Rapid Assessment of Swasth Nagrik Abhiyan (SNA) erstwhile IEC Programme

Information Education Communication

Social Behaviour Change Communication

Submitted To

ADVISOR (HEALTH)

Niti Aayog

नीति आयोग

National Institution for Transforming India

Submitted By

DR. PAWAN K. TANEJA & DR. ROMA DEBNATH

भारतीय लोक प्रशासन संस्थान

Indian Institute of Public Administration

2020

Final Report

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Disclaimer

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Pawan Kumar Taneja **Roma Mitra Debnath**

Abbreviations

AIDS	:	Acquired Immune Deficiency Syndrome
AIR	:	All India Radio
ANM	:	Auxiliary Nurse Midwifery
ATR	:	Action Taken Report
AWW	:	Anganwadi Worker
BARC	:	Broadcast Audience Research Council
BCC	:	Behavior Change Communication
BPM	:	Block Programme Manager
CHC	:	Community Health Centre
CMO	:	Chief Medical Officer
CRM	:	Common Review Mission
CVD	:	Cardio-vascular Disease
DD	:	Doordarshan
DFP	:	Directorate of Field Publicity
DM	:	District Magistrate
DPM	:	District Programme Manager
FB	:	Facebook
FGD	:	Focus Group Discussions
HIV	:	Human Immunodeficiency Virus
HPDs	:	High Priority Districts
IDCF	:	Integrated Diarrhoea Control Fortnight
IDI	:	In-depth interviews
IEC	:	Information, Education, and Communication
IIPA	:	Indian Institute of Public Administration
IITF	:	India International Trade Fair
IMI	:	Immunization Mission Indradhanush
IMR	:	Infant Mortality Rate
IPV	:	Inactivated polio vaccine
IRS	:	Indian Readership Survey
JSY	:	Janani Suraksha Yojana
MCTS	:	Mother and Child Tracking System
MMR	:	Maternal Mortality Ratio
MO	:	Medical Officer
MoHFW	:	Ministry of Health And Family Welfare
MoU	:	Memorandum of Understanding
NFHS	:	National Family Health Survey
NGO	:	Non-Governmental Organisation
NHM	:	National Health Mission
NIHFW	:	National Institute of Health and Family Welfare
NITI AYOG	:	National Institution for Transforming India

NPCDCS	:	National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular Diseases
NRHM	:	National Rural Health Mission
NVBDCP	:	National Vector Borne Disease Control Programme
OBC	:	Other Backward Classes
ORS	:	Oral rehydration Salts
PHC	:	Primary Health Centre
PMSMA	:	Pradhan Mantri Surakshit Matritva Abhiyan
PPS	:	Probability Proportional to Size
PRIs	:	Panchayati Raj Institutions
RCH	:	Reproductive and Child Health
RHTC	:	Rural Health Training Centre
SC	:	Scheduled Castes
SPSS	:	Statistical Package for the Social Sciences
ST	:	Scheduled Tribes
TRP	:	Target Rating Point
TV	:	Television
UNICEF	:	The United Nations Children's Fund
USAID	:	United States Agency for International Development
WHO	:	World Health Organisation

Executive Summary

BACKGROUND

The importance of IEC for achieving better health outcomes in public health interventions has become more significant in developing countries where health outcomes indicators are very poor (Elmendorf et al., 2005; Waisbord and Larson, 2005). Over the last four decades, IEC strategies have evolved to Behaviour Change Communication (BCC) strategies and further to a more comprehensive level i.e. Social and Behavior Change Communication (SBCC) strategies in many countries. While designing an SBCC strategy the policymakers formulate an evidence-based, participatory, and well-targeted researched communication intervention to address community knowledge, attitudes, and practices with an appropriate mix of interpersonal, group, and mass media channels (McKee et al., 2014).

Like other Sustainable Development Goals (SDGs) signatories, the Indian government has shown its commitment towards SDGs by adopting New Health Policy in 2017 focussing on ensuring healthy lives and promoting the wellbeing of all at all ages. At the IEC front, the policy articulates the need for the development of communication strategies and institutional mechanisms by initiating Swasth Nagrik Abhiyan – a social movement for health.

Considering all the above developments, it became imperative to review and take stock of the existing IEC strategy, plan, and activities of the Ministry of Health and Family Welfare (MoHFW)[1]. NITI Aayog, the premier policy 'Think Tank' of the Government of India (GOI), responsible for providing both directional and policy inputs to GOI assigned this task to the Indian Institute of Public Administration (IIPA), the premier policy training and research institute of the Government of India.

IIPA carried out this independent rapid assessment of the Central IEC strategy and activities of the MoHFW for the Finance Commission Cycle (2017-20). The scope of this study is restricted only to the IEC activities financed under the Central Government Scheme. It does not include only IEC activities carried out by State Governments. The period for the field study was August 5 to December 5, 2019. Considering resources and time constraints the focus of the study was restricted to NITI Aayog aspirational districts.

[1] Nodal Ministry for policy, planning and implementation of national health policy and programmes.

OBJECTIVES OF THE STUDY

The central objective of this assessment study is to document the learning from the experiences and bring out suggestions to improve the planning, designing, and implementation of Swasth Nagrik Abhiyaan (IEC program) keeping in view the targets of National Health Policy 2017.

RESEARCH PROCESS & METHODOLOGY

To meet the above assessment study objectives, a study using a cross-sectional research design with a mixed-method research approach was planned. Both primary and secondary data sources were used in the study. Secondary data sources include annual reports of MoHFW, Common Review Mission (CRM) Reports, action taken report of IEC divisions, expenditure records for IEC division, research studies by development partners and states NHM divisions, Feedback, comments, and shares received for social media content analytics and data on TRP published by Broadcast Audience Research Council (BARC), etc. Primary data sources included

- Survey with the community for exposure, recall rate, and understanding for communicated messages,
- Focus Group Discussions (FGDs) with the community for comprehension, appeal of the theme/ specific spots and ascertaining individual health-seeking behavior change, and
- In-depth interviews (IDIs) and Face to Face Discussions with the key stakeholders at national, state, district, and functionaries at the village level, etc. for policy planning and implementation challenges.

The major three campaigns of MOHFW for National Vector Borne Disease Control Programme (NVBDCP), National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), and Immunization Mission Indradhanush (IMI) have been selected based on the budget spent, the timing of campaigns and relevance. To get geographical representation, the NITI Aayog's aspirational districts are divided into 6 geographical regions i.e. North, East, West, South, Central, and North-East. One aspirational district was selected from each region from a separate state. Since the Northern Region has more states and aspirational districts, therefore, instead of one state, two states (one district each) were selected from the same. The survey was carried out with 2214 beneficiaries from the community selected across 7 sample districts. In each state, 4 FGDs were carried, out of which, one FGD was conducted only for women (especially of the rural area) to gain female perspectives. In addition to female FGDs, two focus group discussions

(one urban and one rural) were carried out in each aspirational District. Similarly, a special focus group discussion was organized with the school children about the messages on NVBDCP. Further, in-depth interviews and semi-structured discussions were also conducted with various stakeholders at the national, state, district levels including grass-root level functionaries like ASHAs, AWWs, ANMs, and school teachers. Collected quantitative data were analyzed by using statistical software SPSS and qualitative data were analyzed with the help of ATLAS-ti8 software.

IEC ACTIVITIES OF CENTRAL IEC DIVISION OF MOHFW

The Ministry has designed a strategic framework for targeted IEC activities encompassing mass media, along with mid-media and inter-personal activities to disseminate information about the various health schemes in the masses. MOHFW has a year-long IEC/Communication Plan with a month-wise focus on health days and health themes. While some activities are taken up to coincide with 'Health Days', others are week and month-long plans for focused multi-media campaigns on schemes of the Ministry. These center on topics such as Integrated Diarrhoea Control Fortnight (IDCF), Breastfeeding Week, and Tobacco Control, etc. Seasonal ailments such as Dengue, Malaria, H1N1, etc. need campaigns for a longer time. All the IEC activities have a print media component coupled with TV, Radio Plans, Social Media, and Outdoor Media activities.

MANPOWER AT IEC DIVISION

Ministry of Health and Family Welfare has an exclusive IEC Section headed by Joint Secretary to the GoI followed by a Director, Under Secretary, and Section Officer as an additional charge. Other officers also look after IEC activities i.e. Chief Media, PO (AV), Editor (Hindi), Editor (English), and DO (MMU). Some technical officers and consultants are working for designing advertisements, issuing of media plans, Social Media, exhibitions, etc. IEC Division has technical officers like Chief Media, Programme Officer (AV), Editors (Hindi and English), and Consultants for traditional and social media. They provide technical support to the Division. Further, almost all campaigns are carried out through the Department of Audio Visual Publicity (DAVP) for print media and private satellite and FM radio Channels or through Doordarshan (DD), All India Radio (AIR), LokSabha TV, etc.

FINDINGS - EXPOSURE TO HEALTH PROMOTION MESSAGES

In general, 66 percent of rural and 72 percent of the urban sample respondents, out of 2214 respondents have seen advertisements/posters/messages educating about health and family welfare programs without any assisted recall. After assistance, every respondent was able to recall some health promotion messages. Respondents from the Chitrakut district of the Northern region, have maximum exposure i.e. 86 percent followed by 75% of respondents from the Eastern region whereas the least exposure has been observed in respondents of the North Eastern Region i.e. 58.5%. Sixty-two percent (62%) of respondents from the Southern and the Central region respectively have seen advertisements/posters/messages educating about health and family welfare programs without any assisted recall.

Program Wise Exposure Level

NVBDCP Promotion Messages

Overall, 68 percent of the respondents from the rural locations across states have seen advertisements/posters/messages related to the national vector-borne disease control program and 72 percent of respondents, from the urban area, have seen advertisements/messages related to a vector-borne disease control program. For the NVBDCP, in the northern region, Chitrakut district from UP has the highest exposure level i.e. almost 85% followed by Baran District in the western region i.e. almost 73%. The eastern region's district Begusarai has the least exposure level for NVBDCP i.e. almost 60%.

Exposure to NPCDCS Promotion Messages

Across the regions in the study, out of 2214 respondents, 64 percent of respondents from a rural location across states have seen advertisements/posters/messages related to NPCDCS and 73 percent of respondents, from an urban area, have seen advertisements/messages/posters related to this program. There is a significant difference within the Northern region districts i.e. Haridwar (77%) and Chitrakoot (65%) on viewership related to NPCDCS advertisement. The western region has the lowest level of exposure to NPCDCS health promotion messages i.e. 50.77%. Similar to NVBDCP exposure, a major source of exposure for NPCDCS advertisements/message are TV, in health facilities and through health workers and in posters.

Exposure to IMI Promotion Messages

Compare to other programs, IMI has the highest exposure rate i.e. overall, 71 percent of people from a rural location and 74% of urban population across regions have seen advertisements/posters/messages related to the Mission Indradhanush (IMI) program. There is a significant difference across the regions again and within the region on the account of the level of exposure for Mission Indradhanush. Chitrakoot District, in the northern region, has the highest level of exposure for IMI i.e. around 87%, followed whereas Haridwar district in the northern region has the lowest exposure level for IMI i.e. around 60%.

FINDINGS- RECALL OF MESSAGES

First Recalled Health Promotion Message

In general, with the use of the Pareto Principle (also known as the 80/20 rule) it was observed that, out of 2214 respondents, 80 percent of respondents could recall dengue, cancer, and malaria-related health advertisements across regions. Very few (around 20%) could recall other health-related advertisements.

FINDINGS- INTENTION TO BEHAVIOUR CHANGE

Disseminate Information/Motivate/Inform Others

Across programs in the study, most of the respondents or their families disseminate the benefits of the advertisements to others. It was interesting to found that respondents in the Northern region do not like to share information with others as compared to respondents in other regions. For example, it was found in NVBDCP, in Ramanathapuram district of the Southern region, almost every person i.e. 99% share and disseminate information received with other family, friends, and known. But information-sharing habits are very less in the northern region as in both Chitrakoot and Haridwar just 57% and 53% person share/disseminate information with others.

Perception about Impact of Health Promotion Messages on Suggested Actions

Overall, the majority of the respondent's regions believe that these advertisements have been able to change their mind and action. In Chitrakut district of the Northern part of the nation, only 5 percent of respondents reported that these advertisements have not been able to change their mind and action, out of this 5 percent, 17 percent of respondents reported the reason for this is no TV at their home and 11 percent of them feel that so much of information

overloaded and no regional flavor in these advertisements whereas almost all respondents were taken into our study from the Southern region felt that these advertisements have been able to change their mind and action. Ninety-eight percent of respondents from the Central and Haridwar district of North India respectively felt that these advertisements have a great role in changing their minds and people's action.

In the North-Eastern region, 85 percent of respondents believed that these advertisements have been able to change their minds and action whereas 15 percent of respondents don't believe the same. Out of this 15 percent, 24 percent of respondents believe that too much information is overloaded in these advertisements. Some respondents (18 percent) claimed that because of the non-availability of the TV at their home and 20 percent of respondents claimed no regional flavor in these advertisements as one of the reasons for not changing their mind and action after watching these advertisements.

IMPLICATIONS OF THE EXPOSURE, RECALL AND INTEND TO CHANGE FINDINGS

The rapid assessment study of the central IEC Division, MOHFW, clearly brings out that, despite challenges and constraints, they are doing a good job and must continue to be supported and further strengthened. It can do much better and achieve greater impact provided some SMART, strategic, organizational, creative, operational, human, and financial resources management is undertaken for SBCC as outlined in the following detailed analysis of reasons for such behaviour, challenges, and way forward.

MEDIA USAGE AND BEHAVIOUR FINDINGS

Desk Review

From the desk review, it has been found that most of the IEC Strategy /Plan is based on days and events spread across the year and there is no baseline or formative study as evidence available to form the IEC strategy/plan. A somewhat reactive approach was adopted where messaging only is not based on primary generated evidence but as required and needed.

Community Survey Findings

From the community survey, it has been analyzed that just 6% of the overall sample population is having **access to the radio**, in a rural area it 5% whereas in urban areas it 9%. Further, in the Southern Region, access to radio is 29% mainly due to the use of

Smartphones, whereas in the Eastern and the North-Eastern region it is almost 0%. FM Channels are mainly used while driving mainly in urban areas.

The penetration of mobile phones is just overall at 44%. In the central region, it is just 33%, whereas in the Southern region it 52%. A significant variation across regions (UP 86%, Uttrakhand 66%, Assam 58.5%) and within regions (across districts) have been observed concerning exposure of health promotion messages.

Qualitative Findings from Community

During the in-depth interaction with the community members, it has been observed that most of the community members especially in the rural areas don't watch Paid TV Channels. Also, religious and crime-related shows are preferred by the community on free private channels over DD and the best time for viewing TV is 6:00 pm to 8:00 PM in the rural areas whereas prime time in the urban areas is 8.00 PM -10.00 PM. Also, it has been observed that viewership and preference for watching TV channels vary across regions. These findings are supported by recent BRAC TV audience viewership reports which started segregating urban and rural viewership data.

Findings from Interviews with Functionaries

In one of the interactions with the functionaries, it was suggested by the district administration that the success of community radio is doubtful in the rural areas because of the absence of radio sets and smartphones.

MEDIA PREFERENCE FINDINGS

Qualitative Findings from the Community

During the in-depth interaction with the community members, it has been noted that Inter-Personal Communication (IPC) by ASHA and ANM is the better mode in rural settings. Also, the respondents from the Northern, Southern and Central region suggested television as the best medium among all other media whereas most of the respondents from Eastern, Western, and North Eastern regions suggested that awareness workshops and seminars are the best way to educate people of their communities. Also, the participation of the Local Community/Faith Leaders, members of the PRIs will also be useful. These TV advertisements/other forms of IEC help the community to better interact and understand ASHA workers.

Findings from the Interactions with Functionaries

During the interaction with the functionaries, it has come out that the Miking/Munadi and the announcements made by religious leaders has been taken up seriously by the community. According to them, the combination of short audios and visual messages on the mobile vans/boat is a better IEC method as done by political parties during the elections.

RECOMMENDED WAY FORWARD

Rework Communication Strategy and Media Plan as per SBCC

MOHFW needs to go beyond special days and events. It should plan a communication strategy based on community needs (epidemiological and behavior data) and targets fixed in NHP. Urban and rural areas are required to have separate specific strategies and media plans to address regional priorities and challenges. In this strategy, a dynamic robust media plan is required to be developed by considering regional and urban timing and channel preferences mentioned above. In the media plans, rethinking, re-planning radio is required as it has lost its relevance in rural areas. In urban areas, the penetration of digital and social media platforms should be increased aggressively. For the rural areas, social media can be used through IPC by grassroots level functionaries as there is very low penetration of smartphones and the internet. The Bureau of Outreach and Communication (BOC) constituents Directorate of Field Publicity (DFP) and Song & Drama Division (S&DD), the partner institute of MOHFW for communication, should leverage effective partnerships for IEC strategy with Local NGOs and community leaders as they are better heard by the community.

FINDINGS- EXECUTION OF IEC STRATEGY

Desk Review

During the desk review, it has been noted that there is no formal unified document as “National IEC guidelines”. Some Letters/ circulars contain some operational instructions for the NHM whereas some of the states like Madhya Pradesh and Tamil Nadu have prepared IEC guidelines. Also, there is no formal linkage between Central IEC (SNA) Division, IEC activities of other national programs, State IEC divisions, and the NHM funding for the IEC. Every activity/scheme functions as a standalone activity.

Findings from the Interactions with Functionaries

During the in-depth interaction with the functionaries, it has come out that the District officers do not plan and propose IEC activities as per the local needs in the district PIP. Templates are filled as per past data or a model document shared by the state government. Hence, neither local community needs are identified nor media planning for the same has been done at the district level with few exceptions. Also, 25 percent of the grass-root level functionaries didn't receive any IEC material (Posters, Hoarding, and Booklets). Across all the districts in the study, the district level officials and the grassroots level functionaries had shown concerns about the delays in receiving material, and even some times, it reaches after the scheduled campaign. No specifications about where to display and how to use a particular IEC material are given. Further, materials to fix hoardings/banners/flex material are not sent. According to them, the display of different IEC material in LED/LCD screens found interesting to the community. Also, the use of PICO Projector by ASHA Supervisor/ANMs as a pilot found useful to conduct IPC in the Uttrakhand and Tamil Nadu region. Moreover, these TV advertisements/other forms of IEC by the state governments help ASHA/ANM workers to better interact and make the community understand, change behavior, and sustain it.

Study Team OBSERVATIONS

During the visits, the study team observed misplacements and out of context usage of IEC material at several places. Also, many IEC materials received and pasted in health facilities lead to disinterest in the community. Moreover, most of the IEC/BCC officers do not know about his role and responsibilities beyond the routine jobs of sending and receiving IEC materials.

Suggestions During the National Consultation Workshop

During the National Consultation Workshop, it has been suggested that the SNA division should develop detailed National Guidelines for states so that not a single penny should get wasted. Also, Quarterly Coordination meetings of National SNA, Programme, and State IEC divisions should be in place, and further, the states should carry similar meetings with the districts to improve the results. Also, it has been suggested that IEC Best Practices Summit on IEC should be organized annually to share, learn, document, and reward IEC experiences across the nations.

WAY FORWARD

Synergising Operational and Implementation Plan

To synergize IEC operational and implementation plan at Center, State, districts, and IPC at the village level, the SNA division should issue National Guidelines containing various aspects of IEC planning, implementation, and evaluation. These guidelines should be followed up with a national strategy with the regional and local level approach as mentioned earlier. For effective partnerships to implement a national strategy, a coordination mechanism needs to be institutionalized between the SNA division and other National Health Programmes, States, and Districts. This mechanism may be established in the form of half-yearly strategic planning and review meetings followed by a quarterly meeting to monitor the progress. Further, the SNA division should organize national level IEC Summit annually to share, learn, and reward IEC experiences across nations. In addition to the above, IEC efforts should be integrated with other outreach schemes and databases of Centre and State governments. For example,

a) Mobile Van used for Rashtriya Bal Swasthya Karyakram (RBSK) can be fitted with an Audio Video screen for spreading IEC messages in the village when the RBSK team works in the school

b) Registration data collected at OPD (mobile number with diagnosing) should be used for sending specific IEC material or SMS.

FINDINGS: CONTENT OF ADVERTISEMENT

Desk Review

A Concurrent Evaluation of Phase II of the NRHM BCC Campaign by ORG Centre for Social Research funded by USAID and PFI concluded that the need for producing content that can be localized and the contents are majorly developed by the development partners. MOHFW is not having the capacity to produce such content at its due shortage of skilled manpower, financial resources, and research base.

Community Survey Findings

Across all the regions, 73 percent of respondents could recall in the NVBDCP advertisements that diseases spread by mosquitos, 72 percent of respondents could recall the breeding places

of mosquito whereas just 15 percent of respondents could recall that free blood examination facility is available in all government centers.

Respondents have been asked to recall the messages communicated in the NPCDCS advertisements. Across all regions, 56 percent of respondents could recall the risk factors cardio-vascular diseases whereas only 7 percent of respondents could recall symptoms of Cancer and 6 percent of respondents could recall symptoms of diabetes respectively.

Across all the regions in the study, 66 percent of respondents could recall in the IMI advertisements that vaccination age birth to 5 years, 54 percent of respondents could recall that seven times visit for vaccinations in 5 years is a must whereas only 17 percent of respondents could recall that all vaccines are free of cost at Government health facility.

On analyzing the reasons for not sharing information with others, common reasons that come up are "I am not able to understand the message properly" or "Message was not very Interesting" across regions.

Findings from the Interactions with Functionaries

During the interaction with the functionaries, two major findings came out in this regard. Firstly, Posters/Booklets are not very useful with too much information. They need to be more pictorial material in a local culturally appropriate and sensitive manner. For example, local folk dance can replace western dance on NCD posters. Secondly, Localization of IEC material is not done. For example, for the deworming campaigns hoarding translated deworming in the Hindi as *Krimi Mukht Abhiyaan,* community members did not understand the same. It should have used simple local language like *Bachoo ke Paet ke Kide Merne/Mukti Abhiyaan*.

Suggestions during the National Consolation Workshop

During the National Consultation workshop, it was suggested that standard messages should be prepared at the centre, and the state government should involve the state medical college PSM/community medicine departments and other local experts for localization of the materials sent by the centre rather than just simple translation.

WAY FORWARD

1. Improve the internal capacity to generate quality content by getting consultants and empaneling creative agencies those who will design, develop, and pre-test content based on available Behavioural and epidemiological data

2. Content developed by donor and development agencies should be developed in participation with SNA and just taken as given on face value.

3. Both at the National and State level engage communication specialists, Mass communication experts, and experts in various research institutes/public health institutes like NHIFW, IIPA, PHFI, IIMC, and PSM/community medicine department in medical colleges to vet the content as per local needs, pre-test and validate.

4. Be innovative about content and campaign instead of just being 'informative" and technically and medically right considering the SBCC strategy.

5. A diverse range of content should be developed to suit and appeal to the different regional audiences as well as the urban-rural audience.

FINDINGS - MANAGEMENT OF FINANCIAL RESOURCES

Desk Review

The trend analysis of budgeted revised estimates (RE) for expenditure on the *Swastha Nagrik Abhiyaan* (erstwhile IEC scheme) shows that overall there is a decreasing trend over the last 5 years. Similarly, in none of the years, the SNA division could spend annual budgeted funds. The gap between budgeted and actual expenditure was the highest in the year 2017-18. Similar to National IEC expenditure the huge gap has been observed in allocated and actual expenditure under NHM for IEC to Sample State Governments.

The program-wise utilization of IEC funds in the last three years shows that the expenditure on Reproductive and Child Health (RCH) is the highest among all other programs, followed by NVBDP. Though RCH is a historical focus area of MOHFW but is expenditure does not match with national disease profile and epidemiological data. MOHFW has to increase IEC expenditure on NCDs and Mental Health issues, which account for almost 50% of the discease burden.

Findings from the Interactions with Functionaries

During the detailed discussion with the MOHFW officials it was found that other than few planned campaigns, the division spends conservatively so that they can preserve funds for the possible contingent epidemics. Delay in receiving funds under NHM is a major cause of unspent budget reported by state/district officials. District officials informed that either no earmark funds or a meager amount are allocated for local level IEC which is spent for printing stationery. There is no flexibility on national program-specific IEC Budget as even type of media usage is fixed.

WAY FORWARD - EFFECTIVE UTILIZATION OF FINANCIAL RESOURCES

- Increase the National budget of the SNA Division to at least double from the current levels to fulfill the unmet demand for important public health issues like mental health, NCDs, Geriatric care, etc. Further, additional budget allocation is needed for PROMOTIVE care like improving immunity, exercises, healthy lifestyles, etc. to bring a sustainable change in health-seeking behavior and improved health outcomes.
- Since epidemics/pandemics are creating inefficiencies and causing poor financial management and unspent budget, it is recommended to create a separate replenish-able pool of funds to finance unplanned epidemics like Ebola, ZIKA, Swine flu, COVID 19, etc. This will help to stop diverting funds for emergencies and ignoring daily needs.
- Streamline IEC Budgeting and fund flows & empowering State and District under NHM is another area for action. Timely approval and disbursal of the budget at all levels is a must for better utilization of the funds. Further, for local disease, misconceptions, and epidemics separate IEC budget should be given to the districts. On various National Programs, the budget on IEC should give the flexibility to choose media as per local needs. State governments should hold quarterly discussions with districts for the finalization of annual action plans and monitoring of the same inline of national plans.

FINDINGS: MONITORING, EVALUATION OF IEC ACTIVITIES

Desk Review

Following are the few observations which have been made during the desk review-

1. Progress of IEC activities is not monitored based on campaigns based output indicators like exposure, recall, and behavior change indicators rather it has done based on process indicators i.e.
    - Progress on Annual Action Planned activities
    - Proxy Indicator like TV viewership data of BARC India
2. No baseline or formative study as evidence to form the basis of the IEC strategy/plan of MOHFW.
3. No impact assessment or detailed evaluation of the impact of IEC activities
    - Brief studies carried to review Organizational Needs Assessment (2012), issues and challenges faced by IEC Division of MOHFW (IIPA, 2017), or concurrent evaluation of a campaign (2009)
    - No documentation to showcase the success stories of the scheme
4. Swachh Bharat Abhiyan's IEC monitoring and evaluation system has shown a way forward to SNA to learn and set monitoring and impact indicators for each campaign.

Findings From the Interactions with Functionaries

During the in-depth interaction with the functionaries, it has been noted that none of the districts covered in the study has conducted any formative/ need assessment study, which can be used for media planning, targeted intervention, addressing misconceptions, etc. Also, in absence of an effective monitoring system on the usage of IEC material at the district/block level, it creates a hindrance in media planning. Besides, none of the districts or states covered in the study has conducted any impact assessment of its IEC activities. It's important to note that only 29 percent of health workers maintain records of the stock of IEC materials received and used.

WAY FORWARD RESEARCH, MONITORING & EVALUATION

There is a dire need to develop robust research, monitoring, evaluation, & documentation system for SNA. For this purpose, a formative study for each health issue can be crowd funded. In each district, health administration can assign the live project to final year students from the community medicine department of medical college or Masters of social works to carry out formative studies for different public health issues. These studies will help to

initiate localized SBCC campaigns. Based on these studies, for each campaign to monitor its progress and success, output and outcome indicators need to be developed for each campaign. SNA division should conduct a quarterly concurrent evaluation of IEC campaigns for effective monitoring of progress. The outcome report of such concurrent evaluation should be published online and reviewed during the suggested half-yearly progress meetings of central and states IEC coordination committees. For impact assessment, as the recall rate of each campaign is low, therefore, SNA should carry out bi-annual third party external evaluation at the National Level to revisit the strategy.

FINDING - HUMAN RESOURCES & CAPACITY BUILDING

Desk Review

During the desk review, it has been noted that the IEC division officers are neither professionally qualified nor equipped (in terms of resources) or trained to chalk out M&E plan for their campaigns. There is a need to set a PMU for the same (IIPA, 2017).

Observations during the Field Visit

During the field visits, the study team observed that out of 7 districts visited, 4 districts have vacant district IEC official positions and with more than 50% vacant block communication coordinator positions in each district. Also, due to lack of capacity in terms of technical know-how, shortage of human resources, and paucity of time, state governments just carry facial changes and do not localize IEC material open files sent by the Centre. No induction training to newly joined District/Block/State IEC officers has been undertaken, which resulted in the non-performance of strategic jobs (media planning, localizing the content, planning for campaigns for local issues, contributing to DPIPs) and they are just carrying the routine activities. No person has been given any specific or specialized training related to IEC/SBCC at any level in recent times in any state and this has been observed even in the central government. Only sixty-three (63) percent of the grass-root level functionaries have received guidelines on how to use specific IEC material during monthly meetings.

WAY FORWARD HUMAN RESOURCES & CAPACITY BUILDING

1. Fill vacant sanctioned positions by upgrading job descriptions and qualifications as per the present-day IEC requirement.

2. Set up PMU as recommended in an earlier study report by IIPA.
3. The orientation manual needs to develop for newly joined staff.
4. Three to five days Capacity Building Workshop to be organized for the district and block Officials on SBCC.
5. Exposure visits should be organized for the central staff to state for learning and experiencing grass-root level issues.

Chapter 1: Introduction

BACKGROUND

Recipients of the public health services must be well-informed about various services and benefits available to them. The recipient of public health services are not simply users of the services but are strategic partners in generating demand for the same. To meet these ends, the Information, Education, and Communication (IEC) strategy of healthcare service providers take an important function. Effectiveness of the IEC strategy is critical for the success of any public health intervention as IEC plays a crucial role in every stage of the Programme intervention - from awareness generation to demand generation to behavior change and finally to social change.

IEC has evolved as a key concept in preventive care, primary health care, community health, and health promotion (Valente 1994; Cofie, et al. 2013). The importance of IEC for achieving better health outcomes in public health interventions has become more significant in developing countries where health outcomes indicators are very poor (Elmendorf et al., 2005; Waisbord and Larson, 2005). The effectiveness of the IEC strategy depends upon (1) frequent and consistent IEC messages (2) use of right media mix i.e. use multiple media channels (mass and interpersonal channels) (3) active participation of community workers and heads (4) rigorous monitoring and evaluation of campaigns (5) redesign and redevelopment of campaigns and strategy (Cofie, et al. 2013; UN IATF-Religion, 2018).

Over the last four decades, health communication programs of the governments have evolved substantially from largely ad-hoc, isolated prescriptive medical doctor prescriptive message to a strategic approach that treats communities and individuals as participants and as consumers (Figueroa et al. 2002). IEC strategies have evolved to Behaviour Change Communication (BCC) strategies and further to a more comprehensive level i.e. Social and Behavior Change Communication (SBCC) strategies in many countries. While designing an SBCC strategy the policymakers formulate an evidence-based, participatory, and well-targeted researched communication intervention to address community knowledge, attitudes, and practices with an appropriate mix of interpersonal, group, and mass media channels (Neill McKee, 2008). Campaigns are targeted not just to educate people, rather it also includes social change messages to dispel prevailing misconceptions, associated stigma, and discriminations in the society (Bekele and Ali, 2008).

The adoption of the Sustainable Development Agenda by all United Nations Member States in 2015, has further changed the game for communicators in development institutions, especially in the health sector. Sustainable Development Goal (SDG) 3: 'Ensure Healthy Lives and Promote Wellbeing for All at all Ages' not just provides health communicators with a formal mandate and specific targets to raise awareness, build knowledge, and inspire people. Rather it asked for a complete transformation of the public health system by collaborating with new partners to reach all audiences of all ages (OECD Dev Com, 2017).

Like other SDG signatories, the Indian government has shown its commitment towards SDGs by adopting the New Health Policy in 2017 focussing on ensuring healthy lives and promoting the wellbeing of all at all ages. The policy recognizes the pivotal importance of SDGs by including time-bound quantitative goals aligned to ongoing national efforts as well as the global strategic directions, The policy envisages to attain SDG 3 through a preventive, promotive health care orientation and ensuring universal access to good quality health care services without anyone having to face financial hardship as a consequence (NHP, 2017). At the IEC front, the policy articulates the need for the development of communication strategies and institutional mechanisms by initiating Swasth Nagrik Abhiyan – a social movement for health.

Considering all the above developments, it became imperative to review and take stock of the IEC strategy, plan, and activities of the Ministry of Health and Family Welfare (MoHFW)[2]. NITI Aayog, the premier policy 'Think Tank' of the Government of India (GOI), responsible for providing both directional and policy inputs to GOI assigned this task to the Indian Institute of Public Administration (IIPA), the premier policy training and research institute of the Government of India. IIPA carried out an independent rapid assessment of the Central IEC strategy and activities of the MoHFW for the Finance Commission Cycle (2017-20). The scope of this study is restricted only to the IEC activities financed under the Central Government Scheme. It does not include only IEC activities carried out by State Governments. The period for the field study was August 5 to December 5, 2019. Considering resources and time constraints the focus of the study was restricted to NITI Aayog aspirational districts.

[2] Nodal Ministry for policy, planning and implementation of national health policy and programmes.

OBJECTIVES OF THE STUDY

The main objective of this assessment study is to document the learning from the experiences and bring out suggestions to improve the planning, designing, and implementation of Swasth Nagrik Abhiyaan (IEC program) keeping in view the targets of National Health Policy 2017. Specific objectives of this assessment study are to

- Assess the impact of IEC awareness in select aspirational districts for various activities outlined in the scheme;
- Review the monitoring and evaluation activities undertaken in the program;
- Review the budgetary allocation and financial viability of the IEC plan in terms of adequacy, utilization, and relevance;
- Assess the strengths and challenges in existing communication plan and strategy because of the changing health environment; and
- Review the role of social media, electronic and print media, and mid-media activities.

RESEARCH PROCESS & METHODOLOGY

To meet the above assessment study objectives, a cross-sectional study design was used. The study has used mixed method research i.e both qualitative and quantitative research approaches. Both primary and secondary data sources were used in the study. Secondary data sources include annual reports of MoHFW, Common Review Mission (CRM) Reports, action taken report of IEC divisions, expenditure records for IEC division, research studies by development partners and states NHM divisions, Feedback, comments, and shares received for social media content analytics and data on TRP published by Broadcast Audience Research Council (BARC), etc. Primary data sources included

- Survey with the community for exposure, recall rate, and understanding for communicated messages
- Focus Group Discussions (FGDs) with the community for comprehension, appeal of the theme/ specific spots and ascertaining individual health-seeking behavior change
- In-depth interviews (IDIs) and Discussions with the key stakeholders at national, state, district, and functionaries at the village level, etc. for policy planning and implementation challenges.

Sampling Framework

The basic design and operational plan for the communication campaigns of the IEC division of the MOHFW are designed on basis of specific days, spread over the year. Every year, the number of these campaigns ranges from 50-60. Considering the earnestness and paucity of time and resources, the major three campaigns based on budget spent, the timing of campaigns, and relevance have been selected for the study (See Table1.1). The study has included IEC campaigns of the IEC division of MoHFW. State government IEC campaigns under NHM funding were not included in the study.

Table 1.1: Targeted Audience and Sample Campaigns

Sample Campaigns	Targeted Sample from Community	State, District, and Block Level
Immunization Mission Indradhanush	• Married women from 15-29 or Women with Child up to 5 years • Currently Married men: husbands of women of 15–29 years or a Father of Child up to 5 years • Mothers-in-law and fathers-in-law of women of 15-35 years	• Policymakers • State Programme Managers • District and State IEC Nodal Officer (BCC Officer) • District Immunization Officer • ASHA • AWW • ANM • PRIs
National Vector Borne Disease Control Programme (NVBDCP)	• School Children • Adults Male • Adult Female	• Policymakers • Program Managers • District and State IEC Nodal Officer • District Malaria Officer • School Teachers • ANM • ASHA • PRIs
National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)	• Adults Male • Adult Female	• Policymakers • Program Managers • ANM • CMO • MO PHC, CHC

To get geographical representation, the aspirational districts are divided into 6 geographical regions i.e. (i) North, (ii) East, (iii) West, (iv) South, (v) Central, and (vi) North-East. One aspirational district was selected from each region. Since the Northern Region has more states

and aspirational districts, therefore, instead of one state, two states (one district each) were selected from the same (See Table 1.2).

Table 1.2 Sample Size

Region	States	Aspirational District	Final Sample Size	No. of FGDs	IDIs
North	UP	Chitrakoot	314	4	28
	Uttrakhand	Haridwar	315	4	28
East	Bihar	Begusarai	307	4	28
West	Rajasthan	Baran	261	4	28
South	Tamilnadu	Ramanathapuram	374	4	28
Central	MP	Vidisha	318	4	28
North East	Assam	Dhubri	325	4	28
Total			**2214**	**28**	**196**

For the survey with the community, the sample size of target beneficiaries has been calculated statistically. The average sample size calculated for each district was 304. A total of 2214 beneficiaries were selected for the exposure, recall rate, and understanding of communicated messages. Field visits in all the districts were for 2-4 days. In each district, 1/3rd of the sample was collected from the urban area and the remaining 2/3rd of the sample was taken from the two rural blocks (1/3rd each). Three teams were recruited from the fields for 3-4 days. Since beneficiaries for two out of three targeted campaigns are the same almost the same. Therefore, all beneficiaries except school children were part of the process. School children's feedback was taken in Focused Group Discussions. The study team had tried to ensure both genders should represent equally in the total sample.

Focused Group Discussions

For the school children instead of the survey, a special focus group discussion was organized to gain insights from the school children about the message on National Vector Borne Disease Control Programme (NVBDCP). Other than School children FGDs, since the targeted audience in the study were diversified and heterogeneous, therefore, different heterogeneous groups were covered to capture experiences (for measuring impact) and viewpoint (to gain way forward). In each state, 4 FGDs were carried, out of which, one FGD was with all women (especially of the rural area) to gain female perspectives. In addition to female FGDs, two focus group discussions (one urban and one rural) were carried out in each Aspirational District. Each FGD had 10-15 targeted respondents from diversified age groups.

In-depth Interviews

In-depth Interviews and semi-structured discussions were conducted with various stakeholders at the national, state, and district levels.

- National Level – Joint Secretary of IEC division, Joint Secretary of NVBDCP, Director IEC division, Under Secretary, Section Officer (IEC), Consultant IEC.
- State Level- State Program Manager and State Communication/Nodal Officer.
- District Level- Block and district officials like DM, CMO, DPM, BPM, BCMO, DCM/DCC.
- Key Grassroots Level Functionaries: Semi-Structured In-depth interviews were conducted with ANM, ASHA, and AWW health workers.

Quality Control in IDIs and FGDs

Further to ensure the high quality and proper understanding of field situation FGDs and key Informant in-depth interviews were conducted by core team members themselves along with a note-taker. To ensure proper transcription of qualitative data audio version of i.e. FGDs and IDIs were digitally recorded after getting informed consent from the respondents. To avoid loss of data, a double back up of audio files was taken daily. The audio recorded IDIs and FGDs were transcribed and translated then these files were complemented by field notes.

Desk Review

Desk review of the existing documentation includes:

- National Family Health Survey – 4 (2015 -16)
- Situation Analyses: Backdrop to National Health Policy 2017
- National Health Policy 2017
- UN Sustainable Development Goals
- Annual Report of Ministry of Health and Family from 2012-13 to 2016-17.
- IEC material uploaded on social media platforms like Twitter, YouTube Channel, Facebook Page
- Media Plans of MoHFW
- Annual Communication Plan and Action Taken Report (ATR) of IEC Divisions
- Detailed Expenditure summary of IEC division

- Media Research Users Council's Indian Readership Survey (IRS) 2015
- Data on TV viewership published by Broadcast Audience Research Council (BARC)
- All India Listener Data of Audience Research Unit of Prasar Bharti
- Regular program reports, such as from JRM and CRM, which include BCC as one of the key functions for achieving health outcomes
- Discrete BCC studies, such as that by NIHFW on Impact Assessment of IEC Campaign on National Programme for Prevention and Control of Deafness; USAID-FHI Behavior Change Communication Activities and Achievements: Lessons Learned, Best Practices and Promising Approaches; USAID-IHBP Rapid Organizational Needs Assessment of IEC Division of Government of India: Ministry of Health and Family Welfare; UNICEF-ORG Centre for Social Research Assessment of Effectiveness of IEC Materials at Integrated Counseling and Testing Centres; PFI-MCHSTAR-USAID-ORG Centre for Social Research A Concurrent Evaluation of Phase II of the NRHM BCC Campaign

LITERATURE REVIEW

There are many BCC studies conducted in the recent past. Some of the previous studies referred to in the conduct of this study are: Study by NIHFW on Impact Assessment of IEC Campaign on National Programme for Prevention and Control Of Deafness; USAID-FGI Behavior Change Communication Activities and Achievements: Lessons Learned, Best Practices and Promising Approaches; USAID-IHBP Rapid Organizational Needs Assessment of IEC Division of Government of India: Ministry of Health and Family Welfare; Evaluation of IEC activities under NLEP, UNICEF-ORG Centre for Social Research Assessment of Effectiveness of IEC Materials at Integrated Counseling and Testing Centres; PFI-MCHSTAR-USAID-ORG Centre for Social Research A Concurrent Evaluation of Phase II of the NRHM BCC Campaign, 2009. The key findings and recommendations which are common to some of the studies on IEC activities are mentioned in Figure 1.1 & 1.2.

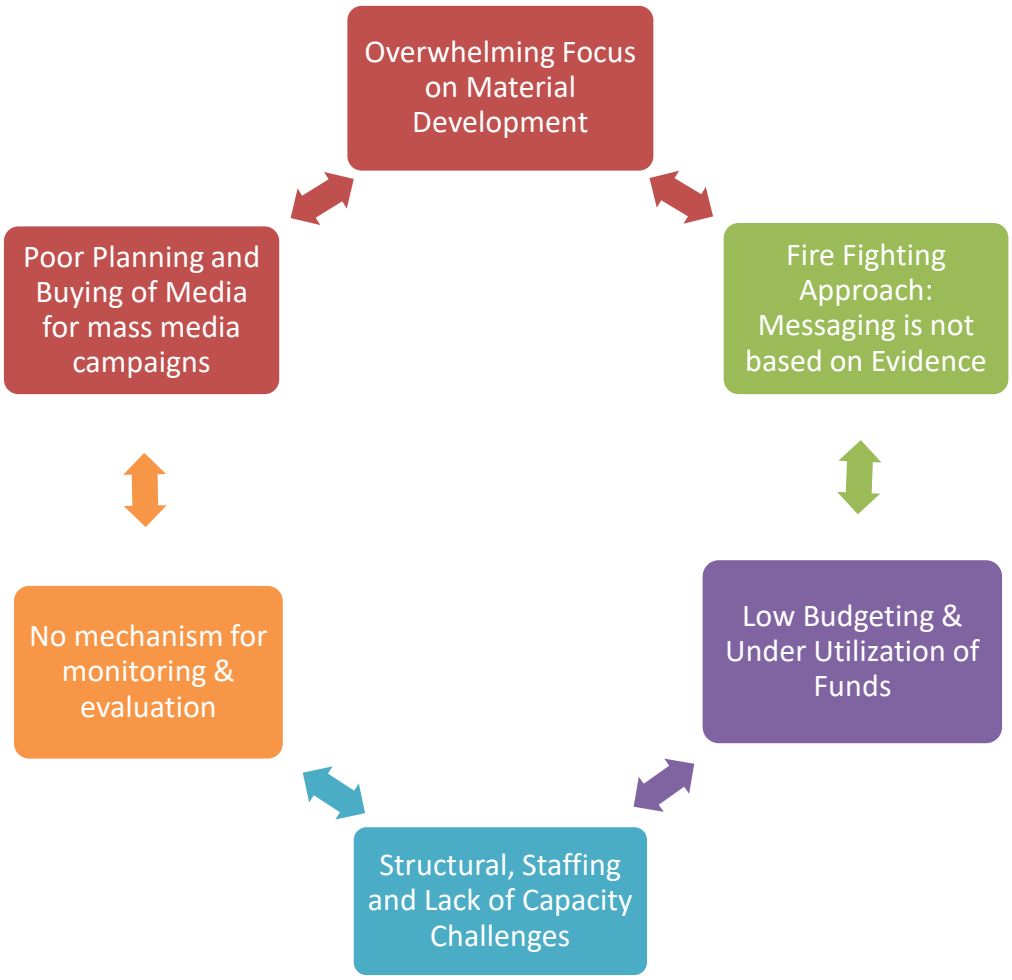


Figure 1.1: Challenges in Planning and Implementation of IEC activities at MOHFW

Key Recomendations of Past Studies

- National level mass media campaigns should link with state level complementary BCC approaches led by local change agents such as ASHAs, ANMs and AWWs.
- To avoid message dilution, it may be beneficial to broadcast fewer themes with more intensity rather than having so many different messages.
- The Ministry should consider tracking the frequency and timing of spots aired on TV and radio through a trackin agency.
- Spots should be creative and entertaining.
- Improve budgetary planning and management.
- Strengthen Implementation and tracking.
- The Ministry should continue to conduct periodic concurrent evaluations to improve the impact of subsequent campaigns

Figure 1.2: Key Recommendations from Past Studies

One of the studies was conducted in the rural area of Delhi i.e. in RHTC Bijwasan comparing it with the urban area. The cross-sectional study design was used whereby patients coming to Base hospital OPD of Delhi cantonment were included. The objective of the study was to

assess the malaria knowledge just before the commonwealth games in both the setups, where intensive IEC activities were undertaken by various public health agencies. It was found that vector control activities like IEC, fogging, source reduction, and most importantly community participation has helped in raising the awareness levels in both the setups (rural as well as urban). The study concluded that these activities esp. IEC activities that were undertaken during the commonwealth games should be regularly carried out routinely in malaria-endemic regions.

Similarly, one study was undertaken to assess the impact of Information, Education, and Communication (IEC) on Knowledge, Attitude, and Practice on HIV/AIDS among the slum dwellers of Dhubri town of Assam. A total of 492 slum dwellers aged 15-60 years were selected from all the slums of Dhubri by probability proportional to size (PPS) sampling method. The study was conducted in three stages. First, a baseline KAP survey on HIV/AIDS was done followed by IEC intervention. Then, just after the intervention, another survey was conducted, and after six months period, the final survey was conducted. It was found that Eighty-seven percent of the study subjects heard about HIV/AIDS. Baseline knowledge regarding prevention of transmission of HIV/AIDS by having one faithful sex partner was there among 65% of the respondents, which increased amongst 82.2% of the respondents just after the intervention and amongst 68.5% of the respondents after six months period; similarly, knowledge of prevention by using condom increased from 70.7% to 80.3% and 76.3% of the respondents; using safe blood increased from 57.7% to 75.4% and 62.9% of the respondents. The study concluded that these intervention programs i.e. IEC activities were useful in enhancing the awareness regarding HIV/AIDS among the underprivileged population.

