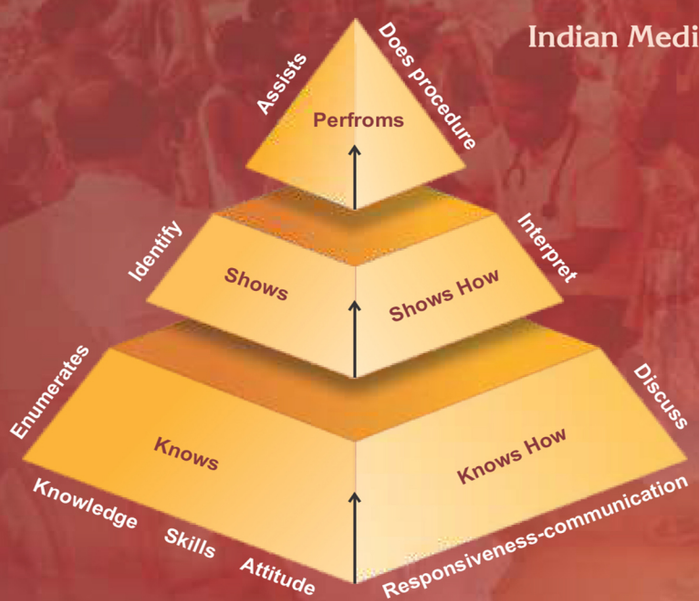
Eighth Edition

# Textbook of Community Medicine

## Preventive and Social Medicine

As per the latest CBME Guidelines |
Competency Based Undergraduate Curriculum for the
Indian Medical Graduate adopted by National Medical Commission




Sunder Lal
Adarsh
Pankaj

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CHAPTER

# 4

# Principles of Health Promotion and Education

Community medicine promotes healthy behaviours and lifestyles as: "Behaviour is the second most important determinant of health"; "Single biggest problem in communication is "illusion" that it has taken place"

*— George Bernard Shaw*

*Competency addressed:* The student should be able to:
**CM 1.6:** Describe and discuss the concepts, the principles of health promotion and education, IEC and BCC.

## HEALTH PROMOTION BY: HEALTHY PUBLIC POLICIES

Ottawa Charter of 1986 described the principles and practice of health promotion. The Ottawa Charter focuses on the following key strategies for health promotion:

i Building healthy public policy.
ii Creating supportive environments.
iii Strengthen community actions.
iv Develop personal skills by life skills education.
v Reorient health services for advocacy.

The goal of healthy public policy is health promotion, i.e. to enable people to increase control over and to improve their health. Healthy public policies mean "Health in all Government Policies/Sectors" such as water and sanitation, nutrition, education, development, agriculture, women and child development, sports, town and country planning, industry, etc. Health promotion is thus a multisectoral activity. Government policies must promote healthy behaviours and lifestyles such as avoiding tobacco, healthy diets, physical activities, personal hygiene, safe sex to promote positive health in schools and at workplace.

## HEALTH EDUCATION

### Health Determinants

The most important determinants of health are *environment*, *behaviour*, *health services* and heredity to some extent.

'Behaviour' comes next to environment. Behaviour means 'visible action or practice in an individual, family and community'. 'Behaviour' of an individual, family and community determines their 'health', hence all efforts must be made to promote 'healthy behaviours' to achieve the goal of 'health in all'.[1]

Healthy actions on the part of individual, family and community should become part of life to prevent diseases and promote healthy life. That is why the 'health education', 'IEC' and 'behaviour change communication' forms an integral part and one of the essential components of all the national health programmes and comprehensive primary healthcare in India. Communication of facts for life on reproductive and child health (RCH), communicable and non-communicable diseases and nutrition has been adopted as one of the important strategies and means to prevent diseases promote health by adopting healthy behaviours (Fig. 4.1).

'Health in all' remains a cherished goal to be attained by an individual, family and community. Goal is "the enjoyment of highest attainable standard of health" inclusive of all dimensions of health as defined by WHO.

'Health education' is an important mean and process to achieve the goal of 'health'. Thus, health education concerns itself with process of change, its aim is to help individuals, families and communities to attain and maintain positive state of health by their own 'efforts' and 'actions'.[2]

### Health Education (Definition)

"Health education (HE) is a gradual process of learning that informs, motivates and helps people to adopt and maintain healthy practices and lifestyles. It also advocates environmental changes as needed from time to time to facilitate this goal and conducts professional training and research for achieving the same end."

According to Lawrence W Green "health education is any combination of learning opportunities designed to facilitate voluntary adoption of behaviour which will improve or maintain health".

### Aims of Health Education and Principles

The main aims of health education are threefolds: First to *inform* and educate people on the principles of hygiene

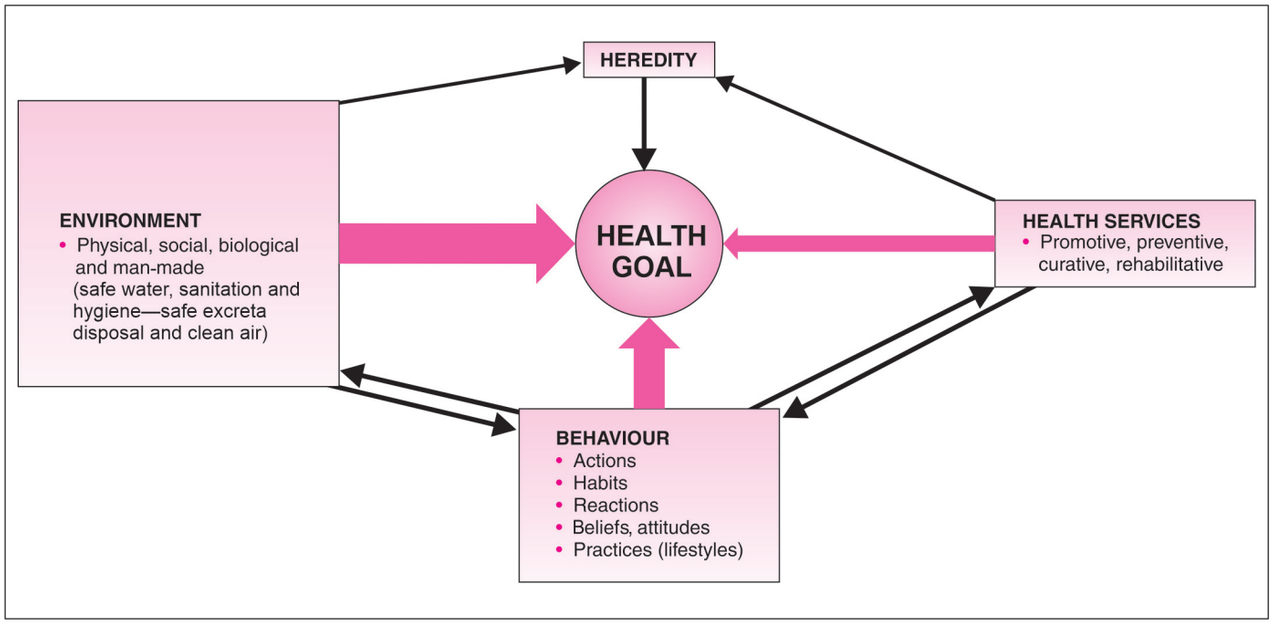



**Fig. 4.1:** Determinants of health and barriers to good health (WHO)

and healthy living; second to *motivate* people to change their habits and ways of living and practices that are detrimental to health; and lastly to guide people into *action* about the medical and health services provided for their benefit and encourage them to utilize these services.

There is a distinct shift from earlier strategies. To begin with, the emphasis was laid on awareness generation, which was considered necessary but not sufficient. Awareness is no guarantee that it will lead onto behaviour change. In India, awareness on contraception is almost universal (100%) but nearly 56.5% of couples practice modern contraception. Therefore, in second phase—health education and extension education strategy was adopted in 3rd, 4th and 5th five-year plan period.

Subsequently, we adopted the strategy of information, education and communication (IEC). Of late we have adopted a strategy of communication for behaviour change, which is much more comprehensive. The stages of evolution were as under.

Awareness generation (by mass media)
↓
Health education and extension education (mass media + interpersonal communication and opinion leaders camps)
↓
Information education and communication (IEC)
↓
IEC provides information, does not specify time frame, what and how behaviours, attitudes and practices to be changed as also the outcomes
↓
Behaviour change communication is more specific and comprehensive

**EVOLUTION OF HEALTH COMMUNICATION IN INDIA**

The shift in policy can be summed-up as:

| *Past focus was on* | | *Present focus is on* |
|---|---|---|
| Awareness generation | to | Behaviour change |
| Instructive | to | Empowering |
| Generic approach | to | Specific information |
| Centralized plan of communication | to | Decentralized approach |

**Behaviour change communication** is a dynamic process, which **specifies** the 'behaviour' to be changed within **specified time** as also **methods** and **outcomes** (*see* Table 4.1).

### Classification of Behaviours

It is an action or observable practice/practices in an individual, family and community. Most prevalent practices or behaviours can be classified into:

***Harmless:*** Such as wearing charms, amulets, worshipping and appeasing gods and goddesses. Leave these behaviours as such.

***Good behaviours and best practices:*** *Best practices*—exclusive breastfeeding, immunization, washing hands, eating clean food, drinking safe water, spacing births and limiting the size of the family, using iodized salt, brushing teeth, regular exercise, etc. These behaviours and practices are to be promoted through communication.

***Harmful practices:*** Early marriages, bottle feeding, drinking unsafe water, tobacco use, chewing pan-masala, excessive use of alcohol, unprotected sex with stranger

and physical inactivity are unhealthy behaviours, hence need to be changed. We have to analyze all the behaviours and practices and put them into these categories for appropriate action.

