



The Right Messages—to the Right People—at the Right Time

A World Vision child survival project called *Pragati* in three Uttar Pradesh districts strove to improve health outcomes and change behaviors related to women’s and children’s health, and to ensure that pregnant women and new mothers had ready access to information about and methods of birth spacing and family planning. With USAID resources, World Vision expanded its audience for family planning to include most couples in the project zone.

World Vision’s innovation in this project was a timed and targeted approach to behavior change communication (BCC) for all project components. That is, BCC on health, nutrition and family planning was timed to a woman’s stage of pregnancy, the age of her infant and/or the fertility intentions of the couple. It was targeted to decision-makers in the family, including but not solely to the individual who might accept a contraceptive method. World Vision developed, tested and launched a comprehensive package of training, tracking tools, job aids

INTRODUCTION

Uttar Pradesh in north-central India lags behind national mortality and fertility declines, according to the National Family Health Survey (NFHS).ⁱ An Indian woman on average bears 2.7 children during her lifetime, but the typical woman in Uttar Pradesh bears 3.8. About 44 percent of married women in Uttar Pradesh use contraceptives, compared to 56 percent of their counterparts nationally. Infant mortality in the state is high at 73 deaths per 1,000 live births (the India-wide ratio is 57 per 1,000). And most health indicators in Uttar Pradesh changed very little from the previous NFHS in 1998/99.

NFHS:	Uttar Pradesh		India	
	1998/99	2005/06	1998/99	2005/06
Total Fertility Rate	4.1	3.8	2.9	2.7
Contraceptive Use ^a	27%	44%	48%	56%
Unmet Need for FP ^b	25%	22%	16%	13%
Infant Mortality ^c	89	73	68	57

^a Among married women aged 15–49

^b Among married women aged 15–49 who want to delay next pregnancy or want no more pregnancies

^c Per 1,000 live births

World Vision believed the time was right to take a new look at old approaches to individual and household behavior change in Uttar Pradesh state, where *Pragati*, its Expanded Impact program (2003–2007), offered a package of preventive child survival and integrated family planning interventions in the districts of Ballia, Lalitpur, and Moradabad.ⁱⁱ

At its onset, *Pragati*—Hindi for ‘acceleration’ or ‘momentum’—found that health workers scheduled behavior change communication (BCC) activities according to the calendar year or according to the providers’ work schedule.



and supervision protocols to ensure consistent content and quality of BCC across time and place. Pivotal to the approach's implementation and ultimate success was the project's ability to tap into India's existing community volunteer structure: most regular home visits/BCC sessions were carried out by *anganwadi* workers whose role and experience is briefly described in this case study.

Over four years, the contraceptive prevalence rate more than doubled in the project zone. World Vision's research indicated that the *timed and targeted approach* was culturally appropriate and that it facilitated the adoption of family planning methods. The Indian government and other NGOs are now replicating the approach, and the innovation shows promise for use elsewhere. However, World Vision notes that the strong, existing volunteer structure in India was a factor in the project's success with this operationally demanding approach. *Timed and targeted BCC* will be more difficult and costly where outreach workers must be identified, trained and supported from scratch.



Anganwadi workers trained in the project's intervention methods and the use of timed and targeted counseling.

That is, people gained information about health not when *they* needed it, but when the health system scheduled it. Weekly 'Nutrition and Health Education Days' and the 'Child Health and Nutrition Month' of the Integrated Child Development Scheme (ICDS)ⁱⁱⁱ were typical of the approach.

The *Pragati* project used a new approach to meet the BCC needs of its participants. Based on the continuum of care model, the approach *timed and targeted* health messages to reach the right people at the right time in their lives.

Appropriately timed information meant that messages were neither too early, lest they be forgotten, nor too late for the behavior to be practiced. Appropriately targeted information meant that messages were delivered to those who would practice the behaviors and those who would influence adoption of the behaviors. *Pragati* ensured that the new approach allowed communication in a confidential environment and encouraged open discussion between an individual or family and a skilled, knowledgeable provider.

