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# Measuring Infant Feeding Health Literacy: A Gap Analysis between Communication Policy and Practice

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**Abstract**

Health literacy is often associated with health outcomes as people with higher health literacy are found to have better health conditions. Past researchers conclude that people with higher health literacy have greater control over the means of their health determinants resulting in better health decisions. Therefore, it is imperative to understand whether government health communication policies are impacting the health literacy levels of its citizens. Moreover, communication plays a vital role in translating policies into practice. However, sub-optimal Infant and Young Child Feeding (IYCF) practices among rural mothers suggest gaps in the current communication strategies. Therefore, this study is objectivized to analyze the current IYCF communication policies for the rural mothers of Gaya, India. For this purpose, an analysis of the IYCF communication policies followed by observation of the key phenomenon, interviews with relevant stakeholders and focus group discussions with the rural mothers were carried out to identify the barriers in the current communication strategies. The study also tried to assess the impact of IYCF communication policies on rural mothers by unveiling their current level of IYCF health literacy.

**Keywords:** BCC, communication gap, health communication, IYCF health literacy

## Introduction

A sizeable number of global child morbidity and mortality is attributed to Undernutrition. Moreover, Undernutrition is majorly associated with poor Infant and Young Child Feeding practices (WHO). According to the National Health Mission IYCF is a set of well-known and common recommendations for appropriate feeding of newborns and children less than two years of age. Moreover, health literacy was initially conceptualized as an individual's basic reading and numeracy skills and had been limited to clinical settings. However, it was later extended to public health and has been conceptualized as the ability of an individual or community to access, understand, evaluate, and act upon health information (Freedman et al., 2009). India has made significant improvements in ensuring optimal IYCF practices. However, these improvements are not equitably distributed among the states. To ensure better growth and development for its children and achieve its SDGs 2030 target India needs to focus heavily on the poor performing states. The government is striving hard to ensure optimal feeding behaviors through various communication channels yet the suboptimal IYCF practices signify communication gaps in the current strategy. Past research indicates that the efforts to promote IYCF practices in India are majorly

inclined toward behavior change communication (BCC) (Mondal et al., 2023; Scott et al., 2022; Mithra et al., 2022; Awasthy et al., 2020; Soofi et al., 2021). However, scholars have highlighted several ethical and implementation problems with the BCC interventions (Barnett et al., 2022; Han et al., 2022; Osman et al., 2020; Laverack, 2017; Korp, 2010; Barnes, 2007; Lyons & Chamberlain, 2006). Critics have argued that BCC interventions are paternalistic, disregards communities' perception of what is important, use manipulative strategy and pseudo-participatory methods, and create health inequalities. With these entry points the current study is objectivized to answer the following research questions 1) What are the current communication strategies regarding IYCF health literacy? 2) what are the gaps in the current communication strategy? 3) what is the current level of IYCF health literacy among rural mothers?

## Methodology

The study was conducted in the Gaya district of Bihar. It adopted a descriptive research design that implied a mixed-method (triangulation) approach. The qualitative analysis was carried out through document analysis followed by focus group discussions (FGD), semi-structured interviews, and observation. Further, a quantitative analysis was carried out to determine the current level of IYCF Health literacy among the rural mothers of Gaya. A framework analysis technique was used to carry out the document analysis. Further, 8 focus group discussions were conducted in 8 different blocks of Gaya. These blocks were randomly selected through a lottery method. Participants for the interviews were recruited purposively. Semi-structured, face-to-face interviews were carried out with 45 stakeholders who were working on infant feeding or associated domains. The observation was carried out through overt participation in several meetings (VHSND), training sessions (ASHA Divas), and community-based events (such as Poshan Mah, Annprashan, and Godbharai). The population for the quantitative analysis was comprised of mothers residing in rural Gaya having at least one child aged between 6 to 24 months. The sample size for this study was 384. The survey was used as a method and schedule was used as a tool for data collection. Health Literacy Instrument for Adults (HELIA) was adapted for carrying out the survey.

## Findings

### Current communication strategies regarding IYCF health literacy

Three policy documents were analyzed to identify the current communication strategies 1) Saksham Anganwadi and Poshan 2.0 2) Mothers' Absolute Affection (MAA) programme 3) JEEVIKA-Behavior Change Communication Module roll out. The communication strategies extracted from these policies are divided into three major themes i.e. Macro level, Meso level and Micro level. These Macro, Meso and Micro level communication strategies are carried out at national or state levels, district or block levels and block or village levels respectively. The communication activities under these major themes are divided into following sub-themes:

1. **Development of Information, Education and Communication (IEC) materials:** The Macro level communication strategies emphasizes on the use of Mass Media such as Newspaper, Television and Radio to create mass sensitization. The Meso level communication strategies are mainly characterized by the development of IEC materials in local languages followed by its placement at appropriate places in district and block level health centers and the use of mid-media activities such as song and drama division activities, folk performances, Street theatre, puppet show and video vans.

