COMMUNITY RADIO AND COMMUNICATIONS ABOUT WOMEN'S HEALTH: AN INTERVENTION STUDY OF HENVALVANI COMMUNITY RADIO, UTTARAKHAND

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Chapter 6

Summary

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6.1 Introduction

In its essence, the purpose of health communication is the effective dissemination of health information to influence personal health choices and to improve people's quality of life. Approaches to health communication include tensions between expert-led didactic methodologies which aim to provide technically efficient messages, and those that situate health communication within the contexts of intrapersonal relationships, cultural practices, and economic and social conditions (Parker & Beckor-Benton, 2016). While health communication has largely been dominated by the persuasive approaches aimed at disseminating technical information, there is a growing concern that factors which promote good health seeking behaviors are not solely rooted in individuals, but rather are dynamic in nature possessing more collective and interactive elements (MacKian, 2003). This calls for changing the focus of our attention to explore the ways in which local dynamics among communities can be influenced to improve the well being of its members, and holds special relevance to the lives of women whose care seeking behavior is largely influenced by socio-cultural norms and community dynamics. Constraints on women's health-seeking behaviour are seen to operate through social structures, norms, beliefs, taboos and perceptions, which influence the opportunity women are provided to voice their health concerns (Peplau et al., 1997; Otalike, 2009; Idowu, 2013). Building mechanisms for women to communicate, and increase their participation in health communication can go a long way in attaining sustainable improvement in health outcomes. Thus, developing communication to support health and well-being of vulnerable segments of the communities (like women) requires a multifaceted understanding of local perspectives of contextual challenges and potentials for change.

The top-down approaches tend to involve audiences only at the end of the development cycle as mere recipients of the messages and thus deliver health messages at the expense of understanding specific communication needs and contextual nuances of the audiences. Participatory approaches, on the contrary, are

bottom-up approaches and call for the involvement of the audience in the entire cycle of a programme. While persuasive strategies rely on mass media to achieve a wide reach and combine it with communications that are mostly monologic in nature, the CFSC approaches are more concerned with horizontal communications and focus upon how audiences negotiate various health concepts (Parks, Gray-Felder, Hunt & Byrne, 2005). Participatory communication is dialogic and focuses not just on exchanging information and experiences, but also calls for exploration and generation of new knowledge which is aimed at addressing situations that need improvement. It leads to collective identification and prioritization of needs, goals, indicators of change, and desired outcomes by community members (Tufte & Mefalopulos, 2009).

Community media (CM) are privileged forces driving participatory communication (Saez, 2013). Working on the principles of participatory communication, these media platforms offer new communication spaces, especially for community groups living on the fringes of society, to make their voices heard, establish horizontal dialogues with different stakeholders, negotiate complex issues and arrive at sustainable solutions for community development (Coyer, Dowmunt & Fountain, 2007; Dagron, 2009).With community members participating as planners, producers and performers, these media serve as medium of expression of the community (Berrigan, 1979).These media not only allow, but also facilitate participation of members of the community in both the produced content and the content producing mechanisms (Prehn, 1992: 259). Many visualize these media as processes where communities take control of their own development and use communication technology. Stressing the importance of building multiplicity of ideas, a CM enable communities to reflect and look for solutions collectively. These media allow formation of public sphere by facilitating audience access and participation within the frames of democratization (Lewis, 1993).

The present work is a study of a health communication intervention, *Khushiyon ke aangan mein* (KKAM) broadcast by a participatory CM, namely, Henvalvani Community Radio (HCR) which has been functioning in Tehri-Garhwal district of Uttarakhand state, and whose roots of HCR were laid in 2001. HCR endeavours to act as a catalyst by not only encouraging flow of information from the informed to the uninformed, but also by facilitating dialogue among stakeholder groups. Dialogue has

immense potential for open discussions among people from different social groups and for developing consensus about solutions and plans of action (Freire, 1970; Melkote & Steves, 2001). Participation in the process of media production leads to acquisition of new knowledge, aids in voicing and listening to the concerns of those involved and enables self-reflection. Through participation, people undergo a process of 'conscientization' and are able to reach out and garner support for their issues, aided from networking in their extended 'public sphericules' (Malik & Bandelli, 2012).

The overarching aspect this study attempts to explore is **the role HCR as a participatory community media can play in influencing the perceptions of women and other community members towards various women's health issues, and health communications within a community.** In order to achieve this, we explored few supporting aspects. So, first, various aspects which could promote participation of women and other community members in health communications, were explored. Then, the effects triggered by communicating health messages on the aspects deeply rooted in socio-cultural norms and beliefs of the community and processes underlining these effects were proved. Finally proved the role of the CR within the larger context of health communication, in order to comprehend its ability in communicating health messages within the normative frameworks, was analysed.

6.1.1 Research Objectives

Objectives formulated for the study were :

- To explore the prevailing perceptions encompassing women's health and their care seeking behavior.
- To study health information sources and differentials in credibility accorded to them.
- To document the production process of HCR- led series on women's health, i.e. *Khushiyon ke aangan mein* (KKAM).
- To ascertain the role of HCR in influencing knowledge levels about women's health.

- To study the significant changes perceived by listeners of KKAM subsequent to broadcast of the series.

6.2 Review of Literature

This section attempts to provide theoretical anchors to the aim of the study.

6.2.1. Communication for development and social change

During the dominant paradigm, the different theories and models used for bringing social and behavioural changes were premised on lack of knowledge as forming the root causes of problems of development. The generation of development communication studies during 1980s suggested cultural and information deficits as the key underlying causes of development problems and view existence of traditional culture as the root cause that inhibited development (Waisbord, 2001). The emphasis shifted to media-centred persuasion activities and , the developmental model majorly focused upon adoption of media technologies and modern culture and ideas as forming the key indicators of development. Later, concerns arose over the extensive application of social marketing campaigns for bringing behaviour change. The issues and agendas reflected in these mainstream discourses rarely proved the spaces for expression of the contextual issues and concerns of the masses. This led to the marginalization of those at the receiving end. Shifting of focus from dominant to the alternative paradigm emerged from the need to maintain a more human-centred development. Freire's (1970, 1973) perspective of a 'liberating pedagogy' laid the foundations of participatory approaches to development.

6.2.2. Participatory Communication

The essence of participatory communication is the need for an exchange of information by means of dialogue with the intent to revolutionize the quality of life of those involved in it (Bessette, 2004; Chintis, 2005). There are various approaches to participation . Some view participation as a means while other view it as an end in itself. CM also known as alternative media (Carpentier, Lie &Servaes, 2003),and citizen's media (Rodriguez, 2001), are viewed as "media which have some form of accountability to their communities and are characterized by the objective of

empowering communities through voice" (Coyer et al., 2007:210). CM are managed by grassroots communities and enable a bottom-up and two way flow of communication among various social groups. Managed by the community members, t facilitate their participation in both the produced content and the content producing organization (Pateman, 1970). CM defies compartmentalization. Various forms of CM continue to exist in diverse contexts, including community papers (written and edited by women like Khabarlahariya.org, ujalachaddi), CRS run by village members (Pavarala& Malik, 2007), small community video units funded by NGOs and run by local marginalized communities (videovolunteers.org), mobile phone based voice-driven platforms (graamvaani.org, cgnetswara), and even internet based social media blogs and weblogs (Coyer et al., 2007). Some forms of theatre such as street theatre and other traditional folk-based media forms are also examples of community media (Coyer et. al., 2007). The potential of various types of CM (including CR) in contributing to the processes of social change lies in their ability to cultivate more broad-based participation in deliberation and debates at the grassroots level and create a public sphere capable of engaging multiple voices and perspectives (Tufte & Mefalopulos, 2009). Putnam (1993) aids in understanding the potential of community media in mobilizing collective action. The two dimensions of social capital, namely structural social capital and cognitive social capital have been shown to have direct links to public health (Agampodi et al., 2017). The generation of social capital takes place in civic organizations (Matthews, 2015). The observable characteristics of a CM can aid in furthering the social capital of a community and can affect the participation of community members. Factors such as type of participation and level of participation can influence the social capital existing within a community or a group (Travaglini, 2012).

6.2.3. Health and Health Communication

For increasing the awareness, mass media and multimedia have been used to disseminate health information. Two distinct yet interrelated approaches to health promotion efforts have developed in response to the call for examining the role of culture in health care settings: the cultural sensitivity approach (Brislin, 1993; Brsilin& Yoshida, 1994; Bronner, 1994) and the culture-centered approach (Dutta-Bergman, 2005). Efforts to promote health are generally founded on a universal logic

of scientific rationality, are based on individualistic hypotheses of risks in the field of health, and consequently are ignorant of cultural contexts (Resnicow et al., 2002). On the contrary, the culture centered approach focuses on ways to create, reiterate and sustain conditions health promotion efforts which aim to disrupt the dominant paradi gm of health promotion by introducing subaltern voices into discursive space (Dutta & Basnyat, 2008). Health is affected by macro level influences, such as social structur es and institutions which shape women's and men's expectations and the way they org anize their lives(Johnson & Oliffe, 2012). Gender power relations determine how power is constituted and negotiated in terms of access to various resources, division of labour, social norms and decision making and are found to affect maternal health care access and utilization (Morgan, et al., 2017). Gender disparities faced by women get translated into lack of autonomy and control over household resources - both material and knowledge and even over their own bodies and living has often been indicated in studies (Kabeer, 2005). Patriarchy and socio-cultural norms form another set of factors inhibiting the access and control of healthcare services by women. Media and new technologies of communication including CR informed by a gender perspective, can play a central role in the balancing the inequities by empowerment of women (Girard & Siochru, 2003). Results from various researches have shown that social norm diffuse is more likely to be driven by a social mechanism, than by individual persuasion, which the traditionally top down approaches to health communication have been propagating (Chew, 2001; Arias, 2016; Parker & Benton-Beckor; 2016).

