Social and Behaviour Change (SBC) for SRHR, including FP: *India on the Move*

IAPPD

Indian Association of Parliamentarians on

Population and Development

Social and Behaviour Change (SBC) for SRHR, including FP:

India on the Move

A Qualitative Enquiry*

(*Review Monograph*)

Dr. Deepak Gupta and

Prof. J. S. Yadav

Indian Association of Parliamentarians on Population & Development

This paper is based on the secondary data analysis, literature review and qualitative assessment gauged through the key informant interviews (KIIs) held with a select national experts.

TABLE OF CONTENTS

Message

IAPPD strives for advocating accessible, affordable and good quality sexual and reproductive health, including family planning (SRH/FP), services to all the Indian citizens. It conducted qualitative research of the Social and Behavioural Change (SBC) dimension of the national programme. The study report is presented in this volume as a qualitative monograph analysing the evolution of health communication and the current challenges and opportunities therein.

It is well recognized that the SRH/FP sector is confronted with multiple behavioural stumbling blocks. Addressing these barriers requires thorough understanding of multiple behavioural drivers and the social determinants under which the SRH/FP decisions are made. Therefore, considered resources, both technical capacities and skills, are suggested in strengthening the proven approach of social and behaviour change and community engagement.

I hope, the readers of this study will find it useful in their programming, research and academic pursuits.

Prof. P.J. Kurien
Chairman, IAPPD

About Shri Sat Paul Mittal, MP, Founder Chairman IAPPD

Shri Sat Paul Mittal started his political career when he was a student. He was actively involved in addressing problems concerning the youth. In 1958, Pandit Jawahar Lal Nehru picked him as Deputy Leader of the Indian Youth Delegation to the former Soviet Union where he met top Soviet leaders including the then Prime Minister Nikita Khrushchev.

An excellent orator and a keen debater, Shri Mittal gained prominence in Punjab's legislative circles in 1961 when he was elected to the Legislative Council. He became Deputy Minister for Home in Punjab. He was elected twice to the Rajya Sabha for a term of six years each in 1976 and 1982. Further, President of India nominated him as a member of the Rajya Sabha in appreciation of his contribution to the public causes especially his dedication to the cause of the downtrodden and towards population issues globally.

Throughout his political career, Shri Mittal was part of several industry associations and policymaking bodies and served as Member of Parliament; Chairman, Indian Association of Parliamentarians on Population and Development (IAPPD) and Centre for Parliamentarians on Population and Development (CPPD); Founder, Secretary General and Vice Chairman, Asian Forum of Parliamentarians on Population and Development (AFPPD); Secretary General Emeritus, Global Committee of Parliamentarians on Population and Development (GCPPD); Co-Chairman, Global Forum of Spiritual and Parliamentary Leaders on Human Survival; Chairman, Parliamentarians Action for Removal of Apartheid (PARA-India); President, Nehru Sidhant Kender Trust (NSKT); Vice President, Punjab Pradesh Congress Committee (PPCC); Member, All India Congress Committee (AICC); Member, Indian Council of World Affairs (ICWA) and Member, Advisory Panel of Indian Council of Cultural Relations (ICCR) for South and South-East Asia.

As Chairman of IAPPD, he took upon himself the daunting task of tackling the problems of population facing the country and made it a peoples' movement. He single-handedly established the Centre of Parliamentarians on Population and

Development involving all Parliamentarians irrespective of their political affiliation. Unique in Asia, the Centre catered to ideological orientation courses, seminars and data information on population, development and related subjects.

Shri Sat Paul Mittal's perseverance and zeal in promoting new ideas on population control, world peace and development were recognized world-wide when the United Nations Secretary General, Mr. Javier Perez De Cuellar, decorated him with the prestigious United Nations Peace Medal in 1987.

He organized several National and International conferences which involved spiritual and parliamentary leaders as he believed that they could influence communities. He spoke passionately at the historic Global Survival Conference at Oxford in 1988 and in Moscow in 1990 and made valuable suggestions for human survival and sustainable development.

He was equally concerned about apartheid in South Africa. He organized a conference of parliamentarians from several countries in Delhi where a joint declaration was made condemning apartheid. It was presented to the Indian Prime Minister. Shri. Rajiv Gandhi, the then Prime Minister appreciated his Shri Mittal's efforts.

At a prayer meeting held in Shri Mittal's memory on January 24th 1992, the then Prime Minster, Shri. P.V. Narasimha Rao described Shri Mittal as a man of very strong will power who was passionately involved in activities related to population and development and had observed that Shri Mittal's presence at any meeting would ensure that a balanced result would emerge out of the discussions.

Posterity will gratefully remember the significant contribution made by him in giving direction to the parliamentary movement in promoting basic awareness and understanding of population and human survival issues in the world.

ABBREVIATIONS

BCC	Behavior Change Communication
SBC	Social & Behaviour Change
SBCC	Social & Behavior Change Communication
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Scheme /Services
IEC	Information Education Communication
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IPCD	International Conference on Population and Development
IAPPD	Indian Association of Parliamentarians on Population & Development
C4D	Communication for Development
MOHFW	Ministry of Health and Family Welfare
NGO	Non-government Organization
KIIs	Key Informants Interviews
NFHS	National Family Health Survey
RCH	Reproductive and Child Health
SRH	Sexual & Reproductive Health
SRH/FP	Sexual & Reproductive Health, including Family Planning
SRHR	Sexual & Reproductive Health and Rights
SDGs	Sustainable Development Goals
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
IUCD	Intra Uterine Contraceptive Device
TFR	Total Fertility Rate
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
PHC	Primary Health Center
MPV	Mission Parivar Vikas
SHGs	Self Help Groups
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
SIFPSA	State Innovations in Family Planning Services Project Agency
JHU-CCP	Johns Hopkins University, Center for Communication Programs
USAID	United States Agency for International Development
WHO	World Health Organization
WB	The World Bank

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We are grateful to many widely acclaimed experts in the field of Population, Family Planning services and Health Communication, such as Dr. Poonam Muthreja (Executive Director, Population Foundation of India – PFI) and Mr. Alok Vajpeyi, PFI, Dr. Sikdar (formerly with the MOHFW, Govt. of India), Dr. Punia and Dr. Chillar (Sr. CMOs, Haryana), and the other IEC staff of the district health services, Mr. Bhai Shelly (C4D Specialist, UNICEF Lucknow/UP), and Mr. Samresh Sengupta (IEC expert & former USAID expert) and others. Their active participation in the KIIs provided deep insights in conducting the analysis of the SBCC sector in the context of SRHR/FP issues.

Authors also wish to specially acknowledge the research study *(Deshmukh & Chaniana, 2020)* which brought in the forefront a few highly relevant and pointed results on the issue of adolescents' sexuality and sexual health issues. The outcomes of the study are appropriately quoted in the current analysis.

We are also grateful to the IAPPD's office team for their very enthusiastic and energetic collaboration for they volunteered in facilitating gathering information and in conducting the KIIs with the well-known experts in the Health & Population Communication sector.

- Authors

A NOTE ON AUTHORS

Dr. Gupta, Deepak

Dr. Gupta has several decades of extensive experience in the areas of development programming; strategic communication, including Social and Behaviour Change (SBC), Community Mobilization & Advocacy (civil society, political & media advocacy) – Design, Programming, Review, Monitoring & Evaluation and Mentoring/Leading multicultural teams. His experience with the **UN system (UNFPA, UNODC, UNICEF and WHO)** commenced in 1991; it includes relentless field work experience in the entire South Asia region, many South- East Asian countries and in Mongolia & Ethiopia. With a **Doctorate in Strategic Communication**, Dr Gupta has a Master's degree in Sociology, Advances course in Health Communication from the Johns Hopkins University (JHU), Baltimore (USA), an Advance Certificate in Information & Communication from the DPI, UN HQs (NY/USA) and an advance course from LSHTM (UK) in Ebola Virus – Prevention, Care & Treatment. He has many published papers to his credit in the international & national peer-reviewed scientific journals and publications. Dr. Gupta was awarded the **National Award – 1996**, the highest civic honor for Youth conferred for his contributions to youth leadership & development communication. (Email: drguptad11@gmail.com , Mobile: +91-9810105423)

Prof. Yadav, J. S

Dr. J.S. Yadav is the **Chairman of Communication Management Foundation (CMF)** and International Media Institute (IMI) New Delhi. Earlier he was the **Director of Indian Institute of Mass Communication**, New Delhi, premier national Institute of communication for 12 years and professor for 18 years. He has published six books, over 150 articles in professional journals and popular newspapers/magazines. He has a Ph.D in Social Anthropology from Delhi University and an Advance course in Communication Policy and Planning UNESCO/AIBD. He conducted/coordinated over 150 national/ international research projects. He has served as a consultant to many bilateral and multilateral organizations like WHO, World Bank, UNICEF,

USAID, EU, DANIDA, GHK, Plan India-International etc. Dr. Yadav has extensive experience in advocacy, campaign design and capacity building for social behavior change communication (SBCC). He planned and conducted several national and international orientation and skill development workshops for media and development professionals.

He closely worked with Ministry of Information and Broadcasting and had opportunities of interacting with senior officials of other Ministries, Departments of Central and State governments, and served many committees and technical advisory groups of the Government and international agencies. (Email: drjsyadav16@gmail.com, Mobile: +91-9810355350)

SYNOPSIS

This IAPPD supported monograph, titled 'Social and Behaviour Change (SBC) for SRHR, including FP: *India on the Move*', is a modest attempt to qualitatively capture the evolution of the health communication component (erstwhile termed as 'IEC') of the Sexual & Reproductive Health, including Family Planning (FP) programme in India. Through the process of literature review, experts-based KIIs (key informant interviews) and secondary analysis, the authors also reflected on the theoretical underpinnings and conceptual frameworks that have been employed, from time to time, in designing strategic interventions under the health communication for the SRH/FP programmes. Based on the wide-spectrum analysis, a set of very pointed recommendations and conclusions were drawn that are consolidated in the last section.

Key Messages from Sections

Section-1

Recognizing the link between population and development, India initiated the Family Planning program in 1951 soon after her Independence in1947. Since then, the program expanded and many streams were added on in light of experience and the ground realities. However, the thrust of the family planning remained on 'small family' and 'population stabilization'.

Communication for population stabilization would necessitate orientation and skill development, motivation, commitment and communication skills of all the stakeholders in Family Planning /Family Welfare program. These include policy makers (including Elected Representative), planners, experts, service providers, officials, the target groups, and the community so as to accept, adapt and adopt the suggested behaviour change and practices.

Section -2

Reaching correct and timely information to (*and shared knowledge with*) individuals and community is the key first step towards bringing about a positive behaviour change on SRH & FP issues. Scientifically designed social & behaviour change interventions – based on time-tested conceptual framework on health communications – help in delivering desired results. Community engagement and ownership of the SRH/FP programme, through proactive participatory methods, is an essential element of a successful and rights-based SRH/FP programme.

Section – 3

Based on multiple research studies, generated programme evidence and per the conceptual frameworks on social & behavioural change, the need for more comprehensive and sustained behaviour-change strategy on SRH for promoting enhanced engagement with the adolescents and young people cannot be emphasized more. It must substantively cover the issues of better parent-based interpersonal communication. In addition to a strengthened parent-child communication on SRH issues, a well branded multi-media campaign penetrating through varied platforms, including new-media and digital space will be a complementing SBC strategy; thus, reinforcing the core messages through heightened reach, recall and reiteration value.

Section – 4

KIIs held with renowned experts in the health and communication sector, by and large, opined that scientific design of social & behaviour change is integral to the rights-based and results-driven SRH/FP programmes. Building SBCC technical skills of managers and providers and institutional capacity of all those departments and organizations that are engaged in SRH/FP communication design/delivery is of paramount significance. Regular field monitoring of SBCC interventions, thus comparing the data with the desired outcomes, needs strengthening under the SRH/FP programme.

Section – 5

Effective and results-based SBC strategies use concepts that range from psycho-social learning theories of role modeling communicated via multiple modes, including mass media, to the use of advocacy and social mobilization. Dialogue with and active participation of individuals is an essential element in communication for behaviour and social change, especially in the SRH/FP interventions. Many communication programmes have for long focused much on the metaphorical 'tree' and not enough on the 'forest', i.e. the attention was on the individual as the focus for change. For behaviours to change on a large scale, harmful cultural values, societal norms and structural inequalities have to be taken into consideration. Effective communication strategies have to be cognizant of and in tune with the policy and legislative environment and linked to the service delivery aspects.

Section 1

India's Sexual & Reproductive Health Programme – Communication is the Key

Mere awareness generation through various IEC (Information, Education, and Communication) strategies about SRHR (Sexual & Reproductive Health and Rights), including varied FP (family planning) methods and services that the Government and other agencies are providing is not enough. Rather, there is a need for Social and Behaviour Change in the target audiences regarding a whole set of beliefs and practices having bearing upon SRHR/FP; wherein communication plays a significant role.

Communication is the essence of organized human life. It is essential for both continuity and change. In the context of SRH, communication is a process of exchange of information, ideas, and values that shapes the perception, and leads to action and behaviour related to sexual & reproductive health and family planning.

SRHR touches life from womb to tomb. Hence, it is important. SRH Communication/Population Communication terms used in the post ICPD writings/literature need to be strengthened across all sectors and levels. It involves awareness, orientation, commitment, and skill development including communication skills of all stakeholders-policy makers, service providers, and users to achieve the SRHR/FP objectives and move toward achieving Sustainable Development Goals by 2030 thereby successfully meeting not only the current challenges but also new challenges of Covid-19 and its variants and sub-variants like Omicron.

Recognizing the link between population and socio-economic development, India was one of the first countries in the world to adopt the Family Planning Program as a part of its planning and development process in 1951.

India's Five-Year Plans

The First Five Year Plan (1951-19560) stated that the main appeal for family planning is based on the consideration of the health and welfare of the family. Family limitation or spacing of children is necessary and desirable to secure better health for the mother and better care and upbringing of children.

The Second Five Year Plan (1956-1961): Pointed out that the rate of population increase was one of the key factors in the development and underscored the fact that a high rate of population growth is bound to affect adversely the rate of economic advancement and living standards per capita.

The Third Five Year Plan (1961-1966): While considering population control in the context of long-term development stated that the objective of stabilizing the growth of the population over a reasonable period is a must and therefore it should be at the centre of planned development.

The Fourth Five Year Plan (1969-1974): Viewed population not only from the point of view of economic development but also from that of the social change. The quest for equality and dignity of people requires a high rate of economic growth and a low rate of population increase. Even far-reaching changes in the social and economic fields will not lead to a better life unless population growth is controlled. The limitation in family size is an essential and inescapable ingredient of development. For this, the timeline and target-oriented approach to family planning was introduced in the fourth plan and that continued in the fifth plan.

The Fifth Five Year Plan (1974-1979) also laid down targets for a birth rate of 25 per thousand and a population growth rate of 1.4 percent by the end of the sixth plan period.

