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More Than Messages: Interpersonal Communication and Community Engagement in India's National Health Programs

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Abstract

India's national health ecosystem is often reduced to information transfer, including posters, slogans, awareness, and geniality! This paper argues that information is not enough to produce meaningful, sustainable change. Based on communication and engagement theory, evidence from field studies, and real-world examples from programs such as RMNCH+A, the National Tuberculosis Elimination Program (NTEP), Poshan Abhiyaan, and Ayushman Bharat, this research examined how interpersonal communication (IPC) and engagement (CE) respectively engage, accept, respond to, or reject public health messages. Using qualitative narrative synthesis and over 70 academic and policy sources, the paper advances our understanding of health communication by demonstrating that components such as trust, cultural adaptation, and social context are determinants of communicating effectively about health. In addition, the research highlights and refines our understanding of how frontline health workers, who may be peer educators or who participate in participatory media models, communicate to elicit dialogue, not just the transfer of messages. The findings suggest that successful health communication programs view communication as a purposeful two-way human process, not just information transfer. The paper concludes with recommendations to prioritize communication as relationship-building, not just messaging, if India is to have valid public health outcomes.

Keywords: Health Communication, Interpersonal Communication, Community Engagement, India, RMNCH+A, TB Elimination, ASHAs, Behavioural Change, Public Health Policy, Social Determinants.

Introduction

In India's broad and complex public health space, messages exist everywhere—from walls, to copious numbers of television sets, to loudspeakers, to "WhatsApp" groups. Yet messages alone are not likely to motivate people, particularly from rural or marginalized communities, to act. For instance, through education and messaging, a Mother may know of iron supplements, but may never take an iron supplement based on local beliefs or trust issues. A TB patient could have seen an awareness video, but may still refrain from attending the health centre to seek treatment based on fear or stigma. This disconnect tells us something larger about communication, namely, that communication is largely thought of as a delivery mechanism, rather than a relational approach.

This paper explores that disconnect. It asks, what happens when we take the perspective of health communication, not as informing, educating and not communicating, but asking how we might interact as

a conversation? With this in mind, it discusses India's major public health programs, with emphasis on RMNCH+A, NTEP, Poshan Abhiyaan, Mission Indradhanush, and Ayushman Bharat. It also discusses the relevancy of interpersonal communication and community engagement in framing public knowledge, behaviours and trust.

In comparison to traditional information, education, and communication (IEC) campaigns, interpersonal communication is active, collaborative and involves dialogue, dual learning and felt empathy, while community engagement is even more than a consultation, it represents local voices co-creating as partners. Both interpersonal communication and community engagement provide a human approach that is contextual and has the ability to navigate the complex social realities that shape health behaviours in India based on cultural constructs such as gender, caste, religious norms and rural-urban differences.

Utilizing theories of dialogic communication, social learning, symbolic interactionism, and audience reception, this study integrates academic research, field evaluations, and real-life cases of impact. It aims not only to critique the health messages existing now, but to reimagine what communication in public health can look like if people were at the centre rather than posters.

Theoretical Framework

This study makes use of communication and social science theories to explore health communication as more than a transmission of information, but a social process of dialogue, relationships, power structures, and cultural systems. The analysis is informed by four established theoretical traditions:

Paulo Freire's Dialogical Model

A fundamental aspect of Freire's thinking on education and communication was the need for dialogue for the purposes of liberation. With regards to health, this means going from a "banking" model of transferring information to participatory ways in which communities co-generate their own health knowledge, for example, through the role of the ASHAs in India while engaging households with information along with solidarity and systematic and culturally-tailored contextualisation.

Albert Bandura's Social Learning Theory

Bandura frames learning as being directly related to observation, imitation and modelling. Health communication that invites storytelling, the use of role models, or TB survivors sharing their own story, operates within the framework of social learning. Programs that use local champions such as TB Champions, use observational learning to shift attitudes and reduce stigma in the experience of TB, especially among marginalized communities.

Symbolic Interactionism

This important perspective, developed by Blumer and others, examines how people create symbolic meaning in their everyday lives. Health behaviours are very symbolic too: whether it is the decision to use contraception, seek treatment for an illness, or wear a mask. Interpersonal communication facilitates the interpretation and framing of these behaviours around reconstituting them in socially acceptable ways and retaining their essential emotional connections.