## PRINCIPLE 1—Define Objective, Target Audience and their Concern

### Health Information to People (Information for All)

Information means knowledge, ideas, emotions, skills and data on health. The fundamental **principle** of health education is to provide or give scientific health information or knowledge to people, which would empower them for self-reliance and actions. Health knowledge is a power and great mean to improve their health. On health/disease knowledge explosion has occurred and health technologies have made rapid advance. The knowledge and information on simple health technologies and advances is unfortunately confined to hospitals, doctors, paramedical workers and other health professionals. The knowledge and information has not reached to those who need it most. The poor, illiterate and disadvantaged have been deprived of 'vital health information and knowledge' which they need most to save their lives and of their children apart from promoting and maintaining their health. Adequate information on health is the right of everyone.

**Information,** which could enable parents and families to drastically reduce disease, malnutrition, deaths and disability among their children, is the **information,** which every parent should have. It is the **information,** which ought to be part of every family's basic stock of knowledge. It is the **information,** which ought to be part of the normal way of bringing-up children, and made available to every community through multiple channels. It is the information to which all families now have a right and almost all parents can put into practice, in some degree, at very low cost (UNICEF).

## PRINCIPLE II—Frame what you Expect from Audience

### Information Revolution

The coming decades should be observed as information revolution and communication (IRC) decades. All out, intensive efforts be made in these decades to create people movement for self-reliance in matters of health. Information which could enable individual, families and community, to reduce disease, malnutrition and deaths is the information which all must have. It is the information which ought to be made available to every community via schools, the radio, the television, the newspaper, the religious leaders, the health workers and every other possible means of communication and support. In other words, it is an urgent task of **mass communication** to most needy, the poor. Task is too big for health sector alone, others have to join hands and intersectoral approach will pave the way.

The following are top ten **messages** adopted from facts for life (UNICEF) for action, which are most relevant to our country and we can add to these messages, the messages of lifestyles and chronic non-communicable diseases which are emerging fast in our country besides the epidemic of HIV/AIDS and accidents and COVID-19.

1. The health of both women and children can be significantly improved by spacing births at least 3 years apart, by avoiding pregnancies before the age of 18 and after 35 and limiting the total number of pregnancies to two or less.
2. To have safe pregnancy by having adequate prenatal check-ups and safe delivery by trained person.
3. Exclusive breastfeeding for first 6 months of life and adequate complementary feeding after 6 months of age by home available foods.
4. Complete all immunization by one year of age and get booster doses at 1 and ½ years of age and every woman in child bearing age should be immunized against tetanus.
5. Diarrhoea kills by dehydration (loss of fluids from body). Home available fluids, breastfeeding and ORS prevent dehydration and deaths due to diarrhoea. Handwashing before eating prevents diarrhoea.
6. Most coughs and colds get better on their own. But if the child with cough is having difficult and fast breathing and there is indrawing of chest, then the child is seriously ill and it is essential to go to a health facility quickly. A child with cough and cold should be kept warm, continue breastfeeding, give more fluids and continue feeding.
7. Children under 3 years have special feeding needs. They need to eat 5 to 6 times a day. Adequate feeding of young children is essential for their growth. Fats and oil should be added along with vegetables. Whatever is cooked in home should be fed to child in enough quantities.
8. Many illnesses are caused by germs and germs enter the mouth. This can be prevented by clean eating, drinking safe water, and handwashing with soap and water and by using sanitary latrines.
9. After each episode of illness, one extra meal should be given to every child for a few days to make-up the losses due to illness.
10. All girls and boys should be enrolled in schools at the age of 6.

Malaria, HIV/AIDS, injury prevention and disasters and emergencies are other areas.

We can add to these the messages on: Healthy lifestyles, such as no smoking, no alcohol, and regular exercise, maintaining appropriate weight, eating healthy foods, avoiding junk foods and regular brushing can prevent many illnesses (chronic diseases).

## PRINCIPLE III—Select Right Channel

The major task remains as **how to communicate** the **available information** and **knowledge** to individuals, parents, families and community in rural, tribal, and urban

slum areas. Communication for behavioural change has become a major strategy in reproductive and child health as also for all other national health programmes.

We have over 10.72 lakh ASHAs, 13.4 lakh *Anganwadi* workers, 180769 health worker females, 52696 male health workers, 161829 sub-centres, 31053 primary health centres and 6064 community health centres and manpower of Indian system of medicine and non-governmental organization to inform and educate people besides self-help groups and system of village *Panchayats* and *Nagarpalikas*. Thus, India has a massive manpower to reach rural and urban slums of the country. Apart from this, the system of elementary education is near universal to reach every village to cover the schoolchildren for inculcation of healthy lifestyles and healthy habits. If the knowledge and information is made available to target population and is acted upon, it will save millions of lives and disabilities. It is needed most in India.

**Expected outcomes:** The student classifies observed behaviours into harmless, beneficial and harmful and prepares health messages.

*Competency addressed:* The student should be able to:
**CM 4.1:** Describe various methods of health education with their advantages and limitations.

## Various Methods/Strategies/Approaches in Communication/Health Education their Merits/Demerits

Three approaches are commonly used, individual, group and mass communication/education.

### *(A) Interpersonal (Individual Approach)*

It is one-to-one communication, which happens during home visits by health workers when they contact family and care givers. It is most precise and specific communication dealing with the precise needs of an individual for behaviour change communication (BCC).

#### *Merits*

It occurs in most friendly manner. It is also called interpersonal communication (IPC). It is most interactive and participatory. Message passes directly from source to receiver.

Interpersonal communication skills of workers need to be sharpened through training and retraining in group dynamics, group discussions. Home visits programme of health workers, their beat programmes should focus attention on interpersonal communication based on individual's health needs and suggest home-based actions within the capacity of family. Every contact of worker with the people should have an element of need-based education. This should be the major strategy in the clinics and hospitals. Support health education material (printed and visuals) and case material or live situations can enrich the interpersonal communication process.

**Demerits:** Reach in limited coverage is minimal, and it is time consuming activity.

#### *Enhancing Interpersonal Communication*

Interpersonal communication can be enhanced by:

- Empowering *Mahila Swasthya Sanghs* (MSS) who could take responsibility of contacting married women in their neighbourhood on regular basis.
- ICDS functionaries like *Anganwadi* workers and health workers should be trained together and make joint home visits for interpersonal communication.
- *Mahila Mandals* and *Mahila Arogya Samitis* and elected women *Panchayat* members and ASHAs can spearhead interpersonal communication in RCH programme to the best advantage of women in reproductive age group.
- Interpersonal skills—to be nice, polite, friendly, empathic, and patient.

### *(B) Group Communication/Group Discussion*

When health worker female organizes a small group of *Mahila Swasthya Sangh* (10–20 women), she organizes a group discussion and group meets to discuss a common problem say problem of anaemia in pregnant women it is called group communication. All members of the group are encouraged to participate and express their views and come to an agreed upon solution for an identified problem. In a group discussion, group dynamics are important. Many methods are used in group communication, it could be a demonstration, discussion, an audio-video show, organized listening and watching television, question–answer, etc. It all depends upon the communication skills of health workers and their supervisors. Group communication with *Mahila Swasthya Sangh, Mahila Mandal*, village *Panchayats*, self-help groups and adolescent girls and boys could be most rewarding experience. Health workers must be trained on how to organize a group communication. Sitting in a circle and semicircle, on ground or on chairs, provides an opportunity of visual contacts and generates a sense of equality amongst all group members. In this arrangement, group members can see each other and can interact in a friendly manner. Regular Village Health Sanitation and Nutrition Committee meetings must be organized at *Anganwadi* centre once a month.

## Merits of Group Discussion

It is participatory method of education and two-way communication process based on felt needs. Group discussion is a process in which a group of individuals come together; deliberate on an issue or problems so as to arrive at a solution or consensus opinion. In this process the group goals are jointly set, all the members participate and contribute to group discussion, usually facilitated by a leader, find solution, evaluate their effectiveness and finally try to arrive at a consensus.

*Anganwadi* workers and health workers have been made responsible to organize mother's meetings once a week and *Mahila Swasthya Sangh* meeting/VHSC meeting once a month at the village level. This has been done to enhance **interpersonal communication** for behaviour change on pressing problems, such as breastfeeding, illegal abortion or sex-selective abortions and PNDT Act, sex-ratio of under six children, anaemia and maternal mortality, safe pregnancy and safe delivery.

### Demerits

Workers have seldom organized group meetings and they have seldom been adequately trained to organize meaningful group meetings. The purpose is not clear and end results are obscure. Hence, the health manager should take-up this challenge to build capacity of health workers for organizing women groups, group formation, group dynamics, group discussion and ensuring their regular meetings at least once a month. Every month, a chosen subject is discussed by a group of women. It can be organized more frequently with the help of *Anganwadi* worker, traditional birth attendants and accredited social health activist (ASHA).

Women are already busy and have least time for group discussion. This is a big challenge. Only meaningful, informative and interactive group discussion lasting for 30–60 minutes time is enough. If women cannot come out because of busy work schedule, the smaller group meetings can be held during home visits to discuss the pressing problem and behaviour change.

### *Essential Component of Group Meeting*

The group size consists of 10–15 men or women of a locality. Priority should be women of economically weaker sections. The group could be homogeneous say—pregnant women, lactating mothers, women having children below 2 years of age, and adolescent girls. There could be heterogeneous group as well.

