CHAPTER - 1

INTRODUCTION

1.1 Communication for Development

Development cannot take place in isolation and communication can never be standstill. Development of society is dependent on choosing from the available resources, approaches and alternatives. In this process, communication plays an integral and significant role in laying all alternatives before policy planners, development practitioners and other stakeholders. Therefore, it can be said that helping, assisting and leading the process of development is called communication for development.

Several organisations have been working with local governments since years to develop communication in societies. The main motto of these organisations is to bring: Persuasion, changing what people do; education, changing social values; and informing, empowering people to change by increasing knowledge. The third approach has become very important and useful motto because it concentrates on each and every individual to develop themselves. Thus, it has become the most important factor in developing the society (Sood et al., 2014).

Development Communication's main role is not only to provide information on development activities but also creating opportunities for the people to know about new ideas regarding development in all spheres. It mainly provides ideas to people to generate useful ideas in their daily lives for their overall development: economic, social, and political (Khandekar, 2015).

Communication has become a major factor in improving the social and economic condition of society. Media plays a vital role in making effective communication in societies. Media came into existence in the Third World in early 1950, radio and television played a vital role in transferring news regarding the changes and developments taking place in a society. It was through these mediums

of communication that backward areas of societies came to know about prevalent ideas that operated a society. Thus, it has played a vital role in spreading awareness throughout the country. Gradually, the role of mass media become vital for development of a society and people started giving importance to education, essential skills, social unity, and the modernization (Narula, 2006).

Many behavioural, social and media theorists from different schools of thought have contributed in the field of Communication and Development, UNICEF (2005) has summarised communication approaches for better clarity (box 1).

Box 1

Communication Approaches-Some Definitions

Strategic Communication: is an evidence-based, results-oriented process, undertaken in consultation with the participant group(s), intrinsically linked to other programme elements, cognisant of the local context and favouring a multiplicity of communication approaches, to stimulate positive and measurable behaviour and social change.

Programme Communication or Behaviour Change Communication: is a research-based consultative process of addressing knowledge, attitudes and practices through identifying, analysing and segmenting audiences and participants in programmes by providing them with relevant information and motivation through well-defined strategies, using an audience-appropriate mix of interpersonal, group and mass-media channels, including participatory methods.

Advocacy: is a continuous and adaptive process of gathering, organising and formulating information into argument, to be communicated to decision-makers through various interpersonal and media channels, with a view to influencing their decision towards raising resources or political and social leadership acceptance and commitment for a development programme, thereby preparing a society for its acceptance.

Social Mobilisation: is a process of bringing together all feasible and practical inter-sectoral social partners and allies to determine felt-need and raise awareness of, and demand for, a particular development objective. It involves enlisting the participation of such actors, including institutions, groups, networks and communities, in identifying, raising and managing human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements.

(Source: UNICEF (2005). Strategic Communication for Behaviour and Social Change in South Asia, p.6)

At the Experts' Consultation on Strategic Communication for Behaviour and Social Change in South Asia, New Delhi, India (September 2004), Scandlen (2004) explained 'Social change is most commonly understood as a process of transformation in the way society is organised, within institutions and in the distribution of power within various social and political institutions' (p.12). Singhal (2004) deliberated that 'Communication for social change is a process of public and private dialogue through which people define who they are, what they want and how they can get it' (as cited by UNICEF,2005, p.8)

1.2 Paradigm Shift in Communication for Development

During 1950s to 1960s, the capitalistic approach was adopted from western countries where capital-intensive technologies and centralised planning was in practice. Development was measured using the Gross National Product (GNP).

Mass media was assumed to be the magic multiplier that transported a load of information to all at a time. It has the potential to sensitize people for behavioural changes. A large number of radio stations and newspapers were established and used as vehicles to disseminate messages among the targeted population. This was a one-way approach where a feedback mechanism was lacking. Efforts could not yield desired results because of a lack of personal touch and scope for interaction.

It was assumed that mass media was of prime importance for countries with limited resources to provide information to a huge mass of population but at the same time, it was also realised that magic multipliers alone would not produce the desired results. Hence the concepts of 'opinion leaders' as well as 'Inter-Personal Communication' came into existence and got recognition. Wherein individuals from communities and groups were identified and trained to promote and influence masses.

Subsequently, during 1970s and 1980s the focus was on 'Behaviour Change Communication (BCC)' and 'Social Marketing Strategies' aiming at promoting a particular behaviour or social change using small media and communication approaches. Moreover, the concept of Information, Education and Communication

(IEC) was also progressing where the prominence was on the propagation of messages through production and use of audio-visual and print materials. BCC and Social Marketing approach revolved around community interaction and communication process for convincing the audience about change in behaviour whereas the concept of IEC was more about production and usage of various media for change.

However, in all the approaches, the involvement of the stakeholder was completely missing. It was during the late 1990s and beginning of 2000s that human beings started to be considered at the core of development planning. This gave birth to the human development paradigm. Participation began to be recognised as a critical right of every individual, family or community and the concept of participatory approaches in specifically making 'informed-choices'.

Communication is no more seen as a top-down approach where families and communities are targets for behaviour change. Today, development communication is considered to be a multi-stakeholder and participatory process where the involvement of all stakeholders is important.

In recent times 'development' is perceived as providing a conducive environment in which people can reach to their full potential and lead productive and inventive lives in harmony with their necessities and interests. According to the UNDP Human Development Report 2012, people are the real wealth of nations and there should be an emphasis on the need for expansion of their choices so that they lead lives that they value.

In today's development context, it is important to understand that wide social acceptance about the need for specific change has become a precondition for individual behaviour change. Change is often influenced by other people's expectations, which is in turn shaped by the current social and cultural norms. Therefore, it is important that communication strategies address social change, creating community norms. Social and Behaviour Change Communication (SBCC) addresses both social and individual behaviour change (UNICEF-New Concept, 2014, pp. 5-6). With the emergence of new media and technologies like the internet, mobile

phones *etc.* common people are significantly influenced by their use. These technologies have widened the opportunities to inform, educate and influence an individual as well as communities at large. Hence concept and philosophy of Behaviour Change Communication, Social and Behaviour Change Communication with effective use of Information Education Communication strategies have taken charge in recent development programmes of almost all countries globally, reaching to mass and class individually so that no one (stakeholder) is left behind in striving to achieve their goals of betterment.

UNICEF (2005) in Communication for Behaviour and Social Change in South Asia, documented shifts in the communication paradigm as given in the box 2.

Box 2

Shifts in the Communication Paradigm

Widen focus	from individuals to households to networks, communities and civil society
Widen behaviour emphasis	From individual behaviour change to collective action and social change
Widen view	of parents, families and communities from beneficiaries or recipients to stakeholders and active partners in social development
Widen orientation	from mobilisation to create demand and sensitise community to external concerns to participation and empowerment
Wide knowledge acquisition process	from top-down information dissemination "selling mode" campaigns to community-based, participatory problem-posing approach "learning mode"
Shift in situation	from needs to rights
Shift in output	from messages and products to dialogue and interaction
Shift in situation analysis	From needs assessment to rights analysis, assets mapping, and participatory assessment
Balancing among interventions	from mass media and electronic communication to interpersonal and traditional communication
Balance the focus	from art and creativity to science and evidence-based

(Source: UNICEF (2005). Strategic Communication for Behaviour and Social Change in South Asia, p.3)

1.3 Behaviour Change and Communication

Behaviour change is a part of communication process that takes place within individuals, communities and societies to develop communication in a positive manner. It helps people to make good initiatives and provide ideas to sustain and maintain positive and desirable behaviour in the society. It is a powerful means of communication to promote positive health outcomes. Only teaching how to sustain and behave does not lead to desirable change in human behaviour but providing a supportive environment with information and communication will lead to desirable changes in their behaviour. Thus, Behaviour Change Communication has a close relationship with education and communication (Adewuyi & Adefemi, 2016).

USAID (2002) mentioned in 'Behaviour Change Communication (BCC) for HIV/AIDS: a strategic framework', certain stages of Behaviour Change Communication as listed below:

1. State programmegoals.
2. Involve stakeholders.
3. Identify target populations.
4. Conduct formative Behaviour Change Communication assessments.
5. Segment target populations.
6. Define behaviour change objectives.
7. Define the Behaviour Change Communication strategy and monitoring and evaluation plan.
8. Develop communication products.
9. Pre-test.
10. Implement and monitor.
11. Evaluate.
12. Analyse feedback and revise.

Behaviour Change Communication has various levels at which it can be implemented. The levels include: Individual, Community, Organisation and public policy level. It is an important tool to deal with problems of community and groups. It is considered to be a powerful tool for community mobilization, health and

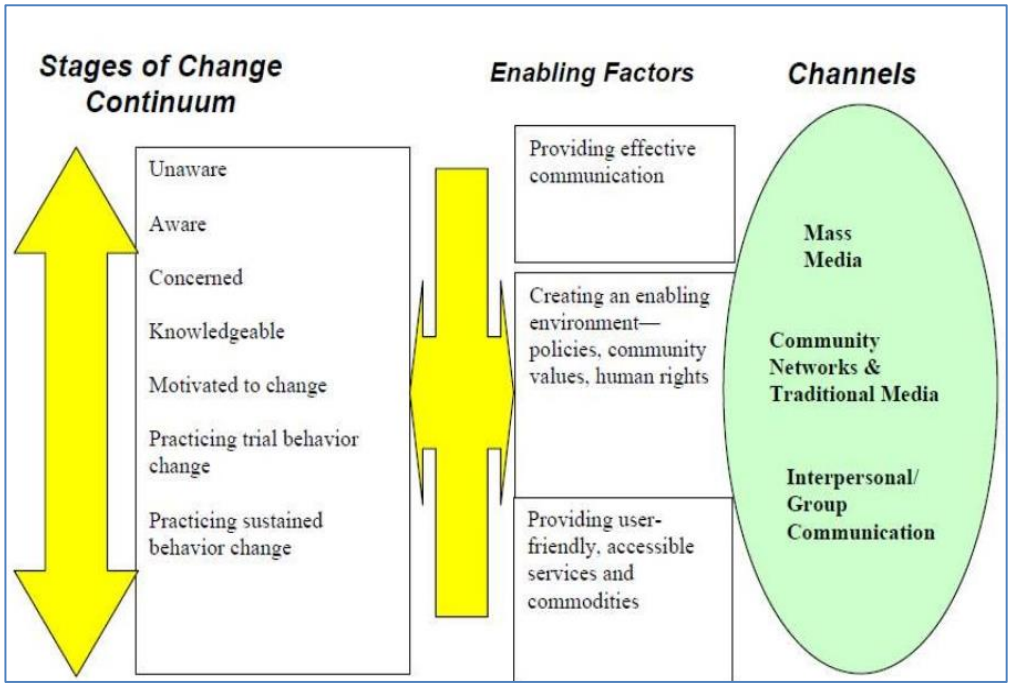
environment education and various outreach programs. Recent researches claim that it is a vital tool for spreading programs to cover high-risk groups such as injecting drug abusers, HIV positive groups *etc.* Ghosh and Saha (2013) enumerated on how BCC plays a crucial role to:

1. Increase knowledge
2. Stimulate community dialogue
3. Promote essential attitude change
4. Advocate for policy changes
5. Create a demand for information and services
6. Reduce stigma and discrimination
7. Promote services for prevention and care

Rao (2016) also explained the process of Behaviour Change as given in the figure 1 and described on stages of behaviour continuum and its linkage with enabling factors with the appropriate channels at each phase for specific purposes.

Figure 1

Process of Behaviour Change



(Source: Rao, 2015, Behavioural Change Communication, slide no.23 https://www.slideshare.net/drsrinivasraod/behavioural-change-communication)

1.4 Health and Behaviour

NICE (2007) Health is directly linked with social and economic positions which also have a direct or indirect linkage with one's behaviour. Evidence has shown that different patterns of behaviour are deeply embedded in people's social and material circumstances, and their cultural context. Therefore, inequalities in health are there all over the world. Again, these inequalities differ from underdeveloped to developing countries and from developed countries depending upon their social and economic status. Social and economic position is deeply associated with one's behaviour towards health. Thus, social and economic conditions can prevent people from changing their behaviour to improve their health, and can also reinforce the behaviour that damages it.

There has been remarkable evidence that by changing people's behaviour towards health can have a major impact on some of the largest causes of mortality and morbidity. However, changing one's behaviour is the toughest task (Komolini Devi, 2013 as cited in Nongmaitthem, R., 2014, p.18).

Following theories at individual and community levels are apt for behaviour change at both levels.

Individual-level

- Theory of reasoned action (Fishbein and Ajzen 1975) and planned behaviour (Ajzen 1985, 1991; Ajzen and Madden 1986)
- The Health belief theory (1950s by social scientists at the U.S. Public Health Service)
- The Transtheoretical Model or Stages of Change (Prochaska and DiClemente in the late 1970s)
- Social Learning or Social Cognition theory (1960s by Albert Bandura)

Community-level

- Diffusion of innovations theory (E.M. Rogers, 1962)
- Social Marketing Theory (Stephan Dahi, 2009)

The recent concept of Social and Behaviour Change Communication (SBCC) emphasised upon social approval, influence and advocacy for individual's behaviour change. This concept has also its roots in Social learning and Socio-Ecological model of communication given by Bandura in the late 1960s.

Social Cognitive and Social Learning Theory are relevant to Health Communication. It helps in designing health education programmes. How people acquire and maintain certain behavioural pattern is studied through this theory. It provides a basis for intervention strategies (Dubey and Bishnoi, 2008, pp.309-312).

1.5 Health Communication

According to UNICEF (2005), communication is as much science as it is an art. The science of communication is a research-driven consultative process involving planning, design and implementation of strategic interventions. It provides relevant information and adequate motivation to impact on attitudes and behaviours of individuals or groups of people. It involves monitoring the changes in peoples' attitudes and behaviours as laid down by the programme objectives. Good communication programmes which help achieve public health goals are derived from using a mix of epidemiological and social science research. Epidemiological data, for instance, provides information on incidence, distribution and control of a disease in a population. It tells "where" the problems lie. On the other hand, social data tells the "why" of the problem, *i.e.* why people behave the way they do. Social data, informed by behavioural theories (for example, the diffusion of innovations) provides a lens to understanding how recommended behaviours are adopted by different individuals within the population over a period of time. The behavioural analysis also explains show attitudinal and behavioural challenges can be overcome.

In addition to epidemiological and social data, evidence-based and scientifically planned and monitored strategic communication interventions have to be linked to service components of the programme. For instance, a communication initiative which seeks to create demand for immunisation programmes is not helpful if vaccination services are not easily accessible. Thus, for a programme to be effective

both communication and service delivery components have to work in close synchrony. The artistic side of communication involves designing creative messages and products and identifying effective interpersonal, group and mass-media channels based on the sound knowledge of the participants one seeks to reach. (pp.2-4). Figure 2 gives clarity on a Framework for Communication programme and the interwoven layers.

Figure 2

A Framework for Communication Programmes

(Source: UNICEF (2005) Strategic Communication for Behaviour and Social Change in South Asia, p.4)

Health communication involves the study and use of communication planning to provide information, influencing individual and community knowledge, attitudes and practices with regard to health and healthcare. It contributes to prevent all kinds of disease and promotes things which are useful in maintaining health (Thomas, 2006).

