COMMUNICATION STRATEGIES FOR FAMILY WELFARE PROGRAMME*

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The post-partum approach has had considerable success in the family planning programme. Special efforts are made to provide information, education and motivation to recently delivered women in the field as well as post-partum hospitals. It was seen in this experiment that family planning workers, talking to women who had been exposed to family planning messages through making use of lady medical doctors' "competence credibility" and communication skills, were able to motivate them to action at a faster rate.

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Introduction

What is a Communication strategy? Rogers defines strategy as a plan or a design for changing human behaviour on a large scale basis through transfer of new ideas (Rogers, 1973:405). Basically we have to transfer important information about family welfare programmes with an intention to change behaviour. Three types of communication are essential in any family welfare programme. These are informational, motivational and belief-clarifying. They can be overlapping. Informational communication includes population details, family welfare methods, programme services and their locations, and motivational communication includes benefits of a small family in contrast with a large family and acceptance of family planning methods. This is difficult to communicate. Belief clarifying includes answering query clients have about the programme and family planning methods etc. This is the most difficult and hence most neglected part of communication in the programme. Most often the worker ends up by giving a directive communication in the form of a lecture. This is not very satisfying for the client as this does not remove his doubts, misconceptions, etc., from the side effects of various methods.

Basically our communication strategies should help in increasing knowledge, making attitudes favourable, more practice and more crystallised intention about future contraceptive behaviour. We have to devise special strategies for specific areas of emphasis like post-partum programmes, urban slum dwellers, organised labour (Arora and Sharma, 1978). We also have to make special efforts to communicate with the rural masses, illiterate women in rural areas, village influentials and local leaders so as to increase proper knowledge of various family planning methods, bring about increased utilization of MCH and Family planning facilities and services available in the areas. Special strategies will have to be devised to communicate effectively with the rural masses, — illiterate women and persuade them about the advantages of the small family in contrast with the large family, stimulate inter-personal communication, provide knowledge and remove fears and doubts about the side effects and impart knowledge about family planning facilities, location etc., and finally to motivate them to use family planning method. For this purpose a number of things have to be kept in mind as follows:

I. *Communicator's Credibility*

This is one of the most important varia-

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bles for making communication effective. Credibility is the degree to which a communicator is perceived as trustworthy and competent by the receiver (Rogers, 1973). His expert knowledge of the topic and the trustworthiness with which a communicator is viewed by the recipient have great influence over his success in communication. Hence, a credible source communicates more effectively than a less credible source. The lady doctor in a maternity ward has a certain amount of credibility because of her technical expertise. Similarly the family doctor has rapport with his clients and hence he is best suited for advising on family planning. A satisfied acceptor has credibility because of her positive experience with family planning methods in the past. So her communication introduces an assurance for someone like herself and hence is trustworthy for the receiver. This is called safety credibility. Both these are very necessary for effective communication.

II. *Communication Skill*

This is a must on the part of the communicator. Lack of proper communication skills affect adversely. Some communicators do not listen to the clients patiently and carefully nor do they encourage them to ask questions and clear their doubts. How to initiate a discussion, repeat the messages at times and influence opinion are all very important considerations in which many family planning communicators are often wanting. As far as family planning workers in the field are concerned, there is a need to increase their interpersonal communication skills. The Population Centre has conducted an experiment to study interpersonal communication in the field and it was seen that this was not carried out properly (Rao, 1977). Proper training would help them in identifying the needs of clients and supplying information according to what is needed. This would also help the worker to give belief-clarificative information so as to remove doubts and misconceptions about the side effects of family planning methods.

III. *Communicators' Empathy*

Empathy is the ability of an individual to project himself into the role of another. Empathy with clients is very difficult for the communicator when the clients are too different from himself. The communicator's success is positively related to his empathy with clients. A status-conscious, educated urbanite does not seem to be the best choice for interpersonal communication in rural areas. He cannot communicate effectively with the ruralite because of his different background, status and mannerisms. Hence a local field worker duly trained would be more effective with clients.