- The day/date of meeting should be well publicized and place should be well prepared for their reception.
- The meeting should be organized at familiar place, like *Anganwadi* centre, *Mahila Mandal* premises, or sub-centre. It should be easily accessible.
- Make arrangement for sitting. Everyone in the group is equal. Prefer a circle or semicircle arrangement.
- Select a most pressing problem you wish to address or women feel to know/understand.
- Arrange or obtain learning resource material—printed material, posters and demonstration material if possible. Demonstration is best method in a group.
- Health workers should act as facilitators and not as teachers and they should not talk at people.
- Let women discuss the chosen problem themselves and arrive at a solution. Let women express different/ divergent views on the chosen subject. The health workers should facilitate and ensure that everyone participates. Health worker's responsibility is to prepare notes or record salient points of discussion and provide supportive information on the subject.
- Prime role of the worker is to listen attentively all the viewpoints and discuss the various facilities made available at village *Anganwadi* centre, Sub-centre and PHC.
- Worker should never forget that women themselves and family itself are very important resource to deal with the identified problem.
- The group must reach to a consensus decision and workers must ensure follow-up actions on decision made to build confidence amongst the women group. It should not be merely a discussion but followed by a concrete action either by women or by family themselves or with the supportive services available at various levels.
- Group discussion, which are purely theoretical are least effective. These can be made most productive and interactive by use of demonstration, women-to-women communication of a life experience, such as use of copper-T as spacing method, preparation for safe delivery, early breastfeeding initiation and exclusive breastfeeding, and immunization.
- The workers in group discussion should never sit on chair and act as teachers, they should sit with women on mat.
- It is better to identify a group leader on voluntary basis to conduct meeting and regulate time.
- Refreshment during group meeting is optional, it should be offered by community and women group leader and not by government expenses.

During the group discussion, if health manager or supervisor is available, it provides additional support and it enriches group discussion and status of discussion rises, but health manager must sit with women group and have face-to-face discussion.

In this manner, direct feedback can be obtained from group.

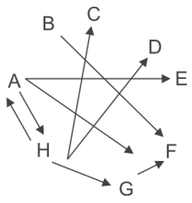
### *Role of Members*

Some members in the group dominate and do not give chance to other women to speak, this should be discouraged and controlled by group leader.

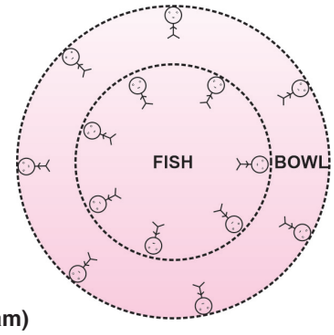
Some members keep silent and do not participate at all. Encourage such women to speak on the issue and tell them nothing is wrong or right. Other members obstruct and disturb the proceedings and they play negative roles, discourage this practice. Some women are quite positive they give information and seek more information and promote harmony in the group, some members may even be hostile and some are engaged in mutual discussions.

Interaction between group members and interaction of group members with the facilitator/resource person during group discussion is known as *group dynamics*. This can be shown by arrows (who interacted with whom and how many times). If arrows are connected it becomes a *sociogram*. Regular group discussions provide lot of feedback

to improve the health services. The students can be given this exercise for better comprehension of group dynamics.




**Group dynamics (sociogram)**




**Fish Bowl**

### Fish Bowl

The group sits in two circles. Inner circle group members (FISH) deliberate a problem/issue to arrive at solution. The outer circle group members record, and observe the behaviour/interaction of each member of the inner circle group and later on present and discuss in the group. This is known as **fish bowl formation** in group discussion.

### Focus Group Discussions (FGDs)

Focus group discussions are thematic discussions among small homogenous group of potential programme beneficiaries. It is a method of learning directly from the 'clients' in the clients own words, what they think of certain products or why they uphold certain practices and what benefits they hope to experience from both. FGD is a technique adapted from **applied psychology** to obtain 'top of the mind' responses from clients or beneficiaries of the programme. A theme is chosen on the basis of observations made by the workers during their home visits or contact with the clients during mother and child protection sessions or contacts at sub-centre or *Anganwadi*. The theme could be use of ORS to prevent dehydration and deaths in children having diarrhoea or use of home available fluids to prevent dehydration.

***Participants in FGD:*** Their number should be 6–8. They could be young mothers with child under 36 months, whose child has had diarrhoea at sometime in the past. The FGDs are conducted by a moderator and someone takes the notes and analyses the results of discussion. Recruiters recruit the participants. This way consultation of consumers is obtained and right message for right client, at right place and right time is delivered, suited to their need and cultural practices.

FGD method is commonly used in social marketing to popularize a product or service such as contraceptives, ORS, immunizations, etc. Thus, FGD is an extremely valuable research technique and can be used along with other research techniques to collect information directly from the clients on behaviour change communication (BCC) needs.

### *Projective Methods*

Like FGD, projective techniques are also adapted from applied psychology to collect data on perception of individuals or more complex emotional information. The projective tests have been standardized to know the personality of a person. Standard set of pictorials are used and inferences drawn based on established criteria. We can analyse the make-up of a person by these research methods.

### *Case Study Method*

This method conducts in-depth analysis of a social unit and is widely used for learning purposes and assessing Communication and management needs (CNA and MNA). Case could be an institution such as functioning of sub-centre or primary health centre or it could be a person such as work schedule or home visit of health worker or it could be a disease event or beneficiary of a programme.

### *(C) Mass Communication—Merits*

Radio, television, and print media (newspapers) reach and communicate masses and **cover a wide geographical area** and population in short time. The message can be disseminated to large population with a clear focus on target groups. This is known as mass communication. The mass communication is most **cost-effective** and is primarily used to generate awareness and impart knowledge to masses. It needs to be followed up and supplemented and supported with group and individual communication to facilitate the process of adoption and acceptance of a practice. Family planning programme used mass media to build-up awareness and as a result, now the awareness about contraception is almost universal (100%) but 56.5% are using modern contraceptives. Similarly, pulse polio programme used mass media at national level to build a favourable climate and message through a popular actor (Amitabh Bachchan) ***Do Boond Zindgi Ki*** (two precious drops of polio vaccine for life) had a mass appeal for massive social mobilization. Similarly, message of Honourable Prime Minister on polio had mass appeal. Mass communication must be supported by services and accessibility to quality services to achieve the desirable success.

Commercialization of media by producing audio-tapes and video-tapes for self-learning and learning at family level on the pattern of social marketing strategy can go a long way. Weekly audio messages in "KILKARI" and SMS Messages in "Mother and Child Tracking System is a revolution".

### Demerits

It is a one-way communication.

### Effects of Communication

The health message reaches the audience, they gain attention, understand, accept it, change their behaviour leading to improvement in health.

The most important effect of communication is change in behaviour. Effective communication results into change in behaviour or practice. There are three main effects of communication.

1 ***Change in knowledge:*** It adds on the knowledge and builds 'cognitive domain' and generates awareness.
2 ***Change feelings/attitude:*** Attitude means a human attribute indicating a particular mental state or an outlook to life. It mainly includes affective domain chiefly related to feelings, moods, thinking, thoughts, emotions and inclinations. The communication may lead to change in thinking and perception of an individual, group or community. This is second effect that the feelings (attitudes) may change. Negative attitudes may change to positive attitudes and often indicates an action that the individual may take.
3 ***Behaviour change:*** Change in action (practice). These are changes in overall behaviour, such as adopting a contraceptive, quit smoking, starts brushing teeth, and ultimately reduction of fertility, incidence of disease and improved health status.

These three changes usually occur in sequence that is a change in knowledge precedes change in attitude which precedes change in behaviour, but not always; attitude change often follows an action.

### Adoption Process

Emerging out of interplay of ideas in a given environment, the communication leads individuals and communities to 'action' passing through stages of awareness, interest, evaluation, trial and adoption. Thus, the diffusion of new ideas and knowledge passes through distinct stages:

1 ***Awareness:*** In this stage, the person acquires new knowledge about the issue or his health need.
2 ***Interest:*** In the second stage, person develops interest and seeks more knowledge to solve the problem.
3 ***Evaluation:*** In this stage, the client evaluates the pros and cons of the decision involved, evaluates its usefulness to him or her and this may result in decision.
4 ***Trial:*** The method, idea, or skill is tried. The idea may be tried out on himself or a friend or other trusted source, such as relative. The person seeks the approval of friends and relatives at the trial stage. During the stage of trial, the health system should support the person in implementing the decision and see that he/she succeeds in the attempts. The support may include health counselling, providing supplies and referral services.
5 ***Adoption:*** If the result of trial is good the method, idea, or best health practice is adopted for regular use.

*Competency addressed:* The student should be able to:
**CM 4.2:** Describe the methods of organizing health promotion and education and counselling activities at individual, family and community settings.

## METHODS OF ORGANIZING HEALTH PROMOTION, EDUCATION AT INDIVIDUAL, FAMILY AND COMMUNITY SETTINGS

### Learning Health Behaviour

Most of health behaviour is learned through:

#### *Family*

The foundation of learning (behaviour—healthy practices) is laid by the family and its environment.

The first school for child is the family. Family and parents have the responsibility to cultivate healthy behaviour in their children. The behaviour or practice of washing hands, wearing shoes, using toilets, brushing teeth and no smoking, dietary habits are developed and nurtured in the family and in home. Parents have to become ideal role models for their children. By the time the child is 5 years, over 80% of his brain gets developed. ASHAs and AWWs regularly contact families by home visit for health promotion and education.

#### *Extra-familial Institutions*

*Anganwadi* and creche are extra-familial institutions where the young children learn a lot. Here learning is informal and through play-way activities and it is joyful learning. *Anganwadi* workers provide varieties of stimuli and lay down foundations of physical, mental and social development and motivate parents to provide learning stimuli at home. Habit of handwashing, brushing teeth, rinsing mouth, eating clean and eating enough, nail cutting, getting themselves weighed, use of toilet/sanitary latrine, drinking clean water and playing safe are promoted by AWWs apart from language and psychomotor development. It has positive influence on parents who continue what *Anganwadi* workers initiate and vice versa is also true. This is a first or initial organized step in education and health promotion.