In April 1976, the Ministry of Health and Family Panning introduced a national population policy. The policy envisaged a series of fundamental

measures including raising the age at marriage, female education, the spread of population values and the small family norm, strengthening of research in reproductive biology and contraception, incentives for individuals, groups, and communities, and permitting state legislatures to enact legislation for compulsory sterilization.

The Sixth Five Year Plan (1980-1985): The sixth five-year plan laid down the long-term demographic goal of reducing the net reproduction rate (NRR) to one by 1996 for the country as a whole and by 2001 in all the states. The implications of these long-term demographic goals are as follows:

Table-1

Indicators	**Year 1978**	**Year-1996**
A. Birth rate per thousand population	33	21
B. Death rate per thousand population	14	09
C. Infant Mortality Rate	129	60
C. The average size as the family	4.2	2.3

Further, the plan envisaged that as against 22 percent of eligible couples protected in 1979-80, 60 percent will be protected by the year 1984-85; and the population of India will be around 900 million by the turn of the century and will stabilize at 1200 million by the year 2050.

In the seventh five-year plan (1985-1990) the focus of the family planning program shifted to "family welfare" and "human resources development" to improve the quality of life of the people. Further, the promotion of the family planning programme was to be on a voluntary basis as a people's movement. The health policy had targeted a long-term demographic goal of reaching a net reproduction rate of 1 by the year 2000.

Eighth five-year plan (1992-1997): It was towards human development that health and population control were listed as two of the six priorities (literacy, primary health care, provision of adequate food, safe drinking water, employment generation, and basic infrastructure) as objectives of the eighth plan.

The eighth plan had targeted achieving the following demographic goals by 1997.

A. Crude birth rate 26.1
B. Effective couples protection rate 56.1
C. Infant mortality rate 70.1
D. Literacy rate 75.1
E. Net reproduction rate equal to unity by the period 2011-2016.

To achieve the above-mentioned targets the Government had prepared an "Action plan" which had the following features:

- Improving the quality of family welfare services.
- Introducing a new package of compensation and incentives with the cooperation of the State Governments.
- Initiating innovative programmes in the urban slums for propagating family welfare.
- Adopting a differential strategy for focusing attention on 90 districts of the country where the crude birth rate is above 39 per thousand.
- Increasing the involvement of voluntary agencies and private organizations in the family welfare programme.
- Linking grants that are provided to the state governments for rural development and poverty alleviation to districts based on their performance in the birth rate.
- Reducing a strong preference for a son on part of a family having one or two daughters by providing social security measures.

During the eighth plan, a sum of Rs. 6500 crores was spent on the implementation of the programme. The Plan envisaged a series of incentives and disincentives to promote and popularize the family

planning programme. The incentives had been given to the employees of the central government, state government, and public sector undertakings who had accepted the two-child norm. These incentives included special increments, a cash award, priority in house-building schemes, and grant of leave travel concession benefits. Disincentives included a restriction on free medical benefits, no maternity leave, and no preference for government services.

Ninth five-year plan 1998-2002 abolished centrally defined method-specific targets for family planning. The emphasis shifted to decentralized planning at the district level based on the assessment of community needs and the implementation of programmes aimed at fulfillment of these needs. The state-specific goals for process and impact parameters for maternal and child health and contraceptive care were worked out and used for monitoring progress. Efforts were made to improve the quality and content of services through training to upgrade skills for all personnel and build up a referral network.

During the tenth five-year plan (2002-2007) the paradigm shift that began in the ninth plan continued. The focus was on enabling couples to achieve their reproductive goals and meeting all their unmet needs for contraception and reducing unwanted pregnancies.

The eleventh five-year plan (2007-2011) continued to advocate fertility regulation through voluntary and informed consent.

Outlay and expenditure of family welfare programme over different plan periods in India:

It is clear from the above analysis that the family planning program in India witnessed many changes and paradigm shifts. In the process, the programme expanded over the years, and various schemes were initiated in light of the experience of ground realities. These among others included: RCH, SRH, ICDS, Immunization, RMNCH+, etc. The purpose was small family, healthy family, the welfare of the people, and

development and growth of the country. The thrust all along was on lowering the TFR (Total Fertility Rate) and IMR (Infant Mortality Rate).

Some of the Milestones of the SRH & FP journey and IEC/SBCC that can be identified are as follows:

Independent India 1947 to Emergency 1975

The Founding Fathers of Independent India opted for a democratic, secular, and socialist India and adopted Five Year Plan process for the development and growth of the country.

Percent Outlay Investment

(%)

Plan	Health	Family welfare	Ayush	Total
First plan	3.3	0.1	--	3.4
Second plan	3.0	0.1	--	3.1
Third plan	2.6	0.3	--	2.9
Fourth plan	2.1	1.8	--	3.9
Fifth plan	1.9	1.2	--	3.1
Sixth plan	1.8	1.3	--	3.1
Seventh plan	1.7	1.4	--	3.1
Eighth plan	1.7	1.5	0.02	3.2
Ninth plan	2.31	1.76	0.03	4.02
Tenth plan	2.09	1.83	0.05	3.9
Eleventh plan	6.3	merged with Health	0.18	6.5

Source: Ministry of Health and Family Welfare.
Family Welfare Programme in India Year book, 2011.
Government of India

As part of the planning process for development, it was realized and emphasized in the First Five Tear Plan (1951-56) itself that peoples' participation was essential to achieve development objectives and for this, there was a need for communicating with the concerned people through all possible mean of communication viz. mass media, exhibition, folk forms, and interpersonal communication. Towards this, the Government played a major role in strengthening and expanding infrastructure facilities for communication with the masses.

India adopted a Community Development approach and top-down agriculture extension strategy and methods for increasing food

production and fighting hunger. Similarly, the country adopted Family Planning to control population growth and stabilize the population to limit the feeding mouths and provide access to resources for a better quality of life for its citizens. With the passing years and experiences of both these (Agriculture and Family Planning) programs implementation at the field levels necessary changes in strategies, methods and techniques were done. Advertising and marketing played increasing roles in the planning, programming, and implementation of these programs. Evolving and innovations in communication technologies also hugely impacted these programs.

National Emergency-1975-1977

Creating mass awareness and achieving the 'targets' of adopting different FP methods including sterilization of males became the hallmark of the Emergency, especially in some of the north Indian states. The forced sterilization brought a bad name to the FP program as a whole and revulsion among the people. They revolted against the ruling Congress Party in North India and the result was the emergence of the Janata Party as the ruling party at the Centre.

National Family Health Survey (NFHS-1 1993)

In 1993 the National Family Health Survey in India revealed that widespread awareness was not enough for the actual adoption of the small family norm and related health practices. The survey showed that only 6 percent of India women between the age of 13 and 49 used any modern contraceptive. The survey further showed that sterilization the mainstay of the National Family Program was not effective in population 'control' as most of the sterilization was undertaken only after having three or more children.

International Conference on Population and Development (ICPD), Cairo 1994

The 1994 ICPD emphasized the need for moving away from the 'contraceptive target approach' to RCH and population control/stabilization. The paradigm shift was to decentralize planning

focusing on the quality of health including Reproductive Health services to encourage couples to make informed choices about reproductive behaviour and the decision on family size.

The paradigm shift of the family welfare program toward Reproductive Child Health (RCH) had major implications for IEC strategy and programming. Several health issues like maternal and infant mortality, prevention and management of reproductive tract infection, sexually transmitted diseases, sexuality, and gender equity must be addressed together with the prevention of unwanted pregnancies and the promotion of child health through immunization and better-balanced nutrition. Also, the issues of gender violence and the age of marriage were to be addressed.

World Bank National Communication Strategy for Reproductive and Child Health 1999

The major thrusts of the World Bank suggested IEC strategies were as follows:

1. Participatory planning and interpersonal communication (IPC) for behaviour change have to be the mainstay of the new strategy at the field level encouraging greater interaction and dialogue with user /client.
2. Decentralized planning of communication activities following the roles and responsibilities assigned to the centre, state, and districts.
3. Advocacy of the RCH issues to affect social behavioural norms has to be an important component of the new approach.
4. Increased involvement of NGOs and the private sector in a partnership with the government for social mobilization and IEC for RCH.
5. Critical need for capacity building at all levels to undertake the newly defined tasks. Also, initiating research and improving the information/knowledge base to plan the new communication activities for RCH better.

Various multilateral and bilateral funding agencies like UNICEF, UNFPA, and USAID sponsored/supported projects related to RCH, FP, and Health in many states across the country broadly keeping in view the World Bank framework.

Still, the success in SRHR /FP was below the expectation. Many research studies and also different National Health Family Surveys (NHFS) showed it. According to the National Family Health Survey (NFHS-1-1993), only 6 percent of the women between the age of 13 and 49 used any modern contraceptive, and sterilization was the mainstay of the National Family Program; hence not effective in population control as most of the sterilization was undertaken only after having three or more children.
Since then (NFHS-1-1993) noticeable progress has been made through still, the results were below the expectations. The NFHS-4, 2015-16 and NFHS-5, 2019-20 also showed that India was behind its goal of providing Sexual and Reproductive Health (SRH), especially in coverage of women of reproductive age.

Population Growth

It may be flagged that India's population increased from about 35 crores in August 1947 when the country became free from British colonial rule to 135 crores in August 2021. Such an increase in population tells a story in itself and has many implications in terms of resource utilization for the development and growth of the country.

The National Family Health Survey (NFHS-4 -2015-16) showed that:

- 79 percent of women had institutional delivery,
- 47.8 percent of women were using modern family planning methods,
- Unmet need of about 13 percent existed-women wanted to stop or delay pregnancy and still were not practicing family planning methods, and
- Only about 62 percent of children were found to be fully immunized

It is in this context that there is another debate on the new 'Population Policy' and the need for 'two-Child' norms/laws for 'controlling population' in certain political circles and thus, the resulting uproar in media.

Bill on 'Population Control' July 2021

While some elected leaders (members of the ruling party) were planning to introduce a bill on "population control", legislation on a two-child family in the Parliament with accompanying provisions for both incentives and disincentives, there were others who opposed this move. Moreover, as per the ICPD 1994 declaration to which most countries including India are signatories, Population Control/Stabilization is to be voluntary; and incentives and disincentives are perceived as coercion. Further, India's population program is doing well in achieving its goals of population stabilization; that is in achieving the Total Fertility Rate (TFR) of 2.1 or the two-child family norm.

The success of the Population Stabilization Programme has not been uniform. Some of the states like Kerala achieved the replacement level (TFR- Total Fertility Rate 2.1) in 1988 while the states like Bihar and Uttar Pradesh it may take another 50 years or more to attain the replacement level of population growth. Uneven growth of populations of different states, religious communities, and even caste groups has political, economic, social, and cultural implications leading to tensions and conflicts among and between these groupings.

But others thought that there was no need for such a law for population 'control'. They were of the opinion that passing such legislation was not needed. India's 'Family Planning Program' has done well in achieving its goals of population stabilization; that is in achieving the Total Fertility Rate (TFR) of 2.1 or two-child family norm except in six states: Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh of 22 large states in India where TFR is of more than 2.1.

Even in these six states the people are aware of and have realized the benefits of small and planned families and are 'willing' to have small and

planned families, but still, they have not achieved their desired family size because of some reservations they may have with the FP programme services (Unmet Need). It demonstrates social and behaviour change communication (SBCC) as a 'missing link' and the need for strengthening supply aspects in ensuring quality, accessibility and affordability of contraceptives to young people, women, and men. Therefore, there are clearly marked areas for strengthening India's strategic efforts under the National Population Program. Rather, it should be "Voluntary" acceptance of a small and planned family; the thrust is that people should be motivated to plan and practice contraceptives; coercion or incentives/disincentives in any form should be avoided. Instead, the Family Planning (FP) / Population Stabilization program should be supported and strengthened through a well thought "Strategy" for social and behavioural change communication.

Covid-19 adversely affected Sexual and Reproductive Health (SRH)

On March 11, 2020, World Health Organization (WHO) declared COVID-19 a global pandemic. COVID-19 has had a widespread impact on the utilization of routine health care services. The fear of COVID-19, lockdown with restricted movements, the urgency to check the spread of Coronavirus, and provide health care and cure to Covid-19 infected persons shifted the attention of the medical professionals and associated service providers to focus on COVID-19 pandemic related issues.

As a consequence, the sexual and reproductive health of the people including adolescents and youth was adversely affected. World Health Organization (WHO), in anticipation of the detrimental impact/disruption of the pandemic, had published operational guidance for the health services during Covid-19 on June 1, 2020, in the form of "Maintaining Essential Health Services Operational Guidance for Covid 19- Context" making some practical suggestions and recommendations that countries can take at national, regional and local levels to re-organize and safely maintain access to high-quality essential health services.

In India, the Ministry of Health and Family Welfare has also been writing and sending necessary guidelines, on regular basis to all the states and Union Territories for ensuring that essential SRH services (for that matter, all essential health services, covering preventive health care, affordable health care, improvement in supply chain and mission mode of implementation) are continuously given. Despite national and international organizations' warnings and recommendations, almost all countries, particularly, the low and middle-income countries had seen a big disruption in the normal SRH services. There is a need for Population Communication Strategy to improve SRHR /FP outcomes. A well-thought research evidence-based population communication strategy is required to cost-effectively achieve the goals/objectives of the Health & Family Welfare programme of the country.

A top-down vertical Communication Strategy is generally more effective in a dictatorial regime. A word/message from the ruler/leader has effectively carried down the ladder. But in a parliamentary democracy with a multi-religious, multi-linguistic, multicultural society top-down approach does not work that well. Decentralized and participatory communication would be more effective.

Research evidence-based communication strategy would be more effective and would involve the following:

- Situation analysis based upon secondary sources and formative research
- Clearly define the purpose of communication and specific objectives of the communication inputs
- Segmentation of audience for targeted communication intervention
- Monitoring the intervention and undertaking the necessary course correction measure
- Mid-term evaluation; lessons learned and readjustment of the programme and communication interventions

- End line evaluation; lessons learned and the way forward for future similar projects.
- Preparing project closer report and sharing with others and dissemination.

To effectively implement the population communication strategy orientation & skill development of a whole range of service providers would have to be undertaken. As RCH & Family Planning services are multi-dimensional these touch many Ministries and different Departments (both central &state).

Orientation, Sensitization, and Skill Development

To effectively implement a 'population communication strategy' would necessitate orientation, sensitization, and skill development of a whole range of stakeholders in the Sexual Reproductive Health & Rights and Family Planning programme. These include civil service staff, doctors, and paramedical staff. In addition, Elected Representatives (ERs) from national (Parliament), state (State Assemblies), and local (*Panchayati Raj Institutions*-PRIs) are to be involved in policy directions and facilitate willing cooperation and participation in various programmes and activities associated with effective use RCH and Family Planning services.

The aims and objectives of orientation, sensitization, and skill development workshops would be to provide direction to policy issues and to strengthen and support the programme implementation through a better understanding of issues and coordination between and among service providers, and activities and actions involved in the process.