The health communication surrounds the development of effective messages about health, the dissemination of health-related information through broadcast, print, and electronic media, and the role of interpersonal relationships in health communities. At the core of all of the communication are the idea of health and the emphasis of health. The goal of health communication is to identify and provide better and more effective communication strategies that will improve the overall health of society. (Don & Michael (1978) as quoted by Bora, Devajit, 2016, p. 35).

Health communication is delivering the messages and planning based on consumer research, to promote health of individuals and communities. It has four components: planning, intervention, monitoring and evaluation. Health communication campaigns in underdeveloped regions are designed to improve awareness, knowledge, and behaviour associated with positive health outcomes.

Health communication plays several roles that include:

- Increasing the knowledge and awareness of a health issue, problem or solution.
- Influence perceptions, beliefs, attitudes, and social norms.
- Prompt action
- Demonstrate or illustrate skills
- Show the benefit of behaviour change
- Increase demand for health services
- Reinforce knowledge, attitudes and behaviour
- Refute myths and misconceptions
- Help in uniting organizational relationships
- Advocate for a health issue or a population group

However, many patients have reported that they are not satisfied with the quality of their interaction with healthcare professionals. This gap between healthcare professionals and patients can be seen more among the marginalised groups such as those with disabilities, low literacy, limited language proficiency, HIV infection, obesity, mental illnesses, and minorities like African-Americans and refugees (Sood et al. 2014).

Nkanunye and Obiechina (2017), in their paper entitled 'Health Communication Strategies as Gateway to Effective Health Promotion and Well-being' mentioned that Health promotion supports personal and society development by providing information which improves health and enhance wellbeing. Communication creates meaning to any information given. Changing an already existing behaviour is very difficult. However, with effective communication and application of effective strategies, behavioural change could be achieved.

Benefits of health communication include increasing audiences' knowledge and awareness on health-related issues and its advocacy for health issue and policies. The barriers such as low health literacy and poor communications were identified.

Health communications contribute to all aspects of disease prevention and health promotion. It is relevant in many contexts including the well-being of individuals and the communities. Health communication galvanizes people into action, promotes a healthy lifestyle, prevents diseases and improves the health through eschewing destructive behaviour like abuse of substances (cigarette, drugs and alcohol), maintaining personal and environmental hygiene as well as cultivating a positive healthy sexual relationship. These will promote health and improve well-being.

Bernhardt (2004) explained that 'Public Health Communication' with its transdisciplinary nature, ecological perspective, change orientation, and audience-centred philosophy, has the potential to make significant contributions to the health of the public. When well-conceived, carefully implemented and sustained over time, public health communication programmes have the capacity to elicit change among individuals and populations by raising awareness, increasing knowledge, shaping attitudes and changing behaviours. It was noted that public health communication recognizes that for programmes to be both ethical and effective, information from and about the intended audience should inform all stages of an intervention, including development, planning and implementation, to ensure that the programmes reflect the audience's ideas, needs and values. Although communication

initiatives often target to change those behaviours that contribute directly to morbidity and mortality, it also targets social, physical and environmental changes that can influence health outcomes.

Institute of Medicine (US) in2002, described their review, evaluation and recommendation focusing on the importance of theory and ethics in designing health communication, communication interventions for diverse populations and infrastructure needs. The committee writes that theory can increase the potential effectiveness of health communication by identifying critical beliefs to target, by structuring communication, and by guiding the selection sources and channels of communication. The proper implementation of behaviour change theory requires that one goes to a sample of the population to identify the outcomes, referents and barriers that are relevant for that population.

Further, new uses of current and widely accessible communication media, have been possible because of computer applications that have permitted content to be tailored to individuals, thus allowing people to use older tools in new ways.

The changing trend can be seen at global, national as well as local level.

1.5.1 Global and Indian Trends in Health Communication

Since Health Communication is focused on the promotion of truly available benefits and behaviour change for betterment, it has to be in line with the society, existing media consumption pattern and public health programme scenario.

According to Healthy People 2020, Effective use of communication and technology by health care and public health professionals can bring about an age of patient and public-centred health information and services. By strategically combining health IT tools and effective health communication processes, there is the potential to:

- Improve health care quality and safety
- Increase the efficiency of health care and public health service delivery
- Improve the public health information infrastructure
- Support care in the community and at home

- Facilitate clinical and consumer decision-making
- Build health skills and knowledge

Sood et al. (2014) summed up trends in Health Communication by explaining four eras like;

- **Clinic Era** was marked by the mantra 'build it and they will come', and was based on the medical model that if services existed then people would find their way to them (Rogers 1973).
- **The Field Era** emphasised the use of outreach workers, community-based distribution, and information, education and communication (IEC) products (Rogers 1973).
- **Social Marketing Era** the borrowed from commercial marketing strategies of brand promotion to generate demand and improvement in supply chain mechanics to improve access to services. This Era was characterised by the idea that consumers will buy products they want at subsidised process (Rimon 2001).
- **Strategic Behaviour Change Communication Era** uses behaviour change models and theories as the foundation for interventions and emphasises the need to influence social norms and policy environments to facilitate both individual and social change (Figueroa et al. 2002). (p.85)

Frieden (2014) explained 'Communication' as one of the components in his article on 'Six components necessary for effective public health programme implementation'. He writes new communication tools and technologies facilitate interactive conversations, giving public health practitioners the ability to have dialogues with people from affected communities and other stakeholders. With the increase in communication channels and voices, public health communications can be drowned out unless communication strategies are timely, well defined, well-executed and sustained to meet specific objectives. Effective communication can convey critical information, convince key individuals to support or lead an initiative, and perhaps most importantly, change the context for public health action. With

better information, individuals and communities can make better decisions about their health and public health programs. Different audiences need to be presented with different types of data in different ways to have the intended impact. An effective programmeneeds to effectively communicate its success and benefits, as well as the threats to health and health equity being addressed, with anecdotes and case studies to illustrate these points.

Intrusion to advance global health is centred on clinical and research endeavours, but has been changing over past three decades. Studies show that there is a constant expansion of social media services which is helpful in spreading awareness regarding health globally. Digital platforms are providing new ways to people to interact regularly. By using new technologies, it has become easier to improve public health communication globally. Other significant factors of improving health communication globally include health communication research, campaigns, and social marketing strategies (Khandekar, 2015).

Health communication research represents an image of knowledge, attitude, and behaviour of individuals and communities. Health communication and social marketing campaigns use multiple channels to raise awareness and provide culturally appropriate messages about disease, environmental conditions, nutrition, safety, literacy, and a host of other issues. To open up access to new knowledge regarding various issues of health globally, health communication must continue as an essential part of the society (Sood et al., 2014).

Health Communication has spread far and wide to create awareness about various diseases and its' treatments in India. Earlier, it was difficult to spread awareness in rural areas but in present generation technology is playing a vital role to provide information. India organizes health communication campaign in rural and urban areas so that not only literate and elite but people from the diverse economic background can be aware of health-related issues. However, in the busy schedule of an individual, group and community, the growing technology and social media remain two main and easy means of spreading awareness throughout the country (Khandekar, 2015).

Parvanta C. (2002) detailed that public health experiences have demonstrated that interventions conducted on multiple levels of the models are more effective than those focusing solely on one level. The author explained the overall approach to planning each with an inherent research task:

- **Macro plan** that includes analysis of the problem (PRECEDE-PROCEED model), the ecological setting (People and Place model), the core intervention strategy, and target population.
- **Strategic Health Communication plan** that focuses on specific change objectives, audiences, messages and media.
- **Implementation (or tactical) plan** that says what will be done, when, where, how, with what money and who is responsible for every piece.
- **Evaluation plan** that says what aspects of the intervention will be monitored or evaluated in order to determine the intervention's worth to key stakeholders.
- **Partnership, Continuation and/or Expansion plan** initiated at the outset of a programmeto ensure a broader reach, diffuse expenses and provide continuity of leadership and ownership
- **Dissemination and Publication plan** when desired.

The macro plan is often developed in consultation with organizational partners, each of whom will have a topical focus, methodological expertise and a constituency base.

Thus, keeping in mind the extensive potentials of Health Communication and its strategies for achieving national goals, like goals of health, the rigorous efforts have been made, policies have been drafted and implemented to achieve health equality in society.

1.6 Health Programmes in India

Health programmes in India were very much part of the first Five-year plan and was essentially a concern for the administrators. The scenario is described as under.

In 1943 under the chairmanship of Sir Joseph Bhore 'The Health Survey and Development Committee' was constituted which in 1946 recommended and provided the basis for the organisation of well-structured and comprehensive health services for the public. Hence, Primary Health Care Centres were established in 1952 to promote, prevent, curate and rehabilitate the services to the entire rural population, as an integral component of the wider Community Development Program.

In 1959 Mudaliar Committee was formed, which recommended (1961) following salient features including upgrading and strengthening of PHUs, strengthening of District hospitals, mobile service teams for rural areas, levying of a small fee for availing hospital facilities, long-range health insurance policy for all citizens, formation of Central Health Cadre, an extension of the functions of UGC of Education in the fields of medicine, Engineering, Agriculture and Veterinary Sciences, Institution of National Programmes for Education of Malaria, Smallpox, Cholera, Leprosy, Tuberculosis and Filariasis and Director-General should enjoy the status of an Additional Secretary.

1961-66, Department of Family Planning was created under the Ministry of Health and adopted extension education and Target free approach. Mukherjee Committee (1966) strongly recommended strengthening of administrative set up at all levels from grass-root Primary Health Centre to State level Headquarters.

In the early 1970s, Central Government implemented the vision of Sokhey Committee of having one Community Health Worker for every 1000 people to entrust ‘people health on people's hand' akin to Alma Ata Declaration on Primary Health Care made by all the countries of the world in 1978.

During 1970-79 Family Planning was renamed as Family Welfare and community involvement was given due importance. Child Marriage Restraint Act was passed in the year 1978.

Population acted as a hindrance in achieving high indicators of Development. However, it was also taken care of. During 1980-85, after the International Health Initiative Conference in 1982, the National Health Policy was designed to make architectural alterations in the health care system. The National Health Policy offered

a general description of the policies which required recommendation in the situations then prevailing in the health sector. It mentioned the provision of universal and comprehensive primary health care services with special emphasis on the preventive, promotive and rehabilitative aspects. Community Health Approach was adopted and direction was given to formulating a National Medical and Health Education Policy for health manpower development.

The National Health Policy (1983) also strongly recommended the decentralising of Primary health care system, removal of existing regional imbalance and promotes Community Participation in both urban and rural areas. Efforts were made to strengthen MCH and Family welfare.

The Universal Immunization Programme (UIP) was executed in 1985 to offer universal coverage of infants and pregnant women with immunization against identified vaccine-preventable diseases.

1992-97, Child survival and Safe-motherhood component report, based on Target Free approach was published. In 1997, the Reproductive and Child Health (RCH- Phase1) programme was introduced which combined child health, maternal health, family planning, treatment and control of reproductive tract infections and adolescent health. National Population Policy-2000 recommended addressing unmet needs of contraception, Health care infrastructure, integrated service delivery *etc.*

National Health Policy (2002) was launched to achieve an acceptable standard of good health amongst the general population of the country. Main initiative components included an increase in access to decentralised health facilities by establishing new infrastructure in scarce areas and improvisation in existing facilities. One of the salient features of the policy was an increase in health sector expenditure to 6 % of GDP with 2 % of GDP by 2010.

In 2005 National Rural Health Mission was launched as a mission mode programme of central government based on Public-Private Partnership (PPP) and community level decentralised approach. Popular national efforts ensuring effective health care through a range of interventions at the individual, household, community and most critically at health system levels were taken up. It was a significant project

in the Indian health sector in the last 55 years after independence to ensure Universal Access to Health.

Considering the benchmarks of NRHM the same was expanded to the urban areas as the National Urban Health Mission (NUHM) under the flagship programme renamed as National Health Mission (NHM) in 2012. The recent past efforts like *Ayushman Bharat, Poshan Abhiyan*, Mission MR (Missals and Rubella vaccination for all under 10/13 years) *etc.* are towards achieving the aim of Universal Coverage of Health, Japan declaration by WHO in the year 2017. (Bhore (1960), National Health Policy 2017, NITI Ayog (2018)).

1.7 National Health Mission (NHM)

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening, Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A), Communicable and Non-Communicable Diseases. The NHM envisions the achievement of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs.

The National Health Mission (NHM) is a national effort at ensuring effective healthcare through a range of interventions at individual, household, community, and most critically at the health system levels. NHM is the biggest-ever project in the Indian health sector in the last 60 years and (2012-2013) was launched as the Mission Mode Programme with NHM.

1.7.1 Goals of NHM

National Health Mission (NHM) caters to the following goals;

- Reduce MMR to 1/1000 live births
- Reduce IMR to 25/1000 live births
- Reduce TFR to 2.1
- Prevention and reduction of anaemia in women aged 15-49 years

- Prevent and reduce mortality and morbidity from communicable, non-communicable; injuries and emerging diseases
- Reduce household out-of-pocket expenditure on total health care expenditure
- Reduce annual incidence and mortality from Tuberculosis by half
- Reduce the prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
- Annual Malaria Incidence to be <1/1000
- Less than 1 per cent microfilaria prevalence in all districts
- Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

(Source: Ministry of Health and Family Welfare (GoI) NHM framework for Implementation 2012-2017)

1.7.2 *Institutional Framework of NHM*

Ministry of Health and Family Welfare (GoI), NHM Manual for District level Functionaries (2017), at the national level, NHM is a joint Mission Steering Group (MSG), headed by the Union Minister of Health and Family Welfare, and an Empowered Programme Committee (EPC), headed by the Union Secretary for Health and Family Welfare. Mission Steering Group (MSG) provides policy direction to NHM. A Mission Directorate has been created for planning, implementation and monitoring day-to-day administration.

At the state level, the State Health Mission headed by the Mission Director carries out the activities through State Health Societies. It is further reinforced by the State Programme Management Unit, State Health Resource Centre and State Institute of Health and Family Welfare.