Pragati originally intended to offer information about birth spacing to pregnant women and to married women with children less than two years old. With the addition of USAID resources early in the project life, World Vision expanded its intent: It offered family planning information, services, and referrals to *all* married women of reproductive age, and tailored BCC to meet the needs of women (and men) in three categories: newly married couples, couples with children, and women who were pregnant and/or whose youngest children were less than two years old.

This case study describes how *Pragati* used timed and targeted BCC with women during and after their pregnancies as a way to increase their uptake of modern family planning methods.

PROJECT APPROACH

Training Volunteers to Use Timed and Targeted Counseling

If timed and targeted counseling were to lead to the desired behavior change, key messages had to be organized and delivered at appropriate times during a woman’s pregnancy and postpartum period. World Vision noted three prerequisites for success:

- A cadre of community volunteers trained to identify women in early pregnancy and track them over time to deliver the counseling,
- Registers to track conception and birth cohorts and some outcomes, and simple job aids that detailed the benefits of each behavior and helped dispel myths that may have deterred people from practicing the behaviors, and
- A standardized kit of job aids to ensure that messages were consistent across time and place.

Pragati trained more than 2,800 community volunteers—most were *anganwadi* workers from the ICDS program and some were linked to local NGOs—and auxiliary nurse-midwives in the project’s intervention methods, especially in the use of timed and targeted counseling and how to use registers to track women’s health behaviors and outcomes. World Vision used a cascade approach to training, so that the nearly 3,000 volunteers were trained in three stages over eight months in *Pragati*’s first year. Smaller batches of trainings were implemented for new volunteers to replace those who left the project over time.

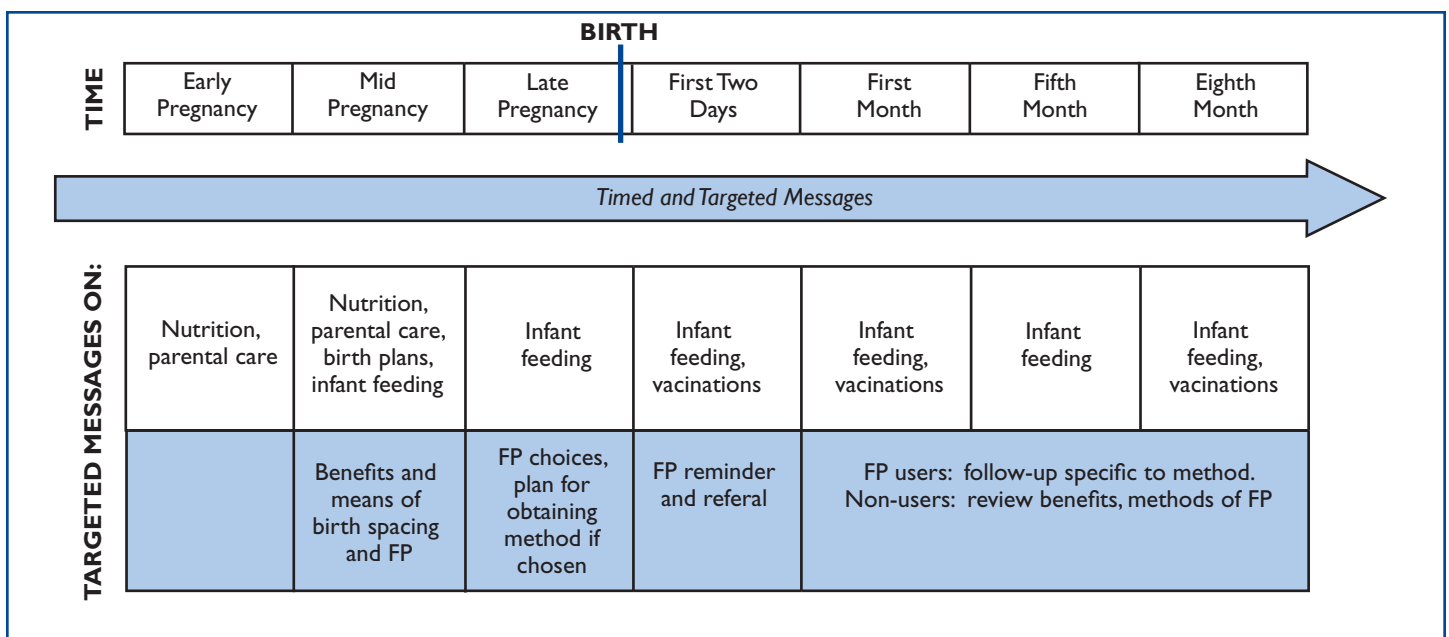


Typical village in Uttar Pradesh.