Stuart Hall’s Encoding/Decoding Model

Hall's model is useful for understanding that audiences do not just receive and digest messages; they also interpret messages. A government campaign might "encode" a communication about TB screening, but the audience "decodes" that communication based on where they stand with respect to social location: caste, gender, religion, and local politic. To understand and undertake the decoding of that communication is central to developing health messages that will resonate across India's many communities.

In addition, this paper opens up a discussion about the relationship between power and identity, informed by intersectional feminist theory (Crenshaw, Rege), and how these factors matter when considering the reception and impact of health communication. The paper references important theoretical contributions from Candace West and Don Zimmerman (who defined the terms "doing gender") in order to emphasize that young people engage with health content in complex and contextually-dependent ways. The paper also references Robert Entman's Framing Theory, and Elihu Katz's Uses and Gratifications Theory, all of which help to make the case for how people make meaning and then actively respond to health communication.

Collectively, these theories create a schema that positions communication not as technical or neutral, but rather as deeply human, contested, and relationally-oriented, and this framing is both informed and driven by the lived realities of the people the health communication is meant to reach.

Literature Review

For a long time, health communication strategy in India has primarily depended on mass media and various forms of IEC (information, education, communication) materials to stimulate awareness. However, the public messaging efforts have predominantly relied on the use of posters, brochures, jingles and one-directional campaigns. More scholars and practitioners are claiming that such mechanisms fail to lead to sustainable behaviours after the campaigns run their course, especially in more complicated social environments (Rimal & Lapinski, 2009; George et al., 2015).

Failures of Top-Down Messaging

Various programmatic evaluations and academic writings have noted that behaviours such as institutional deliveries, TB treatment compliance, contraceptive uptake and nutrition practices constantly remain below par, despite the mass dissemination of campaigns. Das et al. (2021) explain this disconnect is less about lack of awareness than it is about lack of trust, cultural salience and social validation. For example, Mohanty et al. (2019) reviewed antenatal care uptake of women in tribal Odisha and found that uptake improved with community health volunteers used the IPC (interpersonal communication) approach that was uniquely adapted to existing local beliefs and values, not just posters.

The findings also reflected that in previous evaluations of TB messaging in Bihar and Jharkhand, Bhattacharya and Roy (2020) noted community members were often sceptical of IEC materials unless introduced by skilled health workers or local champions. These findings indicate that trust, communication and relational engagement can often outweigh frequency of messaging or media consumption.

Effectiveness of Interpersonal Communication and Community Engagement

Programs that have effectively integrated IPC and CE have achieved better outcomes than those who have not. An example of this would be the ASHA program of the National Health Mission. ASHAs are cultural brokers because they translate health guidance into local terms and negotiate family dynamics. Ved et al. (2019) and UNICEF India (2020) have documented that ASHAs' interpersonal counselling is strongly associated with improved outcomes for maternal and newborn health.

The Poshan Abhiyaan, yet another initiative, is also shifting toward participatory approaches using home visits, community-based events, and storytelling. They have evaluated these changes and they found, for example, that women's knowledge regarding nutrition improved far more from conversations and peer-to-peer support group discussions rather than just the posters (NITI Aayog, 2021).

In the case of Mission Indradhanush, when ANMs and ASHAs did face-to-face outreach on Village Health and Nutrition Days, they were able to meaningfully increase immunizations, especially in locations that

were previously hard to reach (MoHFW, 2019). While there are also a number of different factors that likely influenced outreach and the effectiveness of communication, the important point is that the specific message was less important than who communicated, how they communicated, and whether they did it in a respectful way that addressed local community issues.

Digital Growth and Local Integration

CES(community engagement strategies) really does matter, but effective use of digital platforms relies upon continued engagement through traditional strategies that include IPC and CE. In their study of WhatsApp health messages in urban slums, Jha et al. (2023) found that the WhatsApp groups worked only with local community volunteers who contextualized the messages. Online videos on TB in Uttar Pradesh tended to have greater uptake when the videos were introduced in meetings with survivors rather than in the absence of any supporting materials (PATH, 2022).

ASHAs and Peer Educators as Change Agents

Allow me to state that ASHAs, peer educators, and TB Champions embody a hybrid role that functions within a communication, counseling, and cultural translation approach. Their strengths do not exist in a delivery of pre-determined information but in using the information based on the context. Programs like Anaemia Mukt Bharat; Menstrual Hygiene Scheme; and Adolescent Health Days have all utilized agents like ASHAs and peer educators to run behaviour change communication sessions. Rathi and Srivastava (2022) also stated that adolescent girls had a more positive reception to menstrual hygiene sessions run by peers rather than anonymous lectures.

