

## **Perceptions of Healthcare among Underprivileged Villagers: A Qualitative Inquiry**

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### **Abstract**

Apart from many other issues, health issues plague the life of people in the margins. Health is a major issue for the poor sections of society in India. The issue is amplified in the light of dismal public health infrastructure and the burden of communicable and non-communicable diseases. The government's response to such a situation has been through various initiatives including health related schemes. In such a scenario, perceptions are created among the poor people living in interior villages of the country about health and existing healthcare delivery system. Such perceptions lead to scope for studying the role of culture in understanding of health and health communication. Using qualitative method this article delves into such issues of culture and communication mediating with health and healthcare delivery system in the realm of the experiences of poor villagers in interior places.

**Keywords:** health, culture, communication, perception, poor, villagers.

### **Introduction**

Health is a major area concerning development for countries like India which is yet to be able to provide basic health care services to its entire population. Among the major health issues confronting the country are increasing disease burden, maternal health and child health issues. Its health problems are manifested in various forms like deaths due to diseases, high mortality rate due to preventable diseases among children and death among women during child delivery. Various studies by governmental and multilateral agencies have established these facts (WHO & UNICEF, 2014; Arnold et al., 2005; Hazarika, 2010). According to the "WHO World Health Statistics Report, 2016" non-communicable diseases are on the rise in the country and prominent among the non-communicable diseases which afflict the country are diabetes, cancers, cardio-vascular and pulmonary diseases (Wal, 2016). Such a scenario of non-communicable diseases presents the country a huge challenge along with the existing communicable disease burden to tackle with. Many scholars link the rising cases of non-communicable diseases in a country like India to the changing life styles of people in the country (Upadhyay, 2012; Boutayeb & Boutayeb, 2005; Sugathan, Soman, & Sankaranarayanan, 2008.).

Maternal and child health issues are another major area of concern in the country. Major issues related to maternal health include, among others, high maternal deaths, ante natal care (ANC), post-natal care (PNC), safe delivery, nutrition and contraception. The country has seen lot of efforts to surmount these problems but still issues related to maternal health persists. While the country did

not achieve Millennium Development Goal (MDG) 5 target for reducing maternal mortality rate (MMR) to 140/100000 live births (LB), there are some states which have managed to achieve this target, the southern states like Kerala and Tamil Nadu are at the forefront in this regard (Sample Registration System, 2014). Though ANC is very important and contributes to lower MMR there are problems both with the quality and scale of ANC throughout the country due to lack of adequately trained man-power to perform this task or other reasons like lack of awareness (Rani, Bonu, & Harvey, 2008).

Although post-natal care (PNC) is very important in the recuperation of a woman after delivery it is often neglected by married adolescents and women in India who are largely unaware of the importance of it, apart from this socio economic and cultural factors also play a role in utilization of PNC facilities in government health institutions (Singh, Rai, Alagarajan, & Singh, 2012; Singh et al., 2012). While nutrition plays a vital role in the well-being of a pregnant women and the foetus in her womb but due to various reasons nutritional levels are found to be very low among not just pregnant women but also among adolescent girls in general in India (Toteja et al., 2006; Bentley & Griffiths, 2003). According to many studies institutional deliveries have increased in the country and the credit for this is often given to the central government sponsored scheme called Janani Suraksha Yojna (JSY) under which monetary incentives are provided for delivering a child in a government hospital (Randive, Diwan, & De Costa, 2013; Lim et al., 2010). The reasons for high MMR are many and ranges from poor health infrastructure in interior areas to lack of awareness of maternal health issues, poverty and absence of proper communication infrastructure in interior parts of the country (Black et al., 2008; Vora et al., 2009).

Child health issues also present a very strong challenge to India's health care system. There are many issues pertaining to child health in India including child mortality, nutrition and breastfeeding. Mortality among children in India is very high compared to the world average and India has not been able to achieve the MDG 4 target of reducing infant mortality rate (IMR) and child mortality rate (CMR) in spite of all its efforts but at the same time there are many states within the country which have already achieved the target set under the MDG. Kerala, a southern state of India has an IMR of just 13 (NIMS, ICMR, & UNICEF, 2012). While some states have already achieved or are on the verge of achieving the target, there are many states which have fared very badly and are likely to take a long time to achieve the target. Assam which is among the worst performing states on the count of reducing child mortality is likely to achieve the MDG4 target only by 2032 (Paul et al., 2014). It is far established that vaccination is an effective way for protecting children from many killer diseases in their childhood as they have low immunity against those diseases.

