

# Is Focus on Prevention Missing in National Health Programs? A Situation Analysis of IEC/BCC/Health Promotion Activities in a District Setting of Punjab and Haryana

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## ABSTRACT

**Context:** Health promotion (HP) has been an integral part of all national programs although it has been a low priority in India, which has resulted in a failure to achieve the desired results. **Settings and Design:** Situation analysis of information education communication (IEC)/behavior change communication (BCC)/HP activities within the existing national health programs was undertaken in the district of Hoshiarpur in Punjab and the district of Ambala in Haryana during 2013-14. **Materials and Methods:** Facility-based assessments were done by conducting in-depth interviews with stakeholders, program officers, medical officers, health workers, and counselors. Household survey (332 individuals) and exit interview (102 interviews) were conducted to assess the knowledge of the community regarding key risk factors. **Results:** There was a high vacancy in the mass media division with 40% (2 out of 5) and 89% (8 out of 9) of the sanctioned positions vacant in Hoshiarpur and Ambala, respectively, with low capacity of staff and budget. There was no annual calendar, logbook of activities with poor recording of IEC material received and disseminated. The knowledge of community members regarding key risk factors such as tobacco use, salt intake, blood pressure level, anemia, and tuberculosis was 77.3%, 26.4%, 16.4%, 32.7%, and 91.8%, respectively, in the district of Ambala as compared to 77.5%, 37.5%, 33.3%, 25.8%, and 88.3%, respectively, in the district of Hoshiarpur. The village health and sanitation committee (VHSC) in the district of Hoshiarpur and village level core committee (VLCC) in the district of Ambala were found to be nonfunctional with no IEC/BCC activities in the covered villages in the last month. Monitoring and supervision of IEC/BCC activities were poor in both the districts. **Conclusions:** IEC/BCC/HP is a neglected area in national health programs in the selected districts with inadequate budget, human resources with poor implementation, and requires strengthening for better implementation of the national health programs.

**Keywords:** Analysis, health promotion (HP), information education communication (IEC)/behavior change communication (BCC), integrated, situation

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## Introduction

“Health status of the population at large in India leaves much to be desired despite having a well-developed administrative system and technical skills.”<sup>[1]</sup> Despite significant contributions toward improvement of the population’s health in the last six decades, the health outcomes remain inadequate.<sup>[2]</sup> The acceptance of this vast gap between its capabilities and the actual reality of the health situation in India has focused the attention of governmental and nongovernmental agencies on rebuilding public health. The series of papers by Lancet has highlighted the important health care challenges that are impeding in our health system, namely, coexistence of substantial burdens of infectious diseases, reproductive and child health problems, nutritional deficiencies, chronic diseases, and injuries.<sup>[3]</sup> Several adverse social determinants, along with behavioral risk factors such as smoking, smokeless tobacco consumption, and alcohol abuse aggravate the situation.<sup>[4]</sup>

Health promotion (HP) has emerged as a viable approach and tool for comprehensive and equitable health development globally and it holds considerable potential for strengthening public health in India.<sup>[5]</sup> Common HP activities include adherence to healthy behaviors such as the consumption of low-fat and low-cholesterol balanced diets, regular exercise, not smoking, and moderate consumption of alcohol.<sup>[6]</sup>

Lack of information is the major barrier to the effective access to services. It has been an integral part of all national programs although health education has been a low priority in India. Generally, the lack of convergence within the programs and services is resulting in a failure to achieve the desired results. Keeping in view this background, the situation analysis of information education communication (IEC)/behavior change communication (BCC)/HP activities was planned in the district of Ambala in Haryana and the district of Hoshiarpur in Punjab and the awareness level of the community members regarding ongoing health programs was also assessed.

## Materials and Methods

The graphical presentation of the methodology adopted for the present study is given in [Figure 1].