#### *School—Right to Education Act*

It is a formal institution of learning. Elementary education infrastructure is universal. Learning in school is a cherished memory for lifelong period. The teachers are role models for the taught. Universal elementary education, schooling of minimum of 8 years for everyone is a nation building activity apart from personality development and developing 'healthy lifestyles' and value system. It is sustainable development goal 4. Personal hygiene (washing hands, brushing teeth, nail cutting, balanced diet, drinking clean water, no smoking, regular exercise, etc.) is best learnt in schools during an hour of socially useful and productive work (SUPW). Teachers leave an indelible impression on the minds of students.

Health and nutrition, reproductive health, adolescent health practices can be best improved and built in the schools through curriculum and extracurricular activities. Not only children learn themselves but also they act as ambassadors of health to their families and neighbourhood.

Learning through peers has great influence on the life of schoolchildren. The learning continues in colleges. Prevention of HIV/AIDS and reproductive health can be taught at appropriate age.

### Ayushman Ambassadors

Ayushman Bharat aims to create about 2.2 million teachers—one male and female teacher as Health and wellness ambassadors in 1.1 million government schools. These Teachers will be trained to transact health promotion and disease prevention sessions of one hour every weak on every Tuesday. These health promotion sessions will promote healthy lifestyles of young children and adolescents and use students force to act as messengers to communicate messages to their family and community. Health promotion strategy has been laid down in the National Health Policy 2017—"Health in all". The states would plan coordinated action plan on seven priority areas for health promotion through inter-sectoral convergence. Convergence is visible and operational with education department for school-based health promotion, for Rashtriya Bal Swasthya and Kishore Swasthya Karyakarm, Pre-school health promotion through ICDS at *Anganwadi* centres, and water and sanitation department for safe water supply.

#### *Population Education*

It was an effort initiated under family welfare programme by Government of India with an emphasis on life cycle approach—population education for the young. Its focus is young adolescents in schools, colleges and out of schools; systematic population education by formal and non-formal methods was one of the important planks of the revised family welfare strategy. In pursuance of the revised strategy, population education was introduced in the school education system, adult education programme and higher education system in the country with UNFPA assistance. Population education messages were included in the textbooks of schools through National Council of Education, Research and Training (NCERT). The emphasis was on population explosion, trends, raising the age of marriage, safe motherhood and spacing, child survival (ORT and immunization), antenatal and postnatal care with stress on women's status to counteract the son preference and to promote male responsibility.

#### *At Sub-centre, PHC, CHC/Hospitals (Health Facility)*

These are the storehouses of information and learning. The education and information is provided or targeted to specific groups like women in reproductive age group, eligible couples, pregnant and nursing mothers and young children. The focus of education is reproductive and child health besides the major killer diseases, their prevention by immunization and by other means. Adequate information depends upon the skills of person managing such institutions as also availability of information material in such situations. These institutions can enrich the process of education by demonstration and participation of mothers and families in the total process during home visits.

These institutions can provide organized information for action and are available to offer any clarification and remove doubts of the clients. During waiting time in hospital, patients and attendants can be provided health information. Home visits focus on specific health need of household with precise health information for action.

#### *At Workplace*

The owner or corporate house/industrial set-up or business organizations have the responsibility to provide health information to their staff, regular health check up, healthy environments, healthy diet and physical exercise. Peers have great influence on the behaviour of the person. Peer education holds the promise in these situations.

Swasthya Nagric Abhiyan—*see* page 54.

## COMMUNICATION SKILLS IN HEALTH

*Competency achievement:* The student should be able to:
**CM 1.9:** Demonstrate the role of effective communication skills in health is simulated environments.

### Definition

Communication is a process of transfer of information (including ideas, emotions, knowledge-skills, data, etc.) from a person or persons to others. Daily in our life we perform activities of **listening, speaking, reading, writing, Reasoning** and take recourse of facial expression, gestures, movement of hands and arms, body movements and feelings. Spoken words are the most important means of communication. We call it oral or *verbal communication*. We also communicate through facial expressions, gestures and body movements, signals, which we call *non-verbal communication*.[3]

### Purpose and Goal

Communication has a purpose. Identify the behaviour you would like from your audience. Single over-riding communication objective (SOCO) guides the communication strategy. Purpose and goal of communication is to change behaviour of people. Promoting and adopting healthy behaviours, which improve and maintain health and discontinue behaviour, which is harmful to health.

### Verbal or Oral Communication

Spoken words are often the most common means of communication. **Oral method** of communication is a weak

method of communication. Some doctors and health workers are very good in speech and they articulate it so well that it leaves indelible impression on the minds of people. Most often, we 'talk at people', it should be discouraged. This is authoritative communication. 'Talking with people' by group discussion, demonstration of a good practice and having return demonstration are the examples of *participatory communication*. Discussing the results of growth monitoring with mothers is *participatory communication*. Verbal/oral communication, which is traditional or conventional method of communication, can be enriched by use of pictorial and action photographs and live situations like demonstration techniques, which leave good impression and motivate people to accept the things.

### Non-verbal Communication

Body language and silence also communicates a lot and makes much more sense. You communicate through visual contacts, nodding your head, symbols, movement of your body parts, facial expressions, gestures, sadness and anger. Combining verbal and non-verbal skills is an art to enrich the process of communication. One should learn how to interpret body language.

*Anganwadi* worker in ICDS programme uses her skills of non-verbal communication for developing cognitive, affective and psychomotor domains in young children through play-way activities.

### Elements of Communication Process

There are various elements of communication process which are: *Source* of information, *message* or content of information, *channel of information,* the *receiver* of information and *feedback*.

#### *Source*

The first element in the process of communication is the source. The source is the originator of the message. The source can be an individual, group of individuals or an institution or an organization. The source of '*Hum do Hamare do*' message was the Government of India. The source should be credible, accessible, acceptable and legitimate. Source creates an idea (ideation) or chooses a piece of information for communication.

"Only 10–30% of ever married women in India had comprehensive knowledge of HIV/AIDS." The most important source of information on HIV/AIDS to these women was television (78.8%) followed by radio (41.5%). About one-third of women who know AIDS also report receiving information on AIDS from friends and relatives. Health workers appeared to be marginal source of information on AIDS (3.6%).

Similarly, family planning messages disseminated through mass media were seen or heard by 60% of ever-married women in India. The most common source of message was again television. 44% of women reported having seen a family planning message on television and 38% heard on radio. The major source of pulse polio immunization (PPI) happened to be *Anganwadi* workers.

#### *Message*

The message is an idea or information being communicated. The message is the intended action, which the source wishes the receiver to take. The message links the source and receiver. The message should be very simple, in local language and dialect, easily understandable and action oriented. Longer the list of actions lesser is the likelyhood to perform any of them. The message should be pretested among the intended audience before being communicated. Too often, the messages are designed centrally and may not be relevant to specific situation. The messages and pictorials (visual literacy) should be produced locally. A picture is worth thousand words. It should address both men and women and would be most effective if this is supported by adequate supportive services and information. For example, message "get your child fully immunized before 12 months of age" will go well if vaccines are made available when the children need these with arrangement of safe injection. Further the message should address the most significant problem or needs of target groups. **Message creates demand** and we must have arrangements to meet these demands.

##### *Key Messages*

1. Space births at least 3 years apart—use spacing methods. Why? For healthy mother and healthy child, to improve chances of survival, to avoid low birth weight babies, to reduce anaemia in mothers, to reduce morbidity and mortality in mothers and children. The risk of death for young children is increased to 50% if interval between births is less than 2 years.
2. Becoming pregnant before 18 years and after 35 increases the health risk for both mother and child.
3. Know AIDS for no AIDS.
4. Prenatal sex determination is unlawful.
5. Sex test of foetus is illegal.
6. Diarrhoea can be killer.
7. Deaths due to diarrhoea can be prevented by giving plenty of fluids, home available fluids, ORS and feeding.
8. Breastfeeding is best for a child and a complete food for child up to 6 months of age.
9. Hypertension is a silent killer.
10. Use iodized salt only.
11. Tobacco kills, tobacco causes cancer.

#### *Channel of Communication/Select Right Media*

The channel is the means or vehicle by which the message or information travels from source to receiver/audience. The important channels of communication are media (television, radio, newspaper or print media), person-to-person, telephone, or satellite transmission. The choice of channel is important. To ensure maximum coverage of audience

or receivers, more than one channel can be used to convey the message or information. Ownership of television in urban areas is 76.7% and in rural India is around 33.4% while radio ownership is maximum 93.3% of households own mobile phone. Apart from mass media, interpersonal communication channel should be extensively used. Health workers should increase the frequency of home visits and contact with family and women in reproductive age group and adolescents. At the moment, 7–31% of women in rural and 10% of urban women have received a visit of health worker in the past 1 year which is quite distressing.

### Receiver or Target Audience

Define your audience and their concern. *Seek first to understand then to be understood*. Who are the target audience or receiver of information and specific messages? Target audience needs to be segmented according to their knowledge, beliefs and practices, incidence and severity of illness or health problems, literacy level, economic level, geographic locations, media reach and social network. The audience or receiver is not the end-point. Audience segmentation is seldom done. Examples of target audience are:

1. Currently pregnant women.
2. Married women with 1, 2 and 3 children.
3. Adolescent boys and girls.
4. Women with child below 6 months (lactating mothers).
5. Newly married couples.
6. Community leaders—men and women.
7. Health workers male and female, ASHAs, AWWs and their supervisors.
8. Women who have accepted IUD or satisfied customers.