Section2

Communication for Family Planning & SRH: Evolution & Theoretical Underpinnings

Using communication in reaching family planning information to communities, including the then available contraceptives and its uses, was integral to the population programme since its inception in India. With the mostly 'one-way' information dissemination in the previous decades and near absence of interpersonal form of community interaction, the programme was largely restricted to promoting FP methods, which were limited to a handful of spacing methods and vasectomy and tubectomy.

Promoting Contraceptives – Methods Mix

Worldwide research so far suggests that the choice among various contraceptive methods for family planning, rather than restricting the choice to a few, is more likely to result in the optimum use of any specific contraceptive. Data demonstrates that to increase the use of birth-spacing measures it is necessary that couples are given comprehensive information about all the available contraceptive options and that there is access to sustained support for facilitating decision making regarding use of a FP method through interpersonal methods and multi-level interactive communication outreach. Studies have also shown that countries in which all couples have easy access to a wide range of contraceptive methods have a more balanced methods mix and higher levels of overall contraceptive usage than countries with limited access to various contraceptives.

A balanced approach to methods' mix is also an indicator that there is no "systematic limitation of contraceptive choices" for women, men and young people. In addition to having an overall supportive policy environment, well resourced and funded national SRHR programme

framework and strengthened health delivery systems, a crucial essential denominator to a successful SRHR programme is a well-designed and inclusive health communication strategy.

Within the context of family planning, it is well reckoned, as is also informed by the research, that the use of a variety of contraceptive methods are influenced by a number of factors. Largely, these factors are (i) policies and programmes: affirmative government promotion of certain methods, regulatory provisions and barriers, capacity and motivation to provide range of contraceptives, (ii) providers: providers' own preference for specific contraception, (iii) historical perspective: previous time-line since introduction of each of the given contraceptives in a given country, (iv) inherent properties of given contraceptives: ease of distribution, high cost, side-effects, effectiveness, and (v) client characteristics: knowledge of various contraceptives, desire for limiting vs. spacing, given religious beliefs, political environment, personal preferences, age and life stage and (vi) effective implementation of well researched health communication strategy, i.e. SBC.

From 'Information' to 'Engagement': People's Participation in SRH Communication

Conventionally, when the traditional FP programme is reviewed from the lenses of health communication (also popularly referred to as *IEC*), the development partners invested in the health promotion and health awareness activities that were mono-linear and information-based models. Therefore, most countries, including India, were found tilting to perpetuate the top-down use of mass media and did not adequately appreciate the potential of participatory and community -based media. However, through evolving social research it became increasingly clear that members of the public were not passive recipients of information, and that mass media alone could not change people's perceptions, mind sets and behaviours, especially so when the desired outcomes address core health & development practices, including such issues that would deal with their sexual health and decisions about birth of a child.

Health communication for the population programme i.e. the then family planning programme – at different timelines - invariably employed a number of conceptual frameworks. These Health IEC activities would well represent select theoretical underpinnings.

'Another Development' – Community at the Center-Stage

As the top-down information awareness model started undergoing a conceptual-shift, the 'Another Development' paradigm began to influence communication practitioners and scholars who argued, as it was within communities that the reality of development was experienced, community participation in the design and implementation of development programmes was an essential element to the positive change process. Alternative communication systems and media practices were therefore, regarded as important means for local people to engage in development activities, and as a two-way process in which communities could participate as key agents in their own development.

By the late 80s the notion of participatory development, particularly participatory rural collective action and appraisal, in which poor communities were directly engaged in defining their own problems and solutions, had gained considerable currency within development organizations, especially non-governmental organizations (NGOs). This is particularly applicable to the then family planning/welfare programme. Since then, increased priority has been given to horizontal, multi-directional communication methods that utilize a mix of channels and emphasize the importance of two-way communication through sustained dialogue in facilitating trust and mutual understanding, providing center-stage to the voice of socially-excluded and disempowered people and empower them to identify ways of overcoming the targeted problems in order to improve their own well-being and the overall quality of life issues.

Bottom-up approach, i.e. heightened use of community participation in health communication gained currency soon after conclusion of the ICPD 1994 (International Conference on Population & Development) held in

Cairo that emphasized a holistic approach in addressing sexual and reproductive health and rights issues with the women-centric slant in policy and programmes. Considering this as a turning-point, the programme gradually evolved from the conventional IEC to a more comprehensive and holistic SBCC at a time when the national population programme too was evolving from a mere promotion of the family planning to broader SRHR interventions.

In fostering a sustained social and behaviour change interventions in communities, within the gamut of development and health programmes, the proponents of various communication theories and frameworks have cited how social change takes place and how a positive and progressive change is communicated through select communication channels over a period of time to individuals, communities and society.

Health Communication Journey - Information > IEC > BCC > SBCC >SBC

Health communication has evolved from Information, Education and Communication (IEC) to Behavior Change Communication (BCC) to Social and Behavior Change Communication (SBCC) and now to SBC (Social and Behavioural Change). Communication for Development (C4D) or now termed as SBC, inherently encompassing community engagement, is construed as the set of strategic interventions enshrined with equity, that are rights-based and foster accountability-driven principles of community engagement and ownership in promoting positive behaviours in children, young people, women and men through focused communication and mobilization methodologies in attaining overall development objectives. At the other end of the spectrum, IEC was usually practiced focused on delivering information to a target, with an inherent assumption that subsequent to delivering accurate information, people would reduce damaging/harmful behaviors and thus, adopt desired positive behaviors. BCC acknowledged that information is necessary but not sufficient in most cases.

BCC uses context-specific formative research to determine the motivators, barriers and facilitators to behavior change, and responds with a variety of techniques designed to incite the individual to change his/ her behavior. SBCC expands BCC, explicitly recognizing the importance of changing social norms and increasing social support for behavior change, and acknowledging that change at the individual level occurs within the concentric circles of influence of family, community and society. This dynamic inter-relationship between individual, family, community and society is also well illustrated through the *Socio-Ecological Model* in the Communication for Development (C4D) or SBC (Social & Behavioral Change) paradigm.

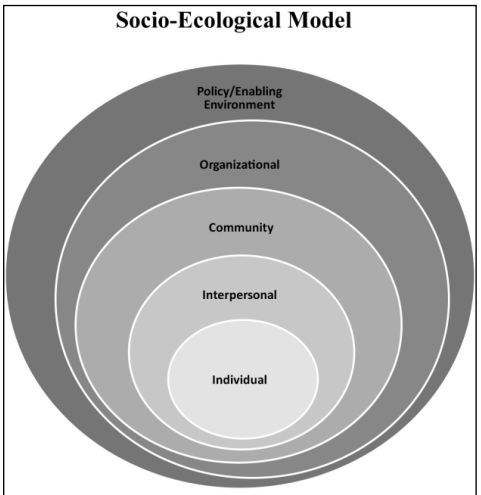


Fig. 1

Currently all the successful behavior change interventions are built on an understanding of the complex social, cultural and economic factors that make up the multiple levels of determinants of health and health behavior. Two complementary (and sometimes overlapping) theories are used in designing behavior change interventions: explanatory or predictive theories, which examine why a particular behavior occurs; and change theories, which focus on how behaviors can be changed *(Schmidt, Karen, 2014).* Explanatory models are essential for guiding the formative steps of designing a BCC intervention: Without a clear understanding of why people perform or do not perform a particular behavior, interventions are not likely to succeed. This also signifies the inherent need for integrating qualitative and formative research into any SBCC design and interventions, which essentially bring forth the true human-faces behind the hidden statistical data.

Among various available SBCC conceptual frameworks that are usually employed in the health & development interventions design, especially under the SRHR programme, a select few are analyzed:

Health Belief Model (HBM): This model addresses the individuals' perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors that influence the decision to act. Since health motivation is its central focus, the HBM is a good fit for addressing problem behaviors that evoke health concerns (e.g., behaviour of unsafe sexual practices leading to unwanted pregnancies; high-risk sexual behavior and the possibility of contracting HIV). Together, the six constructs (perceived susceptibility/ severity/benefits/barrier, cues to action, and self-efficacy) of the HBM provide a useful framework for designing both short- term and long-term behavior change strategies (*Hochbaum & Rosenstock 1952)*. When applying the HBM to planning health programs, practitioners should ground their efforts in an understanding of how susceptible the target population feels to the health issue, whether they believe it is serious, and whether they believe action can reduce the threat at an acceptable cost. Attempting to effect changes in these factors is rarely as simple as it may appear.

The Theory of Planned Behavior (TPB): This framework examines the relations between an individual' belief, attitudes, intentions, behavior, and perceived control over that behavior. This theory posits that **behavioral intention** is the most important determinant of behavior. Behaviors are more likely to be influenced when: individuals have a positive attitude about the behavior; the behavior is viewed positively by key people who influence the individual (**subjective norm**), and the individual has a sense that he/she can control the behavior (**perceived behavioral control** – Ajzen, 1991).

The TPB and the associated Theory of Reasoned Action (TRA) assume all other factors, such as culture and the eco-system, operate through

the models‟ constructs, and do not independently explain the likelihood that a person will behave in a certain way.

The TPB differs from the TRA in that it includes one additional construct, perceived behavioural control; this construct has to do with people's beliefs that they can control a particular behavior and was added to account for situations in which people's behavior, or behavioral intention, is influenced by factors beyond their control. This addition came with the argument that people might try harder to perform a behavior if they feel they have a high degree of control over it. In other words, people's perceptions about controllability may have an important influence on behavior.

The Diffusion of Innovations Theory addresses how new ideas, products, and social practices spread within an organization, community, or society, or from one society to another. The theory addresses how ideas, products, and social practices that are perceived as "new" spread throughout a society or from one society to another. According to Everett Rogers, diffusion of innovations is: "the process by which an innovation is communicated through certain channels over a period of time among the members of a social system."

Diffusion Theory has been used to study the adoption of a wide range of health behaviors and programs, including condom use, use of soap for hand-washing, smoking cessation, and use of new tests and technologies by health practitioners. Diffusion of innovations that prevent disease and promote health requires a multilevel change process that usually takes place in diverse settings, through different strategies. At the individual level, adopting a health behavior innovation usually involves lifestyle change. At the organizational level, it may entail starting programs, changing regulations, or altering personnel roles. At a community level, diffusion can include using the media, advancing policies, or starting initiatives. According to Rogers, a number of factors determine how quickly, and to what extent an innovation will be adopted and diffused. By

considering the benefits of an innovation, practitioners can position it effectively, thereby maximizing its appeal.

The Stages of Change Model: This conceptual framework is also termed as "trans-theoretical model", wherein it describes individuals' motivation and readiness to change a behavior. Promoting sustained use of contraceptives typically employs this model. The model's basic premise is that behavior change is a process, not an event (*Prochaska, DiClemente, & Norcross, 1992)*. As a person attempts to change a given behavior, he or she moves through five stages: *pre-contemplation*, *contemplation*, *preparation*, *action*, and *maintenance (and relapse)*.

Definitions of the stages vary slightly, depending on the behaviour on a given issue. People at different points along this continuum have different informational needs, and benefit from interventions designed for their stage. This theory was well developed to explain the different given stages of change in an individual/community that appears to be most common for the majority of advocacy campaigns and behaviour change processes under Health Communication, including the contraceptives use or seeking services of a skilled birth-attendant for a child-birth. Based on the assumptions that behaviour change is an on-going process, not an event, and that individuals have varying levels of motivation or readiness to change, the theory identifies five stages of change.

This model has been applied to a variety of individual behaviors, as well as to organizational change. The Model is circular, not linear. In other words, people do not systematically progress from one stage to the next.

People often go through a behavior change process. Instead, they may enter the change process at any stage, relapse to an earlier stage, and begin the process once more. They may cycle through this process repeatedly, and the process can end at any point.

Positive Deviants: Making a Difference

In the process of behaviour change, the ultimate end result is also gauged with the number of change-catalysts also termed as advocacy-agents, who in turn serve as positive deviants in a given community. These are converted advocates of a given health- behaviour, as they not only practice it but also serve as positive examples in a community. The concept of positive deviance was further refined and consolidated by *Jerry Sternin*, Tufts University, Boston, USA. It demonstrated how positive behaviour by a few individuals in the community (called ***positive deviants***) who do things differently or practice healthy behaviours as compared to others in the community can eventually lead to far-reaching changes within the community. More often than not, in any given community setting in India such „catalysts" (positive change-agents) encourage rest of the peers and community in opting for a specific FP method or practice prescribed ANC visits or make arrangements for child delivery by a skilled birth-attendant.

Application of Frameworks | Strategic Health Communication

As is demonstrated, while reviewing the health communication component of India's Population Programme, the choice of a suitable theory or a combination of theories under a strategic communication programme should begin with identifying the problem, goal, and units of practice, not just by selecting a theoretical framework. Programmatically, a model is selected with a logic base of the problem and work backwards to identify potential solutions, which is best prescribed through risk-factors" analysis *(Behavioural Insights)* or, in other words, through formative study of existing behaviours and practices and community preparedness for accepting the desired healthy behaviours.

The process of determining which conceptual-framework or communication approach and planning strategy to adopt in development

communication projects is expected to be a strategic and systematic endeavor. The designing of development communication programs, therefore, takes as its starting point, both the "felt needs" at the social system level, and the "action needs" as identified by development partners and key gate-keepers. And throughout this given process, are the people-centered participatory methods of engaging communities in defining developmental and behaviour-change goals, designing field-based activities, identifying required material and key messages and in building bridges with the local influential community-leaders.

Design & Management Stages: SRH Communication

Translating and effectively converting technical-information and complex socio- behavioral messages into creative, appealing and acceptable approaches that trigger sustained dialogue among participants is often one of the most difficult and daunting tasks within the design and delivery of social and behaviour change communication initiatives. Hence, health & development communication takes as its starting point both the „felt needs' at community or local level, and the 'action needs' as identified by stakeholders and gate-keepers. The operational strategy for meeting these two sets of needs shall follow four stages of activities.

The ***first*** stage is identifying and analyzing the innovations sought by the community and those that development agents want to introduce to whom, when and with what material means. This is generally known as the diffusion stage in the conceptual framework of development communication.

At the ***second*** stage, which is also known as the social process stage, the fulcrum of activities is towards determining how existing social, cultural, psychological and indigenous communication factors, as well as government organizational factors, would help or hinder the adoption of new practices and behaviors among the groups of people targeted under the programme.

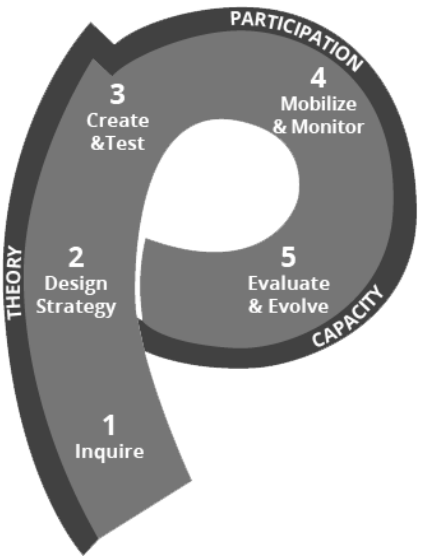
In the ***third*** stage, all efforts are put together towards identifying available media and how they relate with the people. At this stage, an expert

would always look at what best combination of communication channels exist and how they can be used in the communities most effectively – that includes traditional and interpersonal channels, as well as modern print and electronic media - for communication 'feed' both into and from communities.