### IEC/BCC activities in the districts

The district of Hoshiarpur from Punjab and the district of Ambala from Haryana were selected for data collection after consent from the state government. The noncommunicable disease (NCD) program is being implemented in both the districts. One district hospital, one community health center (CHC), two

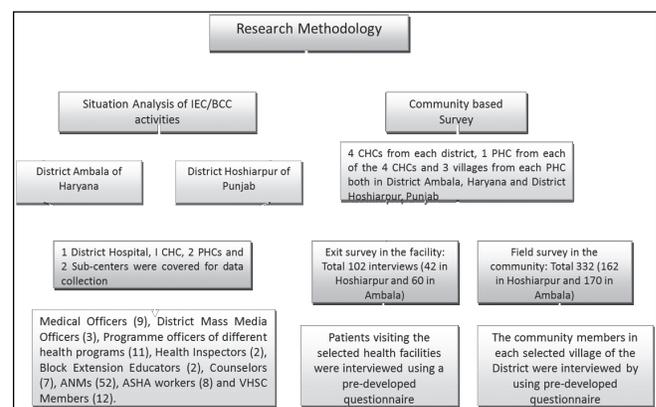
primary health centers (PHCs), and two subcenters (SCs) were selected randomly for data collection from each district. District mass media officers, program officers of different health programs, health inspectors, block extension educators, counselors, auxiliary nurse midwives (ANMs), accredited social health activist (ASHA) workers, and community members were interviewed. Focus group discussions (FGDs) were carried out with ANMs/lady health visitors (LHVs), and VHSC members.

The situation analysis of IEC/BCC activities was carried out on the basis of eight parameters, namely, the availability of skilled human resource for carrying out IEC/BCC activities, presence of a district action plan specifically for IEC/BCC activities, annual activity calendar for IEC/BCC activities, logbook of IEC/BCC activities, availability of adequate IEC or resource material, budget for IEC/BCC activities, monitoring and evaluation of IEC/BCC activities, and integration and convergence of IEC/BCC activities.

### Community-based survey

The community-based survey was conducted at both the facility and village levels in the selected districts. Exit interviews were conducted with the patients visiting the health centers/hospitals to study the accessibility, availability of IEC material such as pamphlets, posters, and wall paintings, and implementation of IEC/BCC activities. House-to-house visits were also conducted in the selected villages by multistage random sampling.

Four CHCs were randomly selected in both the districts. One PHC from each CHC was randomly selected and further three villages from each PHC were selected randomly. Five males and five females were randomly selected from each village. In total, 204 community members (42 exit surveys



**Figure 1:** Showing the methodology adopted for situation analysis and community-based survey. This figure gives the separate methodology for situation analysis and community-based survey. It comprises the number of centers covered and the number of personnel interviewed

and 162 field surveys) from 12 villages in the district of Hoshiarpur and 230 community members (60 exit surveys, 170 field surveys) from 12 villages (3 each from 4 PHCs) in the district of Ambala were interviewed.

## Results

### Sociodemographic profile

The sociodemographic profile of the district of Hoshiarpur and the district of Ambala is given in [Table 1].

#### *District of Hoshiarpur*

Hoshiarpur district comprises 4 subdivisions, 10 community development blocks, 9 urban local bodies, and 1417 villages. The district has an area of 3,365 sq. km. There are 12 CHCs, 36 PHCs (9 block PHCs and 27 mini-PHCs), 244 SCs, 85 subsidiary health centers (SHC), and 6 urban civil dispensaries. The administrative control of the blocks is within the block PHCs. SHCs are under the control of Panchayati Raj Institution (PRI), i.e., under the Zilla Parishad.

#### *District of Ambala*

The district of Ambala is one of the 21 districts of Haryana in India. It has two subdivisions, which are further divided into three tehsils – Ambala subdivision comprises two tehsils, Ambala and Barara and Naraingarh subdivision comprises only one tehsil, Naraingarh.

### Status of IEC/BCC/health promotion activities in the district

The results have been presented as per parameters given in methodology and explained as below:

### Availability of skilled human resource for IEC/BCC activities at the district level

#### *District of Hoshiarpur*

The district's mass media wing carries out all IEC/BCC/HP activities in the district under the supervision of District Mass Media Officer (DMMO). Out of five sanctioned posts in the mass media wing, only three

posts were filled.

No written guidelines regarding roles and responsibilities of the staff were found to be in place at the district level. Only verbal instructions are given during the routine meetings. There was a lack of awareness about the IEC component among the staff of the district's mass media wing. Most of the IEC/BCC work was delegated to the BCC facilitator, who happened to be a contractual worker.