Apart from the problems related to maternal health, child health and disease burden the health care scenario in India is marked by high out of pocket expenditure for treatment and low public expenditure on health (Kumar et al., 2011). Among many developing and emerging economies of the world the public spending on healthcare is among the lowest in India (Lakshman, 2016). In order to improve the overall health scenario and strengthen the healthcare facilities in the country many

efforts have been made by the government in the form of special programmes. One such programme launched in 2005 for overall improvement of health and healthcare scenario in the rural areas of the country was National Rural Health Mission (NRHM). This scheme was subsequently turned into a scheme covering the urban areas also and has been rechristened as National Health Mission in 2012 (Dhar, 2012).

### **Importance of Communication in Health**

Communication plays a vital role in the prevention and control of diseases and improving health in a society. Proper communication is very important especially in rural areas as per development activities are concerned (Nwosw, 1987). Simpson-Hebert and Wood (1998) puts emphasis on starting a successful advocacy by identification of groups that are to be influenced upon and he also suggests finding out the most appropriate manner to communicate the message.

For having an effective public health system, communication has to be at the core of the system. Bernhardt (2004) summarizes the nature and importance of communication in public health as “with its transdisciplinary nature, ecological perspective, change orientation, and audience-centered philosophy, public health communication has the potential to make significant contributions to the health of the public” (Bernhardt, 2004, p.2052).

Hutchinson et al. (2003) brings to the fore the role of communication in meeting health challenges and part mothers can play as a very important communicator of risk to adolescent females in their study that ‘examine the relationship between mother–daughter communication about sex and selected sexual risk behaviors among inner-city adolescent females’. The importance of communication in health is also demonstrated by Laser and Becker (1997) in their study on the role of husband wife communication in the use of contraceptives. They find in their study that communication between partners enhances the effectiveness of spousal perception of the other spouse’s approval for contraception use and also affects the use of contraception by the partners.

Desai and Alva (1998) shows that there is a strong correlation between maternal education and markers of child health like infant mortality, children’s height-for-age and immunization status as they are in a better position to understand health communication messages on such issues. Among the best examples of the positive role played by communication in health issues is the polio eradication campaign of India (Arora, Chaturvedi and Dasgupta, 2010). It has also been well recognized that communication played a major role in the eradication of polio from India (“India is now polio free,” 2014).

A study by Phongosavath (2015) showed the success of communication in increasing breastfeeding rate in Laos. The increases were attributed to a communication campaign comprising newspapers, television and inter – personal communication. Health Communication effects doesn’t work alone in vacuum, it is influenced by a host of other factors. Viswanath and Bond (2007) also explores this view in their selective review of literature and elaborates how a host of social contexts

like socioeconomic status, social engineering, race and ethnicity and place play a major role in effects of health communication related to diet and nutrition.

Community action through social mobilization especially those led by women can help in easing many tasks related to the welfare of communities especially those related to women's health as shown in the success of the Gadchroli and Nepal initiatives to reduce maternal mortality and morbidity (Paul, 2004). Social mobilization is very important in achieving success in campaigns like polio eradication initiative and in such mobilization, communication plays a major role (Waisbord, 2007).

Based on the findings of many qualitative research McGinnis (1990) in his editorial for the 'Public Health Reports' argues that lack of knowledge alone cannot be considered enough, for explaining differences in health behaviour of people. According to him people's behaviour related to their health is formed by their individual characteristics and factors ranging from social to environmental. He also adds that the people who are at a greater risk of health related problems tend to be influenced by their 'unique cultural, linguistic, and socio economic factors'. At the same time, he contended that the reception of health messages by these groups depends a lot on the content of a message and its sender along with the manner or technique and the time when it is delivered. The author also harped on direct involvement of the target audience in the health communication process as it was likely to result in better outcomes through the audience translating the message into action.