IV. *Compatibility between Communicator and Clients*

No source communicates as a free agent without being influenced by his position in the Socio-cultural system. A communicator should know the cultural context in which he communicates, the cultural beliefs and the values that are dominant for him, norms of behaviour that are acceptable. Rogers (1969) has reported, that wide cultural differences between communicator and communicatees affect adversely effective communication between them. Language incompatibility between communicator and clients in terms of not only dialect but also the appropriateness and communicability of words used, and the differences in their interpretations can be an obstacle to effective understanding. Southern ANMs and LHVs have this kind of problem in Uttar Pradesh as they cannot quite effectively speak the same language. Besides, the com-

municators, like extension personnel, sometimes develop a jargon of their own which is beyond the comprehension of the average client of the area. Hence, as far as possible the language used should be compatible with the clientele. More effective communication occurs when source and receiver are homophilous (Repetto, 1977). Similarity in background, appearance, status and knowledge between source and receiver are important for effective communication to occur.

Post-partum Approach

The International post-partum programme was launched in 1966 to demonstrate the feasibility of providing efficient and effective family planning services in the context of the obstetrical care provided by Hospitals (Castadobt, 1975). This proved to be quite effective and hence in India, hospital based post-partum programme was started in 1969, in 59 selected urban hospitals and later it was extended to 324 post-partum centres as on March 1976.

The is one of the approaches which has had considerable degree of success in the programme. It has many advantages. Women involved are those who are currently fertile and they are the ones who need to be protected at the earliest before they can be pregnant again. Motivation for accepting any family planning method is highest during post-partum period. The post-partum period is normally taken as three months following delivery. This approach is particularly suited for women who had an institutionalised delivery. Institutionalised deliveries in India generally occur in urban areas. In fact one of the aims of India Population Project is to increase post-partum acceptance. This is possible through contacting women in hospitals. This does not seem economical at times if the maternity facilities have to be constructed. But these facilities have been constructed in six project districts in the form of eight maternity homes in Lucknow, maternity and sterilisation Annexes in district hospitals, and maternity and sterilisation wings in 10 PHCs of two intensive districts of India Population Project. The intention is to increase institutionalised deliveries and conduct an effective post-partum programme for acceptance and thereby increase post-partum acceptance. This is relatively quite effective for increasing family planning acceptance. In fact, this is one of the things being tested in the India Population Project, namely to increase institutionalised deliveries and thereby increase post-partum acceptance of family planning as well as MCH. Most of the advantages of post-partum family planning programmes can be had if the field workers contact women just after delivery at their residence. Our field staff has maternal and child health responsibilities besides family planning work, hence the scope for post-partum work is considerably enhanced. The post-partum programme usually focuses on women who have recently delivered a child, and hence may become pregnant after post-partum amenorrhea. They need to be protected at the earliest possible moment in contrast to the national programme aiming to protect all women all the time.

These recently delivered women have a fresh memory of labour pains, and so they should be ready to listen to family welfare informational and motivational messages, which may result in a higher commitment to use some method in the near or distant future. Taking advantage of this situation, acceptors can be created at younger ages and lower parities through combining MCH and family planning services. Post-partum programme has the advantage of a more suitable place for providing integrated health and family planning services.

The Contents of the Post-partum Programme

In the presently run post-partum programme in Indian Hospitals, information, education and motivation are provided through films on various aspects of family welfare but the communication through these films does not seem very effective at times. Also the range of communication which can be included in a few films is limited and so would be its impact. Hence there is a need to increase the effectiveness of post-partum — communication in hospital as well as in the field. The present experiment with inputs of a public address system and a social worker has been designed to increase effective communication among the patients in the hospital. This system has certain advantages over the present system as will be seen later. Each doctor has to deal with a large number of patients, and she can't pay much time and attention to individual patients. Under such conditions, it would not be possible for the lady doctor to advise each and every patient about family welfare and thereby provide complete knowledge and remove doubts. Overcoming this problem, we have used a public address system in the maternity wards of two urban hospitals in Lucknow for spreading the doctor's voice to each delivered women. During the day, when doctors' round and visitors' times are over, and the atmosphere was conducive to listening, with most of the women lying in bed without sleep, recorded family welfare messages were played. The first commentator would introduce the lady doctors of the hospital and the subject of population problem and then the doctor's voice takes over. These messages were in the form of a well structured dialogue and contained assurances and reassurances to the patients, about the advantages and side-effects of the various methods available for limitation and spacing of children. A few messages also included the narration of actual experiences of some satisfied acceptors in the hospital, who got them-selves sterilised in the past. Their experience are of great relevance to a would-be-acceptor, as this gives her security about their use. Different messages covered different aspects of family welfare so that these clients in the hospitals were subjected to 'competence credibility' of the lady doctor and 'safety credibility' of the satisfied user and this should hopefully make them more knowledgeable and turn them into acceptors by removing their fears and misconceptions about family planning methods. Family planning workers are already provided in this programme. A discussion between patient and this lady worker helps in providing more complete information, assurance, reassurance and increased motivation for action. However this experiment was specifically designed to increase knowledge, post-partum and post-abortion acceptance and also to test whether such a public address system in maternity wards can increase the output of family planning communication to which each target woman was exposed. Also to test whether credibility of the lady doctors of a maternity ward can be exploited for an effective communication to the women during their lying-in period. The main hypothesis being tested in this experiment was that lady workers, talking to women who had been exposed to family planning messages would be able to motivate to action at a faster rate. If so, the same messages can be played in the field as well during group meetings, hence communication would become more effective.