#### *District of Ambala*

There is a provision of IEC division in the district. Nine posts are sanctioned for the division. At present, only one position of the District Family Welfare and Education Officer (DFWEO) is filled. In addition to his jobs and responsibilities, the DFWEO is also handling the charge of DMMO. The remaining positions were vacant.

### Presence of district level action plan

#### *District of Hoshiarpur*

District level action plan was not available. State level action plan is circulated to the district but no microplanning of activities is done at the district level. The Deputy Mass Media Officer reported organization of following IEC/BCC activities

- District level advocacy workshop for maternal and child health.
- One FGD on maternal and child health each at 244 Sub centers.
- Competition of healthy girl children in 94 subcenters to save the girl child under Pre-Conception and Pre-Natal Diagnostic Techniques (PNDT) Act.
- Road show for August 15 and January 26 or any other special program.
- 10 drug deaddiction workshops: One at the district level and nine at the block level.

#### *District of Ambala*

A broad action plan is prepared at the district level but microplanning of activities is not done.

### Availability of annual activity calendar

The districts did not have any annual calendar of IEC/BCC/HP activities.

### Logbook of IEC/BCC activities maintained

#### *District of Hoshiarpur*

There was no structured reporting format specifically for IEC/BCC/HP activities. Only physical reporting of activities in the form of numbers was done. The detailed reporting of the activities was not done. Logbook consisted of press releases and photographs.

#### *District of Ambala*

In the absence of a structured reporting format specifically for IEC/BCC/HP activities, only the number

**Table 1: Sociodemographic profile of districts of Hoshiarpur and Ambala**

Indicators	Hoshiarpur	Ambala
Total population (Census 2011)	1,633,237	1,136,784
Crude birth rate (SRS, 2011)	15	17.6
Crude death rate (SRS, 2011)	7	4.6
Total fertility rate (SRS, 2011)	1.9	1.8
Infant mortality rate	37	27
Maternal mortality ratio	109	144
Sex ratio	890	877
Literacy rate (Census, 2011)	84.59%	81.75%
Male literacy rate	88.75%	87.34%
Female literacy rate	80.31%	75.50%

of group meetings was reported without any detailed information or minutes of the meetings.

### **Availability of adequate IEC material: The focus of the IEC material available was more on RCH issues and communicable diseases**

#### *District of Hoshiarpur*

IEC material pertaining to immunization, tuberculosis (TB) control, PNDT Act, human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), etc., were displayed. The IEC material is sent from state to the district in bulk and it is further sent to the PHCs. But the IEC material is not disseminated at the community or village level and stock of the IEC material, procured and distributed was not maintained. Only few materials were available in the local language.

#### *District of Ambala*

A majority of the IEC materials available at the district level pertained to physical activity, healthy diet, immunization, TB, vector-borne diseases, ambulance services in the district, etc. The IEC materials on prevention and control of NCDs such as cardiovascular diseases, stroke, and substance abuse were not available in the district.

### **Funds**

#### *District of Hoshiarpur*

Funds are sanctioned from The Center to the state NHM, which is further disbursed to the District Health Society and National Health Mission. ₹4.44 lakhs were sanctioned to the district's mass media wing for the financial year 2013-2014. The mass media wing further disseminates the budget to all blocks equally for carrying out the IEC/BCC activities as mentioned earlier.

#### *District of Ambala*

No funds were sanctioned to the district of Ambala for carrying out IEC/BCC activities for the year 2013-2014.

### **Monitoring and evaluation of IEC/BCC activities**

Inadequate monitoring and evaluation by the district and block level staff were observed in both the districts. No supervisory format was available in both the districts.

### **Integration and convergence of IEC/BCC activities**

#### *District of Hoshiarpur*

Various national health programs such as reproductive and child health (RCH) program, HIV/AIDS, National Program for Prevention and Control of Cancers, Cardiovascular Diseases, Diabetes and Stroke (NPCDCS), Revised National Tuberculosis Control Program (RNTCP), National Mental Health Program, and RBSK, and the school health program are being implemented

at the district level and their implementation is vertical in nature. There is no integration and convergence of the IEC/BCC component within the programs. The district's mass media wing and each program function vertically.