At the sub-state/ District level, the District Health Mission shall be led by the Chairman of the Zilla Parishad, and be convened by the District Head of the Health Department. It shall have representation from all relevant departments, NGOs and private professionals. District Health Societies are responsible for preparing

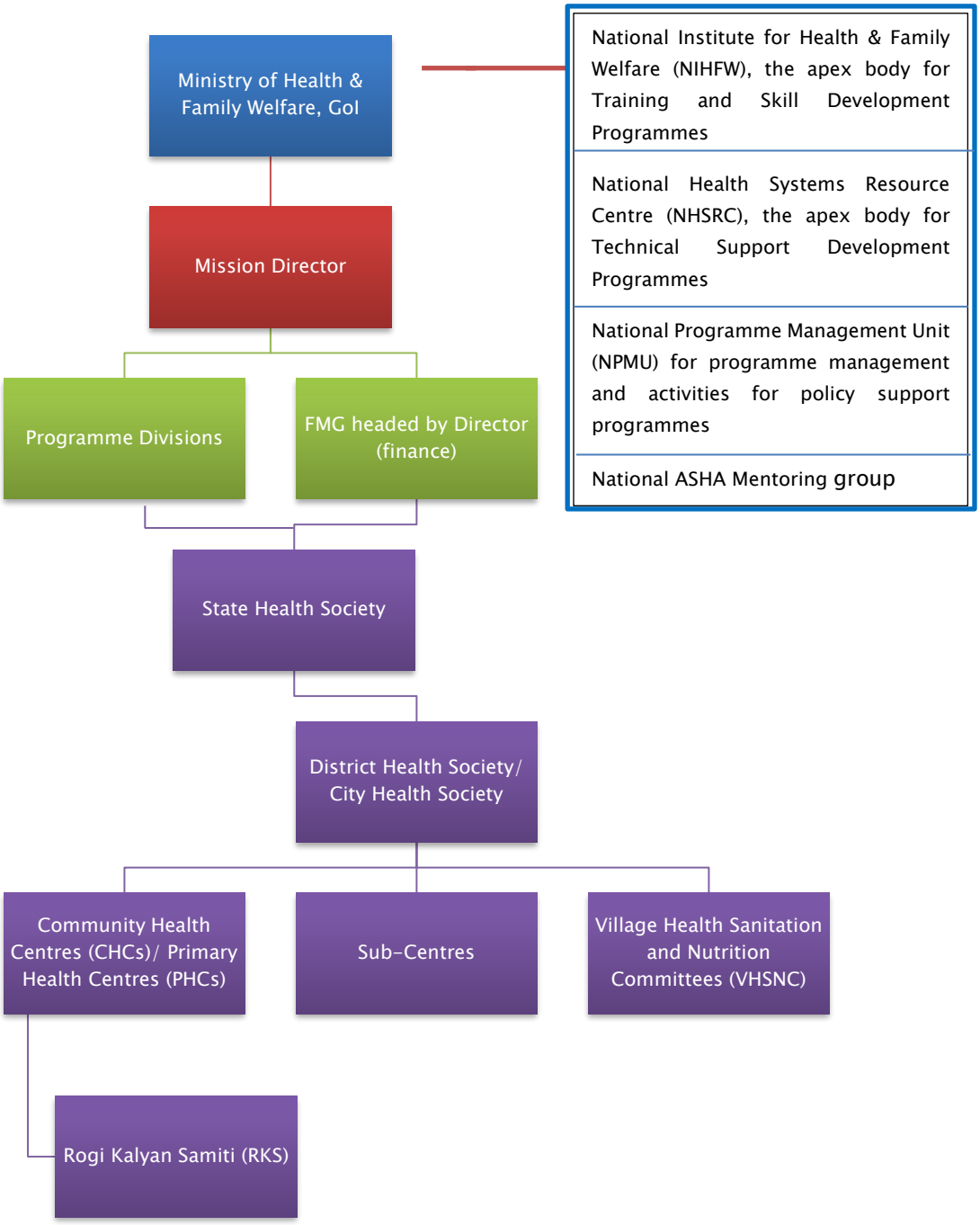
prospective plans for the entire period, annual plans of all NHM components and for integrating public health plans with those for water, sanitation, hygiene and nutrition.

Block-level health plans based on district plans are formulated to integrate the village plans. *Rogi Kalyan Samitis* (RKS) at the block level is responsible for the day-to-day management of hospitals. In each village, a Village Health Sanitation and Nutrition Committee (VHSNC) is accountable to the Panchayat and is comprised of a female Accredited Social Health Activist (ASHA) who is the bridge for the village, an ANM, a teacher, a Panchayat representative, and community health volunteers. PHCs are staffed by a medical officer and fourteen paramedical staff and provide integrated curative and preventive care. PHCs are the first point of contact with a medical officer. At the block level, CHCs, serving as referral units for four PHCs, are manned by four medical specialists (surgeon, physician, gynaecologist and paediatrician) and provide obstetric care and specialist consultations. NHM seeks to bring CHCs and PHCs on par with Indian Public Health Standards (IPHS) and makes the provision of adequate funds and powers to enable these committees to reach desired levels.

The following figure 3 explains the governance structure of the NHM.

Figure 3

The Governance Structure of NHM



(Source: Ministry of Health and Family Welfare (Government of India), NHM Manual for District Level Functionaries, 2017, https://darpg.gov.in/sites/default/files/National Health Mission.pdf)

1.8 Gujarat State and its Health Mission

The Gujarat state is also known as '*The Land of the Legends'*, shares its borders with Pakistan and Rajasthan in the north-east, Madhya Pradesh in the east, and Maharashtra and the Union territories of Diu, Daman, Dadra and Nagar Haveli in the south. The Arabian Sea borders the state both to the west and the south-west. It has the largest coastal area in India. Table 1 shows the brief details of profile of Gujarat State.

Table 1

Profile of Gujarat State

Characteristics	Details
Area	1,96,024 sq km
Population	60,383,628
Districts	33
Capital	Gandhinagar
Principal Language	Gujarati
Literacy Rate	79.31%
Rainfall	93.2 cm
Temperature	Summer (March to May): min 25 degrees to 45 digs' Winter (November to February): min 15 degrees to max 35 dig's
Eco System	Ranges from deserts, scrublands, grasslands, deciduous forests, and wetlands to mangroves, coral reefs, estuaries, and gulfs.

Source: https://gujaratindia.gov.in/about-gujarat/fact-file.htm retrieved on 1.4.2019

Gujarat State health goals as defined by NHM (under 12th Five Year Plan are as listed below:

- Reduce maternal and child mortality
- Address adverse sex ratio
- Stabilize population
- Effectively implement National Health Programmes and address locally endemic diseases like leptospirosis, sickle cell anaemia and thalassemia
- Provide state of the art health and medical education relevant to local needs
- Work with the citizens to make the health system more equitable, accessible, accountable, transparent, and cost-effective to enhance overall satisfaction with health services
- Provide an environment in which the health teams blossom fully to lead a fulfilling life and effectively achieve the above goals
- Develop public health capacities and systems, to effectively address determinants of good health such as potable water, sanitation, nutrition and healthy environment as well as to promote healthy lifestyles

The Gujarat health system is organized on the principle of a dynamic concentration of medical facilities round about the teaching hospitals having all the medical specialities and facilities for treating serious patients referred from lower-tier hospitals and the radical downward flow of active services from the teaching hospitals to peripheral levels through mobile teams of specialists, are the essence of a well organised regionalisation." (Study Group on Hospitals, S.N. Chatterjee, 1975 as cited on https://nrhm.gujarat.gov.in/hospitals-gujarat.htm).

Health set up in Gujarat is defined in three-tier fashion as shown in figure 4 catering to the components of NHM presented in figure 5.

Figure 4

Three-tier Health Set up in Gujarat

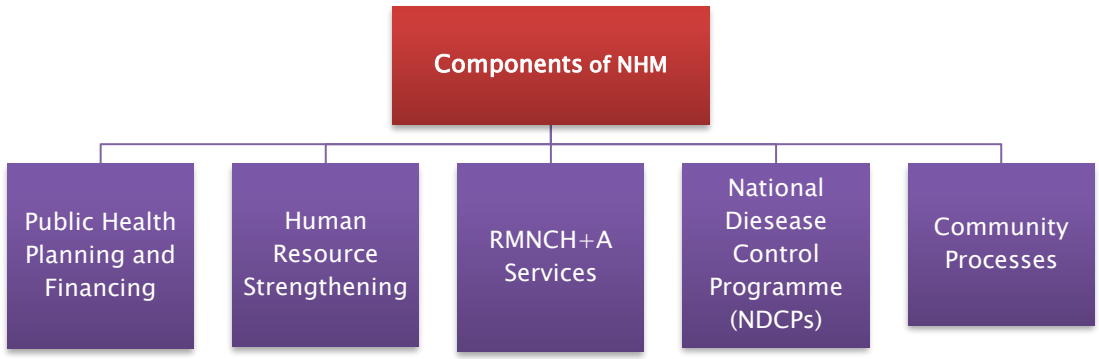
Source: Department of Health and Family Welfare (Government of Gujarat)
https://nrhm.gujarat.gov.in/hospitals-gujarat.htm

Medical relief is provided to the rural and urban people through 56 District and Taluka General Hospitals, four Mental Hospitals, three Specialty Hospitals (two Ophthalmic Hospitals and one Infectious Disease) and 60 Dispensaries. A total of 6,648 beds are available in these hospitals.

Class 1 District Hospitals are equipped with Operation Theatre, Intensive and Cardiac Care Units, X-Ray, Ultrasound and Laboratory facilities, E.C.G. and Blood Transfusion services. Sub-district (Taluka) Hospitals have limited specialities like Surgery, Obstetrics and Gynaecology, Paediatrics and Dentistry. Ambulance services are available round the - clock in both the categories of hospitals. (Department of Health and Family Welfare, GoG, https://nrhm.gujarat.gov.in/hospitals-gujarat.htm)

Figure 5

*Components of NHM**



Note: *Figure recreated by the researcher

(Source: Ministry of Health and Family Welfare (Government of India), NHM Manual for District level Functionaries, 2017 https://darpg.gov.in/sites/default/files/National Health Mission.pdf)

NHM focuses on decentralized health planning, service delivery, creating knowledge hubs within district hospitals, strengthening secondary level care at district hospitals, expanding outreach services, improving community processes and Behaviour Change Communication, human resources development, public health management, and health management information systems. NHM particularly focuses on equity: prioritizing the health of tribal populations, those in Low-Wing Extremism (LWE)

and urban poor. A key outcome of NHM is to Reduce Out of Pocket expenditures. Health outcomes, output and process indicators are monitored through large scale surveys conducted periodically with evaluations, use of HMIS data and periodic reviews are done.

The main aim is to create a fully functional, decentralized and community owned system with greater inter-sectoral coordination so that wider social determinant factors affecting health of people like water, sanitation, nutrition, gender

and education are also equally addressed. (Ministry of Health and Family Welfare, GoI, NHM Manual for District Level Functionaries, 2017)

The following strategies are helpful in achieving goals of NHM,

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services;
- Health plan for each village through Village Health Committee of the Panchayat;
- Strengthening sub-centre through an untied fund of Rs.10000 for local action and planning. This fund will be deposited in a joint Bank Account of the ANM and Sarpanch and operated by the ANM, in consultation with the Village Health Committee, and more Multi-Purpose Workers (MPWs);
- Provision of 24-hour service in 50 per cent PHCs by addressing the shortage of doctors, especially in high focus states, through mainstreaming AYUSH manpower;
- Preparation and implementation of an intersectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation, and hygiene and nutrition;
- Integrating vertical Health and Family Welfare programs at national, state, block, and district levels.

1.9 Major Initiatives under NHM

In line of the goals and designed strategies, NHM administrators have undertaken below listed (figure 6) major initiatives.

Figure 6

Major Initiative under NHM

Note: *Figure prepared by the researcher

Source: Ministry of Health and Family Welfare (Government of India), Annual Report 2018-19, pp. 13-27)

1.10 Information Education Communication (IEC), Behaviour Change Communication (BCC) and Community Process

The Ministry has designed a strategic framework for targeted IEC activities using 360-degree communication approach. All possible means of media including mass media, mid-media and inter-personal activities are used to disseminate information about various health schemes. The year-long IEC/Communication Plan has a month-wise focus on health days and health themes. While some activities were taken up to coincide with 'Health Days', others were week and month-long plans for focussed multi-media campaigns on schemes of the Ministry. These centre around topics such as Ayushman Bharat, Immunization, TB management, Anaemia Mukt Bharat, Integrated Diarrhoea Control Fortnight (IDCF), Breastfeeding Week, Tobacco Control, *etc.* Seasonal ailments such as Dengue, H1N1 *etc.*, are dealt with through targeted campaigns.

All the IEC activities have had a print media component as well as comprehensive AV spots through TV and Radio Plans. Social Media and Outdoor Media activities substantially supplement the IEC efforts. The Media Plan was monitored at the highest level to ensure due implementation, mid-course correction, and possible change in the focus to suit the needs. The Ministry created wide awareness regarding the Ayushman Bharat programme, especially Health and Wellness Centres and new AIIMS sanctioned and made operational as part of PMSSY and the hosting of a global health event – the Partners' Forum 2018 – through print, outdoor and social media. This was complemented through media outreach, Op-Eds by Hon. Health Ministers, Q&A in select newspapers of Hon'ble Ministers and Secretary (HFW) and featured articles. (Ministry of Health and Family Welfare (Government of India), Annual Report 2018-19, pp. 361-363).

The Information, Education & Communication (IEC) strategy aims to create awareness and disseminate information about the health seeking behaviour, and about the benefits available under various schemes / programmes of the Ministry. The main objective of IEC is to generate demand for health services and to promote health seeking behaviour. The IEC strategy has catered to the different needs of the

rural and urban masses through different modes of communication. (Ministry of Health and Family Welfare (Government of India), Annual Report 2018-19, p. 361)

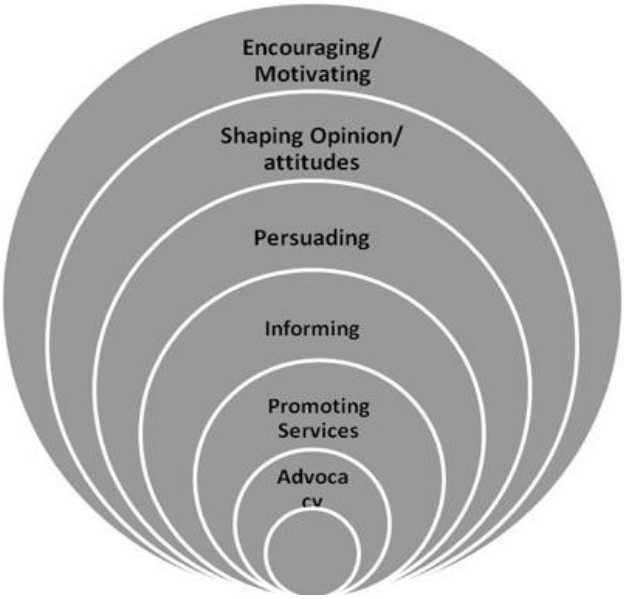
Information Education Communication (IEC) is used for generating awareness. It refers to a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviour that is appropriate to their settings. Behaviour Change Communication (BCC) is used for enabling action. It means provide a supportive environment that will enable people to initiate and sustain positive behaviour. (Department of Health and Family Welfare, GoG, https://nhm.gujarat.gov.in/iec-bcc.htm)

Comprehensive communication strategy adopted with a strong behaviour change communication (BCC) component in the IEC strategy; dissemination in villages and lowest levels. There is the participation of non-government agencies and professional and specialized agencies, visible mass media efforts in massive health communication efforts. There is a substantial portion of the interpersonal BCC effort is through local ground-level workers including ASHA and ANMs, and community level structures equipped with communication kits, interacting on a one to one basis with families. (Ministry of Health and Family Welfare (Government of India), NHM Manual for District level Functionaries, 2017)

As shown in figure 7, IEC/BCC activities play a very important and strategic role in the area of public health. Strategic IEC/ BCC programs use a systematic process to understand people's behaviour and influences. A successful IEC/ BCC plan would help in refuting myths and misunderstandings prevalent in the society and will lead to a demand for various health services being provided, thus bringing about a behavioural change among individuals and the community at large. (Department of Health and Family Welfare, GoG, https://nhm.gujarat.gov.in/iec-bcc.htm)

Figure 7

Role of IEC/BCC



(Source: Department of Health and Family Welfare (Government of Gujarat) https://nhm.gujarat.gov.in/Images/Role.jpg)