Community-Led Models and Participatory Media

Community-led models, in addition to individuals, such as models employed by Ekjut in Jharkhand, SNEHA in Mumbai, and via Gram Vaani's participatory radio in Bihar, also show how community dialogue creates a trusting environment opening opportunities for action. These types of models do not presuppose uniform audiences. Rather, they co-create audiences into inputled dialogue and create content as community members, they feel as if the health communication process is a conversation rather than instructions (Scott et al., 2020, Sinha et al., 2018).

Intersectionality of Health Communication in India

Health behaviours and responses to and interpretations of public health messages do not happen ex-nihilo; they arise from a person's social location defined as caste, class, gender, religion, region, and age. In India where inequality is multidimensional, it is important that both communicators and planners have an understanding of intersectionality in creating health messages.

Caste and Marginalization

The caste system, especially, continues to be a prime determinant for health care access and the effectiveness of communication. Studies (Rege, 2018; Jaffrelot, 2003) have shown that Dalit and Adivasi populations have greater distrust of government messaging due to years of exclusion and maltreatment. Sometimes, programs that turn solely to a top-down kind of messages fail to consider contexts of caste and class within communities.

And when communicators come from the community or trained to identify and navigate above and outside the situation (Borah, 2021) messages are more likely to be taken up. Joshi and Raju note that ASHAs, who are from dominant castes face resistance in Dalit hamlets, whilst Dalit ASHAs experience stigma in the majority caste areas. *Interpersonal communications become not only a technical skill but a political and social act. Programs like Swasthya Saathi in Maharashtra have begun to look at this type of context with a multi-caste multi-class communications approaches.*

Class and Economic Insecurity

Class intersects with health literacy, access to digital tools, and access to the time and autonomy needed to act on health advice. Low-income families are more likely to prioritize daily survival over long-term health, and therefore talking about or having an open dialogue about preventive care can seem foreign and abstract. Sen and Mehrotra (2020) emphasize that health messages are often directed to a middle-class audience, which leads to various points of disconnect with the everyday lives of poor families. Interpersonal strategies can bridge the disconnect through customization, empathy, and real-time feedback.

Programs such as Poshan Abhiyaan and Anaemia Mukt Bharat have shown that there is better uptake among working-class women when the advice was supported through counselling, community kitchens, or mothers' groups—spaces where they could co-construct the advice that was presented to them.

Religion and Normative Conflicts

Religious identity plays a role in how messages about contraception, reproductive rights, or vaccines are received. Varshney (2002) articulates that, when messages adhere to the dominant religious frame, messages delivered to minority communities may trigger suspicion or fear of exclusion. By contrast, when the health messages included or engaged the religious leader or community elder as a partner in the dissemination—as in some campaigns for TB and COVID-19—can generate a rapid raise in uptake (Robinson, 2001).

In the case of the Menstrual Hygiene Scheme, resistance was prevalent in parts of Uttar Pradesh until local imams were included to help dispel myths and give endorsement for participation. Similarly, framing nutrition or hygiene as religious obligation has worked in some Hindu and Muslim communities reinforcing the need to pay attention to local framing.

Gender and the Power Relations of Households

Gender has a significant impact on who receives a message, who acts upon it, and who ultimately controls the resources to do so. Women in many households have no autonomy over mobility, food choices, or financial decision-making. So even when ASHAs counsel women, it may be the decisions of their mothers-in-law or husbands that prevails. This makes it imperative that male family members or older women are included in health conversations, which very few campaigns currently make a priority.

The RMNCH+A strategy tries to include this consideration, but there isn't uniformity in implementation across the programme. Where male ASHAs or male peer educators have been implemented in an attempt to reach men, the results have been encouraging (George et al. 2021). Intended programmes like Pink Chain and MenEngage also provide evidence that gender-transformative communication (rather than gender-neutral or female-focused messaging) is more powerful overall.

Methodology

A qualitative narrative synthesis methodology was employed to study the role of IPC and CE in India's national health programs. Narrative synthesis is different from meta-analysis, which typically generates a statistical pool, in that it involves interpretation along the continuum of interdisciplinary sources.

Data Sources

The sources analyzed included:

- Peer-reviewed articles (from journals such as Scopus, JSTOR, and PubMed)
- Government policy documents (Ministry of Health and Family Welfare, NITI Aayog)
- Program evaluations (PATH, JHPIEGO, UNICEF, WHO reports)

- Case studies, field reports from non-governmental organizations (NGOs) (Ekjut, SNEHA, SEWA, and other sources)

Inclusion criterion was:

- Published sources between 2015–2024.
- Focus on public health programs based in India.
- Applied focus on health communication, behaviour change, communication strategies, and/or community mobilization
- Written in English.