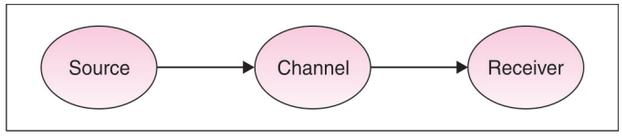
### Feedback

Feedback is an essential element of communication. Feedback is the reaction or response of the receiver to the source. Feedback from receiver helps the source to improve the message and information or its modification. An experienced and wise communicator is always keen to get a feedback and continuously modifies his message in the light of what he observes or hears from the intended audience. Without feedback, the communication is one-way traffic or one-way communication. In a group discussion, the feedback is obtained on the spot.

### Case Study in Communication

After audience research on listening and reading habits we launched a programme of "Radio in support of mother and child development". Organized listening groups were formed with the help of AWWs, who acted as group *animators* (a local person chosen by community trained in communication who canvases from house to house and facilitates 'mother's meeting'). After listening the broadcast programme, the reply paid letters received from AWWs (incorporating the views of mothers who listened the programme) helped us a lot to improve the programme. Continuous feedback from audience is seldom obtained hence it is weakest element in the system of communication. Continuous feedback guides the source and planner to improve the contents of message and better management of the programme.

## ONE-WAY AND TWO-WAY COMMUNICATION MODELS



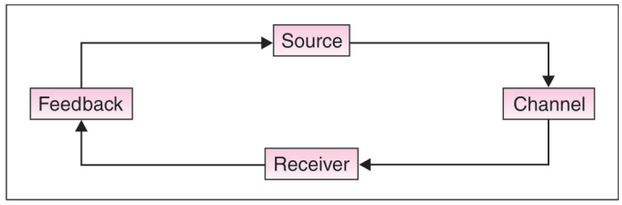

**One-way communication model**

i Systems that provide health information to the user (one-way communication)

ii Systems that tailor specific information to the user unique situation (customized communication)

iii Systems that allow the user to communicate and interact with healthcare providers or other users (two-way communication).

When the source is communicating the information to receiver or audience and there is no feedback it is one-way communication. It has many disadvantages.




**Two-way communication model**

When there is feedback from receiver to the source it is two-way communication.

*Example:* When mothers are involved in growth monitoring and their reactions are obtained, it is two-way communication. When AWW weighs alone and mothers are not involved, it is one-way or no communication. Mass media is one-way communication most of the time. Interpersonal communication is two-way communication.

*Competency addressed:* The student should be able to:
**CM 4.3:** Describe and demonstrate steps in planning, organizing, implementation and evaluation of health communication/education programme

## Steps in Planning, Organizing, Implementation and Evaluation of Health Communication/Education Programme

Planning of health communication means who says what to whom, where, when, how with what effect and why?

This involves collecting data on Knowledge, attitudes, beliefs, practices, and information on channels reaching to potential beneficiaries of a programme. This requires application of epidemiological and behavioural sciences to the selection of appropriate objectives and planning of communication processes as explained below:

### (a) Planning

The objectives must be defined—what behaviour needs to be changed and within what period? Example is 'to increase the acceptance of condom from current level of 9.5% to 12% within a span of 4 years' could be objective. You must define objective for communication (single over-riding communication objective (SOCO) to guide the strategy) as illustrated in Table 4.1.

### (b) Communication Needs Assessment (CNA)

Determining the communication needs means measuring the prevalence of knowledge, attitudes, beliefs and practices specific to a chosen problem. This can be done by contacting the clients through routine visits and annual survey of eligible couples, or any opportunity of contact with mother or parents, such as immunization sessions. Communication needs are seldom assessed. Communication needs assessment (CNA) are to be listed client-wise, family-wise; so that these can be met **(a best practice)**.

*Example:* Need of newborn is survival, breastfeeding, asepsis, clean cord. Communication should focus on these needs. Know the practices and list the harmful practices and change these harmful practices to **best practices,** focusing on most urgent ones, which save lives. In short know your people, know their knowledge, attitudes, beliefs, practices, myths, and misconceptions on the issues of MCH and family welfare and NCDs.

#### Key principles of communication

i Define your target audience
ii Understand the concern of the audience
iii Frame what you expect from audience—the expected behaviour of audience.
iv Select the right media
v Find the right tone

### (c) Define your Target Audience and Understand their Concern

Seek first to understand the audience then to be understood. Identify the families, which need your help most. Weaker section of community or those families which have problems; families having pregnant women, infant and young children could be your target audience. Segment your audience based on their economic status, caste and literacy, practices/behaviour. Segmentation is essential as one size does not fit all.

### (d) Message: Frame what you Expect from Audience

Message should be specific. It should not only generate awareness but also lead onto behaviour change. In family planning, messages on promoting the norms of small families are disseminated to build up an awareness rather than providing method specific information to clients. Provide information on all methods to promote informed choice. Adequate education material must be made available to communicate message to target groups.

### (e) Selecting Right Channel to Reach the Audience

Select appropriate channel of communication, such as television or radio, print media, women groups (MSS), health workers (male and female) and person or persons (inter-personal channels) whom you think to be most effective. It should reach to maximum number of clients; the intention is maximum coverage and channels chosen must be effective to carry the message to target audience. Always use multiple channels to enhance the coverage. Priority channel for each audience needs to be selected and planned.

### (f) Tracking Clients to Sustain Behaviour Change

After messages have been given, these must be repeated. Use a tone that will create trust with audience (empathy) and keep contacts with the clients to observe the effect of communication and measure your success and failure and learn lessons from those who have understood your message and who have changed their practices and who have adopted a method of contraception, etc. Sustained contacts with client build a mutual trust, increase understanding and generate confidence. Right now the health workers ever talked to only 24% of females non users of contraceptives, it means tracking of client is very low or insufficient. Information on all these elements (a to f) is collected for evaluation.

Manage activities within the budget provided and train the staff for communication (particularly on communication skills and organization of groups and use of educational material).

*Competency addressed:* The student should be able to:
**CM 4.3:** Demonstrate and describe the steps in evaluation of health promotion and education programme.

**Objective:** The objective of this competency is to assess the **gaps** in health communication for behaviour change communication.

### (g) Steps in Evaluation

Finally, we need to evaluate the results of communication. Evaluation means change in KAP as a result of health education. The evaluation is done by the workers themselves during their home visits and contacts with the audience or clients, exit interviews as also through annual surveys and updating of couples or through district rapid household surveys under RCH programme.

i The knowledge can be evaluated by asking standard questions about a specific problem.

ii The feeling (attitudes) can be evaluated by 'Likert scale'—a scale measuring the degree to which people agree or disagree with a statement; usually on a 3–, 5– or 7– point scale.

*Example:* Spacing births 2 years apart is good for the health of mother and survival of child (statement).

*3-point scale:* Agree.....neutral.....disagree

*5-point scale:* Strongly agree.....agree....neutral... disagree.....strongly disagree.

iii Behaviour change—practices can be evaluated by observations—like practice of washing hands, nail cutting, delivery room, cord cutting, cooking food and feeding practices.

The prevailing pattern of evaluating health promotion and education programme is to just count the activities generated such as number of clients contacted, number of orientation training camps held, handouts distributed, villages visited, group discussions held, film shows held, leaders contacted, etc. However, real test of effectiveness is how many individuals have changed their behaviour in terms of thinking, feelings and actions/practice. This involves collecting information on current behaviours/ practices (base line data) and expected behaviour/practice after a specified time interval (repeat or annual survey data) to know the effects of sustained health education/health promotion intervention as shown in Table 4.1. Varied methods of evaluation can be adopted (*see* Chapter 16: Monitoring and Evaluation).

### How?

Learner can assess the knowledge, belief, attitudes and practices of potential beneficiaries of a specific national health programme (immunization, FP, HIV, NCDs) by exit interviews, observation, group discussion and interaction with community and family, adolescents, and school teachers.

NFHS 1–5 have been undertaken nationwide to provide useful information on evaluation of communication efforts. Similarly, behavioural surveillance surveys under National HIV/AIDS Control Programme provides useful information on evaluation for further action to improve the communication process. The process evaluation is most important.

The communication gaps, barriers, health seeking behaviour, and needs as identified by NFHS 4 and 5 in 2015–21 were:

1 Among the women aged 20–24 years, almost one-quarter 23.3% got married before 18, the legal minimum age of marriage.
2 The total fertility rate was 2.1 in rural and 1.6 in urban area which indicates high fertility rates in rural area.
3 Teen age (15–19) contributes to 6.8% of total fertility.
4 Nearly 64% of children under 6 months of age were exclusively breastfed.
5 Early initiation of breastfeeding (<1 hour) 41.8%.
6 Sex ratio at birth for children born in last 5 years 929.
7 Female sterilization is predominant method of contraception, men participation is low; only 0.3% of men accepted sterilization against 37.9% of women.
8 High maternal mortality rate of 97 per 100,000 live births.
9 Nearly 58.1% of mothers received at least four or more antenatal check ups.
10 15.6% or men and 13.5% of women were diabetic.
11 Under 5 years children who were underweight 32.1%.
12 Postnatal care was provided to 78% of mothers within 2 days of birth.
13 Nearly 40% of currently married women in India report at least one reproductive health problem (RTI).
14 Immunization coverage: 76.4% of children age 12–23 months were fully immunized.
15 ORS used rate was nearly 60.6%.
16 22% of births weigh under 2.5 kg.
17 38% of men and 8.9% women used tobacco.
18 People without latrines 29% in 2020.

Thus, the communication needs are obvious. This tells us clearly, where we stand and what are the cardinal needs for behaviour change communication (BCC).