6.2.4 Radio for development

A critical review of the literature around the issue of improving public health has shown strategies of communication based on use of radio either alone or along with other mass media to influence individual behaviours. Findings from various studies point that though there are number of projects which have used only radio as their main channel of communication to reach out to large numbers (Singhal, et. al, 2004; Khan, 2007; Manyozo, Nassanga & Lopes, 2010; ITAP, 2012; UNICEF, 2011) but studies trying to explore the aspects of such a vibrant communication ecosystem created by CR are still less in number (Pavarala& Malik 2007; Bandelli, 2011; Yalala, 2015). The present

study attempts to study one such CR, HCR in influencing the perceptions of its listeners.

6.3 Methodology

6.3.1 Locale of the study

Tehri-Garhwal district of Uttarakhand state of India where HCR is operating , was selected as the locale.

6.3.2 Study design

The study is an intervention study following a 'mix-method' study design. Radio health communication series, KKAM broadcast on HCR formed the intervention. Four-group design was followed. Two Intervention Groups, I1 and I2, and two control groups C1 and C2 were formed. Pre-tests and post-tests were applied to these four groups.

6.3.3 Sampling

Selection of the sample followed a multistage sampling process. A CR transmits within an area of 30 km radius. Of the nine blocks of Tehri-Garhwal district, HCR transmission reaches only four blocks.

6.3.3.1 *Selection of HCR blocks*

The call-in database available from an open source software, GRINS (installed at the HCRS by GramVaani) was utilised. The software records call-in flows, and identifies locations from where the calls are made. Quantum of listenership was determined by the volume of calls received by HCR during its programmes in year 2012-13. Chamba and Narendranagar, having maximum quantum of listenership were selected and named HCR blocks.

6.3.3.2 *Selection of Non-HCR blocks*

Of the five blocks where HCR transmission was not available, two blocks Thauldhar and Jaunpur received erratic or nil transmission, and matched the two selected HCR

blocks in terms of population parameters were selected purposively, and together termed as Non-HCR blocks.

6.3.3.3 *Selection of villages*

HCR has listener clubs in villages falling within its transmission range. In some such clubs HCR programmes are narrowcast in form of recorded programmes in monthly meetings. HCR team holds discussions and take feedback at least once a month. In Chamba, narrowcasting is there in 23 villages and Narendranagar 18 villages. Fish bowl method was used for the random selection of villages.

The total number of villages was guided by the number of respondents required for the sample. Of the villages selected from these blocks, two more villages were added to the pool of villages to get the required number of respondents. Villages Jardhar, Syul, Swari, Kuriyal, Indwal, Chopariyali from Chamba, and villages Agar, Ampata, Koti and Thapaliyal from Narendranagar were selected. From Non-HCR blocks, a sample of four villages from each of the two blocks was selected randomly.Villages from Non HCR blocks having. Four villages Bor, Kirgani, Manjkot and Kafalpani from Thauldhar; and four Satyun, Uniyal gaon, Manjgaon and Jadgaon from Jaunpur were selected.

6.3.3.4 *Selection of respondents*

Respondents were selected from the chosen villages. Using the Fisher et al. (1998) formula, a total sample size of 480 was calculated .

6.3.3.4.1. Sample criteria

Criteria were largely decided to control aspects that could confound the study.

Inclusion criteria

- Age: 18-49 years
- Having resided continuously in the village for at least one year preceding the commencement of the study.
- Listener of HCR (persons listening to HCR programmes for at least 1.5 hr per day)

- For posttest, listeners of KKAM series (persons who had listened to at least 5 episodes of the series).

Exclusion criteria

- Left or likely to leave the village for more than one month during the study period.
- Not owning a functional mobile phone.

6.3.3.4.2. Sample selection

Event-based sampling was used. In HCR blocks, villagers attending narrowcasting in the monthly meetings organised by Community Based Organisation (CBO) were considered. In Non-HCR blocks, villagers attending monthly meetings were considered.

Initially, 80 people from Chamba randomly selected from listeners of HCR and fulfilling the sample criteria, formed group I1. Another 80 people from Thauldhar (of Non HCR blocks) randomly selected fulfilling the sample criteria, formed group C1. Thus a total of 160 respondents were selected for baseline survey.

After the intervention, additional sample of 160 was taken from the respondents of group I1 and C1 were considered. In this, 80 people from Narendranagar randomly selected from listeners of HCR and fulfilling the sample criteria, formed group I2. Another 80 people from Jaunpur (of Non-HCR blocks) randomly selected from those fulfilling the sample criteria, formed group C2. Thus for the post test, total of 320 respondents were taken (group I1, I2, C1, C2). Thus, total of 480 was considered for the study.

6.3.4. Tools and Techniques

Different tools were utilized in five phases.

6.3.4.1 Tools of Phase I

Aiming to enquire prevailing perceptions of men and women encompassing women's health issues and their seeking of care, following two tools were used.

6.3.4.1.1 Focus group discussions (FGDs)

FGD is a qualitative research technique which draws upon respondent's perceptions, opinions, beliefs and attitudes towards an issue.

6.3.4.1.1(a) Tool Development

FGD guide was prepared in Hindi language. The community members and HCR staff were consulted during preliminary visits by the researcher. and questions were formed revolving around concepts on women's health, perceptions and beliefs about women's key health problems, different procedures women and their families adopted to deal with those issues, etc. For checking the comprehensibility of the questions, group discussions (on the line of FGD) were conducted in the blocks of Chamba and Thauldhar. Questions felt ambiguous by the participants were removed and a final list of seven questions was prepared to be FGD guide. FGDs were conducted in selected villages with the help of the HCR staff and volunteers. Two separate FGDs were conducted in each village, one each for men and women.

6.3.4.1.1.(b) Sample for FGDs

Sample for the FGDs was selected using event based sampling. In HCR blocks, those adult villagers who attended the narrowcasting and fulfilled the inclusion and exclusion criteria of quantitative sample baring the age criteria were included. Similarly, in the Non-HCR blocks, those adult villagers who attended the monthly meetings and fulfilled the inclusion and exclusion criteria except age were selected as sample. In the HCR blocks, a total of 85 respondents from the villages of Swari, Indwal, Agar and Ampata, participated in FGDs (41 men and 44 women). In the Non-HCR blocks, a total of 83 respondents (41 men and 42 women) participated during the FGDs.

6.3.4.1.2. Narratives of health

Narrative is a powerful tool that allows holistic understanding of the socio-historical contexts and is helpful in capturing the subjective experiences of the individual on an issue (Muylaert, Jr, Gallo, Neto & Reis, 2014).

6.3.4.1.2.(a) Development of tool for 'Narratives of health'

An open-ended interview guide was prepared for the collection of narratives of health. The focus of the guide was on obtaining narrators' perspectives of the key health issues faced by women and how they and their families dealt with the same. So questions were developed so as to explore their experiences about seeking of care during episode of illness and the challenges faced. For men, the questions were related to any episode of illness faced by an adult woman in the family.

6.3.4.1.2.(b) Sample for narratives of health

The sample for the narratives was drawn from the people who had participated in the FGDs and had faced some illness in their family in past six months. Narratives were collected only from those who consented to share their stories. At times, visits were made twice to collect the narratives. A total of 40 narratives (18 from men and 22 from women) were collected.

6.3.4.2. Phase II

During this phase, a workshop was organized by HCR for conceptualization of the contents of the intervention. The issues to be addressed through the intervention were identified. A comprehensive message grid enlisting key messages to be focused upon in the upcoming interventions was collectively prepared by the women participants.

6.3.4.3. Tools of Phase III

During this phase, baseline data of the respondents of I1 and C1 groups was collected to ascertain the knowledge levels. Further, for designing and structuring of the intervention, sources of health information preferred by these respondents of I1 and C1 and the credibility accorded by them to each source were enquired.

Tools used included **Knowledge inventory** and **Interview schedule**

6.3.4.3.1 Knowledge inventory

Pre-test was carried out prior to intervention. For this, a knowledge inventory was prepared, based on the women's health issues identified in the workshop conducted during Phase II.

6.3.4.3.1.(a) Development of the knowledge inventory

For the development of the knowledge inventory, following steps were taken:

i *Forming a pool of questions*: On the basis of the comprehensive message grid prepared by community women during the workshop, a pool of 33 questions was prepared. This pool was divided into three themes and contained questions on the key messages planned to be covered by the KKAM series. These themes were: anemia and its identification; marriage and family planning; and pregnancy and antenatal care. There were 9-11 knowledge questions in each of the themes.

ii *Establishing Content validity*: For establishing the content validity of the tool, Garrett Ranking method was used. For this, the comprehensive message grid along with the pool of questions (prepared by the researcher) were given to ten experts having expertise in the concerned area. These experts were asked to rank the questions in each theme as per questions' respective relevance. For each question, ranks given by each of the experts were tabulated. Based on the ranks obtained from the experts, percent position for each question in each theme was calculated. The percent position value for each question was converted into Garrett values and Garrett scores using Garrett Ranking Conversion Table. Eight questions per theme with highest Garrett scores were included in the final knowledge inventory.

iii Checking for Reliability of the tool

Test-retest method was used to ascertain the reliability of the knowledge inventory. It was administered to a group of 25 people of the villages which were not part of the sample. The Cronbach Alpha of the knowledge inventory was calculated to be 0.82, indicating good reliability of the knowledge inventory.