Further, the communication strategy at the Micro level proposes the development of IEC materials in local language/dialect by involving both frontline workers and beneficiaries followed by their display on community walls, Anganwadi Centres and Panchayat Bhawan.

2. **Training:** Training modules are developed at the Macro level for capacity building of the various stakeholders. The developed modules are further implemented at Meso and Micro levels at decided frequency. The communication policies proposes a cascading model of training in which a state level team trains the district team which further trains the block level team and so on. Moreover, the policies also suggest incorporating participatory methodologies at all levels of training to facilitate greater engagement and longer retention by the participants.
3. **Community based events:** Policies suggest creation of a Janandolan through Janbhagidari (public participation) by organizing various community based events to make India malnutrition free (Kuposhanmukt). In addition to planning, monitoring and evaluation, development of IEC materials and awareness generation through different mass media are continuously carried out regarding these events at the Macro level. The community based events are organized at Meso and Micro levels. Some of the major community based events are Poshan Pakhwada, Poshan Mah, Annprashan diwas, Godbharai diwas, Suposhan diwas and Wajan divas.
4. **Counseling:** Policies on IYCF recommend both individual and group counseling at the micro level through different stakeholders. For example, AWW is responsible for carrying out group counseling of mothers at various CBEs and individual counseling of mothers during home visit. ASHA is responsible for carrying out periodic counseling of both pregnant and lactating mothers through mother's meeting and home visit. Policies also recommend use of visual aids such as flipcharts, projectors etc. for effective counseling.

**Communication gaps in the current communication strategies on IYCF health literacy**

The observation of IEC materials (posters and banners) placed on the walls of different health facilities in Gaya district revealed that they were mostly created at macro level. Lack of locally developed posters and banners shows a disregard towards local needs, beliefs and participation of the beneficiaries and the compliance of a top-down communication strategy. Moreover, all posters and banners were created in Hindi language despite the fact that the native language of the Gaya district is Magahi. Further, the placement of these posters and banners are poorly done at dark corners of the room or in torn conditions at most Anganwadi centers thereby prohibiting the beneficiaries from taking its full advantage.

The overt participant observation of several CBEs revealed that these events were mostly organized for photography purposes as it was compulsory for the AWWs to share photos of such events to their respective Lady Supervisors. It was found that the physical arrangements during these events were rarely complemented with counseling on IYCF practices. Even at some places were counseling takes places the use of visual aids were negligible and the counseling was mostly carried out through oral communication.

Another major gap in the current communication strategy was the inefficiency of the field functionaries which could be attributed to the poorly organized training sessions. Most of the newly joined AWWs and ASHAs reported during the interviews that no specific training on IYCF had ever been imparted to them. Many others also reported that neither the induction nor the in-service training had been imparted to them in the previous three years. This had resulted in knowledge gap regarding optimal IYCF practices and poor awareness among the functionaries about their complete roles and responsibilities.

Almost all meetings at the micro level such as review meetings, mothers' meeting, Jeevika meeting, and meeting at Anganwadi etc. were carried out in a non-participatory manner. This was primarily because of the poor conceptualization of the term participation among the field functionaries.

**Current level of IYCF health literacy**

Among the studied participants, 25.26 per cent had a low level of IYCF health literacy, 48.18 per cent had a moderate level of IYCF health literacy, and 26.56 per cent had a high level of IYCF health literacy. The health literacy score of all the participants ranged from 29 to 77 with a mean score of 46.20 and a standard deviation of 13.09. There was no significant difference in the IYCF health literacy among different age groups (P=0.53). However, differences between the levels of IYCF health literacy among all other variables such as caste category (P <0.001), place of delivery (P<0.001), educational qualification (P <0.001), and occupation (P <0.001) were highly significant.

Analysis of the gathered data suggests that most participants belonging to schedule caste had low IYCF health literacy (65.3 per cent). On the contrary, most participants from the general caste had a high level of IYCF health literacy (97 percent). Further, low IYCF health literacy is widely prevalent among participants who had opted for home delivery (93.8 per cent). Data analysis also revealed that all participants (100 per cent) who had at least completed their graduation had high IYCF health literacy and most participants with no education had low levels (75.3). Analysis based on occupation suggests that most of the daily wage laborers had low levels of IYCF health literacy (75 per cent) whereas all participants with jobs had high IYCF health literacy. Further, approximately half of the total housewives who participated in this study had moderate levels of IYCF health literacy (53.2 per cent).

**Conclusion:**

The findings of the study suggest a wide gap between the IYCF communication policy and practice. The reasons for this gap are multifaceted yet one of the most important reasons is the top-down communication strategy through BCC models. The study also revealed that the current communication strategy has resulted in health inequalities between the marginalized (scheduled castes) and the rural elites. Moreover, study findings also suggest that approximately half of rural mothers of Gaya had a moderate level of IYCF health literacy which widely varies across caste, place of delivery, education, and occupation.

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