### **An Alternative Approach to Health Communication**

Though the importance of communication in health is undisputed but the "dominant cognitive approach" to health communication has been a subject of debate (Dutta-Bergman, 2005). In the meanwhile culture as the centre of health communication research has gained attention and importance in recent years (Airhihenbuwa, 1995; Dutta and Jamil, 2012, Dutta-Bergman, 2005).

In the light of increasing disparity between health rich and health poor around the world, especially in the third world, Dutta-Bergman (2005) critically analyses the dominant cognitive approaches to health communication and calls the Theory of Reasoned action (TRA), Health Believe Model (HBM) and Extended Parallel Process Model (EPPM) as "the three most widely applied theoretical approaches that inform much of the published scholarship on campaigns" (p. 104).

Dutta-Bergman (2005) summarizes that the dominant cognitive approach to health communication campaigns suffers from individualistic bias as they are founded in an individualistic epistemology where the locus of choice is the individual. The author also criticizes these approaches as they overemphasize the role of cognition in shaping audience outcomes. Further the author critiqued the dominant approaches for minimizing and ignoring the contexts of a health behavior being studied. Finally the author proposes new approaches like recognizing the role of structures and basic capabilities, culture centered approach and polymorphic theorizing of health communication for targeting the marginalized populations as the dominant approaches fail to address the problem of health from a marginalized group's context.

Culture in health communication has also been looked from different epistemologies as in Kreuter and McClure (2004) where the authors explore the importance of culture of in health communication with the help of McGuire’s communication/persuasion model. The authors delve into previous studies to see how culture as a factor in increasing the effectiveness of communication affects the three components of the model – source, message and channel and also how each of these components affects communication and persuasion.

Airhihenbuwa (1995) in his book “Health and culture: Beyond the Western paradigm” lays stress on the importance of culture in international health communication research as culture constructs and interprets meanings from within rather than bringing the meaning from outside and imposing it.

It is further argued that culture should be at the centre while studying marginalized groups in order to elicit narratives from them about themselves. According to Freire (1970) the marginalized peoples are dehumanized and the project for their humanization can only be achieved through and by the marginalized peoples themselves, thereby making it clear that the marginalized peoples have a voice of themselves which is suppressed by their oppressor. Hence Freire (1970 as in Dutta-Bergman, 2004) saw culture-centered approach as promising “to open up legitimate discursive spaces for marginalized cultural groups, bringing to the fore the narratives that are articulated within these cultural spaces”. (p. 1108)

Escobar (1995) in his book ‘Encountering Development’ lays emphasis on the importance of giving recognition to the ability of marginalized peoples to choose their own path of life, shape behaviours for themselves and build upon philosophies which are grounded on the understanding of themselves which also forms the basis of their culture. According to him culture has the ability to guide narratives to bring into the open the ability of marginalized peoples to speak for themselves. He draws attention towards the role narratives guided by culture could play in bringing forth the marginalized people’s ability to speak for themselves which highlights their abilities and stories told from their perspective.

Gao, Dutta and Okoror (2016) in their study on Chinese immigrant restaurant workers follows the culture centered approach to demystify the monolithic notion of wealthy and well to do Chinese community in USA. The study which is done with the help of in-depth interviews brings into focus important issues related to access to health care and the hardships of restaurant workers in getting health care access. Restaurant workers hardships are understood in the study from the perspective of their work, which is very difficult. Many problems faced by the Chinese workers which are structural in nature are highlighted in the interviews. Among these problems is their status of immigration, not having insurance protection and their poor understanding of the health care system of USA.

Building on culture centered approach to health communication further Dutta-Bergman (2004) puts forth a “structure-centered communication model” which traces meanings of health inside the sphere of structure. His model conceptualizes communication as a “process of constructing, negotiating, and transforming cultural meanings” (p. 119) through interactions between culture and structure for transformation of structural barriers that obstructs the lives of marginalized peoples from leading fuller lives by accessing health care in the context of health. As participants in the communication process tries to understand about their marginalization, they evoke cultural meanings continuously. Hence any attempt to give structural access to marginalized people by changing the structure should be informed by the nature of the culture. Basu and Dutta (2007) in their article following the culture centered approach explore the role of context in the formation of meanings of health among tribals in India. As the tribal population in India according to them is isolated and exploited, they are denied their rights and their resources are plundered without giving them their due, hence context and culture are context are central to the study. Using participant narratives and grounded theory analysis the authors try to find out how tribals in India create meanings of health and how those meanings have a contextual bearing. The findings of the study bring to the fore perennial sufferings and pain of tribals and the dilemma among them in the face of creeping modernization and multiple treatment options existing side by side along with their own traditional form of treatment.

