years of study to come up with that! We answer all e-mails. Part of what we are there at Tufts to do is to learn about new applications, people wanting to use it, so if you do decide to try and use it we would be thrilled to hear from you. If you have questions we will definitely get back to you. So that would be the connection and I'm going to end this part of our session before we take questions by saying as you go back tomorrow, wherever back is, and as you look at the problems that you are facing in your work think donkeys.

Thank you.

[Applause]

Andrew Lyon:
Unless somebody jumps up in the air with an absolutely bursting question right now I'm going to draw matters to a close because people are starting to drift off and it's rather warm in here. So I think we should do that. Just before I do that I'd like to remind you that this is the third seminar series which means we have had two series before and my colleagues at the Glasgow Centre for Population Health and Glasgow Caledonian University have been working very hard to make all of the resources from those previous two series available to you. So if you want to go and look for other events like this you will find slides, the like the ones that Jerry has used, audio files, podcasts, two-page summaries and transcripts of 12 marvellous events all up on the website for you to use in any way that you choose and I'd ask you to go and do that. We will be putting Jerry's lecture up there just as soon as we can and all of the other lectures which are on the sheet on the seat when you sat down, all of those will be going up on the website too. The next lecture in the series is on the 13th of December when we have Irene McAra-McWilliam who is the Head of Design at Glasgow School of Art who is going to talk to us about 'Creative Communities and Design for Life' and I would say in the 21st century. Wonderfully vibrant experienced women who is thinking very hard about some of these issues that we are all grappling, so I urge you to come to that. At the same time, in a venue still to be confirmed and registration for that will open on the 15th of November. Okay, so if you want to know any more about that just ask me or Valerie when you go through to have a drink.

Well what a marvellous start to the third series. I've had a really thoughtful and wonderful time over the past couple of days with Monique and Jerry and the great news is we continue tomorrow morning with a workshop so for those of you who have signed up for that we will see you tomorrow morning at the Lighthouse. But in the meantime I would like to thank you for coming and to join with me in thanking both Jerry and Monique for being prepared to come from Boston and share their experience with us.

Thank you.

[Applause]