Sampling Procedure

The sample size for each of the baseline and final surveys was 200, for both the

experiments in Queen Mary's and Dufferin Hospital. The samples were selected randomly among the clients about to be discharged from the maternity ward. This generally included delivery or Medical Termination of pregnancy. Finding out a control group for an experimental design is always a problem. In the present experiment, it was not possible to find out a strictly comparable control group. Hence the inferences remain on a level of plausibility rather than on a highly compelling evidence. As strictly comparable groups are difficult to get the same wards in both the hospitals, had been taken as control and experimental groups at two different points of time. In the control group, no such programme was introduced and general effects of routine post-partum programme were studied through baseline survey. In the experimental group women were exposed to public address messages, and final survey was carried out.

FINDING OF THE STUDY

(I) *General characteristics*

Age: Average age of respondents were 31.5 and 28.5 in Queen Mary's Hospital and 26.6 and 27.5 in Dufferin Hospital in baseline and final surveys respectively. Sampled population in final surveys was on an average 3 years younger than in baseline survey in Queen Mary's Hospital, whereas in Dufferin Hospital baseline was on average a year younger than final survey. There were no significant differentials as far as age was concerned.

Religion: In Queen Mary's percent of Hindus in baseline and final survey were 89.5 and 91.5, (Table 2) while corresponding figures for Dufferin were 80.0 and 75.0. Around 8 percent were Muslims in Queen Mary's Hospital, whereas proportions of Muslims in baseline and final survey of Dufferin were as high as 17.5 and 22.5 per cent respectively. There does not seem to be any significant differentials due to the religious composition of the population.

TABLE 1

AGE DISTRIBUTION OF RESPONDENTS

Age-Groups	Queen Mary's Hospital		Dufferin Hospital	
	Baseline	Final	Baseline	Final
15-19	1.0	3.0	6.5	1.5
20-24	14.5	27.5	37.5	35.5
25-29	27.0	34.5	32.0	34.0
30-34	29.0	21.0	17.0	19.5
35-39	18.0	11.0	5.5	9.0
40-44	10.5	3.0	1.5	0.5
Total	100.0	100.0	100.0	100.0

TABLE 2

PER CENT DISTRIBUTION OF RESPONDENTS BY RELIGION

Religon	Queen Mary's Hopital		Dufferin Hospital	
	Baseline	Final	Baseline	Final
Hindu	89.5	91.5	80.0	75.0
Muslim	8.0	7.5	17.5	22.5
Others	2.5	1.0	2.5	2.5
Total :	100.0	100.0	100.0	100.0

TABLE 3

PER CENT DISTRIBUTION OF RESPONDENTS BY CASTE

Caste	Queen Mary's Hospital		Dufferin Hospital	
	Baseline	Final	Baseline	Final
High	60.0	61.0	54.0	44.5
Middle	10.0	21.0	18.0	22.5
Low	19.5	9.5	8.0	8.0
Others*	10.5	8.5	20.0	25.0
Total :	100.0	100.0	100.0	100.0

* Others constitute Muslim, Sikh, Jain, Christian etc.

Caste: Comparing baseline and final surveys of Queen Mary's Hospital, it was seen that per cent respondents belonging to higher caste were almost same. Per cent belonging to middle caste was higher by 11.0 per cent and per cent belonging to lower caste was, less by 10 per cent in final survey than in baseline survey. In Dufferin surveys proportion of low caste women was same, while proportion of higher caste was less by 9.5 per cent and proportion of middle caste was higher by 4.5 per cent in final survey.

Education: Per cent illiterates was around 40 in Queen Mary's Hospital surveys, and 43.5 and 49.0 in baseline and final surveys of Dufferin. In Queen Mary's final survey 29.5 per cent and in Dufferin baseline, 38.0 per cent and final survey 28.5 per cent were educated up to Primary or Middle level. No significant differentials by education were noted.

