Unmasking Realities: Public Health Communication in India During the COVID-19 Pandemic

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Abstract The authors take a critical look at India's public health communications during the COVID-19 pandemic. The case study method is used. Data include what was gleaned from interviews with key informants engaged in outreach communication, news reports, and artefacts from select COVID campaigns as they evolved through the first and second waves of the pandemic. Learnings are drawn from previous health communication campaigns that focused on behavior change including India's successful and well recognized communications interventions during its HIV and AIDS campaigns, as well as its remarkable Pulse Polio efforts.

Introduction

India has a rich history of health communication campaigns in response to varied public health challenges that include HIV/AIDS, polio, tuberculosis, and reproductive and sexual health among many others. In this chapter we review some of the lessons learnt from these campaigns and examine the extent to which COVID-19 communications have integrated valuable insights gleaned from campaigns of the past. While the differences between COVID-19 and other public health challenges such as HIV/AIDS and polio in terms of the disease, transmission routes, vulnerable communities, measures of protection, and the nature of risk behaviors involved are very distinct, there are significant learnings from a public health communication lens that India acquired through its national polio and AIDS control programs that lend themselves to application in the ongoing pandemic. These learnings draw on theories in behavioral science that have found wide application and acceptability, resting on

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an evidence base of experience of several countries that successfully grappled with polio and the AIDS pandemic over the years.

In order for public health communication to make a significant difference in efforts mounted to address COVID-19 and its ramifications, the behaviors sought to be influenced need to be internalized and sustained over time (unlike communication that calls for one-time action, such as an appeal to donate blood). Messaging around COVID-19 encompasses a spectrum of issues ranging from preventive behaviors to testing, care, treatment, vaccination, and others. While we cannot cover the complete spectrum of communication issues around each of these, we have attempted to focus on the underlying determinants that would make for recommended behaviors to be sustained over time. This assumes significance in light of the uncertainty that has marked the progress of the pandemic, with the medical fraternity and public health specialists learning along the way, as the body of empirical evidence grew with the passing of time.

We use the analytical framework of the Self-determination Theory to contextualize our observations and to help us identify the areas where our COVID-19 communication efforts can be augmented. According to the Self-determination Theory, the maintenance of behavior change over a period of time has been shown to be achievable if it is anchored in one's experience of (1) autonomy (as in providing choices), (2) competence (feeling effective and believing one can act upon the messages), and (3) relatedness (feeling cared for by others, trusted and understood) [1].

This chapter is divided into six sections. We begin with a short review of the main concepts of the Self-determination Theory in the first section. Section two evaluates COVID-19 communications in India from the point of view of relatedness. It is followed by sections three and four which present insights into the importance of community engagement and the importance of building trust. In section five we explore how COVID-19 communications can appeal to individuals' need for competence. Section six highlights the importance of credible information and the role of community leaders and community champions in contributing to it. In the final section we present some guidelines for action.

Self-Determination Theory

The Self-determination Theory focuses on the different types of motivation for human action [2]. Autonomous motivation that is intrinsic to and integrated with the self offers volition and self-endorsement and is more effective than controlled motivation which originates from external sources (even if it is partially internalized and involves approval and shame among other things) when it comes to predicting a range of outcomes in domains including health, problem-solving, parenting, sports, and learning [2, 3]. The three central concepts of this theory are the needs for autonomy, competence, and relatedness. Satisfaction of these needs is related to beneficial mental health and behavioral results, irrespective of whether the individuals are in individualistic or collectivist cultures [4]. Most importantly, social

conditions can aid or obstruct individuals depending on the extent to which they create situations for these needs to be met [4]. A meta-analysis of 184 empirical datasets from 166 publications in the fields of both physical and mental health as well as health promotion (over a wide range of issues including tobacco cessation, weight management, dental care, diabetes, fitness, and adhering to prescriptions) that applied the framework of the Self-determination Theory revealed strong support for its arguments [5].

Relatedness: The Importance of Feeling Connected to Others

The concept of 'relatedness' (feeling cared for by others, trusted, and understood) is important and justifies a closer examination to understand its centrality to the COVID-19 response in India, especially among marginalized and vulnerable communities, including slum dwellers and migrants. As the pandemic spread and countries began to put into place response measures, UNAIDS shared guidelines that encompassed key learnings from forty years of responding to the HIV epidemic [6]. An important lesson it highlighted was: "…the need to have a community-centered and informed response, one that embraces solidarity and kindness, that prioritizes the most vulnerable, and that empowers people to be able to take action to protect themselves and others from the virus. These are essential for creating trust between affected communities, the government, and public health officials, without which it is unlikely that the response will be either rapid or effective. Equally, swift action must not be rendered ineffective by existing inequalities, lack of information, and barriers related to cost, stigma, privacy, and concerns around employment and livelihoods".

