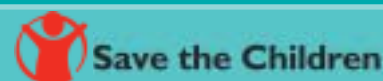




# Positive Deviance

## A Strength Based Approach to Behavior Change and Social Mobilization



### INTRODUCTION

The Positive Deviance (PD) approach, like other "assets-based" approaches, improves social outcomes by capitalizing on existing community strengths. The PD approach rests on the observation that in most communities, the uncommon behaviors of a few successful individuals enable them and their families to find more effective solutions to pervasive problems than their neighbors with whom they share the same or worse resource base. The "Positive Deviants" are those individuals who have a good outcome despite high risk for a bad outcome. The Positive Deviance (PD) approach has proven to be an excellent tool to mobilize communities for behavior change. A PD inquiry rapidly

identifies, at low cost, with the community, those uncommon practices linked to a good outcome that a follow-on program can help spread more widely in the community.

Save the Children (SC) has applied the PD approach to developing and implementing programs designed to improve health outcomes in other countries, including Bolivia, Egypt, Ethiopia, Haiti, Mali, Mozambique, Myanmar, Nepal, and Pakistan. SC launched the Positive Deviance initiative under Saving Newborn Lives program in District Haripur, in August 2000. This Initiative aimed to: 1) strengthen the theoretical underpinnings of PD, 2) apply PD to new programmatic settings, and 3) document the experience.

# POSITIVE DEVIANCE APPROACH IN MATERNAL & NEWBORN CARE

The PD approach is divided into two phases: During phase one, PD process is conducted. Through this process villagers discover uncommon beneficial household maternal and newborn care behaviors (PD behaviors) already practiced in the community which contribute to the survival and good health of newborns and their mothers. The PD process covers the first 3 "D" of the general PD approach conceptual framework (Define, Determine and Discover), which are carried out with the community: The phase one takes around 10 days. Phase two covers the 4th, 5th and 6th "D" of the PD approach and consists of the implementation of a PD-informed project at the grassroot level which lasts for 12 months.

The Positive Deviance approach is characterized by the following 6 steps or "6 D's":

1. **Define** with community members, what is the problem, the perceived causes and related

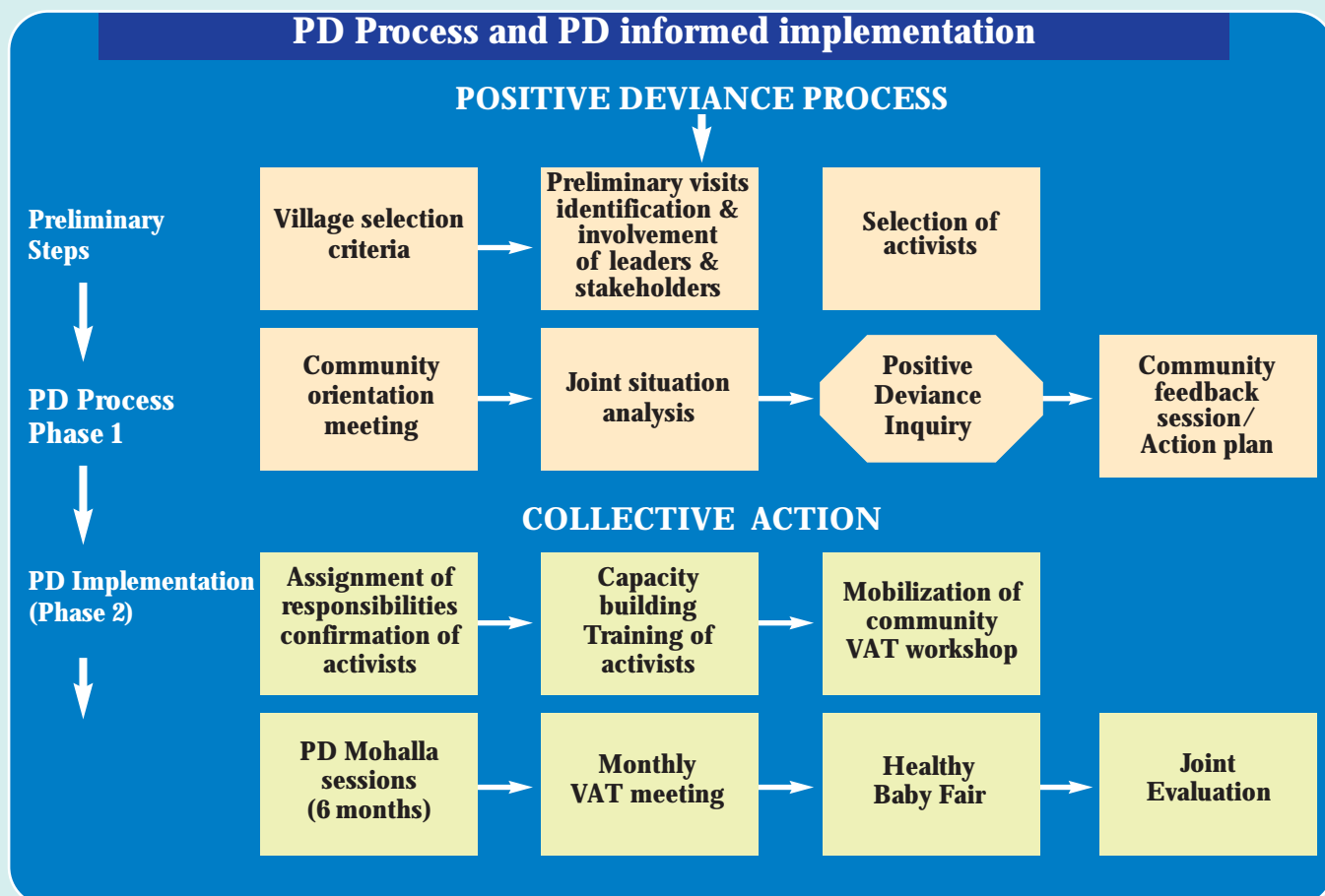
community behavioral norms? What would a successful solution/outcome look like?