DATA COLLECTION AND ANALYSES

The study team consisted of 4 professionals who visited all the 7 districts from August 25, 2020, to December 15, 2020. The study team spent 2 to 4 days in each district to collect and carried out detailed discussions with all defined stakeholders. Primary data was collected by using several research tools such as in-depth round table discussions, interviews with key stakeholders, semi-structured questionnaires, etc. The study tools are attached in Annexure 1. From each campaign output and outcomes were selected and these indicators were related to viewership, reach, recall, awareness level, and individual health-seeking behavior change. Some of the selected indicators are mentioned below:

- Percentage of the population exposed to the healthcare advertisement
- Percentage distribution of the population by their media exposure – TV, Radio, Newspaper, booklets/leaflets/posters
- Percentage of the population found difficulty in understanding the advertisement
- Percentage of the population who can recall the advertisement among the rural and urban population
- Percentage of the population who intends to take action after watching advertisements

Collected quantitative data were analyzed by using statistical software SPSS and qualitative data were analyzed with the help of ATLAS-ti software. Obtained qualitative and quantitative data were triangulated by using a triangulation design mixed method convergence model (Creswell and Clark 2007) (Figure 1.3). Further, qualitative data obtained through In-depth Interviews with National, State, and district level functionaries were analyzed by comparing their views with plan documents and field notes with the help of strategic analysis techniques.

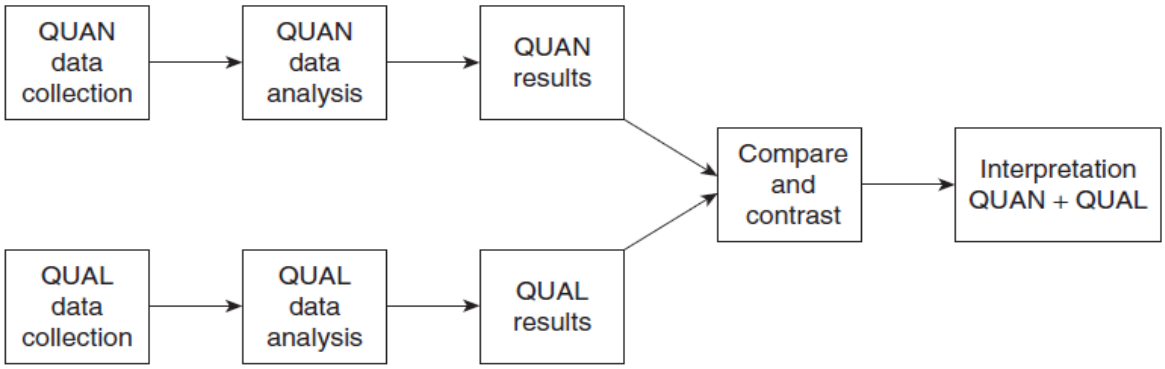


Figure1.3: **Triangulation Design: Convergence Model (**Creswell and Clark 2007, pp. 63)

LIMITATION OF THE STUDY

Considering earnestness and paucity of time and resources, just major three campaigns based on budget spent, timing and relevance were selected for the study. The study included IEC campaigns of the IEC division of MoHFW and allied campaigns of program divisions of MOHFW. State government IEC campaigns under NHM funding were not being included in the study. From each campaign, 2-3 individual level health-seeking behavior outcomes were selected. These indicators were related to viewership, recall, awareness level, and individual health-seeking behavior change. The study has not included service-related behavior change indicators. The study included only aspirational districts which are not very high performing.

Chapter 2: IEC Activities of MOHFW

OBJECTIVES OF IEC ACTIVITIES OF MOHFW

The Information, Education & Communication (IEC) of MOHFW aims to create awareness and disseminate information regarding the benefits available under its various schemes/programs and to guide the citizens on accessing them. The other broad aim of the IEC activities of MOHFW is to encourage the build-up of health-seeking behavior among the masses in keeping with the focus on promotive and preventive health. The IEC strategy caters to the different needs of the rural and urban masses through various communication tools. Specifically, the main objectives of the IEC activities of MOHFW are to:

- inform people about the healthcare facilities and services available to them
- increase acceptance and uptake of government services, schemes, initiatives, and programs
- to raise levels of public knowledge on important health issues; promote positive attitudes and norms to facilitate health promotion and disease prevention
- reach out to various and diverse regions and communities through targeted programs that leverage mass, mid and interpersonal media choices while harnessing the advances in technology via the use of social media
- build capacity of the state governments to design, implement and monitor effective communication strategies

The Ministry has taken up several, targeted campaigns focusing on Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), Mission Indradhanush, Mother's Absolute Affection (MAA) (for promoting breastfeeding), family planning services, new vaccines such as IPV, MR, rotavirus, etc., TB-free India, Tobacco Control, Oral and Mental health, Blood Donation, Healthy practices such as hand washing, for prevention and control of vector-borne diseases such as dengue, malaria, H1N1, etc. Campaigns to counter myths and apprehensions and to inform masses of emergency response mechanisms during outbreaks such as Ebola and Zika have used various media platforms of traditional and new media.

KEY ACHIEVEMENTS

IEC has been a key component in the notable achievements of the Health Ministry, and some illustrative ones are listed as under:

- The country rate of decline in IMR and MMR has been more than the global rate of decline.
- Women age 20-24 years married before age 18 years (%) has come down from 47.4% to 26.8% (NFHS 4)
- The percentage of institutional deliveries has increased from 38.7% in 2005-06 to 78.9% in 2015-16 (NFHS 4)
- Institutional births in a public facility (%) have been improved from 18% to 52.1% (NFHS 4)
- The total fertility rate (children per woman) declined from 2.7 to 2.2 (NFHS 4)
- Early initiation of breastfeeding (Children under age 3 years breastfed within one hour of birth) has improved from 23.4% in 2005-06 to 41.6% in 2015-16 (NFHS 4).
- The percentage of children with diarrhea in the last two weeks who received oral rehydration salts (ORS) has improved from 26% in 2005-06 to 50.6% in 2015-16. (NFHS 4)
- As per the NFHS 4, 90.7% of the children age 12-23 months received most of the vaccinations in public health facilities, which was 82% in 2005-06.
- The number of JSY beneficiaries has risen from 7.39 lakhs in 2005-06 more than 104.38 lakhs in 2015-16.
- The incidence of TB has reduced from 300/lakh (1990) to 217/lakh (2015), and mortality has reduced from 76/lakh (1990) to 32/lakh (2015).
- There has been a 60.12% reduction in mortality rate and a 35.63% reduction in the incidence of Malaria in 2015 since 2005.
- HIV/AIDS has registered a 67% decline in new infections since 2000 against the global average of 35%. AIDS-related deaths have dipped by 54% since 2006-07 against the global average of 41%.

STRATEGIC IEC/ COMMUNICATION PLAN

The Ministry has designed a strategic framework for targeted IEC activities encompassing mass media, along with mid-media and inter-personal activities to disseminate information

about the various health schemes in the masses. The year-long IEC/Communication Plan has a month-wise focus on health days and health themes. While some activities are taken up to coincide with 'Health Days', others are week and month- long plans for focused multi-media campaigns on schemes of the Ministry. These center on topics such as Integrated Diarrhoea Control Fortnight (IDCF), Breastfeeding Week, and Tobacco Control, etc. Seasonal ailments such as Dengue, H1N1, etc. need campaigns for a longer time.

All the IEC activities have a print media component coupled with TV, Radio Plans, Social Media, and Outdoor Media activities. The following sub-activities have been taken up as part of the IEC activity. There is a mix of these depending on the need for outreach, visibility, and the diverse audience:

Mass Media

1. Radio jingles on national and private radio, and Community Radio
2. TV spots on national and private channels
3. Out of Home (OOH) advertising including posters, banners, hoardings, public utilities, metro rail, and airport spaces, TV screens on railway stations, bus queue shelters, train wrap, etc.

Mid –media

The IEC Division has partnered with the Directorate of Field Publicity (DFP) for activities such as street theatre, songs, and on-ground activities like video on wheels, projections on screens, *Melas,* etc. It has also participated in annual events such as the India International Trade Fair (IITF) at Pragati Maidan which draws lakhs of visitors, and some fairs/exhibitions organized by State governments.

Digital Media

a. E-advertisement on select platforms and internet sites
b. Tweets and infographics to highlight various health issues
c. Videos on campaigns uploaded on YouTube; links provided on You-tube
d. SMSs like Kilkari using MCTS
e. Using mobile technology for messaging through mobile apps

Events

a. Media sensitization workshops at the Centre and States
b. Training and workshops for strengthening capacity at the state level
c. Press conferences and launch events
d. Visits of media persons for reporting from the field
e. Health Melas

Other activities

a. Printing of books, pamphlets, leaflets, policy documents, etc.
b. Research to provide an evidence base to IEC interventions
c. Monitoring and evaluation of the campaigns
d. Project monitoring Unit within the IEC unit at MoHFW to strengthen its capacity

MEDIA PLAN IN ACTION

The Media Plan is monitored to ensure due implementation and mid-course correction, and possible change in the focus to suit the need. Ministry of Health and Family Welfare has laid renewed emphasis on promotive and preventive health which is being advocated through expansive and targeted IEC Campaigns by using traditional as well as New Media.

Print Media

The IEC Division regularly publishes advertisements in all the leading newspapers of India, including regional languages. The aim of such advertisements is not only to encourage people to adopt positive behavior but also to raise awareness and disseminate information regarding availability and access to quality healthcare provided by the Government. Significant health messages are delivered across the country through print media on International Days like **World Population Day**, **World Health Day**, **No Tobacco Day,** etc. For example in 2016-17, regular advertisements were published on spreading awareness on preventing Ebola. Similar advertisements were released to create awareness about Malaria, Dengue, Kala-Azar, etc.

The Division publishes advertisements to mark the launch of various health campaigns like H1N1, Pulse Polio campaign, Conference on Population and Development of

Partners (PPD), India International Trade Fair (IITF), the launch of MAA Campaign on breastfeeding, PMSMA (Pradhan Mantri Surakshit Matritva Abhiyan), COP 7 – Tobacco Control Convention, India-Africa Health Summit, Mental Health Pulse Polio and Gandhi Jayanti, to name a few.

Apart from newspaper advertisements, the IEC Division also publishes pamphlets/booklets to disseminate information and raising awareness on crucial health issues. These documents have been distributed to various stakeholders in advocacy meetings, workshops, and other platforms.

MoHFW also brings out a wall calendar on various themes like 'Newborn and Maternal Health'. The calendar covered several issues highlighting mother and newborn care. It is distributed to different departments of the central government, state governments, NGOs, donor partners, etc.

Television

The IEC Division uses this medium extensively to spread positive health messages amongst its target audience. The MoHFW has signed an MoU of Rs. 50 crores for 300% bonus airtime with Doordarshan (Prasar Bharati) for the telecast of the spots/advertisements on policies, programs, and schemes of this Ministry (See Annexure 3 for MoU between MoHFW and Doordarshan (Prasar Bharati)). The signed MOU is utilized at the National Network and 300% bonus airtime is utilized through all Regional DD Kendras in the States. The objective is to highlight policies, programs, and schemes of the Health Ministry at the grassroots level. The DD has also telecast spots on Reproductive Child Health (RCH) and Non-RCH themes on different occasions on the national network as well as through regional channels. TV and radio spots are aired during the launch of Intensified Diarrhoea Control Fortnight, National Nutrition Week and National Breast Feeding Week, etc. Educative and informative TV spots have been telecast on Doordarshan and satellite channels to spread awareness on Swine Flu, Dengue, ZIKA, and other crucial health issues. This highlights the symptoms, ways to protect oneself against it, and the need for timely medical help. The Ministry has also coordinated the production and telecast of programs on the Lok Sabha Channel.

The Ministry also uses media like Satellite Channels, Digital Cinemas as well as FM Channels through DAVP from time to time to air/broadcast spots on critical issues on Maternal Health, Child Health, Family Planning, Adolescent Health, and Immunization.

Radio

The Ministry has approved an amount of around Rs. 25 crores for the broadcast of the spots on all health issues of this Ministry particularly Swine Flu, Dengue, Zika, and other health issues. The programs are broadcast through Primary channel/ Local Radio Stations, Vivid Bharati, Regional News, News Bulletin on FM Gold, Mann ki Baat and National network in the national news broadcast from Delhi in the morning and evening.

Radio jingles are played on private radio stations and FM channels of AIR to create awareness regarding Dengue & Chikungunya. This provides information on its symptoms, ways to protect oneself, and encourages timely medical intervention.

Bureau of Outreach and Communication (BOC)

The Ministry of Health & Family Welfare has also utilized the services of the Bureau of Outreach and Communication (BOC) *previously known as Directorate of Advertising and Visual Publicity* (*DAVP*) through channels empaneled with DAVP within guidelines approved by the MoIB. The MoHFW avails of the services of all national and regional satellite channels, all FM radios, Community Radios as well as Digital Schemes for highlighting the issues related with RCH/Non-RCH.

Social Media

Social Media is being used by the Ministry for coverage of events as well as for the dissemination of health messages to people. Currently, MoHFW uses the two most popular social media services: YouTube and Twitter. Videos related to health are uploaded regularly on YouTube with their links tweeted through its twitter handle. The YouTube channel of the Ministry has a wide array of videos including short films, video updates, and speeches and has had nearly 2 million views and counting.

There are more than 8 lakh followers of the Twitter handle of the Ministry. The handle has been effectively used for various campaigns including PC&PNDT, Child Health (MAA), PMSMA, Mission Indradhanush, Dengue & Chikungunya, etc. All the new

launches of Ministry have campaigned on the twitter handle viz. MAA program, NDD, PMSMA, the new vaccine, etc. to name a few.

MoHFW has been working with the My Gov team for utilizing their 'Creative Corner' for designing posters for the MAA program of MoHFW besides regularly sharing info-graphics of new schemes and programs on My Gov.

Health Pavilion at Fairs

The Ministry of Health & Family Welfare participates in fairs also to disseminate information and awareness on health issues. MoHFW is regularly participating in the India International Trade Fair (IITF) at Pragati Maidan, New Delhi every year. During the trade fair, visitors are offered free health check-ups, counseling for population stabilization, HIV/AIDS, family planning methods, yoga demonstration for lifestyle diseases, etc. Additionally, the fair includes performances by the Song and Drama Division of the Ministry of Information and Broadcasting, health quiz, interactive lectures by health experts, "Swasthya Chetna" stalls for screening for Non-communicable diseases viz. diabetes, cancer, and oral checkups.

STRUCTURE AND ORGANOGRAM OF IEC DIVISION

Ministry of Health and Family Welfare has an exclusive IEC Section headed by Additional Secretary, Joint Secretary to the GoI followed by a Director, Under Secretary, and Section Officer as an additional charge. Other officers also look after IEC activities i.e. Chief Media, PO (AV), Editor (Hindi), Editor (English), and DO (MMU). Some technical officers and consultants are working for designing advertisements, issuing of media plans, Social Media, exhibitions, etc.

IEC Division has technical officers like Chief Media, Programme Officer (AV), Editors (Hindi and English), and Consultants for traditional and social media. They provide technical support to the Division. Further, almost all campaigns are carried out through the Department of Audio Visual Publicity (DAVP) for print media and private satellite and FM radio Channels or through Doordarshan (DD), All India Radio (AIR), Lok Sabha TV, etc.

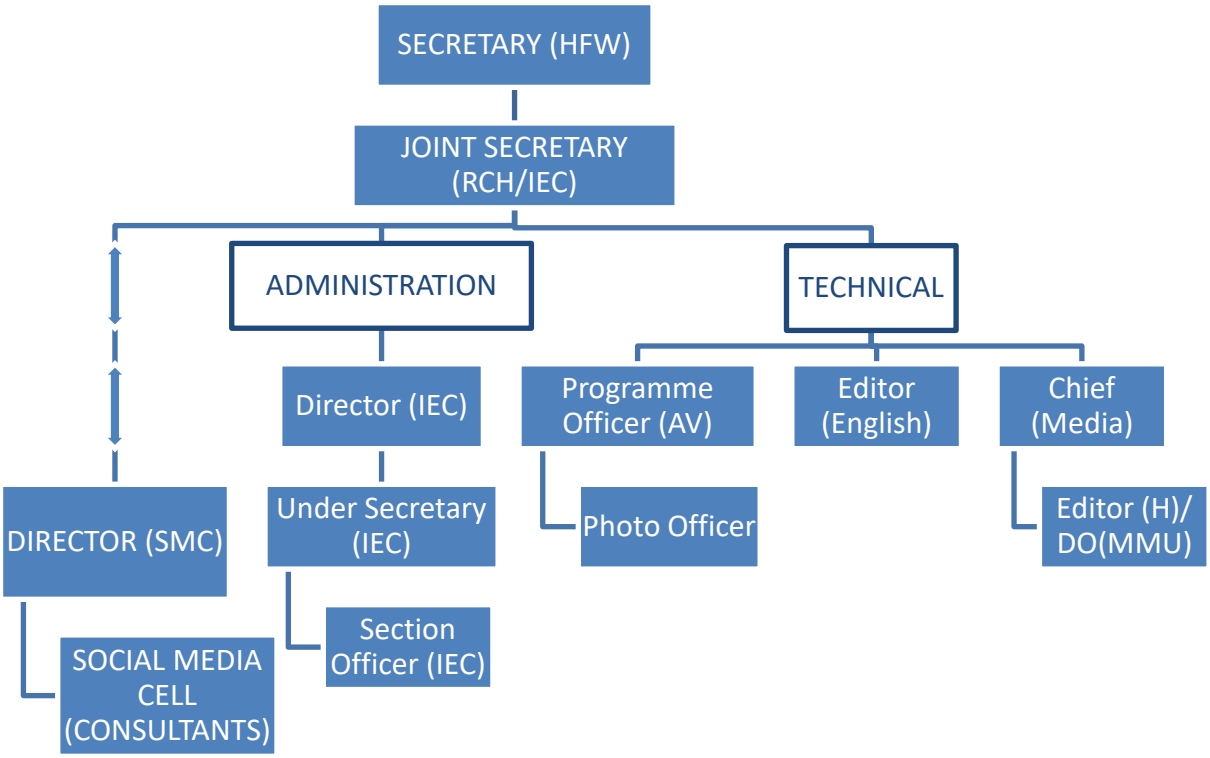


Figure 2.1: Organogram of IEC Division

MANAGEMENT OF FINANCIAL RESOURCES

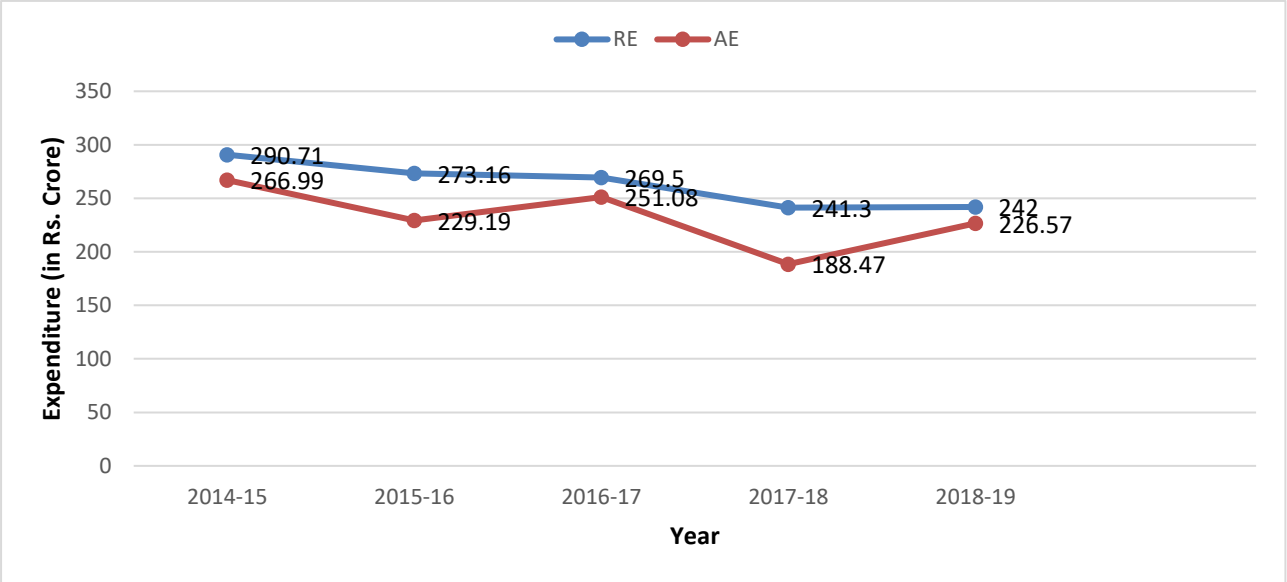


Figure 2.2: Total Revised estimate and actual expenditure for SNA scheme (in crores)

The trend analysis of budgeted revised estimates (RE) for the *Swastha Nagrik Abhiyaan* (erstwhile IEC scheme) in Figure 2.2 shows that overall there is a decreasing trend over the last 5 years. Similarly, in none of the year SNA division could spend annually budgeted

funds. The gap between budgeted and actual expenditure was the highest in the year 2017-18. During the detailed discussion with the MOHFW officials it was found that other than few planned campaigns, the division spends conservatively so that they can preserve funds for the possible contingent epidemics.

Financial Resources at State Level for IEC under NHM Funds

In each state for the targeted IEC/BCC interventions as per the State Programme Implementation Plan (SPIP), there is a provision of budgeting Rs.5 per capita for the target vulnerable population. This will also include funds for community mobilization, identification of recently settled urban poor families and support through NGO/CSO, etc. The details of the mobilization strategy are given each district PIP. Further, states can use Flexi pool funds for IEC/BCC intervention. Figure 2.2 represents an analysis of budgeted (revised) estimates Vs actual expenditure on IEC activities for the states covered in the study. Among these states, Uttar Pradesh has the highest budget approval i.e. Rs. 14352.05 whereas another state of the same northern region i.e. Uttrakhand have the least budget approval i.e. 671.86. Figure 2.3 highlights also a major cause of concern similar to national IEC expenditure i.e. the huge gap between allocated and actual expenditure on IEC activities except in the state of Rajasthan[3].

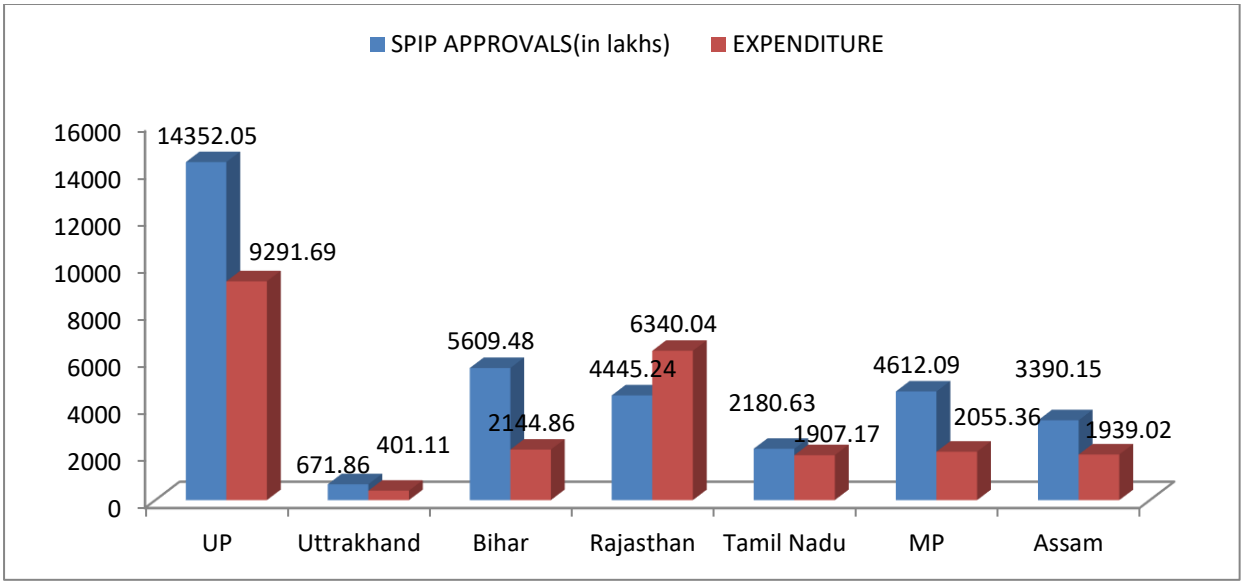


Figure 2.3: SPIP approvals and Expenditure on IEC activities in 2018-19

[3] It is important to note that year 2018 was year of election for the state legislation.

National Programme-wise Expenditure on IEC Activities

Figure 2.4 represents the program-wise utilization of IEC funds in the last three years. Expenditure on Reproductive and Child Health (RCH) is the highest among all other programs, followed by NVBDP. In the year 2016-17, other programs include MOU with DD and Prasar Bharti for the telecast of the TV spots on the national channel. In this MOU IEC has given advertisements for the various national health programs including RCH, NCD, and NVBDP, etc. and got 300% airtime as a bonus. Through this 300% bonus airtime, they reached out through 25 regional *Kendras* to various states/UTs. Expenditure Non-communicable diseases that account for almost 50 % of disease burden are not just minimal but are continuously decreasing in the last three years. The expenditure on RCH and family planning activities has increased mainly because of the launch of Mission Indradhanush over the last three years.

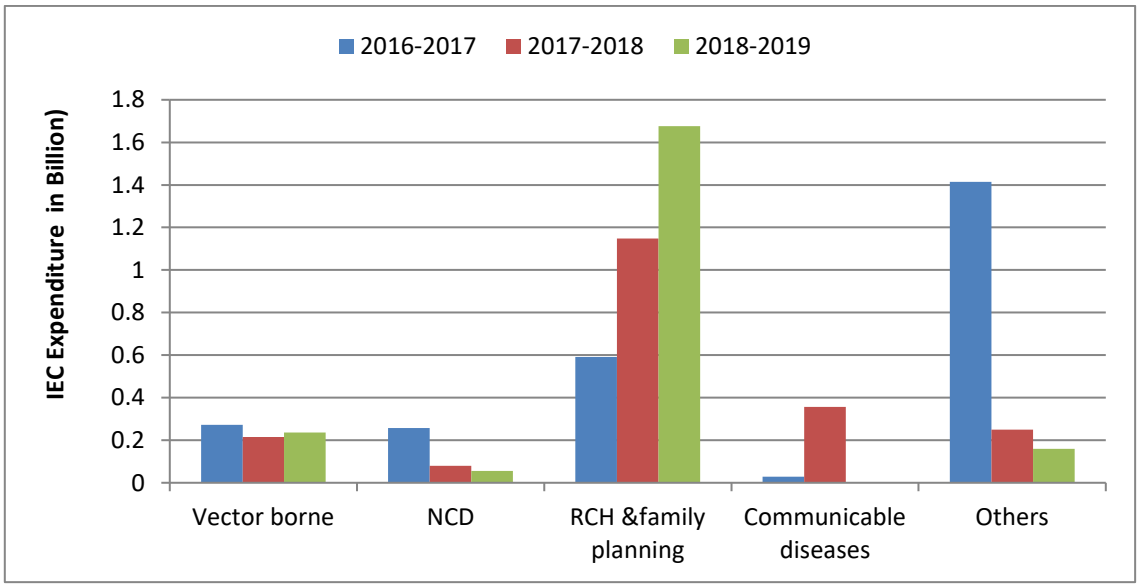


Figure2.4 National Programme wise IEC Expenditure of SNA Division

Media Wise Usage of Funds

Expenditure on electronic Media including Audio & Visual i.e. TV and Radio is the highest spend among various media options over the last three years (See Figure 2.5). It accounts for more than 90% of total expenditure. SNA division expenditure is an *Umbrella cover* over other IEC/BCC activities done through NHM. The use of Mid-media is very limited. Further share of electronic media is increasing every year through overall expenditure is reducing.

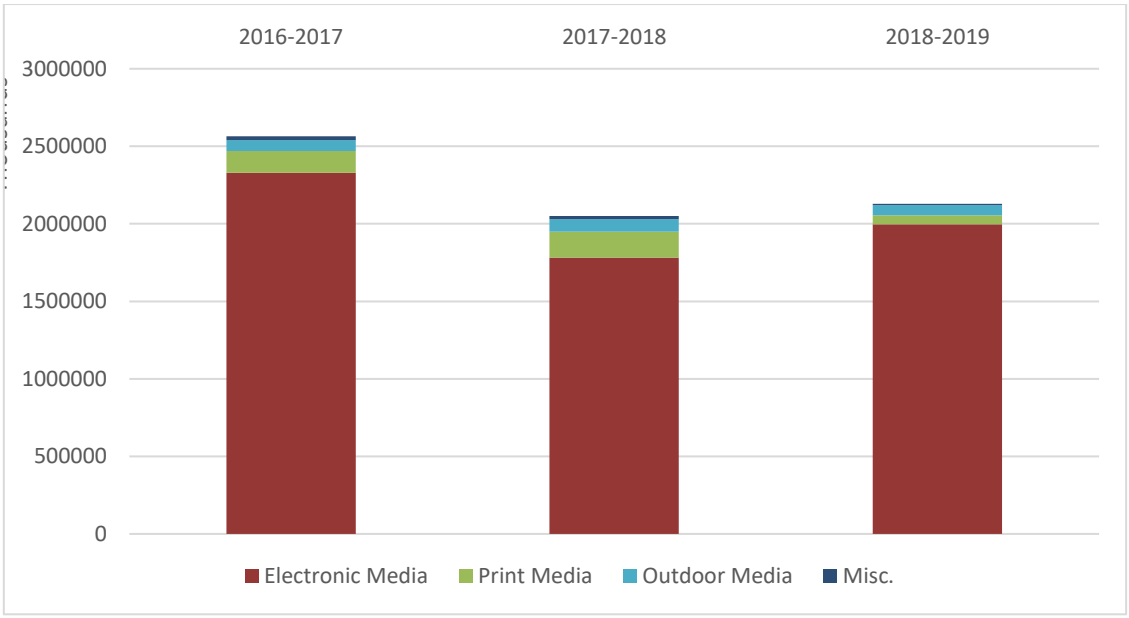


Figure2.5 Media wise IEC Expenditure over last 3 Years

ISSUES AND CHALLENGES FACED BY NATIONAL/ STATE/ DISTRICT LEVEL HEALTH FUNCTIONARIES

Based on in-depth interviews with the various government functionaries at national, state, and district levels following major challenges were identified at various levels.

Localization

For various national programs to standardize the messages advertisement and other IEC material like hoarding, wall hanging, etc. designed at the Centre are sent in open files to the state governments. However, due to lack of capacity in terms of technical know-how, lack of human resources, and paucity of time, the state governments either change the photograph of the Primeminister or write the name of the state government or just simply translate/dub the message into regional language. Further, the state governments sent IEC material to the district level some time printed or some time in open files. But similar to the state government due to the above-stated reasons no localization of material is done.

The study team observed in the district Haridwar, for the deworming campaigns hoarding translated deworming into the Hindi Language as *Krimi Mukht Abhiyaan* but community members were not able to relate the message with same the essence. The community suggested it should have used simple local language like *Bachoo ke Paet ke Kida Mere/Mukti Abhiyaan* as an easily understood message. Similarly, In the district Baran, after explanation by the study team on the importance of physical exercise in the form of any dance team the

community suggested that instead of using a female doing aerobics in the IEC material, a local lady performing local/traditional dance could have better connection and understanding/impact of the message.

Further, it was found after in-depth interviews with district-level officials that though theoretically said, they plan and propose IEC activities as per local needs in district PIP which finally complied as State PIPs. But practically due to lake of human resources, understanding, and capacity state government just send them the template and which they fill as per past data or a model document shared by the state government. Hence, neither local community needs are identified nor the media planning for the same are done at the district level with few exceptions.

Logistics Challenges

Another important challenge identified at the various level is the delays in supplying IEC Material from the State to the district and finally to the block and the sub-center level. Across all districts, in the study, the district level officials and grassroots level functionaries interviewed complained about the delays in receiving material. Even some time IEC material reaches after the program day or week or so. Further, it does not have any mention of specifications about where to display and how to use a particular IEC. This lead to a lot of wastage of IEC material. The study team observed several misplacements and out of context usage of IEC material. Further, materials to fix hoardings/banners/flex material are not sent. Community members during FGDs informed the study team to material written on flex leas to disinterest.

> *"My mother was hospitalized due to illness, in the female wards in district hospitals I read about a poster on male sterilization. Throughout five days, I could not only read about full details as it was a female ward, ... I was also feeling shy.....better could have been if it would have been in the general waiting area...."*
>
> *Male - FGD, Rural, Ramanathapuram, Southern Region*

> *"Our state government has organized a special drive for MR (Missile and Rubella), for this, we have been given with special focussed training for a day, and it was told to us IEC material will be sent to you in due course, it shall be displayed at prominent places of the village. ……when I went to PHC for other work, after the drive, I got this material related to MR vaccination. ……..what do with this now....."*
>
> *ANM, District Baran, Western Region*

Human Resources and Capacity Building

In most of the districts/states visited by the study team, it has found there is an acute shortage of specialized IEC officials at the state, district, and block level. In most of the places, some other officials have been given an additional charge of IEC activities. In places where a person IEC/BCC officer is available, does not know about his role and responsibilities as they are just doing routine jobs of sending and receiving IEC materials. They have not been imparted with any orientation training. Further, no person has been given any specific or specialized Training related to IEC /SBCC at any level in recent times. IEC related issues are just discussed during Monthly meetings sometimes. This leads to the above-stated problems of underspending, poor planning, monitoring, and implementation of IEC activities.

> *"Am I supposed to give what should be budget and what should be activities in my district…….. I know there are many misconceptions are there in some of the tribes/communities in my area, they don't even come forward for immunization, at the same time they are using locally made powder as Lal Manjan, which is full of intoxicant, leading to mouth cancer…..but what can I do for them, I am not having any authority for this……. And we don't have any budget for this"*
>
> *District Communication Manager*

Need Identification Studies, Monitoring & Evaluation

None of the districts covered in the study has conducted any formative/ need assessment study, which can be used for media planning, targeted intervention, addressing misconceptions, etc. In most of the places, media selection, and targeted intervention are done based on plans written in District PIPs, Whims, and experiences of CMO/DPM.

Further, there is no effective monitoring system that exists on the usage of IEC material at the district/block level. Some of the district communication officers have innovated and started using ICT. They ask the official-in-charge at block and grass level to click and send the whats app the photo after placing the IEC material. However, the same has been criticized by their senior officers as it, not a full-proof system.

Further, no state government has conducted any impact assessment of their IEC activities, all IEC activities are based on experiences and whims, without getting a real community perspective.

Financial Resources Planning and Utilization

During the study visit, District communication Officers and District Magistrate complained that there are no earmark funds or a very small amount in budgets for local level IEC. Most of the time this money is spent on printing letterheads or some pamphlets. Further, there is no flexibility on national program-specific IEC Budget as IEC activity is fixed even type of media usage is fixed.

> *"In the national malaria program, we have got Rs. 45000 for IEC activities, it has not just fixed the amount…… it also is written we have to spend this money on giving advertisements on cable TV scrolls. Now, in our district, most of the time in the evenings the electricity is a major problem when people are at home, most of the rural population is illiterate in the community where malaria and dengue cases are happening, people prefer to listen to announcements by miking which is much cheaper and effective……..what should we do, ……….just doing tick mark work"*
>
> *Chief Medical Officer, Northern Region*

Further, delays in the release of budgets on national program heads lead to most of the time unspent IEC budget.

Media Plan and Strategy

The study team felt that in most of the districts, state, and at the national level are following the tick-box approach. No officer has a clear cut vision, plan, sense of urgency, and strategy towards the community for which they are responsible. Most of the people lack motivation and capacity in the absence of a strategic roadmap and shared vision.

Since health is the state subject as per the constitution, each state government has its priority areas of working within the health sector. Therefore, it becomes necessary money spent by the IEC division for the national programs should be coordinated not only at the national level among program divisions but also with the state government efforts. At present other than the PIP approval process of the states under NHM funding, no coordination mechanism exists. This leads to a lot of duplication of efforts and reinvention of wheels. Best practices and learning processes from other states are missed.

Chapter 3: Respondents' Profile & Media Habits

In this chapter, an analysis of the demographic profile of the respondents have been carried to describe their various demographic features like age, sex, location, etc. with access to various media options like TV, radio, print, and mobile phones, time spends on various media options.

DEMOGRAPHIC PROFILE OF THE RESPONDENTS

The study conducted semi-structured conversations with two thousand two hundred fourteen (2214) beneficiaries which include nine hundred seventeen (917) males and one thousand thirty-six (1036) females across all the states. More respondents were in the 25-34 years age group followed by 15-24 years of age group as shown in Figure 3.1.

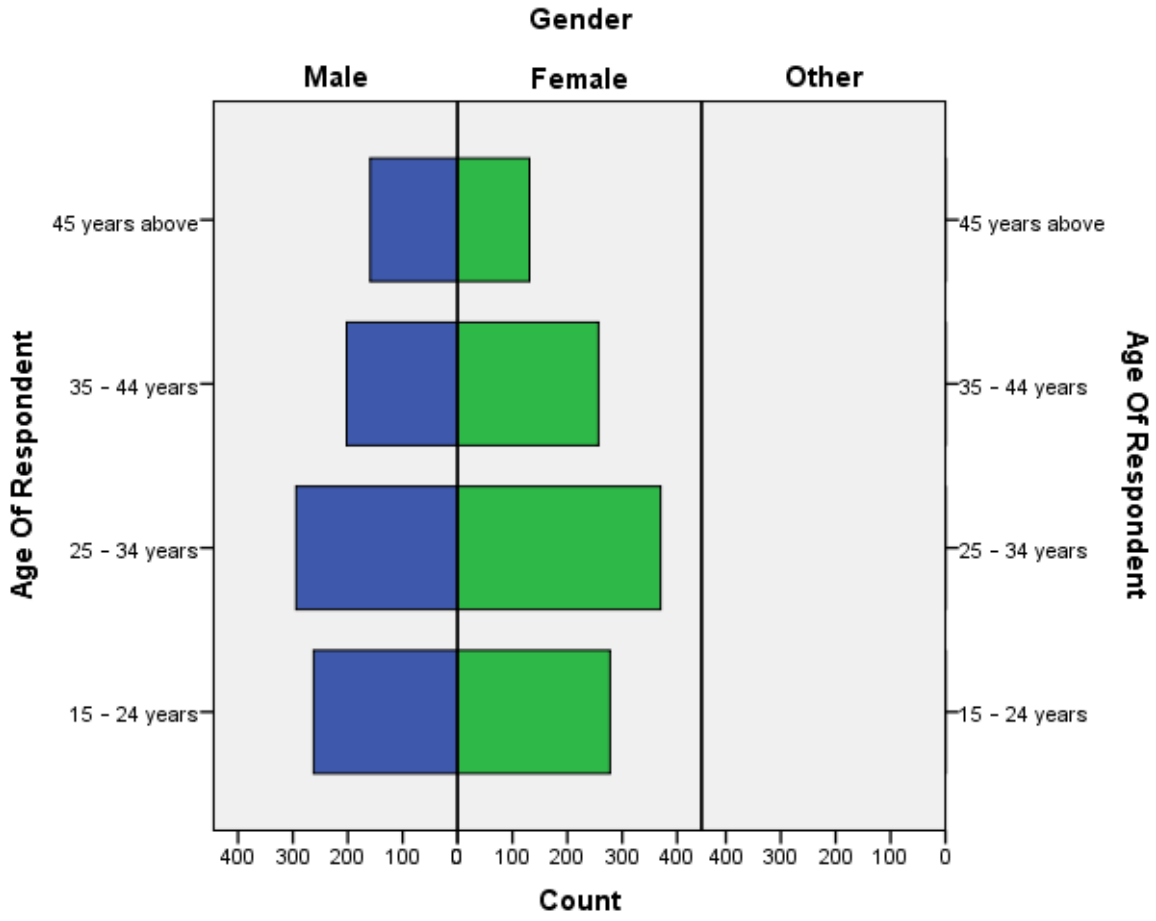


Figure3.1: Distribution of the gender across the age of respondents

Respondents for this particular study were from both urban and rural locations. Thirty-four percent of respondents were interviewed from urban and 66 percent from a rural location to assess their understanding of communicated messages. Table 3.1 exhibits the distribution of the sample across the Blocks in six regions, under the study.

Table 3.1: Distribution of the States and the Block with Urban/Rural division

Block Name	Urban /Rural	North		East	North East	South	Central	West	All India
		UP	Haridwar	Bihar	Assam	Tamil Nadu	MP	Rajasthan	Total
Attru	Rural							31	31
Antra	Rural							13	12
Baran	Urban							108	108
Bahadarabad	Urban		105						105
Bakhri	Rural			107					107
Basoda	Urban						105		105
Bhagwanpur	Rural		106						106
Bolagur	Rural					121			121
Begusarai	Urban			98					98
Dandari	Rural			102					102
Debitola	Rural				111				111
Gauripur	Urban				104				104
Golakganj	Rural				110				110
Karvi	Urban	106							106
Karvi (Ramnagar)	Rural	104							104
Krishanganj	Rural							43	43
Nateran	Rural						106		106
Pahari	Rural	104							104
Ramanathapuram	Urban					154			154
Roorkee	Rural		104						104
Shahbad	Rural							30	30
Thiruppullani	Rural					99			99
Vidisha	Rural						107		107
Others	Rural							36	36
Total		314	315	307	325	374	318	261	**2214**

ACCESS TO MEDIA

The analyses of the collected data from the six regions, it has been found that a majority of respondents have access to TV followed by mobile and newspaper, whereas; access to radio is least across the country. The Southern region of India, having a massive 94 percent of

people access TV followed by the Northern region with 86 percent of people having access to TV. However, the least access to TV is seen in the Eastern region of India where only 60 percent of people have access to TV as shown in Table 3.2.

To drive large-scale socio-economic change, the Government of India prefers to use mobile technology over other media through programs like Digital India, but the study finds that mobile usage is limited to only 44 percent across the country. In the Central region of India, mobile access is only 33 percent whereas, the highest in southern India is 52 percent. Similarly, access to newspapers across the country is less as compared to TV and Mobile. However, despite having an 80 percent literacy rate in Tamil Nadu, access to the newspaper is just 25 percent.

Table 3.2: Percentage of Sample Population having Access to Different Media

Access to Media	North		East	North East	South	Central	West	All India
	UP	Uttrakhand	Bihar	Assam	Tamil Nadu	MP	Rajasthan	Total
TV	86%	82%	60%	73%	94%	85%	82%	80%
Radio	4%	6%	0%	0%	29%	2.50%	2%	6%
Mobile	41%	47%	38%	46.50%	52%	33%	50%	44%
Newspaper	44%	33%	25%	11%	25%	32%	54%	32%

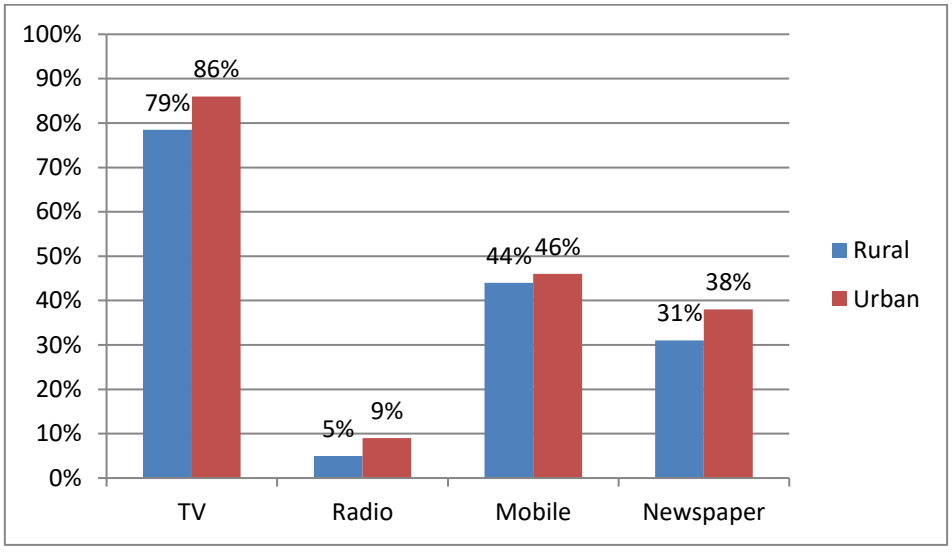


Figure3.2 Access to Media among the Rural and Urban Population in India

As depicted in Figure 3.2, access to mobile is almost the same in both the locations, whereas, access to TV is 86 percent in the urban location and 78.5 percent in rural locations among the urban and rural populations. Similarly, access to the newspaper is more in the urban area as

compared to the rural area. Access to radio is just 5 percent in the rural locations and 9 percent in the urban areas. Similar findings are found in qualitative discussions/interviews.

"…..I *don't have a radio. Further, I don't think anyone in our village would be having the radio set……. Radio is an old fashion thing in today's modern area of TV and mobiles……"*

(FGD Participant; Rural block, North Eastern Region)

"…….Why should we listen to the radio, we have a TV at our home, in the evening everyone watches a TV at his/her home, Radio is there in my father smartphone, but it does not get any radio signal at our home, I tried so many time, I play a game on my father's phone, when so ever get time…….I watch TV after going back home from here (school)……."

(Class X student, School FGD Participant, Rural block; Southern region)

"Radio was a good medium of entertainment, we used to enjoy cricket commentary and Binaca Geetmala program in our young days but with the coming of cable and Dish TV, it becomes redundant, nobody listens to radio or transistors, and in today's' world radio is unavailable in market……. Those who won't listen to songs they get his/her favorite 1000 songs downloaded in their phone for just Rs. 10 from the corner shop…… sir tell me why one needs radio…. Time has changed sir….."

(FGD Participant, Rural block; Northern region)

"I love listening to the radio while driving back home from the office on my mobile phone as you can enjoy a mix of old and new songs on the FM channel……. Radio set, haa haa (laughing) that I have never seen, my grandfather might have used that……."

(FGD Participant Urban block; MP; Central region)

"In our district, I have got a proposal to set up community radio in some of the backward blocks……. I found it very useful in our university days on our campus, we use to get many updates on happenings on the campus and show our talent on community radio……. I am not sure of the success of the same in villages as people do not have radio instruments and most of the people don't have a

smartphone…… people love to watch a movie on TV and other serials….Frankly, I am not very sure……"

(District Magistrate, X Region)

"We are illiterate, how would we read newspapers, this is man's work, one person read and tell the news to other on the Choopal……..did not get much time whole day busy, we go to the field, take care of cows, kids, cook food, we watch some time TV while cooking food……"

(FGD Participant, Rural Women Focus Group Discussion, Western Region)

Region-wise Analyses of Access to Various Media

Access to TV in Different Regions

Across the country, 78.5 percent of people from rural areas have access to TV whereas in the urban area, 86 percent of people have TV access.

In the rural area, the majority of respondents i.e. 90 percent from the Southern region have access to TV followed by respondents from the Northern region. In the same area, the least TV access has been seen among respondents from the Eastern region as shown in Table 3.3.

In the urban area, 99.4 percent of respondents from the Southern region have TV access, followed by 95 percent of respondents from the Central region and the least TV access has been observed in 77 percent of respondents from the North-east region.

