

## **THE VIET NAM STORY: NARRATED BY JERRY STERNIN**

In 1990, the US NGO Save the Children (SC) received an invitation from the Government of Viet Nam to create a program that would enable poor villages to solve the problem of childhood malnutrition.

Because the challenge was so formidable, I eagerly accepted, and in December 1990, Monique, our son Sam, who had just turned 10, and I left for Hanoi to become the thirteenth, fourteenth and fifteenth Americans to take up residence in that city. The daunting challenges facing us were many.

In 1990, about sixty-five percent of all Vietnamese children under the age of 5 suffered from some degree of malnutrition, an intractable problem for a country under a US led economic embargo. It was clear to the government that traditional supplemental feeding programs provided temporary solutions at best and were unsustainable. The government had recently dismantled collective farming and Vietnamese families were able for the first time to farm their land but had no more government subsidies to feed their families. The Soviet Union support in fertilizers had collapsed, the public health system was in shambles, and the country had been battered by unprecedented back to back typhoons that had destroyed not only the rice crop but the seedlings as well, leaving the population without their traditional staple food: rice.

On the political front, many officials were not at all happy to have Save the Children; a US non-governmental organization working in Vietnam at the very time the US government was actively trying to punish the country through its economic embargo. This was summed up by Mr. Nuu, a high ranking official in his office the week after our arrival: "*Sternin, there are many officials who do not want you in this country,*" he warned. "*You have six months to demonstrate impact, or I'm afraid my ministry will be unable to extend your visa.*" So, there it was; the real danger of failure juxtaposed against the extraordinary opportunity if we somehow could succeed.

Because the Government of Vietnam didn't have the resources to address the problem of ongoing malnutrition in 10,000 villages, a strategy had to be identified to enable these communities to somehow solve the problem themselves. The focus clearly had to be preventive as well as curative. Given our six-month deadline, and my concern for sustainability, I knew that this couldn't be "business as usual." We would have to find a new approach based on resources already available within the community. That led us toward Positive Deviance (PD).

Although the PD concept had been around for many years, it had been used primarily as a research tool. In 1990 Marian Zeitlin, a professor at Tufts University, School of Nutrition published a collection of dozens of studies from around the world which identified well nourished children from poor families (the positive deviants) in most vulnerable populations with high degree of childhood malnutrition. The research identified the determinant factors that led the positive deviants to better outcomes than other members of their cohort.

If it were true that some individuals in a community were better able to solve problems than others with access to exactly the same resources, could we use that proposition to build a sustainable national nutrition program? With little more than five months left until our visa renewal deadline, I was more than eager to test the hypothesis.

Hien, by then our closest friend, and advisor on all matters of survival, set up a meeting for the three of us with Hanoi-based health ministry and People's Party officials to discuss potential pilot sites. We finally all agreed on Quong Xuong District in Than Hoa Province, some four hours south of Hanoi, a particularly poor and densely populated area with extremely high malnutrition rates. We were eager to choose a location close enough to the capital so we could travel back and forth easily to be with our son. In late January 1991, with only 17 weeks left until "impact-or-no-visa" time, our gang of three rented a black 1970 Russian Volga and made the first of what was to become hundreds of visits from Hanoi to Quang Xuong. The 75 mile, 5 hour journey south on highway number 1.

Over the next week we met with provincial level members of the People's Committee, Women's Union, and Health Cadre to discuss the proposed project. My most important and difficult meeting turned out to be with the Deputy Chairman of the People's Committee of Thanh Hoa province, Mr Buu. He spent little time on the traditional Vietnamese introductions and got right to the point. "*How much money and what kind of material inputs are you going to provide?*" I explained that in order to create a sustainable model, most of the inputs would have to come from the villagers themselves. We would, of course, provide some material input, but would focus attention on training and developing the capacity of the villagers to address their own problems themselves. He reluctantly gave the go-ahead. But, it was clear to me that he wasn't at all pleased with the rich American NGO which promised nothing more than "capacity building" and "self reliance" instead of medical equipment and supplemental food.

