



VITAMIN A CAPSULE DISTRIBUTION

Key behavioral and communications issues

Community demand for and acceptance of supplements and health system motivation should never be taken for granted, especially in the case of micronutrients. There is always a need for program promotion and communications for behavioral change at both the institutional and community levels. The purpose is to create awareness at both levels of the existence, severity, and consequences of vitamin A deficiency; the benefits and effectiveness of supplementation; and the need for changes in people's behavior aimed at enhancing demand and acceptance of supplements as well as other options to improve vitamin A status.

Behavioral and Communications Training for Health Workers/Providers

Step 1. Agree upon and clearly state expected behaviors.

It is very helpful to state clearly the behaviors that health workers/system providers are expected to adopt. This is best done through agreement with those most involved, including nutrition units, ministries, and the health workers themselves. They must find the expected behaviors feasible, reasonable, and acceptable. It is important not to have unrealistic expectations. For example, useful performance objectives for providers during a NIDs or mass vaccination program are simply to administer the supplements correctly, tell the caretakers that the child is receiving vitamin A, remind the caretaker when to come back, and say something positive to the caretaker about participation.

Step 2. Identify the existing behaviors.

The first step in assuring or supporting these expected behaviors is to have a clear idea of what is actually occurring in the field. Most countries can take advantage of the vitamin A capsule distribution that accompanies the NIDs each year to collect these data. Simple checklists for observation of the contact and exit interviews with the caretakers can be used to monitor the contact between the capsule providers and caretakers to identify performance problems and gaps and to learn their perspective on the experience. One can also learn what caretakers know and think about vitamin A and vitamin A capsule distribution and exactly how long the average contact lasts. These findings can easily be used to design training and worker aids and to give ideas for communications.

Step 3. Identify gaps & barriers to adopting expected behaviors.

Skills. Experience has taught that workers need to be and feel competent in administering vitamin A capsules correctly—proper dosage, estimating age, cutting capsules, vomiting children, tallying, etc. These skills are more complex than expected and need careful training. Demonstration with practice works best, with the opportunity to problem-solve; for example, workers should be asked to demonstrate how to use a 200K capsule for a child under one (or under six months if these are included in your protocols).

Communication. Providers also need to know exactly what communications with caretakers are expected; at a minimum, they should tell them that the child is receiving vitamin A, when to come back, and something positive so that the encounter is a positive one for the caretakers (“thank you,” “you’re a good mother,” “this helps your child”). Observations will have shown how much time is actually available during the provider-caretaker contact. If there is time during the NIDs/measles campaign, or later during a non-NIDs vitamin A focus campaign, a short message on the value of vitamin A capsules can be given. If there is not enough time for desired messages, perhaps more days can be allowed for the campaign. It only frustrates providers if they are asked to provide more messages than they, in fact, have time for. The amount of information has to fit into the time available, so shrink the messages or expand the time. Offering providers a choice of benefit messages relieves some of the boredom of repeating the same lines; for example, they can choose from “this protects your child, saves lives, keeps your child healthy, is like an immunization, makes healthy children, makes children strong, helps them grow well, be energetic, survive serious illness”, or other messages the audience sees as persuasive.

Observations to date have shown that some workers in some countries treat clients poorly, although this seems to be a case of neglect rather than harshness. They fail to give them the key or any messages, or they make them wait, not respecting their time. Interestingly, it was noted in the monitoring observation in Zambia that workers who were respectful of client time had better attendance and coverage than those who did not.

Attitudes and motivation. Workers, and the health care system in general, often do not understand or value the importance of vitamin A and vitamin A capsules for prevention and tend to be overall more comfortable with treatment than prevention. Possible barriers or problems include the following: the system and its leaders do not place a priority on the activity, it is not in annual plans or budgets, and there is very little support or recognition of the activity outside the NIDs. Vitamin A capsule distribution coverage is often not part of the regular MIS, which further suggests to providers that it is not important—that is, it is not something that is scored for or against them. Routine coverage has often been a low priority, and, whether or not they get good coverage, nothing happens in the way of feedback. No one notices whether or not they do a good job.

Step 4. Take actions designed to overcome identified barriers.

Behavior change theory tells us that the three primary determinants for adopting a new behavior are 1) our confidence that we can do it well, 2) the belief that it will “pay-off” or have a positive outcome for us, and 3) that those important to us approve.

Training should therefore also focus on motivating providers by increasing their knowledge of the benefits and “pay-off” of vitamin A capsules for the providers and their systems. One way of doing this is through the use of overheads that stress the mortality effect of vitamin A deficiency, the gains associated with good coverage, and the benefits from vitamin A capsule distribution for health services, as there is less demand for drugs and service.