Timing

BCC on birth spacing and modern methods was particularly crucial for pregnant women. Volunteers learned the counseling schedule they would follow with every pregnant woman they identified, which consisted of seven visits—three during pregnancy, one after childbirth, and three during infancy—to (a) deliver messages related to family planning/birth spacing, nutrition, and immunization, (b) follow up on previously delivered messages, and (c) document services used and changes in behavior.

In the representation of the schedule below, the green highlighted boxes indicate when the volunteers introduced, reminded women about, and revisited the topic of family planning over the counseling schedule.



Sample page of Family Planning Register													
Client Information						Planned/Actual Date of Visit	Method Provided/Referred						
#	Client Name	Husband Name	Age	# Living Children	Age of Youngest Child		Oral (# Packets)	Condom (#)	IUD	Female Sterilization	Male Sterilization	Lactation Amenorrhea Method	Standard Days Method

Messages and Registers

Community volunteers learned to use three color-coded registers to identify and track cohorts of women in the same months of pregnancy and, subsequently, birth cohorts of infants and their mothers for up to three years. They included a pregnancy register, an infant register, and a family planning register.

In the *pregnancy register*, the volunteers recorded details of each woman, her due date, her planned and actual home visit and counseling schedule, and certain aspects of her prenatal care. Family planning counseling was a feature of home visits in mid and late pregnancy, when most women were ready to look toward and beyond childbirth. At the end of the fourth visit—that is, the first post-delivery visit—the woman’s information was transferred to the family planning register. (The infant’s data were entered in the infant register, where information on its immunizations, feeding, and nutrition were recorded up to eight months of age.)

The *family planning register* listed the names of women transferred from the pregnancy register, both those who adopted a contraceptive method and those who did not. The register also listed the names of women who did not have children less than a year old but who sought information on family planning. (The volunteers provided such women with information, services and referrals as needed.) The register was designed for longitudinal tracking of family planning use and non-use. For users, there were columns to record the method provided or referred for oral contraceptives and condoms, and the amount provided. There was no specific column for non-users, but a space for remarks recorded the reasons for non-use, if any. Each line in the register accommodated one initial visit and three follow-up visits, all in the same format. A fresh line was begun for women who continued to be provided with contraceptives or followed up, but each retained her original registry number.

The register also followed married women of reproductive age who had not had a recent pregnancy or birth. As noted, *Pragati* offered three types of counseling plans for women and couples in various life stages, with family planning messages tailored to each: newly married couples, couples with children, and women who were pregnant or new mothers.

All three registers were printed with job aids and counseling plans at the bottom of each page for easy reference. Regular supervision of volunteers indicated that nearly all of them used the registers, and that between 83 and 98 percent of them provided adequate, timely counseling via scheduled visits.

Dispelling Myths and Building User Confidence

Volunteers carried a handbook containing an extensive list of common myths and misinformation about family planning and other health behaviors, and corresponding correct information to counter these misperceptions. Among the myths was the notion that the intrauterine device could wander from the uterus and reach the brain or heart, and that oral contraceptives did not dissolve but formed a growing mass in a user’s body.

The *Pragati* project also made sure, via initial and refresher training, that volunteers were able to demonstrate contraceptive use and talk acceptors through the process as often as necessary, until they felt comfortable in their knowledge and ability to use a method properly. This proved especially important for condom and oral contraceptive users. By the same token, volunteers were able to discuss side effects—actual and rumored—in a clear, matter-of-fact way that also built users’ confidence.