Table 3.3: Region-wise Access to TV as per Location

Region	State	Rural	Urban
Northern	UP	87.5%	84%
	Uttrakhand	81%	84%
Southern	Tamil Nadu	90%	99.4%
North-East	Assam	71.5%	77%
Central	MP	80%	95%
Western	Rajasthan	80%	82%
Eastern	Bihar	60%	84%
All India	**Total**	**78.5%**	**86%**

A cross-tabulation is done between the age of the participants and Rural/Urban having access to TV and has been presented in Table 3.4. Across the country, TV access is more among 15-

24 years age group followed by the 25-34 years age group and the least TV access has been observed in 45 years and above group in both the locations.

A common trend has been observed in the Northern, Southern, and North-eastern regions in terms of access to TV for the age group of 15-24 in both rural and urban locations. This age group has more access to TV as compared to any other age group in the study. In the Central region, respondents residing in rural locations having the highest access to television belong to 35-44 years of age group whereas, in the eastern region, the highest TV access has been seen in 45 years and above group people residing in the urban location.

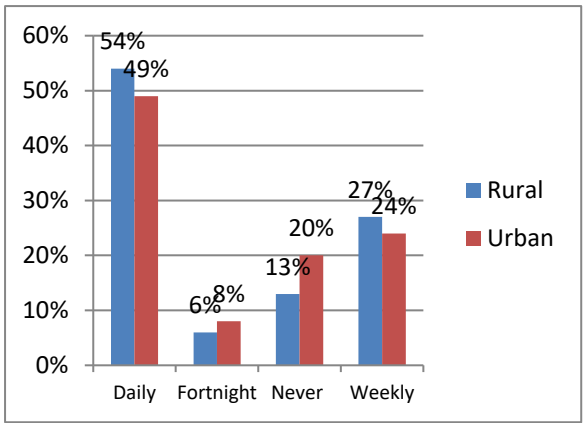
Table 3.4: Cross-tabulation between Access to TV and Age of respondents

Rural/Urban		Age of Respondents			
		15 – 24 years	**25 – 34 years**	**35 – 44 years**	**> 45 years**
UP	Rural	91.5%	84.2%	83.9%	89.5%
	Urban	90.0%	86.3%	77.3%	76.9%
Uttrakhand	Rural	85%	88%	68%	74%
	Urban	94%	93%	60%	81%
Tamil Nadu	Rural	96%	90.5%	90%	85%
	Urban	100%	97.5%	100%	100%
Assam	Rural	82%	72%	72%	46%
	Urban	92%	79%	62%	64%
MP	Rural	80%	81%	87%	64%
	Urban	95%	100%	90%	91%
Bihar	Rural	68%	56%	54%	32%
	Urban	79%	83%	86%	87.5%
All India	Rural	84%	79%	76%	65%
	Urban	92%	89%	79%	83%

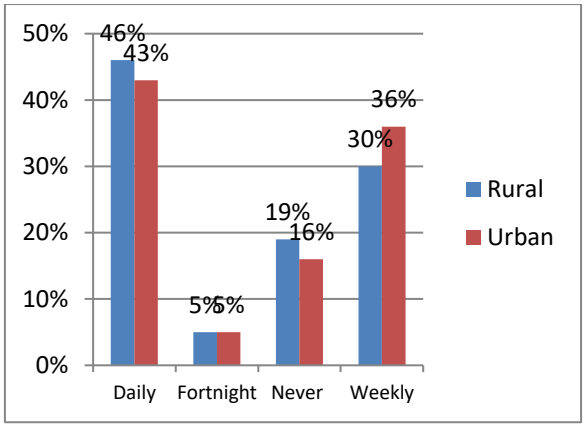
Frequency of TV viewing

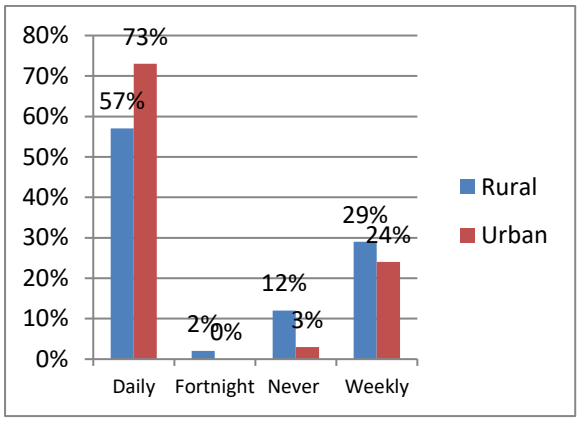
Respondents were interviewed about the frequency of different media which they access. It is been observed that almost half of the sample (~ 50 percent) watches TV daily across the country. Figure 3.3 depicts the frequency of TV viewing among rural and urban areas region wise.

Here also, a common trend has been observed, where almost in all regions, most people watch TV daily in both urban and rural areas. But in the urban areas of the North-eastern region, the situation is strikingly different as a majority of people here view TV weekly.

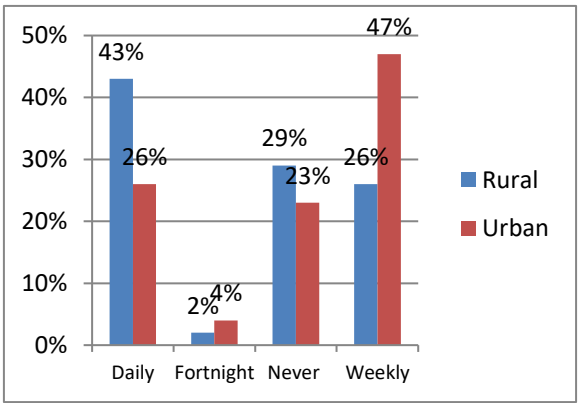


Northern Region

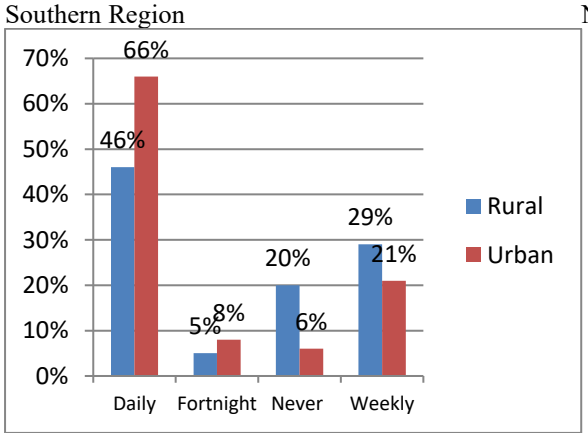




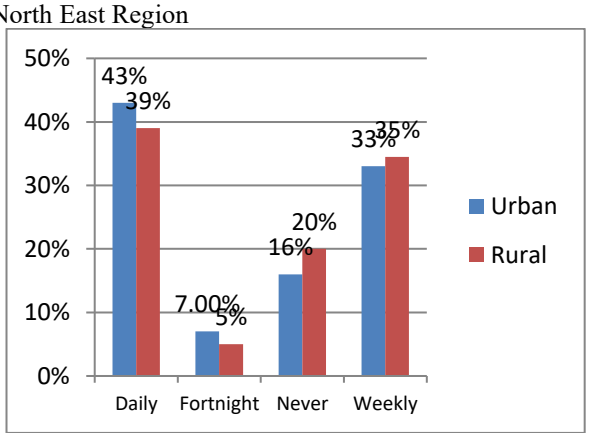
Southern Region



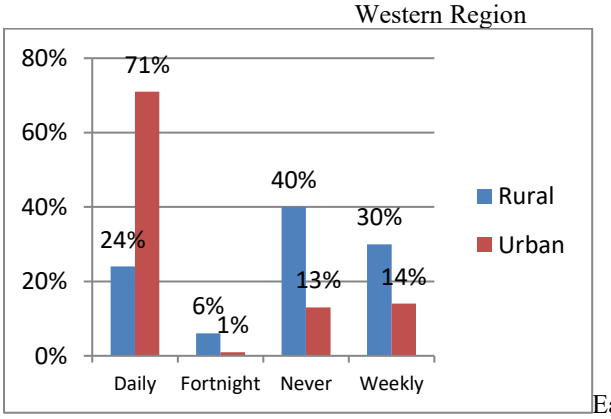
North East Region



Central Region



Western Region



Eastern Region

Figure3.3 Region-wise Frequency of TV viewing

Access to Radio in Different Regions

As mentioned above, access to radio is less across the country. Only 5 percent of respondents from the rural area have access to radio and in the urban area, 9 percent of respondents have radio access as shown in Table 3.5. Among the rural population, 16 percent of respondents from the Southern region and only 3 percent of respondents from the Western region have access to radio whereas respondents from the Eastern and North-eastern regions residing in the rural area only have no access to radio.

In the urban area of the Southern region, 49 percent of respondents have access to the radio (Mostly on Smart Phones), 4 percent of respondents from both the Central and Eastern regions respectively have radio access whereas none of the respondents from the Western and North-eastern regions have access to radio.

Strangely, none of the respondents taken into our study from the North-eastern region has access to radio. In both, the location i.e. urban and rural access to radio is zero.

Table 3.5: Region-wise Access to Radio as per Location

Region	State	Rural	Urban
Northern	UP	6%	1%
	Uttrakhand	7%	5%
Southern	Tamil Nadu	16%	49%
North-East	Assam	0%	0%
Central	MP	2%	4%
Western	Rajasthan	3%	0%
Eastern	Bihar	0%	4%
All India	Total	5%	9%

India, as a country, includes persons with different backgrounds to understand the media preference in different backgrounds each respondent has been asked about their social category.

Across the country, radio access has been observed more in respondents of the ST category residing in both rural and urban locations. In the Southern region, respondents who access radio and residing in a rural area, 50 percent of them belong to the ST category and 24 percent of them belong to the OBC category. Also, respondents from the urban area having more access radio belong to the ST category as shown in Table 3.6.

In the Central region, only 2 percent of respondents from the rural population having access to radio belong to OBC and SC category. None of the respondents from the ST and General category have radio access. Among the urban population of this region only, 11 percent of respondents having access to radio belongs to the SC category and only 3 percent of respondents belonging to the general and OBC category respectively have radio access

Table 3.6: Cross-tabulation between Access to Radio and Social Category

Rural/Urban		Social Category			
		General	OBC	SC	ST
UP	Rural	6.7%	4.9%	7.5%	0%
	Urban	0%	0%	6.3%	0%
Uttrakhand	Rural	15%	8%	3%	0%
	Urban	14%	6%	0%	0%
Tamil Nadu	Rural	18%	24%	5%	50%
	Urban	49%	44%	41%	92%
Assam	Rural	-	-	-	-
	Urban	-	-	-	-
MP	Rural	0%	2%	2%	0%
	Urban	3%	3%	11%	0%
Bihar	Rural	-	-	-	-
	Urban	0%	4%	6%	-
All India	Rural	6.6%	6.5%	3%	8%
	Urban	11%	9.5%	10.6%	15%

Frequency of Radio Listening

Thus, it can be concluded that radio listening among people is very less in both rural and urban regions across the country. Just 6 percent of people listen to radio daily across regions.

Access to Mobile in Different Regions

Across the country, 44 percent of respondents from the rural areas have access to mobile whereas, in the urban areas, 46 percent of respondents have mobile access.

Strangely, in the northern and North-eastern regions, access to mobile has been observed more in respondents from rural regions whereas in the rest of the regions mobile access has been observed in respondents residing in urban locations as shown in Table 3.7.

Among the rural areas, the highest mobile access has been observed in the North-eastern region i.e. 51 percent followed by the Southern region, whereas the least-mobile access has been seen in respondents from the Central region.

In urban areas, mobile access has been observed more in the Western region i.e. 55 percent followed by the Southern region whereas the least-mobile access has been seen in respondents from the North-eastern region.

Table 3.7: Region-wise Access to Mobile as per Location

Region	State	Rural	Urban
Northern	UP	44%	36%
	Uttrakhand	51%	39%
Southern	Tamil Nadu	50.5%	54.5%
North-East	Assam	51%	35.5%
Central	MP	26%	48%
Western	Rajasthan	45%	55%
Eastern	Bihar	38%	53%
All India	Total	44%	46%

A cross-tabulation is done between the age of the participants and Rural/Urban having access to mobile and has been presented in Table 3.8. Across the country, mobile access is more among respondents of 15-24 years age group and the least access to mobile has been observed in 45 years and above group in both the locations.

Table 3.8: Cross-tabulation between Access to Mobile and Age of respondents

State/ Area		Age of Respondents			
		15 – 24 Years	**25 – 34 years**	**35 – 44 years**	**> 45 years**
UP	Rural	56%	47%	29%	5%
	Urban	50%	37%	18%	38.5%
Uttrakhand	Rural	72%	61%	32%	23%
	Urban	56%	46%	35%	19%
Tamil Nadu	Rural	80%	66%	38%	29%
	Urban	46%	57.5%	55%	53%
Assam	Rural	81%	52%	39%	3%
	Urban	67%	29%	17%	18%
MP	Rural	43%	28%	17%	4%
	Urban	59%	51%	35%	18%
Bihar	Rural	49.5%	33%	23%	10.5%
	Urban	29%	47%	64%	54%
All India	Rural	64%	48%	30%	13%
	Urban	51%	45%	63%	34%

A common trend has been observed in the Northern, North-eastern, and Central regions in terms of access to mobile for the age group of 15-24 in both rural and urban locations. This age group has more access to the mobile as compared to any other age group in the study.

In the Southern and Eastern regions, respondents residing in a rural location have the highest access to mobile belong to the 15-24 years group only whereas respondents from the same region but from the urban area having the highest access to mobile belong to the 25-34 years age group and 35-44 years group respectively.

Frequency of Mobile users

Across the country, 33 percent of respondents use mobile daily and 8 percent of them use mobiles weekly. Figure 3.4 depicts the frequency of mobile users among rural and urban areas of all regions. It has been observed that almost in all regions, most people never use mobile phones followed by respondents who use mobile daily in both urban and rural areas.

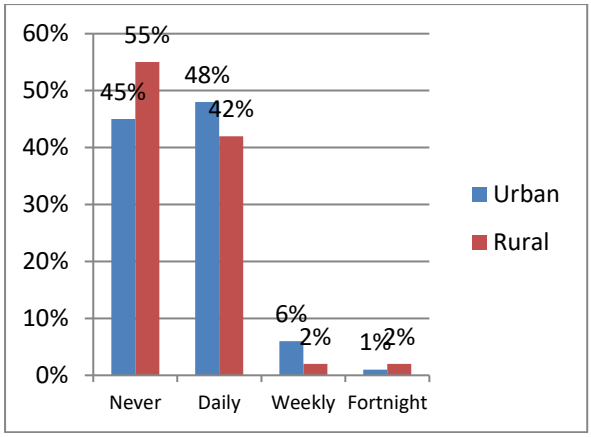
Access to Newspaper in different regions

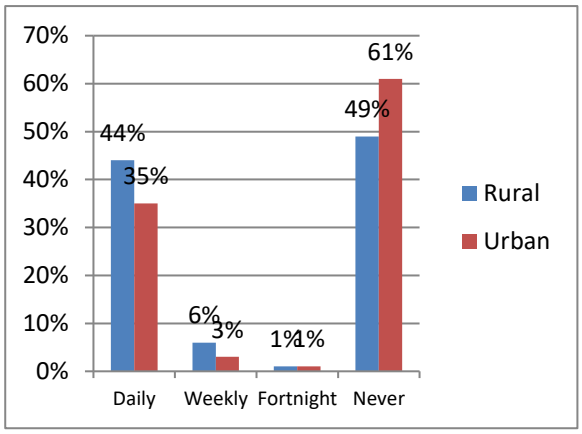
Access to the newspaper is comparatively less in comparison to TV and mobile across the country. Overall, only 31 percent of respondents from the rural areas have access to newspapers whereas, in the urban areas, 38 percent of respondents have newspaper access as shown in Table 3.9.

Table 3.9: Region-wise Access to Newspaper as per Location

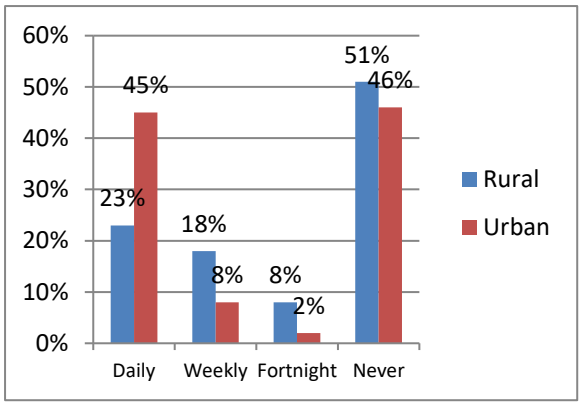
Region	State	Rural	Urban
Northern	UP	49%	34%
	Uttrakhand	34%	31%
Southern	Tamil Nadu	12%	43%
North-East	Assam	9.5%	13.5%
Central	MP	30%	36%
Western	Rajasthan	57%	49.5%
Eastern	Bihar	25%	56%
All India	Total	31%	38%

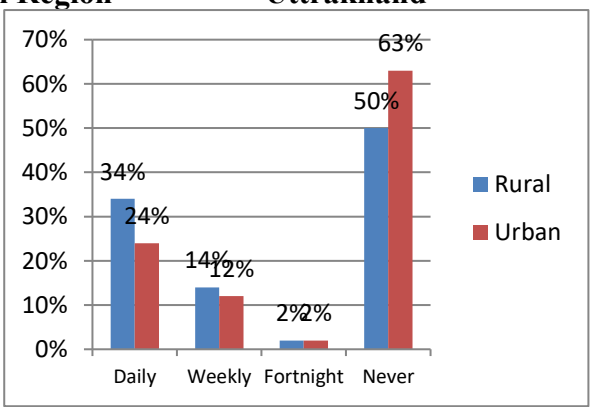
In all-regions, newspaper access has been observed more in respondents from the urban area except for the Northern and Western regions where newspaper access is seen more in respondents of rural areas.



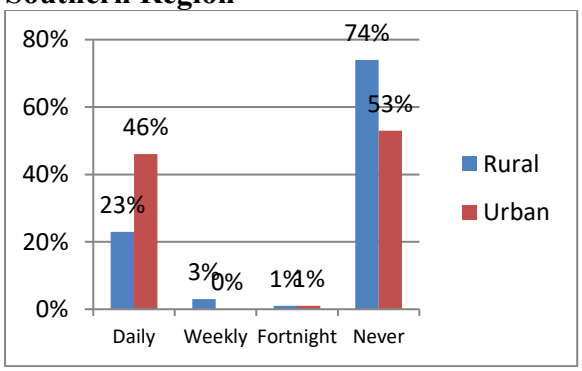


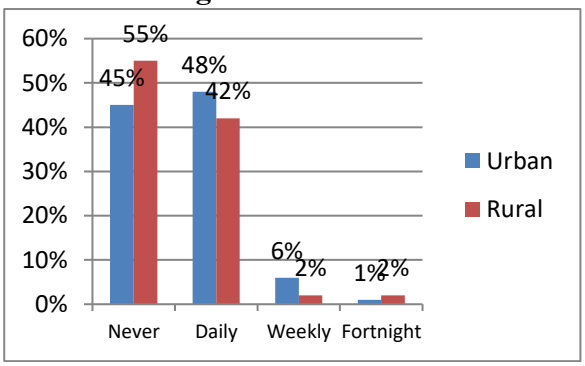
Uttar Pradesh **Northern Region** **Uttrakhand**



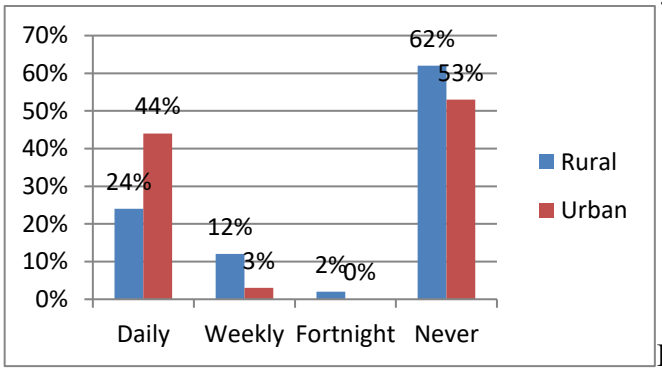


Southern Region **North East Region**





Central Region **Western Region**



Eastern Region

Figure3.4 Region-wise Frequency of mobile viewing

In the rural areas, 57 percent of respondents from the western region have access to newspapers followed by respondents from the Northern region whereas the least newspaper access has been observed in respondents of the Southern region. It is very strange to observe that newspaper preference is least amongst the respondents of the Southern region from both locations. It could be due to the shifting of the preferences to shift to mobile phones and television.

The study tried to find out newspaper reading is common amongst the respondents of which educational background. To understand this, a cross-tabulation is done between the respondents residing in Rural/Urban having access to newspaper and their educational background has been presented in Table 3.10.

It has been observed that newspaper access is more in graduates followed by respondents who have done their education up to high secondary level whereas the least access to the newspapers is seen in illiterates across the country.

Table 3.10: Cross-tabulation between Access to Newspaper and Education of respondents

Rural/Urban		Education of Respondents						
		Graduate & above	High Secondary	Illiterate	Literate without schooling	Middle	Primary	Secondary
UP	Rural	77.5%	63%	6%	33%	37%	21%	61%
	Urban	77%	50%	12%	12.5%	35%	24%	50%
Uttrakhand	Rural	77%	51%	5%	0%	33%	6%	29%
	Urban	77%	25%	0%		41%	14%	42%
Tamil Nadu	Rural	4%	9%	25%	11%	23.5%	17%	11%
	Urban	35%	38%	45.5%	50%	57%	44%	41%
Assam	Rural	36%	17%	0%	0%	5%	6%	22%
	Urban	67%	18%	0%	0%	18%	10.5%	20%
MP	Rural	74%	29%	0%	0%	31%	12%	63%
	Urban	52%	65%	0%		19%	11%	46%
Bihar	Rural	100%	65%	2%	17%	24%	8%	39%
	Urban	40%	59%	65%	67%	56%	65%	40%
All India	Rural	61%	39%	6%	10%	25%	11%	37%
	Urban	58%	43%	21%	21%	38%	28%	40%

Frequency of Newspaper reading

Table 3.11: Frequency of newspaper reading across regions

Region	District	Area	Never	Daily	Weekly	Fortnight
Northern	**UP**	Urban	67%	19%	8.50%	6%
		Rural	52%	16%	17%	14%
	Uttrakhand	Urban	69%	16%	9.50%	6%
		Rural	66%	21%	6%	7%
Southern	**Tamil Nadu**	Urban	58%	40%	1%	0%
		Rural	89%	9%	3%	0%
North East	**Assam**	Urban	85%	2%	7%	7%
		Rural	90%	2%	4.50%	4%
Central	**MP**	Urban	65%	15%	14%	6%
		Rural	71%	12%	11%	6%
Western	**Rajasthan**	Urban	50%	20%	20%	10%
		Rural	43%	28%	20%	7%
Eastern	**Bihar**	Urban	44%	42%	11%	3%
		Rural	75%	5%	15%	5%

Newspaper reading among the rural and urban populations across the country is less. Overall, 15 percent of respondents read the newspaper daily across the country.

Chapter 4: Beneficiaries' Exposure, Recall, and Intent to Change Behaviour

This chapter analyses the exposure level, recall rate, and intent to behavior change of the beneficiaries who have been exposed to health care message through different media. Opinions of the respondents have also been analyzed about the content of the various health promotion material used in different programs, the clarity of information supplied, the nature of appeal used, etc. These opinions taken from the respondents include both self-recall and assisted recall.

EXPOSURE LEVEL TO HEALTH PROMOTION MESSAGES

To evaluate the general awareness of the respondents about health-related programs, the respondents were asked about whether they have seen/heard an advertisement/poster/ message educating about health and family welfare programs in the last one year. If yes, they were have been asked to recall five health advertisements/ messages they can recall (Refer to Annexure 1 – Research Tool 1; question 1.2).

Sixty-six percent of respondents among rural locations have seen advertisements/posters/messages educating about health and family welfare programs, whereas; 72 percent of the urban sample have seen health-related advertisements as depicted in Figure 4.1.

> *"We had seen advertisements on TV related to health, it gives not many interests, but when ASHA DIDI and Nurse Madam explain us we understand that better, we ask some time then, what was that advertisement..... or some time she brings with her a booklet which carries good information with photographs....."*
>
> *FGD Participant, Rural, Northern Region*

> *"Yes, I have seen advertisement..... when so ever we visit PHC; there are many posters and hoarding related to mother-child health, immunization, TB, smoking, etc..... I read some of them while waiting for the doctor....."*
>
> *FGD Participant, Rural, North-Eastern Region*

"In our CHC, we have seen on the TV screen some of these advertisements and health promotion messages, while waiting for our turn to meet the doctor for a checkup of my baby, we get information about many other things..... this is a good initiative by the doctor Sahib..... For example, I get to know about the use of contraceptives for child distancing from the advertisement....."

FGD Participant, Rural, Western Region

"We have seen a lot of pamphlets, which ASHA Didi bring with her, she explains us very well ..... we don't see much advertisement on TV, all health-related things are shared by ASHA and ANM, they also explain with the help of charts which are hanged there in Sub-Centre....."

FGD Participant, Rural, Eastern Region

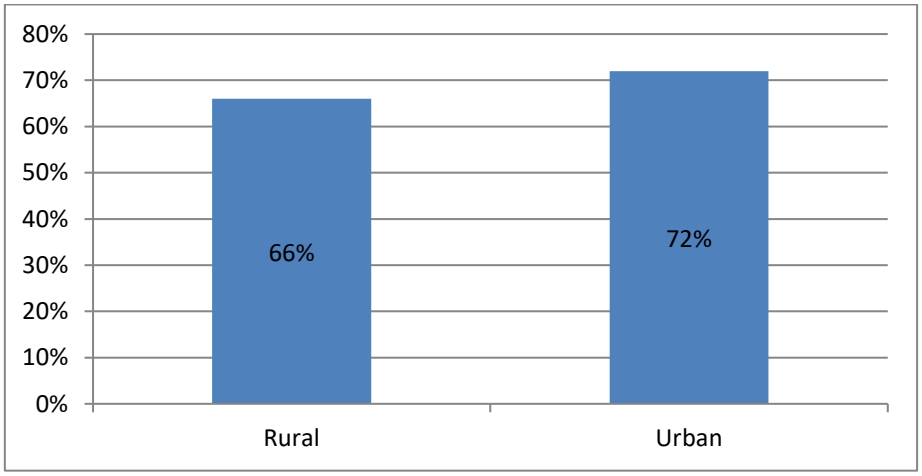


Figure 4.1 Percentage of people seen health-related advertisements/posters/messages among the rural &urban population

Table 4.1 Seen Advertisement /Posters/Message educating about Health and Family Welfare Programme

Region	State	District	Has Seen an advertisement/poster
Northern	**UP**	Chitrakut	86.0%
	Uttrakhand	Haridwar	66.0%
Southern	**Tamil Nadu**	Ramanathapuram	62.0%
North East	**Assam**	Dhubri	58.5%
Central	**MP**	Vidisha	62.0%
Western	**Rajasthan**	Baran	63.0%
Eastern	**Bihar**	Begusarai	75.0%
All India			69.0%

Table 4.1 depicts the percentage of respondents who have seen an advertisement/poster/ message education about health and family welfare programs in the last one year (2018-19). It has been observed that most respondents (86 percent) from Chitrakut district in the northern region have seen advertisements related to health programs followed by Haridwar district where 66 percent of respondents have seen it. In the Southern and Central region, 62 percent of respondents have seen health-related advertisements or messages and in the north-eastern region, 58.5 % of respondents have seen the same.

However, after assistance, every respondent was able to recall some health promotion messages.

FIRST RECALLED HEALTH PROMOTION MESSAGE

With the use of the Pareto Principle (also known as the 80/20 rule), it was observed that, out of 2214 respondents, 80 percent of respondents could recall dengue, cancer, and malaria-related health advertisements across regions and the same can be seen in Figure 4.2. In the northern region, 80 percent of respondents could recall dengue, malaria, cancer, and immunization related advertisements/ posters/ messages. Similarly, in the North-eastern region, cancer and dengue-related health messages have been recalled by 80 percent of respondents. In the southern region, 80 percent of respondents can recall dengue-related advertisements or messages. In the central region also, most people can recall dengue, cancer, malaria-related health advertisements, or messages. In the eastern region, 80 percent of people have seen cancer, TB, and dengue-related advertisements as seen in Figure 4.3.

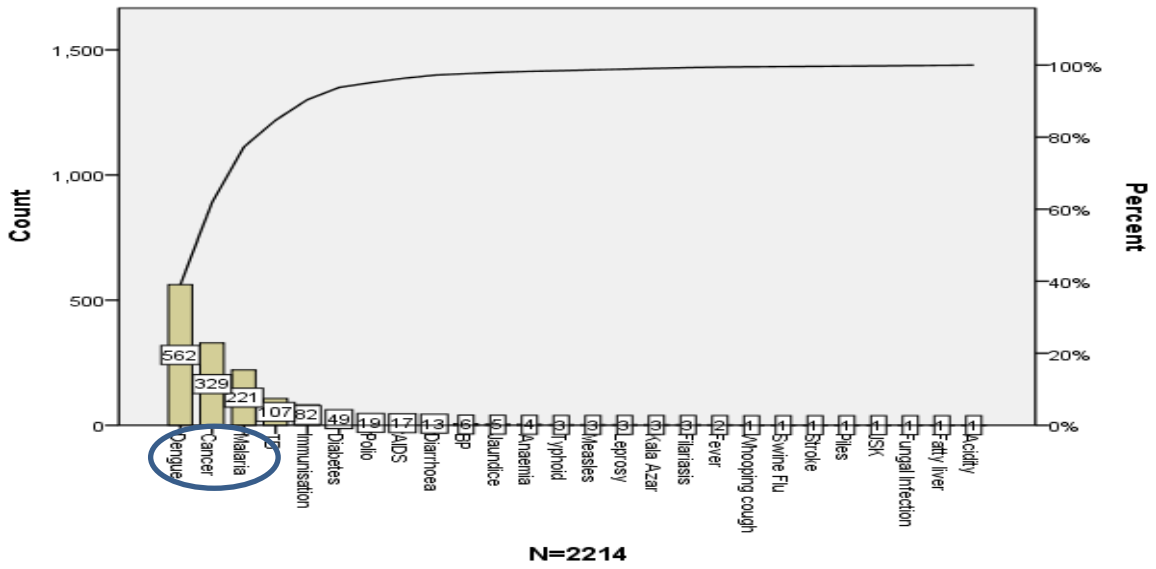


Figure4.2 Overall First Recalled Health-Related Advertisement/Messages

"I watch TV in the bit and pieces in the afternoon when my kids come from the school, most of the time they watch cartoon channels, in the evening, we (me, my mother in law and other members) watch serials like family dramas or some religious serials while cooking…….and you know as break comes in between I rush to the kitchen, I have overheard some of the advertisement like Dengue Mosquitoes ad, family planning, etc……, but did not give much notice to the issues…..but next time I'll do watch carefully….sorry…"

GD Participant, Urban Block, Eastern Region

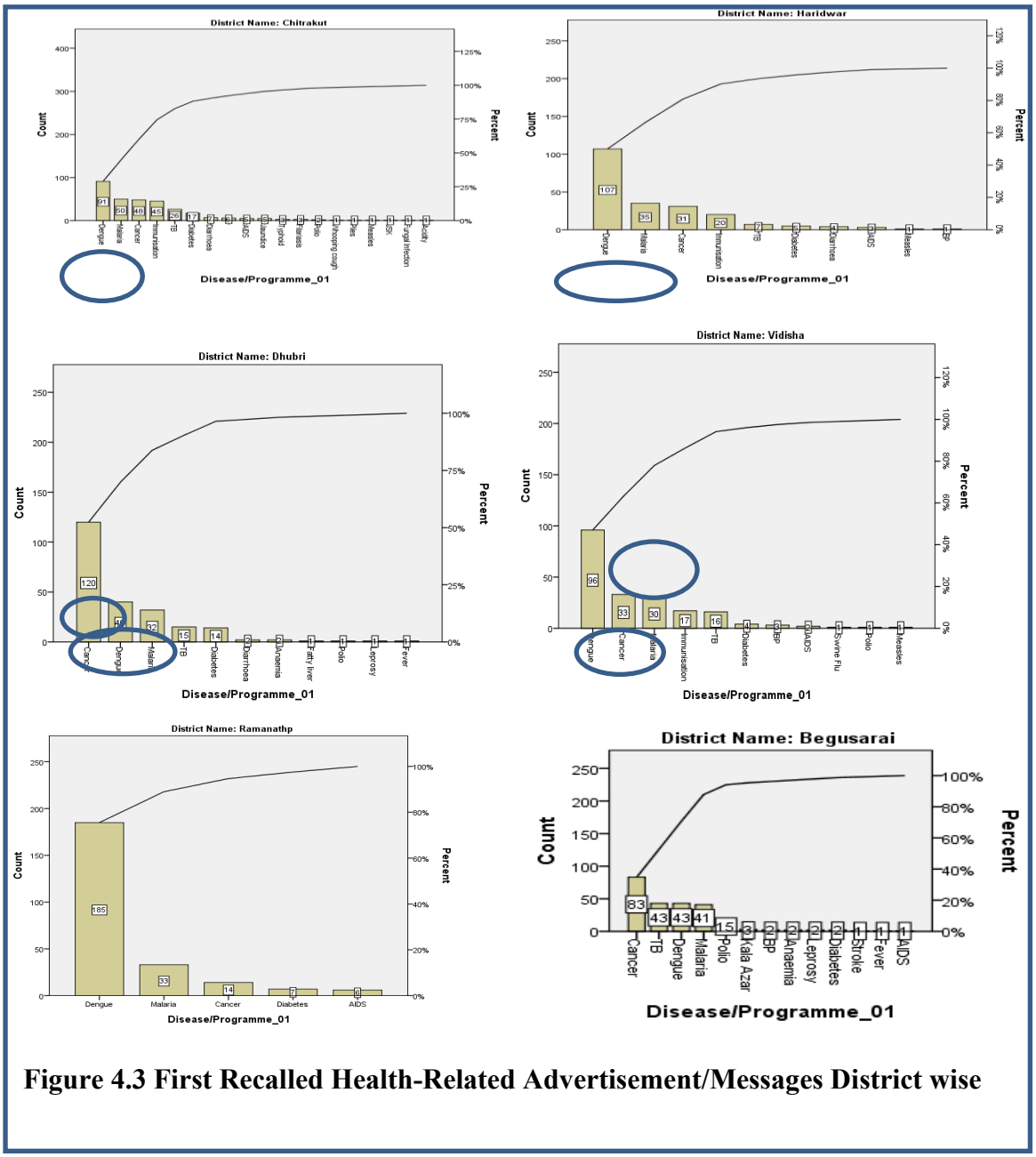


Figure 4.3 First Recalled Health-Related Advertisement/Messages District wise

"…….on TV you know as advertisement come, we switch to other channels, but in a cinema hall, you know, you have no chance to escape, I have seen the advertisement of Mukesh dying due to mouth cancer after tobacco chewing, Akshay Kumar advertisement on use of sanitary napkins in the movie theatre….."

FGD Participant, Urban Block, Northern Region

".....I have seen a big hoarding placed outside my daughter's school about Kirmi Mukt Saptha when I went to drop him..... my child was given the medicine as well..... her teacher explained to me about the same..... "

FGD Participant, Rural, Northern Region

"I saw advertisement related to Dengue, ORS, Malaria, and family planning advertisement on TV....it gives us good information and useful.....but it does not come very often....."

FGD Participant, Rural, Central Region

EXPOSURE LEVEL FOR SPECIFIC MOHFW CAMPAIGNS

As mentioned in the previous chapter, the study has focused on three specific programs namely-

1. National Vector Borne Disease Control Programme (NVBDCP)
2. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)
3. Immunization Mission Indradhanush

For each Programme, the respondents were interviewed (i) about the advertisement seen, (ii) in which media advertisement has been seen, (iii) number of times the advertisement seen, (iv) recall of messages, and (v) intend to change related questions. (See Annexure –Research Tool 1; Section 2)

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Exposure to Health Promotion Messages

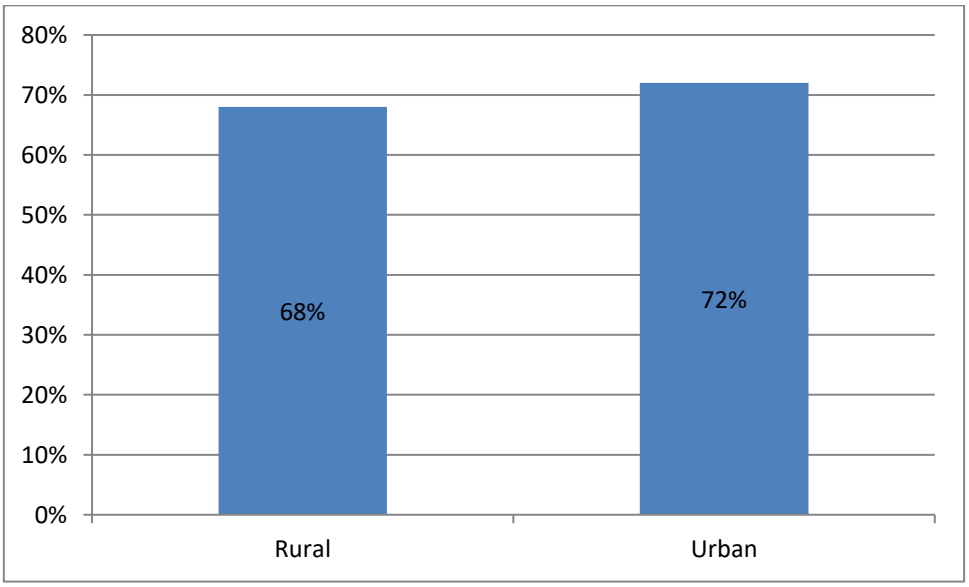


Figure 4.4 NVBDCP – Percentage of Respondent has seen Advertisement in rural & urban areas

Overall, 68 percent of the respondents from the rural locations across states have seen advertisements/posters/messages related to the national vector-borne disease control program and 72 percent of respondents, from the urban area, have seen advertisements/messages related to vector-borne disease control program as depicted in Figure 4.4. This response has been received from a sample of 2214 respondents across all the regions in the study.

Figure 4.5 depicts the percentage of people who have seen the advertisements in all the districts taken into the study. For the NVBDCP, in the northern region, Chitrakut district from UP has the highest exposure level i.e. almost 85% followed by Baran District in the western region i.e. almost 73%. The eastern region's district Begusarai has the least exposure level for NVBDCP i.e. almost 60%.

Source of Exposure

Overall, advertisements/messages related to NVBDCP have been seen on TV, in the health facilities and posters, and through health workers by 80 percent of the respondents, out of 2214 respondents, across regions as depicted in Figure 4.7.

In Chitrakut district of the Northern region, 80 percent of respondents have seen the advertisements/messages related to NVBDCP in posters, TV, hospital, and the newspapers. In another state of the northern region i.e. Uttrakhand in Haridwar district, the majority of respondents have seen this advertisement on TV, informed by a health worker, and in posters. In the southern region, 80 percent of respondents have seen these advertisements on TV, in health facilities, newspapers and listened over the radio. In the Central region, the majority of these messages/advertisements have been seen on TV followed by informed by the health workers and posters. However, in the North-Eastern part of the nation, the majority of people have seen these advertisements on TV, followed by intimated by a health worker as shown below in Figure 4.6.

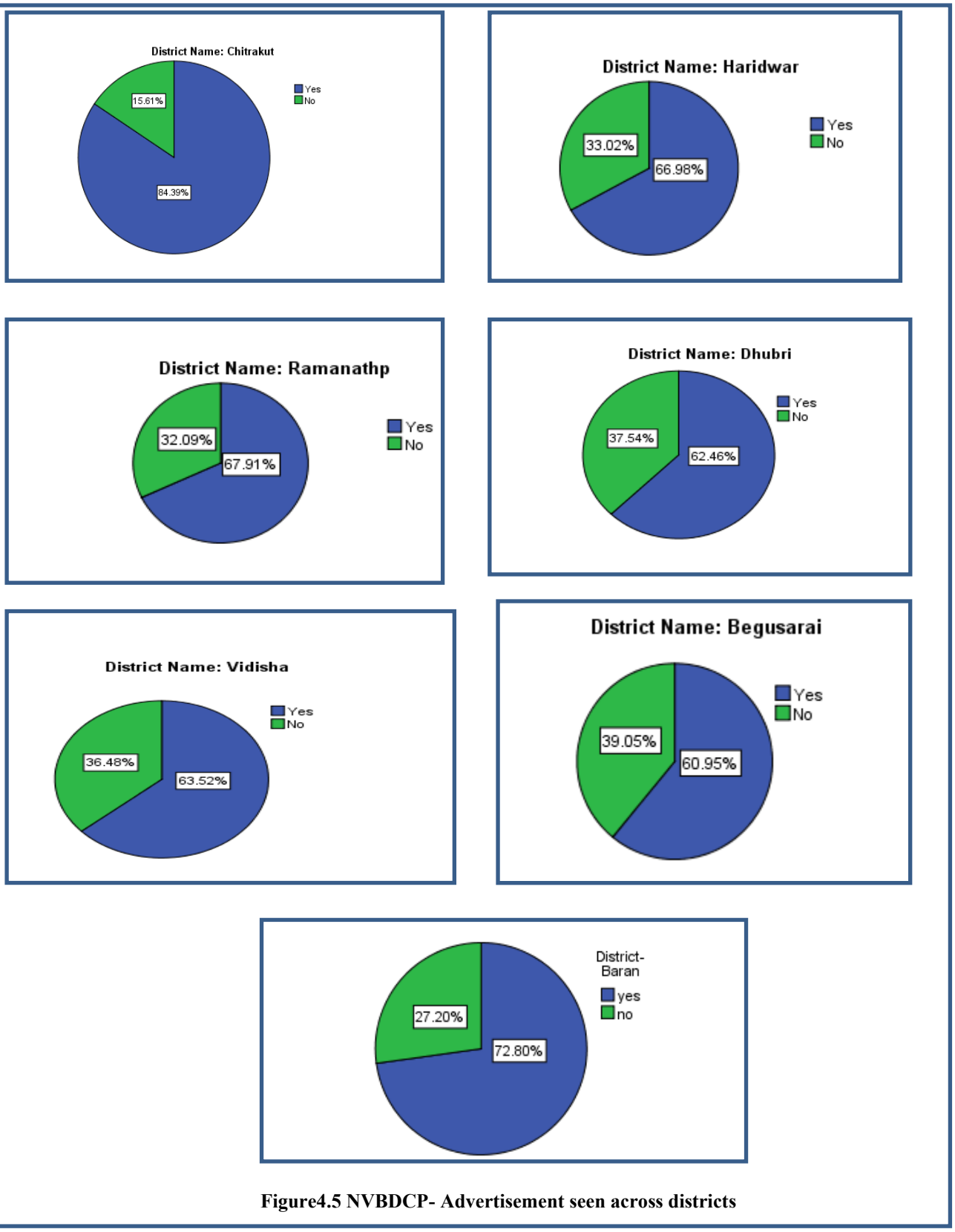


Figure4.5 NVBDCP- Advertisement seen across districts

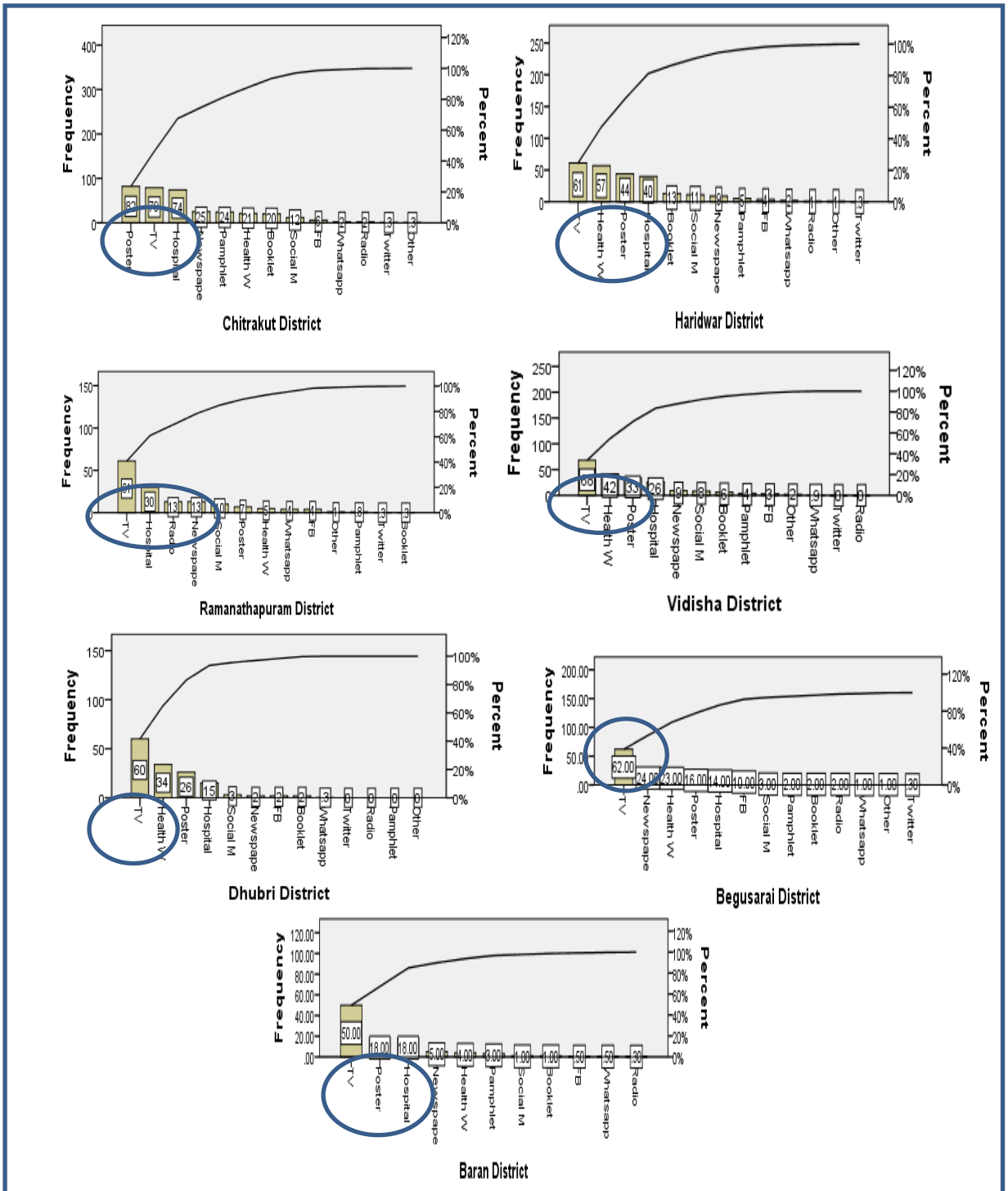


Figure 4.6 Source of Advertisement NVBDCP

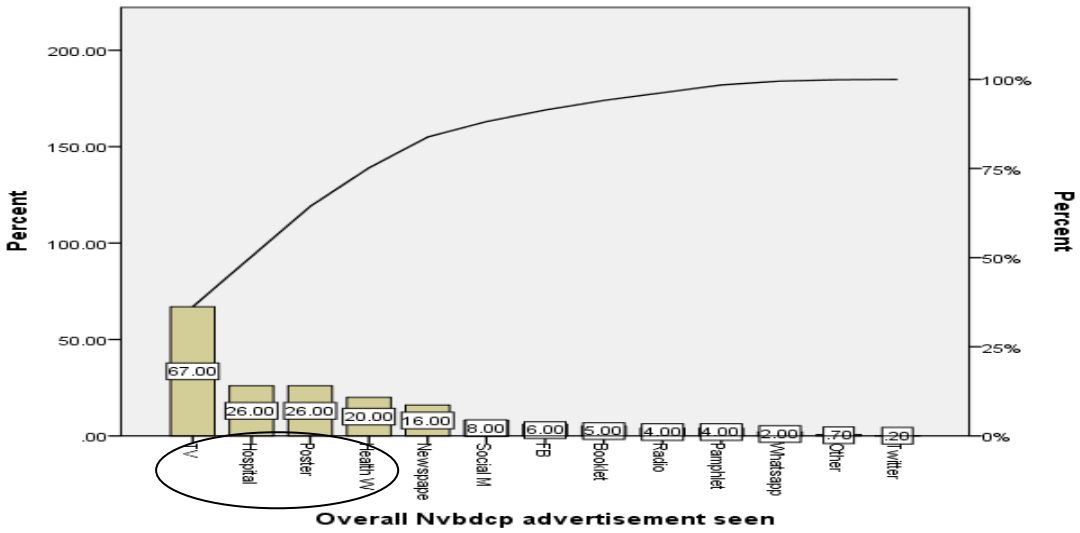


Figure 4.7 Overall NVBDCP advertisement seen on which media

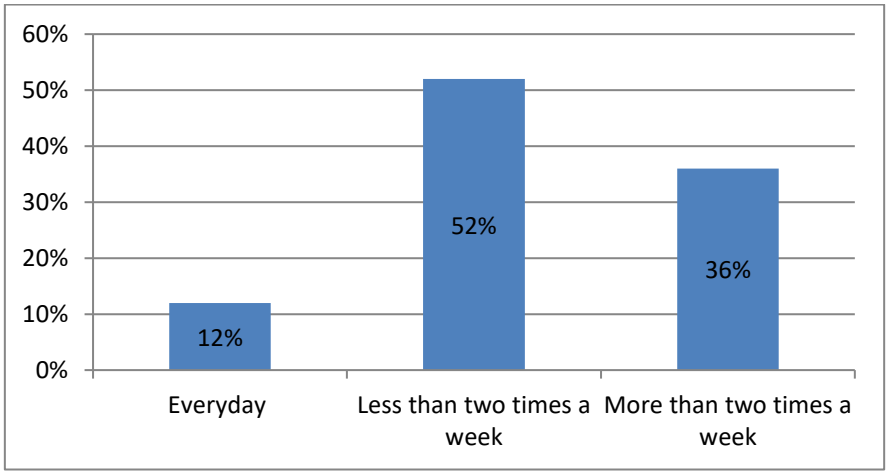


Figure4.8 Overall number of times NVBDCP related advertisements seen across regions

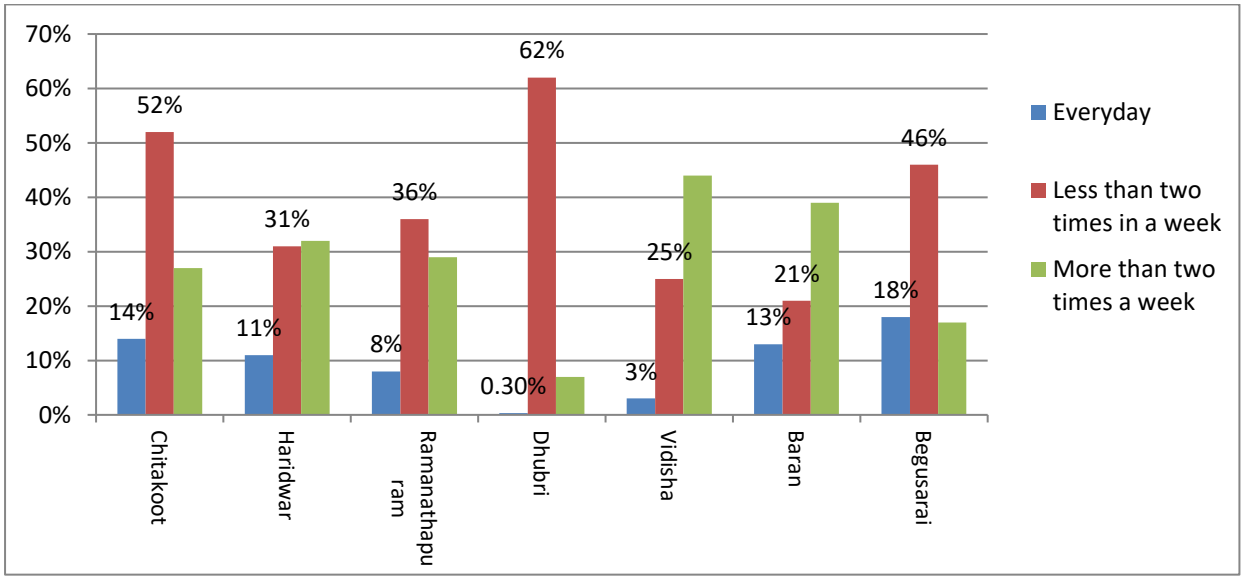


Figure4.9 Number of times NVBDCP related advertisement seen in all districts

Frequency of Exposure

Overall, the majority (around 52%) of respondents, out of 1687 respondents, across regions have seen advertisements in less than two times a week followed by people who have seen the advertisements more than two times a week i.e. 36 percent and only 12 percent of respondents have watched these advertisements daily across regions as depicted in Figure 4.8 & 4.9.