Number of Children: All the women in the sampled population had a child male or female. Average number of children ever born to women in Queen Mary's Hospital baseline and final surveys were 3.5 and 3.0 and in Dufferin Hospital were 2.7 and 3.0 respectively.

(II) *Family Welfare*

Information on knowledge, attitude and intention and practice of family planning, had been collected. Awareness means having heard about a family planning method, while knowledge means awareness plus knowing who uses the method, husband or wife. Most of the women in each survey had heard of family planning. Family planning generally meant small and limited family. Only a few respondents took family planning as improving the economic condition, having healthy children etc. However all these meanings were directly or indirectly related to family planning, meaning small and limited family. Family planning as family welfare or treatment of sterility was not endorsed by any one in the sample. There also seemed to be vagueness as to what constitutes small family and what should be the composition of the planned family. Hence our communication strategies for family welfare should be more specific with reference to the size and composition of the planned family.

Knowledge of Family Planning Methods

Terminal methods were known to most of the respondents indicating the emphasis in the programme. In Dufferin final survey, only one woman did not know about loop and nirodh, while in baseline survey 3.5 and 5.5 per cent women did not know about the respective methods.

TABLE 4

KNOWLEDGE OF FAMILY PLANNING METHODS, PERCENTAGE OF RESPONDENTS

Methods	Queen Mary's Hospital		Dufferin Hospital	
	Baseline	Final	Baseline	Final
Vasectomy	97.5	99.5	100.0	100.0
Tubectomy	99.5	99.5	100.0	100.0
Loop	91.0	98.0	96.5	99.5
Nirodh	83.5	98.0	94.5	99.5
Abortion	78.5	95.0	58.0	93.0
Pill	62.0	73.0	47.5	89.5

However in Queen Mary's final survey, 2.0 per cent did not know about the loop and nirodh respectively. Knowledge of abortion increased from 78.5 per cent to 95.0 per cent in Queen Mary's Hospital and 58.0 per cent to 93.0 per cent in Dufferin Hospital from baseline to final survey.

Also, knowledge of oral pills increased from 62.0 per cent to 73.0 per cent and 47.5 per cent to 89.5 per cent in Dufferin Hospital. Methods propagated through public address system included vasectomy, tubectomy, loop, nirodh, pill and abortion. Hence it seems that there was an increase in knowledge of respondents exposed to this public address system communication. This was one of the hypotheses in this study that such a system can increase the output of family planning communication and it seems to be true. Thus the public address system coupled with a social worker seems to be more effective than showing family planning films for increasing knowledge of various family planning methods available in the programme.

Family Planning Methods Known

Most of the respondents were knowing vasectomy and tubectomy. In baseline Dufferin Hospital 66.0 per cent of respondents knew 5 methods as compared to 85.0 per cent knowing five methods in final survey. Similarly 74.0 per cent in baseline and 99.5 per cent of the respondents in final survey were knowing 4 methods of family planning in Dufferin. These methods were vasectomy, tubectomy, nirodh and loop. This confirms the hypothesis that the public address system increases the total output of family planning communication, particularly knowledge about the methods. This is not to imply that these messages achieve the objective of making an acceptor in all cases but it definitely increases the correct knowledge of various methods available in the programme. So knowledge definitely increases but it may or may not lead to practice.

(III) *Post-partum Family Planning Acceptance*

Post-partum acceptance can generally be divided into three categories Immediate, Direct and Indirect. Immediate acceptors are those who accept family planning before leaving the hospital. Direct acceptors are those who accept family planning method after delivery or abortion and after discharge from hospital but within three months of delivery. Indirect acceptors are those who accept family planning method three months after delivery.

In the final survey at Queen Mary's, 51.0 per cent of the women accepted tubectomy as compared to 36.0 per cent women in the baseline survey (Arora, 1977). It seems that immediate acceptance of family planning methods in terms of terminal methods is considerably more in final than baseline data. All the women with 5 and higher parity had accepted sterilization in the final survey while in the baseline survey only 52.1 per cent of the women accepted sterilization at the same parity. Of the women at 3rd and 4th parity, 84.4 and 96.8 per cent accepted tubectomy, while corresponding figures for baseline were 52.2 and 39.5 respectively. This seems to indicate that it is easier *to* motivate higher parity women for family planning through these messages. Among the women with 1-3 and 1-2 parity 36.0 and 12.8 per cent in the final survey accepted tubectomy as compared to 28.1 and 11.8 per cent of the women tubectomised in baseline survey. There seems to be an increase in the acceptance of terminal methods at all parities from baseline to final. In the Dufferin baseline only 9.5 per cent women accepted tubectomy, whereas in the final survey acceptance was 14.5 per cent.