In the ***last stage*** finally, locally tailored communication programmes are drawn up and implemented in phases with the real action potential in the communities. This process would indeed be taking into account available supplementary inputs from outside the community, which are positioned to compliment the strategic process of SBCC.

"P Process" in Health Communication Design

As is introduced by the CCP, Johns Hopkins University (Baltimore/USA), one of the most well- known tools to guide the developing, implementing, and evaluating of SBCC intervention is the "P Process". **The P Process** has five steps: Step 1: Inquire; Step 2: Design strategy; Step 3: Create and test; Step 4: Mobilize and monitor; Step 5: Evaluate and evolve *(Health Communication Capacity Collaborative 2013).* Initiated by the JHU experts, the P Process is positioned as a management tool for designing and monitoring health communication component of a given health programme. Starting in early 90s and in collaboration with the CCP/JHU trainers, with the USAID support, India's Population Programme initiated skill-building initiative of the communication managers under the Family Welfare. It would expect the better management of the interventions under the Health communication.



However, the P Process is only as useful as the data and thinking that goes into each step. Effective behavior change interventions need to build on three categories of data: (i) theories of change, (ii) evidence for the success and failure of past attempts, and (iii) an in-depth understanding of the target audience. The P Process considers theory to be an essential crosscutting concept, and the evidence from past attempts and in-depth understanding of the audience are part of the first step, "Inquire." The rest of the process builds on that foundation.

Behaviors are generally classified as habitual, normative, and preventive. Habitual behaviors are performed without much thought; normative behaviors are based on powerful forces of traditional and social approval; and preventive behaviors may lack a salient and immediate outcome *(Aboud & Singla 2012)*.

Apparent as is, complex behaviors are more difficult to change than simple ones *(Bongaarts et al 2012)*, and adopting new behaviors, or replacing old behaviors with new ones, is generally easier than prompting someone to stop doing (or avoid starting) an unhealthy or undesirable behavior. Communication studies have demonstrated that new habitual behaviors that require fundamental changes in routines are more difficult to change than one-off behaviors *(Wood et al 2012)*. It is also established through extensive research that the SBCC interventions which tend to use a single channel or technique are generally less effective. The most successful interventions use a variety of methods and media, and they go well beyond information to cover skill building, modeling, ongoing support from peers or others, and other active interventions. The most successful interventions use three or even four categories of techniques, engaging community participants at the behavioral, social, sensory, and cognitive levels.

Community Approaches: The importance of a community approach, especially so in promoting accessible, affordable and quality SRH services cannot be overemphasized, especially in developing countries such as India. Social norms and pressures have a major influence on behavior, and

this is a key not just in initiating behavior, but also for reinforcing it through feedback that makes successes visible and supports maintenance of the behavior. The idea that SBCC should appeal to emotions would seem to flow naturally from the idea that purely informational approaches are insufficient, but as is seen in many health and development interventions in developing countries, it is surprisingly absent in most programmes.

Health communication is poised to foster sustained dialogue in facilitating trust and mutual understanding, thus providing center-stage to the voices of socially-excluded and disempowered people and empower them to identify ways of overcoming the targeted problems in order to improve their own well-being and the overall quality of life issues.

India's Population programme, which broadly covers overall approach of the sexual & reproductive health information & services, has apparently evolved to adapting to the comprehensive SBCC approach. Population issues, over a period of time, have also gained political and social momentum. Yet the strategy for imbibing individual-behaviours in fostering sustained quality SRH services that are accessible and affordable still lags behind. Therefore, the programme goal of equity and reaching out to the most vulnerable, hard-to-reach and socially exclude populace still looms large, thus posing another level of challenge for the SBCC and advocacy experts.

In fostering a sustained social and behaviour change communication interventions in communities, within the gamut of development and health programmes, the proponents of various communication theories and frameworks have cited how social change takes place and how a positive and progressive change is communicated through select communication channels over a period of time to individuals, communities and society.

Section3

SBC for SRH with Adolescents and Youth: A Challenge or an Opportunity

The period of adolescence is considered as the developmental bridge between childhood and adulthood. The term adolescence is derived from the Latin verb *'adolescere'*. It means', 'to grow up', as per WHO (World Health Organization), the period between 10 and 19 years of age is the life-stage of adolescence. This ever growing age group consists of almost 20% of the total population of the world, whereas nearly 85% of the adolescents live in the developing countries. Needless to mention, India has the largest national population cohort of adolescents (approx. 243 million) which is followed by China.

The period of adolescence represents a phase of rapid growth along with myriad physical and emotional changes. It is considered a stage of life in which an individual attains sexual maturity, and in spite of this very crucial development in sexual growth, multiple studies have demonstrated that adolescents lack basic information about their body, sexuality, and contraception.

Adolescents: Caught between 'Norms' and Popular Culture

Time and again it has come to fore that discussing about reproductive health or sexuality issues are considered a taboo in India. However, due to media exposure adolescents find themselves trapped between relatively conservative "socio-cultural norms" and glamorous popular culture. Research studies have also demonstrated that adolescents have many doubts and unresolved questions about their own sexuality, giving a natural rise to increasing anxiety and perpetual confusion. Also, the current education system has a limited contribution in providing reproductive & sexual health knowledge to the adolescents, which tends

to misbelieves and indulgence into unsafe or risky sexual activities by this group of populace.

Risk Factors Surrounding Adolescents

Sexual and Reproductive Health (SRH) becomes a major area of concern during adolescence because of the apparent risky sexual behaviours which include early age sexual debut, multiple sexual partners, unprotected sexual intercourse, and sexual activity under the influence of alcohol or drugs. These behaviours increase the risk of unintended pregnancy and/or Sexually Transmitted Infections (STIs) including Human Immunodeficiency Virus (HIV) infection. Therefore, sex related anxiety and curiosity, sexually transmitted diseases (STDs), unwanted pregnancies, substance/drug abuse, and unsafe backstreet abortions are important problem issues among adolescents. It is noted that the girls are more vulnerable in this age-group because of clearly marked unawareness and biological susceptibility to STDs. Thus, scientifically designed and adequate reproductive health education is the critical requirement.

SRH: Knowledge, Attitude & Practice

Social scientists and education system continue with a sustained debate on who should (eg, teachers, parents, counselors, peers etc.) and up to what extent educate adolescents about sexuality and sexual health issues. There are multiple studies conducted in keeping this background into consideration, such as the one field research, "*Knowledge About Sexual and Reproductive Health in Adolescent School-Going Children of 8th, 9th, and 10th Standards. Journal of Psychosexual Health" (*Deshmukh & Chaniana, 2020). Like many such studies, this study too was planned with aims of assessing knowledge, attitude, and practices of adolescents toward reproductive health, STDs, and common secondary sexual changes, and to find out the source of information of knowledge.

The key results of the study[1] to gain better understanding of the adolescents' and young people's mindset and SRH behaviour are captured below:

Out of the total participants, 57% were boys, while the remaining 129 were girls. Almost equal numbers of participants were selected from each class. About 29% belonged to 8th standard, 33% to 9th, and 36% from 10th class. Only 38% girls knew that babies are delivered through vagina.

Majority of the students, i.e., nearly 60%, believed that girls are impure/dirty during their menses. Only 20% of girls were aware about the functions of penis and only 10% knew that penile discharge contains sperms, which points toward the fact that most of the girls were ignorant about the anatomy of the opposite sex. 92% of boys knew that use of condoms was safe sexual practice whereas only 43% girls knew this fact. Only 28% of the students were aware that the use of birth control pills is a safe sexual practice. Regarding masturbation, 89% were not aware of the fact that it does not lead to weakness in future. Only 23% of students were sure about the fact that masturbation is not a sin, while 56% of them did not know the answer.

In this study, held in the year 2020, a large majority, which is around 78%, of the total students believed that being sexually attracted to a person of the same sex is unnatural. Only around 50% of the students were aware that they have a right to say "no" to sex. Approximately 78%, of the total students were aware that it is not safe to have sex with commercial sex workers.

Most of the participants had satisfactory knowledge about pregnancy-related issues. Still it was found that only 41% girls knew that penetration of vagina by penis can lead to pregnancy. 61% of the total students were

[1] Deshmukh, D. D., & Chaniana, S. S. (2020). Knowledge About Sexual and Reproductive Health in Adolescent School-Going Children of 8th, 9th, and 10th Standards. *Journal of Psychosexual Health*, *2*(1), 56–62. https://doi.org/10.1177/2631831819898916

aware that abortion done by a quack or an unauthorized person, which is also termed as the 'backstreet abortions', is illegal. Only a few students answered "yes" to the questions related to sexual activities including masturbatory habits, forceful sex, with same sex, and with opposite sex. In this study, boys were found to have more exposure to sexual activities. When asked, whether they need more knowledge about sexual and reproductive health, 58.67% responded positively, while 41.33% did not think they need more knowledge regarding the same. The most common source of information regarding the topic, according to the study, were teachers (40%), followed by mass media, television, and internet (36%), friends (26%), magazines (25%), parents (8%), and siblings (3%).

Teachers, media, and friends were found to be the most common sources of information regarding these matters, while parents and siblings were the least. Similar findings were observed in another American study wherein it emerged that school was the main source of information on sexual health issues (54.7%), while parents were among the least at 0.8%. it clearly highlights the significant role played by teachers, mass media, and friends in imparting crucial information on sexual matters. In yet another study, it had been found that adolescents who had a talk about sex-related matters with their parents were more likely to delay the initiation of sexual activities and increase the use of safe sexual practices such as using condoms and contraceptive pills.

Parents & Caretakers are the Key: Behaviour Development & Change

In yet another large study (Tesfaye et al), researchers observed that out of the total participated parents, only 28.76% of them reported that they discussed about reproductive health-related matters in the last 6 months with their adolescent children. But very few parents were bold enough to discuss about the same with their children at home. This study also found that the most common reason for no communication with their adolescents was either lack of awareness of reproductive health (60.75%), fear that this discussion may encourage premarital sex

(51.40%), and the prevailing socio-cultural norms prevented them from free communication. However parental communication is a potential effective tool for promoting healthy and safe sexual practices. For this, teaching parents and teachers regarding certain general communication skills might prove helpful.

In nutshell, the knowledge regarding matters related to sexual and reproductive health (SRH) was found highly inadequate in the study (Deshmukh & Chaniana, 2020). Therefore, there is a need for providing more information about the same to adolescents through multiple 'trusted' outreach strategies. Salient outcomes of the study can be summarized as:

a) Girls were found to have less knowledge compared to boys.
b) Parents need to have adequate communication with their adolescent regarding sex-related topics, as parents were found to be among the least common sources of information regarding the topic; however, imparting the correct information, with an open-minded approach, by them while talking to their children about these matters is equally important.
c) Teachers were the most common source of information regarding the topic; thus, school plays an important role in providing knowledge about the same in adolescents.

It is well established that the traditional cultural norms, most particularly those which relate to the family as the primary unit of social organization and those that treat gender as a core dimension of behavioral standards and practices in India, are pivotal to understanding inter-generational patterns of communication about sexuality. Like in other South-Asian and South-East Asian societies, traditional, individual, and community life in India are largely regulated by collectivist norms, which emphasize family integrity, family loyalty, and family unity. Therefore, individual decisions on key aspects of life, such as: career choice, mate selection, and marriage – largely depend on cooperation among kin (Mullaatti, 1992 & Shangle, 1995).

Traditional gender norms remain dominant in rural India, and the segregated worlds of men, women, and related power differentials influence communication about sex. Hence, parent–child communication about sex is culturally proscribed (Selvan, Ross & Parker, 2005). Interestingly, when communication does occur, it is typically indirect (Lambert & Wood, 2005) and almost exclusively confined to mother–daughter and father–son relationships. Therefore, it has been well established that parental communication and general family dynamics greatly influence adolescent sexuality. Through multiple studies, ample evidence exists that Indian parents are increasingly concerned about their children acquiring HIV and experiencing other negative health outcomes (Khan, Mishra & Morankar, 2007-2008 and Mehra, Savithri & Coutinho, 2002), in addition to wanting to help their children make appropriate decisions about marriage (Alexander, Garda, Kanade, Jejeebhoy & Ganatra, 2007 and Mehra et al.).

Market forces driven by globalization, westernization, and constant industrialization are changing ever evolving social norms about families and gender roles. Therefore, these market forces are contributing to a sharp rise in rural-to-urban migration in developing countries, including in India. These changes always usually occur first to urban areas, however, and reliable sources of information about sexual matters, including contraception, are scarce for Indian youth (Nath, 2009). Studies highlight their reliance on peer groups, teachers, and the media rather than parents or other family members for information about sex. In another study for example, participants in a large survey of Maharashtra youth cited family members as infrequent and inconsistent sources of information on sex-related matters, and reported that they rarely discussed "sensitive topics" such as romantic relationships, sexual reproduction, and contraception with either parent (IIPS, 2008, p. 103).

A growing body of research with young people in developing countries clearly indicates that parents can influence sexual decision making of their adolescent children (Blum & Mmari, 2005; Phetla et al., 2008; Li, Shah, Baldwin & Stanton, 2007).

Interpersonal communication on SRH issues between parents/caretakers and children/adolescents have received a great deal of programme attention recently. Evidence demonstrate that children who interact with their parents about sexuality and sexual health matters are more likely to postpone sexual activity, have fewer sexual partners and are more likely to use contraceptives and condoms. Most of the parents, however do not communicate with their adolescent children because they find this task as a daunting task and they often feel embarrassed and ill-equipped. Furthermore, caretakers do not communicate because of the belief that such communication is immoral, contrary to the prevailing traditional values, and it is likely to encourage premarital sexual activity. Thus research studies have clearly called for a set of interventions involving parents, and it has been suggested that issues interrelated to sex and parental responsiveness should be addressed more systematically, as this may impact parent-child SRH communication practice.

Is Connecting with Adolescents and Youth, a Challenge?

It is well known that the great brands are built on great conversations. To have an effective communication with the intended customer, it is a must to understand them and their media consumption pattern. Today's youth is the most complicated target segment in the 'market-place' because of their exposure to a variety of media, low attention span, unconventional norms and wide spectrum interests. To add to complications, adolescents and young people hold the power to escape, they can escape ads, they can tune to a million other alternative channels, they can buy a billion other products, they can publish a blog/opinions about a specific brand, they can have instant word-of-mouth (good and bad) on it from the web, they can be in a store and punch in product information on their cell phone and find out who else has the product and for how much.