1.10.1 The Major Goals of IEC/BCC of Gujarat State

The official website of Department of Health and Family Welfare, Government of Gujarat reveals that,

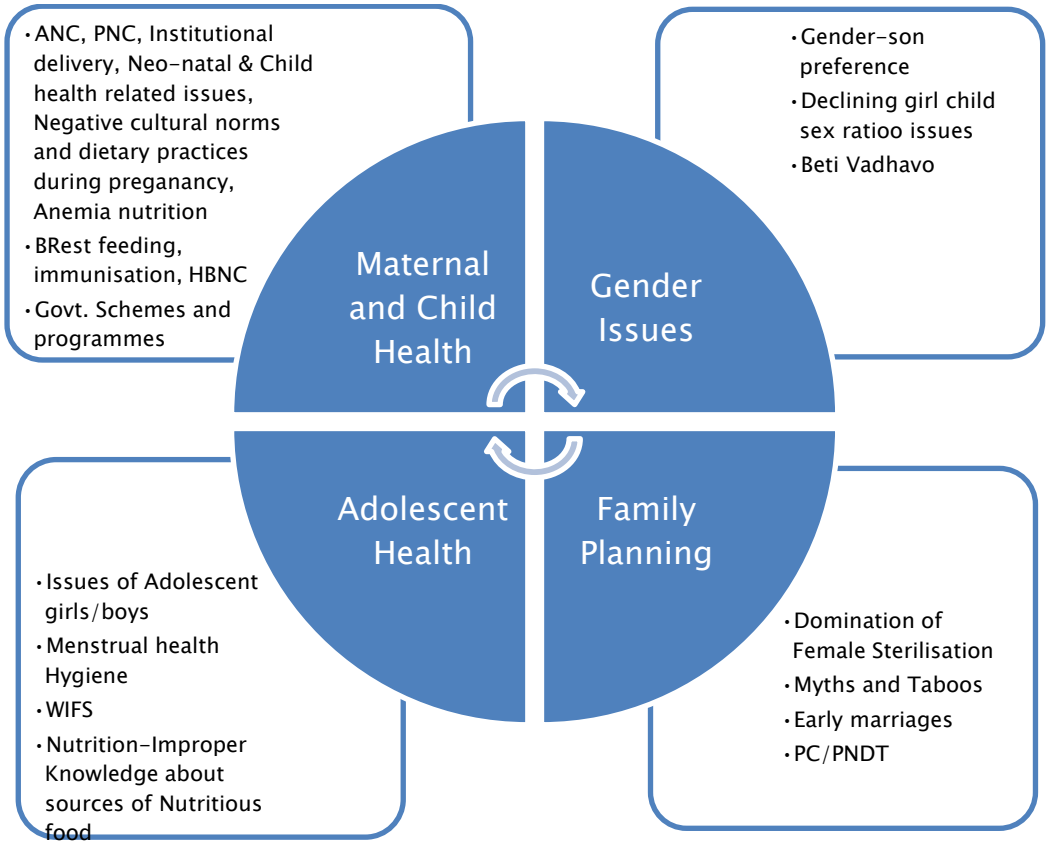
- To connect the programs with people by educating and mobilizing the masses through Information Education and Communication (IEC)
- To encourage individuals of society to adopt healthy behaviours.

The state has decentralized the planning and implementation of the activities by coordinating the process of development of State and District IEC action plans from bottom up. IEC materials like posters, stickers, pamphlets, leaflets, banners *etc.* are produced and distributed to health centres in all districts. Other activities such as wall-paintings and hoardings at important sites are carried out from time to time throughout the State. The State IEC cell is also engaged in health education and spreading awareness through mass media such as newspapers, television and radio. Like for example, to support health services to reduce MMR, IMR and TFR.

- Educate the community about the importance of Ante Natal Care, Institutional Delivery, Post Natal Care and Child immunization and motivate them to utilize maternal and child health services on *Mamta* Diwas.
- Educate and advocate about schemes such as Janani Suraksha Yojna, Chiranjeevi Yojana for promoting Institutional Deliveries for BPL population.
- Beti Vadhao Abhiyan under PNDT
- Promote temporary and permanent methods of Family Planning

Figure 8

*Thrust Areas of IEC/BCC Activities**



Note: *Figure recreated by the researcher

Source: Department of Health and Family Welfare (Government of Gujarat) https://nhm.gujarat.gov.in/Images/iec-bcc-activities.png

The State IEC team is responsible for overseeing the planning, implementation, monitoring, and evaluation of IEC activities, Special Campaigns,

Health Education in an emergency, monitoring of activities and capacity building of staff at the districts and block levels, and front-line health service providers in communication.

Integration of the IEC activities would improve overall coordination, more cost-effective and timely utilization of funds, avoid duplication of resources, and strengthen planning, implementation and feedback. IEC activities are specially implemented through District IEC Officers in all 33 districts with a special focus in tribal districts.

1.10.2 Guidelines for Effective Health Communication Plan under NHM

The Ministry of Health and Family Welfare, Government of India (2013 b) has given following guiding points for effective Health Communication plan for desired Behaviour Change.

- Identify determinants of practices or behaviours
- Priorities practices
- Promote a core set of messages
- Identify the key stakeholders
- Ensure participation of stakeholders at different levels
- Guide the use of a mix of mass-media, mid-media and interpersonal communication (IPC)
- Build state/district capacity on designing effective communication interventions.
- Actively monitor the strategy's impact on changes in behaviour and in health indicators (p.50)

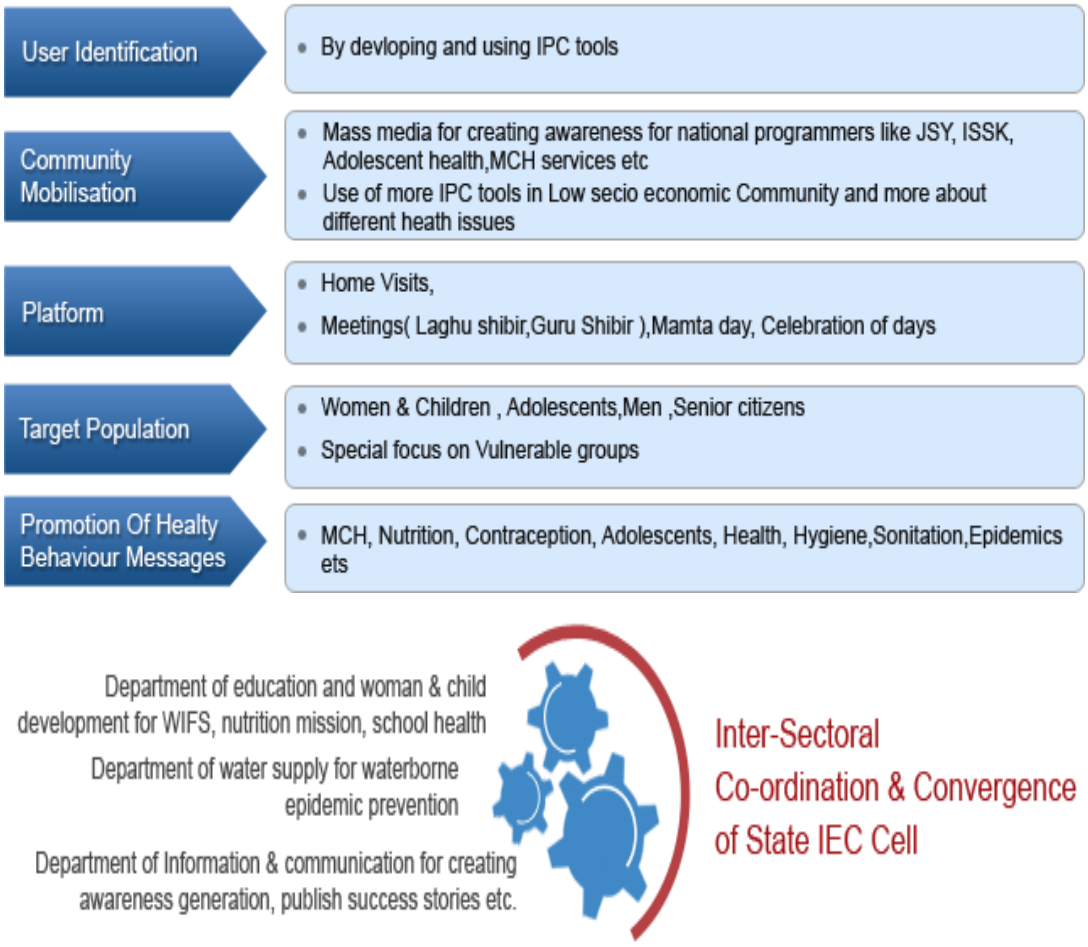
1.10.3 Support Structure for Implementation of IEC / BCC Strategy under NHM

According to NHM official website of Gujarat Government, it is clear how the IEC/BCC activities to be implemented. It explains the following important support structure up to the grass-roots level. This considers user identification at first instance, followed by community mobilization, platform, target population and

promotion of healthy behaviour messages on Maternal and Child Health, nutrition, adolescents, health, hygiene, sanitation, epidemics *etc.* (Figure 9)

Figure 9

IEC/BCC Strategies in Health



(Source: Department of Health and Family Welfare (Government of Gujarat) https://nhm.gujarat.gov.in/iec-bcc.htm)

Thus, the elaborated organizational and governance structure of NHM at national, state, district and block level which are fully functional, decentralized and community owned system have high inter-sectoral coordination so that wide social determinant factors which affect the health of people. Table 2 represents the summary of Community-Led activities which act as a support structure for smooth implementation of IEC/BCC strategies and to attain a status of a healthy nation.

Table 2

Summary of Community-Led Activities under NHM

Community-Led Activities	Functions
Village Health Sanitation & Nutrition Committee (VHSNC)	Formed at each village level within the framework of Gram Sabha. Subcommittee or a standing committee of the Gram Panchayat. Representation of disadvantaged sections including women. Acts as a platform for the convergence of all departments at the village level. It also functions as a Planning and monitoring committee at the village level.
ASHA	The interface between the community and the public health system. They are female health activists at the household level. Involved in educating and mobilizing communities particularly marginalized communities. Functions include home visits, attending the Village Health and Nutrition Day (VHND), visits the health facility, holding village level meetings and maintaining records. In rural areas, one ASHA per village and in urban areas, one ASHA per 1000-2500 population.
Anganwadi Workers	Under the ICDS programme Involved with ASHAs and ANM (Triple-A team) in convening the Village Health & Nutrition Days and VHSNCs.
Jan Sunwai or Jan Samvad	Public Dialogues/Public Hearings - taking direct feedback taken from the Community members and Grievance Redressal mechanism

(Source: Ministry of Health and Family Welfare (Government of India), NHM Manual for District level Functionaries, 2017 https://darpg.gov.in/sites/default/files/National Health Mission.pdf)

1.11 Chhotaudepur District Profile

Chhotaudepur is one of the three princely states of Eastern Gujarat besides Devgadh Baria and Rajpipla the small town situated on the edge of a big lake, with a series of temples along the skyline. The Jain temple is an interesting example of the influence of Victorian art on local building styles. It shares its land borders with the state of Madhya Pradesh and water border with the state of Maharashtra.

Figure 10

Map of Chhotaudepur District

(Source: https://www.google.com/search?q=map+of+chhotaudepur+district&tbm=isch&chips=q:map+of+chhotaudepur+district,online_chips:chhota+udaipur+district&hl=en-GB&ved=2ahUKEwiIndXkvI_qAhULdn0KHfk1DToQ4lYoBXoECAEQGg&biw=1583&bih=789#imgrc=XtNzKTGcHdwAuM)

Chhotaudepur is a Tribal dominated district. The essence of the town, however, is that it lies in the heart of a tribal area with a rich indigenous history and culture. The town is a good base from which to explore the surrounding tribal villages, particularly in the Rathwa communities.

Chhotaudepur district became revenue district on August 15, 2013, with its headquarters at Chhotaudepur town. Earlier it was part of Vadodara district. The district was created to facilitate decentralisation and ease of access to government services. The district headquarters is located 110 km away from Vadodara and is connected with State Transport bus service as well as Trains.

It is the third tribal-dominated district in eastern Gujarat after the Narmada and Tapi districts. As seen in figure 10 the district is to consist of the six talukas of **Chhotaudepur, Pavi Jetpur, Kavant, Nasvadi, Sankheda** and the newly created **Bodeli** taluka. Chhotaudepur district has a large forest area and has deposits of dolomite, fluorite, granite and sand all of which are mined. The Rathwa tribes who live here produce the Pithora mural paintings by mixing colours with liquor and milk and then using it to depict intricate motifs and scenes on the walls of their village dwelling. The tribal local market also called *Haat* is one of the attractions of the place.

Demographic profile of Chhotaudepur district is as seen in table 3. Besides six talukas, the district is divided into total of 892 villages to facilitate work. The district has nearly 3978 square kilometres of geographic area out of which almost one fifth *i.e.* 812.78 square kilometre is the forest area. According to census 2011 data, the population of the district was 10,72,368, a high majority of 77.61 % were Schedule Tribes and 2.36 % were Schedule Cast. Sex ratio reported was 967 females per 1000 males which are better than the state scenario.

Census 2011 reported that Literacy rate of the tribal district was 56.18 per cent, were in males and urban people reflected higher literacy rates than females and rural counterparts respectively.

Table 3

Demographic Indicators of Chhotaudepur District

Indicator		Year	Data	Source
Total Talukas		2015	6	Village Profile
Total Villages		2018-19	892	Village Profile
Total Geographical Area (Sq. KM)		2015	3977.73 Sq.K.M.	Village Profile
Total Forest Area (Sq. KM)		2015	812.78 Sq.K.M.	Village Profile
Total Population	Total	2011	1072368	Census
	Male		547328	
	Female		525040	
Sex Ratio	Total	2011	967	Census
	Male		1000	
	Female		967	
% of SC Population		2011	2.36%	Census
% ST Population		2011	77.61%	Census
Literacy rate	Total	2011	56.18	Census
	Male		66.26	
	Female		45.82	
	Rural		36.91	
	Urban		68.21	
No. of BPL families	(0-16)	2015	59840	Village Profile
	(0-20)		110119	
Households without Electricity		2011	50	Census
No. of Villages not electrified		2015	28	Village Profile
No. of Villages without Drainage Facilities (%)		2015	566	Village Profile

Note: researcher verified above data from District Panchayat office on August 2019

(Source: Government of Gujarat http://chhotaudepurdp.gujarat.gov.in/writereaddata/Portal/Images/district-profile.pdf)

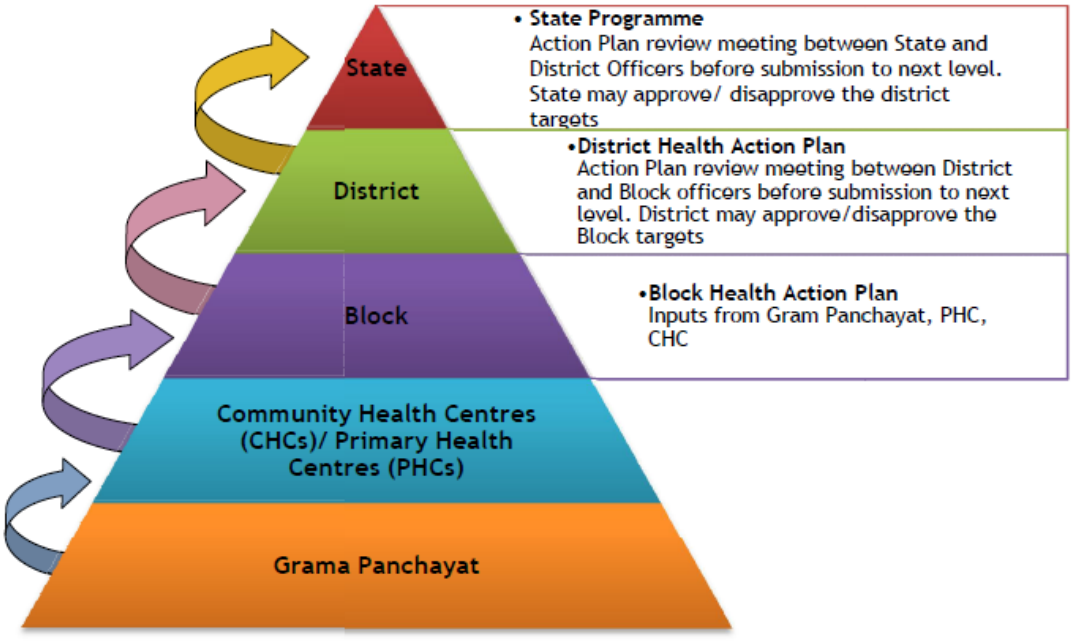
It can be read from the table 3, Chhotaudepur classified as Tribal area where nearly sixty thousand households belonged to Below Poverty Line with zero to sixteen scores. However little higher than eleven thousand families belonged to a category of zero to twenty, as per village profile data, 2015. Only 28 villages in 2015 and 50 households in 2011 were not electrified according to village profile and census data respectively. Nearly sixty per cent *i.e.* 566 villages were without drainage facilities in 2015.