## **Method**

As the study is about the perceptions of health and health care among the poor, only married men and women having at least one child in the age group of 1 – 3 years were selected for the study. Another criterion which was applied for selection of samples was that the source of livelihood of the person had to be daily wage earned through physical labour. Though among them few also engaged in cultivation of their own small land holdings but produce from farming was not enough to sustain their families throughout the year, so they also had to work as daily wage labourer during the non-agricultural season. The third criteria required the samples to be either illiterate or having studied not beyond seventh standard of schooling. Hence only those men and women having a child in the said age group who were either illiterate or had not attended school beyond seventh standard were considered for inclusion in the study. The selected samples were permanent residents of various villages falling under the jurisdiction of the health department of Udalguri district in Assam state of India. A total of twenty four In-depth Interviews (IDIs) were conducted over a period of six months with selected men and women. IDIs and FGDs were held in the native tongue of the research participants and were recorded using a digital recorder. The collected data was translated and transcribed following the methods as suggested by Lincoln & Guba (1985). Transcribed data was treated to thematic analysis as in Braun & Clarke (2006). After the analysis process three broad themes were arrived at reflecting the purpose with which the study was conducted. For the purpose of enhancing the validity the results of the study were shared with few interviewees. Except one observation by a research participant, which was addressed immediately, rest of the participants agreed with the results.

## Results

The following results in the form of broad themes were arrived at after the analysis of the collected data.

### *Persistent attempt to access healthcare*

The villagers attempt to access health care is shaped by their awareness of the location of health services and awareness of self. There is an understanding among the villagers about the location of health services, which they consider to be very far both physically and emotionally. Physical distance appears because “the condition of road is very poor and so very few vehicles ply” (Interviewee 10), which makes connectivity in the villages a real big problem. It also leads to wasting of significant amount of time leading to loss of work. While emotional distance crops up because they have had bitter experiences like rude behavior or callousness of doctors, nurses, other hospital staff and also lack of facilities while accessing public health care delivery system. At the same time there is also awareness among the villagers about themselves as being poor, illiterate and weak without any say in the larger society on matters including those of public health.

“We are poor people, don’t know how to read and write. What can we say about the functioning of the government hospital and facilities there? Who will listen to us?”  
(Interviewee 7, lines 92-93)

In such a scenario the villagers try to access healthcare which will allow them to ‘survive illnesses’ and continue their lives in a normal manner. They try to access the appropriate health care for different health conditions from among different treatment options available in the ‘market’ based on their perceptions and ability to procure the treatment. Economic hardship coupled with market realities affect their decision to seek health care for illness. Poverty limits the choices of health care available to them and at the same time impacts their faith in different treatment options available to them. Some like Interviewee 8 has lost “whatever little wealth I had to medical expenditure in the treatment of my wife and son”. (line 62). In such a situation they try to access health care services according to their ability to cope with the reality. Many responded visiting local pharmacies manned by a doctor or a pharmacist in the village rather than going to the government hospital, private practitioner doctor in town or a private nursing home as local pharmacies were nearer, physically and emotionally, and also cheaper thus saving both time and money. But at the same time there are personal accounts of both good and bad experiences in such pharmacies. Though a few suspect the credentials of the doctors and pharmacists in those village pharmacies still it is generally accepted by the villagers that they are providers of accessible treatment, with or without assurance of quality.

“There is a pharmacy in the chowk (square). The doctor is also good and can cure many diseases. He also charges very less compared to private doctors in the town. So we go to the pharmacy only for any illness”. (Interviewee 4, lines 66-68)

There were some who also responded to visiting government hospitals or private nursing homes; they have lot of negative views of the government hospitals and worries of economic stress as consequence of taking treatment in private nursing homes. Their negative views of government hospitals are based both on past experiences and perceptions created by negative publicity by family members, friends and peers. Though the village level health workers or the Accredited Social Health Activists commonly known as ASHA attempts to improve the image of government hospitals through her talks, but it doesn't help much in changing the views of villagers. But for health conditions related to pregnant women and children the villagers overwhelmingly preferred the government hospital and the ASHA's advice was very much sought and heeded in matters related to pregnancy and childhood illness.