Would-be acceptors: Per cent of would-be acceptors in Queen Mary's baseline was 55.5, while in the final it was 40.0 This decrease was due to the fact that in the baseline 36.0 per cent had accepted sterilisation, in comparison to 51.0 per cent in the final survey. In the Dufferin baseline,

74.0 per cent women proposed to use some method in future as compared to 85.5 per cent in the final. It was also seen that more women would be accepting family planning at lower parity in the final survey. Women with higher parity (3 or above) would be adopting sterilisation later on, and the majority of those who had lower parity (1-2), were ready to practise non-terminal method of family planning. In the final survey at Dufferin Hospital, more women were ready to use contraception at each parity. So there was an increase in immediate acceptance as well as would-be acceptance in both the final surveys.

TABLE 5

PER CENT OF WOULD-BE ACCEPTORS BY PARITY

Parity	Queen Mary's Hospital		Dufferin Hospital	
	Baseline	Final	Baseline	Final
1	80.0	93.6	85.7	100.0
2	68.3	71.4	75.7	89.2
3	43.5	11.1	66.7	88.2
4+	51.2	1.6	72.7	73.2
Total	55.5	40.0	74.0	85.5

Would-be Acceptors by Method

Per cent of would-be acceptors in Queen Mary's Hospital were 55.5 and 40.0 and in Dufferin Hospital baseline and final survey were 74.0 and 85.5 respectively. In Queen Mary's Hospital baseline survey 35.0 per cent were ready to use terminal methods, 16.5 per cent nirodh and 4.0 per cent were proposing to use other methods of family planning in future. In the final survey of Queen Mary's, people desirous to use terminal methods had already adopted, and 20.0, 10.0, 2.0, *6.0* and 2.0 per cent were proposing to use Nirodh, Loop, Pill, Injection and other methods of family planning.

In the Dufferin Hospital baseline survey, 24.5 per cent were proposing to use sterilisation compared to 32.0 per cent in the final survey. Would-be acceptors in Dufferin baseline and final accepting nirodh, loop and pill were 27.5 and 34.0, 5.5 and 4.5, 12.0 and 10.5 respectively. There was an increase in would-be acceptors. This confirms that there was an increase in immediate acceptance as well as would-be acceptance. Increase in immediate acceptance was much larger in Queen Mary's as compared to Dufferin. Hence the main hypothesis that lady workers talking to women who have been exposed to these family planning messages will be able to motivate to action at a faster rate seems to be true.

Conclusion

Tubectomy acceptance increased from 36.0 per cent to 51.0 per cent in the final survey at Queen Mary's Hospital. This represents a substantial increase in comparison with Dufferin Hospital increase which is 5 per cent. Clients in the final survey accepted methods at lower parities. Also most of the clients, who had not accepted tubectomy, were in general, willing to use non-terminal methods. In fact we could not expect all these women to accept terminal methods as some belonged to lower parities. They are the ones who accepted non-terminal methods. This is indicative of the fact that lady doctor's competence credibility can be exploited more than family planning films for an effective communication through the public address system in maternity wards (Dubey, 1969). Also it confirms that the post-partum approach is sound. Receptivity to family planning is strong at this time. Hence it should be used in the field as well, particularly in rural areas. Also for deliveries conducted at home and supervised by dais,

trained or otherwise. The knowledge of different methods of family planning increased among the clients exposed to these experimental inputs. Most of the women in the final survey knew vasectomy, tubectomy, loop, nirodh and pill. This seems to indicate that a public address system using family planning messages through making use of doctor's credibility, satisfied users credibility and persuasive credibility of the family planning worker increases the amount of family planning communication and thereby psychologically prepares client for acceptance. Also, listening to these messages, through the public address system while lying in bed has the additional advantage of positional convenience as compared to film watching which is convenient only when they are sitting. Hence it is worth trying the present education-cum-motivational messages in the following situations to asses the impact of the same.

1. Out-patient clinics and in field by family planning workers.
2. Ante-natal clinics, ante-natal wards and post-natal clinics.
3. Maternity wards of the District Hospitals.

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