6.3.4.3.1.(b) Tool administration

The tool was administered to the respondents of I1 and C1 groups. For taking interviews of women, many times, trips were made to their fields as they would spend majority of their time there. During the interviews, HCR volunteers helped in comprehending the language of the respondents.

6.3.4.3.2.(c) Sample for knowledge inventory

Sample for the pre-test was done using event based sampling. From HCR blocks, those attending the narrowcasting and fulfilling the sample criteria were selected. From Non-HCR blocks, those attending monthly meetings and fulfilling sample criteria were selected.

6.3.4.3.2 Interview schedule

For collecting the data on health information sources, media habits, and the socio-demographic parameters of the respondents, semi-structured interview schedule was used.

6.3.4.3.2.(a) *Development of the tool*

A pool of questions was developed to seek answers about required parameters of the respondents. A total of 38 questions were devised and divided into three sections. The sections of the schedule attempted to understand various details about respondents based on the objectives of the study.

6.3.4.3.2.(b) Reliability and Validity

To ascertain the content validity of the pool of questions for including in the schedule, it was given to experts who had vast experience in the area for review. These were experts in the fields of health communication, extension or independent experts in the area of health. These experts reviewed the pool developed by the researcher, gave their inputs, following which the pool was amended. A test-retest method was utilized for checking the reliability of the schedule. Based on the responses obtained, from these 40 people Cronbach Alpha of the schedule was computed to be 0.78. The finalized interview schedule had three sections. The first section focused on the socio-economic profile of the respondents and comprised questions regarding marital status, educational qualification, monthly income of the household, occupation, size of the land owned, etc. This section focused on understanding the media landscape of the respondents and comprised questions regarding the types of media, i.e., mobile, Radio, TV, etc., available with the respondents and about their access patterns. This

section aimed to investigate the health information seeking behaviour of the respondents. The respondents were asked to select the sources of health information accessed by them and give order of their three top preferences. It had questions on the nearest health facilities available, the facilities they visited the most and their reasons for their preference.

6.3.4.3.2.(c) Sample and Administration of the Tool

Event based sampling was used. The respondents of I1 and C1 were asked their response to each question of interview schedule. The response to each question was noted and analyzed.

6.3.4.4. Phase IV

Production and broadcast of the series were carried out in this phase. The process entailed various steps viz, scripting, programme segmentation and format, production of episodes, and the broadcast of the episodes of the series. The period for phase IV spanned from November 2014 to October 2015.

6.3.4.5. Phase V

During this phase, a post-test was conducted to quantitatively ascertain the knowledge scores of the respondents of all the four groups I1, I2, C1, and C2. Along with this, the qualitative changes perceived by groups I1 and C1 respondents as affected by KKAM were captured using the Most Significant Change (MSC) technique.

Tools used included **Knowledge inventory, Interview schedule** and **MSC technique**

6.3.4.5.1. Knowledge inventory and Interview schedule

During January to December 2016, post-test was conducted in which knowledge scores of the respondents from each of the groups I1, I2, C1 and C2 were ascertained. The same knowledge inventory used in Phase III was used in Phase V. Apart from this, the respondents from groups I2 and C2 were also interviewed using the same interveiw schedule used in Phase III.

6.3.4.5.2. Most Significant Change technique

In order to map the effects and process factors triggered by the intervention KKAM, Most Significant Change (MSC) technique was utilized. Domain of 'significant change' stories involved recalling of the specific events/experiences of what happened, when why, how, and effect on self and others since the broadcast of KKAM. They were asked to narrate their story of the most significant change perceived by them as an effect of KKAM series.

6.3.4.5.2.(a) Sample for MSC story narrators

Sample for the collection of MSC stories comprised men and women from the intervention groups I1 and I2.

6.3.4.5.2.(b) Story collection

MSC stories were collected were collected during the visits conducted for the post test. A total of 68 MSC stories were collected. Of these, 42 stories were contributed by women and 26 by men who lived in the villages of Swari, Jardhar, Syul, Kuriyal, Indwal, Chopariyali, Ampata, Thapaliyal, Agar and Koti. The reporting period for the respondents was the one between the commencement of broadcast and time of collection of the MSC stories. Availability of time and willingness of narrators were two important factors for collection of the stories. Some opted for narrating their stories in writing, while for others a recorder was used to collect the stories of change. Since the series focused around issues of reproduction and FP, considered too private matters to be discussed, some narrators were at first hesitant to share their stories. Stories were collected only from those respondents who consented to share their stories and repetitive visits were made for enrichment of stories. As women had busy schedules, they were approached during the afternoon time when they were relatively free. For collecting stories from men, it was more difficult as they were initially apprehensive of narrating story to a female researcher. At times, help from the local male volunteer of HCR was sought to obtain their stories.

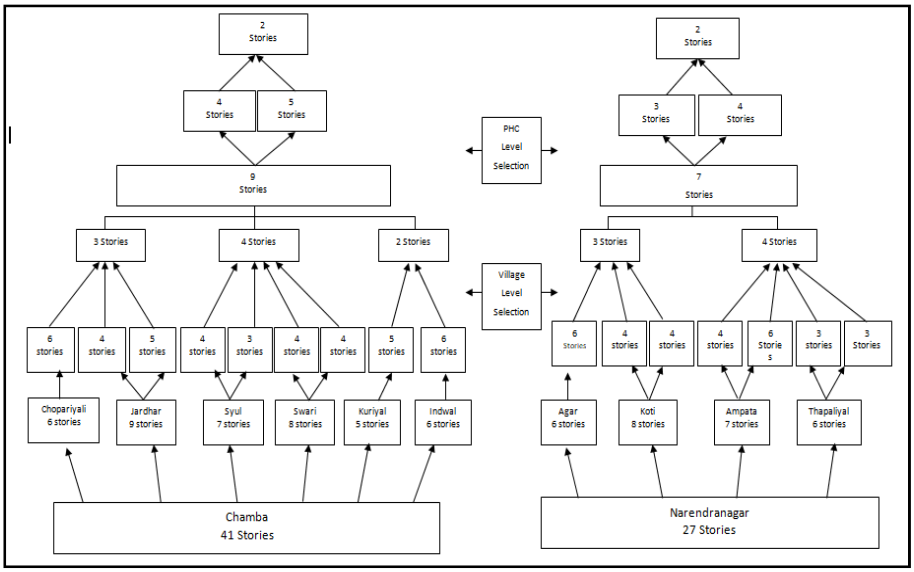

Figure 6.1: MSC story selection process

6.3.4.5.2.(c) Story selection

During the process of story selection, the legitimacy of the collected stories gets established at the grassroots level. The process of story selection was carried out at two levels – at the village level and at the Primary Health Centre (PHC) level.

i. Village level story selection

A neutral place such as anganwadi centres or house of a local leader was chosen for story selection. Selectors of the stories were villagers other than the narrators. As the stories were lengthy and detailed, they were bunched into bundles of 3-6. Nine bundles of stories were made out of 41 stories collected from six villages of Chamba, and seven bundles were formed out of 27 stories collected from four villages of Narendranagar. To prevent bias, names of their narrators were withheld. The titles of the stories were listed on a chart paper. Stories of one bundle were read to the selectors at one time by a local person who could easily be understood by the selectors. For voting, stories were summarized on a chart paper. After listening to stories of each bundle, the selectors voted for the story which they liked the most by show of hands. This was followed by values enquiry. One story receiving maximum votes in each bundle was selected and carried forward to the next level of selection.

Of the 68 stories collected from the two blocks, 16 were selected (one each from 16 bundles) at the village level.

ii. PHC level selection

The selectors at the PHC level included ASHAs, ANMs, PHC doctors and a few local leaders. The venues for the story selection were the respective PHCs of Chamba and Narendranagar. Two bundles of 4 and 5 each were made from the nine stories selected at the village level from Chamba and two bundles of 3 and 4 from seven stories selected from Narendranagar. These were read out to the selectors and the same process of selection was followed as done at the village level. Finally two stories from each of the blocks of Chamba and Narendranagar were selected at the PHC level.

6.3.5. Data Analysis

Data collected using different quantitative and qualitative tools was analyzed using appropriate software.

6.3.5.1 Qualitative analysis of FGDs and Narratives of Health

The inductive method of analysis was followed to analyze the FGDs and narratives collective in phase I. The focus group discussions and the narratives were audio-taped and transcribed verbatim in MS Excel. The data was imported into the qualitative analysis software package Atlas ti 8. Then multiple codes were generated from the transcripts and grouped into three predominant themes, namely, ideas of reproduction, household dynamics, and, quality of health services.

6.3.5.2 Quantitative analysis of Interview schedule

Data using Interview schedule was collected under three sections and analyzed. Data of social demographic variables was analyzed to obtain key socio economic and demographic parameters of all the respondents. Data regarding the preferred sources of health information obtained from groups I1 and C1 in phase III was analyzed. Responses obtained from the respondents were tabulated in Microsoft Excel sheet. Respondents were given all choices of the preferred sources. A preferred choice of a respondent was given value of ‘1’ and the other ‘0’. A matrix was made. This excel

data was converted into a 2x2 UCINET dataset UCINET 6.0. Various maps of health information sources were obtained from UCINET. The arrows indicated the flow of information from the source to the respondent. The size of the each health information indicated the quantum of its preference.