Belch & Belch (2006) suggested that the basic task involved in the development of a communication and media strategy is to determine the best matching of media to the target market, given the constraint of the

budget. The media planner attempts to balance reach & frequency and deliver the message to the intended audience with a minimum waste of coverage.

A research to study media consumption pattern can prove to be very useful in designing media strategy to have an effective communication with the target customer. Select findings from a recently concluded research - Media Consumption Habits of Youth *(Waalia Mann, 2010)* demonstrated that:

- Internet is the most preferred media among youth as around 85% of the respondents preferred Internet to Television but they spend more time watching TV than surfing Internet
- 73% of the respondents today dedicate more time watching TV, some even up to 4-5 hrs per day. A large portion of their spare time goes into watching TV. Late night viewing is also a popular phenomenon amongst this segment
- 76% of the respondents preferred Television to Internet for entertainment purpose. Sports, Movies & Music keeps them busy
- The penetration rate of Internet is very high in Indian households as 86% of the respondents (mostly Urban, Semi-Urban and Peri-Urban settings) have accessibility to Internet and 44% of the respondents surf Internet from their respective homes.
- Social Networking is the most popular activity on Internet, which keeps them busy most of the time.
- At any given time the respondents surf at least 3 websites. Social Networking site was usually found always on.

Based on multiple research studies, generated programme evidence and per the conceptual frameworks on social & behavioural change, the need for more comprehensive and sustained behaviour-change strategy on SRH for promoting enhanced engagement with the adolescents and young people cannot be emphasized more. It must substantively cover the issue of better parent-based interpersonal communication. In

addition to a strengthened parent-child communication on SRH issues, a well branded multi-media campaign penetrating through varied platforms, including new-media and digital space will be a complementing SBC strategy; thus, reinforcing the core messages through heightened reach, recall and reiteration value.

Section 4

Key Informants: Reflections – SBC | Then & Now

In order to derive comprehensive results and to capture wider perspective under the current analysis, select nationally known experts on Sexual & Reproductive Health, including Family Planning (SRH/FP) were proactively included in the process. These experts, through open-ended KIIs[2] (key informants interviews), reflected on a number of issues directly impacting on the strategic health communication, i.e. SBCC or the erstwhile called as 'Health IEC'.

Some of the nationally acclaimed experts included: Dr. Sikdar (formerly with MOHFW), Dr. Poonam Muthreja and Mr. Alok Vajpeyi (Population Foundation of India), Dr. Punia and Dr. Chillar (Chief Medical Officers, Haryana), Mr. Samresh Sengupta (formerly USAID) and Mr. Bhai Shelly (UNICEF, Lucknow). Upon review of the relevant literature related to the 'population' related communication ("IEC in Family Welfare, including Family Planning"), most researchers mention India's FP programme as 'historical' that had an early start which was soon after the country's independence. During the KIIs held with experts, each respondent interpreted the evolution that took place under the FP communication and thus, reflected on the current challenges and opportunities for strengthening SRH/FP related health communication.

Family Planning Programme: Evolution of Communication Campaign

India's launching the National Family Planning Programme in 1952, it became one of the early birds as a nation to implement the largest national-level and government-sponsored Family Planning program.

[2] Open-ended KII structure is appended as Annex-1

Country's Family Welfare Programme has contributed to a great deal in raising awareness on FP (need, methods and source of access/supply) and its benefits by using available tools of communication. Needless to mention, such awareness campaigns positively impacted people's attitudes and beliefs towards FP and its acceptance, although the FP practices remained considerably low for many years due to multiple 'risk-factors' that even included rather restricted use of methods/media of communication. However, communication programs in India have evolved considerably over the past fifty years. In the 1950s, the country largely relied upon the 'branding strategy' while it used the red triangle to foster easy identification of and spreading awareness of family planning programs. An expert responded opined, "…different institutions responsible for promoting contraceptive use acknowledged the important role of communication in this process. Throughout the decades of 1960s and 1970s, the common term used for this approach was information-education-communication (IEC)".

It is noteworthy that concurrent to the evolution of the National Family Planning Program, the communication strategies too evolved and complimented the programme. The Ministry of Health and Family Welfare (MOHFW) have had a robust approach in adopting a multi-pronged information penetration to generate awareness on the available Family Planning methods and services. Thus, the users/clients have had some select choices of the contraceptive methods for decision making. As the FP programme evolved and later when the paradigm shift took place in offering a range of SRH knowledge and services to the clients, the health communication (SBCC) too diversified its approach and outreach.

Most respondents observed that within the FP program, mass media campaigns and FP messaging focused on providing information about the program as well as educating women on the advantages of small family norms and the use of contraceptives. Male involvement and proactive participation was distinctively minimal. It was also opined that the messages through mass media help disseminate information on various

issues to different sections of society in a much simpler manner. This would not have been possible otherwise, especially in the context of uneducated women, who currently comprise 33% of married Indian women. Exposure to mass media also helps women make their own decisions regarding FP use.

With the onset of HIV/AIDS programme at the national level and with re-energized focus given to the community mobilization and behaviour change elements of the HIV/AIDS interventions, the Population programme by then also gradually started adapting to the social & behaviour change communication (SBCC) conceptual underpinnings. In other words, those working in the area of family planning preferred to use the term 'behavior change communication' (BCC) and not a mere erstwhile popular term "IEC". Therefore, it involved a comprehensive communication approach for the family planning program, thus using behavior change as a denominator, i.e. not just imparting information but achieving the desired result of the intended behavioral change. For instance, it entails promoting contraceptive use, effectiveness of interpersonal communication, mass media interventions and so on. BCC moved ahead and a popular concept has taken the form of Social and Behaviour Change Communication (SBCC) to reflect the social and population-level perspective whereby change at the individual level occurs as a result of the influence of family, community and society.

With the conclusion of ICPD-94 (International Conference on Population & Development, Cairo 1994), SBCC evolved further in the nineties that would denote strategic use of communication approaches in promoting changes in knowledge, attitudes, norms, beliefs and behaviors. ICPD-94 also brought women's agency in the centre stage, wherein a comprehensive package of SRH services overrode the mere FP provisions. This further strengthened the SBCC programme and its design and implementation. As noted by a respondent to KII: "While BCC connotes a clearly defined objective to be achieved through a specific communication program, SBCC is grounded in theory and is evidence-based and aims to empower communities with a comprehensive

set of tailored interventions that intends to promote and encourage desired behaviors."

A respondent from the field in Haryana observed that in the initial years 'population control' was the main aim behind all the IEC activities planned during that time. IEC's focus was on small family size and permanent methods of sterilizations. At that time it was considered a difficult task to pass on such (FP) massages to society. Even making a reference to the topic of family planning or sexual health was considered as inappropriate etiquette and thus, a taboo. To make a single slogan or idea didn't work for all in promoting family planning practice. Hence, different types of slogans, posters, wall paintings, jingles etc were made for varied regions. Small documentary films and small talks on family planning in commercial films left good impressions on people in promoting FP with public at large. News papers also played vital role in spreading information in form of news, advertisements, small stories etc. a small clip before the start of feature films in the cinema halls was also found successful in conveying massage. Similarly, pictorial messages on matchbox, cigarette or other articles of adults' use were employed.

A respondent (formerly with the MOHFW, GOI), observed that the Information, Education, and Communication (IEC)/Behavior Change Communication (BCC) material (including Video and print advertisements, posters, banners, leaflets, etc.) for promotion and uptake of contraception as the most cost-effective way to improve maternal and child health, have been developed, updated, and widely disseminated at each stage of evolution of the National Family Planning Program. The messages and relevant material included new contraceptives offering the basket of choices. The developed material has been uploaded on the ministry's web portal which is a free source for all the states/other stakeholders and therefore, amply provides an opportunity to adapt the material into the local language for further use at the field level.

It is evident that India was one of the first developing countries to bring in appropriate policies on family planning. The policy, integral to the five

year plans, introduced clear measures of limiting family size, though mostly 'vertical' in nature. However, aptly matching with the FP programme goals (and inherently emerging FP technologies), the health communication component also emanated through the phases of: a) focus on family size, responsible couples, sterilization, b) focus on (primarily women's) utilization of FP measures, targeted approach and c) Promoting FP choices, promoting spacing, focus on health gains for family.

The health communication, therefore has evolved from being vertical *(Bacche do hee acche, chota pariwar sukhi pariwar)* to increasingly horizontal as part of the evolving reproductive & child health programme (RCH) in India. The formative research in 1990s, particularly in the post ICPD context, started playing a major role in forming strategic communication programmes and interventions therein. In Uttar Pradesh, for example, USAID supported SIFPSA that was such an initiative in which JHU-CCP as the communication support arm was instrumental in large scale implementation of health communication strategy *('Let's talk')*. Access, quality and demand were three key pillars and the demand gained the due prominence as the state engaged an army of CSOs, trained FP communicators and a range of influencers to mobilize decisions at family level.

Another respondent shared his experience wherein the erstwhile IEC approach was found largely restricted to delivery by the paramedics in the field, he opined, "… in the good old days, there used to be IEC, which had a definitive purpose. One of which was spreading Information on FP methods, it happened in a lopsided manner. Those days the entire responsibility of spreading IEC messages was on the Paramedical staff posted at the Primary Health Centers and Sub Centers. MOHFW's slogan through DAVP and other Govt channels was *'Hum Do Hamare Do'*, which would continue for decades. It lost its utility and purpose. All the IEC materials were developed centrally, which had no relevance at the States' level.

Often contents were misinterpreted at the State level either on account of inappropriate visuals and sometimes even wrong translation. All these factors caused considerable damage to the program, and nothing was done by the Health Department to rectify the situation. Method specific IEC materials were ridiculed by the local villagers. For example, when Lippy's Loop-LL (IUD) was introduced, an AD agency in Kolkata was commissioned to publicize the LL. And the agency came up with a slogan "ROOP KA RAAZ LOOP". It was highly successful. When the same was introduced in Northern Belt of the Country, it was a great failure and had to be removed as there was lot of controversy attached to it".

The respondent further opined, "Most of all, FP Targets did maximum damage to the program, both in the area of Spacing and Terminal method. All kinds of misinformation were fed to the clients that caused both confusion and reluctance in the minds of the clients, especially the Males. Again, nothing was done to rectify the situation".

As varied research studies and evaluations reflect, multi-pronged health communication interventions work effectively in a country as diverse as India. It includes, mass-media campaigns, mid-media outreach and, interpersonal communication persuasion/follow-up.

Most respondents, reflected through their views, if the country's FW programme included all the recommended results-driven SBC strategies, the country shall deliver excellent outcomes in the SRH/FP and the maternal and child health goals.

Mixed-Media Approaches in the erstwhile 'IEC'

Most respondents observed that the Union government continues to play a lead role in the national mass media and multi-media campaigns, while the local radio, TV and print media and state specific IEC activities through leaflets, posters, traditional entertainment methods, banners, hoardings etc. have been the exclusive responsibility of the respective states, districts and communities.

Health communication related to family planning programs, until the early nineties, were mostly broadcast through specified time slots in the national media, especially the All India Radio network. Films of various themes were produced for exhibition in commercial theatres as well as in mobile publicity vans. The objective was to have at least one such van for each district. The press carried stories, commentaries, and advertisements. Family planning exhibits, by themselves or through stalls in other fairs, were being held throughout the country. Hoardings and bus boards were erected all over the country. The red triangle (as a major branding logo), adopted as the symbol of family planning, was being used on all family planning centers, contraceptive supply packages, vehicles and the clothing of field workers.

Family planning program through multi-pronged communication interventions has been able to achieve considerable success over the years in almost all the States. Over 26 states in India have achieved a replacement level of fertility. The governments have made consistent efforts to re-conceptualize and reposition the program so that it can be more responsive to the country's differential needs across regions and States. The need to do so is more imperative in India as the National Family Health Survey 4 reveals that women in India desire to have less than two children. Hence, there is an increasing recognition for a small family as well as spacing between births in the population. However, the unmet need for family planning in the country is huge, which is to the extent of 13%. Therefore, recognizing the country's growing family planning needs, the Government of India also expended the basket of choices for contraceptives in the year 2017, i.e. from five to eight methods placing more emphasis on spacing methods. A respondent emphasized that despite these efforts, female sterilization continues to be a predominant method of family planning (75%) indicating the need for accelerated social & behavior change communication efforts to promote other family planning methods, especially spacing methods and their acceptance.

More recent SRH initiatives in many States made use of formative research and hence, consolidated the desired media-mix strategy. In reaping the positive outcomes, the horizontal and participatory means of communication gained significant currency. Capacity building activities covered a range of civil society actors and influencers. In many states, the discouragement strategy (in recruitment and election for people with large families) was introduced and PRI bodies in several instances undertook local measures of naming and shaming. One expert retorted that the high level of illiteracy (especially among women), low agency for women and child marriages still haunt some of the large states in north India.

Within the context of strategic health communication, the models demonstrated by Polio Eradication and a few others by NGOs in some States, including in UP offer effective solutions. A respondent, specifically made suggestions, based on lessons, which includes: a) A targeted high decibel media mix campaign (multiple times in a year) focusing on families and social influencers; b) Maintaining/increasing and empowering the IEC cadre within the health department; c) Promoting inter-department convergence to foster cafeteria approach of health and nutrition service delivery; d) Sharpening effective communication skills among the key frontline functionaries and elected representatives; c) Building *'jan andolan'* (public movement) through engaging social capital such as CSOs, youth organizations and likeminded bodies; d) Engagement with faith based organizations; e) Tapping clients early and effectively; f) Effectively employing digital (mobile) and social media on a sustained basis; g) Strengthening training institutions at all levels for maintaining sustained momentum; h) Use of research and evidence to guide the strategic communication pillar of the programme.

The communication strategy under the National Family Planning Program encompasses a multi-pronged approach, with an appropriate mix of Mass Media campaigns (TV, Radio and Print Advertisements), Mid Media interventions (posters, leaflets, billboards, etc.), and interpersonal communication (through trained frontline functionaries, service

providers, and counselors using appropriate job-aids). These materials are adopted and updated periodically according to the changes in the National Family Planning Program. However, the critical need for better monitoring in assessing the gaps and missing-links exists, which ought to find out how the communication platforms can be best used or even which message is deriving better results.

A senior State Govt. health expert from the field opined that the success of a progamme is dependent on the strict follow-up and feedback systems, i.e. between the actual users/clients of the programme and those who design health communication strategies. Family planning programme IEC, so far, has succeeded in conveying key massages to the target groups. Currently the health facilities are providing basket of choices within the context of SRH. It is observed that if a client desires to discuss his/her health issues that relate to sexual health, including FP, experts are available at the PHC levels.

On the issue of SBCC programme design, respondents had mixed experiences. They were posed with an inquiry on how is the Health and Family Welfare stream of public sector designing and delivering strategies for outreach and behaviour-change communication related to SRHR including FP, Adolescents' health & Gender based violence.