2. **Determine** the presence of any individuals or families in the community who already exhibit desired behavior or status
3. **Discover** through a Positive Deviance Inquiry (PDI) what are the uncommon practices/behaviors that enable PDs to outperform/find better solutions to problems than others in their "community"?
4. **Design** and implement intervention that enables others in "community" to access and practice new behaviors (focus on "doing" rather than transfer of knowledge)
5. **Discern** what is the effectiveness of the intervention? (through ongoing monitoring and evaluation)
6. **Disseminate** to community members and other stakeholders and make intervention accessible to wider constituency (replication/scaling up).

## Preliminary Steps

The preliminary steps are the selection of villages and initial meetings with community members to

Figure 1: Flow chart of PD process and PD informed implementation



prepare for the Positive Deviance Inquiry (PDI). The selection criteria include a village with population of approximately 3,000 people or 400 to 500 households. The PD team conducts two to three visits to the selected villages to meet with village leaders, identify a few key interlocutors and plan the PD process with them.

## Phase 1: PD Process

### Step 1: Community Orientation Meeting

Two separate orientation sessions (for males and females) take place, facilitated by members of the PD team and their local partners. Participants (around 50) include community identified decision makers, parents and grandparents of infants. During the meeting, PD team discuss current problem regarding newborn health and explore PD concept with the help of different activities like story telling and interactive conceptual games. The advantages of using PD method are discussed and role of PD team as facilitators to enable the community to identify PD behaviors is explained. The community interest and commitment to try PD approach is assessed. PD team identifies local terminology related to newborns, details about the village and lists of birth and deaths during last one year are collected. PD team plan for situation analysis and identifies interested volunteers to participate in the process.

### Step 2: Situation Analysis

PD team consisting of both males and females conducts participatory situation analysis to identify community norms regarding maternal and newborn care, engage community members in exploring problems and their potential solutions and to identify potential PD individuals and behaviors to fully



investigate in the Positive Deviance Inquiry. The methods used for situation analysis include newborn mapping, focus group discussions, key informant and in-depth interviews with mothers and fathers of infants up to age 3 months, elders, religious leaders, teachers, mother-in-laws, dais, and families with a newborn. Key topics covered during interviews include behaviors related to pregnancy, labor and delivery, resuscitation, immediate newborn care, nutrition, infection control, maternal care, recognition of maternal and newborn danger signs, care-seeking, and obstacles to care. The findings are reviewed and synthesized by both the PD team and community to establish current normative practices or special maternal and newborn care during pregnancy, delivery, immediate post delivery and post-partum period. Estimated time for situation analysis is between 2 to 4 days.