6.3.5.3 Knowledge Inventory

Knowledge inventory was used to assess the knowledge levels of the respondents for which the knowledge scores of each respondent were calculated.

6.3.5.3.1 Pre-test knowledge levels of respondents of I1 and C1

Independent t-test was applied to test the significance of difference in the mean knowledge scores of groups I1 and C1 before the intervention.

6.3.5.3.2 Post- test knowledge levels of respondents from groups, I1 and C1.

After the year long broadcast of the KKAM series, an endline post test was conducted to analyse any change in knowledge levels and significance of the change. Post-test knowledge scores of each of the respondent of the four groups was obtained.

Change in the knowledge score of pre to post broadcast for respondents of group I1 was calculated and analyzed. Percent change (from pre-test to post-test) in the knowledge score for each respondent of I1 and C1 was calculated. One –way analysis of covariance (ANCOVA) was applied to study the effects of changes from pre to post test knowledge scores of the respondents of I1 and C1 groups while controlling for pre-test knowledge scores.

Independent t-test was used to compare the means of the knowledge scores for respondents from the I2 and C2 groups. To compare the differences in the post test knowledge scores of the group means of post test scores of respondents across four groups, ANOVA was used.

6.3.5.4 Qualitative analysis of the MSC stories

For the analysis of the MSC stories, a qualitative data analysis and research software ATLAS.ti8 was used. As a first step the text of MSC stories was uploaded on

Hermeneutic Unit (HU) of the software. Key aspects emerging from the stories were identified and open coding was done. A list of 57 codes was developed. These codes were clubbed under broad themes. Three broad themes, namely, programmatic aspects, dialogic aspects, and the effects perceived because of the broadcast of the series, emerged.

6.3.6 Limitation of the study

For collection of the data for post test, same set of respondents as for pre test were required to be contacted for assessing the changes effected by the intervention. Data collection was thus a tough and time consuming process. This limited the size of the sample. Hilly terrain and remote location further added to the constraints and limitation of sample size. During pre-test the time of the survey coincided with the time of peak harvest and festivals, and collection of data was contingent upon the availability of the men and women in the villages. Only few senior members could take part in the study because of the constraints of health and terrain. Their experiences could have enriched the information about varied aspects of women's health.

6.4 Findings

Findings have been documented phase-wise.

6.4.1 Phase I

A key aspect of participatory communication is creating mechanisms for allowing stakeholders to voice their ideas, and centre-staging these ideas in the design of programmes and initiatives. So, for planning of health communication intervention, Phase I entailed listening to people's voices and exploring their perceptions on a range of women's health issues.

6.4.1.1. FGDs and Narratives regarding women's health

Analysis of the responses obtained during FGDs and the narratives of health collected from women and men brought out a range of their perceptions encompassing women's health issues and their care seeking behavior. These perceptions of respondents as well as their referents revolved around –

(a) Ideas of reproduction, (b) Household dynamics, and (c) Quality of health services

6.4.1.1.1 Ideas of reproduction

Emerging in the FGDs and narratives was the domination of issues associated with reproduction. These issues were the major concerns in the perceptions of community members about women's health and wellbeing.

6.4.1.1.1.(a) Preference for Male Child

Presence of patriarchal notions leading to necessity of having a male child were perceived to be influencing the social value attached to a woman and consequently to her health issues, by the family and the community. The narratives pointed towards the pressure women constantly faced to deliver a male child, and different ways women and their families resorted to deal with the same.

6.4.1.1.1.(b) Insistence for early conception

Insistence for early conception got reflected as an overarching theme in the discussions and narratives. A woman establishing for fertility quickly after marriage was an aspect ingrained in the minds of women and their families. As a norm, a couple was expected to have their first baby within the first year of marriage. So the aspects of family planning, preparedness to have children, women's overall health, etc., were given low salience.

6.4.1.1.1.(c) Misconceptions about Family planning and contraception

Several misconceptions prevailed about family planning (FP) methods and were found to influence women and men to plan, space and control the birth of children. Most felt that the FP methods of women were not safe and caused health problems.

6.4.1.1.2 Household Dynamics

Narratives and FGDs brought forth the aspects of household dynamics which not only influenced women's own perceptions about various aspects of health and their promptness to seek medical care, but also the kind of communication spaces available to them.

6.4.1.1.2.(a) Increased work burden due to out-migration of males

With husbands migrating to towns looking for livelihoods, women had to look after not only the household chores, children and elderly but even agriculture and animals. They stated facing physical and mental stress during times of emergency, for seeking medical help, locating and paying for transport at the time of childbirth, etc.

6.4.1.1.2.(b) Laxity in attending personal health needs

Another aspect mentioned in narratives was the general disregard of symptoms of illness. Women perceived needs of family members to have higher priority than their own health needs. They postponed visiting a doctor for their personal health problems until a crisis emerged and preferred home remedies.

6.4.1.1.2.(c) Generational differences

FGDs brought out the intergenerational differences in ideas. Older women believed the use of FP methods to be inappropriate. Certain socio-cultural beliefs were stated to inhibit disclosure of pregnancy during initial four-five months. Older women perceived symptoms of pain and swelling as normal symptoms of pregnancy, and disagreed with the practice of younger women visiting doctors frequently.

6.4.1.1.2.(d) Neglect of women's opinion

Most women narrated that men imposed their decisions on women and that women's opinions were largely ignored. Husbands imposed their decisions on wives. Expressing an opinion by women different than that of men was not an acceptable, especially on the issues of marriage, reproduction, health issues like family planning, etc. Many women stated during FGDs about the verbal and even physical violence

that many they had to face. A few women even stated the presence of sexual domination in their lives.

6.4.1.1.2.(e) *Restricted communication*

It was stated that as a norm, an open discussion on the women's issues associated with menstruation and contraception were restricted in the community. The narratives mentioned that that mothers, daughters, peers, older women, younger women of the study area were uncomfortable talking about these issues, and restricted communication about these even with one another.

6.4.1.1.3 Quality of Health Services

Narratives reflected upon aspects related to health services like availability of infrastructure and supplies, attitude of the health personnel, etc., which directly or indirectly affected the care seeking behavior of women of the area.

6.4.1.1.3.(a) Inadequate equipments and facilities

Some people stated that sub-centres (SC) and Primary Health Centre (PHC) lacked adequate infrastructure. Some equipments like X-ray, ultrasound, BP measurement, were either not available or non-functional.

6.4.1.1.5.(b) Availability and attitude of the health staff at PHC/SC

The issue of non-availability of allopathic doctors at the SCs and the PHCs was raised by many respondents. Sometimes, due to absence of adequate facilities, simple cases became complicated because of lack of medical attention and had to be referred to community health centre (CHC) or other private hospitals. It was also stated that the paramedical staff at the PHC held an indifferent attitude towards the patients especially women.

6.4.1.1.5(c) Alternative Health Systems

FGDs pointed towards the faith and confidence of people in alternative health systems and reflected upon the differences experienced by people with the government doctors at AYUSH clinics and at PHCs. It emerged that AYUSH clinics were more in number

and people preferred visiting AYUSH doctors more than the doctors at the PHC, especially in case of seeking treatment for a chronic problem.

6.4.1.2 Discussion

The FGDs and the narratives helped in exploring the perceptions of community members surrounding women's health issues and their care seeking behavior. The high temporal and financial costs attached to accessing care were perceived to be influenced by the low quality of health services provided at the PHC/SC. In addition, the social costs attached to accessing services were perceived to be influenced by the social –cultural norms, beliefs and perceptions of the community members regarding various women's health issues. Many community members perceived the communication on issues of FP and contraception to be inappropriate and causing health problems. The restricted communication on these issues, considered as a taboo, by community members were stated to be influencing the kind of communication women could have on these issues.

6.4.2 Phase II

During this phase, HCR organized a workshop with the purpose was to involve different community stakeholders to (i) prioritize the perceived issues on women's health, and (ii) collectively decide upon the key messages needed to be communicated through the upcoming health communication intervention.

6.4.2.1 Organizing the workshop

Being a community media organization, HCR made special efforts to involve community women and other stakeholders in the designing of KKAM. An open call was made to women of different villages falling under the coverage area of HCR to participate. HCR advertised about the planned workshop in the narrowcast meetings held in the villages under its coverage area. Leaflets were distributed to inform details about the workshop. Announcements were broadcast and promos were designed, and advertised on HCR's Facebook page.

6.4.2.2 Schedule and sessions of the Workshop

The staff of HCR comprised mainly women who were from villages around HCRS and was aware of the challenges women in the villages of Tehri-Garhwal face. Being part of the same community, they were sensitive to the socio-cultural constraints the participating women might have to negotiate to stay throughout the workshop. So, a three-day non-residential workshop was organized.

A total of 40 women in the age group of 18-52 years from the blocks of Chamba, Narendranagar and Jakhanidhar participated in the workshop. These women included HCR's listeners, callers and volunteers; government and private doctors; and field level functionaries. Majority of them were married. These women were relatively new to the functioning of a CR and had only been engaged with HCR as a listener or a caller. Some of them had never got an opportunity to engage with any media platform and this workshop provided them a first-hand exposure. Apart from these women, workshop saw participation of few women who have received training in the field of women's health and care. These included Field level health functionaries (three ASHA workers (one each from Jardhar, Arogi, Agarkhal village) and three ANMs (one each from Kuriyal, Koti and Ampatta village). There were doctors who were experts in their fields and included two local government doctors (one each from blocks of Chamba and Narendernagar).