Recall of Messages

Across all the regions, 73 percent of respondents could recall in the NVBDCP advertisements that diseases spread by mosquitos, 72 percent of respondents could recall the breeding places of mosquito whereas just 15 percent of respondents could recall that free blood examination facility is available in all government centers as shown in Table 4.2.

Table 4.2 Overall Recall of messages of NVBDCP

Message	Overall
Diseases spread by mosquito	73.0%
Breeding places of mosquito	72%
Sign and symptoms of the disease	39%
Free blood examinations in Government health centers	15%
Free treatment at all level	19%
Acceptance of Indoor residual spray	4%
Methods to prevent mosquito bites	20%
No. of Respondents (N)	**1498**

Table 4.3 represents the region-wise recall of the messages communicated in the NVBDCP advertisements. The majority of respondents from the Central region i.e. 96 percent could recall diseases spread by mosquito followed by respondents of the Southern region whereas the least recall of this message has been observed in respondents of the North-eastern region. The message like breading places of mosquito has been recalled by the majority of respondents from the Northern region followed by respondents of the Central region. Only 22 percent of respondents from the north-eastern region could recall signs and symptoms of the dengue/malaria. The messages like free blood examinations in Government health centers, free treatment at all levels, and acceptance of indoor residual spray have been recalled by very few respondents across the regions. None of the respondents from the North-eastern region can recall that free blood examinations are being done in the government health centers and free treatment at all levels is available. Similarly, only 3 percent of

respondents from the Southern region could recall-free treatment at all levels are available in the health facilities.

Table 4.3 Region wise recall of messages of NVBDCP advertisements

	Northern		Southern	Northeast	Central	Eastern
NVBDCP Messages	**UP**	**Uttrakhand**	**Tamil Nadu**	**Assam**	**MP**	**Bihar**
Diseases spread by mosquito	84%	71%	86%	40%	96%	58%
Breeding places of mosquito	93%	95%	53%	46%	78%	67%
Sign and symptoms of the disease	34%	68%	16%	22%	45%	54%
Free blood examinations in Government health centers	38%	11%	9%	0%	8%	20%
Free treatment at all level	47%	25%	3%	0%	15%	22%
Acceptance of Indoor residual spray	4%	6%	5%	0%	6%	6%
Methods to prevent mosquito bites	48%	24%	18%	0%	21%	3%

Table 4.4 depicts the cross-tabulation between the recall messages and the sources of receiving the message. Diseases spread by mosquito messages have been on TV by 50 percent of respondents followed by messages seen in the health facilities by 22 percent of respondents and 20 percent of respondents have seen this in posters. This message is least seen in pamphlets, booklets and listened over the radio.

Similarly, breeding places of mosquito messages have been on TV by 49 percent of respondents followed by messages seen in the health facilities and posters by 22 percent of respondents and this message has been least in pamphlets, booklet, and listened over the radio. Sign and symptoms of diseases and free blood examination in government health centers messages have been seen on TV by 27 and 10 percent of respondents respectively followed by posters which are seen by 11 percent and 7 percent of respondents. Both the messages have been least seen over social media, in booklets, and listened over the radio. The same trend has been seen in a recall of messages of free treatment at all levels and methods to prevent mosquito bites where 13 percent of respondents have seen on TV followed by posters and in health facilities. These messages have been least seen on the radio even compare to social media, and booklets. It can be concluded that though the government is spending much over the radio but radio preference among people is very least.

> *"....We have a dish at home but we cannot afford to buy cable connection (like TATA Sky, Airtel TV, Videocon D2H, etc...) to watch free to air channels like Dangal, Big Magic, Sony Pal, or some movie channels like Set Max TV, Manoranjan TV, etc.....*

We watch TV normally after coming back from the field in the evening and while cooking food and eating food, we go to sleep around 8:30 pm"

FGD Participant, Rural, Central Region

"We don't like Hindi serials and movies we prefer to watch in Tamil channels like Jaya TV, Vijya TV, Tamilan TV, etc....It has a variety of shows, movie programs,..... DD Chennai does not give very good programs but we watch the movie over it most of the times.....DD national channel is watched when a cricket match is on or like Parade of 26th January etc....."

"We watch Dangal TV, Sony Pal TV ..... on that we watch Jai Jai Shani Dev, Maha Bharat, CID and Crime Patrol serial, etc...."

FGD Participant, Rural, Northern Region

"We prefer time to watch TV is evening 8 pm to 10:30 pm and sometimes we watch TV at our shop in the afternoon when customers are not there, in the morning and evening we prefer to watch News channels, etc...."

FGD Participant, Urban, Western Region

Table 4.4 Cross-tabulation between the Recall messages and the Sources of Receiving the Message

Sources of information	Diseases spread by mosquito	Breeding places of mosquito	Sign and symptoms of the disease	Free blood examinations in Government facilities	Free treatment at all level	Acceptance of Indoor residual spray	Methods to prevent mosquito bites
TV	50%	49%	27%	10%	13%	3%	13%
Radio	4%	3%	1%	1%	1%	0.30%	0.30%
Newspaper	12%	13%	7%	4%	4%	0.70%	4%
Pamphlet	4%	4%	2%	2.50%	2.50%	0.20%	2%
Booklet	4%	5%	3%	2%	2%	0.30%	1%
Poster	20%	22%	11%	7%	10%	1%	8%
Healthworker	15%	18%	10%	5%	6.50%	1%	6%
Hospital	22%	22%	10%	7%	8%	1.00%	9%
Social Media	7%	7%	3%	2%	2%	0.60%	2%
Facebook	3%	3%	2%	1%	1%	0.20%	1%
Whatsapp	2%	2%	1%	1%	0.40%	0.20%	0.60%
Twitter	0.20%	0.10%	0.10%	0.10%	0.10%	0.10%	0%
Other	0.50%	0.50%	0.50%	0.10%	0.10%	3%	0.20%

Intention to Behavior Change

Disseminate Information/Motivate/Inform Others

Across the regions in the study, out of 1672 respondents, 75 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 25 percent of respondents do not facilitate to disseminate the benefits of advertisements to others. Figure 4.10 depicts the districts' wise percentage of respondents or their families who disseminate the benefits of advertisements to others.

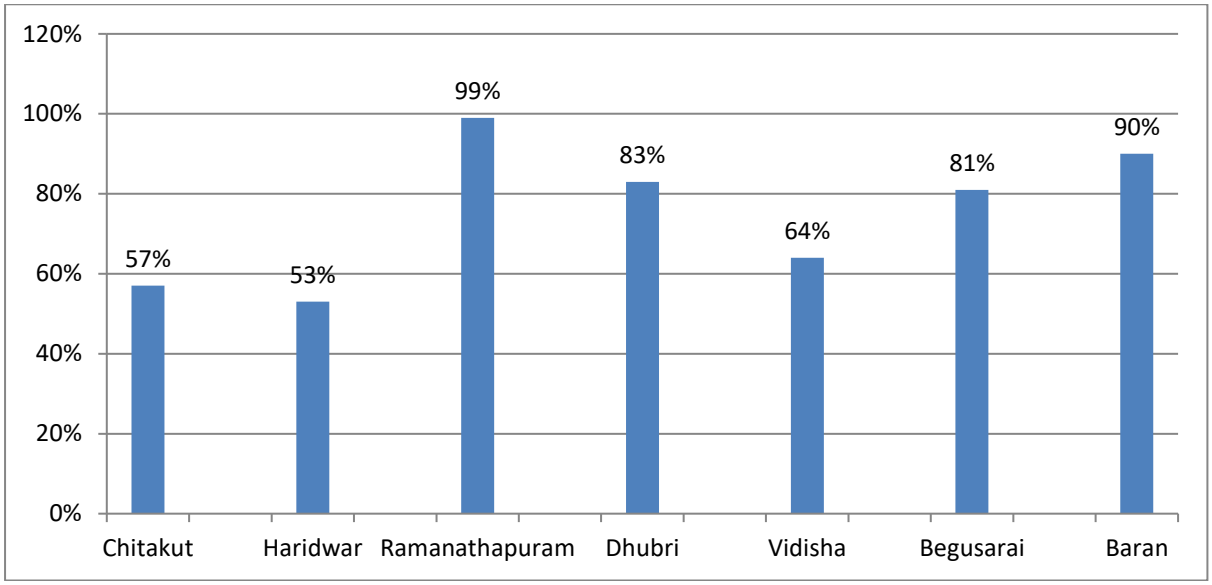


Figure4.10 Percentage of respondents who disseminate the benefits of advertisements or not

In Ramanathapuram district of the Southern region, almost every person i.e. 99% share and disseminate information received with other family, friends, and known. But information-sharing habits are very less in the northern region as in both Chitrakoot and Haridwar just 57% and 53% person share/disseminate information with others.

Reasons for not Disseminating/Share Health Promotion Message

The respondents who don't share information with others were further probed by the researchers to inquire about the reasons for not sharing information with others, in Chitrakoot district, almost half of these respondents i.e. 52 percent say that they don't have time and 36 percent believe that other people already know about this. Whereas, 24 percent of respondents feel that they are themselves not aware much about these advertisements. 10 percent of respondents don't feel the need to educate others and 10 percent believe that why other people will listen to them as shown in Figure 4.11.

Similarly, another region of North India i.e. in Haridwar, out of 230 respondents, 53 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 47 percent of people do not facilitate to disseminate the benefits of advertisements to others. Out of this 47 percent, more than half of these people i.e. 57 percent respondents say that don't have time and 32 percent of people don't find it interesting whereas 27 percent of people believe that other people already know about it. 15 percent of people feel that why other people will listen to them as shown in Figure 4.11.

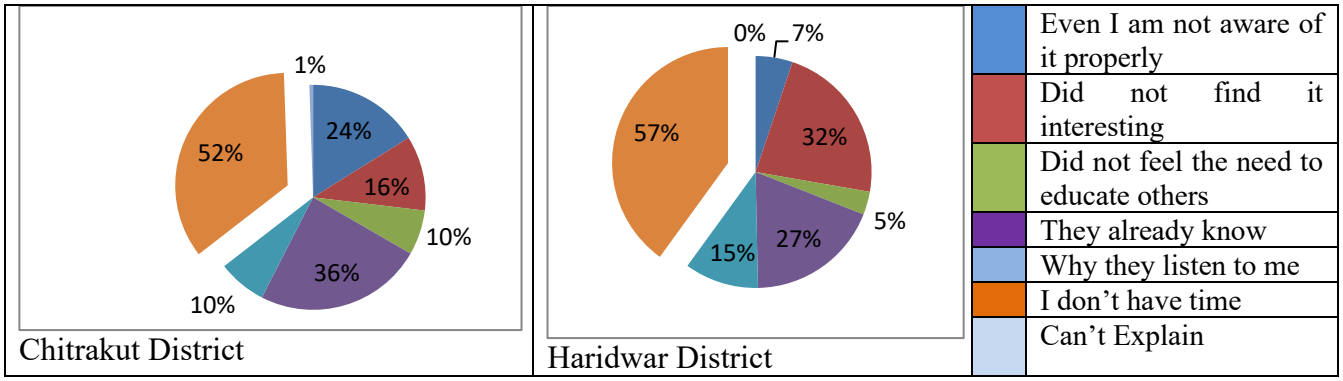


Figure4.11 Reasons for not disseminating the benefits of information of Northern region

In the *Southern region*, out of 257 respondents, only 1 percent of respondents don't disseminate the benefits of the advertisements to others. Out of this 1 percent, almost all respondents believe that they are not much aware of these advertisements.

In the North-Eastern region, out of 226 respondents, 83 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 17 percent of respondents do not facilitate to disseminate the benefits of the advertisements to others. Out of this, half of the respondents (51 percent) feel that why others will listen to them. 21 percent of respondents don't find it interesting and the other 21 percent believe that other people already know about the benefits of these advertisements as shown in Figure 4.12.

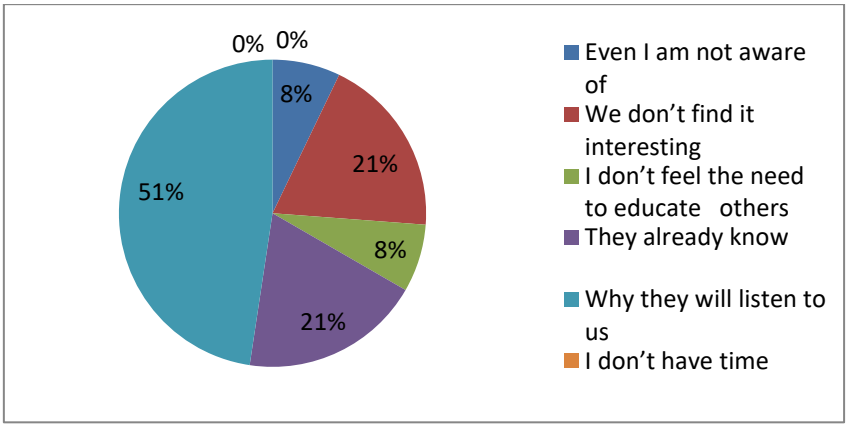


Figure4.12 Reasons for not disseminating the benefits of information of North Eastern region

In the *eastern region* out of 250 respondents, 82 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 18 percent of respondents don't disseminate the benefits of advertisements to others. Out of this 18 percent, 28 percent of respondents believe that other people already know about it 23 percent of respondents don't have time and 21 percent of respondents don't feel the need to educate others as shown in Figure 4.13.

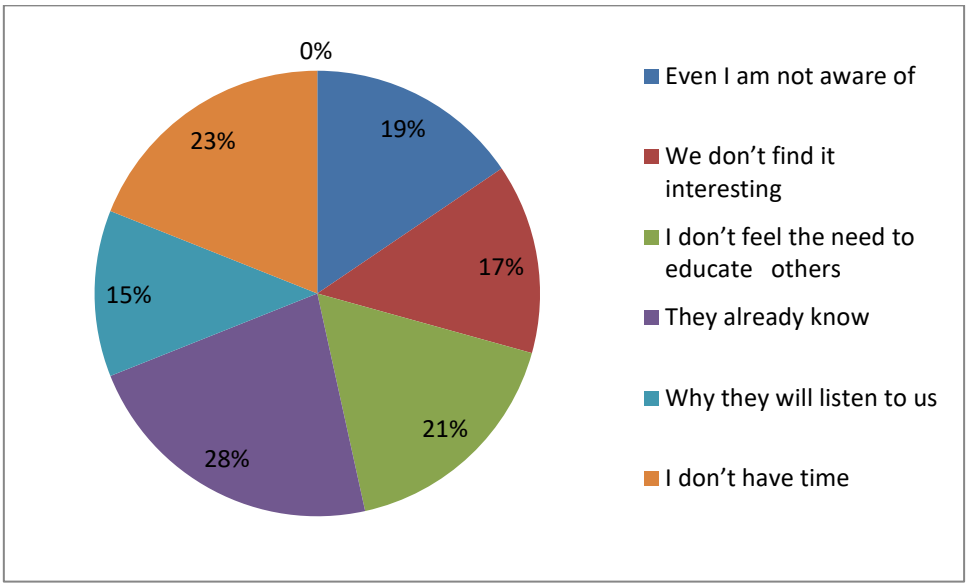


Figure4.13 Reasons for not disseminating the benefits of information of Eastern region

In the *Central region*, out of 227 respondents, 64 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 36 percent of respondents do not facilitate to disseminate the benefits of advertisements to others.

Out of this 36 percent, more than half of these people i.e. 52 percent respondents say that don't have time and 32 percent of people don't find it interesting whereas 16 percent of respondents feel that why other people will listen to them as shown in Figure 4.14.

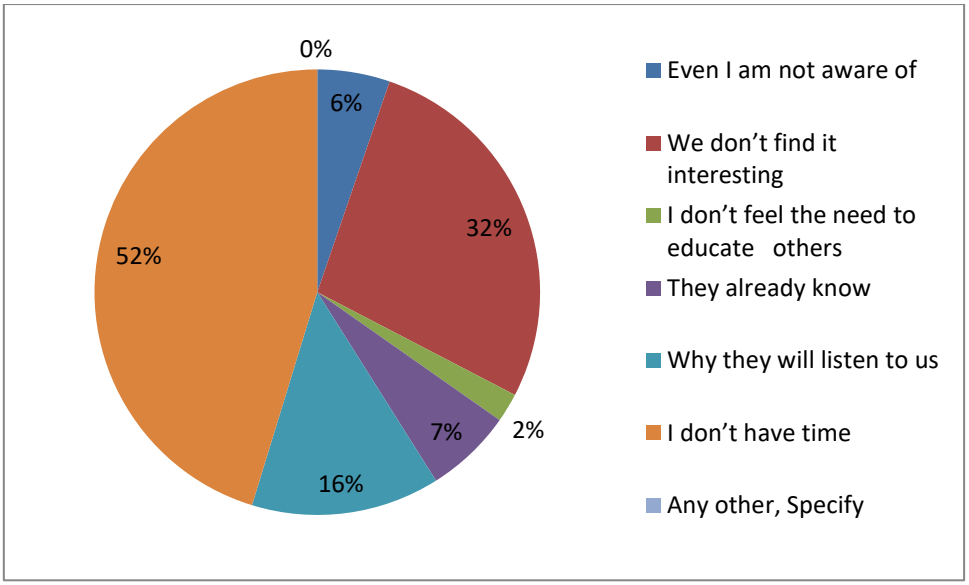


Figure4.14 Reasons for not disseminating the benefits of information of Central region

Perception about Impact of Health Promotion Messages on Suggested Actions

Overall, the majority of the respondents i.e. 95 percent across regions believe that these advertisements have been able to change their minds and action. Only 5 percent of respondents felt that these advertisements are not been able to change their minds and action. This response has been received from a group of 1664 respondents.

Figure 4.15 depicts the percentage of respondents who think these advertisements have been able to change their minds and action or not. In Chitrakut district of the Northern part of the nation, only 5 percent of respondents reported that these advertisements have not been able to change their mind and action, out of this 5 percent, 17 percent of respondents reported the reason for this is no TV at their home and 11 percent of them feel that so much of information overloaded and no regional flavor in these advertisements.

In another district of the Northern region i.e. Haridwar, only 2 percent of respondents believed that these advertisements have not been able to change their minds and action. Out of this 2 percent, more than half of the percent i.e. 60 percent of respondents believes that so much of information is overloaded in these advertisements because of which they got confused in understanding these advertisements fully and 20 percent of respondents claimed that because of no TV and no regional flavor in these advertisements that's why these advertisements have not been able to change their mind and action.

In the North-Eastern region, 85 percent of respondents believed that these advertisements have been able to change their minds and action whereas 15 percent of respondents don't believe the same. Out of this 15 percent, 24 percent of respondents believe that so much

information is overloaded in these advertisements. Some respondents (18 percent) claimed that because of no TV at their home and 20 percent of respondents claimed no regional flavor in these advertisements as one of the reasons for not changing their mind and action after watching these advertisements.

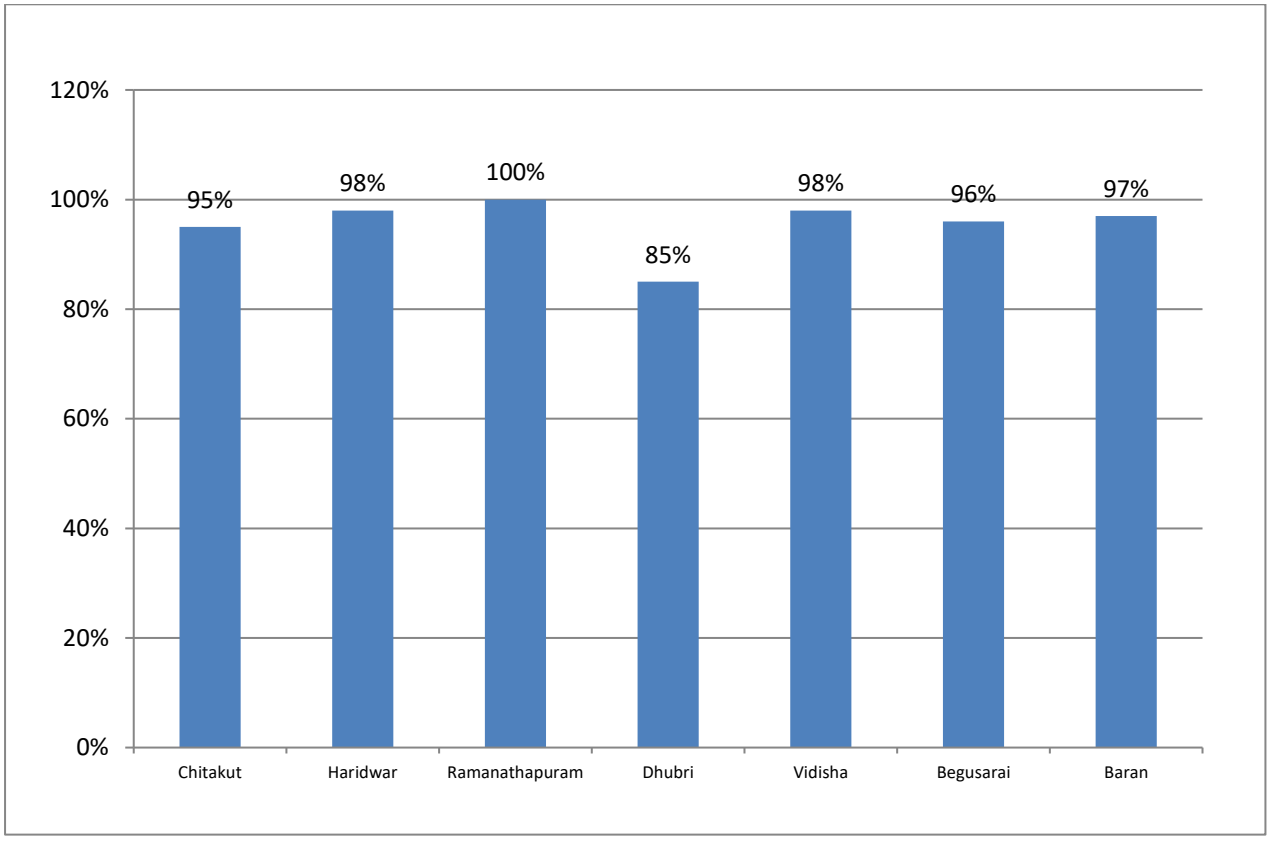


Figure4.15 Percentage of respondents who believes these advertisements change their mind an action

Willingness to Change to Desired Behaviour expected in NVBDCP Messages (Bed Nets)

For any program to be successful the content, benefits, and advantages of the program have to be understood by people and behavioral changes are needed to be understood, to accept and internalize the concept and for taking the advantages of the program. In light of this concept, the study approached various stakeholders and tried to understand they are intended for behavior change. Respondents have been interviewed to know about their willingness to use bed nets if given a choice. Overall, 85 percent of respondents across regions show their willingness to use bed nets. Figure 4.16 shows the percentage of people who are willing to use bed nets district wise. Across regions, respondents of the Northern region show their least willingness to use bed nets followed by respondents from the Western region.

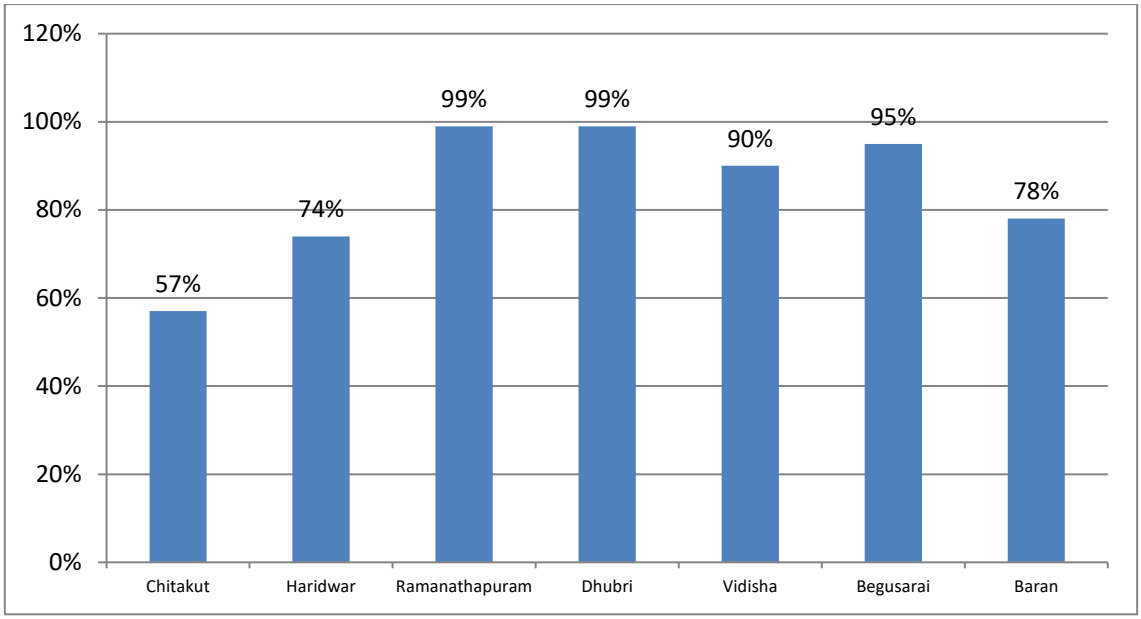


Figure4.16 Willingness to use bed nets.

In Chitrakut district, out of 43 percent who were not willing to use bed nets, 50 percent of them do not use the same because they feel claustrophobic. 40 percent of respondents do not use bed nets because they have to share a bed with others and some felt that these bed nets are ineffective. In Haridwar, more than 50 percent of respondents feel that bed nets are ineffective. 29 percent of respondents reported that they cannot use bed nets because they have to share a bed with others. Similarly, in the Southern and Eastern regions, most of the respondents are not using bed nets because of their usage habits.

In the North-Eastern region, only 1 percent of respondents are not willing to use beds nets, out of this 1 percent, most of them not using nets because they have to share beds and very few felt that small bed nets become un-tucked at night.

Preferred Medium to Receive Information in Future

The study team tried to seek the respondent's suggestion on what would be the best modality to connect with them to propagate health-related messages. In Northern and Southern and Central region people suggested television as the best medium among all other media whereas the majority of people in Eastern, Western, and North Eastern regions suggested that awareness workshops and seminars are the best way to educate people of their communities as depicted in Figure 4.17.

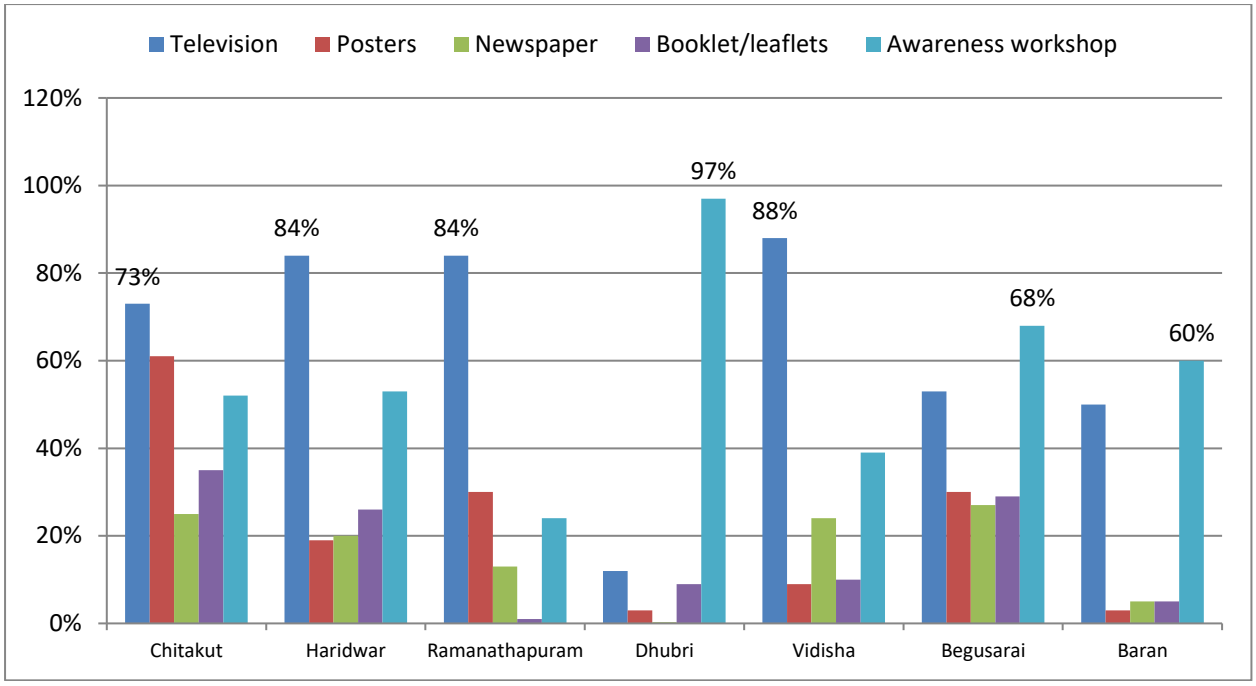


Figure 4.17 Best medium to generate awareness

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE (NPCDCS)

Exposure to Health Promotion Messages

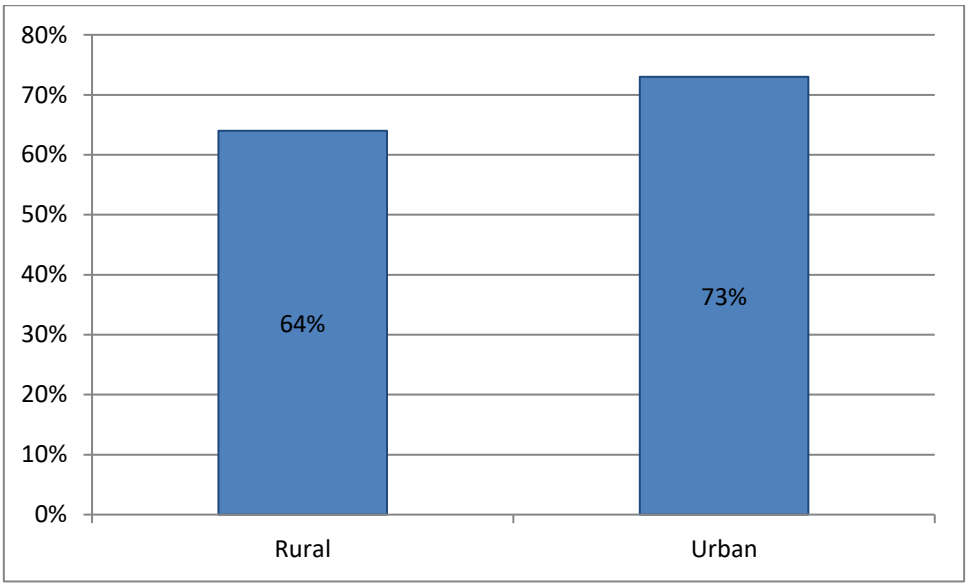


Figure4.18 NPCDCS – Exposure Level among rural & urban groups

Across the regions in the study, out of 2214 respondents, 64 percent of respondents from a rural location across states have seen advertisement/posters/messages related to NPCDCS and 73 percent of respondents, from an urban area, have seen advertisements/messages/posters related to this program as depicted below in Figure 4.18.

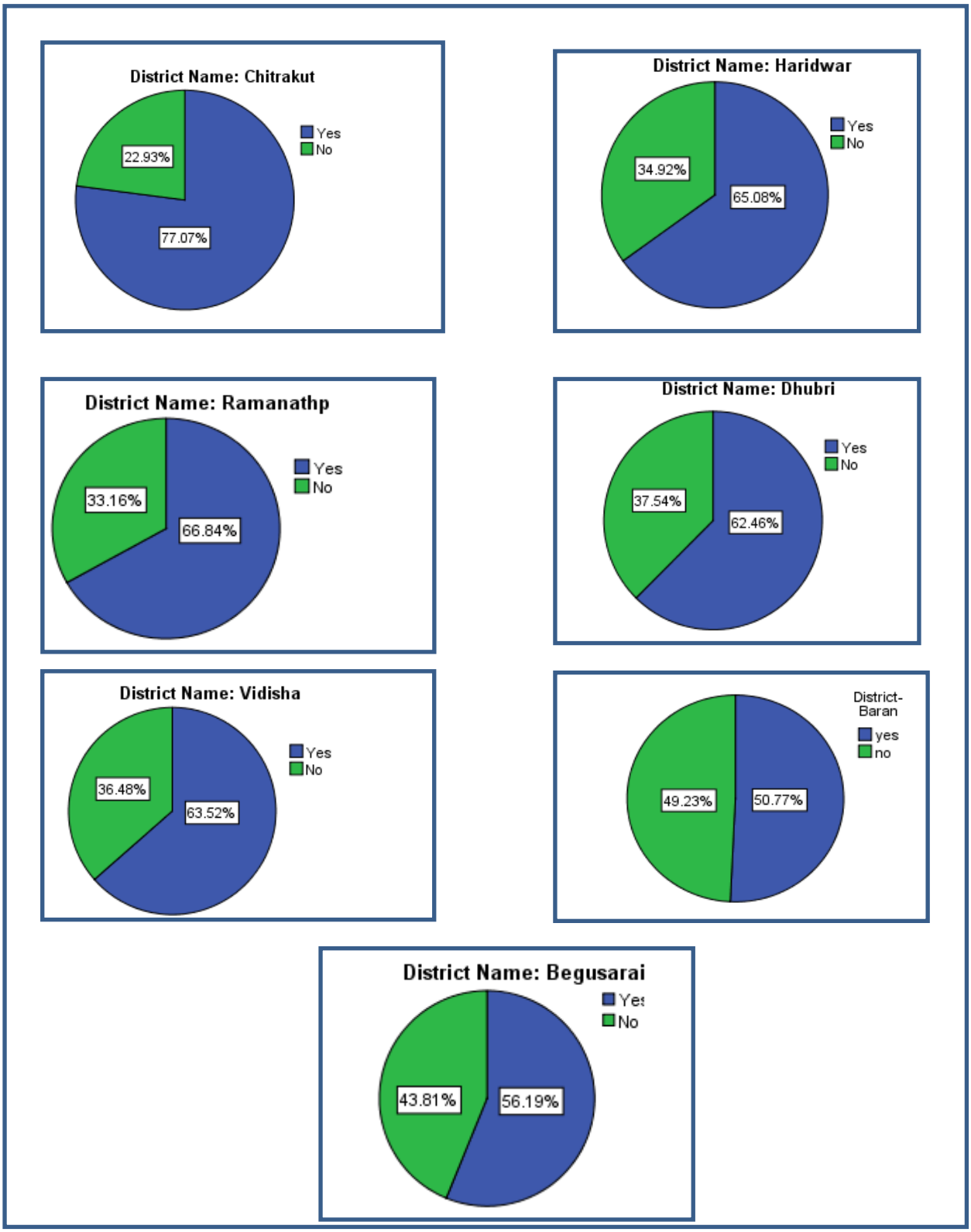


Figure4.19 NPCDCS Advertisement Exposure Level seen across districts

Figure 4.19 depicts the percentage of the respondents who have seen the advertisements related to NPCDCS across districts in the study. There is a significant difference within the Northern region districts i.e. Haridwar and Chitrakoot on viewership related to NPCDCS

advertisement. The Southern region district Ramanathapuram has the second-largest exposure level. Similarly, the Western region has the lowest level of exposure to NPCDCS health promotion messages i.e. 50.77%.

Source of the Exposure

Overall, advertisements/messages related to NPCDCS have been seen on TV, in health facilities, and through health workers and in posters by 80 percent of the respondents, out of 2214 respondents, across regions as depicted in Figure 4.20.

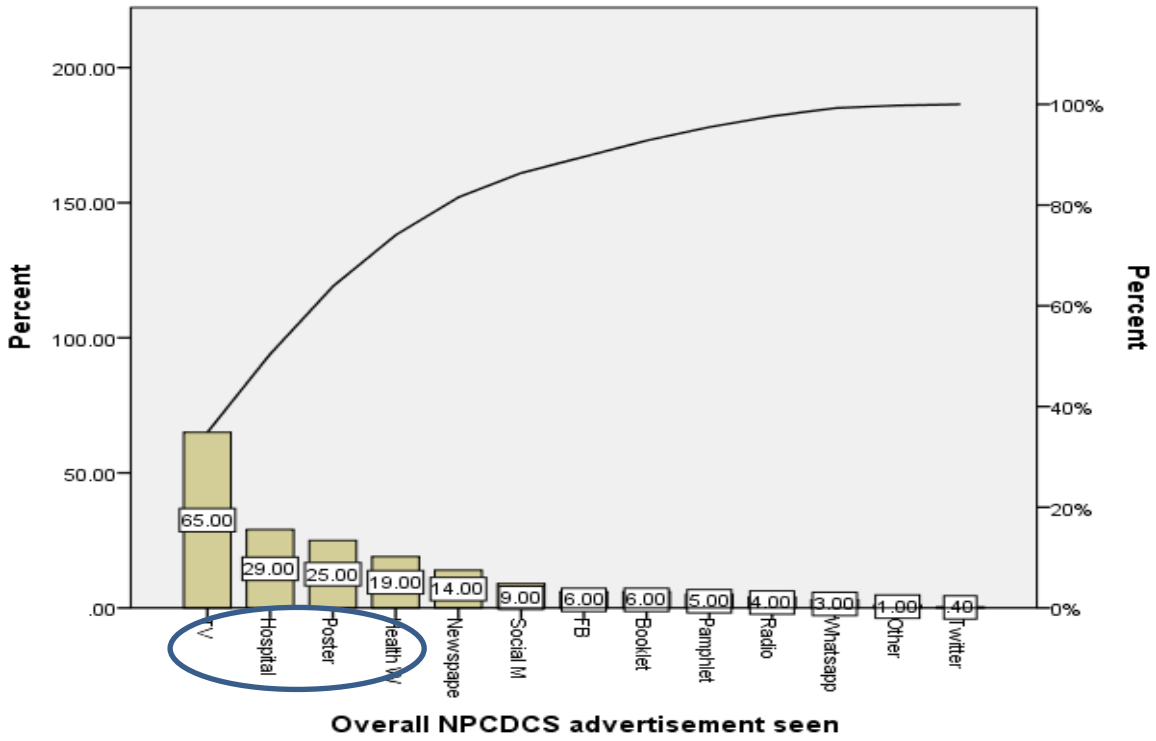


Figure4.20 Source of exposure for NPCDCS related advertisements

In the Northern region, 80 percent of respondents have seen advertisements/messages related to NPCDCS on TV, in posters, health facilities and through health worker whereas, in the Southern region, 80 percent of respondents have seen these advertisements on TV, in health facilities & newspaper and listened over the radio as shown in Figure 4.21. In the Central region, the majority of these advertisements have been seen on TV followed by posters and in health facilities, and the North East region majority i.e. 80 percent of respondents have seen these advertisements on TV followed by social media. In the Eastern region, 80 percent of respondents have seen these advertisements on TV, in health facilities, through health workers, and in posters. In the Western region, 80 percent of respondents have seen these advertisements on TV and in health facilities (Figure 4.21).

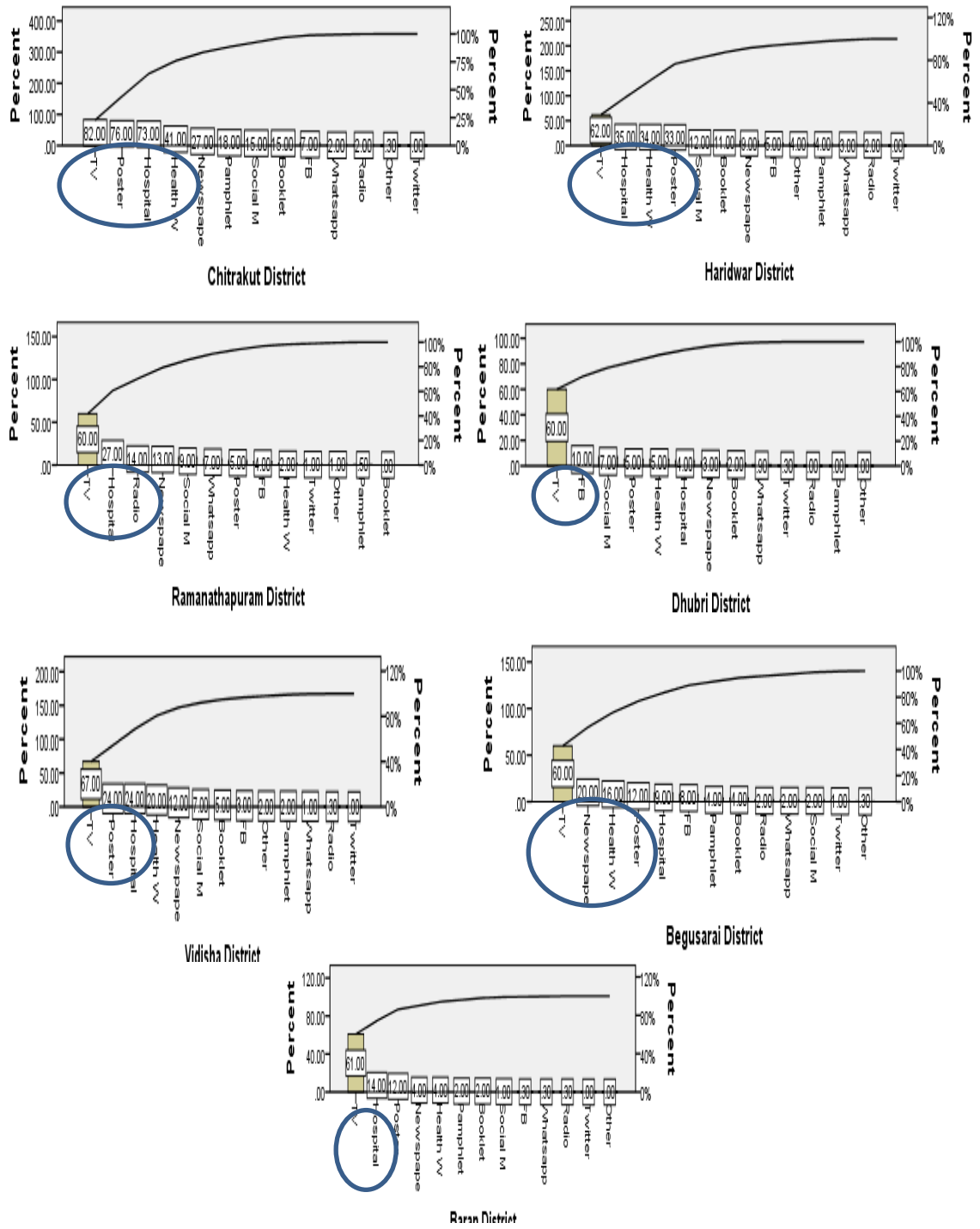


Figure4.21 Region Wise Source of NPCDCS **advertisements Exposure**

Frequency of Exposure

The majority of respondents i.e. 55 percent have seen advertisements less than two times a week followed by 31 percent of respondents who have seen the advertisements more than two times a week. Only 14 percent of respondents watch these advertisements daily out of 1595 respondents across regions as depicted in Figure 4.22.