### Step 3: PD Inquiry

From the participatory situation analysis, the PD team is able to identify a few potential PD cases that represent "high risk" scenarios. Case definitions for PD newborns are:

- An infant under age 6 months who did not breathe at birth and who is healthy now
- A low birth weight baby under age 3 months who is now thriving
- An infant under 3 months who survived danger signs of infection (cord redness, difficulty sucking, difficulty breathing, vomiting, etc.)
- A healthy newborn (under age 40 days) who is exclusively breastfed

Sources for identification of potential PD newborns and other unusual practices include: interested individuals from orientation meetings, participants in focus group discussions, dais, or other village-based health worker. The village PD



team makes the necessary arrangements to carry our PDI activities. The methodology to interview these potential PD families is the same as used for the situation analysis, i.e In Depth Interviews (IDI) and observation check-list, with an additional special questionnaire designed to probe key potential PD behaviors. During the IDI, the interviewer may identify an uncommon practice such as exclusive breastfeeding. In this case the interviewer refers to a one-page supplementary inquiry, to explore the behavioral determinants and to find out if other individuals in the village also practice this behavior. After the information is collected, the PD team reviews the findings and selects uncommon/PD behaviors. Practices which are True But Useless (TBU) because of their non-transferable status are discarded. An example of a TBU finding would be a mother who has expressed her milk when she had to be separated from her infant and kept it in a refrigerator, thus enabling her to practice exclusive breastfeeding. This practice is indeed a very good uncommon practice, however True But Useless because it is not accessible to other families. Estimated time to carry out the PDI is one or two days.

#### **Step 4: Feedback Session and Action Plan**

After the PD behaviors have been identified, the PD team prepares for the community feedback and action plan. This is a very important event which galvanizes the community into action and guarantees community ownership of subsequent activities and their successful outcomes on maternal and newborn health. The purpose of this activity is to review the PD process with a large audience, share and vet the PDI findings, encourage the

villagers to think of ways to enable families to adopt these positive behaviors in order to have healthier mothers and newborns. Participants include all the people who participated in the situation analysis, the whole PD team, teachers, parents of infants, and villagers at large. Main activities of community feedback session include introduction of participants, review of previous activities and situation of newborns with the newly developed



village baseline map. PD team reviews PD concept with the help of interactive games such as the building game, role play on self-reliance or story telling. PDI finding are shared through interactive tools like cardboard box, visual aids and/or skits on PD behaviors. This is followed by discussion for validation of practices as PD (unusual but adoptable) and a simple action plan is prepared to explore ways to enable more families to adopt these behaviors. In the end, PD team identifies men & women as mohallah activists and prepares their training plans. This session usually takes 2 to 3 hours.



## Phase 2: PD Implementation

### Step 1: Training of PD Activists

In all PD informed projects, training plays a central role in building the capacity of the community. It is an integral part of the project itself and is community-based, participatory, process oriented and owned by participants, adaptable, and: "learning by doing". All



the five training sessions follow the program cycle i.e. training session 1- then first implementation (mohallah PD session 1) - feedback and assessment of new training needs- retraining (optional) and training session 2 (introduction of new training material) and so on. Each training and the associated session is conducted weekly and takes a total of five weeks to complete the process. The specific objectives of training include dissemination of information regarding newborn to all member of the community, promoting the practice of key beneficial maternal & newborn care behaviors at household level, providing activists with the skills to carry out mohallah PD sessions and enabling activists to monitor the project and its impact (internal monitoring). Contents of curriculum include group formation, communication skills and monitoring & evaluation.

### Step 2: Establishing Village Action Team (VAT)

The Village action team consists of 8-12 volunteer activists (both male and females), responsible for PD implementation at village level. These activists after receiving training conduct regular mohalla sessions on fortnightly or monthly basis in their respective mohallas. The Village action team selects a coordinator and they meet every month to discuss/share the problems and achievements with each other using "triple A process" (Assessment of

situation, Analysis of problems and Action/solutions) Main responsibilities of VAT include:

- Conduct regular mohalla sessions
- Update birth and death registry of the village
- Ensure the home visits on 3rd and 40th day of the delivery and compile pictorial monitoring checklist
- To organize Healthy Baby Fair and ensure support from and active participation of male and female community members

### Step 3: PD Mohalla Sessions

The mohallah is both a geographical neighborhood and a cultural unit which includes 30 to 50 households. Mohallah PD sessions are run separately for men and for women. Male target groups are married and unmarried adult men, fathers, teachers, local elected representatives, and religious leaders. Female target groups include married women, especially mothers-in-law, dais, LHWs, and other influential females in the community. PD activists carry out mohallah sessions on monthly or fortnightly basis, over a period of 6 months. Topics include all the key routine (preventive)



and special care (curative) behaviors. The curriculum for activist training and the content of the mohallah sessions are same both for men and women groups. However, utilization of certain tools and techniques may vary during training and mohallah PD sessions according to gender. PD behaviors posters, counseling cards, "PD Bazar", stuffed dolls and role play for birth preparedness are some of the tools used during these sessions.