#### *District of Ambala*

All national health programs are being implemented at the district level. The staff under NPCDCS program is available at the district level but not at the CHC level. Each program carries out the IEC/BCC activities specific to the respective program. There is no integration within the national programs.

### **Community participation in health promotion activities**

FGDs with members of the village health and sanitation committee (VHSC) was conducted in both the districts. Their role in carrying out the IEC/BCC activities was assessed.

#### *District of Hoshiarpur*

There is a VHSC in each village of the district. The committee has 10 members including the sarpanch, one ASHA, one ANM, one Anganwari worker, one schoolteacher, one chowkidar, one lambardar, one retired nongovernmental organization (NGO) member, and two panch members (village panchayat members). The VHSC meeting is conducted once in 3 months. If there is any urgency, a meeting can be called as and when any important issue regarding health and sanitation needs to be discussed. The list of activities being carried out by the VHSC includes the cleanliness and sanitation of the village, health awareness activities, building transportation link, purchasing blood pressure (BP) apparatus, hub cutter, chairs or almiraahs, and maintenance of taps or any other local need such as utensils for cooking or chairs for kids required for conducting *Mamta Divas*. They give health education to expecting mothers on maternal and child health, immunization, nutrition, antenatal care (ANC), and postnatal care (PNC) during *Mamta Divas*. A fund of 10,000/ is disbursed to each VHSC for carrying out its proposed activities. Only health issues pertaining to maternal and child health are discussed.

#### *District of Ambala*

The VHSC is known as village level core committee (VLCC) in the district of Ambala. The VLCC is present in every village. The committee comprises of 14 members including 6 Anganwadi workers, 1 social worker, 2 panches, 1 ASHA worker, 1 ANM, 1 schoolteacher, 1 kishori educator, and 1 chowkidar. Generally, two meetings are conducted in 1 month. The VLCC members maintain a logbook of the activities conducted under their purview.

### Community-based survey

Key quantitative findings of the exit survey and community survey in both the districts are presented in [Tables 2 and 3].

#### Qualitative findings of the community-based survey

The community members were asked about the sources to access health information. Television, newspapers, and ASHAs were reported as sources of health information in the district of Hoshiarpur against the television, ASHAs, and local FM in the district of Ambala. ASHAs were reported as the main source of health information by the community members in the district of Ambala. However, the community members have poor participation in the planning and implementation of IEC/BCC activities at the village level.

### SWOT analysis of IEC/BCC activities

The strengths, weaknesses, opportunities, and threats for the implementation of IEC/BCC activities at the district level were assessed during the situation analysis.

#### District of Hoshiarpur

The strengths, weaknesses, opportunities, and threats (SWOT) analysis of IEC/BCC activities in the district of Hoshiarpur is given below:

- **Strengths:** The district's mass media wing is functional in the district. All national health programs including the NCD program are being implemented in the district. ASHAs are available at the village level to mobilize community members regarding different health issues.
- **Weaknesses:** Despite the availability of a functional MIS, the recording and reporting of IEC/BCC material and activities were not done. Lack of integration was found between the district's IEC division and other health programs for carrying out IEC/BCC activities. IEC/BCC/HP activities were mostly found to be concentrated at the district level, along with poor monitoring and supervision of IEC/BCC activities at all levels.
- **Opportunities:** There is enough scope of IEC through culture-specific activities, e.g., *Baisakhi Mela*, *Guru Divas*, *kabaddi* matches, *akhare*, *Arogya Melas*; district level plan for IEC/BCC activities; annual action plan of the VHSC, and pooling of IEC budget for all national health programs
- **Threats:** The low morale of program officers and lack of importance given to the IEC component in the programs were threats.

#### District of Ambala

The SWOT analysis of IEC/BCC activities in the district of Ambala is given below:

**Table 2: Key findings of the exit interviews at the facility level**

Indicators	District of Hoshiarpur	District of Ambala
Number of interviews	N = 42	N = 40
Satisfaction with the services received at health centers	88.1% (37)	31.7% (19)
Sharing of health information by MO/ANM	9.5% (4)	6.7% (4)
Topic of health information shared	Healthy diet, personal hygiene, exclusive breastfeeding, diarrhea	Handwashing, diet, and diarrhea
Provision of IEC material at health center	2.4% (1)	1.7% (1)
Topic of IEC material provided	Free ambulance service for pregnant women	Tuberculosis
Reading of IEC materials (posters/wall paintings) displayed in health centers	28.6% (12)	30% (18)