6.4.2.3 Conducting the workshop

The main objectives of the workshop were to – (a) acquaint the community women with HCR and the scope of participatory communication, (b) dialogue and develop consensus on issues of women's health, and (c) identify key issues to be raised through the upcoming radio series on HCR. HCR staff along with the researcher facilitated the workshop. An introductory session was conducted on the first day. The main aim of this session was to familiarize the participants with one another. After rapport formation and orientation session a visit was made to the HCR station. The participants were given hands-on learning on various equipments used for programme production like mic, mixer, etc.

On the second day of the workshop, since the participants were well oriented and enthusiastic, brainstorming sessions were organized. The participants were divided into four groups of 8 each. The groups were asked to identify key health problems faced by the women in their villages and enlist the causes of those problems. The participating women deliberated in each group on these problems, their proximal and distal causes and their consequences. They discussed about the change in behavior that needed to be advocated and key messages to be emphasized through the series. Each group prepared a message grid. On the third day of the workshop, after thorough discussions and deliberation, one comprehensive message grid enlisting key messages that the upcoming series should focus, was prepared. The series was named '*Khushiyon ke aangan mein'* meaning *In the piazza of happiness,* by the women participants. Thereafter, training on writing scripts was given by the HCR staff.

6.4.2.4. Analysis of the comprehensive message grid

An analysis of the comprehensive message grid revealed that the participants accorded high priority to the issues related to reproductive health and FP. Different types of participants brought to the fore different aspects which could be included in the content of the upcoming health series. While the field level functionaries and the local doctors focused upon the technical information on specific issues, the community women stressed upon the importance of providing multiple perspectives and providing positive examples on the issues. There were informational as well as normative aspects of each issue that were integrated together. The participants prioritized the aspects of (a) breaking the cultural stigma around early conception, (b) acceptance of contraceptive methods, (c) child spacing, (d) need for economic preparedness during pregnancy and childbirth, and (e) need of conducive environment and increased communication around these issues, to form the main focus of the health series. Emphasis was laid not only on building the ability of women to prioritize their health needs and express their health issues, but also on encouraging male counterparts and other family members in helping women to overcome psychological, societal and geographical barriers in accessing medical services when needed.

6.4.2.5 Discussion

The workshop organized by HCR for the conceptualization of KKAM aided in collective identification and prioritization of issues. The participating women from varying backgrounds brought out interrelated aspects of these issues. The perceptions of community women about the issue and the kind of messages that needed to be communicated differed from those of the field level functionaries and local doctors. Unlike persuasive approaches that support dyadic dialog and creates compartmentalization in the kinds of messages designed, the use of participatory communication approach emphasized on reflective dialog and indicated towards the creation of multilayered messages.

6.4.3.2. Health Information Sources

Health information seeking plays an important role in the formation of healthy behaviors. There are various sources from which health information can be received, however, an individual is likely to prefer those sources they consider most credible and trustworthy. In the study, an attempt was made to study the various preferable/credible sources of health information.

The study found that the respondents were seeking information from a wide variety of sources which included both interpersonal and mass media. The sources emanating from the existing health system with training in the area of health were termed as Formal sources and included doctors (both government and private), field level functionaries like ASHA workers and ANMs, and workers of the NGOs working in the field of health. Other sources of health information not emanating from the health systems were termed as Non-Formal sources and included family, and friends, and mass media sources like TV, Radio, newspaper, etc. along with HCR. The media sources were considered Non-Formal sources primarily because they were not originating from formal health systems and were sources of different types of information dissemination including health. The multiple responses were obtained for the most preferred sources of health information accessed by the respondents.

Amongst Formal sources, , while maximum number of men in both groups I1 and C1 reported Private Doctors as their most credible source, maximum number of women accorded highest preference to Government Doctors. Amongst the Non-Formal sources, in group I1 (of HCR listeners), HCR as well as Family emerged as the most credible sources among men as well as women. Both men and women of Group C1 accorded maximum credibility to Family. Thus, more women than men depended on Family for seeking any health information. In Group I1 however, both men and women accorded an almost equal credibility to Family and HCR.

UCINET was used to map the health information sources. In Non-HCR block (C1), Family emerged as the most preferable source of health information. A gender analysis of the maps obtained using UCINET reflected the differences in the preferences of various health information sources between males and females of HCR block (I1).

6.4.3.3 Discussion

The pre-test knowledge levels of the respondents indicated that the respondents had a fair knowledge about the women's health issues identified during the workshop in Phase II. High preference of HCR by the participants was reflective of the perceived usefulness of HCR as stated by the respondents, the credibility respondents attach to HCR, and of the communication potential of HCR.

6.4.4. Phase IV

Access and participation of local community members in programme production and broadcast have been recognized as core principles of a participatory communication. Utilizing the inputs from Phase I and Phase II, production and broadcast of the health series KKAM was undertaken by HCR. Post workshop, a core scripting and production team formed by the women participants (of workshop) and HCR team (most of which were women) was responsible for various tasks related to the production of the series.

6.4.4.1. *Scripting*

The core scripting and production team took the task of completing the scripts and used to meet once a week. Based on the core ideas emerging from the workshop, this team decided upon the number of episodes and number of scripts to be prepared, and distributed the task of writing the scripts. These scripts contained an introductory dialogue (conversation), stories of women revolving largely around the real life incidences of these women. Because the issues to be covered were multilayered, the team decided to follow a magazine format, and had different segments which allowed rendering of multiple perspectives from the community.

6.4.4.2. *Programme Segmentation and Format*

The health messages finalized by the participating women reflected upon the socio-cultural beliefs and perceptions which had been acting as key barriers to women's access to adequate health care services. These formed the main considerations for production of the KKAM series. The finalized messages were blended with technical messages being propagated through government services and initiatives like *Khushiyon ki Sawari*, 108 free escort service, etc. Each episode of the series was planned for 25 minutes duration. There were interviews, music, discussion, etc. all happening within an episode. The structure of each episode had following segments:

Signature tune

The signature tune was prepared by a local artist. Utilizing family as an entry point of communication, each episode began with the signature tune which resonated with the need to take care of both mother and baby, and to seek complete information to promote a happy family, i.e., *Khushiyon ka angan*.

Power Intro

In this introductory segment, the RJs introduced the issue to be raised during the episode. The RJs were characterized as a couple, Binod and Sangeeta. The segment started with a dialogue/ conversation between the couple and revolved around their life event or incidences. These dialogue (/conversations) were guided by the issues

finalized in the workshop and resembled the dilemma and aspirations of a married couple from the community. RJs were presented to be having a happy family – having a planned family, where both spouses care for the views and opinions of each other. Scripting it around real life incidences, the RJs would introduce a belief/norm, commonly practiced by the members of their community and gradually progressed to discuss the need for changing the perceptions and beliefs which were negatively impacting the health of young women and their seeking of timely medical care.

Kahani samuday se

Another segment *Kahani Samuday se* (Stories/Interviews from the community) had vox-pop recorded from the members of the community. Majority of the vox-pop were from community women who shared their perceptions, beliefs, ideas and opinions – either in favour of or against the issue raised in the preceding segment. A few local men also provided bytes. These vox-pops facilitated communication about personal incidences, personal beliefs and occurrences by community men and women.

Apni Kahani (My own story)

This segment had stories of women from within the community who could visualize the harms caused by the prevalent norms and the potential advantages of changing them. It included their real life experiences, and good and bad incidences.

Dadi ma ke nuske

This segment had details about the traditional remedies or advises for maintaining good health. The bytes for this segment were of a senior member or local health personnel like ASHA workers and ANMs.

Expert talk

This segment had the local doctors linking the technical information with the social issue raised in an episode, e.g., benefits of FP methods, complications arising during childbirth due to anemia, psychological effects of violence on women, etc. This segment was followed by call-ins where people from the community called and dialogued about the issue raised.

6.4.4.3. Production and broadcast of the series, KKAM

A total of 16 episodes were produced for the KKAM series

Cyclic process

For the production of the series a cyclic process was followed. Based on the list of key issues identified in the comprehensive message grid prepared during the workshop, episodes were produced in bunches of four. After the completion of a set of four episodes, scripting and production of next set of four episodes was undertaken. These were then recorded and narrowcast in the village meeting. So, discussions were carried out at the community level, and the feedback was fed as input for the next set of episodes.

Launch of the series

After the production of first set of four episodes, HCR organized a community launch of the series. People from the community especially opinion leaders, regular listeners (majorly men), local doctors from private and government hospitals were invited to listen to the episodes and provide feedback. During the event, the community was informed about the prospective plan of production of the next set of episodes, and about the broadcast of the series.

Broadcast

The series went on air for a period from November 2014 to October 2015. There were weekly broadcasts, with fresh broadcast every Saturday and the same repeated next Friday. The time of the broadcast was decided during the launch of the series in consultation with community members. Fresh broadcast time on Saturday was 8:30 pm – 9:00 pm. Repeat broadcasts were done on Fridays from 4:30 pm – 5:00 pm. Once all the 16 episodes of the series had gone on-air, the series was rebroadcast.