In retrospect, India's success story in managing the HIV epidemic was grounded in the recognition of the simple fact that it was by placing communities at the center of the response that meaningful change could be brought about. In the context of public health communications, this translated into identifying community needs, priorities, and importantly barriers to behavior change that needed to be taken into account while designing both programmatic and communications interventions. Studies in India highlighted significant barriers that impeded the adoption of the behaviors recommended. For example, community members were hesitant to come forward for testing as they feared stigmatizing attitudes as well as discriminatory behavior would follow if the test report indicated positivity [7–9]. For many groups that were at higher risk of HIV such as MSM (men who have sex with men), PWID (people who inject drugs), and sex worker communities, societal attitudes were already characterized by disapproval and alienation. Their understandable reluctance to test and then to come forward for treatment if required presented a significant barrier to the program's efforts. It was only when proactive measures were taken to build trust, engage actively with the communities, and bring them to the center of the discourse, did the health communications efforts begin to show results. As S. Y. Quraishi, Former Director General of the National AIDS Control Organization, and currently Chairman of the Governing Board of the AIDS Alliance India, emphasized "It is important to engage

affected communities from the beginning in all response measures—building trust, ensuring suitability and effectiveness, as well as frequent sharing of information" [10].

The above learning, however, did not find expression in the manner in which public health messaging was rolled out in India as the pandemic broke. The imposition of what has come to be recognized as the world's most stringent lockdown by the national government, took place with a lead time of only four hours. The trauma and untold suffering that followed with migrant families being displaced overnight without any safety nets to fall back on has been well documented. Mander noted that "…it was not only the overnight annihilation of their livelihoods which drove millions of migrants home. It was the demolition of their faith and trust—in their employers, in their middle-class neighbors and, most of all, in their governments" [11]. Mander highlights the gaps between the health communication messages that urged people to maintain 'social distancing' when Census 2011 statistics indicate that 67% of urban dwellers live in houses with two or less rooms, with an average family size of 4.9; to 'wash hands regularly' when the National Sample Survey (NSS) 2018 shows that half of Indian households did not have an exclusive water source; and to 'stay at home' when India has 1.7 million homeless people as per the Census 2011. One of the central pillars underlying the Self-determination Theory—relatedness (feeling cared for by others, trusted and understood)—was thus completely absent in this approach.

Linked to the above was the issue of the sense of a lack of autonomy, of real choices which could generate a feeling of inadequacy at not being able to follow the guidance being recommended. The need for autonomy along with the lack of trust made for communications that were unlikely to affect behavior change as it was mere risk communication without the critical component of community engagement that is needed to make a difference. T Sundararaman, Global Coordinator of the People's Health Movement and a former Director of the National Health Systems Resource Centre, stated, "…the mainstream messaging has a terrible subtext. And that subtext does not help to follow COVID appropriate behaviors or support public health measures" [12]. Sundararaman notes that India's public health communication strategy emphasized victim blaming and stigmatized behavior. In his words, "The overall approach to public health behavior has been authoritarian, a law-and-order approach, enforcement, and fines. In some sense you are saying people are irresponsible and so they get the disease. So when a person gets COVID-19, they may feel ashamed, they may feel guilty" [12].

Community Engagement: Partnering for a Meaningful Response

The meta-analysis by Gilmore et al. of 37 campaigns across 32 publications examining five epidemics in the twenty-first century such as Ebola, Zika, Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome (MERS), and H1N1 identified the six main actors for community engagement as (1) local leaders, (2) community and faith-based organizations, (3) community groups, (4) health facility committees, (5) individuals, and (6) other key stakeholders whose inputs and coordination are required for six main functions that include (1) designing and planning, (2) community entry and trust building, (3) social and behavior change communication, (4) risk communications, (5) surveillance and tracing, and (6) logistics and administration [13].

In the entertainment and financial capital of India that is home to Asia's largest slum Dharavi, officials feared the worst when the first case of coronavirus was detected on April 1, 2020. The slum's population of about one million residents live in a tightly packed area of just over 520 acres, making this one of the most densely populated areas in the world. Response to the outbreak called for swift action on multiple fronts. Unlike the national response to the situation of other vulnerable communities such as migrant labor, the local municipality responded by understanding that strategic behavior change can only be sustained when it incorporates aspects of autonomy, competence, and relatedness and that without effective partnerships with civil society organizations on the ground, this was not going to happen. What is notable about Dharavi's success story, which went on to be hailed by the WHO as a model worth emulating across the world, was its recognition of the fact that the public health response to such a situation necessitated going beyond the measures of lockdown, testing, surveillance, and engagement of multiple sectors to include a focus on community engagement and communication, without which none of the other measures would have succeeded [14–16]. Dharavi's 'Chase the Virus' model was seen to be effective because it included (1) community participation and risk communication, (2) governance, multi-sectoral coordination, and a stringent lockdown, (3) public private partnerships, (4) ramping up of quarantine, isolation, and treatment facilities, and (5) robust surveillance, contact tracing, and screening [16].