1.12 Workflow Management at District and Grass-root level

According to 'NHM- Manual for District-Level Functionaries, 2017', Implementation of programme and utilization of funds starts at the Block level. Block Accounts Officer disburses the grants to Block Level PHCs, CHCs, Sub-Centres and VHCs under his jurisdiction and monitors its utilization. (Figure 11).

Figure 11

Decentralised and Bottom-up Approach: Preparation of State, District and Block level Health Action Plan

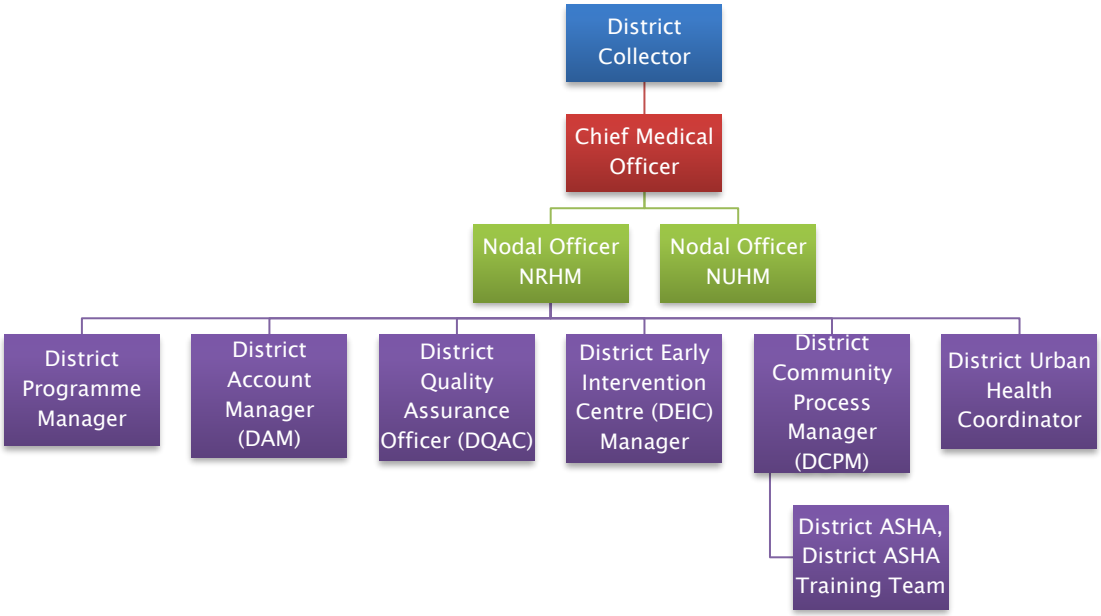


Note: *The number of units in each level varies from State to State.
(Source: Ministry of Health and Family Welfare (Government of India), NHM Manual for District Level Functionaries 2017, p.25)

The following figure 12 shows a diagrammatic representation of the operational structure of National Health Mission at the district level.

Figure 12

*Operational Structure of NHM at the District level**



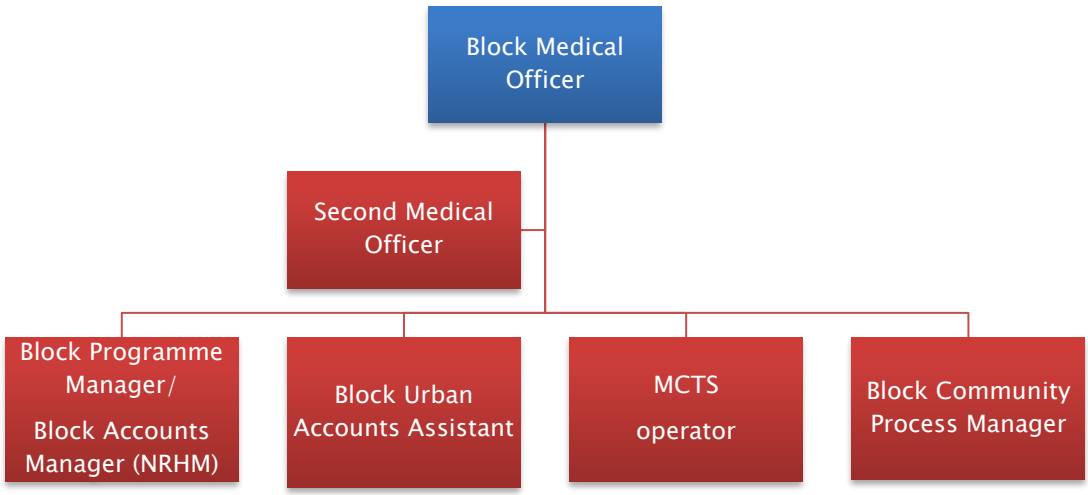
Note: *Figure recreated by the researcher

(Source: Ministry of Health and Family Welfare (Government of India), NHM- Manual for District-Level Functionaries, 2017, p.19)

Further, a diagrammatic representation of the operational structure at the Block level is shown with the following figure 13 and 14.

Figure 13

*Operational Structure of NHM at Block level**



Note: *Figure recreated by the researcher

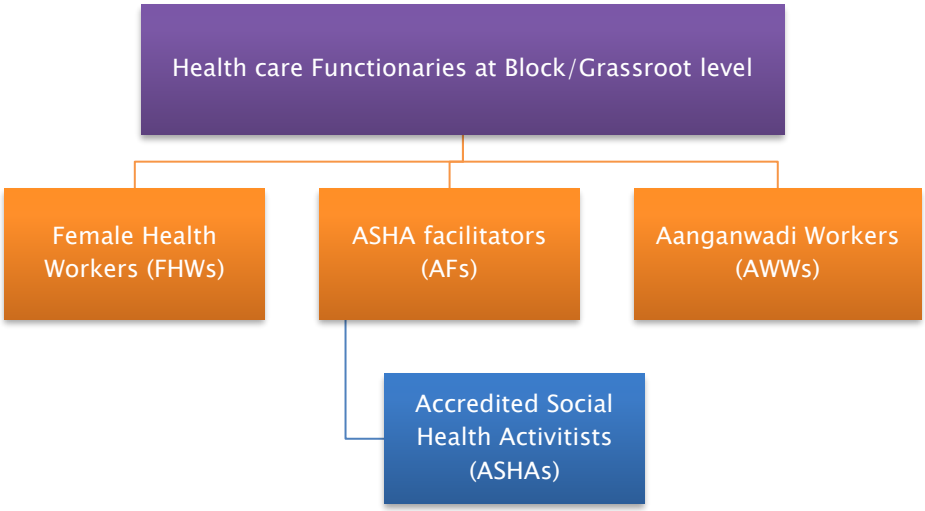
Source: Ministry of Health and Family Welfare (Government of India), NHM- Manual for District-Level Functionaries, 2017, p.20)

At Village level, there is PHC Medical Officer in Charge and ASHA Facilitators (1 per 20 ASHAs) supported by ANM; AWW and Village Health Sanitation and Nutrition Committee (NHSNC). VHSNC acts as a platform for the convergence of all departments at the village level.

Recognizing the importance of community participation in making the health programme implementation successful in terms of improved health-seeking behaviour and sustainability of the intervention, under National Health Mission (NHM), Community Processes component has been made as an integral part. The key objective of the community process is to promote public health and bringing public health amid people, thus in simple words community ownership of health. The community processes component includes- Accredited Social Health Activist (ASHA), Village Health Sanitation & Nutrition Committee (VHSNC), *Rogi Kalyan Samiti* (RKS) and Community Action for Health (CAH).

Figure 14

*Healthcare Functionaries at the Block/Grass-root level**



Note: *Figure prepared by the researcher

Source: Ministry of Health and Family Welfare (Government of India), NHM- Manual for District-Level Functionaries, 2017

Therefore, in present research ASHAs, ASHA Facilitators and Female Health Workers are considered besides Chief District Health Officer as samples to gauge the existing Health Communication Strategies.

1.12.1 Accredited Social Health Activists (ASHA)

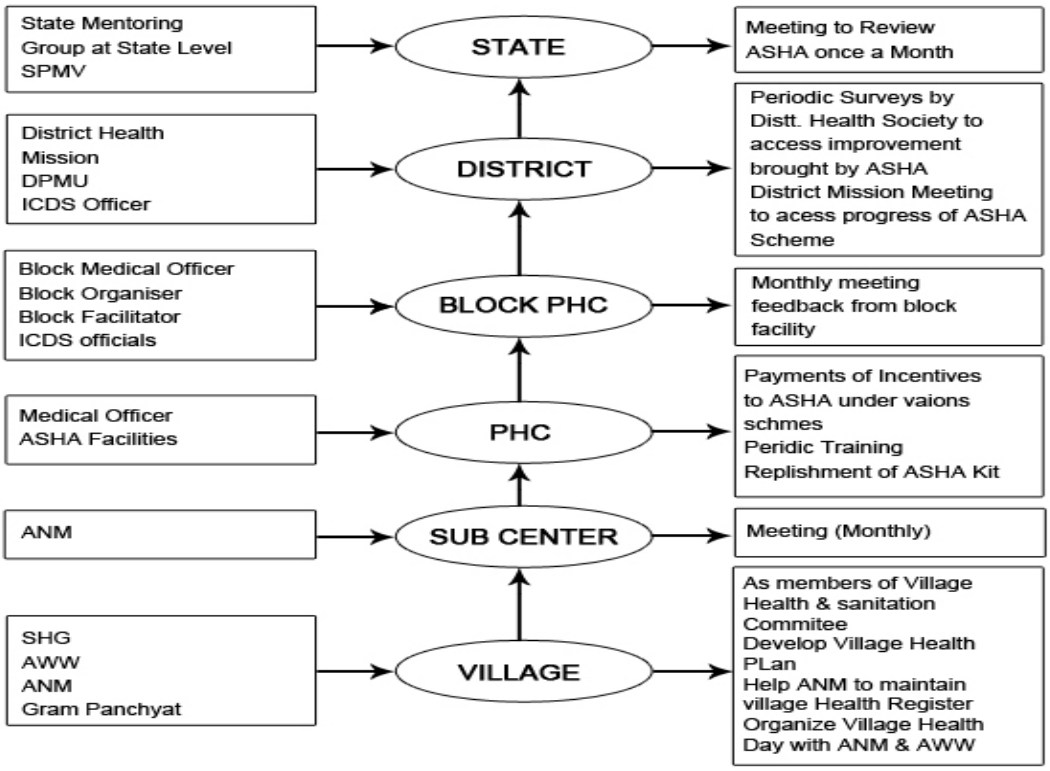
One of the key machineries of the National Rural Health Mission is to offer every village in the country with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be competent to work as an interface between the community and the public health system. Following are the key components of ASHA, as described by the Ministry of Health and Family Welfare, GoI (2005) in Operational Guidelines for ASHAs:

- ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.

- She should be a literate woman with due preference in selection to those who are qualified up to 10 standards wherever they are interested and available in good numbers. This may be relaxed only if no suitable person with this qualification is available.
- ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.
- Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo a series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelt out roles. She has to undergo induction training of 23 days within a year out of which first round is of 7 days and then 4 days X 4 days training programme.
- The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets.

Figure 15

Support Structure for Effective Service Delivery through ASHA



(Source: Ministry of Health and Family Welfare (Government of India), https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=181&lid=254)

The guideline also envisages three different roles for ASHAs. First, ASHAs are to function as a 'link worker', a bridge between the rural and vulnerable population within the health service centres. Second, ASHAs are to function as a 'service extension worker', whereby they are trained and provided with a kit that includes commodities such as condoms, oral contraceptive pills, delivery kits and simple life-saving drugs including clotrimoxazole and chloroquine. Third, they are conceptualised as 'health activists in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services'.

As per Ministry of Health and Family Welfare (Government of India), Guidelines: Accredited Social Health Activists (2005), ASHA's roles and responsibilities are explained in detail. (figure 16)

Figure 16

Roles and Responsibilities of the ASHA

ASHA performs her role through five activities based on Guidelines: Accredited Social Health Activists, Government of India (2005):

1. **Home Visits**: For up to two hours every day, for at least four or five days a week, the ASHA should visit the families living in their allocated area, with the priority being accorded to marginalized families. Home visits are intended for health promotion and preventive care. They are important not only for the services that ASHA provides for reproductive, maternal, new-born and child health interventions, but also for non-communicable diseases, disability, and mental health. The ASHA should prioritize homes where there is a pregnant woman, new-born, child below two years of age or a malnourished child. Home visits to these households should take place at least once a month. Where there is a new-born in the house, a series of six visits or more becomes essential.

2. **Attending the Village Health and Nutrition Day (VHND):** The ASHA should promote attendance at the monthly Village Health and Nutrition Day by those who need Anganwadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services.

3. **Visits to the health facility**: This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility-based care. The ASHA is expected to attend the monthly review meeting held at the PHC.

4. **Holding village level meeting**: As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), the ASHA is expected to help convene the monthly meeting of the VHSNC and provide leadership and guidance to its functioning. These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.

5. **Maintain records**: Maintaining records which help her in organizing her work and help her to plan better for the health of the people. (p.3)

The first three activities relate to facilitation or provision of healthcare, the fourth is mobilisation and fifth is supportive of other roles.

1.12.2 ASHA Facilitator

According to Guidelines for ASHA Facilitators District ASHA Resource Centre, Government of Gujarat (n.d.), ASHA Facilitator is a paid worker, who will have to handhold the activities of ASHA. ASHA Facilitator is the person to be in direct touch with the frontline ASHA and providing supportive supervision is the main role of ASHA Facilitator.