We began immediately to conduct a sample nutritional baseline survey of children in four villages proposed as pilot sites. The good news was that the villages definitely needed help and provided a most appropriate choice for the first PD trial. The bad news was that sixty-three percent of the children under the age of three were malnourished!

Immediately after the sample survey, we met with the four village leaders and members of all the well established community networks (the local People's Committee, Women's Union and Farmer's Union, and community health cadres) to discuss the proposed project in each of the four "communes." It was the first time that they met together to discuss childhood health issues. Villagers shared their beliefs about the causes of malnutrition and talked about their hopes for the future.

With more faith than actual proof, I explained that the PD approach could help them address the problem of malnutrition through the identification of solutions, which already existed within their community. It would require some initial help with those children who were already malnourished, but the PD approach could show them how to independently sustain their children's improved nutritional status once they had been rehabilitated. If this was going to work, I told them, you would have to assume major

responsibility for the program. Fortunately the villagers had previous experience with a supplementary food program initiated by the World Food Program, (WFP) a UN agency. They explained that when the project was finished they had to do without the donated foods and their children became sick and unhealthy again. So they embraced the idea of PD wholeheartedly, to our great relief.

The first step towards community management of the program was the creation of Village Health Committees (VHCs), comprised of members from the Women's and Farmer's Union, People's Committee, and village health cadre. Once established, the VHC chose health volunteers from among those women's union members in the community willing to serve in that capacity.

The newly selected health volunteers were trained to weigh the children and chart their nutritional status on an already available Unicef growth chart. They conducted the first community-wide weighing of children under three in late February 1991. After the children had been weighed, we met with the VHC to review the findings. Consistent with findings from the sample survey, 64% (rather than 63%) of the children suffered from some degree of malnutrition.

That information was shared with the entire community with all the fanfare that a propaganda machine can muster, during a special commune meeting. A villagers-designed graph showed the results and a village leader explained it to the assembled folks and asked them what they wanted to do about it. The answer is easy to guess: they wanted their children to be healthy, to remain healthy and they also said they wanted their future children to be healthy as well!

Because we sought solutions to the problem of malnutrition which would be accessible to everyone and the most vulnerable in the community, the volunteers were asked to do a socio-economic ranking of all the children on their weighing lists. With no pre-set categories, the volunteers chose "poor," "very poor," and "very very poor," as the most accurate description of the economic status of families in the community. When they completed their ranking, we met with the volunteers and asked them to study their lists to see if any of the well-nourished children came from "very very poor" families. They looked at their notebooks and several volunteers literally jumped up from their benches: "*Co, co vay chao rat ngheo nhunhg khong suy dinh duong.*" ("Yes, yes there are some children from very very poor families who are well nourished!") "*Do you mean,*" we asked, "*that it's possible today for a very very poor child in this village to be well - nourished?*" "*Co, co!*" came the reply, "*it is, it is!*"

The "Co, co!" epiphany happened in the modest dirt floor of Quang Vong commune town hall where we were meeting that February day. It was clear that the discovery of the solution by those who needed to believe it already existed, was immensely powerful. From the very onset of the program it enabled the community to feel ownership for discovering the solution to their own problem. As the Positive Deviance approach became refined over the following months and years, the Vietnamese "co co" equivalent

of the "aha," moment took on ever increasing importance and became a central component of the PD design.

Having established the possibility of being well nourished despite poverty, the volunteers explored the implication of the discovery. If some very poor families in the village had well-nourished children, it was clearly possible for their poor neighbors to do so as well.

Because the positive deviants are only deviant within the context of their divergence from the norm, (in this case, the traditional feeding, caring and health-seeking behaviors), all of us needed to first identify those common practices and behaviors, as well as common challenges and difficulties faced by caregivers, before discovering what the positive deviants were doing which was different.

Over the next week, the trained volunteers conducted many group discussions in each of the program villages. Meeting informally with mothers, grandmothers, fathers, older siblings and community health providers, they discussed the conventional behaviors regarding feeding, caring, hygiene and health-seeking practices in the community.