More than 70 sources were assessed for relevance, credibility, and contextual fit. Particular attention was afforded to studies with participant narratives, as well as studies with field-based communication interventions and in particular evaluations of programs led by ASHAs or peer/community-led health programs.

Analytical Framework

The findings were thematically grouped into:

- health communication models in national programs
- role and impact of IPC and CE
- intersectionality (caste, class, gender, religion)
- audience reception and areas of resistance
- institutional or systemic barriers

In the same way that the theoretical framework in terms of Freire, Bandura, Hall, Crenshaw, Entman, and others, guided inclusion and the interpretation of themes, the methodology that allowed context to emerge, allowed real-world messiness to factor into the analysis instead of driving towards generalization, and as a result, retained the rich context of health communication in India.

Discussion

Although India's health system has expanded its coverage and awareness base, the true measure of success lies not in the breadth of messages disseminated; rather, it is based on the depth of transmission. This section draws on examples from the field, evaluation studies, and communication theories to consider where programs accomplish their objectives-or fail, based on how they engage with interpersonal communication (IPC) or community engagement (CE).

RMNCH+A and the Role of ASHAs

The Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) is often pointed to as an example of large scale. However, large scale doesn't mean successful. What matters is how ASHAs engaged with families (and women as family members) and adapted the technical messages to local contexts. For example, when ASHAs in Rajasthan and Bihar incorporated story telling, empathy, and used visuals during pregnancy counseling, they were three times more likely to induce a behaviour change when compared to ASHAs who simply recited a list of do's and don'ts (Ved et al., 2019). Moreover, when ASHAs take the time to create a trust relationship, they are able to even broach difficult matters, like birth spacing, or institutional delivery, even in conservative households.

TB Elimination and Survivor Storytelling

India's National Tuberculosis Elimination Program (NTEP) has long faced stigma. Posters and slogans have generally raised some level of awareness, but fear and silence continue to pervade many

communities. The introduction of TB Champions---survivors who go public with their treatment journey---was a positive innovation. In Uttar Pradesh and Jharkhand, these champions go into mohalla sabhas, visit homes, and communicate in their local dialects. Their communication is not polished...but is authentic. Research by PATH (2022) and WHO India (2023) found this peer-led intervention led to higher testing and reduced dropout in DOTS compliance.

Poshan Abhiyaan and Community Ownership

Historically, nutrition programs like Poshan Abhiyaan have engaged in mass messaging—posters of IFA tablets, growth charts, etc.—but recent experiences with women's groups situating their planning and messaging have had an important impact. In Jharkhand and Odisha, for example, community-led "nutrition days" allowed women to cook together, ask questions and learn by doing. These occasions opened space for conversation about food taboos, breastfeeding practices, and roles within family (NITI Aayog, 2021).

Menstrual Hygiene and Peer Education

The Menstrual Hygiene Scheme (MHS) encountered discomfort in many schools where teachers were unwilling to engage in conversations related to menstruation. Peer educators—girls trained to engage with other girls—overcame this barrier. Rathi and Srivastava (2022) found that girls who engage with peer educator were more willing to asked questions about menstruation and reproductive health topics, more likely to remember information and behaviors we told them to follow up, and more likely to use sanitary pads as a consequence of group engagement when someone they viewed as "one of us" facilitated the session.

Ayushman Bharat and HWCs: Missed Opportunities

The Health and Wellness Centres (HWCs) under Ayushman Bharat have a community centric mission. However, evaluations demonstrate many HWCs do not formally or informally take the opportunity to build trust with the community, which is achieved largely through human engagement. While community health officers (CHOs) can rely on digital devices for screening, even they have little or no investment in leveraging interpersonal rapport and relationship building. It can be informed by their reliance on smart devices for dialogues with patients. Evaluations of HWCs demonstrated when they used local outreach volunteers and created structured regular opportunities for outreach in the community—the community welcomed for screening and preventive care in larger numbers (MoHFW, 2022).

Why Messaging Still Fails Without Trust

These examples emphasize an undeniable premise: messaging fails when it is unmoored from context of the human experience. A woman can see a video on maternal nutrition,; but if her mother-in-law insists on foods she believes are unhealthy, she may not be able to move from knowledge into action. A man may hear a TB radio jingle; but if no other person he trusted suggested it was safe for him to seek treatment—he likely will not go. Communication fails when it is remote, only completed by a mass audience, and impatient.