Of course, World Vision went beyond reaching women of reproductive age with carefully timed information, and targeted men and other influential family members too. Volunteers learned to include husbands and mothers-in-



A supervisor checks the register of a community health worker

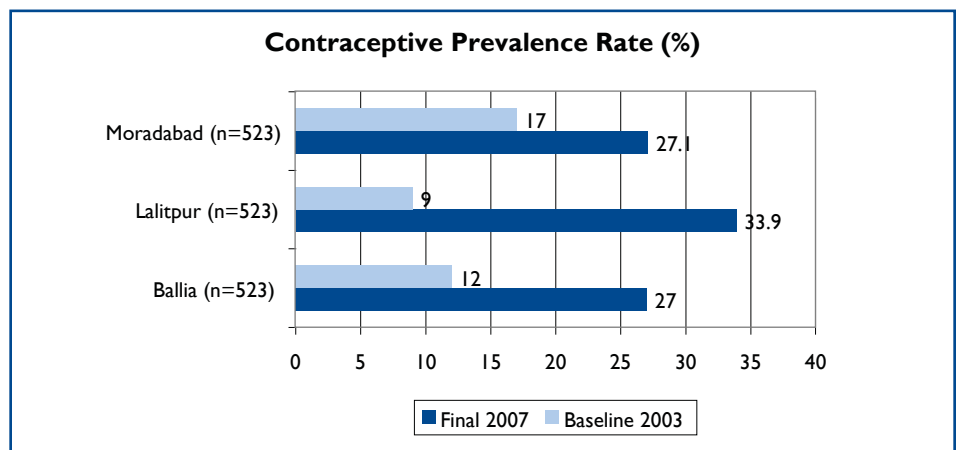
law during their house-to-house counseling sessions. Men were invited to men’s meetings held by project supervisors, and family planning was even the topic of street theater in the three districts.

Supervising the Volunteers

World Vision developed a standardized supervision checklist, used by field supervisors to track the work of the community volunteers. The checklists required supervisors to pay close attention to the quality of counseling done by volunteers. Regular supervision meant that any problems in a volunteer’s knowledge, skills, or attitude would be readily recognized and corrected. *Pragati* achieved solid supervision coverage: In the vast project area—more than 2,800 volunteers serving over 5,000 villages—between 85 and 93 percent of community volunteers were supervised every month.

KEY FINDINGS

The *Pragati* project undertook a baseline survey in 2003 and a final evaluation in 2007 to measure the effect of its work. Each study used a two-stage, 30-cluster sampling method and a sample size of 300 mothers in each of





the three districts. Most outcomes with a significant household-level behavioral component increased substantially over the life of the project. Here, changes linked to family planning are highlighted.

Contraceptive Use and Awareness

Contraceptive use rose among postpartum women in all three districts (as shown at right), more than doubling in Ballia and nearly quadrupling in Lalitpur. The women represented here:

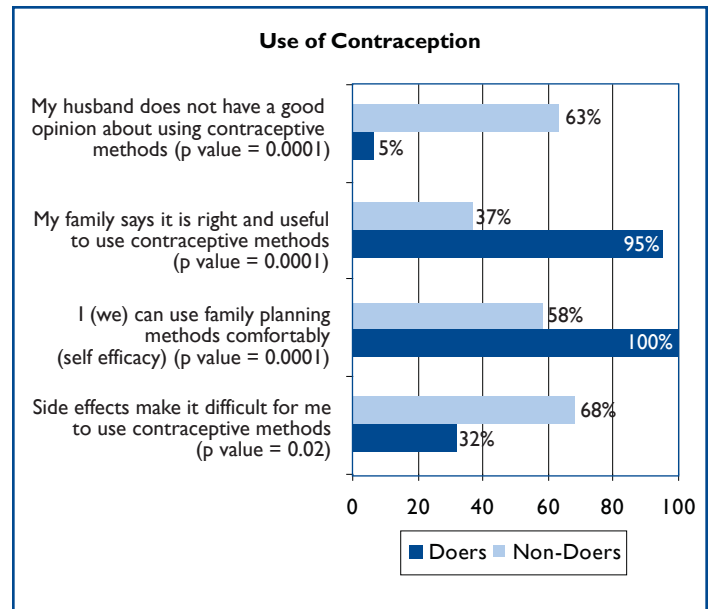
- Had a child less than two years old,
- Did not want another child within the next two years (or were unsure), and
- Were using a modern contraceptive method.