Technology interface

In each of the fresh broadcasts held every Saturday, people from the community were provided an opportunity to give their feedback either in the form of live call-ins and/or through SMS. During the broadcasts, the RJs would encourage community members to enter into dialogue with each other on the issues raised in the episode.

6.4.4.4 Discussion

According to Servaes (2008), participatory model incorporates the concepts in the framework of multiplicity and stresses the importance of democratization and participation at various levels. Following a participatory approach, the process of production and broadcast of the KKAM series was cyclic in nature and provided multiple entry points for people to participate and dialogue. Falling in line with the principles of the participatory communication, local people from the community were provided the 'access' to participate in varying ways. They partook in different segments of the series. 'Flexibility of ideas' and 'freedom to express' extended to the content contributors helped them to willingly contribute their stories of good and bad experiences.

6.4.5 Phase V

After year-long broadcast of the KKAM series, the changes in the knowledge levels of the respondents were ascertained for the quantitative study. During this phase, the MSC stories were collected and analyzed for the qualitative study.

6.4.5.1. Quantitative changes in the knowledge scores

After the broadcast of KKAM, an endline was conducted to find the changes, if any, in the knowledge levels of the respondents from pre-test to post-test.

To understand the impact the intervention (broadcast of KKAM) had on the knowledge levels of I1 respondents, mean of their knowledge scores before and after the broadcast were calculated and compared. A paired-sample t-test was done to check the significance of difference in the knowledge scores. The results indicated a significant difference in the

knowledge scores of these respondents from pre-test (M= 14.77, SD=4.083) to post-test (M=17.41, SD=3.939) conditions; t (79) =6.150, p = .02.

The percent change in knowledge scores for each respondent of I1 and C1 groups, from pre to post broadcast was calculated. The results of the independent t-test indicated a significant difference in mean percent change in the knowledge scores of the respondents of the I1 group (M= 5.20, SD=3.230) and C1 group (M=1.84, SD= 4.380) conditions; t (158) =7.192, p = .02. To determine significance of difference between respondents of I1 and C1 groups' post test knowledge scores, while controlling for their pre-test knowledge scores, ANCOVA was used.

The results showed that after controlling for pre-test, the group has had an effect on the respondents' post test knowledge score; F (2, 160) = 61.908, p < .05. Also a significant difference was observed in the post-test knowledge scores of the respondents of group I2 (M= 17.72, SD=4.576) and of group C2 (M=15.36, SD=4.446) conditions; t (158) =3.853, p = .013.

6.4.5.2. Socio-demographic profile

The mean age of the respondents was 28.4 years. 73.4% were from General caste, 18.2% SC and 8.4% STs. 57.2% of the respondents were married. Average family size was 5.5. Nearly 60% of the respondents had less than 10 years of schooling. About 20% of the respondents had 12 or more years of schooling. Nearly 33% of respondents were cultivators. The average size of land holding of the respondents' households was 12.3 Nali. The key socio-economic and demographic parameters of the respondents from HCR and Non-HCR blocks were comparable .

6.4.5.3. Qualitative Change in perceptions post broadcast

These stories highlighted not only the effects of change but also aspects of KKAM that led to those changes, and included (i) Programmatic aspects, (ii) Dialogic aspects and, (iii) Effects of change. The set of factors of these three aspects had a complex relationship.

6.4.5.3.1. Programmatic aspects of the KKAM series

A central aspect emerging from the analysis of the stories was about the content and the style of presentation of the messages in the series.

6.4.5.3.1.(a). Content of Messages

The listeners perceived the content of the messages communicated during the broadcast of the series to be socio-culturally relevant, interlinked and providing multifaceted perspectives.

i. Relevant topics

The stories indicated that the health messages included in the series were of immediate relevance to its listeners. The topics discussed in the series were what they wanted to know more about and were interested in. Information about the local health services provided by the State Government was beneficial.

ii. Multifaceted Perspectives

Stories revealed that the health messages provided multifaceted perspectives about the issue discussed in each episode. It helped in developing a holistic understanding of the topic. There was an amalgamation of the traditional and modern knowledge.

iii. Inter-Linkages of messages

An important aspect that emerged from the stories was the inter-linkage of the messages being communicated during the broadcast. Messages in each episode were linked to the ones in the consecutive episodes and were carried forward to other episodes, but without being repetitive and monotonous.

6.4.5.3.1.(b). Style of Representation

The stories not also focused upon the style of how these messages were presented. Following were perceived as crucial aspects by the narrators.

i. Use of Local Language

Use of the local language, Garhwali along with Hindi was an important aspect resulting in its preference. It aided in the comprehensibility of the messages

communicated. Local language was used to communicate concepts like asthir prasav, balanced diet (bari pait), remedies using traditional food products like chulu ka til, etc. The information presented in the programmes was comprehensible.

ii. Edutainment mode

The narrators of MSC stories enjoyed listening to the HCR programmes and found the series to be not only informative but also entertaining. They got 'reeled in' with emotions depicted in the series. Plot used was interesting with anchors acting as an ideal couple together deliberating and opening up on several social beliefs and commonly held perceptions on issues like FP.

iii. Personal Testimonies

Narrators pointed that the stories of personal experiences, especially of women in the '*apni kahani' (Own story)* segment of the series were very powerful. The listeners were able to relate with these stories and the dilemmas presented therein, and perceived that what was someone else's story could have been theirs too. This linking with of the situations of women discussed in the '*apni kahani*' segment created a bond of connectivity between the audience and the programme.

6.4.5.3.1.(c). Scheduling of the programme

From the MSC stories, two aspects of scheduling that emerged from the narratives were – 'Time of broadcast' and 'time of repetition of episodes'. The focus on health messages in repeated episodes and their scheduling at a suitable time were significant factors influencing the uptake of health issues by the audience and got highlighted in many stories.

6.4.5.3.2. Dialogic aspects

Dialogue is a unique form of conversation which can improve collective enquiry processes, facilitate coordinated action for bringing social change (Isaacs, 1996). The stories reflected upon the three crucial aspects of dialogue, namely, modes/mechanisms, nature and content.

6.4.5.3.2.(a). Modes of dialogue

The stories brought forth an aspect of mechanism or mode provided to the listeners to enter into the process of dialogue and discussion on the issues raised during KKAM. The three modes of dialogue experienced were:

i) Pseudo dialogue: The dialogue happening within the programme was an aspect people liked the most. In each episode, there was conversation happening among the two RJs. These dialogues were so presented that people could relate to the conversations and the dilemmas. Based on research and understanding of people's perspectives on the issues, the series brought forward the topics/aspects which majority had concerns about.

ii) Technology mediated dialogue: Stories dwelt upon the opportunities HCR provided to its listeners to express and discuss their views and opinions. Listeners were encouraged to call towards the end of broadcast of each episode and express their points of view. The delayed and asynchronous nature of dialogue facilitated during KKAM kept the issues alive and enabled people to focus their attention on the issues raised.

iii) Off-air face to face dialogue: Regular practice of HCR to narrowcast its programmes, to obtain feedback about the episode and to plan future episodes accordingly was an aspect recognized in some stories. The narrowcasting allowed people from the community to debate and discuss on different issues and provided an opportunity to especially those community members who were shy and hesitant to call, to also participate in the discussions.

These multiple dialoguing opportunities aided in clarifying the concepts prevailing in the region about the issues raised in KKAM and understanding each other's view points, on them.

6.4.5.3.2.(b). Nature of the dialogue

Stories were replete with reference to the nature of the dialogue. Following aspects emerged about the nature of dialogue to provide opportunities to people to engage with the medium (i.e. HCR) through the production and broadcast of the series.

i. Inclusive

The argumentation and deliberation on women's health issues included not only the experts but also different stakeholders who could potentially influence or be affected by these issues. Local health experts were also included in the discussions. HCR was non-discriminatory and people having opposing ideas also expressed their views and opinions.

ii. Open and Reflexive

People were not only sharing their own experiences but were also narrating life incidences of their own or of someone known to them. The series acted as a core discussion point that branched out in various directions. The reflexive nature of dialogue gave it a diverse structure and feasibility that narrators readily acknowledged.

iii. Just and Fair

KKAM was perceived to be providing a platform where everybody got an equal opportunity to articulate their ideas and opinions on a wide range of issues, without any fear or coercion.

The nature of dialogue being open and reflexive enabled people to participate freely and triggered continuous participation of its listeners. The non-discriminatory and free nature of the dialogue led listeners to honestly express themselves, thereby leading to an active participation by different stakeholders of the community during KKAM.

6.4.5.3.2.(c). Content of the dialogue

In the discussions people were not only providing information about norms, beliefs, taboos, local events and occurrences, but were also communicating their feelings and emotions. Two aspects of the content of the dialogue, namely, normative and emotional, emerged from the stories and were inextricably woven with each other.

i. Normative aspects

During the broadcast of KKAM, people discussed about their ideas, attitudes, beliefs and expectations towards prevailing norms, practices and behaviors.

- *Prevailing norms and practices* - Dialogue brought the prevalent norms and practices into focus. Normative aspects of certain practices, beliefs and perceptions of one's own and of others around these, leading to ill-effects on the health and wellbeing of women were frequently discussed.

- *Taboos & Restrictions* - Some of the culturally tabooed issues which were deemed private were also dialogued and discussed. There were discussions on various issues like use of condoms, despite their discussions openly in public being culturally inhibited.