National Rural Health Mission emphasizes on the ASHA Facilitator facilitating the activities of ASHA and also to ensure the outcome of ASHA programme primarily through providing support, supervision and on the job training to the ASHA in their villages.

ASHA Facilitator is responsible to carry out her assigned tasks as per said norms, out of which ASHA Facilitator should attend the following activities, which are mandatory for each Facilitator:

- Monthly PHC meeting by respective Medical officer- PHC or in charge.
- Must have a monthly meeting with ASHAs under her supervision.
- Monthly meeting with Block Nodal officer/Block Community Mobilizer
- ASHA Training Programme
- *Mamta* Diwas Session
- Village Health Sanitation & Nutrition Committee (VHSNC) meeting
- Local Panchayati Raj Institutions (PRIs) meetings to discuss health issues
- Monthly E-*Mamta* (MCTS) data entry meeting of ASHA Monitoring and reporting format B.

Apart from the above-mentioned assignments, ASHA Facilitator should carry out maximum 15 field visits to interact, facilitate and support ASHAs day to day work in the field including accompanying ASHA on household visits, for which she gets Rs.150/- per visit.

1.12.3 Female Health Worker

In the 1960s, India created a cadre of two-year trained rural midwives called "Auxiliary Nurse Midwives" (ANMs) to provide maternal and child health services. They substantially fitted the definition of a skilled birth attendant. (Mavalankar.D., et al. 2008))

The National Rural Health Mission (NRHM) was launched in 2005 with the focused on improvising primary health care in villages and further increased the importance of the ANM as a link between health services and the community. ANM is referred to Female Health Worker by the Department of Health and Family Welfare in Gujarat and is appointed at Sub Centre.

As explained by Ministry of Women and Child Development (2013), FHW provides services like immunisation, ANC, PNC, basic management of sick children and primary health care to the local population. She is mandated to provide outreach services in the villages under her jurisdiction, usually ranging from 5-8. Accordingly, she is expected to plan for these outreach services and support from AWW, ASHA, AWH arranges Village Health and Nutrition Day in each village.

Her responsibilities include the following:

- On Village Health and Nutrition Day, extending services like immunization, ANC, PNC, micronutrient supplementation, deworming, treatment of Children and women, if required arranging for referrals.
- Counselling of pregnant and lactating mothers and adolescent girls
- Care of undernourished children
- Management of Early childhood illness
- Anaemia control amongst Adolescent girls through health education and supervision of IFA tablets consumption
- Managing referrals given by the ASHAs and AWW
- Managerial responsibilities like holding a meeting with ASHAs and AWWs at SC to review the health and nutrition issues and resolve them

All these elaborated literature and discussion about Health Communication, NHM and community process left the researcher with the certain unanswered questioned in the mind. These questioned are listed below.

1.13 Research Questions

- What is the status of existing Health facilities in Chhotaudepur district of Gujarat state?
- What is the process of Health Communication Strategies under NHM in Chhotaudepur district of Gujarat state?
- What is the profile of ASHAs in Chhotaudepur district of Gujarat state?
- What is the provision, use, perceived benefits, barriers and need of additional Health Communication Strategies felt by the ASHAs in Chhotaudepur district of Gujarat state?
- What is the provision, use, perceived benefits, barriers and need of additional Health Communication Strategies felt by the ASHA Facilitators and Female Health Workers in Chhotaudepur district of Gujarat state?

1.14 Justification of the Study

Health communication is an applied area of study concerned by the roles performed by human and mediated communication in health care delivery and health promotion. It is not limited to checking the pragmatic influence of human communication on the provision of health care and promotion of public health, but further also to enhance their quality.

It can be inferred that health communication is mostly problem – based, aiming at identifying, examining and solving problems related to health care and its promotion among the larger public.

Concept of Health Communication evolved for almost the past three decades. It has received recognition among international scholars, policy planners and practitioners ranging from communication and mass media, sustainable

development, public health, sociology, psychology, epidemiology *etc.* for their local and large-scale development programmes, researches and academic up-gradation.

However, the same is not observed and true to Indian scenario. Only countable researchers have paid their attention towards Health Communication and Indian Health Programmes catering to Health concerns of the second largest populated country on the world map.

The National Health Mission envisages achievement of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs.

The Health system lies on both human and Non-human resources spread from top to grass root level. In such a massive public health programme, human resources using supportive non – human resources – infrastructure provides health services and promote health/healthy behaviours among the public. Health Communication is an essential integral ingredient in health service delivery and promoting desired behaviours using various Health Communication Strategies like Inter-Personal Communication (IPC), mid media and mass media channels. The past models of health care programmes like Family planning (Population Control), chicken-pox control, malaria control *etc.* had different perspectives and hence different communication approaches used to achieve the targets. The National Health Mission has adopted, decentralised PPP model for its implementation up to grass root level (Ministry of Health and Family Welfare (Government of India), NHM Framework for implementation, 2005).

The Ministry of Family and Family Welfare along with other ministries and agencies has designed a strategic framework for targeted IEC activities using a 360 – degree communication approach. The year-long plan has a month-wise focus on health days and health themes.

Under the strategic communication component, which is basically to strengthen and facilitate the work performance of health service providers stationed at facilities (Doctor, Nurse, Pharmacist *etc.*) or on fields (ASHA, ANM, AWW *etc.*). Several MOUs and tie-ups have been established for effective inter-sectoral

convergence and a greater possibility of achieving aims on health indicators through communication such as agencies at the national and local level like Directorate of Field Publicity (DFP), Print, Television – Doordarshan (Prasar Bharti), Radio, Outdoor publicity, Directorate of Advertising and Visual Publicity (DAVP), Social media platform and participation in events like Vibrant Gujarat Global Trade Show 2019.

The objective of IEC is to generate demand for health services and to promote health-seeking behaviours. The different strategies have catered to the different needs of rural and urban masses through different modes of communication, be it Interpersonal Communication, Mid-media or Mass media activities using various IEC and ICTs. (Ministry of Health and Family Welfare (Government of India) 2018-19, pp. 361).

The present study aims at preparing a profile of Health Care System with special reference to Health Communication component of National Health Mission at Chhotaudepur district, Gujarat State.

The investigator could find a very few empirical research evidences *viz*.; Nongmaitthem (2014) "A study of RCH communication: A critical analysis of NRHM, Manipur', Thakur et al. (2017) 'Is focus on prevention missing in National Health Programmes? A situational analysis of IEC / BCC / Health Promotional Activities in a district setting of Punjab and Haryana' and Tripathy et al. (2018), 'Use of IEC materials by ASHAs during Home Visit to disseminate New-born Care Messages in Uttar Pradesh.'

These studies highlighted on serious loopholes in availability, provision/supply chain management, use, barriers faced by the health functionaries and lack of absence of motivation, monitoring and evaluation of the use of Health Communication strategies by the seniors. In addition to it, Thakur et al. (2017) reported that 'IEC / BCC / Health Promotion - is a neglected area in the selected districts of Punjab and Haryana with adequate infrastructure and human resources and poor programme implementation and requires strengthening for better implementation of the national health programme.

Moreover, such important data with regards to the use of IEC are rarely available even in large scale surveys like the National Family Health Survey (2015-16)

The literature reviewed regarding Health communication policy by Bora, Devajit (2016) highlighted the following:

- lack of apparent directions in Health communication policy research in India as well as Assam,
- the enormous growth of health communication as a discipline at international level but in India as well as in Assam it lacks direction,
- failures of most of the health communication plans, policies either at planning or at the implementation level because it is insensitive towards common people,
- the health communication policy lacks direction on pro-people issues where presentation is either dull or more often verging towards negativity,
- the disparity in information generation and dissemination which communication policy does not raise and the health communication policy suffers from the malaise of routine exercise. (p.59)

Sharma, A. K. (2014) in 'The National Rural Health Mission: A critique' discussed the achievements and limitations of the Mission. It has raised nine questions about the approaches and strategies of NRHM and suggested that the most effective way to attain goals of NRHM is to strengthen the primary health care system rather than taking up a large number of programmes simultaneously without any focus. About the development of optimum strategies for health education, behavioural change and communication, he suggested the involvement of education department, media, administrative action, community leaders and political parties. Moreover, the quickest and most effective method for spreading health education and behavioural change is to involve the local doctor at the PHC/CHC.

Kreps (2014) in his article 'Evaluating Health Communication Programs to Enhance Health Care and Health Promotion' published in Journal of Health Communication, mentioned, 'Health communication programs are essential and ubiquitous tools in the delivery of care and promotion of health. Yet, health

promotion experts are not always well informed about the influence communication programs have on the audiences they are designed to help. Too often health communication programs evoke unintended, and even negative, responses from diverse audiences. It is critically important to conduct a regular, rigorous, ongoing, and strategic evaluation of health communication programs to assess their effectiveness. Evaluation data should guide programme refinements and strategic planning. This article outlines key strategies for conducting meaningful evaluation research for guiding the development, implementation, refinement, and institutionalisation of effective health communication programmes.'

NITI Aayog, Government of India. (2018), embraces upon the way forward to mobilise public health action at multiple levels by strengthening the Village Health Sanitation and Nutrition Day platform to cover a broader set of health issues across various population groups instead of only focusing on child health.

- Active multiple channels (Schools, Colleges, women's groups, traditional events like fairs, social media platforms, National Cadet Corps *etc.*) and prepare communication materials for catalysing behavioural change towards greater recognition of preventive health care.
- Make nutrition, water and sanitation part of the core functions of Panchayati raj institutions and municipalities.

Hence the most important carriers of health information *i.e.* the IEC/ICT/BCC strategies from the health planners to that of grass-roots' needs to be paid utmost attention. The country needs expedited efforts with regards to planning need-based effective Health Communication Strategies, its proper flow to the health workers, and also efficient system to monitor and evaluate its usage related issues and challenges for appropriate results.

Therefore, the present research is planned to initiate research efforts in this neglected area of knowledge to gather insight into the ground realities related to Health Communication, it's Strategies, Provision, Use, Barriers, Benefits and additional felt needs *etc.*

1.15 Justification of the Study in Context to the Department of Extension and Communication

The Department of Extension and Communication plays active and efficient roles as prescribed by the University Grants Commission (UGC) in all three areas concerned with Higher education *viz.,* Teaching, Research and Extension.

The department is involved in disseminating knowledge on the applied, core and allied concepts of Extension and Communication focusing not only theoretical understanding but offering practical experiences, skills related to selecting, designing and using appropriate communication strategies for the priority-based development issues. Therefore, the department curriculum includes courses like Extension Methods and Materials, Communication Media for Development, IEC for Development, Basics of Development Communication, Writing for Development, Software in Print Media, Software in Electronic Media, Software in folk Media, Communication for Development, Social and Behavioural Communication, Development Communication, Communication theories *etc.* Further, curriculum updating is a regular feature in the department.

The study findings may contribute to the curriculum designing and updating as per the prevailing current trends of usage of Health Communication Strategies by the health personnel.

Findings may also provide evidence-based experiences for designing various training programmes, capacity building workshops for the health care providers highlighting the proper usage of various IEC and ICT materials while catering to the various developmental issues. Moreover, findings may also highlight the ground realities of IEC/ICT based activities, which in future can be very well undertaken in the department's community outreach programmes in urban and rural areas. To carry out systematic outreach programmes at both Undergraduate and Post Graduate programmes is a constant feature of the department which has helped earn respect in the field of a development programme for need-based planning, effective execution and systematic evaluation. Thrust areas like health-specifically reproductive health, adult and non-formal education, environment education, value

education, skill development *etc.* catering to women, children, adolescents, school teachers, community health workers *etc.* are taken up regularly. In past department had collaborated with government and Non-Government Organisations for the several such development programmes. Department can create/provide a platform to share such knowledge while organising need-based and pertinent seminars and workshops for communication media planners, practitioners, academicians, public health educators and public health providers.

Apart from this, in totality, the department is actively engaged in research in the field of Extension and communication. In past, the department has undertaken some studies and action projects on various government efforts pertaining to programme appraisal, skills development *etc.* on Right to Education, Integrated Child Development Scheme (ICDS), Indira Aavas Yojana *etc.*

However, the present investigation would be a torchbearer study with the conceptual framework of Health Communication and National Health Mission in the tribal district of Chhotaudepur. The study would throw light on various emerging areas of research related to Health Communication Strategies, availability, use, barriers, needs for diffusing relevant specifically Health and which are broadly applicable to behavioural change and developmental messages too.

Hence the present study may be contributory in the three well-laid dimensions of higher education *i.e.* teaching, research and extension and is justified in context to the Department of Extension and Communication.

1.16 Justification for the Selection of Locale of the Study

Tribal population in India is undergoing demographic, socio-economic and health transformation besides other indicators resulting in changes taking place at a global level and in India too. This applies to Chhotaudepur district too. On 15th August 2013, Chhotaudepur was carved from Vadodara district for ease of administration for bureaucrats and government programmes.

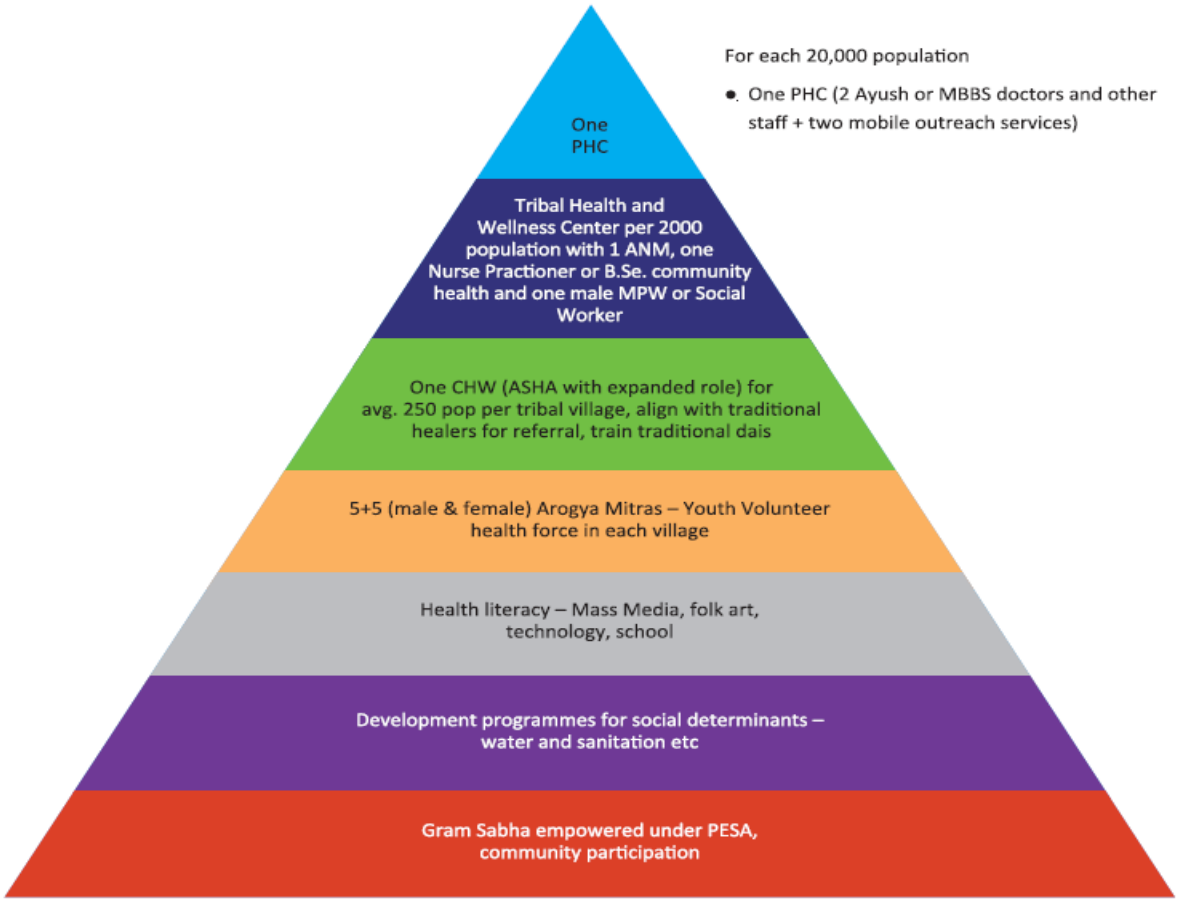
The Chhotaudepur district is one among the 14 tribal districts of Gujarat, constituting 33 districts in total. The district shares border with Madhya Pradesh and

Maharashtra. The major tribal population inhibits in rural and forest area; the habitats are mostly amidst natural set up surrounded by jungles, water resources and small mountains.