**Table 3: Key findings of the community survey at the household level**

Indicators	District of Hoshiarpur	District of Ambala
Number of interviews	N = 120 (%)	N = 110(%)
Communicable diseases		
Spread of HIV/AIDS		
Unsafe sexual practices	35	59.1
HIV-infected blood transfusion	27.5	53.6
HIV-infected needles and syringes	32.5	54.5
Prevention of STIs by use of condoms	62.5	36.4
Symptom of tuberculosis	88.3	91.8
Noncommunicable diseases		
Tobacco use is a risk factor of NCDs	77.5	77.3
Smoking is harmful for both active and passive smoker	95	89.1
Recommended salt per person per day (5 g/1 teaspoonful)	37.5	51.8
Normal blood pressure level (80/120)	33.3	16.4
Common symptoms of stress		
Increase or decrease in blood pressure	69.2	44.5
Insomnia	53.3	54.5
Impatience	60.8	45.5
Key RCH issues		
Cause of anemia (Iron deficiency)	25.8	32.7
No. of TT injections for a pregnant woman (2 injections)	34.2	29.1
No. of IFA tablets for pregnant woman (100 IFA tablets)	22.5	10.9
Permanent method of family planning (tubectomy and vasectomy)	84.2	83.6

#### Strengths

Supportive attitude of the civil surgeon; availability of adequate trained ASHAs, and implementation of

national health programs including the NCD program in the district were observed.

### **Weaknesses**

Vacant positions of staff in the district's mass media division, lack of funds, poor capacity of the available human resources, incomplete documentation of activities and stock registers, lack of integration, convergence, and multitasking, and poor monitoring and supervision of IEC/BCC activities were notable weaknesses.

### **Opportunities**

The district level plan for IEC/BCC activities and annual action plan of the VLCC could be utilized properly.

### **Threats**

The low morale of program officers, more focus on the service delivery component than the component of HP, and an inadequate budget were threats.

## **Discussion**

The Government of India provides a budget for IEC for its national health programs under the National Health Mission; however, these funds are meager and are underutilized or used for conventional information material such as print advertisements.<sup>[7]</sup> Furthermore, a separate IEC budget for each program has led to a sectoral approach to communication activities while there are cross-cutting issues and behaviors to be addressed. Therefore, there is a need for coordination of efforts in communication planning at the district level and communication activities at the district, subdistrict, and village levels. The basic underlying model for situation analysis studies holds that the degree of readiness of the subsystems such as IEC, equipment and supplies, logistics, supervision, recording, and reporting influences the actual quality of care delivered by providers and received by clients.<sup>[8]</sup>

Review and discussion with key stakeholders indicates that human resources are limited with low capacities, which are not sufficient to support appropriate IEC/BCC approaches at the community and health center level. Given the limited human resources, mass or group education may be the most appropriate current platform for health message dissemination.<sup>[8]</sup> The capacity of the health staff at present is not built for carrying out planning (use of innovative approaches), development of IEC/BCC materials, and implementation and documentation of IEC/BCC/HP activities at the community level. There is a need to build the capacity of the DMMOs, counselors, health inspectors, health workers, and Block Extension Educators (BEEs) in the districts and blocks for designing and implementing context-specific IEC/BCC program activities locally.

A comprehensive manual covering communicable diseases, noncommunicable diseases, and RCH issues could be used for the skill development of the staff.

A majority of the IEC materials available at the district level is not relevant as per the local needs and requirements. The focus should be to develop local context-specific IEC/BCC materials, especially in emerging areas of health such as NCDs, substance abuse, in addition to re-emerging diseases, and conventional health problems such as water, sanitation, and hygiene (WASH), diarrhea, vector-borne diseases, tuberculosis. It was found during the survey that though IEC materials such as posters, handbooks, and pamphlets are distributed from the state to district and from the district to concerned CHCs and PHCs. But these IEC materials are kept as a stock in the health centers and are not disseminated at the village/community level. IEC/BCC materials (posters, pamphlets, flip charts) need to be adapted at the state and district levels, and reproduced considering the sociocultural context and need, and then be disseminated in the community, especially hard-to-reach areas.