- *Dominant behaviours* - Discussion on the dominant behaviours and practices as an aspect got highlighted in a number of stories. The discussions on the pros and cons of different practices and on the need and importance of changing the beliefs and perceptions were discussed. Story narrators highlighted the importance of including positive stories of people. These gave new perspectives and insights about people adopting new practices. People were thus able to address their doubts and apprehensions.

ii. Emotional aspects

It was highlighted that expression of peoples' emotions took place during the broadcast of KKAM over HCR.

- *Agreements and Disagreements* - During the dialogue, people communicated what they agreed or disagreed with, liked or disliked about a situation or dominant discourse. Aspects of grounds of accord and discord emerged about the issues. This was important especially when people raised their voices against taboos and some harmful age old beliefs and practices prevailing in the community.

- *Empathy* - Story analysis also revealed that as people discussed about various norms, practices and societal expectations, etc., they also communicated their empathy for the people, their situation and events.

- *Fear and trepidations* - *S*tories also focused upon fears and trepidations people articulated during discussions. During an episode, people expressed their fears

and apprehensions about adopting new ideas. Following this, many shared the barriers they faced, through call-ins. With people from within the community sharing their perceptions, along with positive examples by a few others from their community, the silence around some of the traditionally tabooed issues like condom use, vasectomy, etc., were broken.

6.4.5.3.3. Effects of KKAM

Listeners in their stories described a range of effects that they perceived consequent to the broadcast of KKAM, both at micro and macro levels.

6.4.5.3.3.(a). Effects at the Micro level

Changes were perceived at an individual level by the listeners of the series, leading to various forms of learning.

i. Informational learning

Stories were full of references about the information listeners received from the series. Due to the sharing of traditional as well as contemporary knowledge, listeners were able to add new dimensions to the information they already had on various women's health issues and the interrelated aspects.

- *New knowledge*

Many men and women narrated having gained new information on women's health issues. They became aware of the various maternal health services provided free of cost by the government.

- *Demystification of myths and misconceptions*

Demystification of various myths and misconceptions was perceived as another significant change by majority of the participants.

ii. Introspectional learning

Introspectional learning is said to take place when individuals who are exposed to divergent viewpoints understand and critically reflect on these issues, and eventually begin viewing themselves as agents of change of their own situation (Freire, 1970).

- *Self reflection*

The very first step in introspectional learning involves people raising question about their own thoughts and beliefs, and critically examining its appropriateness. It emerged from the stories that post broadcast of KKAM people started reflecting upon their beliefs and perceptions. Thoughts and opinions on some of the traditionally held beliefs resulting in domestic violence and subordination of women, and beliefs like maintaining silence on issues of contraception, etc. led to people critically examining these thoughts at a personal level.

- *Increased sensitivity of issues*

During KKAM, the dialogue and discussion on a range of women's health issues led listeners to share their own experiences and opinions. It is sharing of these diverse perspectives that raised the awareness and prompted a holistic understanding of the health issues faced by many women. Many men and women narrated having become more sensitive towards such issues and started acknowledging the need of modifying the existing beliefs and perceptions that were negatively impacting the wellbeing of women. As an effect of KKAM, mothers-in-law exhibited a change in their behaviour and narrated accompanying their daughters-in-law during ANC visits.

- *Receptivity towards new ideas*

The process of critical conscientization can lead to modification of old ideas and beliefs and/or adoption of new aspirations, goals and practices, and cause change in the conventionally held attitudes and beliefs. Deliberation by community members and portrayal of positive examples of women and a few men from the local community resulted in people becoming aware of their potentialities and exhibiting courage to change the existing beliefs and perceptions. Some even reflected their will to act as change agents.

- *Social learning*

Social learning occurs through imitation or modelling of other people's behavior, with an increase in the magnitude of social learning when people are similar (Bandura, 1986).

- *Increase in self esteem and confidence*

Many women perceived an increase in self confidence in talking about their health needs and problems.

- *Extended networks and linkages*

The local people who shared their stories of changed behaviors and occurrences had got into extended relationships with the other listeners. Weak ties were formed by the local people who narrated their stories, participating women and the listeners with the HCR staff, social activists and the health personnel in the region.

6.4.5.3.3(b) Effects at Macro level

The dialogue and discussions facilitated by HCR during KKAM were significant in bringing out the discrepancies in the prevailing beliefs and practices, and allowed people to enter into a continuous process of reflection. This process of dialoguing facilitated by HCR during KKAM series provided an opportunity for critical thinking, allowed questioning of conventional beliefs and ideas, and facilitated in development of a new perspectives among its listeners. The dialogue which was reflective in nature and provided a just and fair space allowed women including the marginalised ones to share their life stories, feelings and emotions.

i. Improvement in communication at the familial level

An improvement in familial communication got highlighted in a number of stories. Post broadcast there was improvement in parent-child communication. Mothers narrated discussing the issues like menstruation and conception with their daughters. Even men reported an improvement in communication with their sons on the issues of FP.

ii. Shifts in social expectations

Post broadcast, story narrators reflected on how modifying the prevalent notions of 'a happy family' and highlighting the benefits of 'physically and mentally fit daughters-in-law or wives', HCR encouraged the family members to take care of women,

thereby increasing the emotional support and informational support offered to these women.

v. Improvement in health services

During the broadcast of KKAM, community members identified constraints in provisioning of health services needed by local women. Post the broadcast of KKAM, community members tend to mobilize around issues of healthcare in the region. A few narrated complaining about the attitude of paramedical health staff.

6.5 Discussions and Conclusions of the Study

The findings indicated that there was a significant change in the knowledge scores of the listeners of KKAM from pre to post broadcast of the series. The programmatic aspects and the dialogic aspects were perceived as significant process factors influencing the change in the perceptions. The health messages communicated during KKAM related to the lives of the community members. Listeners perceived a gain in knowledge and their myths and misconceptions were demystified. Findings suggested sharing of ideas, beliefs and expectations during KKAM brought out the discrepancies within the beliefs and perceptions of the listeners. With community people entering into an active and continuous dialogue, there was a constant process of reflection that got built.

HCR being non-discriminatory in nature provided a platform to people to share their ideas and opinions, even if different and opposing in nature. An open and inclusive dialogue on events and occurrences and commonly held behaviors resulted in people viewing the possibilities of changing their beliefs and expectations. We know that for the formation of rational opinions, questioning the adverse norms and transcending one's initial preferences is important (Mackie, 1996), and the same was seen to happen through dialogue during broadcasts of the KKAM series.

Social influence research indicates that behavioral changes can occur if people are able to view discrepancies between their personal beliefs and perceptions and those of their fellow group members. Tankard and Paluck (2016) have stressed upon the need to focus on subjective perceptions of the community members. In a given situation,

salience of a norm is a significant factor in influencing behavioral changes (Cialdini, Kallgren & Reno, 1991). Many studies have shown that shifting an individual's attention to a specific source of information or motivation can lead to changes in the way individual responds (Kallgren & Wood, 1986). The findings indicated that the two-way process of dialogue and deliberation facilitated by HCR wherein conventional beliefs and norms that were negatively impacting the health of local women came to be debated and discussed increased the salience of modifying the perceptions of the community towards positive norms and perceptions around women's health issues. The dialogic communications over HCR during the broadcast of KKAM encouraged people to freely express their views and opinions and was helpful in bringing the discussions on some of the socially tabooed issues like FP, generally considered as private issues, into the public domain.

6.5.1. Discussions of the Study

Perspectives of health have shifted from an individualistic angle to a comprehensive positioning of the health aspects. It is now recognized that an inter dependence of various socio- economic determinants, situated in the conditions of people's lives influence their health and ability to handle their morbidity and mortality. Participatory communication models on the other hand are focused on ways that allow communities to co-construct meaning of health, identify the perceived risks and causes, and together look for potential solutions to their prevailing health problems. With health of women being disproportionately influenced by the macro influences caused by the social structures, the CM can play a balancing role by enhancing women's participation in issues that concern their living.

6.5.1.1. Contextual communication of health

In the study, it was seen that many respondents had a fair knowledge levels on a range of women's health issues which were identified prior to the intervention (KKAM). However, the health communication around issues of women health was seen to be governed by some socio-cultural norms, beliefs and perceptions of the community members. Various socio-cultural beliefs and perceptions of the community members revolving around the issues of FP and reproduction were found to affect the health of

local women and their seeking of care. The norms of insisting for early conception and limited concept of child spacing, negative perceptions revolving around these issues of family planning and reproduction, restricted the communication around the issues and led to various misconceptions.

Being a CM, HCR was seen to provide 'voice' to the health needs and concerns of these women. Participation of community women in KKAM provided them with an opportunity to raise their concerns and offered them a platform to design communications around some of the negative perceptions affecting their health and wellbeing. As a participatory media, HCR invited women to set the 'agenda' themselves. With women being the 'prime decision makers' in KKAM, the access provided by HCR to these women helped them to take charge of the 'relevant media production'.

The process of production of the intervention (KKAM) saw participation of women in varying ways. Right from preparation of scripts for various episodes till the production of these episodes, the core ideas illustrated by women participants in the workshop were considered. The health issues to be covered, the aspects of health to be discussed, and the key themes of these health messages to be delivered via KKAM, and even the name of the series - were all decided collectively. The content of the series was packaged in such a manner that it helped in centre-staging perceptions of women about the prevailing health scenario and in bringing forward some socio-cultural norms and beliefs which were deemed too private to be discussed on a media platform like radio, and how silence on these issues was negatively impacting health of a woman, eventually inhibiting her access to timely medical care.