Ministry of Health and Family Welfare and Ministry of Tribal Affairs (2018) recommended ASHA with an expanded role, Health literacy through mass media, folk art, technology, school programme, development programmes for social determinants–water and sanitation *etc.* and community participation under community process. This signifies contextual importance of health communication in tribal areas. (Figure 17)

Figure 17

Recommended Primary Healthcare Pyramid for Tribal area



Source: Ministry of Health and Family Welfare and Ministry of Tribal Affairs (2018) Bridging the Gap and Roadmap for the Future
https://www.nhm.gov.in/nhm_components/tribal_report/Executive_Summary.pdf

Many researchers have realised the urgency and significance of research in such tribal areas. One of them, Narain (2019) in his editorial article, stressed that 'At present, the national data are scant thereby providing a fragmented picture of tribal health and obscuring tremendous diversity among tribal groups scattered across the country. Disaggregated data by specific tribal groups and assessing the social, cultural and economic determinants of health is, therefore, urgently needed. Such research data will have a crucial role in designing and initiating evidence-based health policies, strategies and public health action suited to their unique social, cultural and geographic environment.'

Decentralised planning and implementation of National Health Mission is a core value of the overarching nationwide programme.

Ministry of Health and Family Welfare and Ministry of Tribal Affairs (2018), elaborates that 'Health literacy is low among the tribal population. Since, knowledge is the best pill and vaccine, a massive health literacy drive for continuous health education of women, men, youth and children is a cost-effective intervention. Some health literacy strategies are targeted mass communication (wall paintings, posters and media); health science exhibitions on mobile vans eg. 'video rath'; folk media (folk theatre, street plays, cultural groups, health education courses and activities at schools; every contact with the health system (ASHA, ANM, PHC, MMU) must be accompanied by a five-minute health education; information Technology (tablets, mobile phones, village volunteers and VHSNCs).'

The same report further noted the significance of BCC campaigns and research while achievement of Objective 3, *i.e.* To empower the tribal people to adopt healthy practices to enhance their capacity for self-care.

Design effective Behaviour Change Communication campaigns.

a) The promotion of healthy behaviours requires formative research with ethnographic inputs to feed into health education and communication strategies and to define the content of the communication.

b) Health campaigns must necessarily mix a strong endorsement of good practices inherent in tribal cultures-with a reasoned and sensitive disavowal of harmful practices.

c) All BCC strategies must recognise the heterogeneity of tribal groups and the need for the tribe and region-specific interventions, in the local language and dialect.

Almost all researchers (mentioned in Chapter 2-Review of literature) noted the need and significance of culture-specific, need and evidenced-based, comprehensive and coordinated empirical data and thereby development and roll-out of tailored Health Communication Strategies. In the case of Health Communication Strategies under National Health Mission there existed immense dearth and therefore the present study foreseen significant scope in tribal dense Chhotaudepur district of Gujarat state.

Researcher's inclination towards health communication study and personal concern for tribal population, past exposure of field supervision and feasibility to travel to Chhotaudepur were the added reasons besides above described points of rationale for selection of the district as locale for the present enquiry.

1.17 Justification of Samples of the Study

Sullivan et al. (2012) noted that 'an adequate assessment of health information needs, including opportunities, barriers and gaps is necessary for designing effective communication strategies and producing actionable information.'

Comprehensive communication strategy adopted with a strong Behaviour Change Communication (BCC) component in the IEC strategy dissemination in villages and lowest levels. There is the participation of non-government agencies and professional and specialized agencies, visible mass media efforts in massive health communication efforts. There is a substantial portion of the interpersonal BCC effort is through local ground-level workers including ASHA and ANMs, and community level structures equipped with communication kits, interacting on a one to one basis

with families. (Ministry of Health and Family Welfare (Government of India), NHM Manual for District Level Functionaries, 2017)

NHM has a well-defined implementation framework up to grassroots. In such a framework the vertical and horizontal flow of communication plays a very crucial role and thereafter contribution made by each official and health worker. A huge amount of budget is allocated for achieving health behaviours and thereby improved health status of all sections of society through the ASHA programme under NHM; it becomes essential to check proper utilization of the resource *vis-à-vis* the health status of the people.

Few studies could be found on the exploration of role performance and service delivery functions of health workers in India. There is a dearth of researches concerning provision, use and perceived benefits of Health Communication Strategies expressed by the key health functionaries (ASHA, ANM/FHW and ASHA Facilitator). The researcher did not want to leave a single stone unturned while measuring the status of Health Communication under NHM in Chhotaudepur, tribal area. Therefore, it was decided to select samples from majorly all grass-root level health functionaries to understand the Health Communication component properly.

The study may highlight the various barriers related to Health Communication Strategies if any by them. This may help in eradicating the felt barriers and bringing change in designing, distributing policies of the health communication system used under NHM. This, in turn, may help in increasing the effectiveness of health communication efforts in the selected tribal district-Chhotaudepur.

1.17.1 Justification for Selecting the ASHAs

ASHA being the grass-root level health activist under NHM, her responsibility as link worker, mobiliser and service provider using Inter-Personal communication approach with beneficiaries and health care machinery is very crucial and significant.

ASHAs are first port of Information and health care needs. She has to actively work in coordination with AWW and ANM/FHW for organizing and celebrating some special days in communities like *Mamta* Day, Village Health and Sanitation days *etc.*

She has to imbibe better health care behaviour amongst community people specifically vulnerable groups like women, adolescents, new-borns, children and old age people. ASHA has been assigned many responsibilities to provide health care facility at the household level.

To be able to perform all her assigned roles, ASHA has to be an effective Health communicator. Therefore, it was felt necessary to study different strategies used while performing her prescribed roles.

On the supply side, she should be able to provide correct information and treatment to beneficiaries. While attending to queries during ANC visit, pregnancy complications, Home Based New-born Care, Initial Breastfeeding practice *etc.* She should be able to guide and counsel most appropriately.

In some places, NGOs are working in close partnership with government NHM programme. They have provided ASHA with some IEC materials in their areas and some parts of the state ICT based devices like Handheld device, PDAs and mobile facilities are given on an experimental basis.

Government of India has also developed a separate IEC department under NHM which is responsible for designing general BCC/IEC materials for all over India. However, states are given the responsibility to adopt and modify those IEC/BCC strategies as per local applicability and requirements.

There is a provision of the State Level guiding Resource centre to facilitate the ASHA programme. Immediately after selection, ASHA undergoes rigorous training. She is also trained to use Communication to promote behaviour change. Therefore, the present study is well justified in terms of use and benefits perceived of the Health Communication strategies by ASHA to perform her roles.

The present study was an attempt to check the availability of communication strategies with ASHA. It further aims to identify needs and requirements related to Health Communication strategies be it IEC (Chart, Poster, Cards, flipbook, booklet *etc.*) Mass Media (Radio, TV, Newspaper, Magazines, Hoardings/Banners, Wall painting *etc.*) ICT (Computer, internet, handheld devices, mobile and smartphones *etc.*) to perform roles of ASHA as a key health worker, Behaviour Change agent,

Record-keeper and Key informant. There are evident gaps concerning the extent to which ASHAs can be health activists or agents of change, supporting community participation and empowerment which are crucial aspects of health improvement and sustainability in context to her use of Health Communication Strategies.

The study would be able to provide a guideline for proper planning and utilization of budget allocated for communication on the most appropriate tailor-made model and theories of Development Communication and Health Communication in particular for ASHAs under NHM.

1.17.2 Justification for Selecting ASHA Facilitators

According to Department of Health and Family Welfare, GoG (n.d.), Guidelines for ASHA Facilitators, there is one ASHA facilitator for every 10-20 ASHAs, as the first level of support. The ASHA facilitator is involved in the selection of the ASHA.

ASHA facilitators' main roles comprised of monthly review meetings, respond to grievances, maintain records of ASHA activities, attend Village Health and Nutrition Days with the ASHAs, and attend monthly block PHC centre meetings. A very important role is to support ASHA to promote healthy behaviours and improve service access among difficult families during household visit. The ASHA Facilitators use the IEC materials to perform such diverse roles.

During the course of study, it will also bring to the notice the responses expressed by the ASHA Facilitators with regards to selected aspects related to Health Communication Strategies (provision and use) for promoting desired behaviours.

A systematic study of barriers related to Health Communication Strategies may help development and health care planners to make alternation or improvement in the present communication strategies for future use. Thus, due to these reasons, it was considered important to include ASHA Facilitators as one of the samples of the study.

1.17.3 Justification for Selection of Female Health Workers

The Female Health Worker is based at Sub Centre, which is the first level of the health system. So, her role is very crucial for stepping in patients at the Sub Centre. Moreover, she is also responsible to convene Village Health Nutrition Day in a village, which is a monthly activity wherein she carries out vaccination and provides ANC services, conducts counselling session and contraceptive services to eligible couples.

So overall, VHND provides a good scope for mobilising beneficiaries for adapting key health messages through effective use of Health Communication Strategies.

Female Health Worker also has to attend a monthly meeting of Village Health Sanitation and Nutrition Committee as a member, convened by the ASHA as a secretary. There also she can sensitise and put forth her opinions on agenda concerned to social-cultural and environmental determinants of health.

Therefore, it is significant to find out provision, availability, use and barriers related health communication approaches at Anganwadi on VHND and during a meeting of VHSC (mostly at Panchayat office).

In the recent past (2018), Female Health Workers are armed with TeCHO mobile – a smartphone. It is a new technology lead initiative of the health department for robust management of data and health information. Female Health Workers also called as FHWs (Female Health Worker) are responsible for collecting and maintaining data from ASHAs and ASHA Facilitators. Further, they have to coordinate with PHC level staff for data entry and retrieval. Since it a transition phase, they have to maintain registers, entre data in e-*Mamta* portal and TeCHO mobile too. The findings of the present study may throw light on the experiences of ANMs while using new technology, which may give a guideline for further implementation of new technology for all other Frontline Health Functionaries (ASHA, AWW and ASHA Facilitators)

Hence selection of FHW as one of the samples is justified in the present study, which is focused on selected aspects of various Health Communication Strategies for

delivering the Health messages and performing various preventive and curative roles and responsibilities.

1.17.4 Justification for Selection of Chief District Health Officer (Chief Medical Officer)

There is a District Health Mission in every district and under it functions a District Health Society (DHS) to support its activities. It has a governing body with District Collector/District Magistrate as the chairperson and Chief District Health Officer (also known as Chief Medical Officer) acts as the Chief Executive Officer (CEO) of the NHM.

DHS is responsible for planning and managing all NHM programmes and activities in the District. District Programme Management Unit (DPMU), District Public Health Resource Centre and District Education and Training Centre perform similar functions as their state and national counterparts.

CDHO being the CEO of the governing body of DHS, the officer would be best to evaluate and triangulate the research data gathered from ASHAs, ASHA Facilitators and FHWs in Chhotaudepur district. Being at the higher position in the DHS hierarchy the CDHO would have better insights, planning, experience and expectations in achieving goals of better health and behaviour change through Health Communication.

Therefore, it was felt critical to interview the CDHO and seek his responses to achieve the objectives of the present research.

1.17.5 Justification for Selection of Variables of ASHAs

In the present research enquiry, the ASHAs are selected as a key sample for both qualitative and quantitative data. Following points highlight upon justification of personal characteristics/variables of ASHAs, selected under the present study.

1.17.5.1 Block. The Chhotaudepur district has six blocks in its revenue boundaries. Block Health Office, headed by the Block Health Officer serves as a coordinating link between PHCs and District Health offices for implementation of all health programmes and distribution of required resources.

Health Communication Strategies provided by District level office would be channelized by BHO and distributed up to PHCs. Further, the respective PHC distribute them into 2-3 part, one for frontline functionaries (ASHAs, ANM, ASHA Facilitators and AWW), second for display and use at PHC and other health facilities and third for display and distribution in communities and other public places.

The Provision of Health Communication resources and materials is based on demand from the block and also on the supply from the state health department in line with the available budget.

Apart from this, each block varies with respect to geographic, demographic and cultural characteristics which effect their health indictor, although the whole district is dominated with the tribal population.

ASHAs belonging to different block may have different say with regards to Health Communication Strategies and its selected aspects *viz.*, provision, use, perceived benefits, barriers and need.

Therefore, it was felt necessary to study block-wise variation amongst the ASHAs for the selected dependent variables of the study.

1.17.5.2 Age. Age is generally linked with an individual's maturity and capability to handle the situations. With the growing age, an individual gathers more experiences in life. The more matured individual would be in a better position to handle situations at personal and professional fronts. Age of a person may affect his/her readiness to adopt the changes occurring at home and workplace and expected to handle them. There may be high possibilities that an older individual may behave more reluctant, hesitant and younger may be curious, motivated and more adaptive towards the communication aspect of National Health Mission.

The ASHAs are envisaged with multiple roles where she would come across a variety of people in different setups handling challenging tasks. Crispin et al. (2012) in their study related to Community Health Workers, found significant relationships of age with good record-keeping ($p = 0.0001$), appropriate use of job aids ($p=0.0001$), client satisfaction ($p = 0.018$) and client enablement ($p = 0.001$).

Bajpai and Dholakia (2011) observed significant differences among older and younger age groups of Female Health Workers in Karnataka for using mobile phone for their job, older used less as compared to younger.

The Age of an ASHA may act a significant factor for being able to carry and use the Health Communication Strategies for performing responsibilities. The ASHAs may differ concerning their age for her responses regarding perceived benefits, barriers and additional needs regarding Health Communication Strategies.

Therefore, it was decided to take age as one of the variables under the study.

1.17.5.3 Educational Qualification. Education provides knowledge of the world around. Education develops in us a perspective of looking at life. It helps us build opinions and have points of view on things in life. An individual can bring changes among society to lead a letter life.

The ASHA possessing higher educational qualification may have a different perspective than her counterparts. Higher education status may lead ASHAs to perform her duties in a better way.

Sharma et al. (2014) have recognized that the education of ASHA affected her motivation and performance.