IEC/BCC activities were mostly concentrated in the district headquarters and the peripheral urban areas. Therefore, there is a need to focus more on rural areas. For this district-specific bottom-up planning is recommended. Involvement of local development bodies, Panchayati Raj Institutions (PRIs), other nonhealth sectors in the planning and implementation of IEC/BCC/HP activities is strongly recommended. DMMOs and the District Program Officers (DPOs) need to explore opportunities for securing technical support from local development partners, local bodies, and other partners in implementing IEC/BCC activities at the local level. There is a need to generate more resources for IEC/BCC activities through public-private partnership.

No fund has been sanctioned specifically for carrying out IEC/BCC activities to District Ambala of Haryana for the year 2013-2014. Each national health program is sanctioned a meager amount of money to celebrate a few health days specific to the respective program. The IEC/BCC budget for carrying out health preventive and promotive activities should be pooled and be available as per requirement.

During the community-based survey, it was reported by the respondents that no IEC/BCC activity had taken place in their respective villages in the last 1-3 months. This reflects that there is a possibility of misreporting as observed in cross-checking of the records. Street plays, rallies, and interactions with the local community are important strategies to reach the families and households.

Monitoring and supervision of the IEC/BCC activities in both the districts was found to be weak. There is no supervisory format for monitoring of scheduled IEC/BCC/HP activities. DPOs/DMMOs should regularly monitor and supervise the IEC/BCC activities. It will help in improving reporting and checking fictitious reporting.

Implementation of IEC/BCC activities can be improved by integrating and pooling the human resources and financial resources of all national health programs and developing a common integrated manual of HP. There is a disconnect between the district's mass media division and the national health programs' specific activities, which need to be streamlined. The program officers of all national health programs should collaborate with the district's mass media division to organize their IEC/BCC/HP activity.

The community survey was undertaken to supplement the facility-based assessment in the selected districts. So, the sample size was kept small for rapid assessment, which may have been a limitation of the study. The results of this study can be generalized to the selected districts and further assessments are required in other districts.

## Conclusion

The IEC/BCC/HP component in national health programs under the National Health Mission is a neglected area in the selected districts, with inadequate infrastructures and human resources and poor implementation. The scope of IEC/BCC activities in the district is limited to distribution of IEC materials and conducting a few group meetings on reproductive health issues *per se*. There is a need to strengthen the IEC/BCC/HP component, which could be possible by a pooling of resources, development of resource material, and integration and convergence within the ongoing national health programs.

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## Conflicts of interest

There are no conflicts of interest.

## References

1. World Health Organization [Internet]. Health Work Force in India; 2007. Available from: [http://www.whoindia.org/LinkFiles/Human\\_Resources\\_Health\\_Workforce\\_in\\_India\\_-\\_Apr07.pdf](http://www.whoindia.org/LinkFiles/Human_Resources_Health_Workforce_in_India_-_Apr07.pdf). [Last accessed on 2014 Nov 5].
2. John TJ, Dandona L, Sharma VP, Kakkar M. Continuing challenge of infectious diseases in India. *Lancet* 2011;377:252-69.
3. Paul VK, Sachdev HS, Mavalankar D, Ramachandran P, Sankar MJ, Bhandari N, *et al.* Reproductive health, and child health and nutrition in India: Meeting the challenge. *Lancet* 2011;377:332-49.
4. Patel V, Chatterji S, Chisholm D, Ebrahim S, Gopalakrishna G, Mathers C, *et al.* Chronic diseases and injuries in India. *Lancet* 2011;377:413-28.
5. Riegelman RK, Garr DR. Evidence-based public health education as preparation for medical school. *Acad Med* 2008;83:321-6.
6. Wylie A. Health promotion in general practice. In: Stephenson A, editor. *A Textbook of General Practice*. 2<sup>nd</sup> ed. London: Hodder Arnold; 2004. p. 187-210.
7. Behaviour Change Communication UNICEF Supported Integrated Districts. Key Sheets Series: Integrated District Approach in India November 2010.
8. Miller K, Miller R, Askew I, Horn MC, Ndhlovu L, editors. *Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies*. Africa Operations Research and Technical Assistance Project. New York: Population Council; 1998. p 265.