**Table 4.1: Evaluation of health education matrix of behaviour change communication to increase men participation**

| *Area of concern* | *Current behaviour or practice 2021* | *Expected behaviour in 2025* | *Target audience* | *Message* | *Media and channel* | *Outcome indicator of change in 2025 (evaluation)* |
|---|---|---|---|---|---|---|
| Use of spacing methods by women | 7.8% of women practice | 10% | Currently married women with one child | Spacing births at least 3 years apart to improve the health of mother and survival of child | Interpersonal communication by health worker female<br>• TV<br>• MSS groups | • Percentage of women with one or two children who are using spacing methods (annual survey data of workers) |
| Use of spacing methods by men (condom use) | 9.5% of men use condom | 12% | Currently married men with one child | Do | Interpersonal communication by health worker male<br>• Opinion leaders<br>• TV | • Percentage of men using condoms (annual survey data of workers) |

Responsibility of planning and evaluation lies with medical officer incharge of primary health centre and community health centre.

### Barriers or Blocks in Communication

i Only talking at gives advice not listening
ii Physical barriers—noisy situation, obstruction or blocks
iii Cultural and social barriers and arrogance
iv Lack of empathy, trust and understanding
v Poor or no eye contact or facial expressions, looks away
vi Low credibility and respect of source
vii Language, and dialects and medical Jargon as barriers
viii Frequent interruptions—attending telephones, office files/papers
ix Lack of visual literacy and health literacy
x Looks at watch, looks bored, gets up to do something and returns, begins to do some work and does not stop.

### National Communication Strategy in Reproductive and Child Health Programme (RCH)[4]

The communication strategy aims to facilitate awareness, dissemination of information regarding availability of and access to quality healthcare within public health system. The key objective of the strategy is encourage a health seeking behaviour that is doable in the context in which people live. The strategy views recipients of health services as not merely passive *users* of services but key *participants* in generating demand for services.

The national strategy on communication under RCH programme lays stress on:

- Interpersonal communication for behaviour change at the field level.
- ***Decentralized planning for communication:*** Production of material and messages at state and district level. Districts will prepare their own plans for IEC.
- Use of mass media for advocacy and awareness.
- Increased involvement of non-governmental organizations (NGOs).
- Capacity building and training at all levels to undertake the newly developed tasks and thrust areas under RCH I and II.

  The responsibilities of central government, state and district have been defined. In the decentralization of IEC activities, the role of states and district is crucial.

*Thrust areas for communication under RCH:*

- Meeting the unmet needs of contraceptives, both for spacing and terminal methods.
- Improving maternal health.
- Raising chances of survival.
- Adolescent health.
- Implementation of PC—PNDT Act to achieve balanced child sex ratio.
- Coverage of urban slums and tribal areas.
- Newborn care.

### Evaluation

In order to achieve the goals of RCH programme, the communication interventions have to focus on behaviour change. Accordingly, the matrix of behaviour change has been indicated under the RCH strategy on communication (Table 4.1).

The areas or issues to be focused are: Unwanted fertility, unmet need of contraception, unsafe abortions, high maternal mortality, maternal morbidity, adolescent reproductive health, RTI/STI, infant mortality, drop in immunization coverage, newborn care, adverse child sex ratio, urban and tribal health.

**Expected outcome:** The student assesses the knowledge, attitude and practices of potential beneficiaries exposed to a messages of a specific programme in community or allotted family, e.g. chronic disease or common childhood problem-diarrhoea and ARI.

*Competencies addressed:* The student should be able to:
**CM 4.2:** Describe concept and method of health counselling.

## COUNSELLING IN HEALTH AND DISEASE

### COUNSELLING IN RCH AND OTHER PROGRAMMES

#### Concept of Counselling[5]

Counselling is one person helping another as they talk person to person. When you help a client make a decision or solve a problem you are counselling.

Through counselling, you help clients make informed choices that suit them. For example, some clients are choosing family planning methods; other clients are deciding how to avoid sexually transmitted diseases. Young clients (adolescents) may be choosing whether to delay sexual activity. All these clients make better decisions with your help.

#### Definition

"Counselling is **face-to-face** communication by which you help the person to make decision or solve a problem. Counselling is a helping process aimed at problem-solving. It helps people to understand themselves better in terms of their own needs, strengths, limitations and the resources they can avail of. It brings about a change through supportive relationship aiming to make client independent

through the interpersonal contact along with an opportunity to ask questions and to seek frequently needed help greatly."

## Counselling Skills

### *1. Greeting*

Make a good connection and keep it. Make sure that each client is greeted in a friendly and respectful way. It makes good connection between provider and client right from the start.

### *2. Asking*

The provider asks questions effectively and listens actively to client's answers. Asking question to understand clearly the clients problem or worries and help client go deeper into his/her own awareness or insight. The question is centered on the prime concern of the client and open-ended questions are better than close-ended.

- Use words, such as 'then'? 'And' 'Oh' these worlds encourage clients to keep talking.
- Show your interest and understanding at all times. Express empathy. Avoid judgment and opinion.

### *3. Listen Actively*

You have to listen actively. Attentive and active listening is essential. How to listen actively? Some guidelines are as under:

- Accept your clients as they are, treat him/her as an individual.
- Put yourself in the client's shoe as you listen. Listen to what your client says and how they say it. Notice tone of the voice, choice of words, facial expressions gestures and body movements.
- Keep silent sometimes. Give your clients time to think, ask questions and talk more at the client's speed.
- Listen to your client carefully instead of thinking what you are going to say next.
- Every now and then, repeat what you have heard. Then both you and your client know whether you have understood.
- Sit comfortably. Avoid distracting movements. Look directly at your clients when they speak, not at your papers or out of the window.

### *Responding to Client's Feelings*

Once you recognize client's feeling let them know in clear and simple words that you understand. This is called 'reflecting feelings'. Two examples are given hereunder. You cannot change client's feelings. Only they can do that, but when you reflect feelings, you are showing that you understand. You also are saying it is all right to feel that way (Fig. 4.2 and Table 4.2).

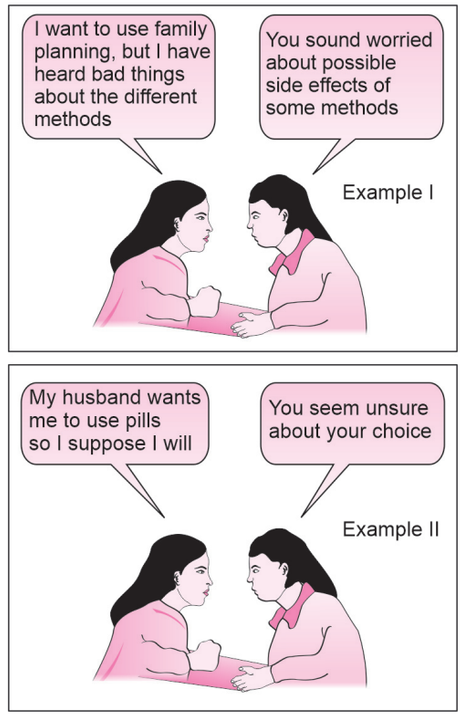



**Fig. 4.2:** Reflecting feelings

**Table 4.2: Sharing facts and feelings***

| | *Share facts* | *Share feelings* |
|---|---|---|
| **Provider's job** | • Give clear, accurate information that the client wants and needs<br>• Help the client apply this information to his/her own life | • Care for client by showing understanding respect and honesty |
| **Client's job** | • Describe personal situation and health conditions<br>• Ask questions and make sure of understanding | • Express attitudes, preferences, concerns, expectations and wishes |

***Note:** The client makes good decisions when provider and client share facts and feelings.

### *Paraphrasing*

Repeating in one's own words 'what the client has said' to show one understands. Saying it in a few words, so that it gives a summary essence of client's words.

### *Interpretation*

Giving back to client the core or basic issue he/she is talking around or hinting at. Picking-up what the client is feeling but not saying. This skill involves going to a slightly deeper level of the issue to point out the feeling of meaning or meanings, which are just below the surface of the client's awareness. Check with the client, if one's interpretation is correct.

### GATHER Approach to Counselling about IUDs

There are six steps to counselling.
Word GATHER stands for: Greet, Ask, Tell, Help, Explain and Return for follow-up.

**G:** *Greet clients:* The provider greets clients politely and gives them full attention. It makes good connection between provider and client, builds trust and clients rely on providers they trust.

**A:** *Ask clients about themselves:* The provider asks clients about their family planning needs and obtains information that will help the provider to advise and inform each client individually.

**T:** *Tell clients about family planning methods:* The provider lists the available family planning methods and clearly describes those that interest the client—how they work, advantages and disadvantages and possible side effects. Even clients who immediately express a preference for the IUD or some other method should know of other available methods for future reference and so they can inform friends and family members.

**H:** *Help clients choose a family planning method:* Some women may have already decided that they want an IUD. Others may want advice and guidance from the provider. In either case, the provider helps the woman decide on a safe method that suits her needs and plans. If the method is not appropriate, the provider explains why and helps the client select another method. If there are reasons that another method would be preferable, the provider and client compare the risks and benefits of the IUD and of other contraceptive methods and consider the risks of an unintended pregnancy. The final decision to use an IUD—or any other method must be an **informed choice** made by the client. If possible, involving the husband in counselling is a good idea. In an African study, husbands' wishes accounted for many IUD removals after postpartum insertion.

**E:** *Explain how to use the chosen method (IUD):* Once a woman decides to use an IUD, the provider explains:

- When, where, and how it will be inserted
- The common side effects
- The slight chance of more serious complications, expulsion, or unintended pregnancy
- Reasons to return to the clinic or see another provider
- When a copper or hormone releasing IUD should be replaced.

Women who understand that mild cramping and bleeding in the days following insertion and heavier menstrual periods while using an IUD are common and usually harmless will be less likely to have their IUDs removed unnecessarily.

It is helpful to give clients printed material to take home, particularly a card with the name and picture of the IUD, noting the date of insertion and time for removal (printed materials can help providers, too). During counselling and screening, flip charts, wall charts, cue cards, and checklists help providers maintain accuracy and remember what to cover and they help clients to understand.