### Step 4: Advocacy Event (Healthy Baby Fair)

Healthy Baby Fair (HBF) is a village-based advocacy event. It is a one-time activity and serves as a last formal session with large community as part of the



phasing out strategy before final evaluation. Objectives of the HBF include:

- Re-enforcement of key messages on maternal and newborn care
- PD Advocacy at village/community level
- Acknowledging PD activists
- Handing over the project to the community members

The community members both males and females participate in the show with separate seating arrangements. The venue is decorated with colorful illustrations, PD behavior flip charts and balloons, to attract community members and children. Male and female PD activists from other villages also

participate in this event to learn from each other's experiences. The objectives are achieved through



various interesting and interactive activities. A mini-theatre performance is carried out to highlight the role of men as husbands/fathers, head of the household and major decision-maker. Community members share PD success stories and how they used PD behaviors to overcome the problems. This is followed by question answer session to reinforce key messages. Different interactive games and competitions are held to involve parents and their children. Before the beginning of the show children of different age groups are weighed and ranked



according to weight-for-age nutritional status. This forms the basis of healthy baby's competition. The winners are awarded with various gifts to encourage parents and motivate other community members. In the end, PD activists are publicly acknowledged for their voluntarism and contribution for the improvement of maternal and newborn health.

During this event, the project is formally handed over to the community through the group of trained local PD activists, who continue to work for the development of their community, thus ensuring sustainability of the PD project.

## PILOT TESTING OF PD APPROACH ON MATERNAL & NEWBORN CARE

### Background

Save the Children (SC) launched an initiative in 2000 to apply Positive Deviance in new programmatic settings to improve the understanding of this promising approach. Save the Children has an extensive experience of applying this approach in Vietnam on nutrition with some excellent measurable results. Saving Newborn Lives initiative provided an opportunity to pilot and validate PDI, first time on the newborn health through Haripur district RH Program. PD Pilot Phase 1 was initiated in village Kaag and Chanjala in August 2002, to refine the process, tools, and gain more understanding of the approach on newborn health. Available resources and some successful examples of behavior change prompted for a Pilot Phase II in 4 more villages, Garamthone, Nilorepaeen, Bhaira and Chambapind of district Haripur and was completed in June 2004. Final

external evaluation of the initiative was carried out in Oct-Nov 2004. To evaluate it on scientific basis, four identical control villages were identified besides the four intervention villages. The intervention villages were selected from different geographic and demographic settings, maximizing the diversity of areas and social set-ups to assess its real impact in different situations.

### Objectives

Positive Deviance initiative in Haripur had the following objectives:

- To implement and document PD methods, applied to maternal and newborn care
- To mobilize and sensitize community on better maternal and newborn health care through the PD process
- To make existing PD and other key preventive and curative maternal and newborn care behaviors accessible to those at risk
- To enable at risk community members to practice thesekey behaviors
- To assess progress (monitor) and measure results (evaluation), specifically the adoption of new behaviors which contribute to maternal & newborn good health

### Achievements

#### PD Process:

This is an important activity that enables PD facilitators and their community partners to discover PD behaviors and determinants. The process was completed in 6 villages of Haripur in September 2004. The PD process comprised of five steps and took 10 days on average in each village.

- a. **Community orientation meetings:** The PD team organized and conducted orientation meetings in each village to sensitize the community about newborn health issues and discuss the concept of PD.
- b. **Situation analysis:** A situation analysis was conducted to establish the normative behaviors around maternal and newborn care. Qualitative methods including 26 focus group discussions and 85 semi-structured interviews were conducted with mothers, mother-in-laws, fathers, father-in-laws, and community leaders in all six villages.
- c. **Positive Deviance Inquiry:** This was a three

day activity. Newborn mapping was conducted in all six villages, key informants and 'word of mouth' was used to identify potential PD cases (newborns/families). Key in-depth interviews were conducted with the potential PD families to identify PD behaviors and their determinants. During this process 30 PD cases were identified in 6 villages.

**d. Participatory Analysis:** Analysis of PD finding was carried out with the community activists. This process took one day to validate the identified behaviors through the community members. Examples of selected PD behaviors found during PDI were;

- **Birth preparedness:** Unemployed husband collected Rs. 10,000 in case of an emergency during delivery. A father arranged transport before the time of delivery.
- **Clean delivery:** Husband provided *dai* a clean blade for cutting the cord.
- **Thermoregulation:** Family hand-stitched a small mattress (*gadeila*) as a clean and warm surface to place the baby immediately after delivery.
- **Breast-feeding:** A sick and premature baby was exclusively breastfed. A mother gave colostrum to the newborn instead of pre-lacteals.
- **Danger signs:** Family, after recognizing danger signs of pneumonia, sought appropriate care.

**e. Community feedback session and action planning:** Six Community feedback sessions were conducted on the last (10th) day of the process. PD findings were shared with the larger audience. A total of 77 PD activists (39 females, 38 males) were identified and future plans of action were developed during these community meetings.