In short, these women were prime candidates for contraception as a way to space births.

At the same time, women’s knowledge of at least one source of family planning leaped to near-universal levels, from 27 to 99 percent of mothers of children less than two years in Ballia, from 21 to 91 percent of such women in Lalitpur, and from 31 to 75 percent in Moradabad.

Contraceptive Confidence and Approval

World Vision undertook a doer/non-doer analysis to understand the effects of its counseling approach. Such an analysis compares those who adopt a behavior with those who do not, and can help identify factors linked to behavior change. It examines respondents’ perceptions of the consequences (good and bad) of adopting the behavior, of self-efficacy (factors that make it easier or harder to perform the behavior), and of norms (perceived approval or disapproval of the behavior). The results are shown in the bar graph.



This analysis revealed that social norms are significant determinants for the use of modern contraceptive methods. Spousal disapproval and side effects are the greatest deterrents, while the approval of the larger family has a strong, positive influence on use. Personal confidence and efficacy—that is, a respondent’s comfort level in using the method—are also important factors.

RECOMMENDATIONS FOR REPLICATING TIMED AND TARGETED COUNSELING

The timed and targeted approach to BCC that World Vision used in its *Pragati* project is already spreading:

- The ICDS found the approach to be comprehensive, systematic, and effective. It adopted the approach, modified the tools that World Vision had developed, and mainstreamed timed and targeted counseling into its nutrition education work in all 70 of Uttar Pradesh’s districts. At this scale, it can potentially benefit the total state population of 166 million, via 106,000 health volunteers.
- World Vision shared the approach and its related tool kit with members of the child survival community, who meet regularly with USAID in New Delhi. The new *Vistaar Project*^{iv} has decided to adopt timed and targeted BCC as part of its best practices in maternal, newborn, and child health in Uttar Pradesh and Jharkhand states.

World Vision itself has made timed and targeted BCC its standard approach in its 28 programming zones in India, including areas in Uttar Pradesh, Jharkhand, Bihar, Madhya Pradesh, and Chhattisgarh states. Health staff are currently



and followed up with the volunteers and staff, many of whom had already gained a great deal of experience in the child survival program that preceded *Pragati*. Most of these volunteers were *anganwadi* workers of the ICDS, India's enormous, 30-year-old program that reaches deep into communities throughout the country to improve children's health and early education and supports local volunteers with a structured training and supervision program. In short, World Vision did not start from scratch when building its cadre of community outreach workers. Thus, the approach as World Vision used it in Uttar Pradesh may not be easily replicated where there is not a strong structure of community health workers.

To that end, World Vision is working on a somewhat less rigorous version of the approach and a more visual version of the toolkit, and these adaptations are likely to introduce new strengths and manageable weaknesses. Intensive monitoring and supportive supervision may be diluted, but community participation is expected to increase. A picture-based model of the timed counseling plans and registers will increase user-friendliness, but reduce the ability to collect and analyze quantitative data on activities and results.