“For pregnancy and illness of babies the government hospital is also good. The ASHA is always there to help on any matter and if there is some serious problem they immediately send to the Medical College in Guwahati”. (Interviewee 1, lines 54-56)

At times the villagers also visited traditional medicine practitioners and spirit doctors, the term Oja is sometimes used interchangeably to mean both. The traditional medicine practitioner 'Oja' is one who provides treatment using locally available herbs and is usually sought after for treatment of common ailments and health conditions which have traditionally been cured by him. While some people seek the help of the spirit doctor called 'Oja', for illnesses which doesn't subside in spite of exhausting 'other avenues' of medical treatment. Economic cost of treatment in hospital or pharmacy is also an important reason cited by respondents regarding the reason for approaching the spirit doctor apart from the prevailing believe in evil spirits causing illness, casting of black magical spell and use of bad medicines by an enemy who is usually from the same village.

### ***Demands and aspirations***

In spite of the grievances against public delivery systems there is a realization that public delivery systems are their best chance of leading a dignified life. It was explicitly stated by many during the interviews that they are not fully aware of the schemes run by the government for the poor including those by the health department. The reasons cited for not being aware about schemes includes illiteracy, lack of interest as benefits are siphoned off by well to do and well connected middle men, lack of time and not having access to any mass media. Some though wanted to buy television but not having electricity in their village created problems for them in this regard and wanted the government to do the necessary in this regard.

“I am not aware of any schemes, what is the use... I don't have time, nor do I own a TV to know about them. Anyway the benefits are taken by the well to do people who know the leaders, and nothing is left for us. Hence the government should do something in this regard”. (Interviewee 7, lines 43-45).

Though some of the villagers have mobile phones they generally use is for making emergency and very important calls only as the cost of recharge is high for them. Few interview



participants also stated having low cost “Chinese phones (smart phones) for watching movies and listening to songs” (Respondent 4,) apart from making and receiving phone calls. In spite of a lack of awareness of government schemes the general perception that government sponsored health schemes are for the overall welfare of the poor is quite pronounced. Still few schemes of the health department like the cash transfer scheme for institutional delivery called ‘Janani Suraksha Yojna’ and universal immunization programme are quite popular as these schemes are regularly talked about and its implementation is seen on the ground. These schemes enjoy wide acceptance due to the government being behind them and the villagers usually feel that the government’s guarantee comes along with these schemes and hence they are considered safe though expressions of annoyance at government apathy towards them is quite explicit. Though the villagers are aware of their ignorance of government schemes they feel they can choose the best for themselves and are very much aware of the advances made by medical sciences. It is this sense of awareness coupled with anger which they channelize to demand for better health care facilities from the government. Better health care facility is visualized in the form of fully fledged hospitals, with full manpower and amenities. The existing health sub-centre manned by a nurse on certain days along with ASHA is considered inadequate for the well-being of the poor villagers.

“We want a good hospital in this backward place. The health sub-centre with just the nurse, without any facilities is not enough to take care of so many people here”. (Interviewee 5, lines 95-96)

For achieving the same they are forming committees along with local educated men and placing their demands by meeting politicians and health department officials. In this regard the ASHA’s help and suggestion is sought as she is perceived to know health department officials and also politicians. But at the same time they are not very optimistic about their demands being taken in the right earnest by the authorities. Their grudge against the local leaders of various organizations including political leaders is that they are not taking up the basic issues of the poor villagers. This sometimes makes them feel hopeless but still they dream of their demands being materialized someday which make them continue with their effort. Thus in poor villagers’ narratives of health the solutions to their problems present either through dreaming of better days and struggling for it or giving up to hopelessness.

### *Nothing is free*

The villagers based on their life experiences in negotiating with the overall healthcare delivery structure – government hospitals, private nursing homes, private health practitioners, village pharmacies and Ojha, have concluded that nothing comes free of cost in accessing health care. Though the public sector healthcare is supposed to be free many participants have expressed their helplessness at having to spend money for services supposed to be free of cost.