## PD Implementation

■ **Identification and Training of Activists:** Activists were identified and trained from 6 villages. Five weekly training sessions were organized, covering all components (communication, facilitation, ANC, birth preparedness, delivery, postpartum care, immediate newborn care, identification of maternal and newborn danger signs, breastfeeding, and role of father), in all villages. Total 77 male/female activists (15-20 per village)

were trained. Interactive and participatory techniques such as brainstorming, group discussion with visual aids, role plays, games, making tools (stuffed dolls), story telling were used during training sessions. The PD activists commenced regular mohallah sessions in their villages after training. These sessions were regularly monitored by the PD team.

- **Mohallah sessions:** Overall 77 PD activists in six villages conducted 282 mohallah sessions (males and females) over a period of 6 months. Average attendance per session was 15 to 20 participants including mothers, mother-in-laws, fathers, father-in-laws, unmarried men and women.
- **VAT meetings:** In each village, 16 Village Action Team meetings (total 96) were conducted separately for both males and females to discuss/share the problems and achievements with each other using "triple A process" (Assessment of situation, Analysis of problems and Action/solutions).
- **Healthy Baby Fairs:** Healthy Baby Fair (HBF) is a village-based festival that serves as a last formal session with community before the final evaluation. Six Healthy Baby Shows were conducted in all intervention villages with an average of 500 participants. These events were conducted in 11th month of intervention out of a total 12 month implementation phase. The last month was reserved for trickle down effect of the event.
- **PD advocacy through mass media:** SNL produced a 13 episode, TV magazine show "Zindagi ki Dore" which was telecasted weekly on Pakistan Television, during October 03 - Jan 04. All the components of maternal and newborn health care were covered in the program. One episode was allocated to PD and was aired on 31st December 2003. The PD Team during interviews explained the PD concept and a few PD individuals shared their personal experiences and stories. The highlights of PD mohallah sessions were also shown.
- **Developing PD manuals:** Operations and Facilitator's manuals are in the process of development. These manuals will be used for training and will also help in facilitating the process of replicating PD in other areas and fields. The manuals will be completed by mid 2005.

- **Experience sharing:** The experience of Positive Deviance was presented on many national and international forums including American Public Health Association (APHA), 6th World Congress on Perinatal Health, Japan and Johns Hopkins University.

## Monitoring & Evaluation

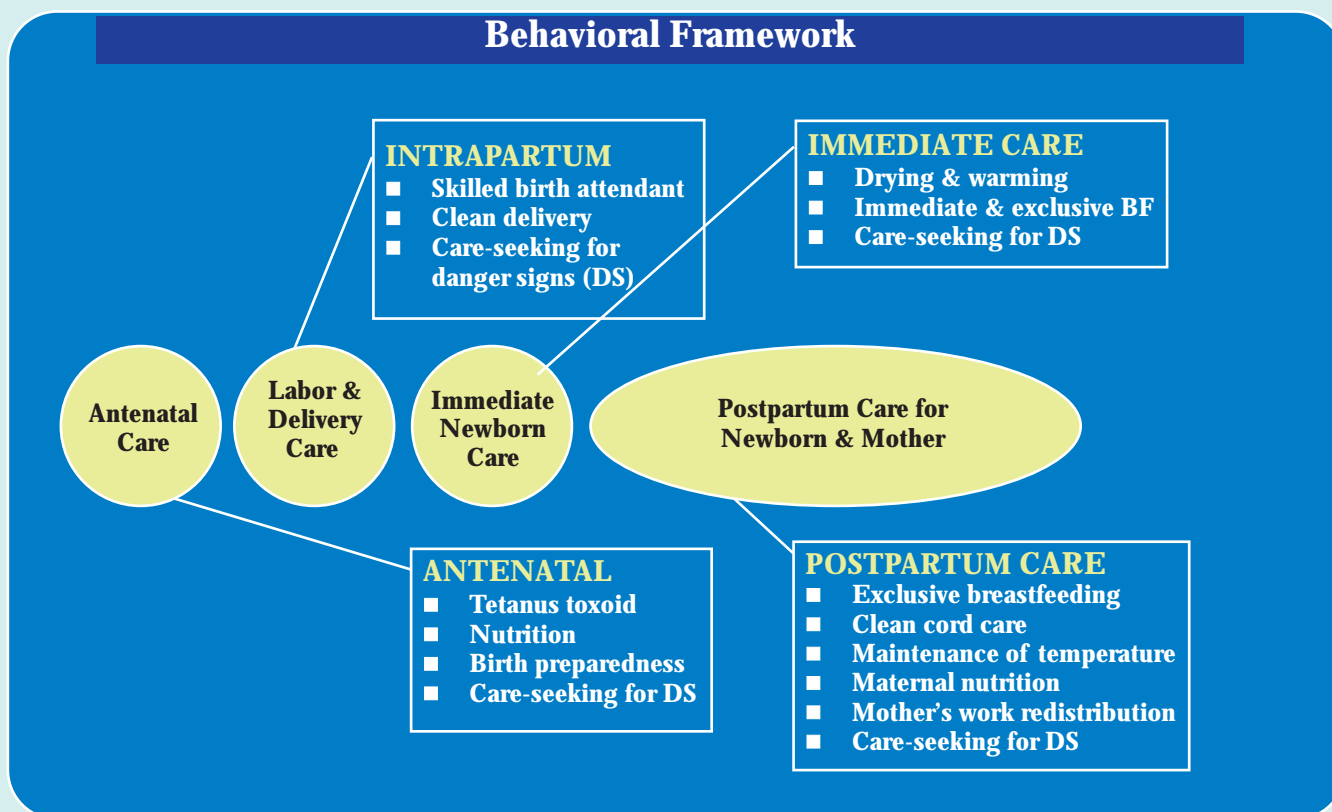
Monitoring and evaluation is an important ingredient of PD approach. Throughout the project period the PD team used various innovative tools for results and process monitoring to appraise the progress and impact of the interventions. External evaluation was conducted at the end to assess the impact of the project.