After the first 8 or 9 group discussions, the volunteers reported that they weren't learning anything new or useful. We were about to call a halt to the sessions when one of the volunteers protested. Tuyen, one of the most active volunteers explained, *"Although I'm not learning anything new either, there are still another 3 or 4 poor households in my hamlet who haven't participated in these discussion groups. If I don't go and listen to them, they will feel hurt, and think that I don't think they have anything to contribute. If I'm going to need their cooperation later on when we begin our program, I better go and listen to their ideas."*

Tuyen's insight made us realize that the groups discussion was not merely extracting useful information from a wide variety of stakeholders but more importantly listening to their sharing of life experiences, challenges and ideas, thus inviting them to be an integral part of the creation of the program. From that time on, one of the first steps in the PD process, is for the local facilitators to go out and LISTEN to the maximum number of people in their community as possible, irrespective of the resulting learning curve for the listeners.

By early March 1991, the moment of truth was at hand. The villagers had completed the group discussions and had identified those very poor families who had well nourished children. Now the challenge was to see if we could actually identify some uncommon behaviors or strategies that would account for these children's better nutritional status.

Choosing six of the poorest families with well-nourished kids in each of the villages, Hien, several health volunteers, a few village leaders and I divided into teams and went to see if our PD hypothesis would actually work. Over a two-day period we visited the six households, asked questions, and most importantly, observed how mothers and other family members fed and cared for their well-nourished kids. We had arranged to visit the PD homes an hour or so before mealtime so that we could observe, rather than merely ask

about the actual food preparation, and hygiene. In every case, our presence at the actual time of food preparation, cooking and serving proved to be invaluable.

What the PD caretakers reported doing, and what they actually did, was often at odds. This wasn't the result of their being disingenuous, but rather, their not being conscious of all their actual practices. The result of an interview without actual observation would have robbed us of the discovery of consistent unusual behavior.

After visiting the positive deviants' homes, we reassembled at the people's committee meeting hall; a palpable buzz in the air. Each team had discovered several uncommon behaviors which the PD's were using. In every instance where a poor family had a well-nourished child, the mother or father was collecting tiny shrimps or crabs or snails (the size of one joint of one finger) from the rice paddies and adding these to the child's diet along with the greens from sweet potato tops. Although readily available and free for the taking, the conventional wisdom held these foods to be inappropriate, or even dangerous, for young children.

Along with these food and atypically strict hand hygiene in 5 of the 6 PD households, other positive deviant behaviors emerged, involving frequency and method of feeding and quality of care and health-seeking behaviors. For example, most families fed their young children only twice a day, before parents headed to the rice fields early in the morning and late afternoon after returning from a working day. Because these children under three years of age had small stomachs, they could only eat a small percent of the available rice at each sitting. The PD families, however, instructed the home babysitter (an older sibling, a grandparent or a neighbor) to feed the child regularly. Their kids were fed four or even five times a day. Therefore, using exactly the same amount of rice, the PD kids were getting twice the calories as their neighbors who had access to exactly the same resource! This was the first of countless examples that PD practices often reflect not only "what" is being done differently, but "how" it is being done.

Through the PD inquiries, community members had discovered for themselves what it took for a very poor family to have a well-nourished child. The challenge now was to get people to translate that knowledge into practice. Monique, Hien, and I asked for a meeting with the volunteers, local leaders and health clinic staff to get their input for a campaign to "teach" the villagers the special practices which had emerged from the PD inquiries.

Lots of ideas for education sessions, hamlet meetings and posters were offered. Everyone was so excited by what we had "learned," the natural instinct was to want to "teach" it to others. Then, just as the meeting came to an end one of the older volunteers said, "*Don't forget our Thanh Hoa saying "Mot ghin nghe, khong bang mot xem, mot xem khong bank mot ghin lam" ("a thousand hearings isn't worth one seeing, and a thousand seeings isn't worth one doing.")*

Throughout the entire dusty trip home, Monique and I talked with Hien about our past development work failures. They had all occurred exactly at the moment in which we

now found ourselves; the moment at which the solution is discovered. The next, almost reflex step, was to go out and spread the word; teach people, tell them, educate them. By the time we reached Hanoi, Monique, Hien and I, were very excited, despite our fatigue and grittiness. We agreed that what we needed to do was to create an opportunity for villagers to discuss how they could “practice”, rather than “know” about the successful PD behaviors they had just discovered.