“We spent 500 for vehicle, doctor... Husband knows better. Sweeper, nurse, injection ... Approximately 2000. ... Oh ... again we came by the hospital vehicle, had to pay 200 Rupees to the driver” (Interviewee 3, Lines 40-41)

This feeling of helplessness has made them conceptualize their relationship with the public health care delivery system as one that of a seller and a buyer. The health care providers - staff of government hospitals, as the sellers and the hapless poor villagers as buyers. Though the ASHA service is free, even in accessing her service some expenditure is to be incurred in the form of paying for her transportation cost and sometimes paying for her food if she had stay at night or for long hours with the patient in hospital. These expressions occur in the background of the ASHA communicating to the villagers about quality and free services in the government hospitals.

While the private healthcare system, according to the interviewees, is marked by either lack of quality or authenticity on one hand and on the other hand quality healthcare is very expensive for the villagers. For them it is either compromise on quality and spend less or gets quality treatment for a heavy price. But the predicament for the villagers is that sometimes even after spending lot of money in a so called quality health institution they don't get the expected services, or the disease is not cured.

“Money will be spent in private treatment. But the problem is that sometimes it is of no use as the disease is not cured and if you go to big hospitals you cannot afford the cost of treatment”. (Interviewee 8, lines 66-67)

And sometimes this results in the villagers being perplexed at the reason for their patient not being cured and the question arises in their mind if it is due to the trickery of the health provider for earning money or is it due to some unseen force, which on occasions leads to villagers accusing fellow villagers of wrong doing. It is under such circumstance that they contemplate of opting for the last resort which is approaching the Ojha and in the process their faith in modern medicine and public health care delivery system becomes weaker or is lost.

The villagers opine that all their avenues of receiving health care is afflicted by corrupt practices, where everyone just tries to make money and performing their duty becomes secondary. In such circumstance the villagers are not left with any other option but to pay for their health. Thus a feeling has evolved among the villagers that they are obliged to pay for their health as nothing is free. Such feelings have harmed the efforts by ASHA to improve the image of government hospitals and have made her listen to the angry voices of the villagers on occasions.

## **Discussion**

Studies like the present one here basically take culture at the heart to explore discursive spaces of marginalized sections of the society (Airhihenbuwa, 1995). The results showed the cultural understanding of poor people about problems confronted by them day in and day out. They considered themselves to be at a great distance both physically and emotionally from the system which runs the government hospitals and also the society itself. These realizations are reflected through their experiences of social, political and economic exploitation by people whom they cannot see but whose existence they are aware of around them. Though on occasions, the images of various

people flash in their memories ranging from an ambulance driver who fleeced them to the doctor in the government hospital who was being rude and unsympathetic to being not taken seriously by anyone because of their poverty and illiteracy induced low status. Still they have taken to accepting and even liking their oppressors' ways and consider them to be more or complete human beings whose lives are worth living.

They wish their own children to be like their oppressors and enjoy a full life, and not like their own wretched ones filled with misery. Freire (2000) calls such urge among the marginalized and oppressed people as internalization of the oppressor and his ways by dehumanized beings, as they have seen them living a life without any material want and care which are very much endemic in their own lives and which they can only aspire for. Also the power which those people wielded really enamored them as it was in stark reverse of their own powerlessness. But seldom do they realize that their oppressors are also dehumanized beings who have lost their sense of being humane. The poor people though are not aware of the official processes, but they are quite aware of public subsidies and schemes meant for their welfare being siphoned off by those known and unknown powers. This is in complete contrast to how at another level, such things are considered nothing unusual but ought to be normal, thus implying doing the same if given a chance.

### Conclusion

The study has been able to show the perceptions of poor people in far-flung interior villages about health care delivery which are seldom taken into consideration in the mainstream discourse on health communication. A culture centered approach to health communication brings to the fore issues and concerns of poor villages about their own health and the healthcare services they access for sustaining their lives. The study throws a light on the understanding of the poor villagers about the existing health inequalities in the society and how they feel unable to overcome the structures which perpetuate this inequality. In the realm of the unjust structure in society and in health care delivery services the poor devise their own mechanisms to deal with health issues and their outlook of the public healthcare delivery system reflects their experiences with those mechanisms.

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