Beneficial behaviors were selected from the maternal and newborn care behavioral frame work (see figure 2)

The selected behaviors range from recognition of newborn and maternal danger signs, to household behaviors such as immediate and exclusive breastfeeding, birth preparedness and clean delivery and use of services for antenatal care, tetanus toxoid vaccination and care-seeking for danger signs. The Project opted not to measure changes in health status (morbidity or mortality), given the small initial total populations served and the expense of the demographic surveillance that would

be required. Further selection criteria included: 1) the likely association between these practices and improved maternal and newborn outcomes, 2) the expected low prevalence at baseline, 3) pre-pilot experience; and 4) the belief that the results can be achieved through follow-on PD-informed interventions.

**Results monitoring:** Activists and community members supported by the PD Team, conducted internal monitoring. A two-village pilot project allowed testing and refining internal monitoring mechanisms to be replicated in the next four villages. Results were monitored using tools i.e. birth and death registry, pictorial behavior change monitoring checklists and Booster PDI (Positive deviance Inquiry). Every birth and death was registered on *Birth and Death Registry* by the PD activists. Behavior change was assessed using pictorial data collection checklist on the third and fortieth day of the delivery by trained PD activists. "Booster PDIs" or in-depth interviews with new adopters were used to identify determinant factors and reinforce positive behavior changes by the PD team and female PD activists. These positive new behaviors were shared with the community by the PD activists at Mohallah sessions and VAT meetings. The data collected was entered and analyzed by the PD team.



**Process monitoring:** To assess the quality and progress of project implementation, specific monitoring checklists were used. Quality of PD process (i.e. preliminary visits to the community, community orientation sessions, situation analysis, community feedback sessions and training of community activists) was monitored by the PD team. Twenty five percent of the mohallah sessions were monitored by the PD Team to assess the quality and progress of these sessions. The VAT coordinator maintained the register of the mohallah sessions. All training sessions, VAT meetings and healthy baby fairs were also monitored by the PD team. Data collected was reviewed and entered by the PD team and results were used to improve the quality and performance of the project activities.

## Evaluation

To assess the impact of PD project, an external evaluation was conducted in September 2004. The final evaluation was divided into two parts:

1. Statistical analysis to assess the impact of the project interventions by comparing the baseline survey and the final end line survey results
2. Qualitative study, focusing on social mobilization aspects of the program by conducting community focus group discussions in the four intervention and four control villages.

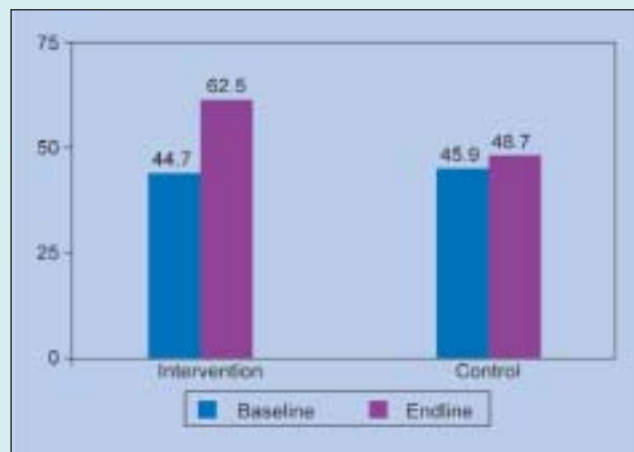
The quantitative study aimed to assess the knowledge, attitudes and practices of the intervention communities in maternal and newborn care, and compare the impact with the baseline survey data and the four control villages. The data reflected the change in the knowledge, attitudes and practices of the mothers, fathers, and mothers-in-laws in maternal and newborn care. The parameters used for comparisons included respondents background information, antenatal care, delivery preparedness, delivery care, newborn care, postnatal care and communication. The primary methodology for data collection was through a census of all mothers in each village, who had a child under the age of one-year and fathers and mothers-in-laws if available at the time of the survey. The tools for data collection were same as the baseline survey to assess the changes over-time. A similar approach was used for both control and intervention villages.