Figure 4.23 depicts several times people have watched advertisements in all districts. In one of the districts of the Northern region i.e. in Chitrakut, Southern, Eastern, and North Eastern region majority of respondents have seen this advertisement less than two times a week whereas in Central, Western, and in another part of North India, i.e. Haridwar majority of respondents watch these advertisements more than two times a week.

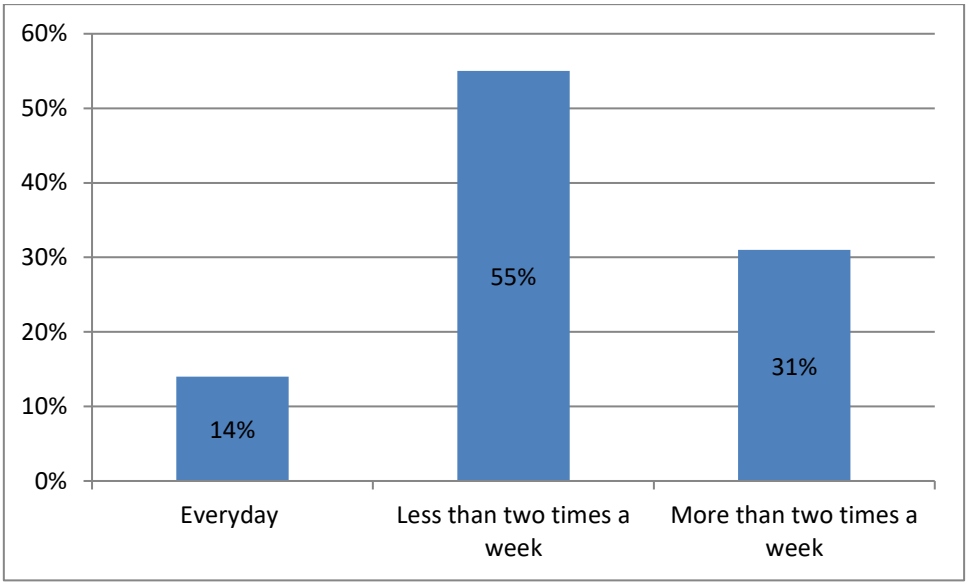


Figure4.22 Overall number of times NPCDCS related advertisements seen across regions

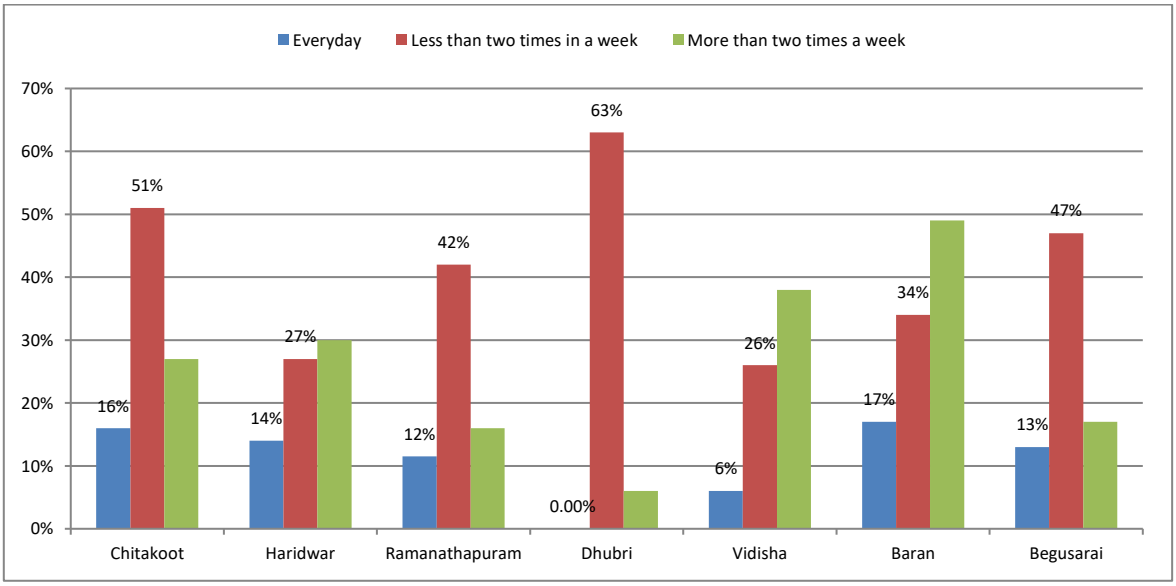


Figure4.23 Number of times advertisement seen in all districts.

Recall of NPCDCS Messages

Across all the regions, 64 percent of respondents could recall the NPCDCS advertisements about the risk factors of cancer, 56 percent of respondents could recall the risk factors cardio-vascular diseases whereas only 7 percent of respondents could recall symptoms of Cancer as shown in Table 4.5.

Table 4.5 Overall Recall messages of NPCDCS

Message	Overall
Frequently getting screening for these diseases	33%
Awareness about the risk factor for cardiovascular disease	56%
Awareness about the risk factor for Cancer	64%
Cancer Symptoms	7%
Cancer is curable with early diagnosis.	9%
Awareness about the risk factor for diabetes mellitus	9%
A Healthy Lifestyle can prevent diabetes	11%
Awareness about the – sign and symptoms of diabetes	6%
No. of Respondents (N)	**1463**

Table 4.6 represents the region-wise recall of the messages communicated in the NPCDCS advertisements. The majority of respondents from the Southern region i.e. 71 percent could recall diseases spread by mosquito followed by 36 percent of respondents from the Central region whereas the least recall i.e. 7 percent has been seen in respondents from the North-eastern region. The majority of respondents from the Northern region could recall awareness about the risk factor for Cancer followed by respondents of the Central region. Three and 1 percent of respondents from the Northeastern region and the Central region respectively could recall cancer symptoms. Sadly, none of the respondents from the Northeastern region has been able to recall message related to the sign and symptoms of diabetes mellitus, cancer is curable with early diagnosis and a healthy lifestyle prevents diabetes.

Table 4.6 Region wise Recall messages of NPCDCS advertisements

Regions	**Northern**		**Southern**	**North Eastern**	**Central**	**Eastern**
Messages/State	**UP**	**Uttrakhand**	**Tamil Nadu**	**Assam**	**MP**	**Bihar**
Frequently getting screening for these diseases	28%	22%	71%	7%	36%	29%
Awareness about the risk factor for cardiovascular disease (CVD)	53%	78%	37%	47%	55%	59%
Awareness about the risk factor for Cancer	90%	96%	15%	42%	91%	47%
Cancer Symptoms	6%	8%	6%	3%	1%	15%
Cancer is curable with early diagnosis.	22%	4%	8%	0%	4%	10%
Awareness about the risk factor for diabetes mellitus	8%	19%	5%	1%	16%	3%
Healthy Lifestyle can prevent diabetes	22%	19%	5%	0%	16%	2%
Awareness about the – sign and symptoms of diabetes	18%	1%	10%	0%	0%	1%

Table 4.7 depicts the cross-tabulation between the recall messages and the sources of receiving the message. Frequently getting screening for these diseases message have been on TV by 22 percent of respondents followed by message seen in health facilities by 10 percent of respondents and 8 percent of respondents have seen this in posters. This message is least seen over social media, in pamphlets, booklets, and listened over the radio.

Table 4.7 Cross-tabulation between the Recall messages and the sources of receiving the message

	Frequently getting screening for these diseases	Awareness about the risk factor for cardiovascular disease	Awareness about the risk factor for Cancer	Cancer Symptoms	Cancer is curable with early diagnose	Awareness about the risk factor for diabetes mellitus	A Healthy Lifestyle can prevent diabetes	Awareness about the – sign and symptoms of diabetes
TV	22%	36%	42%	5%	6%	6%	8%	3%
Radio	3%	3%	2%	1%	0%	1.00%	0.00%	1%
Newspaper	5%	9%	10%	2%	2%	2.00%	2%	2%
Pamphlet	2%	3%	4%	0.60%	2.00%	0.00%	1%	1%
Booklet	2%	4%	5%	0.60%	1%	0.00%	1%	1%
Poster	8%	16%	21%	2%	4%	2%	4%	3%
Health worker	6%	14%	17%	1%	2.00%	1.00%	2%	1%
Hospital	10%	17%	22%	2%	4%	3%	4%	3%
Social Media	2%	6%	7%	1%	1%	1.00%	1%	0%
Facebook	1%	3%	3%	0%	0%	1.00%	1%	0%
Whatsapp	1%	2%	2%	0%	0.00%	1.00%	0.00%	0%
Twitter	0.30%	0.30%	2.00%	0.00%	0.00%	0.00%	0%	0%
Other	0.30%	0.60%	1.00%	1.00%	0.00%	1%	1.00%	0%

Similarly, recall messages like awareness about the risk factors for CVD and Cancer have been seen on TV by 36 and 42 percent of respondents respectively followed by health facilities which are seen by 17 percent and 22 percent of respondents. Both the messages have been least seen in pamphlets and listened over the radio. The same trend has been seen in a recall of other messages of where most of the respondents have seen these messages on TV followed by posters and in health facilities. These messages have been least seen over the radio, social media, booklets, etc.

Intention to Behaviour Change

Disseminate Information/Motivate/Inform Others

Across the regions in the study, out of 1593 respondents, 66 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 34 percent of respondents do not facilitate to disseminate the benefits of advertisements to others. Figure 4.24 depicts the percentage of respondents or their families who disseminate the benefits of

advertisements to others across districts. Similar to the NVBDCP, in the NPCDCS, it was found that respondents in the Northern region do not like to share information with others as compared to respondents in other regions. For example, in one of the districts of the Northern region i.e. Chitrakut district, out of 293 respondents, 51 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 49 percent of respondents do not facilitate to disseminate benefits of advertisements to others.

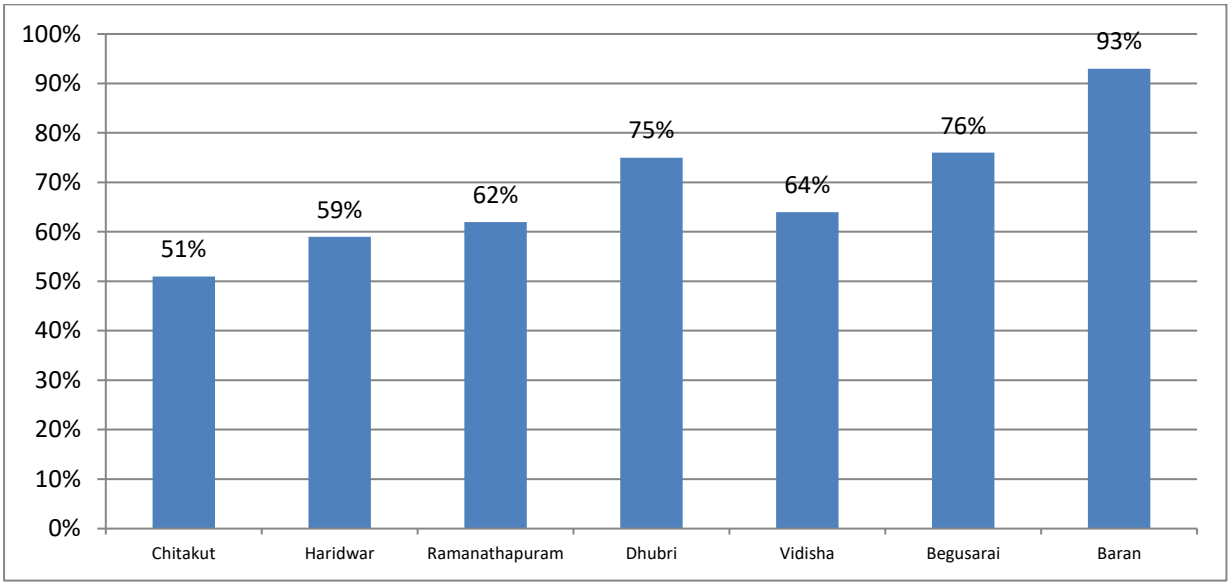


Figure4.24 Percentage of respondents who disseminate the benefits of advertisements or not

Reasons for not Disseminating/Sharing Health Promotion Message

In the Chitrakut district of *Northern Region*, out of 49 percent of respondents who don't share/disseminate health messages with others, more than 52 percent of respondents say that they don't have time. The remaining 24 percent believe that other people already know about this and 25 percent of respondents feel that they are themselves not aware much about these advertisements properly. 20 percent of respondents don't find these advertisements interesting and 10 percent believe that why other people will listen to them as shown in Figure 4.25.

Similarly, in Haridwar, out of 256 respondents, 59 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 41 percent of respondents do not disseminate information gained to others. On asking the reasons for not disseminating the information to others, the majority of respondents i.e. 70 percent reported that they don't have time and 32 percent of people don't find it interesting whereas 34 percent of people believe that other people already know about it. 17 percent of people feel that why other people will listen to them as depicted in Figure 4.25.

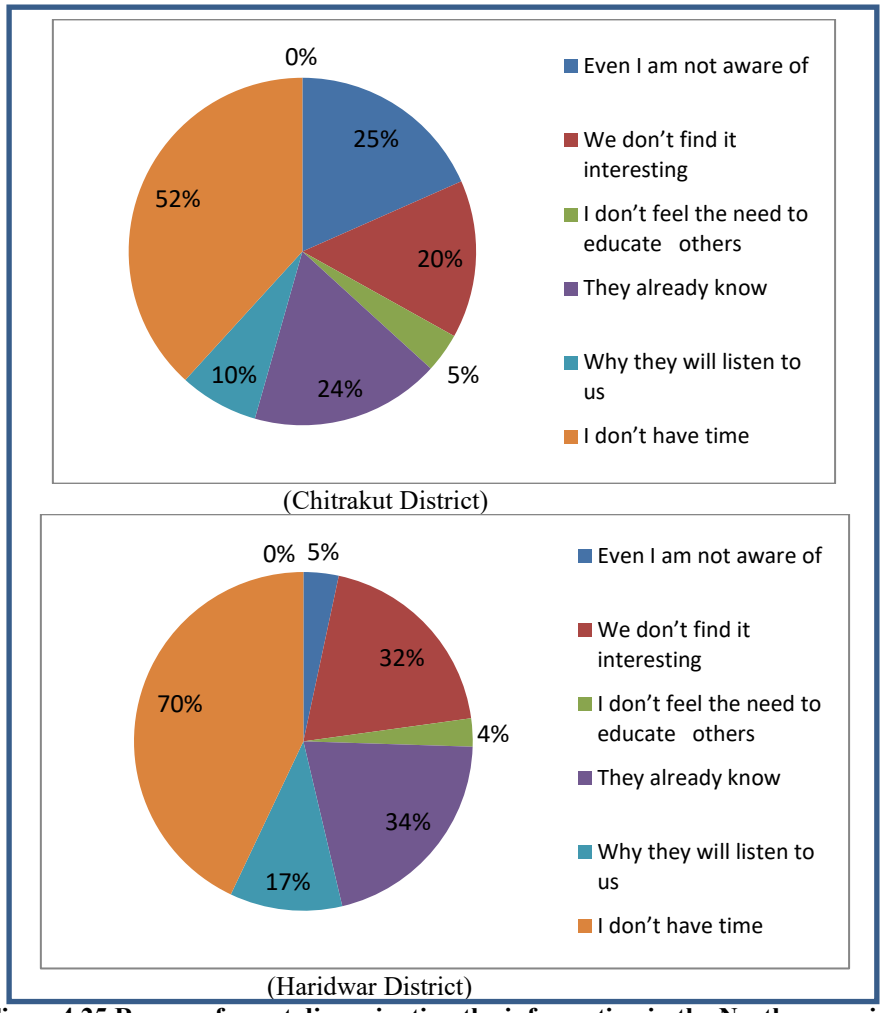


Figure4.25 Reasons for not disseminating the information in the Northern region

In the *Southern region*, out of 256 respondents, 62 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 38 percent of respondents do not facilitate to disseminate the benefits of the advertisements to others. Out of this 38 percent, 88 percent believe that they are not much aware that these advertisements properly and 31 percent of respondents don't find it interesting and 2 percent of respondents reported that they don't have time as depicted in Figure 4.26.

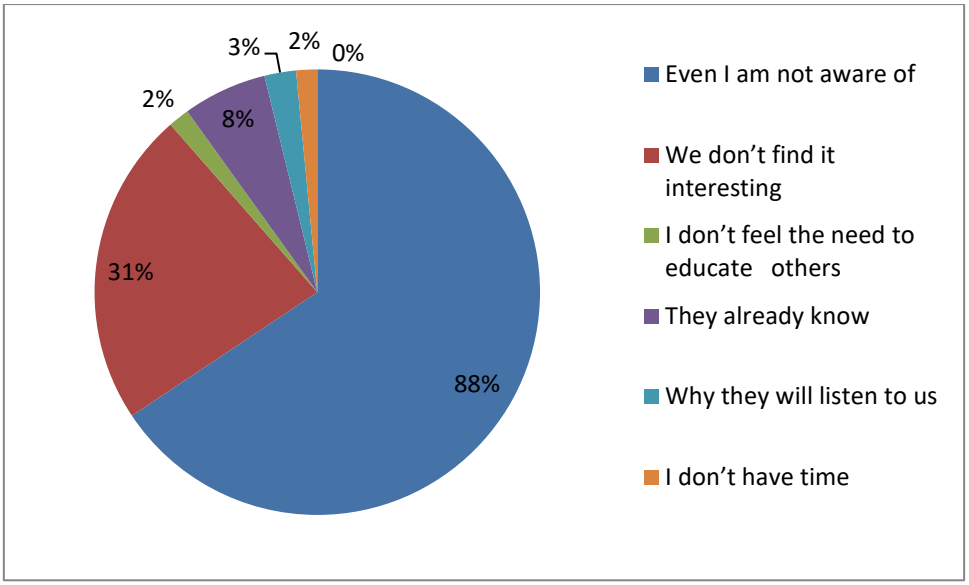


Figure4.26 Reasons for not disseminating the information in the Southern region

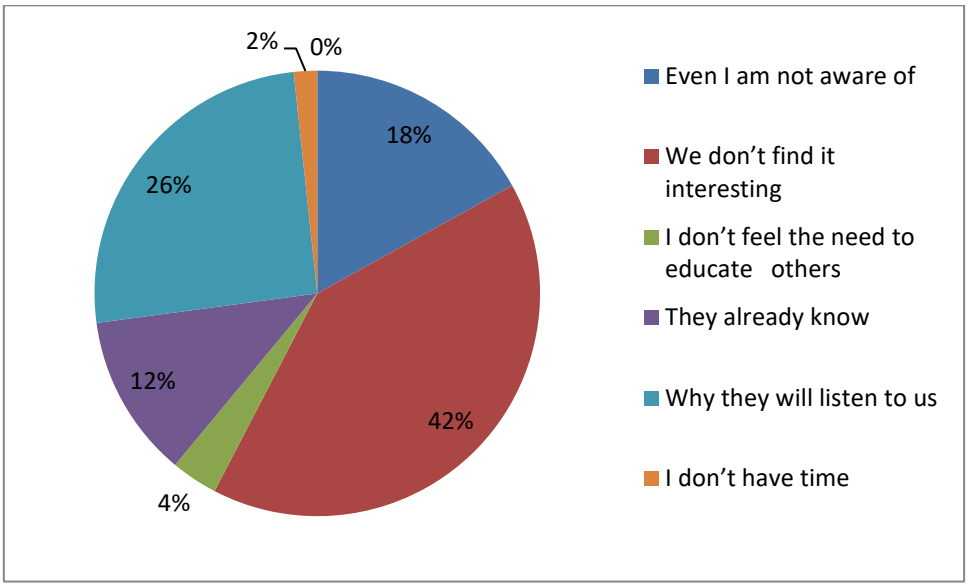


Figure4.27 Reasons for not disseminating the information in the North-Eastern region

In the *North-Eastern region*, out of 224 respondents, 75 percent of respondents disseminate the benefits of advertisements whereas 25 percent of respondents do not disseminate the benefits of the advertisements to others. Out of this 25 percent, 42 percent of respondents don't find it interesting and 26 percent of the respondents feel that why others will listen to their viewpoint and 12 percent of respondents believe that other people already know about the benefits of these advertisements as shown in Figure 4.27.

In the *Eastern region,* out of 242 respondents, 76 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 24 percent of respondents do not facilitate to disseminate the benefits of advertisements to others. Out of this, 24 percent of respondents, 56 percent of respondents believe that they are not much aware of these advertisements properly and 24 percent of respondents don't feel the need to educate others

whereas 14 percent of respondents don't find these advertisements interesting (See Figure 4.28).

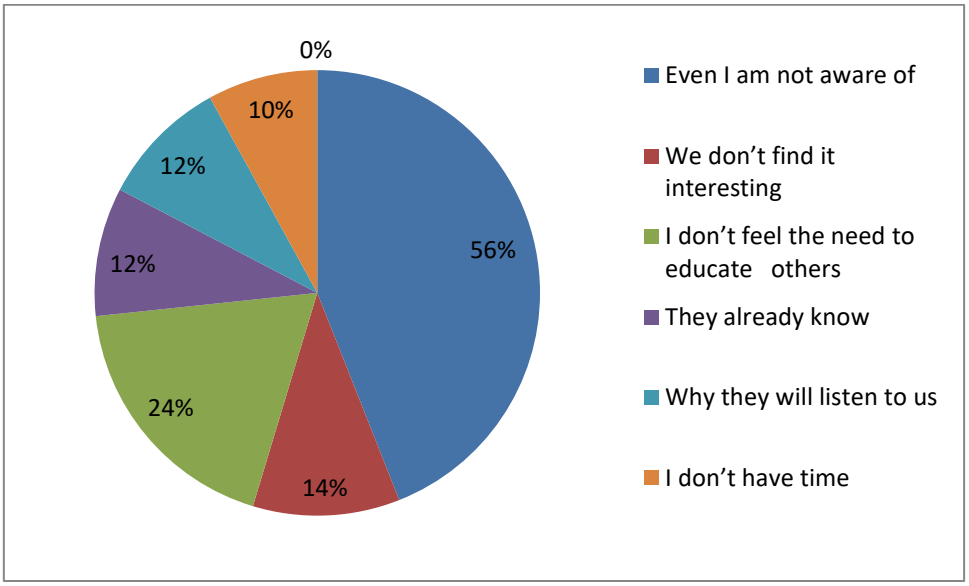


Figure4.28 Reasons for not disseminating the benefits of information of Eastern region

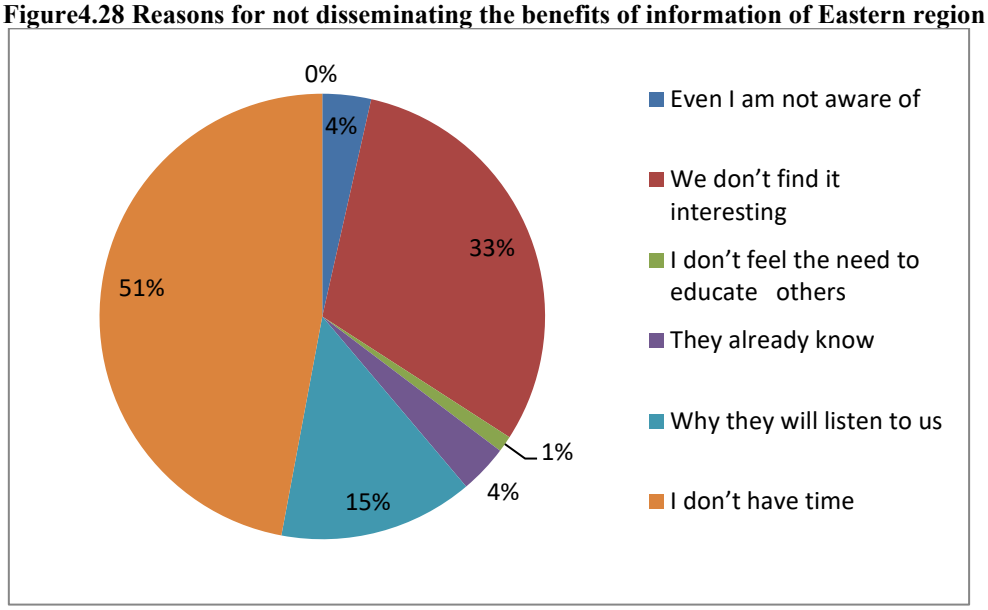


Figure 4.29 Reasons for not disseminating the benefits of information of Central region

In the *Central region*, out of 219 respondents, 64 percent of respondents or their families disseminate gained information in the advertisements to others. Out of this 36 percent, who don't share information with others, more than half of these people i.e. 51 percent respondents say that don't have time and 33 percent of people don't find it interesting. The remaining 15 percent of respondents feel that why other people will listen to them as shown in Figure 4.29.

Perception about Impact of Health Promotion Messages on Suggested Actions

Across the regions under study, out of 1595 respondents, 87 percent of people believe that these advertisements have been able to change their minds and action. Figure 4.30 depicts the percentage of respondents who think these advertisements have been able to change their minds and action.

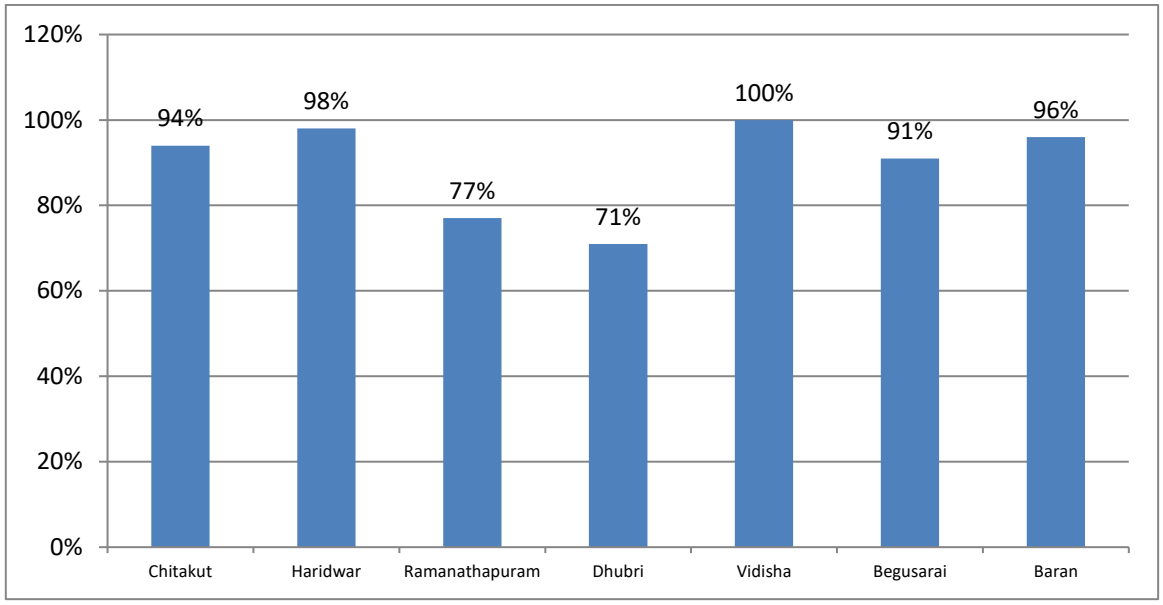


Figure4.30 Percentage of respondents who believes these advertisements change their mind or action

In the Chitrakut district of the Northern part of the nation, only 6 percent of respondents reported that these advertisements have not been able to change their minds and action. Out of this 6 percent who thinks that these advertisements have not been able to change their mind and action, half of them i.e. 53 percent of respondents reported that too much information is overloaded which makes them confused in understanding these advertisements, and 29 percent of respondents claimed of no TV at their home and 18 percent found no regional flavor in these advertisements.

Similarly, in another district of the Northern region i.e. Haridwar, 2 percent of respondents think that these advertisements have not been able to change their minds and action. Out of this 2 percent, all respondents believe that so much of information is overloaded in these advertisements because of which they got confused in understanding these advertisements fully.

In the Northeastern region, 71 percent of respondents believe that these advertisements have been able to change mind and action but 29 percent don't believe the same. Out of this 29 percent, 72 percent of respondents believe that so much information is overloaded in these

advertisements and 38 percent of them did not find any regional flavor in these advertisements. That's why these advertisements have not been able to change their mind and action.

In the Eastern region, 91 percent of respondents believe that these advertisements have been able to change mind and action but 9 percent don't believe the same. Out of this 9 percent, 48 percent of respondents believe that so much information is overloaded in these advertisements and no regional flavor in advertisements respectively. Whereas, 33 percent of respondents, who think that these advertisements have not been able to change their minds and action, reported that they don't have a TV at home.

Willingness to Change to Desired Behaviour expected in NPCDCS Messages

To understand the impact of these advertisements on the behavior of the people, respondents have been asked if they have seen anyone consuming less fried food, sugar, or quitting smoking and tobacco after understanding these advertisements. It has been observed that people are a bit concerned about their diet but a long way to go. Respondents from Western, Eastern, and Central regions are in a better position than Northern, Southern, and North-Eastern regions in terms of having less fried food in their diet as depicted below in Figure 4.31.

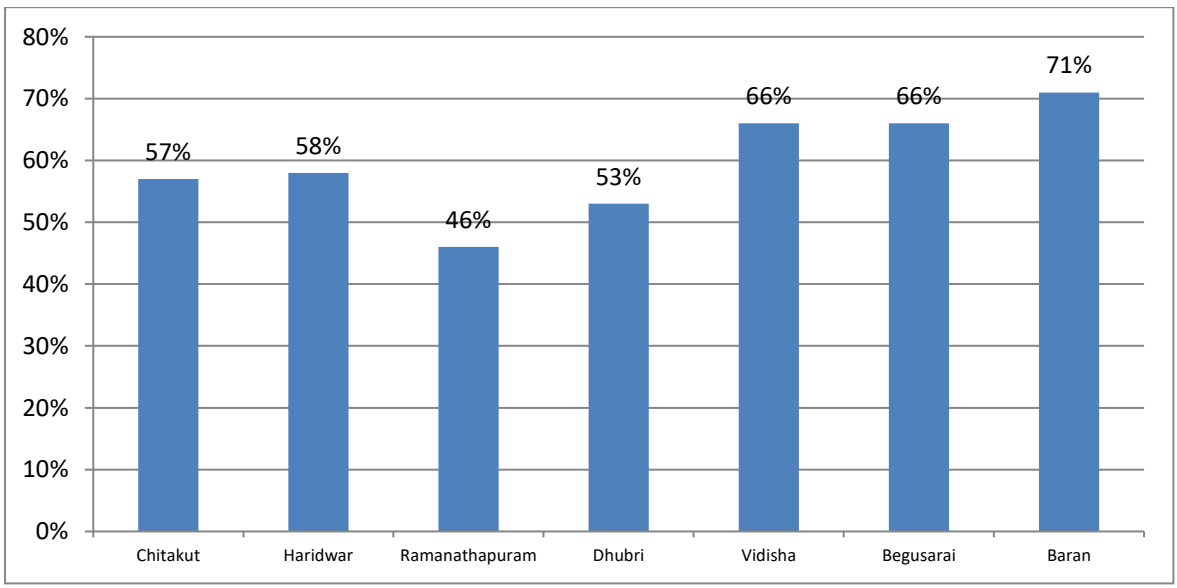


Figure4.31 Percentage of people who have seen others consuming less fried food and less sugar

As observed an earlier good number of people have seen cancer-related advertisements, despite knowing the harmful effects of these diseases, people are not ready to quit smoking or tobacco as 89 percent of respondents from North Eastern region have not seen anyone quitting these harmful products even after understanding these advertisements. Sixty-six

percent of respondents from Ramanathapuram district have also not seen people quitting tobacco after watching these advertisements as depicted below in Figure 4.32.

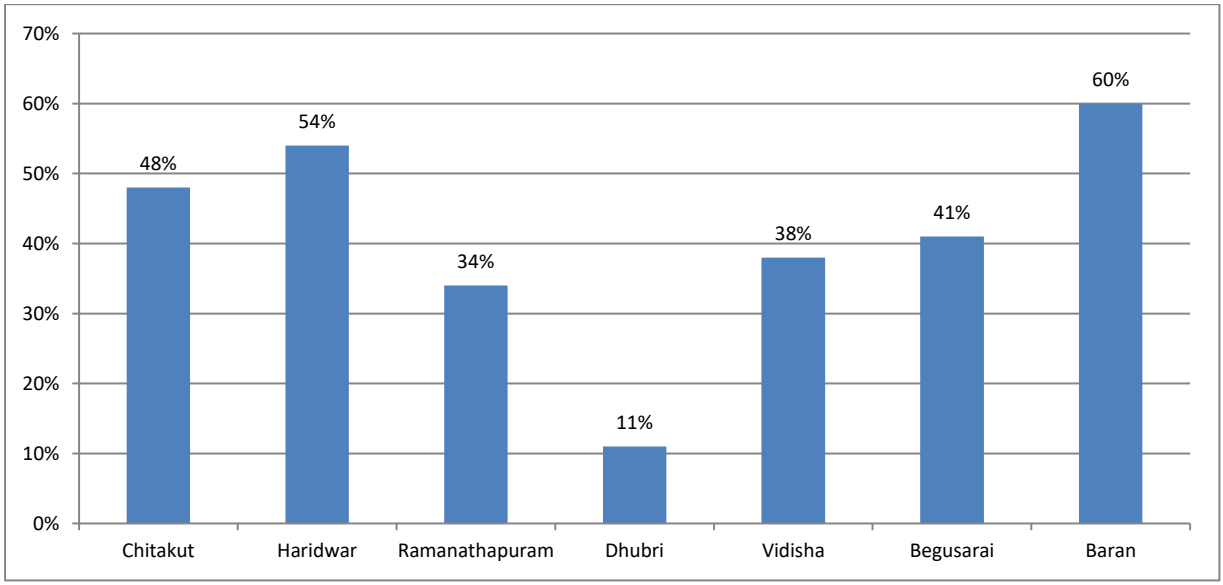


Figure4.32 Percentage of people seen others quitting smoking or tobacco

In the Northern region, 95-98 percent of respondents from both rural and urban locations have shown intend to change their behavior after watching advertisements related to the NCPCDS program. In the Southern region, 15 percent of respondents residing in rural location does not show any intention to bring any change in their behavior even after watching advertisements related to this program.

Preferred Medium to Receive Information in Future

In Northern, Southern, and Central region respondents suggested television as the best medium among all other media whereas most of the respondents from Eastern, Western, and North Eastern regions suggested that awareness workshops and seminars are the best way to educate people of their communities as shown in Figure 4.33. Apart from this, social media has also been suggested by respondents of the Eastern region as the best way to generate awareness.

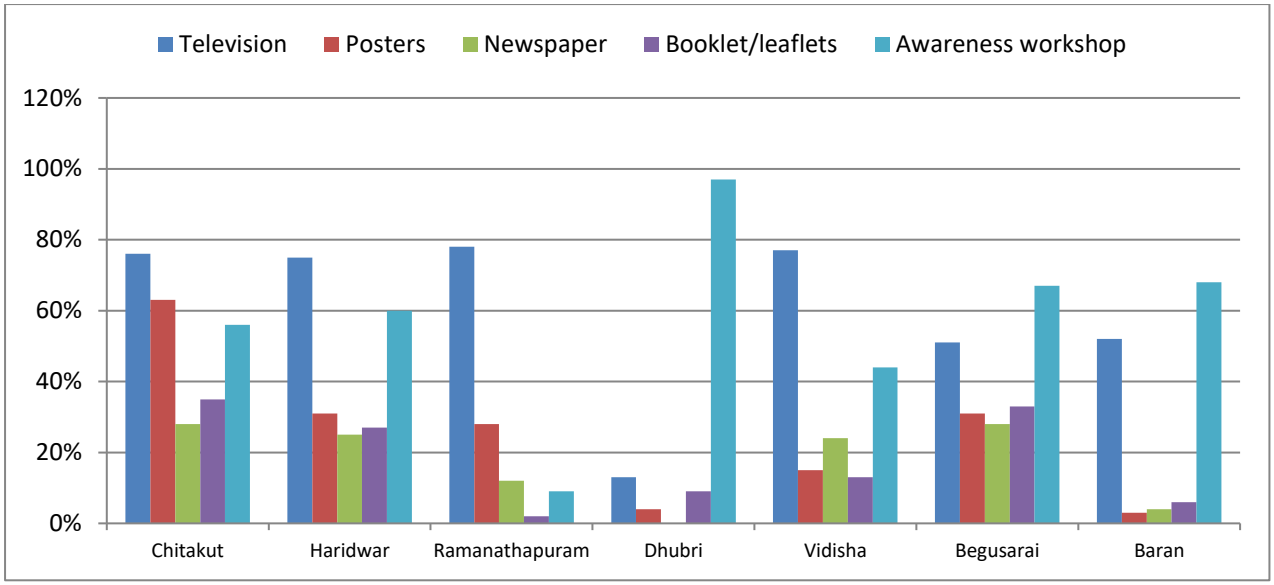


Figure4.33: Preferred medium to receive information in Future

MISSION INDRADHANUSH

Exposure to Health Promotion Messages

Overall, 71 percent of people from a rural location across regions have seen advertisements/posters/messages related to the Mission Indradhanush (IMI) program and 74 percent of people, from an urban area, have seen advertisements/messages related to this program as depicted in Figure 4.34. This response has been received from a sample of 2214 respondents across all the regions under study.

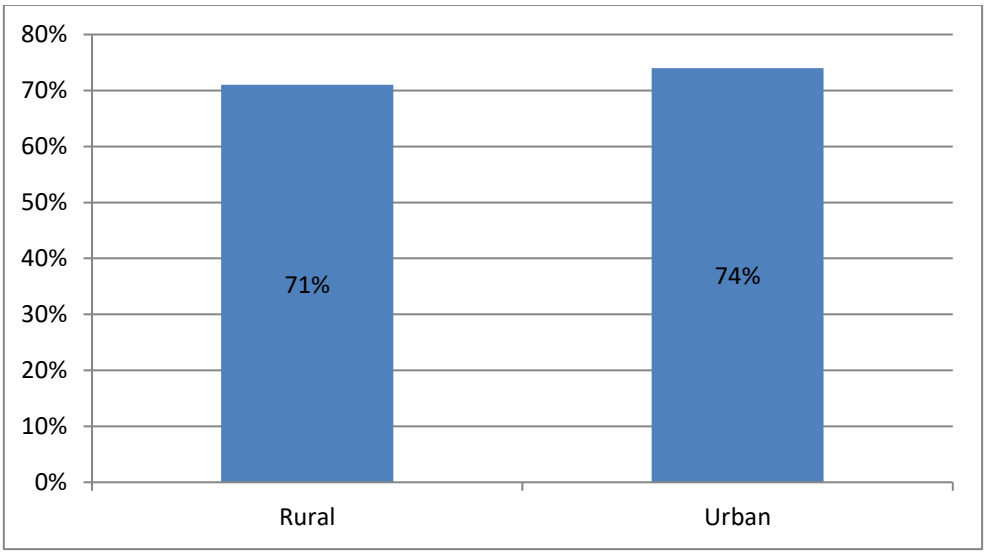
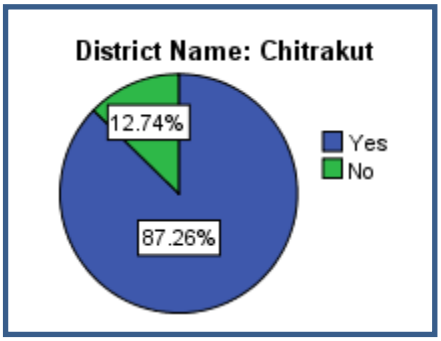
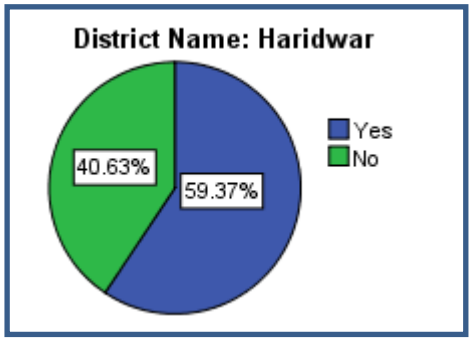
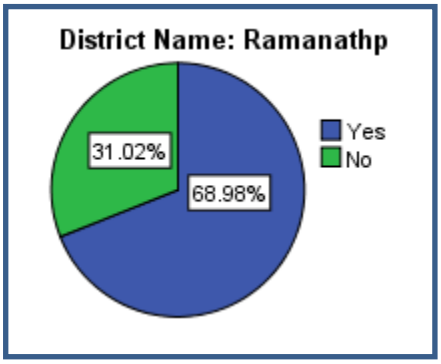
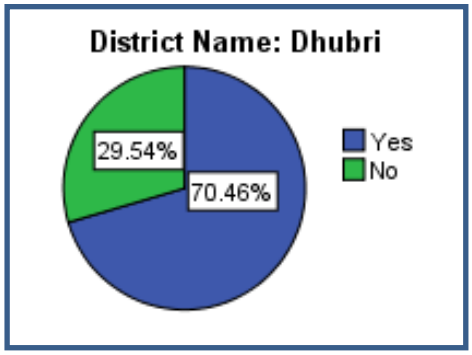


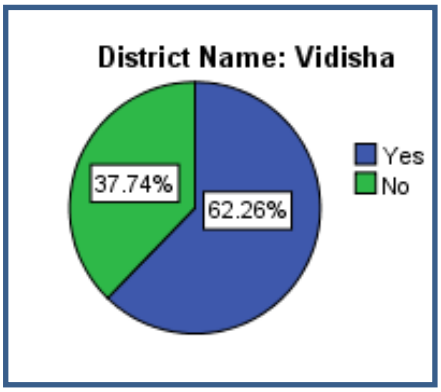
Figure4.34 Mission Indradhanush – Advertisement Exposure level among rural & urban population

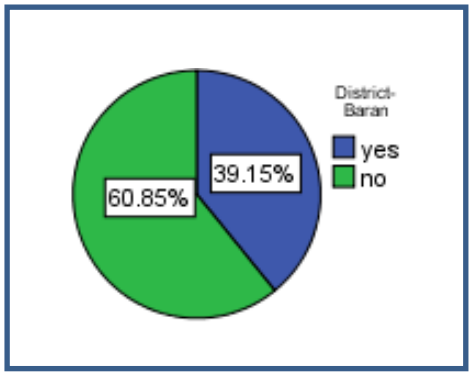












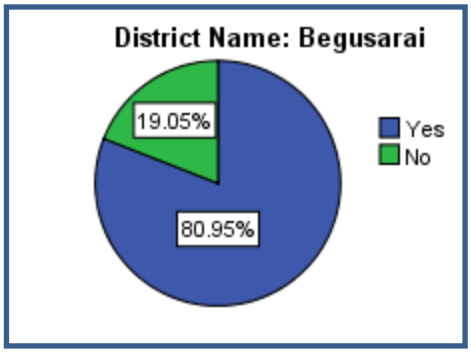


Figure 4.35 IMI- Advertisement Exposure Level across districts

Figure 4.35 depicts the percentage of respondents who have seen the advertisements across the sample districts taken in the study. There is a significant difference across the regions and within the region on the account of the level of exposure for Mission Indradhanush. Chitrakoot District, in the northern region, has the highest level of exposure for IMI i.e. around 87%, followed by District Begusarai in the Eastern Region. District Baran in the Western Region and Haridwar district in the northern region are the laggards in exposure level for IMI i.e. around 60%.

Source of the Exposure

Overall, advertisements/messages related to the IMI program have been seen on TV, in hospital posters, and through health workers by 80 percent of the respondents, out of 2214 respondents, across regions, as depicted in Figure 4.36

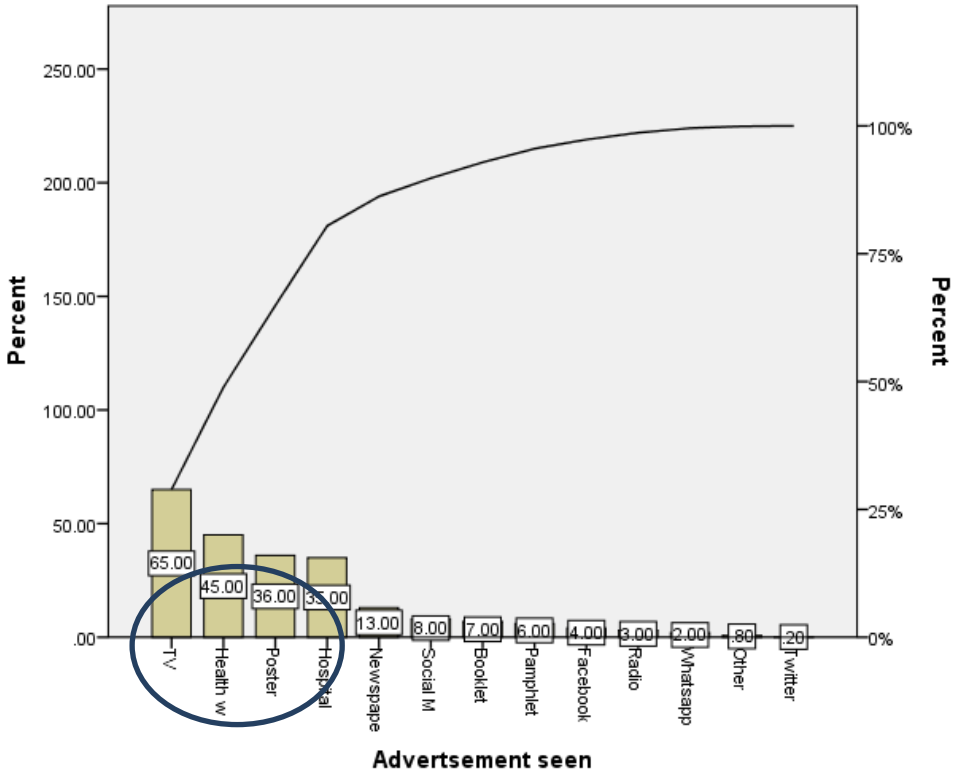


Figure4.36 Overall IMI Source of Exposure

In one part of North India i.e. in Chitrakut district, 80 percent of respondents have seen advertisements/messages related to IMI in posters, on TV, in health facilities, and through health workers. In another region of the Northern region i.e. in Haridwar, 80 percent of respondents have seen this advertisement on TV, by a health worker, and in posters.