The first program objective would be to rehabilitate the malnourished kids. That was simple and only required the provision of sufficient additional nutritious food. The real challenge, however, was to enable the parents to sustain their kids enhanced nutritional status at home after rehabilitation. To address the issue of sustainability, the program would have to avoid the pitfalls the villagers had previously experienced with the supplemental feeding programs. That meant, they would have to acquire new habits and change their behavior.

The newly identified PD behaviors provided the “something different.” The addition of a small handful of shrimps/crabs and greens, in combination with increased frequency of feeding and other uncommon caring behaviors, was clearly sufficient to keep a child well nourished in the pilot communities. Moreover, as we had learned during the PD Inquiry, these foods and behaviors were accessible even to the poorest families in the village. Getting parents and caretakers of malnourished children to adopt these new foods and behaviors, however, was another matter.

With the “no impact-no visa” clock ticking away, we spent the precious next 2 weeks meeting with local leaders, the volunteers, the clinic staff and small groups of interested villagers, and asked : *“We have all learned many valuable secrets about how to have a well nourished child despite poverty from the villagers over the past 2 months. But, we don’t know the best way to help people to practice them. What should we do?”* By the end of the second week, and scores of meetings later, a plan was devised which built on the lessons learned from the Positive Deviance Inquiry.

For two weeks every month, mothers or other caretakers would bring their malnourished children to a neighbor's house for a few hours every day. Together with the health volunteer, they would prepare and feed an extra nutritious meal to their children. But we still faced the challenge of ensuring that they continue those practices at home after the sessions. It was the concern for the sustainability of behavioral change that led to the introduction of the mandatory "daily food contribution" component of the nutrition sessions. Every day, each mother or caretaker was required to bring a handful of shrimps, crabs or greens as the price of admission to the sessions. For 2 weeks every month, someone in the family, (a spouse, an older sibling), had to go out to the rice paddy early in the morning, and ankle deep in the mud, collect the required shrimps and crabs. By the 15<sup>th</sup> morning when the 2-week program was over for that month, the trip to the rice paddy with a small net and empty tin can had become routine and was continued.

At the house, the caretakers of malnourished children, (very often an older sibling was the secondary caretaker) also practiced cooking new recipes with the health volunteers

and also learned and applied basic health and childcare practices. The sessions also provided an opportunity to practice other successful behaviors such as active feeding and washing the caretakers and children's hands and feet with soap and water before and after eating.

This focus on practice rather than knowledge has proven to be a key element in bringing about lasting behavioral change across the range of issues addressed using the PD methodology. *"It's easier to act your way into a new way of thinking, than to think your way into a new way of acting."*

Another tenet of behavioral change, is the ability of people to see and measure the impact of their new practice upon a desired outcome. All the children were weighed on the first and last day of the nutrition session in the presence of caregivers and village leaders. The invariable weight increase, (75% of kids put on weight during each session) was greeted with applause and sometimes hoots. Seeing that their new behaviors had actually resulted in their kids gaining weight and becoming "naughtier" (active and lively rather than apathetic and listless), the caretakers returned home after the two-week session was over to continue practicing their newly acquired feeding, caring and health-seeking behaviors. The kids who reached normal nutritional status during the nutrition sessions "graduated" and those who remained malnourished were signed up for the next one to be held the following month.

The monitoring of the health progress of individual children and the entire cohort of children under three by the village health committee and volunteers was a critical element of the overall success, and sustainability of the program. Each volunteer had a record on each child under 3 in her neighborhood. The weights were captured at village-wide children under three growth monitoring sessions held by the community every two months in each hamlet, and at the beginning and end of each 2-week nutrition rehabilitation sessions.

The village health committee and local leaders met at the end of every other month to review the nutritional status of all the young children over the previous 60 days, assess their status, analyze and act on the issues at hand. The pie charts score board were then updated and were prominently posted in a strategic place in the town hall right next to the bust of the beloved national hero Ho Chi Minh. No Olympic score board could have elicited more excitement than the reductions in malnutrition highlighted on the volunteer-made nutrition charts.