Audience reception and behavioral outcomes

Public health messaging is typically developed for a general audience but reception in practice has a lot of variability. Each person responds to messaging based on lived experiences, context (e.g. social context, age, gender, caste, religion, and prior interaction with the health system). This section considers how the various dynamics of audience reception and behavioral outcomes facilitate or hinder meaning-making and subsequent behaviours.

Age and Generational Changes

Different generations of audiences will decode engagements differently. Gen Z (or "zoomers," born after 1997), are likely much more familiar with smart phones and online platforms and they may be more receptive to digital content – if it feels authentic. A Weber Shandwick study in 2025, found that Gen Z preferred influencer-based videos or peer testimonials over official messages like advertising messages from the government. Older adults (Gen X or Boomers) were also likely to trust the messages if the source was reputable (e.g. doctor, local officials).

Programs that included both approaches, for example, TB related campaigns that included YouTube videos plus community meetings headed by doctors or survivors, produced the most impact in the communities (PATH, 2022).

Gendered Reception

Women often occupy a constricted space in response to health messages. This can be contributed to limited autonomy, time poverty, and gatekeeping by their husbands or family members. Women also have a tendency to be more critical of content that objectifies them or trivializes their experience. Conversely, men are also the least targeted by health messages. This gap widely limits opportunities for engagement.

There are examples of gender-transformative messages in health communication, particularly including men in discussions around family planning and showing fathers that care in child nutrition advertising (George et al., 2021). Female and male audiences also report strong emotional connection to stories; female audiences also report being directed towards meaning-based or narrative-based messages while tensions exist for male audiences who are more likely respond to logic or benefits. This indication suggests two - not one-size-fits-all - directionality.

Caste, Religion, and Local Politics

To a certain extent, audience reception is subject to caste and religious identities. For example, as Taruna Shankar notes, in villages when ASHAs come from a dominant caste, whether through caste hierarchy or another system of domination, Dalit households may resist their visits. In some Muslim households, messages of reproductive health may be framed through Hindu religious metaphors which can feel othering. Several programs described higher success rates when they partnered with local influencers—whether that meant a Maulvi, a priest, or a panchayat leader (Rajagopal 2001).

In West Bengal, menstrual hygiene videos were disregarded in certain schools until community teachers reframed the messaging so that it used culturally neutral language. In Gujarat, TB campaigns only progressed when Muslim TB survivors were found to speak in their own neighbourhoods (Nayar 2020).

Resistance, Reframing, and Negotiation

Not all audiences are passive isolates of messages. Drawing on Stuart Hall's model, many audiences "negotiate" or "resist" the dominant meaning behind messages. For example, a woman may agree that IFA tablets are good, but still resist taking them because they make her feel nauseous or interrupt her fasting. In Jharkhand, adolescent girls resisted the idea of "empowerment" during life-skills sessions—not by acting out in rebellion, but in the ability to study and delay marriage.

These inquiries may not be about rejecting, but rather about reframing. Programs that anticipate, and therefore give space, for people to reframe the messages tend to encourage greater buy-in. As Hall (1980) states, audiences are not empty vessels; they are thinkers, critics, and agents of their own creation.

Conclusion: Towards Participatory Health Futures

In the crowded health messaging space in India, it is easy to fall into the trap of thinking if you commun-

icate louder, you will have a deeper impact. However, as this paper has illustrated, real change often happens not by the sheer volume, but by connection. Interpersonal communication (IPC) and community engagement (CE) are not just bolted-on approaches to behaviour change, they are the basis for it.

Change is relational, whether that be an ASHA enthralling a mother to give IFA tablets a try, a TB survivor breaking stigma in their mohalla, or a group of adolescent girls informing each other about menstruation. Change requires trust, time, and dialogue.

Evidence from programs including RMNCH+A, NTEP, Poshan Abhiyaan, and the Menstrual Hygiene Scheme shows that behaviour change is not simply about knowing, it is about feeling heard, understood, and supported.

And this is where India needs to advance its health communication strategy.

India's public health programs must treat communities as co-creators, not recipients. We must understand communication not as a message, but as a relationship that is situated and ongoing.

For India to truly advance in public health, not just in a statistical way, but socially and ethically, it must adopt a communication model that is strategic as well as human.

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