Field-Based Health Workers Carrying the Flag of SRH/FP Communication

The government, through the Mission Parivar Vikas (MPV), introduced awareness campaigns through ASHAs and Anganwadi workers at the village level like the '*Saas Bahu Sammelan'* to bridge the gap between two generations' women (pregnant women and their mother-in-laws) and thus, engage with them in a healthy discussion on reproductive health issues and practice of family planning. An innovative family planning kit called the '*Nayi Pehal*' is distributed by ASHAs to the identified newly married couples in the rural areas.

A respondent informed that the kit contains information on family planning schemes, use of family planning methods, delay first pregnancy, packs of three different types of contraceptives (condoms, OCPs and ECPs), pregnancy test kit and a vanity pouch for grooming. In order to generate demand as well as in creating awareness on family planning, a smartly designed bus known as '*SAARTHI – Awareness on wheels'* equipped with interactive communication devices, IEC materials and family planning commodities has been operationalized in all remote areas of the select high priority districts under MPV four times a year, i.e. on a quarterly basis.

In addition to the aforesaid outreach, injectable contraceptives are being made available at all levels of public health facilities starting from the District Hospital up to the Sub Centre level alongside strengthening of long-term contraceptives such as the intra uterine contraceptive device (IUCD) in all 146 high fertility districts. Free condom supplies are made available through *Condom Boxes* placed at strategic locations like the public health facilities and Gram Panchayat for ease of access. These multi-pronged approaches to the family planning, through new promotional schemes by using extensive field-based communication platforms, are expected to expand the reach of family planning services effectively in the country. An expert, while responding to the KII, further reaffirms that all through these processes of extensive outreach, the role of field-based health workers remains relentless.

A two thirds (66%) of India's reproductive age population reside in rural areas. According to the National Family Health Survey 4, the total fertility rate (TFR) in rural areas is 2.4, slightly higher than the national level TFR. The unmet need for family planning is comparatively higher in the rural areas (13.2%) than in urban areas (12.1%). The use of modern contraceptives is lesser (46%) in the rural areas. For instance, use of condoms is 3.9% when compared to urban areas (9.1%) wherein female sterilization predominates.

The current outreach in family planning require strengthening and doubling of existing efforts to reach the rural and difficult to reach population. Intensifying quality of care in family planning needs a lot more impetus in these areas. As we understand from the NFHS 4, the reach of health workers to non-users of family planning and providing the right information on contraceptives and its side effects to existing users remain a huge challenge in rural areas. More innovative health communication with the communities and policy advocacy with the leadership and decision-makers should fill such a critical gap.

A respondent, who works with an international agency, specifically addressed Adolescents' health and gender based violence, wherein he observed that the design of the programme by NHM has been quite ambitious. It aims to deliver adolescent focused packages through tested methods of peer groups and institution (education) level transactions. It lacks the implementation rigor and delivery, although trained CSOs could be a better choice. It also works almost in isolation and thus, does not interact with other platforms for convergence. For example, the convergence with ICDS, UPSRLM/SHGs, Education department is minimal and therefore, restricted to adhoc events. The respondent further opined that the 'Dastak' (UP) model offers lessons to streamline the convergence aspects in the RKSK and similar programmes.

The respondent continued in retorting, programmes on gender based violence as of now has limited scope to address the multiple determinants. It needs to be designed holistically with the finite role (outcomes driven) of different stakeholders. It should certainly shift from event-based (or tokenistic activities) approach to more community-based approach. Working on gender and socialization (particularly for boys and men) is very important which does not get a fair deal in programmes. And the SBCC interventions play central to addressing the gender equity & equality in communities, including adolescents and young people.

Over the years, the National Family Planning Program has shown tremendous progress in the country. The increase in the use of contraceptives, reduction in unmet need for family planning, reduction in teenage fertility, and achievement of replacement level of fertility is a

testament to the success of strategies under the program, of which the health communication strategies (erstwhile IEC and currently the SBCC approach) are an integral part. However, the platform of social media for providing contraceptive information and establishing interactive communication, especially to unmarried adolescents and young people, and the newly married couples, should be explored further.

Another respondent felt, "gender based violence and frustrations in young one are due to lack of moral teaching. Parents are busy in earning daily bread and school teachers are overburdened in various other activities along with the large syllabus. Moral values are not discussed at any level. Social media is full of unnecessary information and activities. Moral teachings should be included in the curriculum from very first class".

Integral to the KII was the issue of emergence of social media (SM) and the evolving digital space, as many campaigns are using these technologies in connecting with people (target audiences). Respondents were asked to recall any such experimental strategy where SM was used successfully and in what way would they suggest use of social media and digital platforms for the SRHR/FP communication.

Emergence of Digital Space: Health Communication in SRH/FP

Many civil society constituents and NGOs are designing interactive interactions, especially with young people, in promoting sexual & reproductive health concerns. One such pioneer is the Population Foundation of India (PFI) that has been using digital and social media as part of its 360-degree approach to social and behaviour change communication for many years. PFI has experimented with several different strategies, such as using multiple platforms, languages, and content. A case in point is PFIs online campaign, *'Bas Ab Bahut Ho Gaya'* (Enough is Enough) on ending gender-based violence experimented with a celebrity and non-celebrity strategy to study the impact of using influencers and celebrities on social media.

On the other hand, more recently PFI's COVID work used short videos of senior medical professionals in providing authentic and credible

information on COVID-19. This type of content was successful in countering many of the myths and misconceptions around the pandemic. More recently insights from PFI's on-ground teams and the Facebook Global research team have underscored the importance of local, regional language content to counter vaccine hesitancy and myths and misconceptions on COVID-19 vaccinations.

The use of social media and digital platforms can be a powerful tool both for effecting behaviour change and also advocacy. Platforms such as twitter play an important role in strategic engagement with key stakeholders and policymakers. Many CSOs and NGOs, such as PFI, have strategically used their twitter presence to encourage dialogue on key FP and reproductive rights related issues.
Another campaign, 'People Before Numbers' used explainer videos and data visualization on Facebook and Instagram to change the narrative on family planning and contraceptive use. Furthermore, Facebook serves a powerful space for bringing together numerous stakeholders on one platform. Another case in point is the 'Advocating Reproductive Choices' (ARC) network of 116 organisations working on reproductive health using its Facebook platform to reach out to network partners, share information, build consensus and successfully running campaigns on the select key issues.

During the ongoing pandemic there are successful examples of using mobile telephony, IVR, SMS, WhatsApp and social media channels (FB, Instagram, Twitter etc.). For example, in the state of UP, a youth-based mental health and psycho-social support programme ('Muskurayega India') uses IVR and other means very effectively. Another such example is 'Hello Didi', - where rural outreach (most marginalized) is outstanding in the context of pandemic and nutrition. Therefore, there exists ample social media lessons from these initiatives; hence, it may guide adapting appropriate SM strategy in support of the SRH programmes.

Multiple development partners in the field of Family Planning have been working closely with the Ministry of Health and Family Welfare in

exploring the use of social media and the evolving digital space (like WhatsApp, Facebook, Instagram, etc.) to deliver information on Sexual and Reproductive Health and Family Planning. However, it will be prudent to also examine whether or not such initiatives establish interactive platform or are these interventions merely delivering unilateral information. A respondent opined that the social media use could also be explored through youth leaders, SM influencers, celebrities, religious leaders, etc. Nevertheless, the Ministry of Health and Family Welfare has been using the Twitter platform to disseminate messages on the healthy spacing of births, use of contraception, etc. MOHFW has been disseminating information on COVID-19 cases and the vaccination, which has been successful across the country, especially among the smart phone users.

Another respondent opined, "… several experiments were done in the past using these technologies. However, they were not sustainable, mainly because the audience didn't find most of the content worth remembering or of interest. To bring about any sustainable behavior change in FP and Health takes time. The results are usually non-tangible, resulting in their losing interest. Therefore, to sustain their interest in the message content, the program should introduce the theory of Gamification (converting the information into an interactive game) in the communication content and design it accordingly. The message content should be designed in a manner that it's interesting and thought provoking. It should be so powerful that the audience should crave for more. There should be an element of prizes (mostly nonfinancial) and recognition. If introduced, it will be path breaking communication strategy. Of course, it will be more expensive than the traditional methods being used currently".

A few respondents from the State Govts shared that the WhatsApp groups of ANMs/ASHA workers are frequently used in communicating various information and directions. During the pandemic, these tools were used extensively. Many times dates of camps, doctors' visits, health

talks, govt. schemes are conveyed to all on the same day. Another case in point wherein digital space delivered excellently during the pandemic was the video calling consultation. It was used in a very effective way and benefitted many.

With the digitalization of Media and increasing access to smart-phones, messages are disseminated easily and the recipients (target audiences) are not only the receivers of messages but are also generators/modifiers/ creators of messages.

Social Media Playing a Significant Role in SRH/FP Communication

Around the world, young people are gaining increased access to digital technology and therefore digital media is a key source of information about sexuality. Access to accurate information is a key determinant of sexual and reproductive health (SRH). COVID-19 is reshaping the way in which people access SRH information and services. The pandemic has underscored the transformative potential of digital technologies in improving public health initiatives, yet it also raises a number of rights based issues regarding equitable use of and access to such technologies and information.

Digital media provides scope for targeted interventions and the potential to reach adolescent populations and young population at scale, anytime, anywhere. There is a need for more research to better understand how they impact knowledge, attitudes and behaviour and what increases appeal and usefulness for young people. While there is risk of harm online, digital world offers valuable opportunities for adolescents and young people to learn, communicate and express themselves.

Information asymmetries in the digital SRH sphere also implicate a number of other human rights. The quality of SRH information available on digital platforms impacts both the right to health and the right to freedom of expression. Considering the misuse or unauthenticated

information available, there is a need for appropriate frameworks to guide the development of comprehensive digital sexuality media to address SRH issues.

There are multiple examples from the field, such as from the State of UP, 'Smart Betiyan' and 'Hello Didi' in which the rural adolescents, youth and women have excelled in creating and using content through phone and social media.

The SRH information is important to achieve the goal of universal health coverage. The use of digital media for rendering relevant SRH information may prove useful in the wider dissemination and increased uptake of services. The generators/ modifiers/ creators also get a scope to update the messages based on the feedback of the recipients and evolving program priorities.

One respondent opined that through Gamification, the messages can be made interactive and more knowledge based. He suggested, "This is the side effect of the digitalization of massages. A simple massage with minor modification may spoil the soul of massage. A receiver may spread the same information by altering the facts. This certainly affects the success of programme".

National Programme and the respective State level outreach programme strategies for the SRH, including FP, have earmarked specific 'expected outcomes. However, the issue remains how these strategies and programmes actually convert into realistic actions, which especially includes keeping appropriate focus of SBCC messages on SRHR/FP while reaching the communities.

Gaps (if any) in SBCC messages on SRH/FP in Communicating with Communities?

India's modern contraceptive use is only 47.8% with the female sterilization accounting for 75.3%. The unmet need for contraception remains high at 13% indicating that women who wish to delay or avoid

pregnancy do not have access to contraceptives. Male engagement in family planning is negligible. The use of spacing methods is only 25%, given 18% of the country's young population in the age group of 15-24 years. Young women and men need information on the correct use of contraceptives, access to quality family planning services and spacing methods of contraception, dispel myths around condom use, vasectomy and safe sex. Hence, there is a greater need to shift focus on spacing methods and increase investments in family planning.

While there are several SBCC interventions that have made considerable efforts to change the mindsets and behaviour in addressing social norms and contraceptive use, there is still a long way ahead of the government to achieve the desired results. Many communities still grapple with myths and misconceptions regarding correct knowledge and use of contraceptives. Family planning is still considered as a women's responsibility. We need to stop referring to family planning and sexual and reproductive health and rights, as the women's issue. It is an equally important issue for men and boys and the community, while it is also an issue of social justice and human dignity. The discourse on engaging with men as partners in accessing family planning and health services certainly needs to go beyond contraceptive use.

Male participation is about being responsible and respecting equality rather than just about decision making. It should extend to the role of men as enablers and beneficiaries in the process of ensuring dignity, equal voice, and reproductive rights for women.

Family planning programmes and communication strategies must be designed to encourage male engagement in family planning and reproductive health. There needs to be an emphasis on changing mindsets and stereotypes to empower women to take decisions regarding their own health and promote communication between partners (inter-spousal/inter-partner communication). In addition to condoms, there is a critical need to promote vasectomy as a safe and simple procedure for family planning. Further, men do not feel

comfortable discussing their reproductive health needs with female frontline workers and therefore, it is important to have male health workers who can promote positive behaviours among men towards family planning. Placement of male health workers in the Health and Wellness Centres under the Ayushman Bharat can ensure 1,50,000 male ambassadors of family planning who can play an active role to promote male engagement.

Engaging young men and boys during adolescence can shape their mindsets and could inspire them to become agents of change for improved reproductive health and gender equality. Mindsets of men can also be changed via effective social and behaviour change interventions. One respondent observed that the PFI has addressed this issue through its popular trans-media serial *'Main Kuch Bhi Kar Sakti Hun'* (MKBKSH).

End-line evaluations of the above mentioned edutainment series (MKBKSH) revealed that after watching the series, women had become more confident in communicating with their partners on contraception and accessing family planning services. This evaluation study further found that a group of men from the Chhatarpur in the state of Madhya Pradesh pledged to adopt contraception after watching MKBKSH. They advocate for adoption of vasectomy – termed as *'mastbandi'* (a modification of the phrase 'nasbandi'/vasectomy) in the serial and move from village to village in the region and sing ballads to motivate other men. This proves that behaviour change through positive messaging is the key to changing mindsets of men. The behaviour-change theory of 'Positive Deviants' has been successfully demonstrated through this intervention.

Needless to emphasize, Interpersonal communication (IPC) has a central role in the social & behavior change process wherein frontline health workers reach populations while the other media cannot reach. NFHS-4 reveals a huge communication gap between health workers and beneficiaries both in terms of providing information on contraceptives and their side-effects. The need of the hour is to effectively harness this

resource and build their capacities in order to ensure equitable reach and greater impact.

The only way out is to provide good quality family planning services that also safeguard reproductive rights of women, i.e. their right to decide whether, when and how many children they want, ensure quality of care and better meet the needs of the women and their families. The programme must also provide a wide range of quality contraceptive methods for spacing; give clear and adequate medically accurate information including the benefits and risks, so that women and men can choose the method they want to adopt.

One respondent suggested that comprehensive sexuality education offers a holistic solution to enable positive health seeking behaviours, reduce risky behaviours, increase knowledge and attitudes regarding contraceptive use and reduce vulnerabilities among adolescents and youth to violence by promoting bodily integrity, self-confidence, negotiation skills and gender-equitable norms. The health communication, i.e. SBCC for SRH/FP, need to move beyond creating awareness.

The focus ought to be on communicating for social and behavior change, engaging the audience, and creating an enabling environment for change to take place. Another respondent observed that SBCC should also address socio-cultural norms such as sex-selection, early marriage, early and repeated pregnancies, son preference, undernutrition of girls, domestic violence and gender inequality. In a country like India, area-specific approaches have to be adopted and therefore, decentralization of health communication efforts is the key to address various local and specific needs.