## Key findings

A few key findings from quantitative survey comparing the baseline with end line, in control and intervention areas are given below:

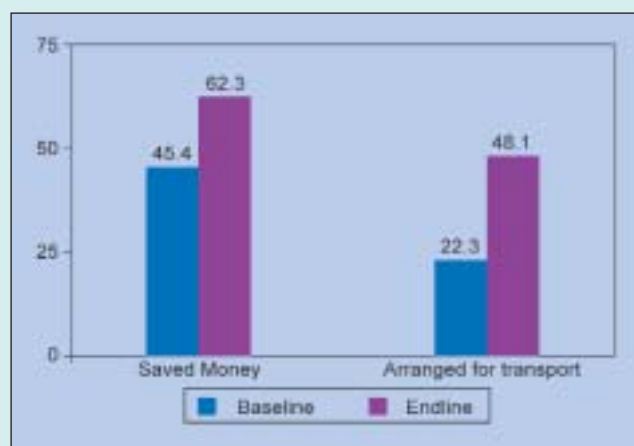
- There is a significant increase in percentage of mothers in the intervention villages who had two or more antenatal checkups compared with the mothers in the control villages as shown in figure 3.

**Figure -3: Two or more ANC visits of mother**



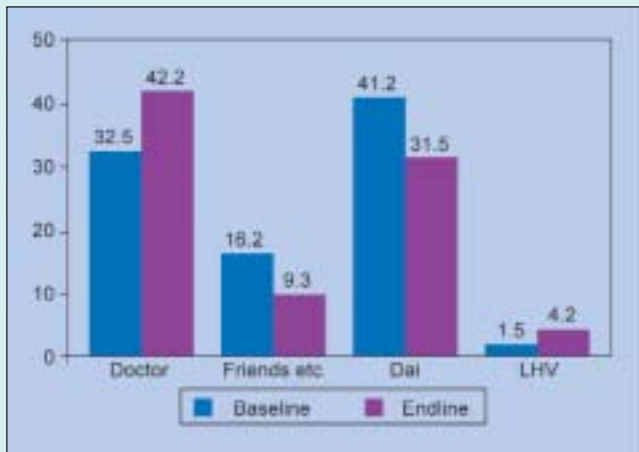
- A definite change is visible in the practices of the communities regarding delivery preparation since the baseline and the end-line surveys in both the control and intervention villages (Figure 4). The most commonly mentioned preparations prior to the delivery were arrangement of transport and saving money for any unforeseen emergency during the childbirth.

**Figure 4 - Percentage of birth preparedness in the intervention villages**



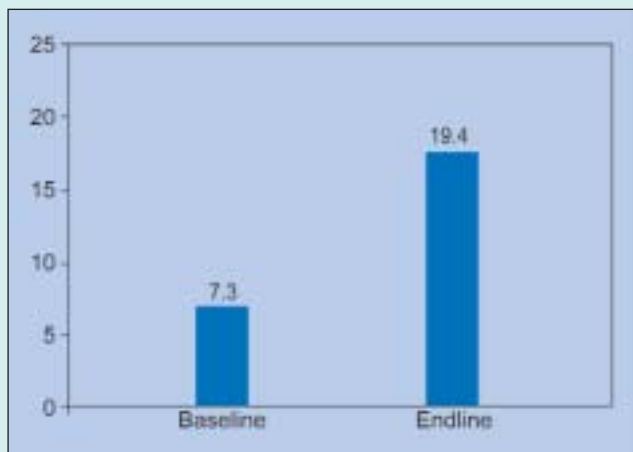
- Figure 5 shows the comparison of type of attendant during delivery from baseline in intervention area.