In the Southern region, 80 percent of respondents have seen these advertisements on TV, in health facilities, newspapers, and listened over the radio. In the Central and North East region, these advertisements have been seen on TV followed by the health workers and in

posters by 80 percent of respondents. In the Eastern region, 80 percent of respondents have seen these advertisements through health workers, TV, posters. In the Western region, 80 percent of people have seen this advertisement on TV and in the health facilities as shown below in Figure 4.37.

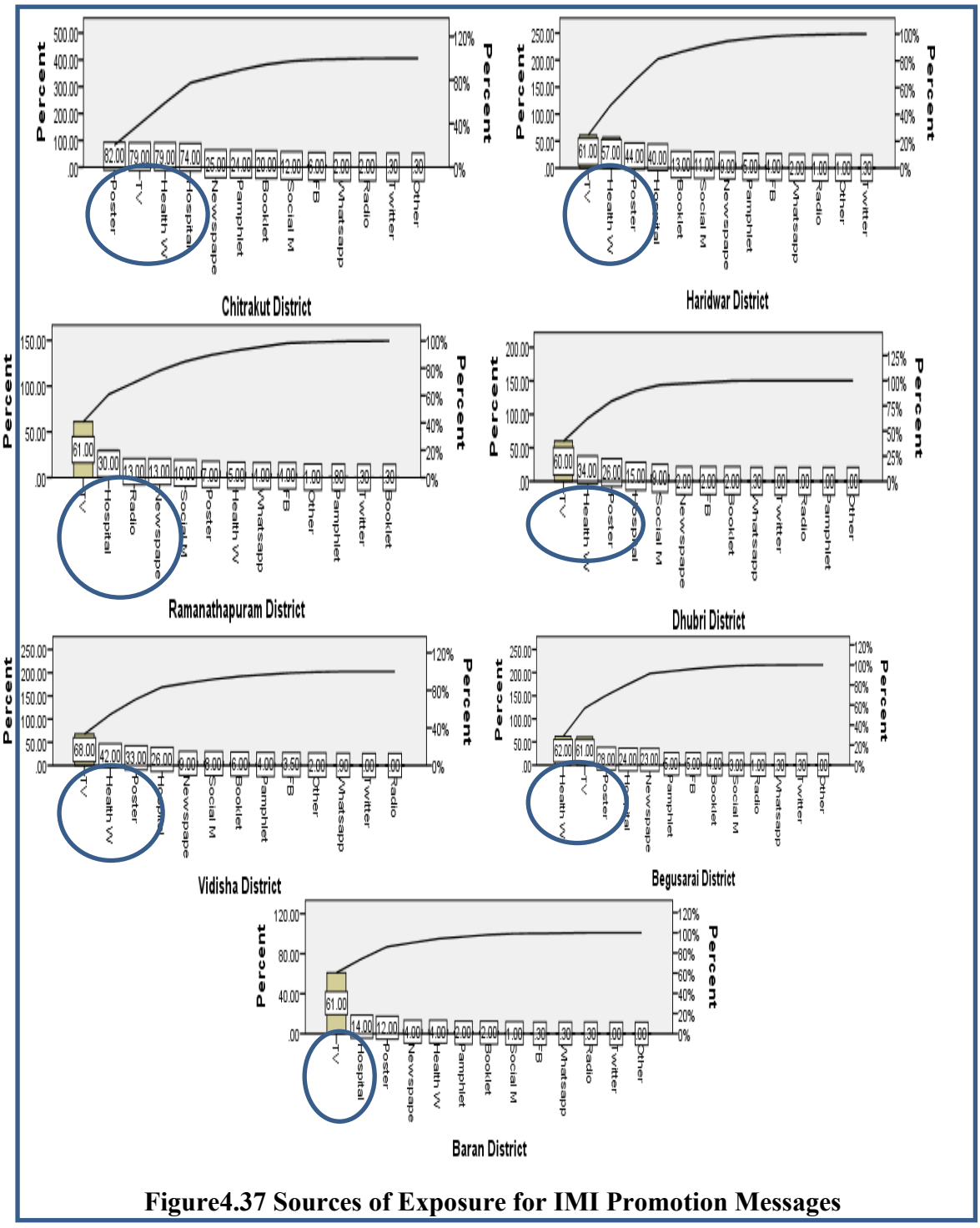


Figure4.37 Sources of Exposure for IMI Promotion Messages

Frequency of Exposure

Overall, the majority of respondents (65 percent), out of 1434 respondents, across states have 55 percent of respondents have seen advertisements in less than two times a week followed by people who have seen the advertisements more than two times a week i.e. 29 percent and only 16 percent of respondents have watched these advertisements daily across regions as depicted in Figure 4.38.

Figure 4.39 depicts the number of times people have watched advertisements in all districts. In all the regions taken into the study except the Western region majority of respondents have seen this advertisement less than two times a week. In the Western region, most people watch these advertisements more than two times a week.

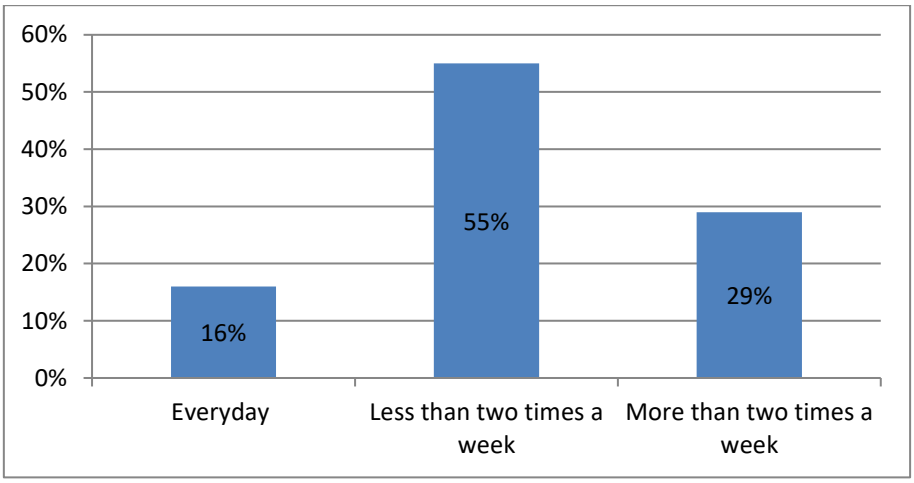


Figure 4.38 Overall number of times IMI related advertisements seen across regions

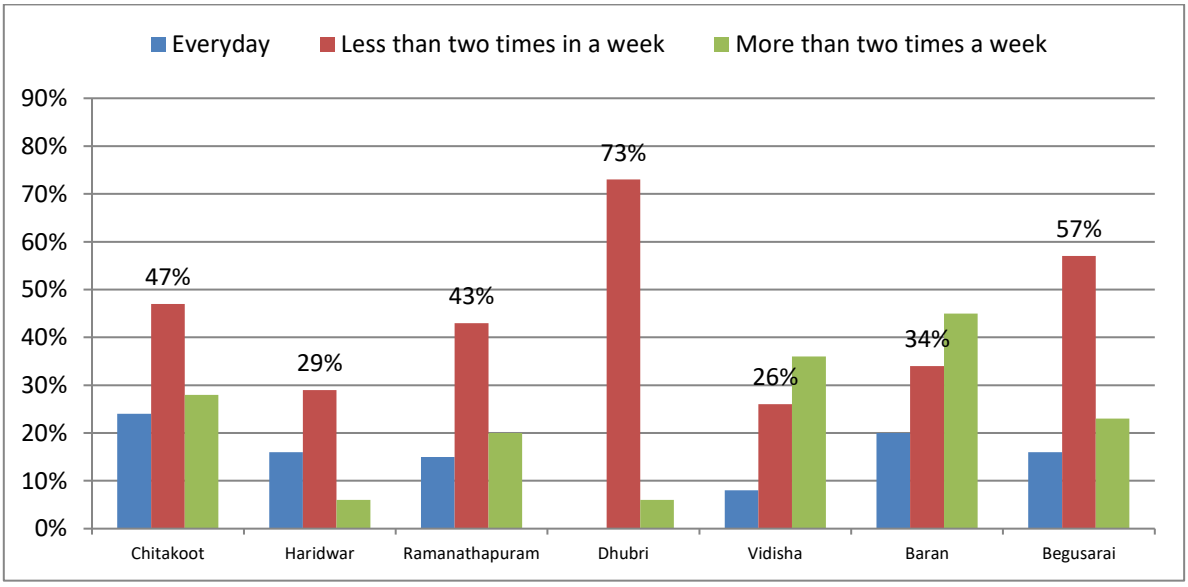


Figure 4.39 Number of times advertisement seen in all districts

Recall of message

Across all the regions in the study, 66 percent of respondents could recall in the IMI advertisements that vaccination age birth to 5 years, 54 percent of respondents could recall that seven times visit for vaccinations in 5 Years is a must whereas only 17 percent of respondents could recall that all vaccines are free of cost at Government health facility as shown in Table 4.8.

Table4.8 Overall Recall Message of Immunization Mission Indradhanush

Message	Overall
No. of times you need to take your child for vaccination	41%
Vaccinations age birth to 5 years	66%
Seven times visit for vaccinations in 5 Years	54%
Mark each Vaccination on Calendar	18%
Don't Skip or forget any vaccination	15%
Responsibility of all of us	18%
Most important Task for the health of the child	16%
Vaccination protects/immunized child from dangerous diseases	15%
All information is written on the immunization card	16%
Go for immunization even child is sick	6%
Take care with you in case you are traveling	4%
After a Vaccination child may get fever or swelling don't get frightened.	2%
All vaccines are free of cost at a govt health facility	17%
Name of the Celebrity depicted in the advertisement	15%
No. of Respondents (N)	**1596**

Table 4.9 represents region-wise recall of the messages communicated in the IMI advertisements. Messages like vaccinations age birth to 5 years and seven times visit for vaccinations in 5 Years have been recalled by a good number of respondents of all regions except the Southern region. Only 1%, 2%, and 5% of respondents from the Southern, Northeastern, and Eastern regions respectively could recall vaccination protect/immunized children from dangerous diseases. None of the respondents from the Northeastern region can recall all the information written on the card, the child needs vaccination even if they are sick, all vaccines are available at the health facilities free of cost-related messages. The majority of respondents from the Northern region could recall the name of the celebrity depicted in the advertisements followed by 10 percent of respondents of the Southern region. None of the respondents from the North-eastern and eastern region has been able to recall the name of the celebrity depicted in the advertisements.

Table 4.9 Region wise Recall of messages of IMI Advertisements

	Northern		Southern	North Eastern	Central	Eastern
	UP	**Uttrakhand**	**Tamil Nadu**	**Assam**	**MP**	**Bihar**
No. of times you need to take your child for vaccination	50%	19%	67%	39%	21%	43%
Vaccinations age birth to 5 years	90%	98%	25%	40%	90%	63%
Seven times visit for vaccinations in 5 Years	80%	77%	7%	38%	77%	51%
Mark each Vaccination on Calendar	31%	7%	10%	17%	17%	23%
Don't Skip or forget any vaccination	16%	24%	6%	3%	29%	19%
Responsibility of all of us	36%	39%	3%	0%	22%	13%
Most important Task for the health of the child	23%	36%	5%	1%	29%	5%
Vaccination protect/immunized child from dangerous diseases	23%	34%	1%	2%	29%	5%
All information is written on the immunization card	61%	18%	0%	2%	6%	4%
Go for immunization even child is sick	11%	19%	1%	0%	5%	2%
Take card with you in case you are travelling	4%	17%	1%	0%	3%	2%
After a Vaccination child may get fever or swelling don't get frightened.	3%	4%	1%	0%	0%	1%
All vaccines are free of cost at govt health facility	49%	27%	2%	1%	21%	4%
Name of the Celebrity depicted in the advertisement	49%	17%	10%	0%	8%	0%

Table 4.10 depicts the cross-tabulation between the recall messages and the sources of receiving the message. No. of times you need to take your child for vaccination messages have been on TV by 29 percent of respondents followed by message seen in hospital and over social by 15 percent of respondents and 12 percent of respondents have come to know about these from a health worker. This message is least seen in pamphlets, booklets, and listened over the radio.

Similarly, vaccination age from birth to 5-year message has been on TV by 45 percent of respondents followed by message intimated by health workers i.e. 35 percent, and 28 percent of respondents have come to know about these from posters. This message has least listened to the radio and social media.

Recall messages like Seven times visit for vaccinations in 5 Years and mark each vaccination on Calendar has been seen on TV by 36 and 12 percent of respondents respectively followed by intimated from health worker which is to 31 percent and 9 percent. Both the messages have been least seen in pamphlets and listened over the radio. The same trend has been seen in the recall of other messages of where most of the respondents have seen these messages on TV followed by posters and in hospitals. These messages have been least listened over the radio and read through pamphlets.

Table 4.10 Cross-tabulation between the recall messages and the sources of receiving the message

Message/Media	TV	Radio	Newspaper	Pamphlet	Booklet	Poster	Health worker	Hospital	Social Media	Face book	Whats app	Twitter	Other
No. of times you need to take your child for vaccination	29%	3%	7%	4%	4%	4%	12%	15%	15%	3%	1%	1.00%	0.20%
Vaccinations age birth to 5 years	45%	2%	10%	6%	7%	28%	35%	25%	6%	3%	1%	0.20%	0.60%
Seven times visit for vaccinations in 5 Years	36%	1%	9%	5%	6%	24%	31%	23%	6%	2%	1%	0.20%	0.40%
Mark each Vaccination on Calendar	12%	0%	4%	2%	3%	9%	9%	8%	2%	1%	0%	0.10%	0%
Don't Skip or forget any vaccination	10%	0%	3%	2%	1%	7%	9%	7%	1%	1%	0.30%	0.00%	0.40%
Responsibility of all of us	13%	0%	4%	3%	3%	9%	12%	9%	1%	1%	0.10%	0.00%	0%
Most important Task for the health of the child	12%	0%	2%	2%	1%	8%	8%	6%	2%	1%	0.40%	0%	0.40%
Vaccination protect/immunized child from dangerous diseases	11%	0%	2%	1%	1%	8%	8%	6%	2%	1%	0%	0%	0.40%
All information is written on the immunization card	11%	0%	3%	3%	3%	11%	11%	10%	2%	1%	0.30%	0%	0%
Go for immunization even the child is sick.	4%	0%	1%	1%	1%	4%	4%	3%	1%	0.30%	0.20%	0%	0%
Take card with you in case you are travelling	3%	0%	1%	1%	1%	2%	2%	2%	1%	0.30%	0.30%	0.10%	0%
After Vaccination child may get fever or swelling don't get frightened	1%	0%	1%	0%	1%	1%	1%	1%	0.30%	0%	0%	0%	0%
All vaccines are free of cost at Govt. health facility	12%	0%	4%	3%	2%	10%	11%	9%	2%	1%	0.40%	0%	0.40%
Name of the Celebrity depicted in the advertisement	11%	0%	3%	3%	3%	9%	8%	1%	1%	1%	0.30%	0%	0.30%

Intention to Behaviour Change – Mission Indradhanush

Disseminate Information/Motivate/Inform Others

Across the regions under study, out of 1698 respondents, 73 percent of respondents disseminate the benefits of the advertisements to others whereas 27 percent of respondents do not facilitate to disseminate the benefits of advertisements to others. Figure 4.40 depicts the percentage of respondents who disseminate the benefits of advertisements to others across districts in the study. Contrary to NVBDCP and NPCDCS programs, more respondents in Chitrakut district share and disseminate information gained about immunization programs share with others. Similarly in District Ramanathapuram of the Southern region %age of respondents sharing information with others is less. But, it is important to note that the full immunization rate in Ramanathapuram is just 59%.

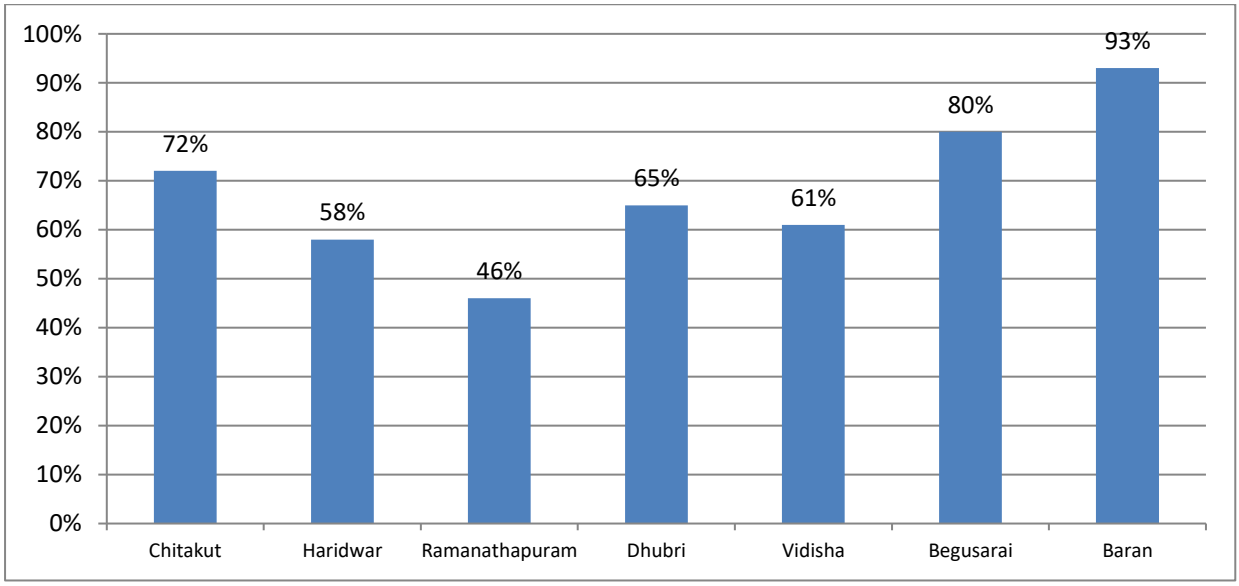


Figure4.40 Percentage of Respondents disseminate the benefits of advertisements

Reasons for not Disseminating/Sharing Health Promotion Message

In Chitrakut district of *Northern Region*, out of 309 respondents, 72 percent of respondents disseminate the benefits of advertisements to others whereas 28 percent of respondents do not facilitate to disseminate benefits of advertisements to others. On asking the reasons for not disseminating the benefits of advertisements to others, more than half of the people i.e. 67 percent people believe that other people already know about these advertisements, and 36 percent of people reported that they don't have time. Nine percent of respondents feel that

they are themselves not aware much about these advertisements and 16 percent of respondents don't find these advertisements interesting as depicted in Figure 4.41.

Similarly, another region of North India i.e. in Haridwar, out of 222 respondents, 58 percent of respondents disseminate the benefits of advertisements to others whereas 42 percent of people do not facilitate to disseminate the benefits of advertisements to others. The majority of people i.e. 61 percent respondents believe that other people already know about these advertisements and 54 percent of respondents say that don't have time and 11 percent of respondents don't find it interesting whereas 19 percent of respondents feel that why other people will listen to them.

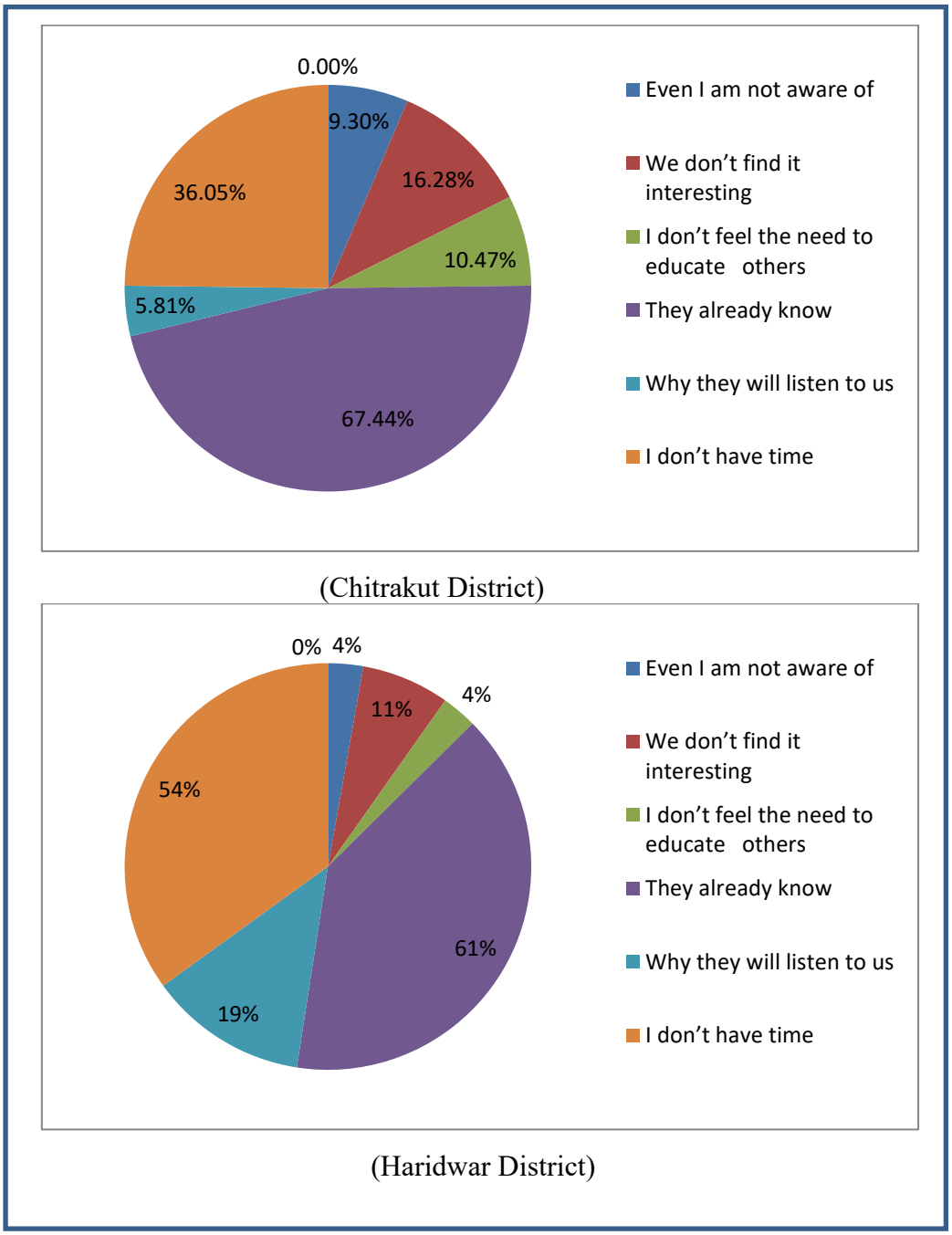


Figure 4.41 Reasons for not disseminating the information in the Northern region

In the *Southern region*, out of 290 respondents, 46 percent of respondents disseminate the benefits of advertisements to others whereas 54 percent of respondents do not facilitate to disseminate the benefits of the advertisements to others. Out of this 54 percent half of the respondents i.e. 50 percent feel that they are not much aware of these advertisements. Whereas 24 percent of respondents don't find it interesting and 14 percent of respondents believe that other people already know about these advertisements as shown in Figure 4.42.

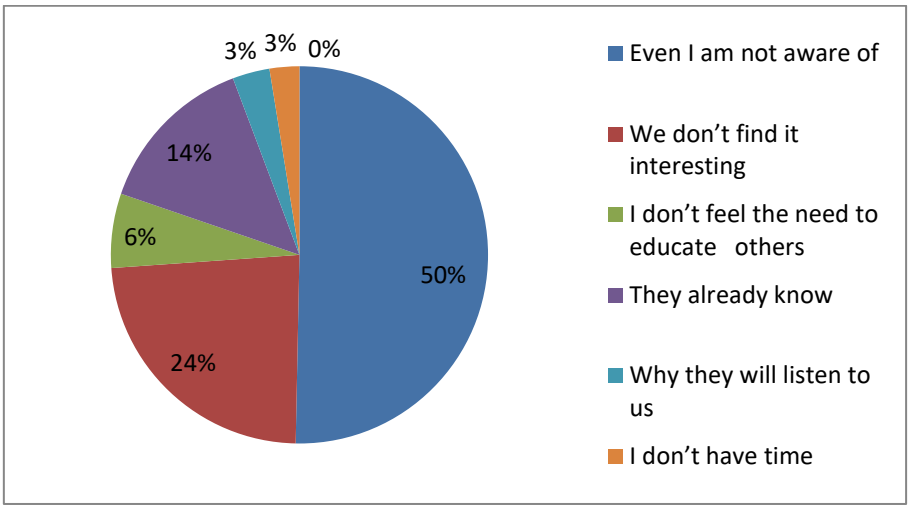


Figure 4.42 Reasons for not disseminating the information in the Sothern region

In the *North-Eastern region*, out of 257 respondents, 65 percent of respondents disseminate the benefits of advertisements to others whereas 35 percent of people do not facilitate to disseminate the benefits of the advertisements to others. Out of this 35 percent, 53 percent of respondents believe that other respondents already know about the benefits of these advertisements. Whereas 28 percent of respondents don't find it interesting and 13 percent of the respondents feel that why others will listen to them as shown in Figure 4.43.

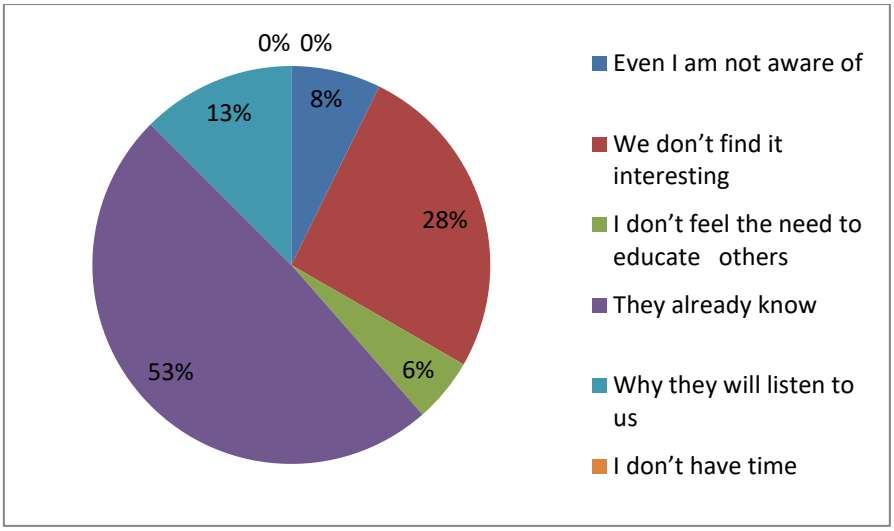


Figure 4.43 Reasons for not disseminating the information in the North-Eastern region

In the *Eastern region*, out of 294 respondents, 80 percent of respondents disseminate the benefits of advertisements to others whereas 20 percent of people do not facilitate to disseminate the benefits of the advertisements to others. Out of this 20 percent, 58 percent of respondents believe that other people already know about the benefits of these advertisements and 23 percent of respondents don't feel the need to educate others. 15 percent of respondents don't find these advertisements interesting as shown in Figure 4.44. Therefore, they don't disseminate the benefits of advertisements to others.

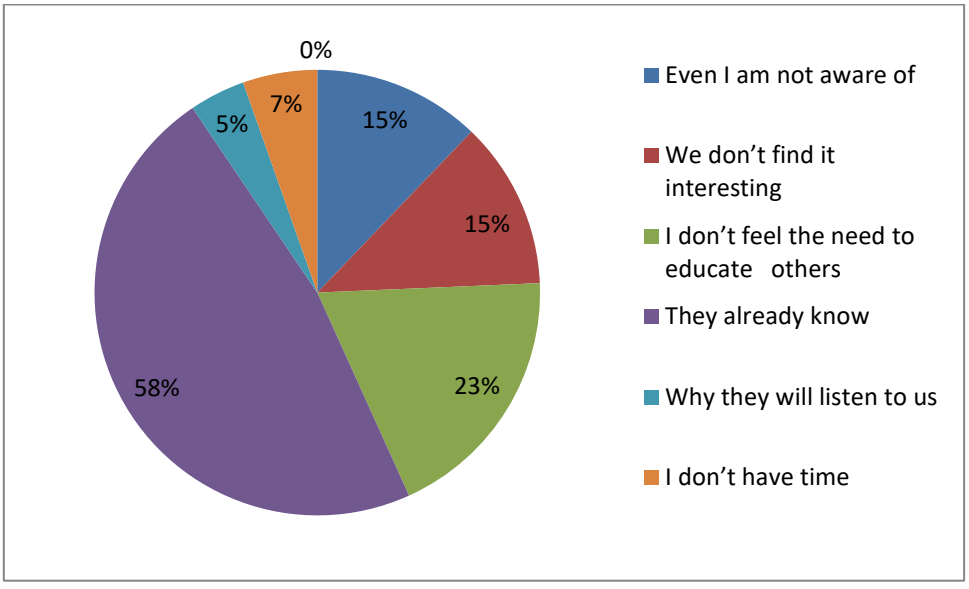


Figure4.44 Reasons for not disseminating the information in the Eastern region

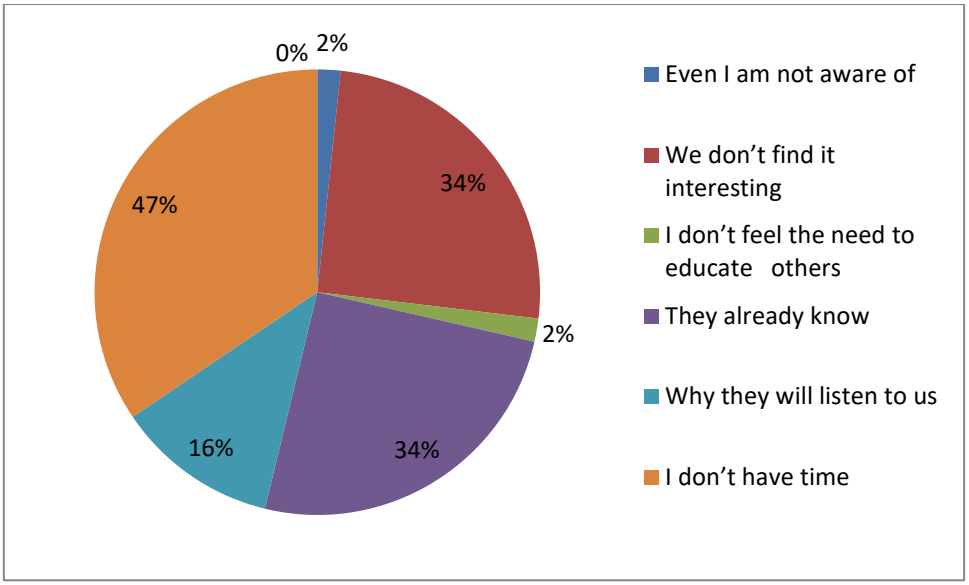


Figure4.45 Reasons for not disseminating the information in the Central region

In the *Central region*, out of 223 respondents, 61 percent of respondents or their families disseminate the benefits of the advertisements to others whereas 39 percent of respondents do not facilitate to disseminate the benefits of advertisements to others. When inquired about the reasons for not sharing the benefits of the advertisements with others. Out of this 39 percent, 47 percent of respondents claimed that they don't have time and 34 percent of respondents don't find it interesting and 16 percent of respondents feels that why other people will listen to them as shown in Figure 4.45.

Perception about Impact of Health Promotion Messages on Suggested Actions

Across all regions in the study, out of 1693 respondents, 92 percent of people believe that these advertisements have been able to change their minds and action and 8 percent of respondents felt that these advertisements have not been able to change their minds and action. Figure 4.46 depicts the percentage of respondents who think these advertisements have been able to change their minds and action or not. In the Chitrakut district of the Northern part of the nation, only 5 percent of respondents reported that these advertisements have not been able to change their minds and action. Out of this 5 percent, 43 percent of respondents reported that there has been no regional flavor in the advertisements and 36 percent of respondents felt that too much information is overloaded which makes them confused in understanding these advertisements. Also, 21 percent of respondents reported that because of no TV at their home these advertisements have not been able to change their minds and action.

In another district of the Northern region i.e. Haridwar, only 1 percent of people think that these advertisements have not been able to change their minds and action. Out of this 1 percent, 67 percent of respondents reported that there is no regional flavor in the advertisements and 33 percent of respondents felt that too much information has been overloaded which makes them confused in understanding these advertisements and 33 percent of respondents don't have a TV.

In the Southern region, 80 percent of people think that these advertisements have been able to change their minds and action whereas 20 percent of respondents feel the same. Out of this 20 percent, 16 percent of people feel that so much of information is overloaded in these advertisements because of which they got confused in understanding these advertisements fully and 12 percent of respondents do not find any regional flavor in these advertisements.

In the North-Eastern region, 74 percent of people think that these advertisements have been able to change their minds and action whereas 26 percent of respondents feel the same. Out of this 26 percent, 67 percent of respondents believe that so much information is overloaded in these advertisements. 20 percent of respondents claimed of no regional flavor in these advertisements and the other 12 percent of respondents feel the absence of TV at their home as one of the reasons for not changing their mind and action after watching these advertisements.

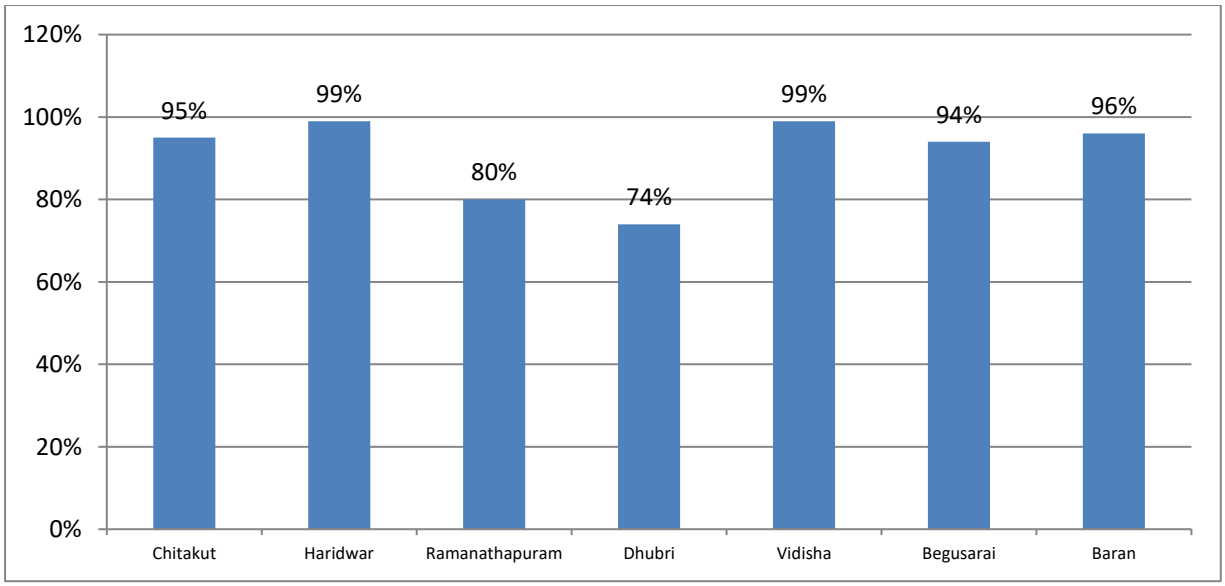


Figure 4.46 Percentage of respondents who believes these advertisements impact their mind and action

Across regions, 93 percent of people have seen immunization cards and 7 percent have not seen immunization cards. This response has been received from a group of 1663 respondents. Figure 4.47 shows the percentage of people who have seen immunization cards across districts. It has been observed that a good number of people have seen the immunization card.

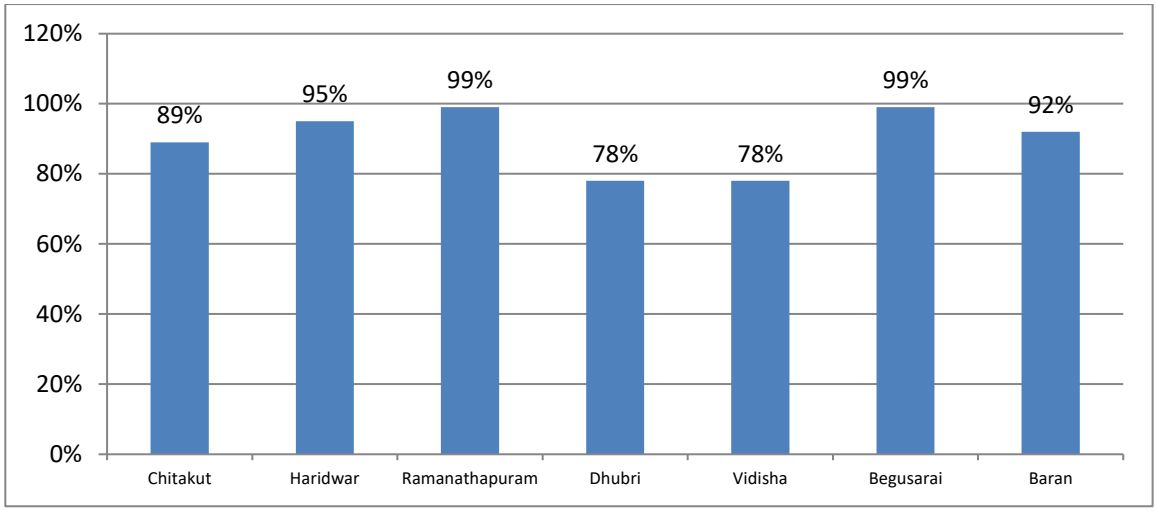


Figure 4.47 Percentage of respondents who have seen immunization card

Willingness to Change to Desired Behaviour expected in NPCDCS Messages

In the Northern and Central region, 99-100 percent of respondents from both rural and urban locations have shown intend to change their behavior after watching advertisements related to the IMI programme. In the North-Eastern region, 8 percent of people residing in rural location does not show any intention to bring any change in their behavior.

Preferred Medium to Receive Information in Future

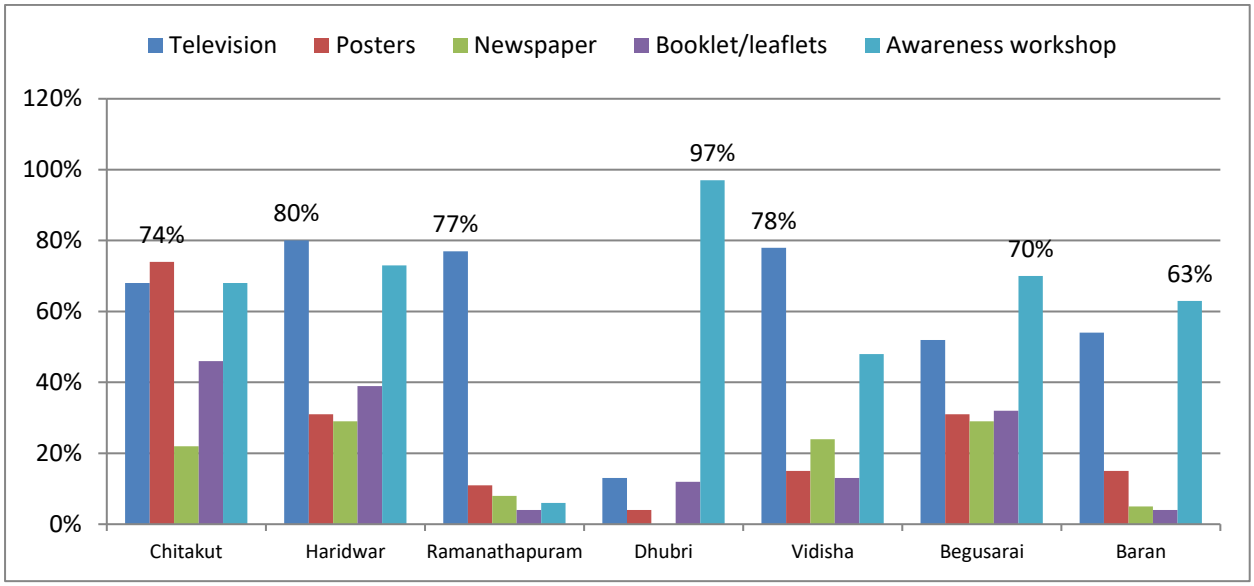


Figure4.48 Preferred Medium to Receive Information in Future

In Northern, Southern, and Central regions, respondents suggested television as the best medium among all other mediums whereas the majority of respondents of Eastern, Western, and North Eastern region suggested that awareness workshop and seminars are the best way to educate people of their communities as shown in Figure 4.48.

Chapter 5 Grass-root Level Functionaries: Access, Exposure, Recall and Health Seeking Behaviour

INTRODUCTION

The chapter aims to gain insight into access to media and knowledge on health-related IEC material among the grass-root level health workers like ASHA, ANM, AWW, and school teachers. These functionaries are responsible for communicating and providing awareness to the community and educating children. Besides, this chapter also gives insight into the exposure, recall of the advertisements by the health workers, and also the change in behavior or action in the community that has been observed as an impact of their training and information being provided through different IEC materials.

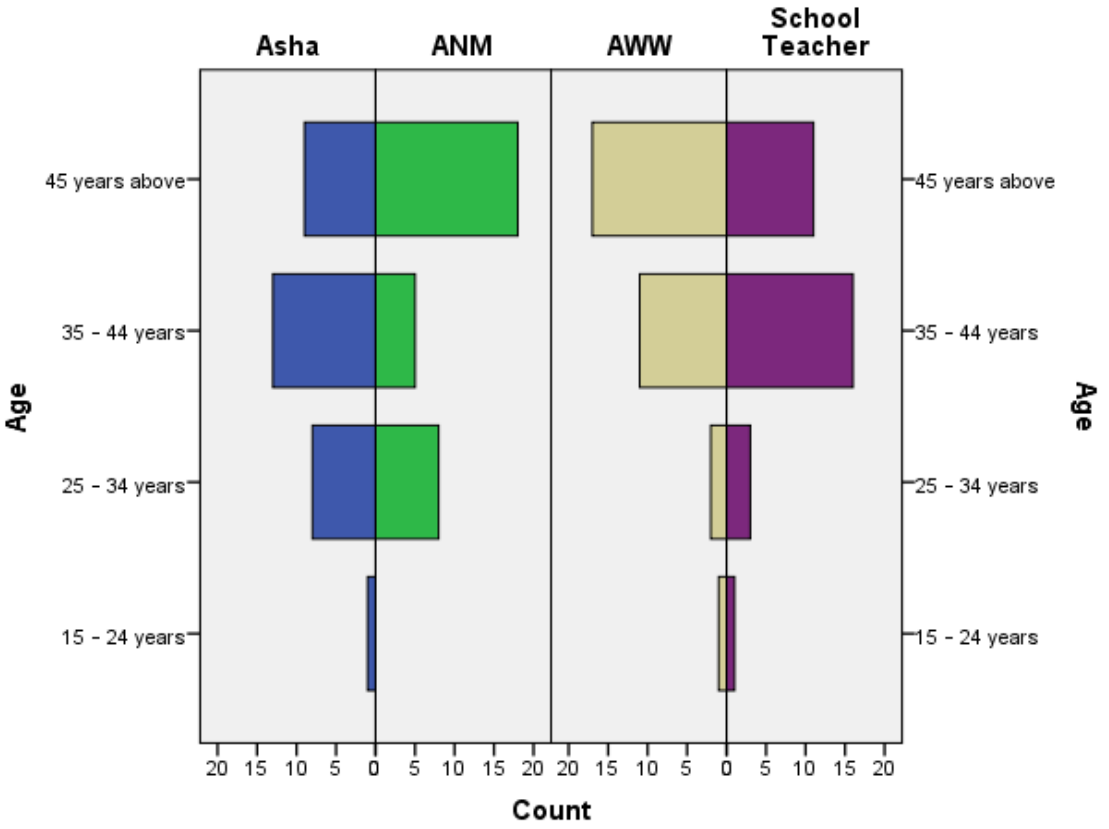


Figure5.1 Distribution of various health workers/School teachers across the age of respondents

During the study, out of total 152 grass root functionaries interviewed, 34 percent ASHAs, 23 percent ANMs and AWWs, and 20 percent school teachers of different age groups. The majority of ASHA workers i.e. 43 percent and school teachers (52 percent) belong to 35-44 years age group, whereas, majority of ANM i.e. 54 percent and AWW (49 percent) belong to 45 years and above age group as shown in Figure 5.1.

ACCESS TO MEDIA AMONG GRASS ROOT LEVEL FUNCTIONARIES

Overall, the majority of health workers and school teachers have access to TV i.e. 96 percent, followed by the newspaper which is 72 percent and mobile (69 percent), whereas, access to radio is least i.e. 5 percent across the samples shown in Figure 5.2.

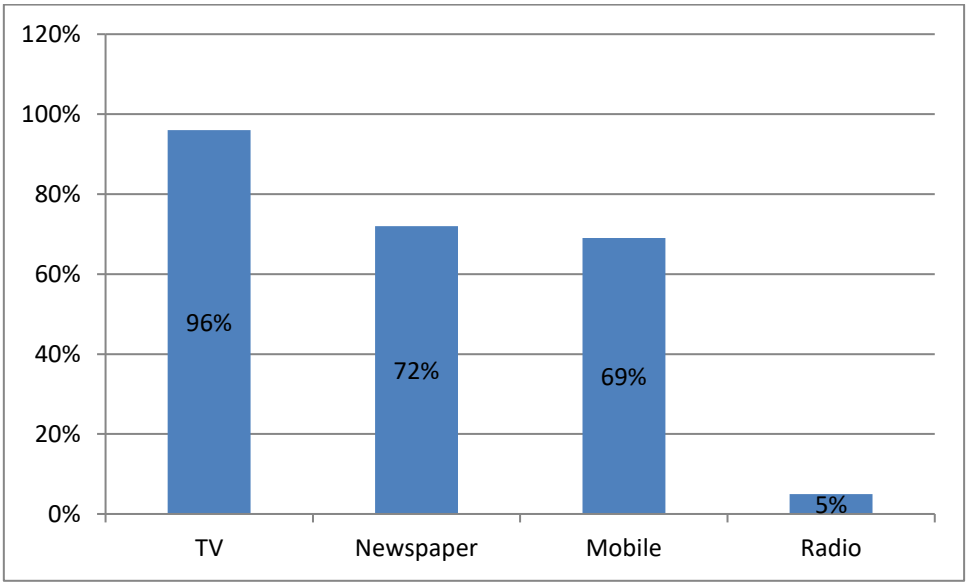


Figure5.2 Overall access to media among health workers/school teachers

In the region-wise analysis, across the sample in the study, 90-100 percent of the health workers have access to TV, whereas, none of the regions has access to radio except the Southern and Northern regions. Only 25 percent of health workers/ school teachers in the Southern region have access to radio, followed by the Northern region where only 8 percent have access to radio. Health workers and school teachers belonging to the Northern and Eastern region have the least access to mobiles and health workers/school teachers belonging to the North-Eastern region have the least access to newspapers as shown in Table 5.1.