HCR aligned its processes on the basis of key elements of participatory communication led to a distinctive packaging. The multi-stakeholder participation enabled representation of multiple views and perspectives led to the creation of multilayered messages, which had both informational as well as normative aspects. Thus, the scope of CR like HCR in centre-staging voices of women and other community stakeholders in structuring health communications within a community needs to be seen in terms of the kind of access such media can provide to women as well as other stakeholders. Further by ensuring participation from multiple

stakeholders, a CR can facilitate in designing health messages which offer multifaceted perspectives and are interlinked, thereby enhancing the acceptability of the health messages.

6.5.1.2 Creation of public sphere to encourage shifts in perceptions

Tankard and Paluck (2016) have argued that institutions can play an important role in changing the perceptions of norms. One of the conditions under which interventions to shift norms and behaviors are likely to be more powerful is, when individuals identify with the source of normative information. In the present study, HCR emerged as the most credible/preferable source of health information for the study respondents from the intervention groups, which listeners were able to identify with.

For message-related concepts to be activated and accessible for judgments, the content of the message must resonate, at least to some degree, with an individual's pre-existing schemas (Uskul & Oyserman, 2010). In the study, the health messages communicated during KKAM resonated with its listeners. Since the messages to be communicated were identified by the local women themselves, the listeners had the relevant schemas. These messages were so framed that the positive aspects of the alternate beliefs and norms were made more salient in the aural text communicated during KKAM. The effects women in the region were facing due to these were highlighted and attempts were made to render positive examples/aspects of changing these norms at various levels.

KKAM being a participatory communication health intervention facilitated participation of people not only during its production, but during its broadcast as well. People from the community with different and even opposing ideas and views were welcomed and given a fair opportunity to discuss and debate. The three modes of dialogue (namely, pseudo, technology mediated and off-air) which were provided by HCR during KKAM served as a medium for creation of public sphere where commonly held beliefs and negative perceptions were dialogued, discussed and deliberated. Cialdini, Kallgren and Reno (1991) in their Focus Theory of Normative Conduct opine that focusing the audience on what most people did or on what most people approved would lead to behavior change that is consistent only with the one

which is made more salient. During the study, KKAM worked towards modifying the negative perceptions and beliefs surrounding the use of FP methods. HCR by means of the various mechanisms of dialogue it offered was seen to create a public sphere where the positive aspects of changing the perceptions and beliefs were made more salient. Thus, the two aspects, programmatic aspects and the dialogic aspects of a CR were seen to influence their potential in shaping the health communications in a community.

Media can function as effective sources of normative influence if the members of a group view the media source as legitimate and people have trust over the media (Tankard & Paluck, 2016). During the study, HCR perceived as a credible and preferable source of health information gives us a plausible reason to comprehend the effects people perceived in their perceptions post broadcast.

As a result, effects were perceived at micro level in the form of informational learning, introspectional learning and social learning. At the macro level, there was an improvement in the communication among family members on issues covered by KKAM. According to Chwe (1998), the type of social interactions created by the conditions under which norms' promotion is received which determines creation of common knowledge and its prospective influence on norms being communicated. This provides us an opportunity to weave in the concept of social capital as significant in explaining the mechanisms through which the changes were brought by the kind of communications/interactions that happened over HCR during the broadcast of KKAM series. In words of Onyx & Bullen (1997) voluntary associations can most likely lead to the generation of social capital. Carpentier, Lie & Servaes (2003) in their approaches to understanding community media have placed it within the domains of civil society. Such media have been conceptualized as being a part of the civil society for reflecting people's agenda and voices and enabling people's participation while acting as an impartial public sphere. The figure 5.1 below diagrammatically explains the process of change in perceptions of the listeners of HCR. When a CR which has the trust of its listeners, and is able to provide access and participation to the members of the community it serves, has its own set of social capital. Such a CM facilitates the formation of public sphere not only for those marginalized and excluded sections but

rather around non-dominant discourses and for breaking the silence on tabooed issues. It is this enhanced civic participation that the social capital around health issues gets build up that the precursors of change are sown. As a result, the effects at micro level and macro level can be observed.

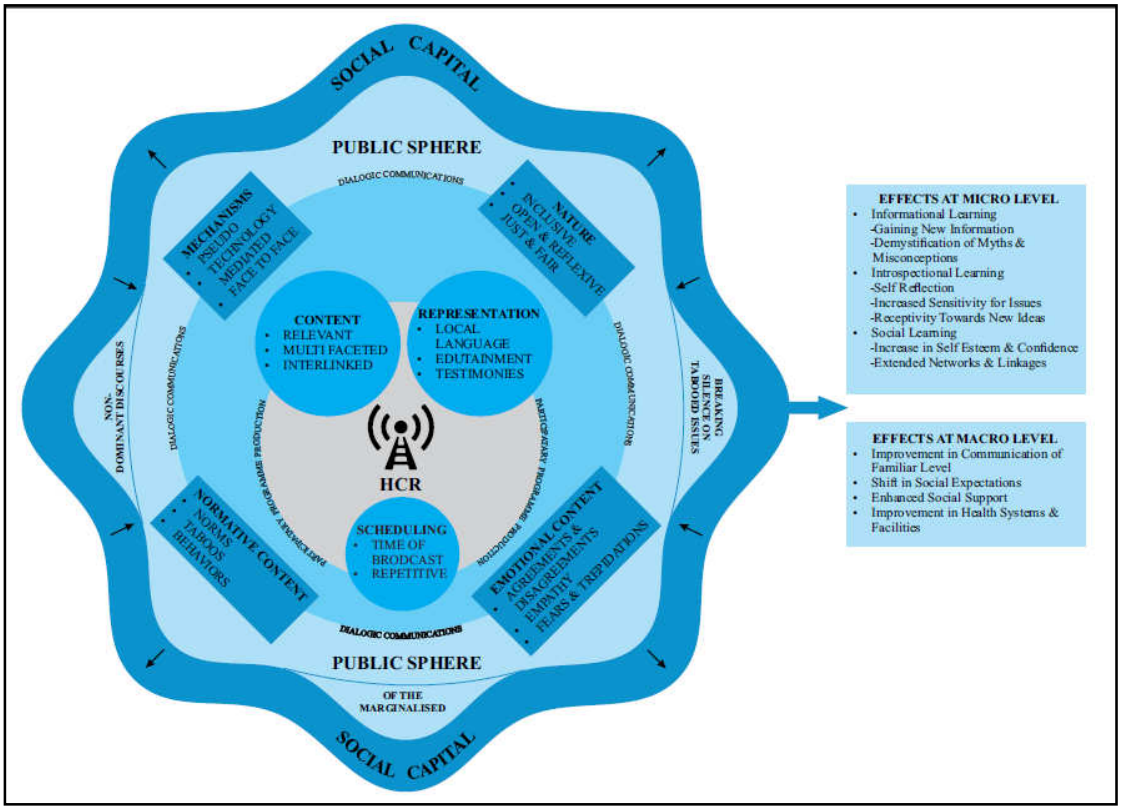

Figure 5.1 Framework of community radios role in health communications

6.5.2. Conclusion and Recommendations

The FGDs and narratives of health brought out the prevalent perceptions of the community members regarding women's health. These perceptions revolved around the ideas of reproduction, household dynamics and quality of health services influenced the kind of communication existing within the community on various women's health issues, and ability of local women to express their health needs.

Through workshop organized by HCR, women could identify and decide upon the key issues of women's health. It led to the prioritization of aspects of reproductive health and FP to form the basis of the content of the series. HCR which has been

functioning in the area of Tehri-Garhwal, Uttrakhand for over a decade emerged as a credible and most preferable source of health information. Activities undertaken at different stages for the production & broadcast of the health communication intervention KKAM, reflected upon the number of ways in which HCR facilitated participation of women and other stakeholders at each stage resulted in creation of a public sphere around the considered issues. Creation of contextually relevant messages, which were interlinked and carried multifaceted aspects resonated with the listeners. The dialogic communications facilitated by HCR during KKAM encouraged confluence of multiple perspectives and increased the salience of modifying the prevailing perceptions and an increase in knowledge of the listeners. HCR was seen to play a significant role in bringing out the discrepancies in the existing beliefs systems of its listeners thereby influencing their perceptions towards some of the tabooed issues like FP, etc. With open and reflective dialogue taking place at various levels and in multiple ways, listeners perceived changes taking place at the micro as well as at the macro level. HCR thus played a crucial role in increasing civic participation around normative issues and increasing the social capital around issues which were negatively impacting the health of women in the region under study.

As we conclude a CM can play a significant role in strengthening communications around causal role of social norms and the interrelated normative aspects, there is a need to strengthen such media. For being able to dialogue and deliberate on normative aspects of health communication, the capacities of those involved in CM must be improvised. They must be oriented towards the concept of social norms and these concepts can be integrated with the other concepts of gender and health, so that such media are able to set a discourse on sensitive aspects deeply entrenched in social norms and beliefs. It is also important to understand that in order for them to continue working as independent and neutral entities serving the community, there is a need to support them with financial resources, failing which, they too may start functioning as mouthpieces of dissemination of information like other mainstream mass media. The need is to provide them with adequate financial resources so that CM are able to conduct such participatory exercises easily, and utilize the knowledge gathered in designing of programming effectively.

It is therefore recommended that in order remain participatory and non-discriminatory in their functioning, such CM be strengthened in every possible way. They have immense potential to create communicative spaces, build networks, and strengthen social capital around normative aspects, from where the precursors of change begin.