A respondent, while sharing his field experience, opined that a robust SBCC strategy goes a long way in generating awareness and demand for services, thereby fulfilling the stipulated goals (like Universal Health Coverage and SDGs). The progress witnessed in Sexual and Reproductive Health indicators (including Family Planning indicators) in

the past few years has been realized through a multi-pronged approach, of which SBCC is an integral part.

The implementation of SBCC strategies is sometimes found to be fragmented (owing to competing priorities by the states/districts) which can well be addressed through on-site mentoring (during field visits) and discussions during thorough technical review meetings.

Section 5

Conclusion and Recommendations

Well strategized and targeted SBC interventions, i.e. community mobilization and demand generation activities, can make a significant contribution to looping in an increased number of young people, women and men with the overall SRH services. This also tends to increase modern contraceptive use, both in the rural and urban areas and could significantly impact the Sustainable Development Goals (Agenda 2030) for improved maternal and child health and access to sexual & reproductive health for all. These community mobilization and demand generation activities can be undertaken at multiple levels including field-level activities such as outreach by health workers, family planning workers, political leaders and religious groups. Needless to emphasize, in engaging with young people & adolescents, involving parents/caregivers and mentors/teachers is the key to strengthening behaviour change in the context of SRH/FP.

Recommendations on Health Communication for SRH/FP Programmes

Based on the review and secondary analysis of the available literature along with the findings of the KII interviews with well-known health and FP communication experts, select recommendations are being drawn. These key observations, if well incorporated in the national programme and reflected into the SBCC strategies for the SRH/FP activities, are expected to deliver results-driven outcomes. It shall foster improving the prospective health communication strategies in the country.

Social & Behavioural Change conceptual frameworks: SBC interventions for the SRH/FP programmes should ideally be based on time-tested theoretical conceptual frameworks – some of which are

illustrated in the previous sections - and the strategy should, therefore be outcomes driven and be guided with the desired results under the social and behavioural change.

Right Based Information and Messages: Every woman, man and young person and their family members should have the right to access the information and messages on sexual and reproductive health & rights, including a range of FP methods and its uses. It's pertinent to ensure that the message content offers informed-choices, facilitate adoption of a healthy life-style/behaviour and do not promote 'prescriptive' method of erstwhile 'health promotion'. In addition, data and evidence driven strategies and design models are critical precursors to the success of the SBCC interventions under health and development sector. Strategic Health communication is a science and art of multi-disciplinary set of approaches that should be derived from the field-based evidences and the available data. As mentioned earlier, prescriptive and top-down approaches in addressing core health behaviors of communities have invariably performed poorly in the past health campaigns, while the evidence-driven design processes in a few health-care interventions, such as HIV/AIDS through sexual transmission and IDUs have largely demonstrated significant results and thus, need to be replicated with the SRH/FP programmes.

Ensuring Wider Access to Core Messages through Multiple Platforms: SBC media and materials should be widely made available and be disseminated from central to district level to the community level in local languages. Ideally, the proto-type master should be devised and conceptualized along with the community at a village/local level in districts following bottom-up planning/participatory methodologies and subsequently, large print orders could be addressed by the State Health departments. However, technical emphasis should be laid on 'tailor-made' messages and materials. This denotes that the overall prototype (primary messages and material formats) could be drawn at the national or state level, whereas in some specific cases of vulnerable populace, hard-to-reach areas, including those areas which are driven with varied

socio-cultural practices and beliefs, need to pretest and devise messages/material with the select communities and thus, adapt to the local needs.

Media Mix: Mix of different mass-communication media, mid-media and field-driven interpersonal communication should be used to deliver the core messages, i.e. to ensure primary content reach widely, be more effective and have much higher access to all the population groups. Therefore, in more than many ways, the 'Integrated Approach' in SBCC works more strategic in creating demands for SRH/FP services and also in fostering the much desired mobilization of communities. For example, entertaining and interactive radio programs and, in particular, local radio programs that target key population groups including younger and poorer groups are also likely to be more successful in engaging with and mobilizing communities and in improving overall SRH status of the population groups, including, increasing modern methods of contraception.

Some common denominators that must be kept into consideration in designing SRH/FP outreach interventions:

- **'Messages with Benefit', Consistent and Appealing:** Clear, consistent, simple and appealing messages for differing audiences should be developed and disseminated**.** The audiences must perceive the personal-benefit of adopting the targeted behavior. *(eg. "how do I directly benefit by changing to the suggested/prescribed behavior")*
- **Localization and Inclusive:** All the SBC materials and messages should evolve from the target audiences and pre-tested for their effectiveness, reach and recall values. They must remain decentralized, localized, tailor-made and socially-inclusive.
- **Gender and Social Inclusion:** Gender and social inclusion issues must be considered while implementing advocacy, social mobilization and behavior change activities.

Partnership: Partnerships, at multiple levels, strengthen inter-sectoral coordination and integration across sectors, which has been instrumental in conceptualizing and organizing large nationwide campaigns in the past. 'Red Triangle' branded campaign on family planning is a case in point. Some of these gathered experiences are well poised that should be incorporated in the SRH, including FP campaigns for future large scale health interventions.

Public private partnership for communication-for-positive-change may be encouraged, which has been witnessed in some successful campaigns in the past. It includes CSRs of various corporate sectors and industry associations. It not only, as is seen in many public-health/development initiatives, generates better resources but also solicits a better ownership by communities. It is also based on the principle of social marketing, wherein the local-investments made by communities, draw stronger sense of ownership.

- **Coordination and Participation:** At all levels for joint planning and implementation of communication activities, audiences involvement should be maintained throughout the communication and mobilization process.

- **Audience Centered** - Audiences should be involved with a view to determine, based on stratified risk-factors, what their specific health needs are and thus, participate in the process of shaping messages to address those needs. This is also critical in participatory methodology in development communication.

- **Evidence and results-based programming -** Evidence-based communication activities which are scientific in nature and devised through data-driven evidences should be included into the SBC Strategy, as prescriptive communication, which has no scientific evidence of results, usually fails.

- **Service linked SBC** efforts should be directed towards promotion of specific services and programs. Demand generation for a specific health service, without complete preparation of supply-cycle, could be counterproductive at the community level.

It has been well established that a scientifically designed, well-researched and well implemented SBC strategy has the potential to significantly bring about a marked improvement in the health-practices of communities and individuals. These healthy behaviors consequently accelerate improved results in morbidity and mortality, both in the communicable and non-communicable diseases.

Enter-Educate Packaging | (Entertainment-Education) formats of health communication packages

Health and development communication activities invariably compete with all of the other communication activities for the attention of the audience, including commercial advertizing. Many health communication scientists strongly believe that one of the strategic ways to get the apt attention of a designated audience, and to sustain it, is to entertain the audience and educate it simultaneously. This concept is also termed as "concept of enter-educate". As has been observed, development and health related messages, when transmitted to the communities in locally tailored and relevant entertainment package, establish higher connectivity with the audiences. There are ample examples in the Enter-Educate approach, if the health messages are packaged with entertainment content *(folk-art/drama/songs/puppet-shows/TV films etc.),* the appeal and acceptance by communities is enhanced. Many studies and evaluations have established the strategic significance of the use of enter-educate formats for health communication in developing countries.

The primary elements of this approach include: (a) Choosing the most appropriate medium in reaching the targeted audience; (b) Enlisting health/social development/communication professionals experienced in the chosen medium in order to have access to the best available resources; (c) Developing a high-quality product that should equally

attract the commercial sector; (d) Using a medium which has a big regional or national audience (varying upon the targeted needs and communication objective); and (e) Making a very appealing programme (TV or Radio Advert, Folk drama/dance, Poster, Comic Strips etc) by including entertainment elements appropriate for the intended audience and not obviously dictatorial or preachy.

Various countries could boast about successfully utilizing enter-educate approach in health communication over the last many years, such as, Communication for Young People project in Latin America, better known as the Tatiana and Johnny project and 'Green Umbrella" campaign for maternal health and family planning in Bangladesh. To an extent, a few initiatives in India such as a long-run TV series "Hum Log" was attributed to the family welfare thematic messages. The project in Latin Americas used popular music, and its spin offs, to reach young people in eleven Spanish-speaking countries with a sexual responsibility message. Similarly, Nigeria used television shows with family planning skits; in Mali the traditional Koteba theatrical format was made into films for short cinema shows before the main feature-film.

With a rich and cultural vibrancy in art forms existing in India's eco-system, it is strongly recommended that popular format entertainment should be interwoven with the SRH/FP and the relevant communication products therein.

"Campaign": It is a well known fact that many public health programmes are surviving with the scarcest of resources. Therefore, for substantive change to happen, leaders and health administrators need to get people's attention and active engagement. And, as gathered from the previous case-studies, both from the development and the commercial sectors, "campaign approach" works effectively to bring about desired results in mobilization and behavior-change strategies on health issues. Such an approach cuts through the clutter and mobilizes people around a strategic theme that has resonance and staying power; hence, much higher reach and recall value. It also includes much higher retention and

reiteration of the message too. **'Campaign' approaches in behavior change and community mobilization**, wherein specific 'real-life' and human-interest characters are created to follow a story (herein all media platforms use the similar characters to reinforce a single story-line along with relevant messages). Multiple health messages are best addressed through this approach with "integrated communication approach".

Some studies demonstrate that campaigns work particularly well in universities, health systems, closely knit communities and other "loosely-coupled" systems where authority is diffuse and windows for change are limited. The action and momentum of campaigns are appealing to many systems.

The campaign approach draws on campaign metaphors from several communication elements (*Cialdini, Robert B, 1993*), these include: Stay on message/s; Build coalitions; Capture events and venues; Ideally should have a dedicated "campaign room/area as a 'war room' and direct campaign teams/volunteers; Define the clear messages and all the tools being used; Dramatize the "benefit-message"; Hook the target emotionally; Simplify and focus; Select milestones and benchmarks carefully; Target those who are the targets and around the real target; Leverage early/previous adopters (eg. Men who have been using condoms, Women who practice oral contraceptive pills); Ensure solid partnerships and funds; Develop strong case for large public support; and most certainly manage momentum.

It is important to capture again that a campaign should follow a specific story-line with specially created story characters and each media-tool re-builds the presence of the same story characters, thus reiterating the messages (eg. *'Meena'* campaign in South Asia). If one such overarching and 'branding' campaign intervention is designed and launched, it shall provide further support to and compliment all the other SRH/FP social & behavioural change efforts across the country.

Schools/Universities Specific Health Communication: In most health campaigns, educational institutions play a vital role. Similarly educational institutes in India that served as the campaign centers have had a significant impact on various health related interventions in the past. It includes HIV/AIDS awareness, promotion of WASH programme, and even menstrual hygiene such as use of sanitary napkins for adolescent girls and women.

Research demonstrates that the school/university-based campaigns and programme delivery is largely successful not only in creating a large mass of 'informed populace', it also enhances overall acceptance of the interventions due to better *Outreach, Community Engagement and Branding of the interventions*. Therefore, it is recommended that social & behaviour change initiatives should be selectively designed for in-school and out-of-school adolescents and young people. With the support of well-trained mentors and counselors, such communication interventions are also known to promote peer-to-peer communication on the sexual and reproductive health issues.

Employing Select Innovations | Fostering Social & Behaviour Change

eHealth and mHealth | Pillars of Innovations

In 2005, the World Health Organization encouraged member states to take action to incorporate eHealth in health systems and services. The term electronic health (eHealth) refers to the practice of supporting health care through information and communication technologies; eHealth initiatives have been recognized for their potential to strengthen health systems and to improve access to care. The subset of eHealth initiatives that make use of mobile phones or any portable electronic devices with software applications are often discussed using the term mobile health (mHealth). Mobile technologies have been applied to a diverse range of initiatives outlined in recent reviews of mHealth interventions globally and in low- and middle-income countries. Given that nearly 100% of the world's population lives within reach of a mobile

phone signal, many regard mHealth initiatives as particularly promising; India's optimum use of these technologies in many other health programmes should serve as a case in point.

Use of e-Tab with Health Workers/Social Cadres for IPC and Field Monitoring (Hard-to-Reach & Vulnerable Populace) – After imparting an orientation training and it's utility (data storage/sharing, real-time monitoring use for audio-visual aids), electronic tablets can be provided to the field workers facilitating the mobilization, real-time data management, A/V communication tool including for the IPC (electronic flipcharts for counseling and small groups' communication).

Mobile Phone Technology: Mass Outreach to young people, women and men with specific pre-recorded audio and text Messages and 'Date Notifications/Reminders'- As an integral part of SRH/FP campaign, national telecom providers should be collaborated with in disseminating key messages through SMS, interactive audio and video clips, testimonies and the pre-recorded audio messages from the Prime Minister and other well-known celebrities (Goodwill Advocates). The mobile SMS intervention should also strengthen the date-notification/reminder for ANC visits, IFA tablets and many such specific actionable-behaviours which are addressed to the targeted populace.

Need for a Political Collective – Sexual and Reproductive Health & Rights

Across the globe, the SRHR (Sexual and Reproductive Health & Rights) advocates are relentlessly fighting the battle for enhanced resources/partnerships, better policy environment, legislative support, provision of essential commodities, skilled human resources and health providers, and fostering civil society collaboration to voice SRH issues. It is well understood that the foremost step in the process of advocacy and social mobilization is identification of problem and there is no denying the fact that health professionals are expert in recognizing the health problem. They are also best at reviewing literature to collect evidence for solving the health concern. However, they often fall weak in

communicating the solution to the public and to the political leaders. To be an effective public health professional, sharing of knowledge with public at large is as important as gaining of knowledge. Therefore, health administrators need to advocate for the evidences.

World Health Organization defines advocacy for health as "a combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems for a particular health goal or program"[3]. It emphasizes responsibility of health professionals as advocates of health at all levels in society, though it is paradoxical that most health cadres still relate with the treatment of the disease rather than to prevention programmes, whereas their role as defined in primary health care relates more to disease prevention. This paradigm lays significant emphasis on evidence-driven advocacy & social mobilization, which essentially include Political Advocacy, Media Advocacy, Faith-based Advocacy and Networking with Civil Society.

Political, economic, socio-cultural, behavioral, environmental, and biological factors affect public health, including comprehensive and equity-driven SRH services for women, men and young people. Social mobilization & advocacy aims at making these conditions favorable for health. Therefore, the challenge before all health professionals is to enter into the arena of sustained social mobilization & evidence-driven advocacy. Most public health programmes across the world, including many SRH/FP programmes, health professionals often remain aloof from advocacy considering that policies and decisions on public health issues are the responsibility of politicians and bureaucrats. Should health professionals not approach political leaders to advocate that health posts should be closer to the community? If the answer is 'yes', health professionals have to consider community not as a mere passive receiver of services but as a responsible and 'informed' stakeholder. And they are not only service providers but are also health advocates. Health communication experts recommend that social mobilization, advocacy and lobbying cannot be left to the market forces.