In June 1991, judgment day had arrived. Six months to the day after we had arrived in country, the Thanh Hoa District Health staff was coming to the villages to see if we had met our impact goal. Just over six hundred children had participated in the first four nutrition sessions, and the authorities were coming to weigh them. We anxiously waited along with a group of the volunteers in a tiny health center for the results. We had tea, waited, had another cup of tea, looked at our watches, checked the time and continued waiting as the weighing went on.

Finally, the district health staff came in with smiles on their faces. Then the highest ranking of the District health staff, Baksi (Dr.) Hanh shared the verdict: A total of 245 kids, (more than 40 percent of those who had participated in the program to date) had been rehabilitated, another 20% had moved from severe malnutrition to moderate malnutrition and we had scored another six-month visa.

By the end of the first year of the program more than 1,000 children had been enrolled in nutrition sessions and more than 80 percent of them had "graduated." The swift and visible improvement in the health status of the kids who participated in the nutrition sessions dramatically impacted on the nutritional status of kids subsequently born into the program communities.

An external evaluation of the program in 1994 by a consultant from Harvard School of Public Health found that "younger siblings, not yet born at the time of the nutrition program implementation, [were] benefiting from the same levels of enhanced nutritional status" [as their older siblings]. The use of the PD approach had not only solved a complex problem but had achieved behavior and social change. By 1992 the model had proven its efficacy and it was time to demonstrate that the success could be replicated by others and elsewhere as well. Five junior staff members from the Vietnamese National Institute of Nutrition (NIN) were deputized to Save the Children for a period of 2 years and expanded to an additional 10 villages, bringing the total number to 14.

Unbeknownst to us, but most powerfully, the People's Committee, the Women's Union members and the district health staff were sharing their experience at national level conventions, bringing village level staff to tell their own story of success to their colleagues.

Soon the government organization in charge of nutrition knocked on our door and told us that they wanted Save the Children to replicate the program nation-wide. We explained that we could not and should not be the instrument for replication, being an outside agency.

As we were struggling to develop a way for scaling-up the program that would enable interested parties to access and practice the PD approach, I brought the UNICEF representative, Steve Woodhouse, to the field to visit one of the pilot nutrition program communities. There were torrential rains that day and we sat together inside a corrugated roof hut with a group of local moms whose kids had participated in the nutrition program. Shouting to be heard over the noisy downpour, they explained to Steve how they had rehabilitated their children and how it was possible for any poor family to have a well-nourished child. After an hour or so, we thanked the women and left the hut. Steve, stood transfixed in the continuing downpour. "*That was amazing*" he said, "*I've never learned so much in so little time. It was a ... a ... a `living university.'*" A name and a concept were born.

The Living University was comprised of the 14 program villages, which provided a "social laboratory" for exposure to the nutrition model at different phases of

implementation. Organizations and government entities who wanted to replicate the model came to Thanh Hoa province to learn the conceptual framework as well as to make field visits to the 14 program villages for first hand observation and hands-on participation in different components of the program.

After graduation, Living University participants who included teams from the people's committee, the health services and the women's union from a given district, returned home to implement the PD Nutrition Program in two sites, which they then used as their own "Mini-Living University" for further program expansion in adjacent areas. Over the next 7 years an estimated 50,000 children were rehabilitated through the efforts of more than 400 Living University graduate teams who replicated the program in 250 communities with a population of over 2.2 million.

Because PD is based on the successful behaviors of individuals and groups within the socio-cultural context of each program community, it is always, by definition, "culturally appropriate." It is very much an "approach" not a "model". This feature of Positive Deviance provides an antidote to the pervasive challenge of scaling up of successful "models" which more often than not, fail, when they are transplanted in "foreign soil". The PD Nutrition program, in contrast, has been successfully adopted and adapted in the last decade by Ministries of Health, UN organizations, local and international NGOs in 45 countries in Africa, Asia, Latin America, and the Middle East.

In June 1996 our family left Hanoi for Cairo, Egypt . In the plane, waiting on the runway, Monique and I sat in silence. Six years of our life had been spent in Viet Nam we had learned more in that country than anywhere else in our professional lives. Viet Nam had given us the opportunity to embark on the PD journey, which has shaped our lives ever since.