**Figure-5: Percentage of type of attendant during delivery in the intervention area**



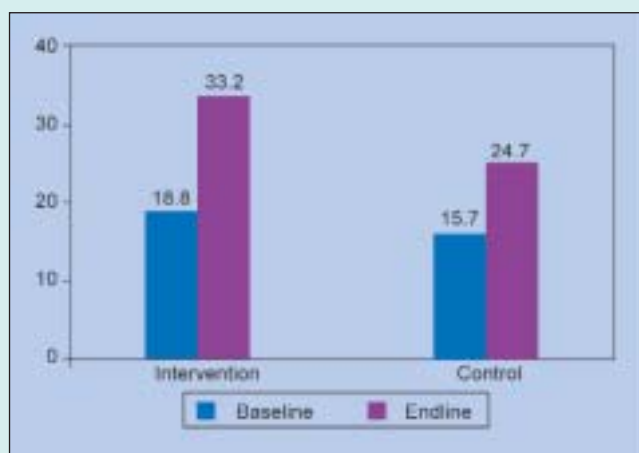
- There is a significant increase from baseline in percentage of family members who did not apply anything on the cord (Figure 7).

**Figure-7: Percentage of those who applied nothing on cord**



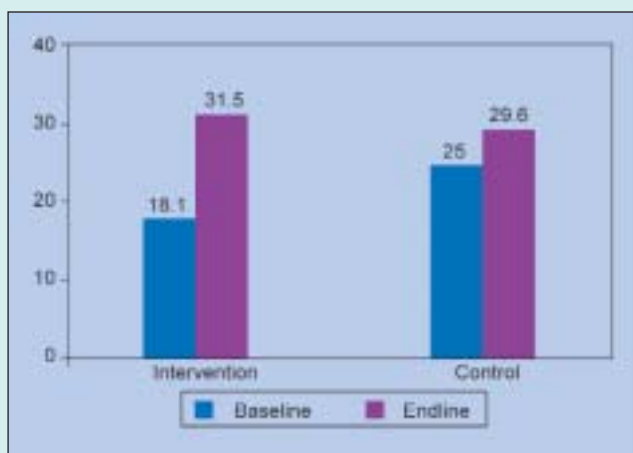
- The use of a new blade has also increased significantly from 19 percent in the baseline to 33 percent in the end line survey in the intervention villages (Figure 6).

**Figure- 6: Percentage of new blade used by families to cut baby cord**



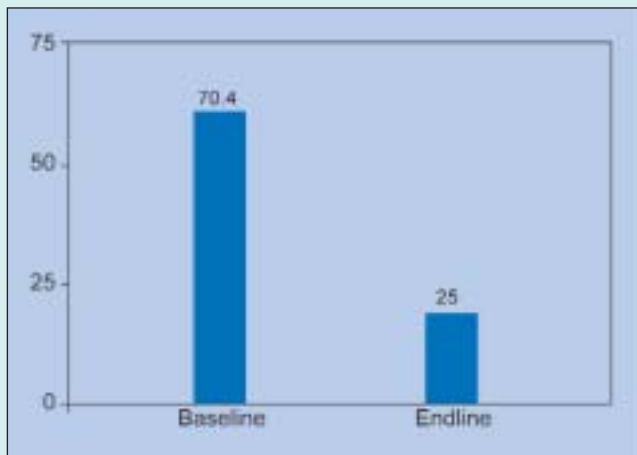
- Figure 8 shows the percentage difference in the baseline and end line and control and intervention villages among those cases who bathed the baby after 24 hours of birth. A positive trend is visible in the program villages, where the percentage went up to 31.5 percent from 18 percent.

**Figure-8: Percentage of time of first bath given to baby (after 24-hours)**



- Figure 9 shows that there is a decrease of around 45% of mothers who gave prelacteal feeds to the newborn within 3 days of birth.

**Figure-9: Percentage of mothers giving prelacteal feeds within 3-days**



## Lessons Learnt

- PD is a strong tool for community mobilization through involvement of community in each step to ensure the ownership
- PD approach can be used in health and other related issues for sustainable behavior change
- The interactive tools i.e. conceptual games, rice filled dolls and local metaphor can play a vital role to involve and sensitize community members for sensitive issues like maternal and newborn health
- Community based training using the "learning by doing" methodology gives the activist confidence to tackle sensitive health topics
- Better participation of males can be ensured if meetings are arranged in evenings.
- Socialization places, cultural and community events can be used for information sharing
- It is a labor intensive and time consuming approach.
- Different strategies can be used in different villages to mobilize the community members such as females can be mobilized through males and vice versa.
- Acknowledgement of volunteers in front of community members can enhance their commitment.
- The PD should be conducted in a population having 3000 - 5000
- It is not recommended to initiate the PD process at planting or harvest times, religious and other holidays and during electoral activities since families may not be available.

*Adopting existing positive behaviors in the community leads to healthy mothers & healthy newborns*