Table 5.1 Access to Media among Gross-root Level Functionaries

Access to Media	North		East	North East	South	Central	West
	UP	UK	Bihar	Assam	Tamil Nadu	MP	Rajasthan
TV	95%	100%	90%	90%	95%	100%	100%
Radio	0%	8%	0%	0%	25%	0%	0%
Mobile	45%	58%	55%	80%	65%	80%	93%
Newspaper	90%	75%	80%	45%	65%	65%	82%

EXPOSURE TO HEALTH PROMOTION MESSAGES AMONG GRASS-ROOT LEVEL FUNCTIONARIES

To check the general awareness of health workers/school teachers about health-related programmes, the respondents have been asked, whether they have seen an advertisement/poster/ message educating about health and family welfare programme in the last one year (2018-19). Overall, 97 percent of health workers/school teachers have seen a health-related advertisement in the last one year has been found. Table 5.2 depicts the percentage of health workers/school teachers who have seen an advertisement/poster/message education about health and family welfare programs in the last year across regions.

Table 5.2 Exposure to Health Promotion Message among Grass-root Level Functionaries

Northern		Southern	North Eastern	Central	Eastern	Western
Chitrakut	Haridwar	Ramanathapuram	Dhubri	Vidisha	Bihar	Baran
100%	100%	90%	95%	100%	95%	100%

First Recalled Health Promotion Message

Across the seven regions under study, around 80 percent of health workers/school teachers can recall few health-related advertisements like dengue, TB, cancer, malaria, and polio as depicted in Figure 5.3.

Health workers/school teachers were also interviewed about the three programmes under the study on various indicators such as (i) exposure to Progamme Specific Message, (ii) Recall of key messages, and (iii) action taken. Besides these, some questions were asked about their day to day functioning specifically related to IEC and training related questions were asked. Further, they were asked about whether they ever have seen any change of behavior or action in the community members as a result of the information by them or given in the IEC material (See Annexure-Research Tool 2 for Semi-structured Questionnaire).

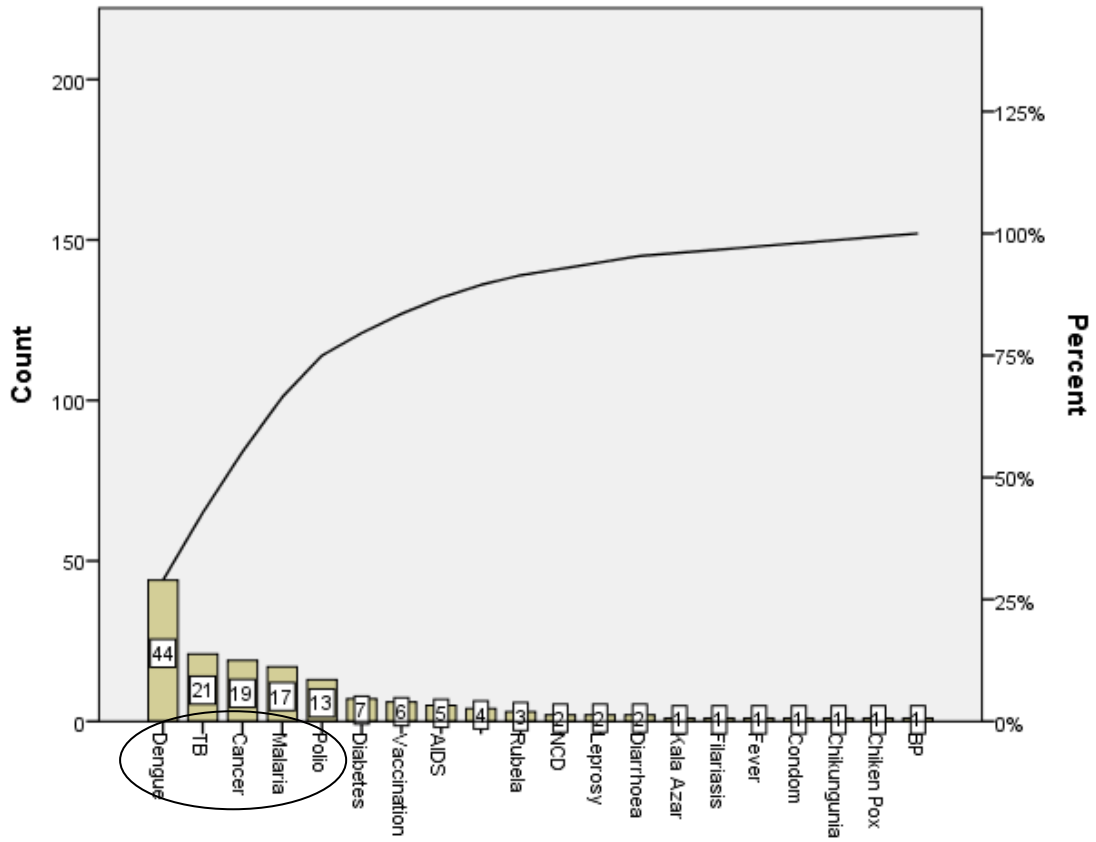


Figure5.3 First Recalled health advertisements

EXPOSURE, RECALL, AND PERCEPTION ABOUT IMMUNIZATION MISSION INDRADHANUSH MESSAGES

Exposure to Health Promotion Messages

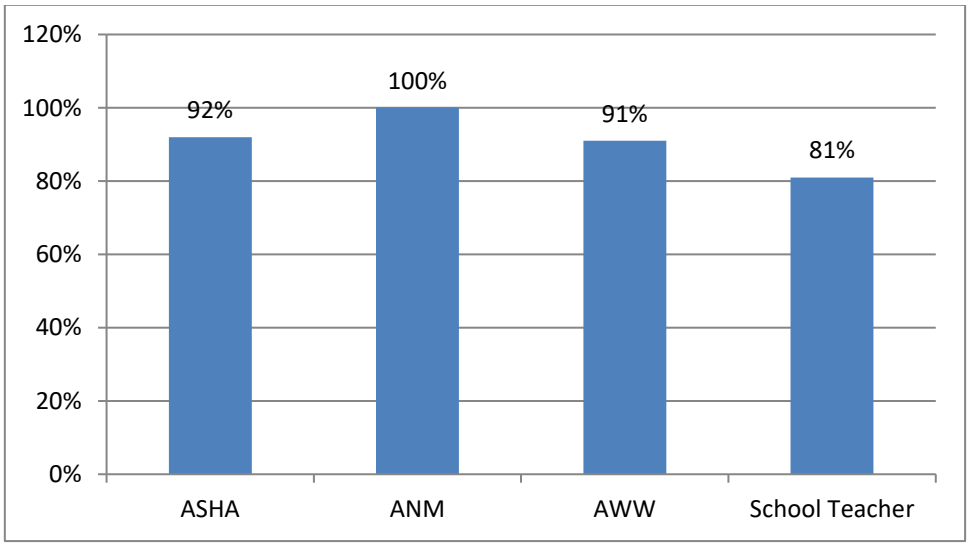


Figure5.4 IMI-Exposure level among health workers/school teachers

Across the study sample, all the ANMs have seen immunization related advertisements to IMI with 91 and 92 percent of AWWs and ASHAs. Though school teachers are not directly involved with the immunization program still 81 percent of school teachers have seen advertisements related to this programme as depicted in Figure 5.4.

Source of the Exposure

Across the sample, advertisements/messages related to IMI has been seen on TV and mid media by 80 percent of these health workers. as depicted in Figure5.5. Around 66 percent of health workers who have watched advertisements on TV, out of which 55 percent of them have watched in private channels followed by DD i.e. 22 percent and 11 percent of these people, have watched in regional channels. Among social media, 15 percent of these people have watched in Whatsapp and 8 percent have watched on Facebook. Among mid media, more than half of the health workers have seen these advertisements in banners and only 11 percent of them have seen it on wall painting.

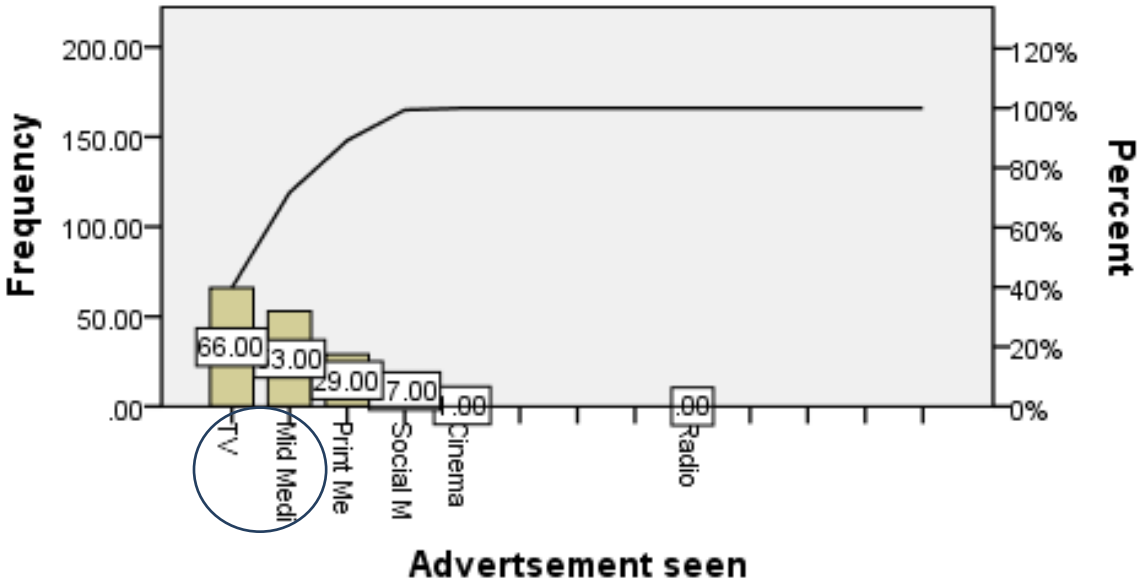


Figure5.5 Sources of Exposure

Recall of IMI Messages among Grass-root Level Functionaries

The recall of IMI advertisements messages has been analyzed by using the Word Cloud Method (Figure 5.6). The analysis shows that most of them recalled that vaccination is important so every child should get it done. No child remains away from vaccination. Vaccination prevents children from infectious diseases. Many of them even recalled that seven visits are a must in 5 years.

Figure 5.6 Recall of IMI Message

Perception about Content of the IMI Advertisements

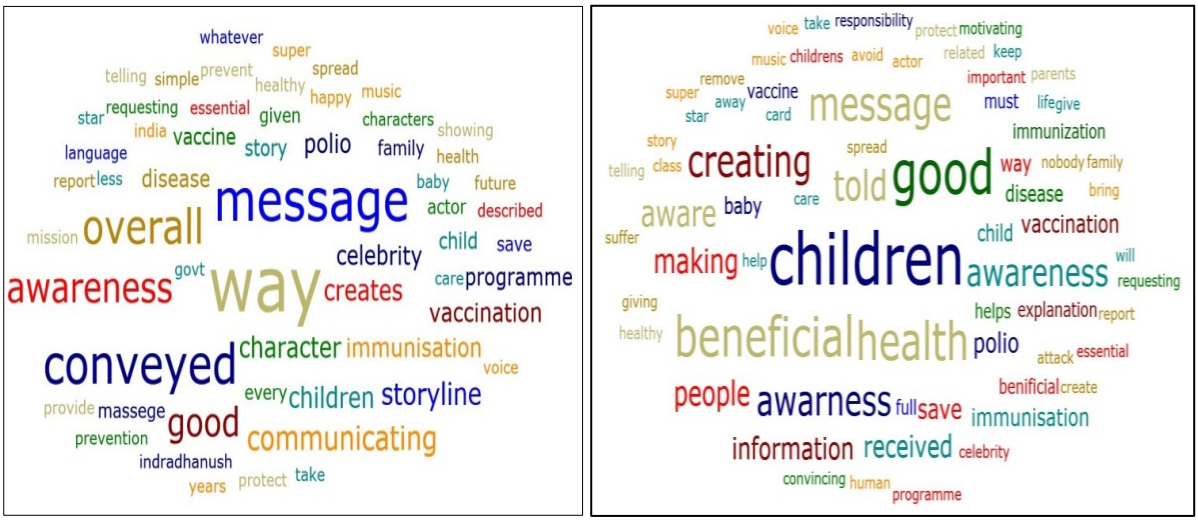


Figure5.7 What of Message and Why Grass root Functionary like Advertisement

Ninety-nine percent of sample health worker/school teacher respondents believed that these advertisements are suitable for the community and they have liked them. Most of them liked the way the message has been conveyed. Many of them liked the advertisements overall. Some of them liked these advertisements because of the celebrity depicted in them and felt that it is a good way to communicate the message as shown in word cloud Figure 5.7. Most of them liked these advertisements because these advertisements help them to create awareness as the community gets to know about the importance of vaccination and its benefits like it prevents children from various diseases.

EXPOSURE, RECALL, AND PERCEPTION ABOUT NPCDCS MESSAGES

Exposure to NPCDCS Health Promotion Messages

All sample ANMs across regions have seen NPCDCS related advertisements followed by 89 and 92 percent of AWW and ASHAs respectively. Further, 97 percent of school teachers have seen advertisements related to this programme as depicted in Figure 5.8.

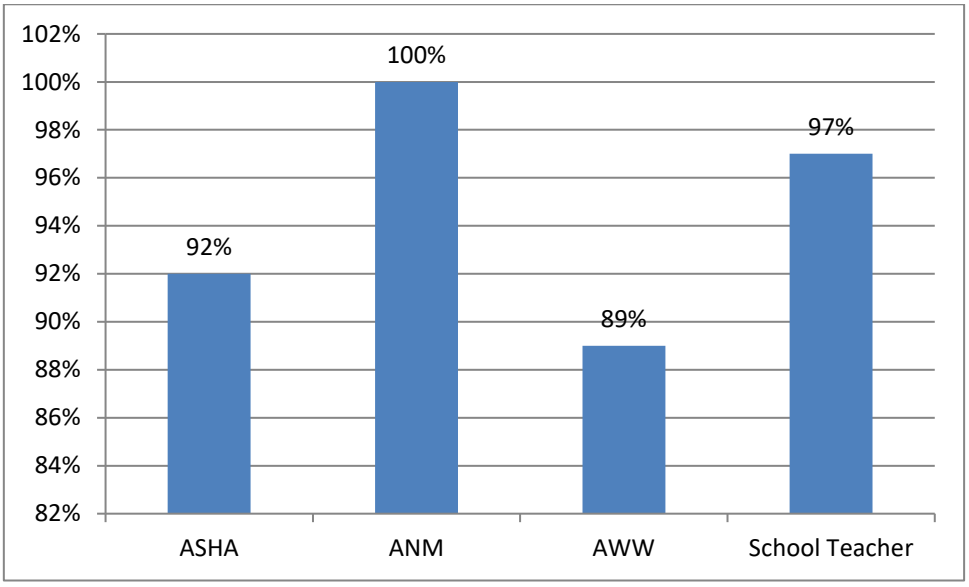


Figure5.8 NPCDCS- Exposure level among health workers/school teachers

Source of the Exposure

Across the sample of 152 respondents, percent advertisements/messages related to NPCDCS have been seen on TV, and through mid-media by 80 percent of these grass root level functionaries as depicted in Figure 5.9. 71 percent of health workers who have watched advertisements on TV, out of which 64 percent of them have watched these advertisements on private channels followed by DD i.e. 25 percent and 13 percent of these people have watched in regional channel. Among social media, 9 percent of these people have watched in WhatsApp and 5 percent have watched on Facebook. Among mid media, 41 percent of health workers have seen these advertisements in banners and only 5 percent of them have seen it on wall painting. Only 3 percent of the health workers have seen these advertisements in cinemas.

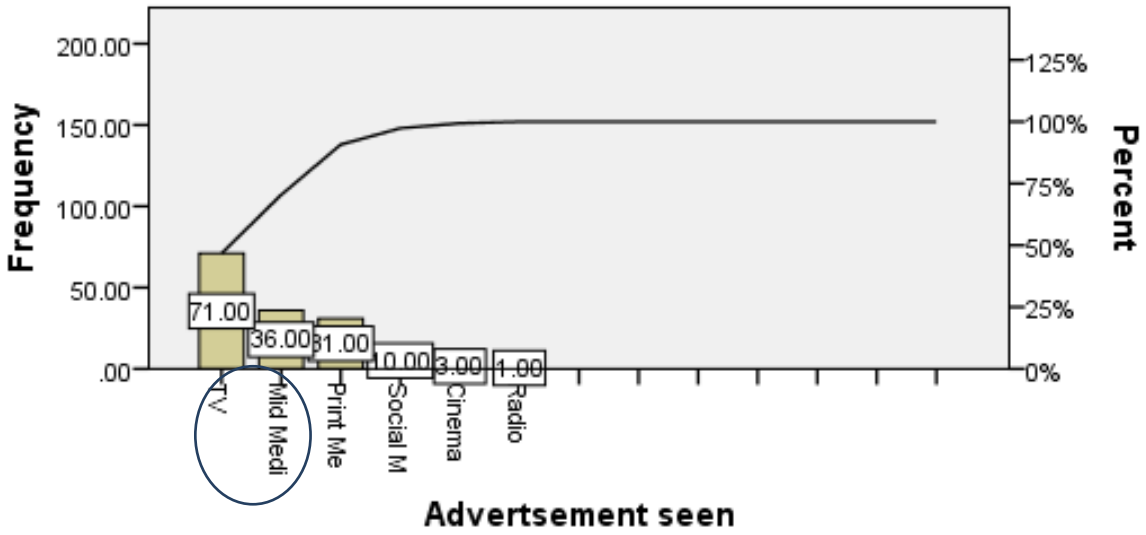


Figure5.9 Sources of Exposure

Recall of NPCDCS Messages among Grass-root Level Functionaries

When asked to remember the advertising messages, it has been analyzed from the word cloud Figure 5.10 that most of them recalled the risk factors of cancer and how to prevent the spread of disease. Some of them even recalled that smoking or tobacco is injurious to health. Few of them could remember the risk factors of diabetes and also about the mandatory screening of the diseases.

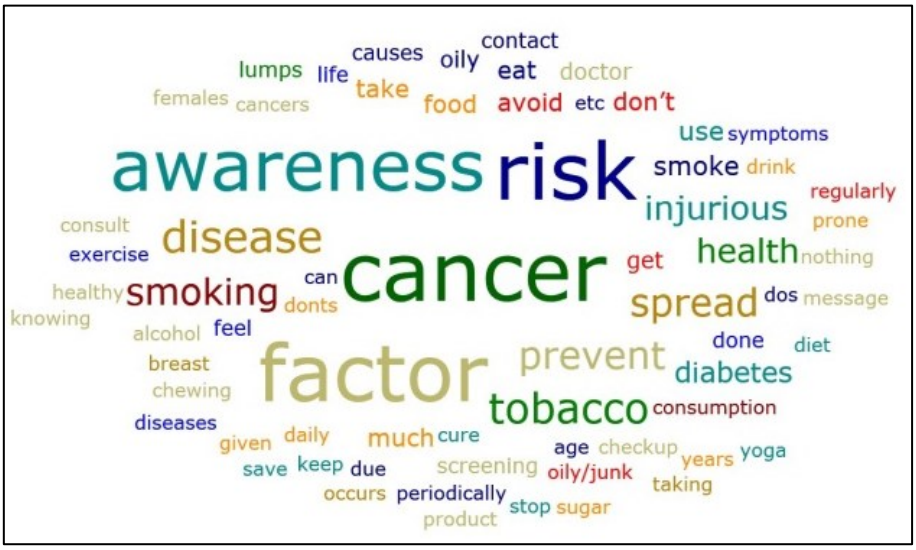


Figure5.10 Recalled Messages NPCDCS

Grass-root level Functionaries' Perception about Content of the NPCDCS Advertisements

Ninety-eight percent of health workers/school teachers believed that these advertisements are suitable for the community as depicted and almost everyone (i.e. 97 percent) liked the advertisements. Most of them liked the storyline and overall. Many of them liked the advertisements as it creates awareness and the way the message has been conveyed. Some of them liked best about these advertisements that methods of prevention are also explained as shown in word cloud Figure 5.11.

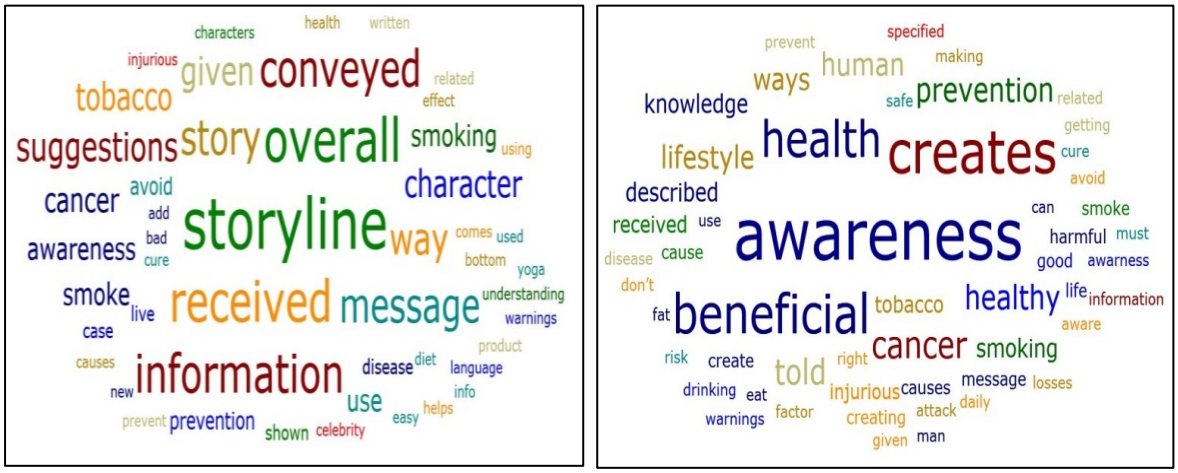


Figure 5.11 What of Message and Why Grass root Functionary like Advertisement

Most of the functionaries liked these advertisements because these advertisements help them to create awareness and they received knowledge about the diseases and their way of prevention. Messages like smoking and tobacco cause cancer have been depicted in these advertisements and these messages are thus beneficial for all. Therefore people liked these advertisements.

EXPOSURE, RECALL, AND PERCEPTION ABOUT NVBDCP MESSAGES

Exposure to NVBDCP Health Promotion Messages

Across the regions under study, out of 152 respondents, all ANMs and ASHAs are taken into the study, have seen NVBDCP related advertisements. 97 percent of both AWWs and school teachers respectively have seen these advertisements related to this programme as depicted below in Figure 5.12.

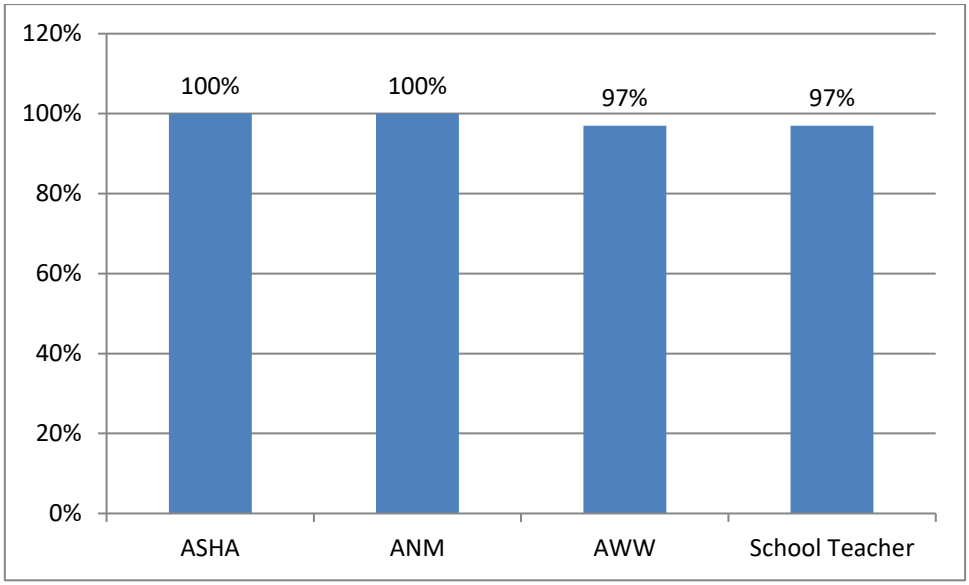


Figure5.12 NVBDCP- Exposure Level among health workers/school teachers

Source of Exposure among Health Workers/School Teachers

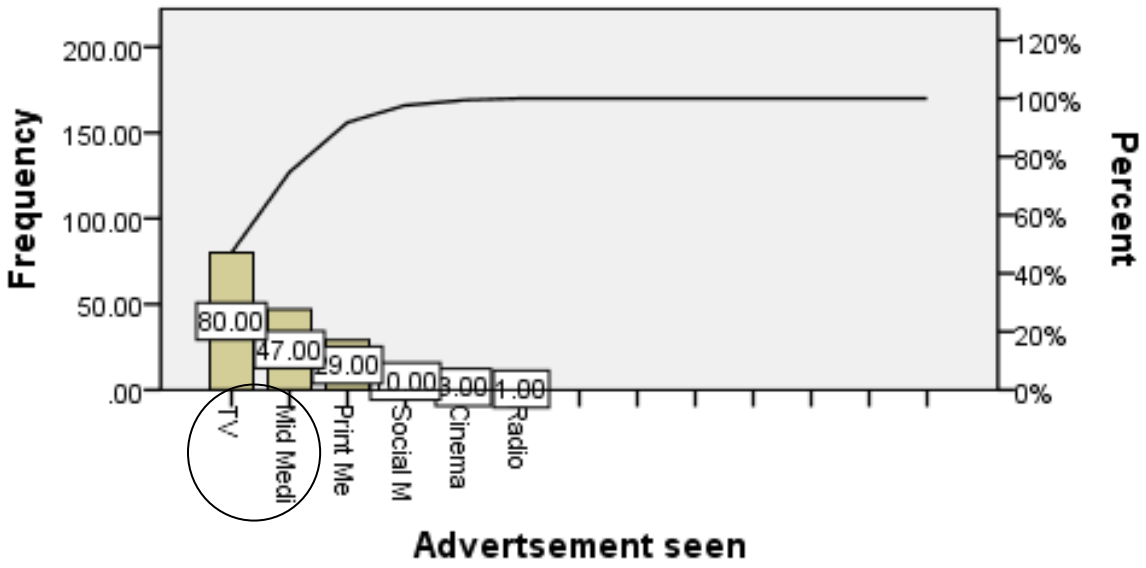


Figure5.13: Sources of Exposure

Across the states under study, 80 percent of people have seen advertisements/messages related to NVBDCP on TV, and through mid-media as depicted below in Figure 5.13. 80 percent of health workers have watched advertisements on TV, out of which 66 percent of people have watched these advertisements in private channels followed by DD i.e. 30 percent and 20 percent of these people have watched in the regional channel. Among social media, 13 percent of these people have seen in WhatsApp and a mere 7 percent on Facebook. Among mid media majority of health workers i.e. 49 percent have seen these advertisements in

banners and only 5 percent of them have seen it in wall painting. Only 3 percent of the health workers have seen these advertisements in cinemas.

Recall of NVBDCP Messages

The majority of the health workers/school teachers recalled about the (i) breeding places of mosquito, (ii) causation of dengue, and (iii) malaria and symptoms of the disease. Some of them even recalled that water should not be accumulated around the locality. Few of them recalled the message in which, it is advised to keep the surroundings clean and to use bed nets, mosquito coils as a preventive measure against mosquito-related diseases as presented in the word cloud (Figure 5.14).

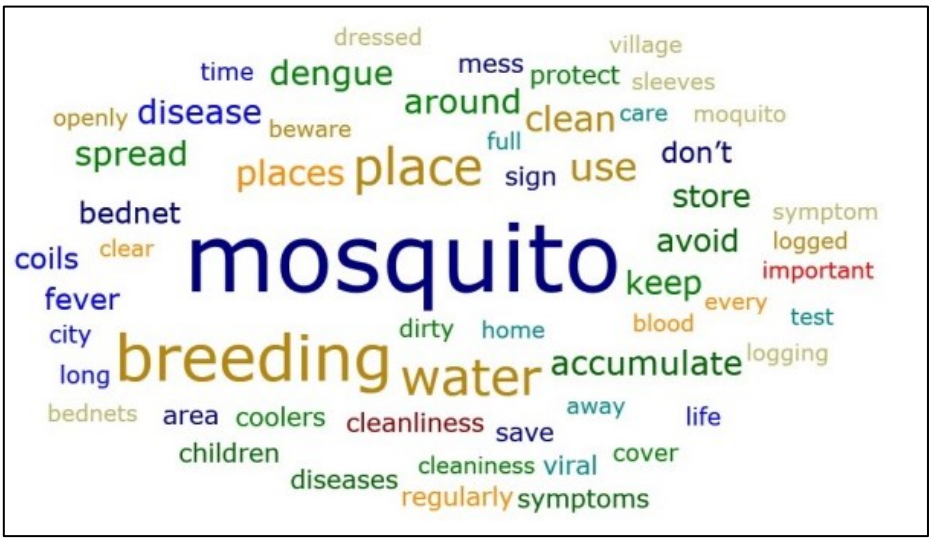


Figure5.14 Recall of NVBDCP Advertisement Messages

Perception of NVBDCP Advertisement Messages

All the health workers/school teachers believed that these advertisements are suitable for the community and almost everyone (i.e. 97 percent) of them liked these advertisements. Most of them liked the storyline as children are depicted in the advertisement. They liked these advertisements as these help them to create awareness. They like the overall content of these messages. Some of them liked these advertisements because methods of prevention are also explained, thus the respondent received new information about the health-related program (See Figure 5.15). They like these advertisements because it educates the community about the diseases, it's spread and the modes of prevention.

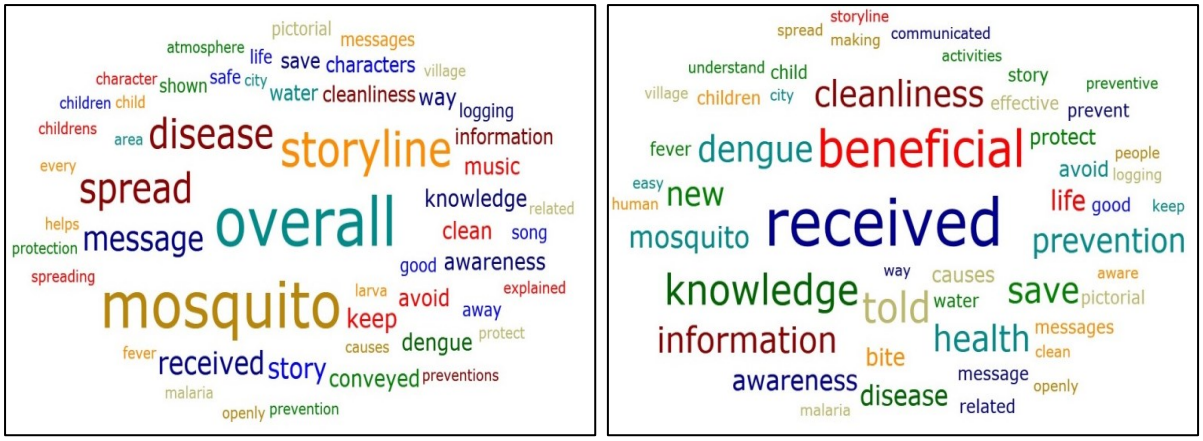


Figure5.15 What of Message and Why Grass root Functionary like Advertisement

SUPPLY OF IEC MATERIAL FROM STATE AND ITS USAGE

Overall, 75 percent of health workers received IEC material from the department whereas 25 percent of them didn't receive it. Figure 5.16 shows the region-wise percentage of grass-root functionaries who have received IEC material in the form of flex material, pamphlets, posters, etc. Almost all the health workers of the western region have received IEC material from the department followed by the Northern and Eastern region whereas in the Southern region only 20 percent of health workers received IEC material and 53 percent of health workers of the North-Eastern region didn't receive IEC material.

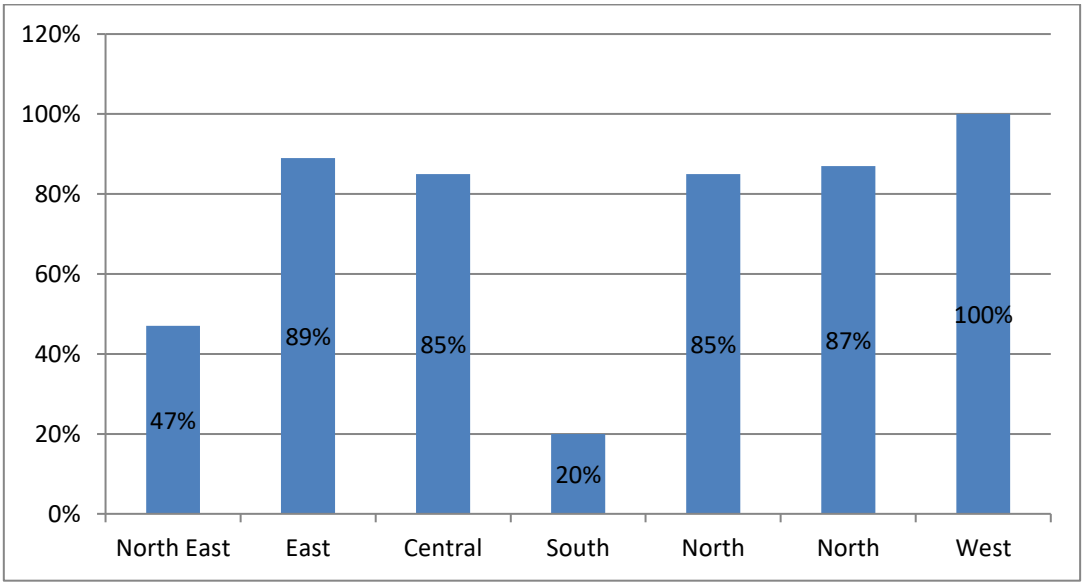


Figure5.16 Percentage of functionaries who received IEC material across region

IEC material, which has been received by the health workers and school teachers, 80 percent of them, used them for distribution among the community members and for display in various

places. The other 20 percent of the respondents use IEC material for showcase and in meetings.

Record Keeping for IEC Material Received

Out of 113 respondents, only 29 percent of health workers maintain records of the stock of IEC material whereas 71 percent of them have no records of the materials, which were received by them as depicted below in Figure 5.17. Those who maintain records, they manually note down in the registers and diaries at their respective sub-centers/ Anganwadi. Some of the records are maintained at their residence too.

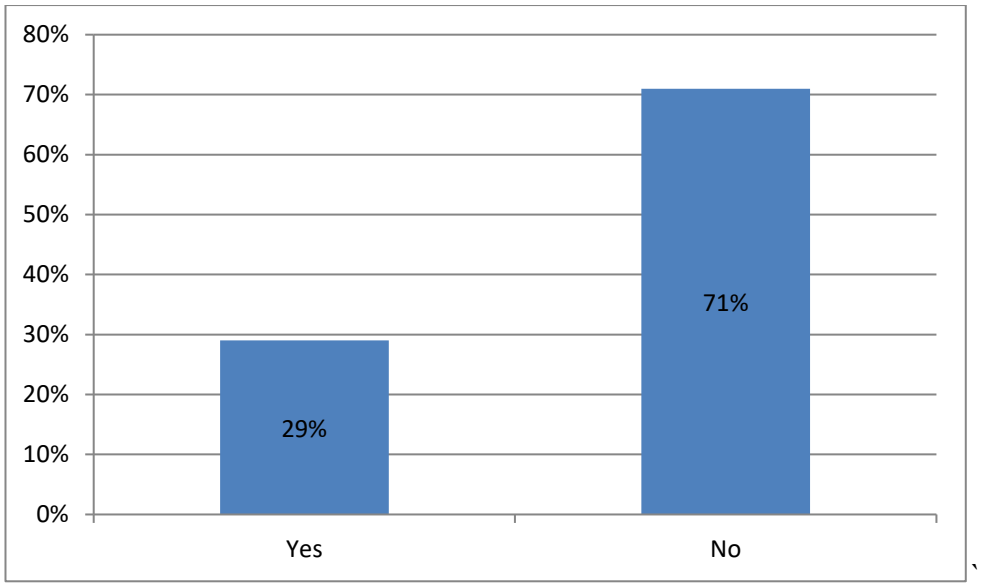


Figure 5.17 Percentage of health workers who maintain records of IEC material

TRAINING AND CAPACITY BUILDING OF GRASS-ROOT LEVEL FUNCTIONARIES ABOUT IEC MATERIAL

Figure 5.18 shows that an overall 63 percent of the respondents received training or guidelines whereas, 37 percent of them haven't got any instructions regarding the same. This response has been received from a group of 110 respondents. Most of them received instructions one month before the start of the programme or when programme starts in a meeting mostly at CHC. Guidelines or instructions are all about how to demonstrate particular IEC material to generate awareness in the people of the community. The majority of these training has been conducted by the Doctors or the CMOs of that hospital followed by block or district programme manager. Few of the ASHAs and AWWs training have been conducted by ANMs as well.

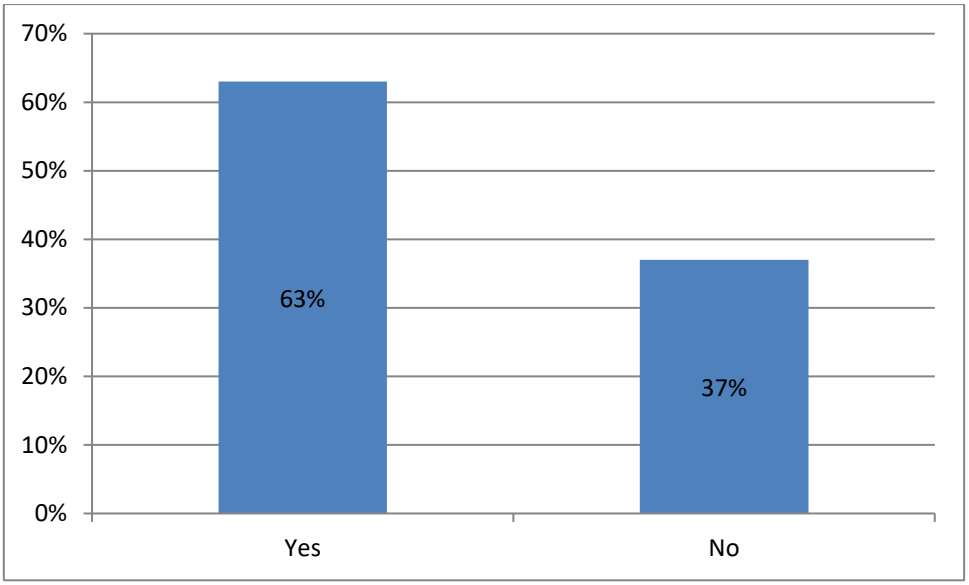


Figure 5.18 Percentage of health workers who received training

USEFULNESS OF NATIONAL IEC IN GRASS-ROOT LEVEL WORKERS FUNCTIONING

Sixty-one percent of health workers/school teachers believed that the impression/feelings/ created by the IEC activities helped them in mobilization and communication with the community members in the village whereas, 39 percent don't believe the same as exhibited in Figure 5.19.

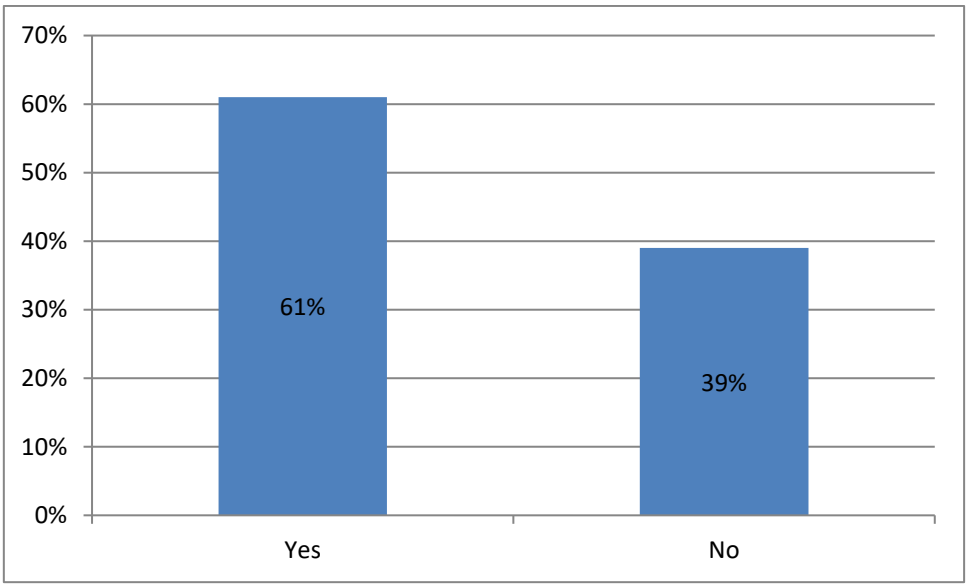


Figure5.19 Percentage of health worker believed that IEC material helped them in mobilization with the community member

Further, Sixty-three percent of health workers/school teachers across states claimed that community members have asked/inquired/talked for further information or clarification about the messages given in the IEC material.

Overall, 71 percent of health workers have seen a change of behavior or action in the community members as a result of the information given in the IEC materials as depicted in Figure 5.20. However, it has been negated by 29% of the respondents,.

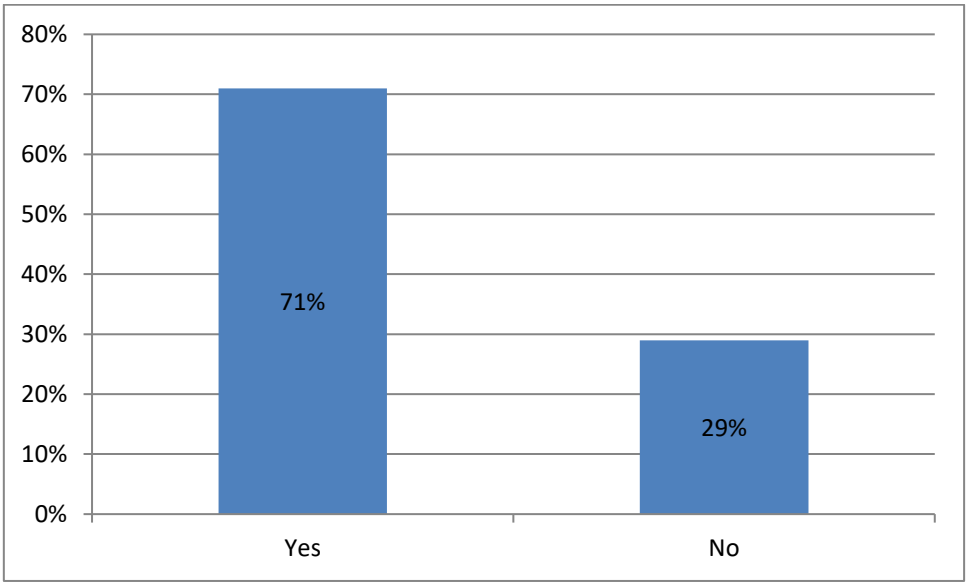


Figure5.20 Percentage of health workers who observed behavior change in community people

To understand the precise change in the behavior of community has occurred after being perceptive towards the advertisements, health workers/school teachers are also probed further towards the behavior change that has been observed in the people of the community. Both the General and programme specific changes have given emphasis. However, few health workers have responded to this question. Increased awareness is one of the major behavior changes that have been observed by the respondents. As claimed by the health workers, there has been an increase in the number of children getting immunized and people have started taking treatment on time.

For example for the Immunisation Mission Indradhanush programme, health workers have observed that the community members inquire them about immunization date and time and availing full immunization services for their children. For NPCDCS, health workers have also observed the community members are proceeding for testing and preventive activities. For NVBDCP, health workers have observed that the community is using bed nets and are involved in preventive activities.

SUGGESTION BY GRASS ROOT FUNCTIONARIES

The following suggestions have been received from the health workers and school teachers to improve the outcome of IEC activities:

- The advertisements should be in the local language and this awareness should be given community meetings as well.
- Miking (announcements using the microphones) should be made before at least one day before the programme starts.
- The usage of big screen audio video for displaying of IEC material and attracting audiences.
- Meetings of the health workers with the community people every month would also be helpful.
- According to the health workers, meetings of community people with them, rally, street plays, roadshows, and involvement of Panchayati members are the best ways to connect with community people to propagate health-related messages.

Chapter 6 Recommendations and Way Forward

The IEC Division of MOHFW provides an umbrella cover to the IEC/BCC plan of various National Programs. It has over the years, undertaken communication campaigns, information dissemination activities, and events across the years and the country. The division and its communication activities have played a significant role in terms of visibility and information dissemination. It also provides a communication environment that could prompt or trigger behavior change among different populations segments. The rapid evaluation research study has dwelled into the various aspects of the IEC activities, campaigns, and events and explored the effectiveness and impact of these efforts and initiatives. The key findings and analysis based on the primary and secondary data have been presented in the previous chapters. Based on the key findings and analysis this chapter presents some suggestions and recommendations and the way forward for the IEC Division and Swasth Nagrik Abhiyan (SNA).

REWORK COMMUNICATION STRATEGY AND MEDIA PLAN

The current communication strategy is designed based on campaigns based on disease-specific days and running a campaign before or sometimes a little after that. These are short term campaigns with heavy reliance on mass media (largely TV and print) and now increasingly on social media. Second, it is also evident from data that the campaign time, frequency, and intensity are rather limited thereby not able to achieve exposure and recall for facilitating behavior change. Third, it is not a coordinated resonating effort in sync with the states' effort on the ground so again as a communication strategy it loses the desired impact. These factors based on the study findings point to the urgent need to rework the communication strategy and the media plan in the light changing burden of diseases and media preferences of the community. The following seven sub-strategies are proposed under this recommendation as action points to make communication strategy and media plan produce better outcomes and results.