[3]World Health Organization (WHO) Health Promotion Glossary. Geneva: 1998

Elected leaders at all levels, from Panchayats to Parliament, need to be engaged with the emerging evidence of the critical need for accessible, affordable and quality SRH/FP services in India. Seeking the support of political leaders at the highest level could yield significant results for the SRH/FP issues in the country.

It is recommended that the National Population Programme, while working with select CSOs, forms a **"Political Coalition of Leaders for Population & Development".** Along with the need of advocacy one should also reckon that the sustainability and effectiveness of any program can be enhanced by the commitment of elected-leaders/policymakers. Seeking such commitment is an important step in planning and launching any SBCC strategy, such as for SRH/FP.

Perceived Roles of Political Leaders in relentlessly addressing SRH/FP in India:

- Legislate progressive policies and bills, wherever needed;
- Advocate in parliament & political meetings;
- Allocate enhanced resources for the SRH/FP;
- Proactively raise issues on the floor of the house;
- Monitor national programme and critique the interventions;
- Field/constituency-based monitoring and discussion with communities
- Ensure coverage of SRH/FP issues in the party manifestos;
- Include SRH/FP issues in public statements and speeches

Indian Association of Parliamentarians on Population and Development (IAPPD) serves as one such platform, where elected leaders are engaged with the population, health & development issues. However, the organization needs strengthening and further more sustained advocacy activities across the country.

Road Ahead for SRH/FP: Health Communication Policy Framework in India

Addressing all-encompassing risk factors that, by and large, grip the issues of sexual and reproductive health, including family planning for women,

men and young people, health communication poses a unique challenge. Therefore, an integrated, holistic yet focused, rights-driven and evidence-based social and behavior change strategy, using the life-cycle and continuum of care approach is critical to addressing the socio-cultural barriers and to help in acceptance and adoption of healthy practices and appropriate care seeking behaviors. A well thought-through and an appropriate SBC (social & behavioural change) strategy shall also address issues that more or less remain underneath the low uptake of health care services in communities, be it in remote rural areas or in the urban clusters.

To conclude, effective and results-based SBC strategies use concepts that range from psycho-social learning theories of role modeling communicated via multiple modes, including mass media, to the use of advocacy and social mobilization. Dialogue with and active participation of individuals is an essential element in communication for behaviour and social change. Many communication programmes have for long focused much on the metaphorical 'tree' and not enough on the 'forest', i.e. the attention was on the individual as the focus for change. For behaviours to change on a large scale, harmful cultural values, societal norms and structural inequalities have to be taken into consideration. Effective communication strategies have to be cognizant of and in tune with the policy and legislative environment and linked to the service delivery aspects. And in order to address the critical need for addressing SRH/FP issues, including maternal & neonatal child health during the emergencies and natural disaster situations, both the Government and the communities should be better prepared now than ever before. Due to COVID19 pandemic waves, development partners, including the respective governments, have well gathered together the requisite experience in the outreach of core communication messages through appropriate modes along with the provision of skilled services at the requisite health facilities.

BIBLIOGRAPHY AND REFERENCES

(In order of appearance and reference made in the document)

1) World Health Organization. Family planning/Contraception. WHO. 2018. Available from: https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception

2) Family Welfare Program in India Year Book, 2011. Ministry of Health and Family Welfare, Govt. Of India publication

3) United Nations Department of Economic and Social Affairs Population Division. Family Planning and the 2030 Agenda for Sustainable Development: Data Booklet. (ST/ESA/ SER.A/429). 2019.

4) Okigbo, C.C., Speizer, I.S., Corroon, M. *et al.* Exposure to family planning messages and modern contraceptive use among men in urban Kenya, Nigeria, and Senegal: a cross-sectional study. *Reprod Health* 12, 63 (2015). https://doi.org/10.1186/s12978-015-0056-1

5) Ahmed S, Li Q, Liu L, Tsui AO. Maternal deaths averted by contraceptive use: an analysis of 172 countries. Lancet. 2012;380(9837):111–25.

6) Todd C, Christian D, Davies H, Rance J, Stratton G, Rapport F, et al. Headteachers' prior beliefs on child health and their engagement in school based health interventions: a qualitative study. BMC Res Notes. 2015; 8:161. pmid:25925554

7) Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. Lancet. 2006;368(9549):1810–27.

8) Darroch JE, Singh S. Trends in contraceptive need and use in developing countries in 2003, 2008, and 2012: an analysis of national surveys. Lancet. 2013;381(9879):1756–62.

9) United Nations Population Information Network (POPIN). Report of the ICPD. UN Population Division, Department of Economic and Social Affairs with support from the UN Population Fund (UNFPA), Geneva, Switzerland;1994. http://www.un.org/popin/icpd/conference/offeng/poa.html.

10) Sternberg P, Hubley J. Evaluating men's involvement as a strategy in sexual and reproductive health promotion. Health Promot Int. 2004;19(3):389–96.

11) Gupta N, Katende C, Bessinger R. Associations of mass media exposure with family planning attitudes and practices in Uganda. Stud Fam Plann. 2003;34(1):19–31.

12) Saha, S. (2005). Dynamics governing women's decision on reproductive health matters: Reflections from a qualitative study in central India. *Online Journal of Health and Allied Sciences*, *4*(2).

13) Sivagurunathan, C., Umadevi, R., Rama, R., & Gopalakrishnan, S. (2015). Adolescent health: present status and its related programmes in India. Are we in the right direction?. *Journal of clinical and diagnostic research: JCDR*, *9*(3), LE01.

14) Ghosh, S., & Saha, M. (2013). Health communication and behavioural change: An exploratory study among marginalized communities in rural West Bengal, India. *Journal of Health Management*, *15*(3), 307-327.

15) Bitzer J, Abalos V, Apter D, Martin R, Black A, Machado RB, et al. Targeting factors for change: contraceptive counselling and care of female adolescents. Eur J Contracept Reprod Heal Care. 2016;21(6):417–30. pmid:27701924

16) Jejeebhoy, S. J., & Santhya, K. G. (2011). Parent-child communication on sexual and reproductive health matters: Perspectives of mothers and fathers of youth in India.

17) Banerjee, S. K., Andersen, K. L., Warvadekar, J., Aich, P., Rawat, A., & Upadhyay, B. (2015). How prepared are young, rural women in India to address their sexual and reproductive health needs? A cross-sectional assessment of youth in Jharkhand. *Reproductive health*, *12*(1), 1-10.

18) Jejeebhoy, S. J., & Sebastian, M. P. (2003). Actions that protect: Promoting sexual and reproductive health and choice among young people in India.

19) Prochaska, J.L., & DiClemente, C.C. (1992). Stages of change in the modification of problem behavior

20) Johns Hopkins University Center for Communications Programs Resource Center https://www.jhuccp.org/resource_center

21) C-Change/FHI 360. 2012. C-modules: A Learning Package for Social and Behavior Change Communication (SBCC). Washington DC: C-Change/FHI 360. https://www.cchangeprogram.org/focus-areas/capacity-strengthening/sbcc-modules

22) Nutbeam, D. (1996) Health outcomes and health promotion: defining success in health promotion. *Health Promotion Journal of Australia*, 6,58–60.

23) Gupta, D., Jai P, N., & Yadav, J. S. (2021). Strategic Communication in Health and Development: Concepts, Applications and Programming. (SAGE) *Journal of Health Management*, *23*(1), 95–108. https://doi.org/10.1177/0972063421994943

24) Andreasen, A. R. (1995) *Marketing Social Change: Changing Behaviour to Promote Health*, *Social Development*, *and the Environment.* Jossey-Bass, San Francisco, CA.

25) Bandura, A. (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory.* Prentice-Hall, Englewood Cliffs, N.

26) Ackerson, L. K., Ramanadhan, S., Arya, M., Viswanath, K. (2012). Social disparities, communication inequalities, and HIV/AIDS-related knowledge and attitudes in India. AIDS and Behavior, 16, 2072–2081. https://10.1007/s10461-011-0031-y

27) Abraham, L. (2001). Redrawing the *Lakshman Rekha*: Gender differences and cultural constructions of youth sexuality in urban India. South Asia, XXIV, 133–156. https://10.1080/00856400108723441

28) Guilamo-Ramos, V., Soletti, A. B., Burnette, D., Sharma, S., Leavitt, S., & McCarthy, K. (2012). Parent-adolescent communication about sex in rural India: U.S.-India collaboration to prevent adolescent HIV. *Qualitative health research*, *22*(6), 788–800. https://doi.org/10.1177/1049732311431943

29) Seif, S.A., Kohi, T.W. & Moshiro, C.S. Sexual and reproductive health communication intervention for caretakers of adolescents: a quasi-experimental study in Unguja- Zanzibar. *Reprod Health* 16, 92 (2019). https://doi.org/10.1186/s12978-019-0756-z

30) Inayatullah (1976) "Western, Asian, or global model of development," in W. Schramm and D. Lerner (eds.) Communication and Change in the Developing Countries: Ten Years After. Honolulu: Univ. of Hawaii/ East-West Center.

31) Freire, P. (1970) *Pedagogy of the Oppressed.* Continuum/ Seabody, New York.

32) Gupta, D., Hassan, B., Agarwal, A. and Bhasin, A. (2019) "Immunization Campaigns: Mitigating Barriers - Designing Communication", *Interações: Sociedade e as novas modernidades*, (36), pp. 158-175. doi: 10.31211/interacoes.n36.2019.e2.

33) Green, E. C. and Murphy, E. 2014. Health Belief Model. The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society. 766–769.

34) Ajzen, I. (1985). From intentions to action: a theory of planned behavior. In J. Huhl, & J. Beckman (Eds.), Will; performance; control (psychology); motivation (psychology) (pp. 11–39). Berlin and New York: Springer-Verlag

35) Everett M Rogers, Department of Communication and Journalism, University of New Mexico, Albuquerque, NM 87131-1171

36) Waterkeyn J, Cairncross S (2005) Creating demand for sanitation and hygiene through Community Health Clubs: a cost-effective intervention in two districts of Zimbabwe. Soc Sci Med 61: 1958-70

37) Bauman KE. The effectiveness of family planning programs evaluated with true experimental designs. *Am J Public Health*. 1997;87(4): 666–669. 10.2105/AJPH.87.4.666.

38) Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. *Lancet.* 2006;368(9549): 1810–1827. 10.1016/S0140-6736(06)69480-4

39) Cialdini, Robert B. Influence: The Psychology of Persuasion. New York: Quill, 1993

40) Sharma V, Sharma A. The letter-box approach: a model for sex education in an orthodox society. J Fam Welfare. 1995;41(4):31–34.

41) Adolescence: development and obstacles. Adolescence, research and reference centre, psychological aspects of AIDS CMC Vellore. Health Dialogue. 2002;28:1–3.

42) Gupta N, Mathur AK, Singh MP, Saxena NC. Reproductive health awareness of school-going, unmarried, rural adolescents. Indian J Pediatr. 2004 September;71(9):797–801.

43) Kushwah SS, Mittal A. Perceptions and practice with regard to reproductive health among out-of-school adolescents. Indian J Community Med. 2007; 32:141–143.

44) Bobhate P, Shrivastava S. A cross sectional study of knowledge and practices about reproductive health among female adolescents in an urban slum of Mumbai. J Fam Reprod Health. 2011;5(4):117–124.

45) Kotecha PV, Patel SV, Mazumdar VS, et al. Reproductive health awareness among urban school going adolescents in Vadodara city. Indian J Psychiatry. 2012 October;54 (4):344–348.

46) Mwaikambo L, Speizer IS, Schurmann A, Morgan G, Fikree F. What works in family planning interventions: a systematic review. *Stud Fam Plann*. 2011;42(2): 67–82. 10.1111/j.1728-4465.2011.00267.x.

47) Speizer IS, Corroon M, Calhoun L, Lance P, Montana L, Nanda P, et al. Demand generation activities and modern contraceptive use in urban areas of four countries: a longitudinal evaluation. Glob Health Sci Pact. 2014; 2(4):410-426. http://dx.doi.org/10.9745/GHSP-D-14-00109

48) MTV, "The Truth About Youth", Brand Equity, The Economic Times, March 19, 2008, Pg. 4

49) Julian Rolfe, Mischa Gilbert, " Young, new media, technology and communication", Young Consumers: Insight and Ideas for Responsible Marketers, 2006

50) Karen Yeung, A Study of the Implications of Advanced Digital Technologies (including AI Systems) for the Concept of Responsibility Within a Human Rights Framework, MSI-AUT (2018) 05, 24 (Nov. 9, 2018), https://ssrn.com/abstract=3286027.

ANNEXURE

(Structure of Key Informant Interviews – KII)

(1) Upon review of literature related to the population communication ("IEC in FW"), most researchers mention India's FP programme as 'historical' that had an early start soon after the country's independence.

How do we interpret the evolution that has taken place under the FP communication? According to you how it evolved and through what stages?

(2) As varied research studies/evaluations reflect, multi-pronged health communication interventions work effectively in a country as diverse as India. It includes, mass-media campaigns, mid-media outreach and, interpersonal communication persuasion/follow-up.

Do you think that India's FW (including FP promotion) programme included all the recommended strategies? Please share your observations.

(3) Are you satisfied with how the HFW, especially outreach and behaviour-change communication related to SRHR including FP, Adolescents' health & Gender based violence is currently designed and delivered? If not, how differently would you do it and why?

(4) With an advent of social media (SM) and the evolving digital space, many campaigns are using these technologies in connecting with people (target audiences). Do you recall any such experimental strategy where SM was used successfully? How would you, and in what way, suggest use of social media and digital platforms for the SRHR/FP communication?

(5) With the digitalization of Media and increasing access to smart phones, messages are disseminated easily and the recipients (target audiences) are not only the receivers of messages but are also

generators/modifiers/creators of messages. What implications does this have in the context of SRH and services?

(6) In the end, do you really think that expected outcomes of the national/state level policies and programmes actually convert into realistic actions, which especially includes keeping appropriate focus of SBCC messages on SRHR/FP while reaching the communities? If you observe gaps, what are those and how can those be addressed?

About IAPPD

The Indian Association of Parliamentarians on Population and Development (IAPPD) is a national-level Non-Governmental Organization established in the year 1978, with an imperative of moderating the pace of population growth for a smoother course of development so as to ensure an overall improvement in the quality of life of the people and maintain a proper balance between population and development.

The IAPPD is convinced that the population stabilization programme will not succeed unless it is backed by a mass movement in favour of general acceptance of the small family norm. It needs to be approached within a developmental framework that offers a well-integrated package of health, education, employment, social and environmental policies. The introduction of innovative mechanisms for decentralized planning and policy formulation is the need of the hour. For this purpose, it is obviously necessary to promote and also ensure well-informed participation of Parliamentarians in local -level development planning.

IAPPD

Indian Association of Parliamentarians on

Population and Development

(United Nations Consultative Status with ECOSOC)