According to Ministry of Health and Family Welfare, Guidelines; Accredited Social Health Activist (2005, p.4) minimum qualification required for the appointment is qualifying primary schooling (Standard 8th), however, in difficult areas, the authorities may have some flexibilities. The selected ASHAs under present study belonged to the tribal area. Their education level may reveal differences in her understanding of the health concerns of her community people. Her orientation towards health issues and understanding for the situation along with her perception may affect her service delivery and health promotion. Education empowers minds that will be able to conceive good thoughts and ideas.

The ASHA may have devised ways of communicating with people and healthcare staff. Her education may influence her choice of communication strategies, use, barriers and perception about the benefits of Heath Communication Strategies. Hence, it was felt necessary to study this variable by the researcher.

1.17.5.4 Work Experience. Experience is considered the best teacher in life. What an individual learns and experiences can often determine his/her success or failure in life. Effortful learning combined with real-life on the job experience is a winning formula for success. ASHAs are dedicated individuals who function along a continuum ranging from individual and community to service delivery and promoting community empowerment and social justice. They help link people to needed health care information and services.

Repeated and long-time of same work make the person more efficient and competent; on the other side, it may lead to monotony and boredom. Whereas individuals with less experience may feel lost, hesitant, need assistance *vis-à-vis* open to experimentation and motivated.

Findings of Siribie' et al. (2016) can provide support to it, that young, single, new CHWs performed better than their old, married, more experienced counterparts. ASHA's appointment is done locally-in her village (ASHA programme Guideline, 2005). Working with the same community people will fetch her proper understanding about determinants of health in her area. Comparatively long years of experience for ASHA may determine her set adoption to job aids on the contrary newly joined ASHAs may be open with variety and trial of job aids.

It is one of the variables which is widely studied by the scholars regarding work performance, however, availability of few pieces of evidence with regards to work experience and selected aspects of Health Communication Strategies motivated the investigator to include it in the present study.

1.17.5.5 Occupational Skills. Occupational skills- is a component of ASHA training module-5. Five soft skills desired for her occupation *viz.*, communication, coordination, leadership, negotiation and decision making are included. Development of these skills would enable the ASHA to work at her maximum potential during interpersonal, group interaction and mobilising the villagers for achieving goals of health. The ASHAs can be effective and efficient in her work who own better occupational skills than her counterparts.

Following research findings prove that the occupational skills are important for the ASHAs.

Personality traits and skills like communication, motivation, leadership and ability to reach out to community members are also important factors shaping the effectiveness of CHWs (Saprii et al. 2015). Garg et al. (2013) 'ASHAs need to improve on negotiation skills while dealing with poor women and children.'

Occupation skills often direct ASHA for her communication approach. She would be more confident, clear and assertive in her discourse on health behaviours amongst the community. It is assumed that she may be able to handle various media effectively. Those owning higher level of occupational skills may have better clarity about use, effectiveness and requirements of Health communication tools to facilitate her roles, also, it is imperative that she may be able to reflect upon barriers related to Health Communication Strategies.

Health Communication strives to bring desirable behavioural change through the promotion of health awareness and provision of health benefits to all beneficiaries. It has a close connection with the occupational skills of the ASHAs. Therefore, ASHAs' occupational skills and her responses related to the provision, use, barriers, benefits and need of additional Health Communication Strategies in Chhotaudepur under NHM may have significant importance in deriving its overall status.

1.17.5.6 Training Received. Training is an integral and ongoing component of the ASHA programme. As mentioned in ASHA Guideline, Capacity building of the ASHA is critical in enhancing her effectiveness. Capacity building of ASHA has been seen as a continuous process, to begin with, induction training, periodical training and on the job training. There is a total of seven modules and a refresher course are planned for the ASHAs under capacity building programme. It has been envisaged that training will help to equip her with essential knowledge and skills resulting in the achievement of the scheme's objectives and ultimately NHM's goals. Following research evident describe the significance of training on ASHAs.

Garg et al. (2013) concluded that ASHAs were satisfied and happy with the training but their perception about the in-job responsibilities appeared to be incomplete and improper. Many of them were not aware of their role in assisting ANM in village health planning, creating awareness on basic sanitation and personal hygiene, birth-death registration. Incentives in monetary terms and capacity building in the weak areas of training can act as delivering better health services.

Similar findings were recorded by Gosavi et al. (2011), 'lack of good training and poor clarity on how to collaborate work with the ANM and AWW.'

This study showed that an ASHA's motivation and performance are affected by a variety of factors; personal (e.g. education), professional (e.g. training, job security), and organisational (e.g. infrastructure) along with others that emerge from the external work environment. (Sharma et al., 2014)

Further, it was assumed that the trained ASHA may be using a greater number of Health Communication Strategies as she has good command over them whereas it may be equally true for the ASHA having incomplete training and trying her hands-on variety of Health Communication Strategies.

1.17.5.7 Knowledge regarding Health Communication Strategies. Knowledge is a key to empowerment, as it is understood generally. A knowledgeable person can take a wise decision by application of the knowledge to the situation.

As per ASHA guideline, the ASHAs are trained for performing her assigned tasks. Their training programme is such where trainers and facilitators use various techniques and media of teaching, training and counselling. On induction, the ASHAs are provided with ASHA kit which includes, ASHA Diary, Health Card (*Mamta* Card) and registers. Besides this during weekly PHC meetings ASHAs may be exposed to charts/posters, counselling cards, flipbook, leaflet, booklet, PowerPoint presentations, Television *etc.* and supportive mass media campaign through wall paintings/wall writings, chat/poster, radio spots, television advertisement *etc.*

Not only this, but ASHAs might also be taught about the method of using different media in individual, group and mass set up. Therefore, it is assumed that ASHAs would know various communication strategies.

Bhattacharyya et al. (2001) reviewed how the use of multiple incentives can contribute to CHW retention in which they mentioned about Identification (badge, shirt) and job aids (Nonmonetary factors) as CHW Incentives.

The Earth Institute, Columbia University (2013) relevant CHW job aids and counselling cards for each participant, participant worksheets and answer keys, necessary materials (e.g., handouts, visual aids, props) for practice activities, Power-Point slides and audio-visual equipment were provided. Brooks et al. (2014), Job aids (or tools) such as checklists, flowcharts, and educational materials, along with an interview, assessment, and data collection forms, facilitate and organise the CHW's work.

The above paragraphs describe that since the ASHAs are exposed, provided and surrounded by many Health Communication approaches and strategies, they would possess knowledge about them and their contextual use in different conditions. The ASHAs with a higher level of knowledge may know the appropriate use at individual, group and mass level for strategic objectives like awareness generation, counselling, behaviour change, mass mobilisation *etc.* Better knowledge level about Health Communication materials will offer a guideline to ASHAs and help shape her responses for use, effectiveness, barriers and needs of Health Communication Strategies in NHM.

Hence, the ASHAs may vary for their level of knowledge about various objectives of Health Communication Strategies covered under the study.

1.17.5.8 Media Use. Media use of the ASHAs, under study, is regarding her use of personal modes of communication and mass media. The ASHA is expected to be studied up to primary (8^{th}) level. It is possible that for keeping herself updated about the latest news she may be reading a newspaper, listening to the radio or watching television. She may use all these mass media for her interests, recreation and entertainment too. These are also the ways through which she may want to keep updating her health-related knowledge.

The rapid growth of telecommunication and mobile phones may have been part of ASHA's family. It is a mean to stay connected with family members for the

reasons of security and concerns besides, a mean to contact relatives, friends for maintaining family relations. This small device assists the ASHA to stay connected with health staff and with community/beneficiaries.

In present research one of the hypothesis is that the ASHAs with higher media use may use more communication strategies as they might have been benefited by them. ASHAs would better understand the importance of using various communication strategies to enhance her efforts in behaviour change, promotion of health and health service delivery. In this process, she might have faced some barriers with regards to availability, accessibility, infrastructure support from the health department and factors related to beneficiaries, staff and her capabilities. Her expectations in all these situations may differ with her use and barriers felt for media at a personal level/front.

Therefore, media use of ASHA- variable is also considered to be included in the present research on Health Communication Strategies under NHM in Chhotaudepur district.

1.18 Objectives of the study

1.18.1. To prepare **Profile of Existing Health Facilities** in Chhotaudepur district of Gujarat state.

1.18.2. To understand the **Process of Health Communication Strategies** from Chief District Health Officer in Chhotaudepur district of Gujarat state.

1.18.3. To seek **Recommendations for future Health Communication Strategies** from Chief District Health Officer in Chhotaudepur district of Gujarat state.

1.18.4. To prepare **Profile of the selected ASHAs** of Chhotaudepur district of Gujarat state.

1.18.5. To find out **Provision of Health Communication Strategies** to the selected ASHAs in Chhotaudepur district of Gujarat state.

1.18.6. To find out the **Overall Use** of Health Communication Strategies by the selected ASHAs in Chhotaudepur district of Gujarat state.

1.18.7. To study the **differences in Overall Use** of Health Communication Strategies by the selected ASHAs in Chhotaudepur district of Gujarat state with the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.18.8 To find out **Use** of Health Communication Strategies by the selected ASHAs in Chhotaudepur district of Gujarat state for the following activities:

i. Home Visit
ii. Planning and celebrating VHND (*Mamta day*)
iii. Visit Health Facilities
iv. Village Health and Sanitation Committee Meeting
v. Keeping and informing about records

1.18.9 To study **activity-wise differences in Use** of Health Communication Strategies by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.18.10 To study the **Perceived Benefits** of Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state.

1.18.11 To study **differences in Perceived Benefits** of Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.18.12 To find out **Barriers** related to Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state.

1.18.13 To study **differences in Barriers** related to Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.18.14 To study the **Overall Need** of additional Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state.

1.18.15 To study **differences in Overall Need** of additional Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state for the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.18.16 To study **Need of Additional Health Communication Strategies** expressed by the selected ASHAs in Chhotaudepur district of Gujarat state for the following activities:

i. Home Visit
ii. Planning and celebrating VHND (*Mamta day*)
iii. Visit Health Facilities
iv. Village Health and Sanitation Committee Meeting
v. Keeping and informing about records

1.18.17 To study **activity-wise differences in Need of Additional Health Communication Strategies** expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.18.18 To study **Provision, Use, Perceived Benefits, Barriers and Needs for Additional Health Communication Strategies** expressed by the Female Health Workers and the ASHA facilitators in Chhotaudepur district of Gujarat state.

1.19 Null Hypotheses of the Study

1.19.1 There will be no significant **differences in Overall Use of Health Communication Strategies** by the selected ASHAs in Chhotaudepur district of Gujarat state with the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.19.2 There will be no significant **differences in activity-wise Use of Health Communication Strategies** by the selected ASHAs in Chhotaudepur district of Gujarat state with the following variables:

a. Block
b. Age
c. Education Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.19.3 There will be no significant **differences in Perceived Benefits related to Health Communication Strategies** expressed by the selected ASHAs in Chhotaudepur district of Gujarat state with the following variables:

a. Block
b. Age
c. Education Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.19.4 There will be no significant **differences in Barriers related to Health Communication Strategies** expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.19.5 There will be no significant **differences in Overall Need of Additional Health Communication Strategies** among the selected ASHAs in Chhotaudepur district of Gujarat state in relation to the following variables:

a. Block
b. Age
c. Education Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.19.6 There will be no significant **differences in activity-wise need of Additional Health Communication Strategies** among the selected ASHAs in Chhotaudepur district of Gujarat state in relation to the following variables:

a. Block
b. Age
c. Educational Qualification
d. Work Experience
e. Occupational Skills
f. Training Received
g. Knowledge regarding Health Communication Strategies
h. Media Use

1.20 Assumptions of the study

1.20.1 Under NHM, ASHAs, ASHA Facilitators and Female Health Workers of Chhotaudepur district are provided with Health Communication Strategies for performing their prescribed roles under NHM.

1.20.2 ASHAs, ASHA Facilitators and Female Health Workers of Chhotaudepur district will express their use, perceived benefits, barriers and need of additional Health Communication Strategies under NHM.

1.20.3 The Selected ASHAs may vary according to the selected variables for their use, perceived benefits, barriers and need of additional Health Communication Strategies under NHM in Chhotaudepur district of Gujarat State.

1.21 Delimitations of the study

1.21.1 The present study is delimited to the data received from District Panchayat Office, Chief District Health Officer, Female Health Workers, ASHA Facilitators and ASHAs from all six blocks, regarding selected aspects of Health Communication Strategies under NHM in Chhotaudepur District, Gujarat.

1.21.2 Responses of the ASHAs are delimited to use and need of additional Health Communication Strategies for prescribed Five activities (*i.e.* Home visit,

planning and celebrating Village Health and Nutrition Day, visit health facilities, Village Health and Sanitation Committee meeting and maintaining and informing records) in ASHA guideline, perceived benefits and barriers related to Health Communication Strategies.

1.21.3 Responses of ASHA facilitators and Female Health Workers are delimited to provision, use, perceived benefits, barriers and need of additional Health Communication Strategies.

1.22 Explanation of Term

Health Communication Strategies

Combination of Health Communication tools-techniques (interpersonal, mid and mass media) broadly known/mentioned as IEC and Health Information Technology system (TeCHO mobile, e-*Mamta*, SATCOM *etc.*) broadly known/mentioned as ICT used under NHM for creating awareness, promoting, motivating, escorting, mobilising community people for availing health services, bringing desirable behavioural change, capacity building and strengthening health machinery and Health Management Information System across all stakeholders.

1.23 Operational Definitions

1.23.1 Provision of Health Communication Strategies

Availability of Health Communication Strategies for the functioning of ASHAs, ASHA Facilitators and Female Health Workers under NHM in Chhotaudepur district of Gujarat State.

1.23.2 Use of Health Communication Strategies

In the present research, it means use of Health Communication Strategies for performing the enlisted activities by ASHAs, ASHA Facilitators and Female Health Workers provided /available under NHM in Chhotaudepur district of Gujarat State.

1.23.3 Perceived Benefits of Health Communication Strategies

It refers to the perception towards benefits of Health Communication Strategies under NHM expressed by the selected ASHAs, ASHA Facilitators and Female Health Workers in Chhotaudepur district of Gujarat State.

1.23.4 Barriers related to Health Communication Strategies

It means barriers expressed by ASHAs, ASHA Facilitators and Female Health Workers with regards to various aspects related to Health Communication Strategies under NHM in Chhotaudepur district of Gujarat State.

1.23.5 Need for Additional Health Communication Strategies

This includes suggestions and requirements expressed by the selected ASHAs, ASHA Facilitators and Female Health Workers for improvements in Health Communication Strategies under NHM in Chhotaudepur district of Gujarat State.

1.24 Limitations of the Study

National Health Mission is an umbrella programme governed and implemented on decentralised, PPP, local target-based approach by Health and Family Welfare department through Inter-sectoral coordination and convergence among state departments like Women and Child Welfare Department, Department of Water Supply and Department of Information and Communications with Non-Government Organisations and other stakeholders. Health Promotion and Service Delivery is addressed by using Strategic Health Communication plan including interpersonal, mid media and mass media Strategies which may vary across the state and in the selected district.

Therefore, the present study has limitation to responses of Chief District Health Officers and grass-root level functionaries (ASHA Facilitators and Female Health Workers) and ASHAs towards provision, use, perceived benefits, barriers and need of additional Health Communication Strategies would be according to their exposure, training and their characteristics.