The client should be told if and how she will be notified when it is time for the IUD to be replaced. The family planning program should keep records for each IUD user showing the type of IUD and when it was inserted. These records should be used to answer questions from women who have forgotten when to have their IUDs replaced and to follow-up users when the time for replacement approaches.

**R:** *Return visits help clients continue for follow-up:* When a woman has an IUD inserted, she and the provider should plan for a follow-up visit 3 to 6 weeks later, after her next menses. While no further scheduled follow-up visits are required for the safe use of the IUD, the women should be strongly encouraged to return whenever she has questions or problems or if she wants the IUD removed. Also she should return as soon as possible if she notices any warning signs. The provider should be sure that the woman knows both when and where to seek medical care.

### Counselling in HIV/AIDS at ICTCs[6]

Counselling is concerned with preventing infection with HIV and its transmission to people from persons living with HIV/AIDS, estimated 2.40 million in India.

*The main steps of preventive counselling are to*:

- Determine whether individual/group has high-risk behaviour pattern.
- Help people understand and acknowledge their high-risk behaviour patterns.
- Define with them how their lifestyle and self-image are linked to their behaviour.
- Help individuals define their potential for changing behaviour.
- Work with individuals to introduce and sustain the modified behaviour.

### Health Promotion

This involves counselling those individuals having high-risk behaviour patterns but not aware of the magnitude and the nature of risk involved to their life. It aims at creating this change focusing on behaviour that presents a risk of HIV infection and reviewing ways of managing individual change.

#### *Specific Protection*

Those infected with HIV should be given instructions as to ways by which they can prevent the spread of infection to others. An attitude of understanding should be adopted as the fact that he has tested positive is traumatic enough to accept. Since behaviour change is going to be difficult, he should be asked to take certain precautions:

- Do not donate blood.
- Use condoms while having sexual intercourse.
- Do not share needles and syringes.

### Psychosocial Support

People diagnosed with HIV infection-related illness and those close to them are confronted by a multitude of problems and often need emotional support and/or practical support. People have anxieties regarding hospitalization and depression because of stigma attached to their conditions. Counselling should help those infected by HIV to live full and productive lives by enabling them to take charge of their lives and help in decision-making, thus enabling people to remain active in their work and in their education. Families and friends can help to reduce their dependence on health and social services and reduce their psychosocial problems.

### Requirement of Counselling

Approaches to counselling will differ from individuals and groups depending upon the characteristics of the people being counselled and their social and family network. Certain points, which remain constant irrespective of the situation, are given below.

#### Rapport

The client must not be rushed with the news that he is HIV positive. Sufficient time should be taken to establish rapport with the client, so, as to understand his mental framework and basic level from where the counselling should be carried forward. This basic level will determine the number of sessions required by the person to take decision about his lifestyle.

#### Acceptance

The people infected by HIV should not be shunned on the basis of the behavioural patterns adopted by them. They should be treated with respect whatsoever their background or behaviour.

#### Accessibility

People found to be HIV positive are bound to develop anxieties and fears, which will be always raising some doubts in their minds. Therefore, counselling services should be available easily where the individual can approach at any time and get clarification.

#### Consistency and Accuracy

Any information provided through counselling should be consistent; therefore, the counsellor must equip himself with all the latest knowledge and management of HIV infection and disease so as to be able to clarify doubts/uncertainties arising in the minds of the client. He should not pretend to know or acknowledge a thing when in doubt but try to clarify it.

#### Confidentiality

Being diagnosed HIV positive creates uncertainties in the mind of the clients. The counsellor should be able to gain the trust of the client and convince him that all information provided by him will be kept confidential.

#### What to Counsel?

As HIV infection is progressive, it is necessary that counselling should be undertaken regularly to understand what the client is going through due to the various changes occurring within him and those around him. The counsellor should also provide to the client necessary information regarding where he will be able to get medical support, community resources and what changes he can make in his lifestyles to cope with emerging needs.

## Counselling before HIV Testing (Pretest Counselling)

Counselling before the test should provide the individuals being tested with information on technical aspects of screening and possible personal, medical, social, psychological and least implications of being tested positive or negative. The information should be simple and up to date. Testing should be organized in a way that minimizes the possibility of disclosure.

### Issues in Pretest Counselling

Pretest counselling consists of two parts:

1. Personal history and assessment of risk.
   - Sexual behaviour multi-partners, prostitutes, unprotected sex, homosexuality, bisexuality.
   - Drug users.
   - Blood transfusion.
   - Organ transplant.
2. Assessment of factors and knowledge.
   - Why test is being requested?
   - What behaviour/symptoms are of concern to the client?
   - What the client knows about test and its uses?
   - What will the client do if test is positive or negative?
   - Beliefs regarding HIV transmission.
   - What roles will family play?

## Counselling after HIV Testing (Post-testing Counselling)

### If Result is Negative

The client may feel relief, however caution should be exercised as following exposure to HIV, there is a **window period** of 6–12 weeks between initial infection with HIV and the time when HIV antibodies can be detected in the blood. A blood test performed during the **window period** may yield a negative test result for antibodies. These cases may require further testing after 12 weeks. A negative test result becomes a certainty if 6 months have lapsed after last exposure. HIV infection can be prevented by avoiding high-risk behaviour, safe sex and avoiding sharing needles. In general, development of safe sex behaviour to be advocated to the client.

### *If Result is Positive*

People diagnosed as having HIV infection should be told about their results privately and in confidence. Single test giving positive result does not necessary mean HIV infection. To establish HIV infection, *three tests* for antibodies based on different antigen methods are to test positive. Time should be allowed for the client to absorb the news. After a period of preliminary adjustment, the client should be given clear and factual explanation or what the news means. This does not mean speculating about prognosis of estimate about the time left to live but for providing support; and encouraging hope for achievable solutions to personal and practical problems that may result. The client must be informed where resources are available and possible treatment for some symptoms to HIV infection and efficacy of antiviral treatment.

### Psychological Issues

The uncertainty involved when the individual comes to know he has tested positive are longevity of life, etc. Clarifications are to be given regarding the fears which arise related to illness, death, etc. Besides these, the individual feels at loss due to stigma attached by society and the speculation in the minds of people regarding the behaviour of those infected with the virus.

There is generalized anxiety regarding all aspects of life, anger and expression of the fact that he has tested positive; can even lead to suicidal thinking within the individual.

These numerous feelings can only be changed through counselling and giving correct information about the infection and disease and building the self-esteem and the positive thinking ability of the individual. Besides the individual who has tested positive, those dealing with them, i.e. the health workers and family face their share of fears and uncertainties regarding their getting the infection. All those involved with those who have tested positive need to be given proper and full information so that they can provide the support, which the individual requires to be able to face their problem.

## VOLUNTARY COUNSELLING AND TESTING CENTRES (VCTCs/ICTC/HCTS) (IT RELATES TO AETCOM 3.4)

Now VCTCs have been renamed as integrated counselling and testing centres (ICTCs). New terminology for ICTCs is HIV counselling and testing services (HCTS) after the release of National HCTS guidelines in Dec 2016.

*The HCTS include:*

1. ICTC/HCTS
2. Prevention of parent to child transmission of HIV (PPTCT) and
3. HIV/TB collaborative activities

The HIV counselling and testing services, started in the year 1997, have been scaled-up in the recent years. Today there are more than 34,500 counselling and testing centres which are located at all levels of the public healthcare system—(standalone and Facility-based ICTCs). The earlier voluntary counselling and testing centres (VCTCs) and facilities providing prevention of parent-to-child transmission (PPTCT) of HIV/AIDS services are now remodelled as a hub to deliver integrated services to all clients under one roof renamed as 'integrated counselling and testing centres' (ICTCs).

Though counselling and testing services have been implemented in India for the past 25 years, now 78% of the people who are living with HIV/AIDS are aware of their HIV status. Under the National AIDS Control Programme Phase III (NACP-III), it was planned to have 22 million clients counselled and tested through ICTCs every year. An equal number of clients will be tested in the private sector.

### *What is an Integrated Counselling and Testing Centre?*

An ICTC is a place where a person is counselled and tested for HIV, on his own free will or as advised by a medical provider. The main functions of ICTC include:

- Early detection of HIV.
- Provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioural change and reducing vulnerability/risk.
- Link people with other HIV prevention, care and treatment services. Such as ART centres.
- Outreach visits to the homes of HIV positive clients facing severe crisis.

ICTC can be located in the obstetric and gynae department for pregnant women, or with tuberculosis microscopy centre for TB patients, at workplace, on national highways, in universities and STD clinics.

Voluntary counselling and testing (VCT) provides for all segments of the population, an opportunity to access complete and accurate information on HIV/AIDS.

This is a critical entry point to prevention, care, support and treatment for all people, and particularly for those already infected and affected. VCT services enable the 'client' to confidentially explore and understand his or her risk of HIV infection, provides an opportunity to fully comprehend the implications of one's serostatus and to learn about precautions for one's protection and preventing the further spread of HIV infection. VCT facilitates personal, and more informed decisions about HIV testing. Counselling is client centered. This promotes trust between the counselor and the client. The client is helped to identify and understand the implications of a negative and positive result.

In the event of positive HIV test result, counselling strengthens strategies for coping with the immediate stress, possible stigma, psychological and social impacts. It provides referrals to appropriate facilities for care, support and treatment and promotes more informed choices for the future.

This common facility will remove fear, stigma and discrimination among the clients. The ICTCs have common television and video-based health education material that are screened continuously in the waiting area. Further two strategies are adopted in ICTCs for HIV testing—'opt out' and 'opt in' strategy.