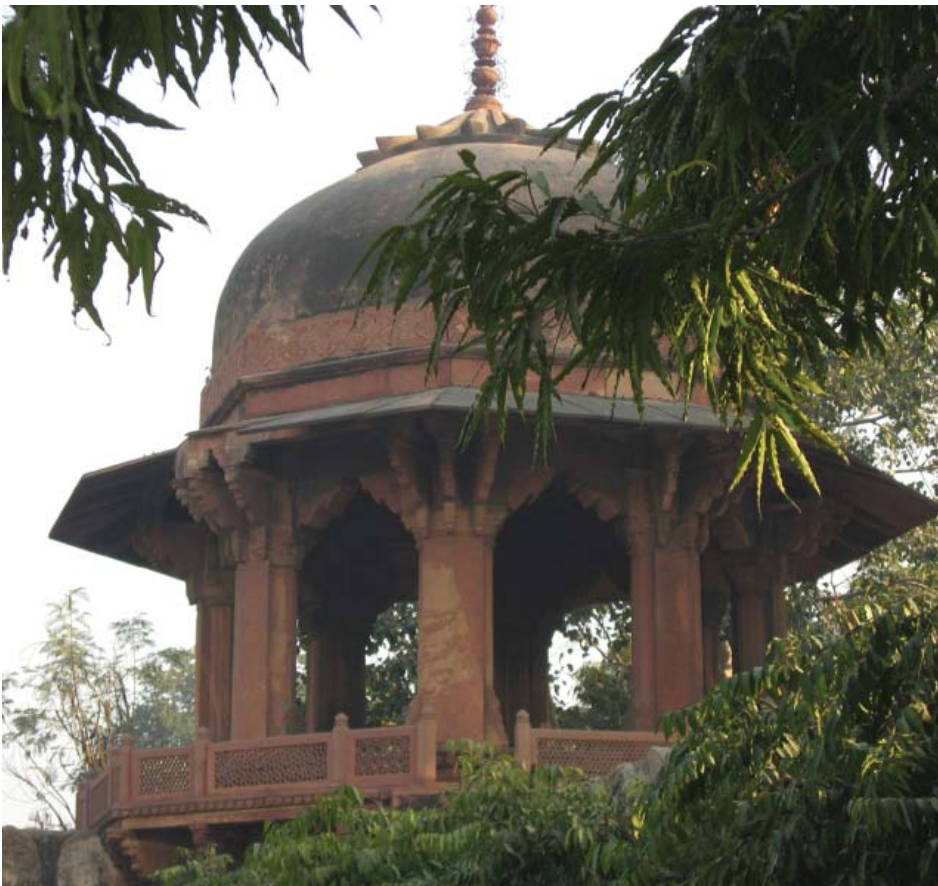
training other staff and volunteers, and are planning the rollout of the timed counseling package.

That said, the timed and targeted approach, and the quality assurance that is embedded in its supervision component, is technically demanding. World Vision intensively trained



Community health workers trained in Standard Days Method.

-
- ⁱ International Institute for Population Sciences (IIPS) and Macro International Inc. 2007. *National Family Health Survey (NFHS-3), 2005–06: India: Volume I*. Mumbai: IIPS.
- ⁱⁱ *Pragati*, funded by USAID, reached some 1.1 million children and 1.6 million married women in more than 5,000 villages of the three districts. In *Pragati*, World Vision carried over and expanded successful interventions from its Ballia Rural Integrated Child Survival program (1998-2002). “The project takes a focused set of child survival and family planning interventions to scale in the three districts. These interventions, with their proportionate levels of effort, are: immunization (40%), family planning (30%), maternal and infant nutrition (20%) and Vitamin A supplementation (10%)... Under a new initiative for child survival grant projects, 30 percent of *Pragati*’s funds were provided from USAID’s Flex Fund.” (World Vision, *First Annual Review, Pragati Child Survival Project*, (World Vision 2004), 4.)
- ⁱⁱⁱ India’s Ministry of Human Resources Development implements ICDS, the world’s largest early childhood care and nutrition program. A major feature of the ICDS is the subdivision of the country into blocks, each with an *anganwadi* and at least one *anganwadi* worker. The *anganwadi* (the word means ‘courtyard’ or ‘play space’) is the locus for early childhood development in the block, and the *anganwadi* worker, in addition to providing childcare, offers services and information to parents on child physical and mental development and, by extension, healthy behaviors for women and for families.
- ^{iv} Funded by USAID, *Vistaar* is implemented by a consortium of agencies led by IntraHealth International, Inc.
-



Written by:
World Vision United States
and India
Catherine Toth

Edited by:
Catherine Toth and
Macro International Inc.

Photos by:
World Vision United States
and India

Design by:
Macro International Inc.