The orientation workshops for providers should directly address the issue of motivation and understanding of the benefits of vitamin A capsules. Benefits for the community and for health workers should be discussed and the behavioral expectations clearly stated, discussed, and negotiated. Messages should be designed to fit into the contact time available, and changes should be made if providers feel they will be overwhelmed by the new demands. Group problem-solving sessions can help managers think through how to anticipate and meet common problems, can help them feel more ownership of the process, and can provide extremely good ideas and analysis. The observation and exit interview findings again can be used here to help look at issues of quality and client-friendly services.

Feedback from the observations should be presented during the orientation sessions to help managers appreciate the problems the health worker in the field encounters, so they can prepare more realistically. This kind of feedback can be very powerful in helping managers to focus on the reality of the peripheral worker.

A short worker aid that will clearly show dosages, and how to give the capsules, including the correct way to cut, may need to be provided with the capsules.

A mechanism should be put in place to assure that the central level provides recognition for good work and organization. A system of incentives, as special certificates for highest coverage centers, choosing high achievers to present their experience in the orientation sessions for the next year, etc., should be put into place. The best way to *stop* a behavior is to punish it or to ignore it.; the best way to *promote* a behavior is to reward it.

Local staff should be involved in the observation and exit interviews. This will enable them to understand and correct specific problems in their areas, and show recognition to the workers. This should be a highly supportive rather than critical effort. Observers from the central level (UNICEF, MOH, etc.) should also take part to provide visible support and to themselves understand the problems.

Caretaker Behavior Change/Demand Generation

The steps are the same for caretaker behavior change, but in the case of supplementation, much simpler than for providers and therefore easier to promote.

Step 1. Choose and state clearly the expected behaviors.

“Bring your children aged x to the distribution points for the protection of vitamin A twice a year in (month of the year or of child’s age, depending on your policy).” For twice-yearly campaigns, you need only tell them to come when they hear the announcements, which should occur in predictable months; e.g., each August and February, which can be identified as ‘the vitamin A months.’ The goal is to make the twice-yearly distributions the norm so that providers and communities take them for granted. If you plan to deliver the capsules through routine services, you will need to decide what you expect mothers of older children to do—come twice a year in special months or at their own child’s six-month intervals. The latter is clearly a more difficult practice. Usually, coverage is lower with routine services than with campaigns, especially for children over one year who do not often come to clinics for preventive care.

Step 2. Identify current practices and beliefs.

Findings from the exit interviews described earlier can give you quick ideas about what caretakers know and do not know, what values they see in vitamin A, and where they receive information about vitamin A. These can help to direct the messages for the next distribution.

Step 3. Address identified barriers.

In terms of barriers to be overcome, there are not many. The vitamin A capsules are free, have almost no side effects, protect their child, save lives, makes their children strong and beautiful, etc. A difficulty may be distance if sites are not well sited. Stress that vitamin A protection is aimed at older children, between two and five, as well as the younger children who are targeted for immunizations. Often parents are pleased that their older children are now offered protection and preventive services.

To encourage integration of services and link to already valued immunization, the program could stress that “full immunizations and vitamin A capsules twice a year offer complete protection to your children under x.” A popular idea is to take advantage of the vitamin A contact to integrate other child survival services, such as deworming and checking immunization cards. The vitamin A contact offers access to children older (one to five) than are usually seen at health centers.

On the other hand, there is no immediate, visible benefit in receiving vitamin A; families often do not notice any real changes or notice them over time. It is important then to articulate these benefits in your materials; e.g., “mothers in your community (mothers like you) say that their children are more energetic, healthier, have brighter eyes, after receiving vitamin A.”

Creative briefs/talking points should be developed to give all members of the vitamin A team a clear idea of the behaviors to be promoted, barriers to be overcome, messages or actions to overcome these barriers, a “key promise” that states clearly and persuasively the main benefits from the audience’s perspective of vitamin A capsules or vitamin A, the tone to use in discussing the issue, etc. This helps to focus messages and communication on key resistance points, promotes consistent and correct messages, and helps take advantage of every opportunity for radio and TV interviews, talks with groups, etc.

Building Systems

In order to create a permanent system that supports and reinforces behaviors it is useful to set up monitoring and feedback loops that provide feedback at the district or smallest administrative level to the providers. This can first be done by or with technical assistance at the central level but should include training for local staff to carry out this monitoring for themselves. This has proven extremely valuable in several countries, helping to keep providers motivated and able to fix problems immediately.

A good way to do this is a simple household coverage survey that validates your coverage. Other questions on caretaker knowledge of the five “W’s” (*what* are vitamin A capsules, *where* and *when* do you get them, *who* are they for, and *why* do you want them), their sources of information about vitamin A, whose opinion matters about this, etc., can be added to help you with your communication planning. These are relatively quick to do on a national level, requiring approximately \$3–5 thousand a round. It is much cheaper when local staff begin to do their own.