1 *Provider-initiated counselling and testing*—'opt out'. These clients are referred by healthcare providers. There are three varieties of patients who are offered provider-initiated counselling and testing:
   a Patients who present at a health facility with symptoms suggestive of HIV infection (pneumonia, TB and persistent diarrhoea).
   b Patients with STI/RTI.
   c Pregnant women who register at antenatal clinic.
   In such cases the client is given basic information on HIV, and educated about testing for HIV. The counsellor will ask each client, "Do you wish to test for HIV or not?" The client can 'opt out' or choose not to test for HIV. If a client does not 'opt out', then he/she is tested for HIV.
2 *Client-initiated counselling and testing*—'opt in' or direct walk in clients/self-referred clients.
   These clients who present themselves at the ICTC of their own free will based on their individual risk behaviour or information and advice received from a friend, sexual partner, or outreach worker or peer educator. Here the client is counselled for HIV and then 'opts in' or actively agrees to be tested for HIV. **Written consent** has to be obtained from such clients before testing.

As per the National AIDS Prevention and Control Policy, all HIV tests are voluntary based on **the clients consent,** accompanied by counselling and confidentiality of the results.

VCT services have reached up to block level in high prevalence states. The moderate and low prevalence states are in the process of extending VCT services to district and subdistrict level.

### Different Types of ICTCs/HCTS—34500 HCTS

There are three types of ICTCs.

1 Fixed facility ICTCs
2 Mobile ICTCs
3 Public–private partnership ICTCs

*A fixed facility ICTC can be of three types*:

1 'Standalone' ICTC having full time counsellor and a laboratory technician located in medical colleges and district and in some sub-district hospitals. It is envisaged under NACP-III to have such ICTCs established up to the level of CHC (block level).
2 'Facility-integrated' ICTC which does not have full time staff and provides HIV counselling and testing as a service along with other services. Such centre caters to small number of clients, below the block level in high prevalent states.
3 Public–private partnership ICTCs.

### Core Staff

Depending upon resources available and size of VCTC/ICTCs the core staff could include:

1 VCTC incharge/VCTC manager (often a microbiologist).
2 Two trained counsellors (one male and one female) or ideally as per client load (per counsellor 8–10 counselling sessions per day).
3 One trained laboratory technician.

Counselling in VCT consists of *pretest* and *posttest* counselling. During pretest counselling, the counsellor provides to the individual/couple an opportunity to explore and analyse their situation, and consider being tested for HIV. It facilitates more informed decisions about HIV testing. After the individual/couple has received accurate and complete information they reach an understanding about all that is involved. In the event that, after counselling, the individual decides to take the HIV test, VCT enables confidential HIV testing.

*Posttest counselling:* Consists of how to cope up with positive test and live positive life and share result with spouse and family members, notify partners and prevent transmission of HIV infection.

### Peer Counselling

Peer counsellors are HIV positive men and women specially trained to hear the concerns of clients and offer support and referral services. A peer counsellor is an individual who is open about his/her HIV positive status and shares experiences with client and is willing to sustain his/her behaviour change and that of peers.

Peer counselling is a process that is carried out as a one to one interaction, followed by group interaction. During this process, experiential information is shared among the peer group to modify knowledge, attitude and beliefs to bring about change at the individual level. Counselling provided through this modality has a component of informality to it and addresses client issues through following processes.

- Sharing feelings about similar experiences and emotions.
- Sharing of information for availability of HIV/AIDS prevention, treatment and care services.
- Narrating their success stories to the peers and conveying messages of positive living.
- Advocating on behalf of the clients rights.
- Supporting clients in becoming more involved in community activities.
- Enable clients to learn self-help skills.

### Goals of Peer Counselling

- To modify the attitudes, beliefs and behaviour of persons with high-risk behaviour.
- To identify actions needed to achieve behaviour change.

*Competency addressed:* The student should be able to:
**CM 4.1:** Describe social marketing programme (SMP) in health and family welfare: An education method.

## Social Marketing Programme (SMP) in Health and Family Welfare[7,8]: An Education Method

The NPP 2000 stressed the need to formulate and implement Social Marketing schemes for advocating 'products and services' through partnerships between the voluntary sector, non-governmental organization and the private corporate sector, government, *Panchayati Raj* Institutions and the community. This will reduce the unmet needs of contraceptives and family welfare services.

### What is Social Marketing?

Social marketing applies commercial marketing skills and technologies to the analysis, planning, execution and evaluation of programmes designed to influence the voluntary behaviour of target groups in order to improve their personal well-being and that of their society.

### Objectives

i Objective of SMP is to increase the number of outlets of services or products, such as condoms, oral pills, ORS, MTP and CUT.

ii To improve the quality of services and products.

iii To involve or enhance partnership between government and private sector.

iv To improve the access to services of family welfare.

### Scope

SMP techniques are used to promote the products and services of family welfare.

Apart from this, the SMPs are also used to change the attitudes and behaviour in areas like smoking, use of seat belts, drug abuse, heart disease and other chronic diseases associated with lifestyles.

### Approach

The SMP recognizes the 'Consumer' as 'king' of services and ensures consumer consultation about the product and services suiting to his/her need. It analyses the needs of consumers, their felt needs, likes and dislikes and satisfaction level. This early 'consumer consultation' is called feed-forward by Manoff. It attempts to define in what the consumer is interested, what do they think and what are their reactions about presentations of products or idea or service.

The viewpoint and concern of clients is ascertained through various techniques, such as focus group, discussions, interviews and surveys.

In conclusion, it is the *precise delivery* of *precise product* or *service*, *precise idea*, to *precise client* at the *precise time* of their *precise need*. This is social marketing's primary tactic, a focus on priority need, when, where and for whom it is essential. In SMP, primary *focus* is on the *consumer*—on learning what people want and need in terms of social behaviour and services.

In government service set-up, this approach is seldom stressed and this sector most of the time considers only providing services, ideas, products, *pushing these as directives*, seldom consults the consumer and works on a strategy to "Take or leave it basis".

### Information Education and Communication (IEC)

While IEC creates health-seeking behaviour, social marketing facilitates the practice of such behaviour by promoting, distributing and selling socially beneficial tangible products, services, ideas at affordable cost to low income group people. Consumer can access these through wide range of private outlets.

### Planning of Social Marketing Programme in India

Planning of social marketing programme (SMP) requires a consumer focus by addressing the different elements of the 'marketing mix', i.e. *the concept of **p**roduct, its **p**rice, distribution **p**lace, its **p**romotion, **p**artnership involved and **p**olicy environment (6 Ps)*.

#### *Product*

People must perceive the problem and need of contraception. The SMP analyses such needs and perception of clients and thereafter SMP for RCH provides a diverse range of products, such as condoms, oral pills, sanitary napkins for girls and services, such as medical termination of pregnancy and to practices, such as breastfeeding, oral rehydration therapy (ORT). The product under SMP is distinguished and bears a special label or logo.

#### *Price*

Price of product should be affordable by the poor also—both in rural and urban settings.

#### *Place*

Place of selling or outlets of products must be identified and known to people. It could be through *Mahila Swasthya Sangh* in RCH or through women's organization or through grocery shops or a pharmacy or chemist.

#### *Promotion*

Promotion of sale of product is through mass media—advertisement, publicity and interpersonal communication. The focus is to create sustained demand.

#### *Partnership Involved*

The partnership in SMP under RCH is essential as no single agency in a diverse country like India can provide or make

impact. Key partnership between private sector, NGOs and government is essential.

### *Policy Environments*

The government policy must encourage and support the SMP to sustain the practice or behaviour initiated by SMP.

## Achievements of SMP in India

1 The social marketing of condoms increased from 16 million pieces in 1968–69 to 483.21 million pieces in 2017–18. Condoms marketed under SMP represent one-third of the total condoms distributed in India.

2 The social marketing of oral contraceptive pills (OCPs) increased from 7.24 lakh cycles in 1987–88 to 206.31 lakh cycles in 2017–18, i.e. one-third of the total oral contraceptives distributed annually in India through social marketing.

3 Since the introduction of the SMP in 1968, for condom promotion and that for oral pills in 1987, awareness regarding condoms and oral contraceptive pill has substantially increased, and is reflected in declining total fertility rates and increased contraceptive prevalence rates from 10.4% in 1951 to 56.5% in the year 2019–21.

4 SMP has helped to change the choices and options within each product (condom and the OCP) for the consumer.

5 Social marketing pilot project in rural India: In Madhya Pradesh, a trust of Hindustan Latex Limited, and in Uttar Pradesh, by the State Innovation in Family Planning Services Agency (SIFPSA) have been successful in demonstrating the feasibility of social marketing in rural area. Lot of field is open in rural area for SMP.

6 The brand name "NIRODH" (GOI-owned brand) also distributed through social marketing, has become a generic name for condom in India.

7 National AIDS Control Programme is promoting use of condoms through SMP.

## National Strategies on SMP in India

- Maximize use of public health infrastructure in rural and urban areas. As till now SMP largely confined to urban areas—make use of sub-centres, PHCs, CHCs and Indian system of medicine as outlets for SMP.
- Expand the basket of products—add diverse brands of condoms, low dose oral pills because usage of contraceptive in India has been quite low; this step may increase usage of spacing methods.
- Enhance partnership between private, NGO and government for SMP products.
- ***Introduce services:*** Social franchises—in India private sector provides higher profit curative services only. Motivate this sector to support national health goals and provide preventive services to weaker sections at affordable cost.
- Promote information education and communication for SMP. The overall thrust of SMP is to accelerate achievement of socio-demographic goals of National Population Policy (NPP)-2000.

Under the social marketing programme both condoms and oral pills are made available to people at highly subsidized rates, through diverse outlets. The social marketing organization are given Deluxe NIRODH condom at ₹ 2 per packet of 5 pieces and this is sold at ₹ 3 per packet of 5 pieces to consumers. One cycle of oral pills is given to social marketing organization at ₹ 1.6 and is sold to consumer at ₹ 3 per cycle under the brand name of 'MALA-D'.

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