1. Going beyond special days and events
2. Separate specific strategy and media plans for urban and rural areas
3. A separate specific strategy for addressing regional priorities and challenges
4. Develop a strategic dynamic robust media plan

5. Rethinking, Re-planning radio in the media mix
6. Appropriate use of digital and social media platforms
7. Leveraging effective partnerships for IEC strategy

Going beyond Special Days and Events

The current communication strategy and action plan of the IEC division are based on special disease or observational days and events. These days are supposedly used as pegs or entry points for the short-term campaign around it. The community does not remember designated special days by UN bodies, international agencies, or even set by the government. The FGDs with community showed that there is no specific connection for the people for those days especially in rural areas. These may be a good idea for observation of the days as part of our international compliance and advocacy efforts and may even have a small potential to make it visible and event giving chance to government officials and machinery to make it an event that gets carried in the news media. The communication strategy needs to be *localized* i.e. with broad aims and objectives at the centre by reworked with people, their perspective, needs, and the local situation in mind. The barriers and benefits guide people's behavior change intents and change in practices.

Separate Plans for Urban and Rural Areas

One of the important insights that have emerged from the study findings is that there is a need to have a distinctive approach to address urban and rural audiences separately. Though both rural and urban audience prefers to get to use audio-visual mode. But the rural population wants a follow-up explanation of the message by the health functionary. Further, most of them don't own TV and Radio. Further, those who own it in rural areas, the timing (6:00 pm to 8:00 pm) and the nature of channels watched by them (Free on-air Channels) and programs (religious and crime based repeat program) don't match. Further, there are regional disparities as people in the Southern and North-eastern regions prefer to watch programs in regional languages than on national channels. Therefore, overall the medium for getting with different appropriate messages, media plans as their situation, needs, issues, challenges, and response mechanisms and capabilities are different. It requires a separate strategic communication efforts to make a difference. This should be undertaken very clearly and urgently based on evidence and creatively as well as strategically different designs and plans should be developed. Use of mobile audiovisual screen as used in Rashtriya Bal Swasthya

Karyakram or used by political parties in election campaigns or giving Pocket Projectors to ANMs/ASHA supervisors could be tried in rural areas.

Develop Regional Plans to Address Regional Priorities and Challenges

India is a large country with huge diversity in terms of language, culture, geography, health system readiness among other things. The study has found enormous diversity in media preferences, timing, resources, and knowledge sharing habits. Therefore, communication strategy and media plan should incorporate these regional variations and requirements, priorities, and challenges to be sharper in response to better value for money and efforts. These regional plans should be jointly developed by region, state consultation, and the synergy of the state and district in that region.

Develop a Strategic Robust Dynamic Media Plan

At present, the media plan is heavily tilted towards mass media in particular TV, print, and radio as is evidenced by the budget and media allocation in the last five years. Technically, the media plan is developed by the Bureau of Outreach (BOUP) (erstwhile DAVP). This media plan is guided by the not exceeding 8% to any particular media channel/publication rule which limits the intensity, frequency of a particular release to a minimum. These many impressions are not enough to be visible and create exposure and recall. Further, the time and frequency of a particular advertisement as well as the choice of the media vehicle chosen are guided by cost consideration and equal distribution logic over the required impression. For this purpose, the capacity of central IEC division officers needs to be built to understand and guide media plans based on TRPs (BARC data) within the ministry.

Additionally, the media plan should have a measurability process and indicators inbuilt into the efforts. Each campaign should be concurrently measured immediately after the campaign to ensure success as well as learning from the effort.

Another action point in the media plan should be a coordinated effort with the states IEC efforts. The IEC units state and district should be informed and readied in advance about the media efforts so that they can use this synergy effectively multiplying the efforts and impact.

Reworking Radio in the Media Mix

The study has also brought about some very important facts about the reach, exposure, and access to radio in the current times. It is true that during the 60s to late 90s, the radio played a very important part in the rural outreach but that has dramatically changed in recent decades. There is a very small number of radios and transistors available anywhere in the country. Most of the radio is now "FM" that is a small number and that too largely urban outreach which is inbuilt in mobile phones or car stereos. Although community radio is a powerful medium in terms of reach and quality to make a difference it is successful only in a few urban communities like universities and institutions. The unavailability of instrument / non-preference for radio among rural users' is important to be considered before planning a community radio. Therefore, it calls for a rethink in terms of how much weight-age should be given to the radio in the media plan. The use of radio should be looked into for better reception and exposure. It should be considered that alternative media and written communication like wall painting, posters, and pamphlets should be used for visibility and pictorial content in rural areas. Radio listenership and listeners' profile needs to be reassessed to make these choices. The need to relook at the content developed for radio is discussed in a different section below.

Appropriate Use of Digital and Social Media Tools and Platforms

As per in-depth discussion with the IEC division of MOHFW officials, in recent times there has been a lot of use of social media platforms in the communication strategy. It is a welcome sign that new media has been utilized to extend the reach of SNA to the audience across the spectrum. But one of the challenges is to gauge the success of social media communication and the difference it has made to the achievement of the goals and objectives of the health communication strategy of the IEC division. Social media can reach wherever the internet access is there but to make it useful and impact requires much more local and strategic efforts in coordination with the states and districts. For example, Whats App groups should be made of Village Functionaries for sharing short communications. Community workers need to be oriented for the same.

Also monitoring the social media and debunking the fake media content should be looked into to make the investment yield much greater results and outcomes. More emphasis should be made to develop User Generated Content (UGC). New platforms should be utilized like Tik Tok can be used to develop localized content for local issues but it should be properly

made and supervised by the district administration. Further, the capacity of the district officials needs to be developed. Facebook page of MOHFW should be more regular in postings and make engaging content and events. The content design and execution are discussed in a different section.

Leveraging and Forging Effective Partnerships for IEC as a Part of Communication Strategy

Partnership for SNA is very explicitly developed and used extensively albeit as a tokenism. IEC division almost works in relative isolation. For example, their partnership with development partners is restricted to sometimes developing content for their program division which is given to the IEC division for transmission. The partnership with the media and private sector, CSR partners is much to be spoken about. Faith-based organizations, NGOs, CBOs, and other potential partnerships with other ministries and units need to be strategically spelled out.

SYNERGISING OPERATIONAL AND IMPLEMENTATION PLAN

The second important and critical aspect of the communication efforts is the operation and implementation strategy and plan. There are several challenges to this aspect as well which makes the efficiency and effectiveness of the SNA rather weak. IEC division is a central unit in the MOHFW and there are no subunits in the states to support the operations and implementation other than the State Health Society (SHS) which is not in any line of control of the IEC division. The on-ground implementation of the IEC division campaigns requires much more strategy and planning to ensure visibility and engagement with the real audience instead of the advocacy audience if the aim is behavior change.

The following four actions are suggested for the same:

1. Synergizing IEC Operational and Implementation Plan at Center, state, and districts
2. Institutionalizing Mechanism for Partnership for Implementation
3. Coordination of Implementation Plan with Frontline Health Functionaries like ASHAs and ANMs and AWWs
4. Monitoring the Performance of Implementing Partners

Synergising Operational & Implementation Plan at Centre, State, and District Levels

The need of the hour is to build synergy and resonance in Center- State- District mechanism for IEC activities. The implementation plan needs to think beyond just releasing the ads on TV or print or outdoor. The IEC action of the Center has to resonate with the state and district efforts to benefit, complement, and supplement each other to get the multiplier effect. Ensuring that the plan and execution are in sync requires some kind of coordination and tracking mechanism with all states. This needs urgent attention as the states together also supposedly use the material and content shared with them but there is no way right now to know how they have (if at all) utilized the materials shared and sent to them.

Further, it requires coordination on the following issues: what is the feedback of the state on to the useful (if at all) of the material and have they some budgetary provision made in the states' IEC budget to use the material, adopt the material replicates the materials and of course share back with the center that this is what they have done with the materials given to them by the center.

It is suggested to set up a **coordination cell** at the center which not just collects data from the states but also empowers, guides, informs, builds capacities, and monitors the action by the states this would also build relationship and trust as well as inform the customization and tailoring of the content for the states and provide insights into what works and why. The second action that is required is to hold an annual review meeting of all IEC officers from states with the central IEC division team along with the program divisions.

Institutionalization of Partnership mechanism for implementation

The crucial role of partnership and networking has been stated and observed in the critical findings of the study. There should be a strategic partnership and not an event-based or Adhoc partnership for the IEC/SNA efforts. This includes all partners whether it is BOUP/DAVP or DD or AIR or private channels and publications or NGOs or Development partners. The implementation mechanism is as important, if not more important, than the creation of content. Since there is no direct line of delivery between States, DAVP, CSR Partners, Development Partners, Research and Academic Institutions, media, and field level functionaries. Therefore, it becomes important to cultivate these partnerships and employ them actively in planning as well as execution of the campaigns with active feedback and course correction dynamic mechanism. This will help the executing agencies like states, IEC

divisions, and DAVP, DFP plan and integrate actions in their action plan. These actions can be done through the use of social media platforms like the What's app groups or the web/internet to keep the partner informed and updated well in time.

Coordination plan of IEC activities with ASHA/ANM work plan

One of the strong on-ground implementation mechanisms is the frontline field functionaries like ANMs and ASHAs along with AWWs across the country. These are the real champions and frontrunners of action with the community. Though they are working under the control of the state governments at the district level, they (ASHAs) can be also guided and facilitated by the Center through NHSRC. There is a requirement of an interface of the Triple As (ANMs, ASHAs, and AWWs) with the IEC/SNA action as they need to and should utilize and spread the message that has been transmitted through the mass media on the various health issue and events by the central IEC divisions efforts.

To gain a multiplier effect, a direct and more engaging field functionary plan should be prepared. This plan should incorporate and utilize the "Umberala cover" support made available by the Central IEC/SNA along with the State level and district level efforts. The last mile efforts in social mobilization and IPC, as well as Home Visits, can greatly benefit from the material and content provided by the Central IEC division. This requires some tweaking of the planning efforts with states and NHSRC as well as ARCs and ANTCs and with NIPPCD for AWWs. The field level functionaries have to be an integral part of the IEC/SNA efforts and not just assumed and implied involvement in the strategic efforts. This will imply a monitoring mechanism whether the integration of the IEC/SNA has happened at the field level. Some specific IEC indicators will have to be incorporated in the MIS at the state and district levels to demonstrate that. This will also require some nudging at the training and capacity building institutes like NIHFW, SIHFW, ANTCs, AAWTCs, etc. to facilitate this integration to happen.

Monitoring the Performance of Implementation Partners

To improve the effectiveness and efficiency of implementing partners like DAVP, DFP, DD, AIR, and private media partners, Central IEC Division should develop a mechanism of performance measurement and monitoring. It is important to have clear indicators – process, output, outcome, and impact indicators. The results of the same should be submitted by the

implementing partners periodically validated by the central IEC team. The repots of output indicators will also feed-forward for the planning of the next campaigns.

LEVERAGING AND INTEGRATING COMMUNICATION OUTREACH WITH SCHEMES AND DATABASES

Several programs and schemes of both the State and Centre governments are simultaneously targeting and focusing on the same population with different messages. These messages have direct and indirect benefits for health actions and health-seeking behaviors by the target population segments. These include, in particular, the ICDS/POSHAN, WASH/SBM Rural and urban, the health programs under Ayushman Bharat, and other ministries like the railways, Rural Development, Panchayati raj, etc. These efforts should be integrated and made part of the coordinated and leveraged strategy to gain better traction and outcomes. These can not continue in isolation either on paper or on an Adhoc basis.

Four specific instances and entry points are described below for the purpose.

1. Mobile Van used for the Rashtriya Bal Swasthya Karyakram (RBSK) may be fitted with an Audio Video screen and equipment to screen shorts films at important locations like Gram Sabha, Common Well for Water, etc. when the RBSK team is functioning at schools.

2. Registration data collected at OPD (mobile number with diagnosing) should be used for sending specific IEC material or SMS. These databases and insights could help develop better engagement and follow up processes increasing the exposure and impressions on social media as well on the ground.

3. Private sector medical and health sectors should be more holistically included in the IEC/SNA plans. They spend a huge amount and effort on communication and reaching out. One should not shy away from them or leave them out but engage with them and bring them in for public health communication efforts.

4. WASH/SBM has been a major flagship program effort in the last five years. Although a dotted relationship exists between the ministries, there are no direct or stronger links or strategies that utilize or feed into each other’s efforts.

STREAMLINE IEC BUDGETING AND FUND FLOWS AND EMPOWERING STATE AND DISTRICT

One of the issues that came up strongly during the study is the issue of release of the IEC budget amount in time and some delays in getting access to the budget allocated. Although the budget allocation is not directly in the purview of the Central IEC division, however, they get into the picture for the PIP and budgetary planning processes. IEC division can oversee and support the IEC efforts and build the capacity of the states to incorporate the critical elements of media planning, coordinated actions, capacity Building, M& E, documentation, and dissemination. The format of the IEC Budget should be redesigned to ensure that the elements/fields are easy and simple and not just quantitative numbers and ensuring that they are not just more of the same from last year. The annual review meeting of the IEC officers should be utilized by extending it for one more day to build capacity to empower them to be strategic and bold to take innovative efforts in IEC/BCC.

Five of the specific suggestions for the same are presented below:

1. Timely availability of budget at the earliest for better utilization of the funds.

2. Specialized IEC Fund should be given for the planning as per local needs as well as for local disease, misconceptions, and epidemics.

3. Program Budget on IEC should give the flexibility to spend as per local needs

4. UCs of IEC plan and spends should be made public online

5. Proper discussion and deliberation should be undertaken before finalization of IEC in District AAP or PIP

ROBUST RESEARCH, MONITORING, EVALUATION, AND DOCUMENTATION UNIT FOR IEC/SNA

Communication strategies are supposed to be based on strong evidence, primary data generated through quantitative and qualitative research from the field. This is an element that is quite missing from the strategy and efforts of the central IEC division efforts. It is presumed that some of these researches are conducted by development partners and are used to generate content that is shared with the IEC division and the IEC division just becomes the postman for the same. This should change. They need to take better control of the process as well as the evidence to make informed decisions not only for the messages and content but

also for the other components such as capacity building funding and monitoring and evaluation of IEC efforts. Six of the specific suggestions under this area are listed below:

1. A formative study should be done for each district to document and avoid whims and wasteful expenditure. These studies could be "crowd-funded" meaning these could be done by inviting students studying in courses like MSW, Mass Communication, MPH, Community medicine for internships, summer placements and conduct the formative research and formulate the communication strategy for the district/state which could feed into the national IEC strategy. It will serve as an evaluation of the previous year as well as provide scientific evidence for the forward communication strategy.

2. Periodic Monitoring of IEC activities need to be done rigorously (a standard Monthly Progress Report (MPR) should be developed for IEC for reporting from each district)

3. It should be made mandatory to put Quarterly progress reports on IEC Online.

4. A third party external evaluation for IEC should be at the end of each year

5. The photograph of politicians should be avoided on IEC materials as these go wastes during the Election Model Code of Conduct.

6. Case studies, success stories lessons learned, positive deviance stories should actively be documented

HUMAN RESOURCES AND CAPACITY BUILDING

Effective communication requires skilled and competent human resources. Trained and professional staff, dedicated staff, passionate staff, creative staff is a prerequisite for the impactful communication efforts. The IEC division staffs do not especially have a background or orientation in the professional communication function but have worked into the domain – learning by doing. It should be noted that this lack of domain training and specialization also gives scope for others especially donors and development partners to come in as experts. The IEC division should beef up their technical capability as well media acumen not just in the domain but in Capacity Building Efforts (for states and other program divisions), Monitoring and Evaluation as well research, and people skills. A well thought out and budgeted capacity-building strategy, in the house as well for states and partners should be developed. Five of the specific suggestions in this recommendation are listed below:

1. Vacant Sanctioned Positions should be filled without any delays.

2. Proper Orientation needs to be done for newly joined staff. A manual of SOPs may be prepared for the orientation, to avoid loss of any significant steps.

3. Three to five days Capacity Building Workshop should be organized for the district and block Officials on SBCC to innovate at the local level.

4. M & E, Finance, and Medical Officers should also be trained in effective communication.

5. Exposure visits should be organized for the central staff so that they can learn and document good IEC practices from the states.

CONTENT DEVELOPMENT

Content is the key as well as the king. At the end of the day, all communication is developing an effective, powerful as well as impactful content. Content creation is not easy. As has been pointed out by the respondents in the research study the content has been a major challenge in the communication efforts of the IEC division. Be it print, TV, radio, or even outdoors as well as social media. It has not connected well, resonated enough, or been easy to recall and make a mark for facilitating behavior change. A large part of AV content is not directly produced by the IEC division. Social media content is done in-house. There has been no or little pretesting of the content and campaign done for ensuring it is found useful and compelling. Some of the suggestions for developing compelling, engaging, and impactful content are listed below:

1. Brush up internal capacity to generate quality content by getting consultants as well as internal full-time staff to learn specialized creative content development offline/online courses.

2. Hire a creative agency that not only develops compelling content but also develops capability in-house for the IEC division.

3. Do not accept content developed by donor and development agencies just on face value and taken for granted that coming from them it will be good and appropriate.

4. Engage community medicine, Mass communication, MSW, and research agencies to wet the content and pretest them thoroughly.

5. Be innovative about content and campaign instead of just being ‘informative” and technically and medically right. Information is good by connecting it to the head and heart is critical for behavior change.

6. A diverse range of content should be developed to suit and appeal to the different regional audiences as well differently for the urban and rural audiences.

IMMEDIATE ACTION POINTS

From the above recommendations, the recommendations which require immediate action of the policymakers are listed below to start with. However, this does not mean other recommendations are not at all important.

1. Develop evidence-based national IEC/BCC strategy and action plan taking rural/urban and regional diversity in mind.

2. Develop and share national IEC guidelines for states and districts to guide the States and districts to develop state-specific IEC strategy and action plans and align them with national IEC/BCC efforts to optimally get results.

3. Develop a performance measuring mechanism (concurrent monitoring and external evaluation) for the national and state IEC/BCC efforts on a campaign basis as well as on a quarterly and annual basis.

4. Re-strategize the national media plan for informed better-customized media mix to make optimal value for many spend calculating the Social Return on Investment.

5. Increase the national IEC budget to double the current levels to make a real and long-lasting change in health-seeking behavior and improved health outcomes.

6. Build the capacity of IEC staff and officers and add professionally qualified and competent people to manage and deliver the IEC strategic outcomes.

7. Develop IEC/BCC capacity building plan and e modules to ensure all IEC staff from top to field has undergone at least one IEC course and utilization plan

8. Build effective strategic partnerships with other ministries, development partners, donors, research agencies, CSR to leverage the multiplier effect in consolidated outcomes.

9. Develop compelling quality content to engage, excite, and energies individuals and communities to information seeking and behavior change by working on localized strategy.

10. Include campaigns on non-conventional areas like Mental Health, Geriatric Care, and enhance the scale of NCD campaigns.

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ANNEXURE 1

Research Tool 1

Indian Institute of Public Administration

Questionnaire for Beneficiary (Male/female) (Urban/Rural)

CONSENT FORM

Project Title: "Rapid Assessment of Swasth Nagrik Abhiyan (SNA) erstwhile IEC Programme of Ministry of Health and Family Welfare"

Principal Researchers: Dr. Pawan Kumar Taneja, and Dr. Roma Mitra Debnath Indian Institute of Public Administration, India

Sponsored By: NITI Aayog, Government of India

The Information, Education & Communication (IEC) strategy of the Ministry of Health and Family Welfare (MoHFW) aims to create awareness and disseminate information regarding the benefits available under various schemes/programs of the Ministry and to guide the citizens on how to access them. The main of objective this study is to review the existing IEC activities concerning health and family welfare activities and suggest a framework to improve upon the Swasth Nagrik Abhiyaan (IEC programme) in the future. Participation in this research study is voluntary. You are not exposed to any risk by participating in this research. The interview will take approximately 20-25 minutes to complete. The results reported will be strictly anonymous; that is, no one involved in this study can identify you personally. Please note that you may withdraw your consent to participate in the study at any time. You do not have to assign any reason to withdraw from this research at any stage. If you have any complaints about any aspect of the study, then you may contact Dr. Pawan K. Taneja/Dr. Roma Mitra Debnath, Indian Institute of Public Administration, IP Estate, Ring Road New Delhi-110002. Email: pawanktaneja.iipa@gov.in, romadebnath.iipa@gov.in Telephone: +91-11-23468327/50.

I, _____, freely agree to participate in this study according to the conditions in the consent form.

Signature …… Date ……

SECTION: PROFILE

State				
District				
Location	**Rural**		**Urban**	
Block				
Name of Village/City				
Date				

Name (Optional) : _____

Age :	15 – 24 years	25 – 34 years	35 – 44 years	45 years above
Gender :	Male	Female	Other	

Educational Status :	Illiterate	Literate without schooling	Primary	Middle
	Secondary	High secondary	Graduate and above	Other

Mobile/Contact number: _____

Marital Status :	Married	Unmarried	Divorced/ Separated/widowed

Occupation :	Self-employed	Agriculture	Service	Housewife	Retired	Student	Unemployed

Social category :	SC	ST	OBC	General

INVESTIGATOR/Name/Date/Time/Place _____

SECTION 1: Media access and general exposure of IEC Campaign/Activities of MOHFW

Now I am going to ask you some questions about your media access and use.

1.1 Do you have access to media and how often you use?

	Never	Daily	Weekly	Fortnight	Monthly
TV					
Radio					
Mobile (Social Media)					
Newspaper					

1.2 Have you ever seen any advertisements/posters educating health and family welfare programme in the last 1 year?

1.2.1 If yes, please tell us the following about those advertisement/education material

Disease/Programme	**Advertisement/Material**	**Media** (TV, Radio, Social Media, Print Media, Cinema, Mid Media)	**Channel** (If TV: DD/ Private Channel/Regional; Social Media: FB/WhatsApp, Print (Newspaper/ Magazine); Mid Media (Street Play/ Wall Painting/ Movie/ Road show/ Banner)

SECTION 2: Exposure to specific MOHFW Campaigns (Now I am going to ask you some questions about health and family welfare programme communication)

Name of Programme	**1.1 National Vector Borne Disease Control Programme (NVBDCP) MALARIA, DENGUE**	**1.2 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)**	**1.3 Immunization Mission Indradhanush**
A. Exposure			
Have you ever seen any advertisements/posters related to this programme?	1.Yes 2.No *(Proceed to section 3 Page No6)*	1 Yes 2 No	1 Yes 2 No
Where all have you seen this advertisement?	1. Television 2. Radio 3. Newspaper 4. Pamphlets 5. Booklets/Leaflets 6. Posters 7. Health Worker 8. Hospital 9. Any other, Specify	1. Television 2. Radio 3. Newspaper 4. Pamphlets 5. Booklets/Leaflets 6. Posters 7. Health Worker 8. Hospital 9. Any other, Specify	1. Television 2. Radio 3. Newspaper 4. Pamphlets 5. Booklets/Leaflets 6. Posters 7. Health Worker 8. Hospital 9. Any other, Specify
How many times you have seen this advertisement?	1. Everyday 2. Less than two times/week 3. More than two times/week	1. Everyday 2. Less than two times/week 3. More than two times/week	1. Everyday 2. Less than two times/week 3. More than two times/week
B. **Recall of messages**	1. Diseases spread by mosquito 2. Breeding places of mosquito i. Drainage ii. Dirty Stagnant water iii. Clean Stagnant water iv. Garbage	1. Do you and your family are frequently getting screening for these diseases? 2. Awareness about the risk factor for cardiovascular disease i. Alcohol ii. High BP iii. Physical inactivity iv. Obesity v. Stress vi. Don't know	1. How many times do you need to take your child for vaccination? i.Vaccinations age birth to 5 years ii.. Seven times visit for vaccinations in 5 Years ii.Mark each Vaccination on Calendar iv. Don't Skip or forget any vaccination

	3. Sign and symptoms of the disease(dengue, malaria) i. Fever ii. Headache, body ache, Fever iii. Nausea and Vomiting iv. Don't know 4. Free blood examinations in govt health centers 5. Free treatment at all level 6. Acceptance of Indoor residual spray 7. Methods to prevent mosquito bites	3. a) Awareness about the risk factor for Cancer i. Smoking ii. Chewing tobacco iii. Alcohol iv. Don't know b) Cancer Symptoms: i. Lumps ii. Not Healing of wound/sore skill, iii. Prolong problems indigestion, iv. Excessive flow of white fluid, v. Blood spots even after mensuration cycle c) Cancer is curable with early diagnosis. 4. a) Awareness about the risk factor for diabetes mellitus i. Increasing age ii. A diet containing fat/ Fried Food iii. Physical inactivity iv. Obesity v. Stressful lifestyle vi. Don't know b) A healthy lifestyle can prevent diabetes i. Exercise/Yoga ii. Healthy Food Eating iii. Physical activities like games/walking etc. c) Awareness about the – sign and symptoms of diabetes	v. Responsibility of all of us vi. Most important Task for the health of the child vii. Vaccination protects/immunized child from dangerous diseases viii. All information is written on the immunization card x. Go for immunization even the child is sick. x. Take the card with you in case you are traveling xi. After a Vaccination child may get fever or swelling don't get frightened. 2. All vaccines are free of cost at the govt health facility 3. Name of the Celebrity depicted in the advertisement

		i. Frequent urination ii. Excessive thirst iii. Frequent hunger iv. Don't know	
C. Intend to change			
Do you or your family members disseminate the benefits of these advertisements to others?	1. Yes 2. No, why	1. Yes 2. No, why	1. Yes 2. No, why
Do you think these advertisements have been able to change your mind and action?	1. Yes 2. No, why	1. Yes 2. No, why	1. Yes 2. No
	Willingness to use bed nets if given a choice 1 Yes 2 No, why	Have you seen anyone consuming less sugar and fried food after getting exposed to these advertisements? 1. Yes 2. No Have you seen anyone quitting smoking/tobacco after understanding this advertisement? 1 Yes 2 No	Do you have/still have your child immunization card 1 Yes 2 No, why

Section3: Effectiveness of the advertisements (Show the advertisement) Now I am going to show you some advertisements about health and family welfare programme communication.

	3.1 National Vector Borne Disease Control Programme (NVBDCP) MALARIA, DENGUE	**3.2 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and**	**3.3 Immunization Mission Indradhanush**

		Stroke (NPCDCS)	
A. Comprehensiveness			
Are these advertisements enough to explain the details of the programme?	1. Yes 2. No, why	1. Yes 2. No, why	1. Yes 2. No, why
B. Clarity			
Is the message clear?	1. Yes 2. No, why	1. Yes 1 No, why	1. Yes 2. No
C. Appealing			
Are these advertisements appealing enough to catch/grab your attention?	1. Yes 2. No, why	1. Yes 2. No, why	1. Yes 2. No, why
What did you like the most in these advertisements?	1. The way the message was conveyed 2. Celebrity/Characters 3. Storyline 4. Music 5. Overall	1. The way the message was conveyed 2. Celebrity/Characters 3. Storyline 4. Music 5. Overall	1. The way the message was conveyed 2. Celebrity/Characters 3. Storyline 4. Music 5. Overall
Difficulty in understanding these advertisements?	1. Language 2. Message too fast 3. Too many messages 4. Any other, specify	1. Language 2. Message too fast 3. Too many messages 4. Any other, specify	1. Language 2. Message too fast 3. Too many messages 4. Any other, specify
D. Recall to action			
Have these advertisements able to explain what to do when you need assistance?	1. Yes 2. No, why	1. Yes 2. No, why	1. Yes 2. No, why
E. Sensitivity			
Is the advertisement acceptable and liked by all sections of society?	1. Yes 2. No, why	1. Yes 2. No, why	1. Yes 2. No, why

Section 4: Suggestions

	4.1 MALARIA, DENGUE	**4.2 Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke**	**4.3 Immunization Mission Indradhanush**
According to you, what should be the best medium to generate awareness amongst the community about this program?	1 Television 2 Posters 3 Newspaper 4Booklet/Pamphlets/leaflets 5 Awareness workshop/seminar 6 Any other specify	1 Television 2 Posters 3 Newspaper 4Booklet/Pamphlets/ leaflets 5 Awareness workshop/seminar 6 Any other specify	1 Television 2 Posters 3 Newspaper 4Booklet/Pamphlets/ leaflets 5 Awareness workshop /seminar 6 Any other specify

Thank you for your time and participation.

Research Tool 2

Indian Institute of Public Administration

Questionnaire for ASHA/ANM/Anganwadi worker/School Teachers

CONSENT FORM

Project Title: "Rapid Assessment of Swasth Nagrik Abhiyan (SNA) erstwhile IEC Programme of Ministry of Health and Family Welfare"

Principal Researchers: Dr. Pawan Kumar Taneja, and Dr. Roma Mitra Debnath Indian Institute of Public Administration, India

Sponsored By: NITI Aayog, Government of India

The Information, Education & Communication (IEC) strategy of the Ministry of Health and Family Welfare (MoHFW) aims to create awareness and disseminate information regarding the benefits available under various schemes/programmes of the Ministry and to guide the citizens on how to access them. The main of objective this study is to review the existing IEC activities to health and family welfare activities and suggest a framework to improve upon the Swasth Nagrik Abhiyaan (IEC programme) in the future. Participation in this research study is voluntary. You are not exposed to any risk by participating in this research. The interview will take approximately 20-25 minutes to complete. The interview will be recorded and transcribed for analysis. The results reported will be strictly anonymous; that is, no one involved in this study can identify you personally. Please note that you may withdraw your consent to participate in the study at any time. You do not have to assign any reason to withdraw from this research at any stage. If you have any complaints about any aspect of the study, then you may contact Dr. Pawan K. Taneja/Dr. Roma Mitra Debnath, Indian Institute of Public Administration, IP Estate, Ring Road New Delhi-110002. Email: pawanktaneja.iipa@gov.in, romadebnath.iipa@gov.in Telephone: +91-11-23468327/50.

I, _____, freely agree to participate in this study according to the conditions in the consent form.

Signature …… Date ……

SECTION: PROFILE

State				
District				
Location	**Rural**		**Urban**	
Block				
Name of Village				

ASHA		**ANM**		**AWW**		**School Teacher**	

Age : | 15 – 24 years | 25 – 34 years | 35 – 44 years | 45 years above |

Gender : | Male | Female |

Educational Status:

Primary	Middle	Secondary	High secondary
Graduate and above	Diploma	Other – Specify	

Marital Status : | Married | Unmarried | Divorced/ Separated/Widowed |

Working Experience in the position:

Year		Month	

Social category : | Scheduled Caste | Scheduled Tribe | Other Backward Class | General |

Mob/Contact No. : _____

SECTION 1: media access

1.3 Do you have access and how often you use

	Never	Daily	Weekly	Fortnight	Monthly
TV					
Radio					
Social Media					
Newspaper					
Mid Media					

SECTION 2: Exposure/Reach/Recall to MOHFW Messages/campaign

2.1 Have you ever seen any advertisement /posters educating health and family welfare programme in last 1 year? | Yes | | No | |

2.1.1 If yes, please tell us following about those advertisement/education material

Disease	Advertisement/Material	**Media** (TV, Radio, Social Media, Print Media, Cinema, Mid Media)	**Channel** (If TV: DD/ Private Channel/Regional; Social Media: FB/WhatsApp, Print (Newspaper/ Magazine); Mid Media (Street Play/ Wall Painting/ Movie/ Road show/ Banner)

SECTION 3-5: SPECIFIC MOHFW IEC REACH/EXPOSURE –

3. Immunisation

3.1 Have you seen any Advertisement/Education Material Related to Mission Indradhanush? | Yes | | No | |

3.2 If yes, please tell us following about those advertisement/education material

Advertisement/Material	**Media** (TV, Radio, Social Media, Print Media, Cinema, Mid Media)	**Channel** (If TV: DD/ Private Channel/Regional; Social Media: FB/WhatsApp, Print (Newspaper/ Magazine); Mid Media (Street Play/ Wall Painting/ Movie/ Road show/

		Banner)

3.3 Key Message do you remember

(If not Seen the advertisement show one advertisement)

3.4 Express your Opinion on-

1	Is it suitable for the community?	Yes	No
2	Do you like this add?	Yes	No
2.1	What do like in the advertisement?		
2.2	Why do you like this advertisement?		
3	Have you understood this advertisement?	Yes	No
3.1	What you understand?		

4. Non- Communicable Disease

4.1 Have you seen any Advertisement/Education Material Related to Cancer/Diabetes/BP/Heart Disease?

Yes		No	

4.2 If yes, please tell us following about those advertisement/education material

Advertisement/Material	**Media** (TV, Radio, Social	**Channel** (If TV: DD/ Private

	Media, Print Media, Cinema, Mid Media)	Channel/Regional; Social Media: FB/WhatsApp, Print (Newspaper/ Magazine); Mid Media (Street Play/ Wall Painting/ Movie/ Road show/ Banner)

4.3 Key Message do you remember

(If not Seen the advertisement show one advertisement)

4.4 Express your Opinion on-

1	Is it suitable for the community?	Yes	No
2	Do you like this add?	Yes	No
2.1	What do like in the advertisement?		
2.2	Why do you like this advertisement?		
3	Have you understood this advertisement?	Yes	No
3.1	What you understand?		

5. **NVBDP - Dengue/Malaria**

5.1 Have you seen any Advertisement/Education Material Related to Dengue/Malaria/ Other Vector Born Disease?

Yes		No	

5.2 If yes, please tell us following about those advertisement/education material

Advertisement/Material	**Media** (TV, Radio, Social Media, Print Media, Cinema, Mid Media)	**Channel** (If TV: DD/ Private Channel/Regional; Social Media: FB/WhatsApp, Print (Newspaper/ Magazine); Mid Media (Street Play/ Wall Painting/ Movie/ Road show/ Banner)

5.3 Key Message do you remember

(If not Seen the advertisement show one advertisement)

5.4 Express your Opinion on-

1	Is it suitable for the community?	Yes	No
2	Do you like this add?	Yes	No
2.1	What do like in the advertisement?		
2.2	Why do you like this advertisement?		
3	Have you understood this advertisement?	Yes	No
3.1	What you understand?		

SECTION 6: DEPARTMENT/CENTRAL IEC/OPERATIONS/TRAINING

6.1	Have you received any IEC materials from the department?	Yes	No

6.1.1	Which material?						
6.1.4	How it is used?	Distribute	Use in meeting	Showcase	Display/Demonstrate	Other ways	
6.2	Do you maintain record of stock?	Yes	No				
6.2.1	If yes, how do you maintain						
6.2.2	Where do you maintain?						
6.3	Have you received Guidelines/ instruction or training to use these specific materials?	Yes	No				
6.3.1	If yes, What						
6.3.2	When						
6.3.3	Where						
6.3.4	By whom						

SECTION 7: CHANGE/IMPACT/STRATEGY/INCLUSION

7.1	Have the "buzz" created by the IEC activities helped you in your mobilization or communication with the community members in the village?	**Yes**	**No**	**How**	
7.2	Have community members asked/ inquired/ talked for further information or clarification about the messages given in the IEC materials?	**Yes**	**No**		
7.3	Have you seen any change of behaviour or action in the community members as a result of the information given in the IEC materials?				
		What change in behaviour			
7.3.1	**General**				
7.3.2	**Immunisation**	**People ask about Immunization date and time**	**Full immunization?**	**Are they asking for referral?**	**Preventive activities**
7.3.3	**NCD**	**Are they going for screening/Testing?**	**Are they going for screening?**	**Asking for referral**	**Preventive activities**
7.3.4	**Dengue/Malaria**	**Are they using bed nets?**	**Are they going for fogging or**	**Seeking information about**	**Preventive activities**

			not?	**blood test in case of fever continuation**	

SECTION 8: Suggestions –

8.1 Would you like to recommend any modifications in these advertisements to make it more consumers friendly?

8.2 Do you recommend any other means to reach to the masses, especially most vulnerable segments?

Thank you for your time and participation.

Name of the investigator _____

Contact details _____

Research Tool 3

Indian Institute of Public Administration

FGD Guide (Male/Female) (Urban/Rural)

CONSENT FORM

Project Title: "Rapid Assessment of Swasth Nagrik Abhiyan (SNA) erstwhile IEC Programme of Ministry of Health and Family Welfare"

Principal Researchers: Dr. Pawan Kumar Taneja, and Dr. Roma Mitra Debnath Indian Institute of Public Administration, India

Sponsored By: NITI Aayog, Government of India

The Information, Education & Communication (IEC) strategy of Ministry of Health and Family Welfare (MoHFW) aims to create awareness and disseminate information regarding the benefits available under various schemes/programmes of the Ministry and to guide the citizens on how to access them. The main of objective this study is to review the existing IEC activities with respect to health and family welfare activities and suggest a framework to improve upon the Swasth Nagrik Abhiyaan (IEC programme) in the future. Participation in this research study is voluntary. You are not exposed to any risk by participating in this research. The discussion will take approximately 20-25 minutes to complete. Discussion will be audio recorded. The results reported will be strictly anonymous; that is, no one involved in this study can identify you personally. Please note that you may withdraw your consent to participate in the study at any time. You do not have to assign any reason to withdraw from this research at any stage. If you have any complaints about any aspect of the study, then you may contact Dr. Pawan K. Taneja/Dr. Roma Mitra Debntah , Indian Institute of Public Administration, IP Estate, Ring Road New Delhi-110002. Email: pawanktaneja.iipa@gov.in, romadebnath.iipa@gov.in Telephone: +91-11-23468327/50.

I,_____, freely agree to participate in this study according to the conditions in the consent form.

Signature …… Date ……

SECTION 1: PROFILE

State				
District				
Location	**Rural**		**Urban**	
Block				
Name of Village/City				
Date				

Name (Optional) : _____

Age :

Gender

15 – 24 years	25 – 34 years	35 – 44 years	45 years above
Male	Female	Other	

Educational Status :

Illiterate	Literate without schooling	Primary	Middle
Secondary	High secondary	Graduate and above	Other

Mobile/Contact number: _____ Marital Status

Married	Unmarried	Divorced/ Separated/widowed

Occupation

Self employed	Agriculture	Service	Housewife	Retired	Student	Unemployed

Social category : SC/ST/OBC/ Gen

Introduce yourself and the members of team. Share the purpose/objective of the meeting. If the deliberation is being voice recorded, inform and take consent. Explain that this is for research purpose only and will be kept confidential and will not be used for any other purpose. Inform that this a group activity and all are encouraged to participate actively and freely. There is nothing right or wrong in what they feel or react to the question or opinion and we are neutrally listening to the and there is no judgement about what they say, tell or share with us. This meeting would take about 30-45 minutes. So, once again, thank you very much for coming and being a part of this exercise.

Background

Health is important component of our lives. But right information and correct information and awareness is very important for prevention as well as treatment and cure. As they say prevention is better than cure. So the Government through the Ministry of Health and Family Welfare makes these programmes and material and activities to inform people about various diseases, illness, conditions, schemes, services, signs and symptoms, dangerous, prevention methods and when to and where to go for information and services. In the village there are health sub centers, PHCs, CHC and district hospitals and of course one can also go to the private sector providers.

1. So are you aware of the Health Sub Center in your village? There is the Nurse Behanji, ASHA Didi and the doctor in the local hospital. Also you have access to newspapers, TV, Radio and now a days' mobile phone which connect you with others and the world.
2. Do you sometime listen to radio, See TV or even go to the cinema hall to see films? What health messages do you remember having seen on TV or Radio? PROBE/PROMPT
3. Mobile phone is much more that talking to someone or receiving a phone call from someone? What would you say? What else can be or are the uses of the mobile phone? SMS? Taking pictures, seeing videos, Internet? Have you received some SMS on your mobile informing you about, e.g. about immunization day and your child requiring the injection? PROBE/PROMPT
4. It is also possible that you would have seen some posters, leaflets, banners, wall writing, nukkad natak, exhibition, miking in your village? Ask who and what they have seen. PROBE/PROMPT
5. So now I am going to ask you about some specific messages about some health programmes and ask you if you have seen them recently of in last one year.
    - **Immunization, Tikakaran**, What have you seen, where have seen, what key message do you recall? Has that been useful to you? Effective?

- **Dengue/Malaria** What have you seen, where have seen, what key message do you recall? Has that been useful to you? Effective?
- **Diabetes, Obesity, Heart attack, Cancer** What have you seen, where have seen, what key message do you recall? Has that been useful to you? Effective?

Show some samples of the three specific campaigns and ask recall and opinion, effectiveness, PROBE/PROMPT. ANY SUGGESTIONS, THANK YOU

Research Tool 4

IDI-SPM/DPM/BCM Interview Guide

1. What is the organisational structure and how much manpower is working for IEC activities in the District/ State/Block?
2. What your annual budget for IEC activities?
3. Is budget sufficient for the implementation of the IEC activities under these programmes as per the need?
4. How IEC activities are planned for different national level, NHM and State Programmes?
5. How media plans are made for different IEC activities?
6. What were the activities planned in the last year and what is plan for the current year for IEC programmes?
7. Do you have any special plan for the following:
    a) Immunization Mission Indradhanush
    b) National Vector Borne Disease Control Programme (NVBDCP)
    c) National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)
8. What all different media channels/mediums are being used?
9. What all different IEC materials you are being used and how you ensure that these materials reach to the target audience?
10. How do you coordinate your activities (field activities) with NHM and Central IEC activities?
11. How do you plan to serve different segments of population especially underserved areas?
12. IEC materials which you receive, are they in local language? If not, then how standard IEC material is converted into local language?
13. Do you have the sufficient manpower to smooth functioning of your activities?
14. Have you given with any training or have you attended any capacity building workshop for the same?
15. How do you build capacity of different staff at District/Block/Village level?
16. Have you done any formative study, baseline and need assessment study for IEC activities in your State/District/Block

17. How monitoring of the IEC activities under these programmes are done?
18. How frequently this monitoring and supervision is done?
19. Have you conducted any Impact Assessment study for IEC under any programme?
20. What is your reporting mechanism?
21. What are the issues and challenges faced during the implementation of the IEC activities in your state/district/Block?

ANNEXURE 2: MOU WITH AIR

MEMORANDUM OF UNDERSTANDING

Between

MINISTRY OF HEALTH & FAMILY WELFARE

And

All INDIA RADIO (PRASAR BHARATI)

The Memorandum of Understanding (MoU) made between All India Radio, Prasar Bharati (India's Public Service Broadcaster), acting in its executive capacity through the Additional Director General(C), All India Radio, Akashwani Bhawan, New Delhi (hereinafter referred to as "All India Radio, Prasar Bharati") ON THE ONE PART and the Ministry of Health and Family Welfare, Government of India acting in its executive capacity through Joint Secretary, Department of Health & Family Welfare, Nirman Bhawan, New Delhi (Hereinafter referred to as H&FW) ON THE OTHER PART.

Whereas the parties intend to enter into as agreement to facilitate broadcast of audio spots in different formats (hereinafter referred to as "spots") on the terms and conditions given hereunder, it is hereby agreed as follows:

1. The spots produced and provided by Ministry of Health & Family Welfare under this MOU would aim at informing and educating the target group of audience through terrestrial channels of All India Radio (AIR).

2. The media plans will be worked out from time to time as per requirements of the Ministry of Health & Family Welfare.

3. AIR shall work out Broadcast schedule in consultation with Ministry of Health & Family Welfare for National and Regional levels. AIR will, however, be within its rights to effect any changes in the schedule if programme exigencies so require with prior information given to Ministry of Health & Family Welfare.

4. Ministry of Health & Family Welfare will provide the software (spots) to All India Radio. All India Radio stands indemnified against any legal dispute for its content.

5. In all spots, high technical/aesthetic standards will be maintained by Ministry of Health & Family Welfare, All India Radio reserves the right to reject if any spot is not technically and aesthetically up-to-the-mark and All India Radio will inform Ministry of Health & Family Welfare about the spots rejected and the basis thereof.

6. Ministry of Health & Family Welfare will be given free airtime as per guidelines of the Prasar Bharati on giving IEC/Media campaign amount to principal amount of Rs. 30,42,79,272/- (including Service Tax as well as less 15% agency commission)

7. Ministry of Health & Family Welfare will make the payment to All India Radio as per GFR.

8. All India Radio will be dealing **only with IEC Division of Ministry of Health & Family Welfare which will be responsible for providing funds**.

9. This MOU shall be in operation for Financial Year 2017-18 only, unless extended further by mutual consultations.

This MOU signed on 20th day of March 2017 by **Ms. VANDANA GURNANI**, Joint Secretary, Ministry of Health & Family Welfare and **Sh. SAURAV KUMAR JAIPURIYAR,** Addl. Director General (C), All India Radio (Broadcasting Corporation of India).

(VANDANA GURNANI)
JOINT SECRETARY
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

(Sh. SAURAV KUMAR JAIPURIYAR)
ADDL. DIRECTOR GENERAL(C)
ALL INDIA RADIO

ANNEXURE 3: LIST OF PARTICIPANTS FOR NATIONAL CONSULTATION WORKSHOP ON DECEMBER 19, 2019

National Consultation Workshop on Rapid Assessment of Swasth Nagrik Abhiyan (SNA) erstwhile IEC Programme

S.No.	Name of Participant	Designation/Address	Mobile No./Email
1.	Padmaja Singh	Joint Secretary MoHFW	011-23061656 Padmaja.singh@nic.in
2.	Shri Suresh.k.Vatta	MOHFW	011-23231666 skvatta@yahoo.com
3.	Raman Prasad	MOHFW	011-23061960 Ramanprp.d@gmail.com
4.	Dr. Niraj Kulshreshtha	MOHFW	9810162485 n.kulshrestha@nic.in
5.	Dr.Niranjan Saggurti	India country Director Population Council	9871211195 nsaggurti@popcouncil.org
6.	Dr.Devashish Bhattacharyya	Director, CHEB	9868201236 dir.cheb@nic.in
7.	RK Sarkar	MoHFW	9810653499 rajusarkar@gmail.com
8.	Ziley Singh Vical	Deputy Secretary MoHFW	9871773328 Ziley.vical@nic.in
9.	Dilip Kumar Sahu	Under Secretary MoHFW	9868936830 Dilip.sahu@gov.in
10.	Dr. Ajay Trakroo	Health Specialist UNICEF	9424201597 atrakroo@unicef.org
11.	Dr. Mayank Shersiya	Senior Consultant, MoHFW	9654007166 Drmayankshersiya.mohfw@gmail.com
12.	Dr. Padam Khanna	Senior Consultant, NHSRC	padamkhanna@rediffmail.com
13.	Dr. Pooja	MoHFW	9811833118 Drpooja.mohfw@yahoo.in
14.	Prof. Poonam Khattar	Head, Department of communications	9910211552 poonamkhattar@gmail.com
15.	Dr. M.A.Elangoran	Deputy Director Tamil Nadu	9443556775 dfwtlr@gmail.com
16.	Raj Kamal Sharma	Consultant, NHM-I MoHFW	9062576910 rajkamal.mohfw@gmail.com
17.	Dr. Pawan Taneja	Faculty IIPA	9818210463 dr.p.k.taneja@gmail.com
18.	Dr. Roma Mitra Debnath	Faculty IIPA	9310338939 Roma.mitra@gmail.com
19.	Dr. Sanjeev Kumar	Consultant IIPA	9810162474 sanjeevbcc@yahoo.co.in
20.	Dr. Shalini Manocha	Consultant IIPA	9654548016 shalinimanocha152@gmail.com
21.	Nina Badgaiyan	Consultant, NITI Aayog	nina.badgaiyan@nic.in

भारतीय लोक प्रशासन संस्थान

Indian Institute of Public Administration

Indraprastha Estate, Ring Road, Mahatma Gandhi Marg,
New Delhi, Delhi 110002