Gaining the trust of the communities was recognized and prioritized as an important first step by the municipal authorities who realized that communities were hesitant to come forward with their health-related problems. The discovery of a COVID-19 positive case in Dharavi led to a heightened fear of stigmatization among its residents [17]. A baseline study carried out by *SNEHA*, an NGO working in the slums of Dharavi, Govandi, and Malvani, revealed that people were hesitant and believed that employment opportunities would further shrink if Dharavi came to be identified as a 'COVID hotspot' [18]. Understanding this, the Assistant Municipal Commissioner of the Brihanmumbai Municipal Corporation (BMC), Kiran Dighavkar, who led the Dharavi response, partnered with local groups and individuals who the community trusted such as NGOs and local doctors whom community members knew and

accessed [17]. Small but meaningful gestures went a long way in cementing the relationship and forging the bonds of trust. For instance, the municipal authorities, sensitive to the challenge patients in isolation wards in the slums faced during *Ramadan*, ensured that meals were provided at the appropriate times when the fast was broken [17]. The administration organized yoga, breathing exercises, and aerobics to address the stress that those in quarantine were experiencing [16]. The recognition of the reality that 70% of Dharavi's residents was daily wage earners, with little or no savings—the running of community kitchens and ensuring of regular supplies of groceries and food through lockdown, all went a long way in gaining trust, and consequently, compliance with recommended COVID appropriate behavior [17]. One of the lessons from HIV communications is that "…life circumstances bring different challenges…the most effective messaging reflects and responds to the real-life issues people face" [19].

Building Trust: Increasing Actionability

The concept of trust between the sender and receiver of communications being central to its acceptability appears to emerge as an important factor, especially in the context of risk communication during a pandemic. Trustworthiness has been defined as, "the source's intentions in the relationship between the message and the receiver of the message" [20]. Transparency plays an important role in building trust, as Abraham notes, "if the public knows that information and the reason behind decisions are going to be fully disclosed, it is more likely to trust advice coming from government agencies" [21]. In an environment of uncertainty, where knowledge of the virus and the disease evolved over time, this aspect became even more important. Yamini Aiyar, President and Chief Executive of the think-tank, Centre for Policy Research described how the distrust between the State and its citizens shaped bureaucratic communication, the relief response, and the health response during the first wave of the pandemic [22]. Bureaucratic 'orders' became the default mode of communications leading to heightened confusion and insecurity. The relief response was perceived to be grossly inadequate. It depended on paperwork and documents that impeded it. The public health response required governments and people to act together. As Aiyar put it, "…participation is critical to ensure symptoms are reported to enable early detection and speedy provision of medical care. It is also essential to ensure long-term behavior shifts." However, the stigma and fear (including the pinning of 'blame' on some communities for the spread of the virus in the first month of the outbreak) came in the way of responding to health communication messages such as the importance of testing, thereby undermining an essential ingredient (early detection) of an effective response to the pandemic [23]. When the second wave hit India, a variety of factors were seen to be responsible for the disastrous consequences. In addition to failures arising from governance and lack of preparedness, there was the letting down of the guard by the general public who believed the worst was over. There was also complacency arising from observing the administration's own example of seeming

indifference to the gathering of crowds at election rallies and religious gatherings such as the *Kumbh Mela* [24].

COVID-19's second wave impacted the residents of the slums very differently from those who live in the high-rise housing complexes of Mumbai. According to the Brihanmumbai Municipal Corporation (BMC), 90% of the infections in the second wave were recorded in high-rise buildings in the beginning of March 2021. It was clear that the main challenge was to contain the spread of COVID-19 in the high-rises and not in the slums [25]. Authorities observed that COVID-appropriate behavior appeared to be better followed among the slum-dwellers than among the more privileged sections of society, supporting the argument that the on-the-ground efforts of the administration, civil society organizations, and local influencers who sustained their outreach work among the slum communities, and building on the relationship of trust and partnership had paid off in terms of the community's continued adherence to the recommended behavior protocols [26].

The above is perhaps best illustrated by the work of NGO *SNEHA* in Mumbai. Before the second wave could hit, behavior change communication initiatives had shifted gear in December 2020 to focus on reminding the communities that COVID-19 had not 'gone away'. A survey undertaken revealed that many in Dharavi believed that COVID was no longer a problem in their community; the case load had decreased significantly [18]. The campaign '*Corona Gaya Nahi? Corona Gaya Nahi.*' ('Hasn't Corona gone? Corona hasn't gone') (Box 1) was designed and implemented by *SNEHA* to address this sense of complacency that had begun to set in. The integrated social and behavior change campaign that was conceptualized, pre-tested, and implemented in the months that followed worked because it was rooted in the reality of the residents of the slums. It addressed their needs and concerns and was designed using a 'bottom-up' approach that engaged communities in the campaign through dialogue. For example, a mirror image activity was conducted that encouraged people to validate the correct usage of a mask by selecting the appropriate image. Key considerations while designing the campaign were that the different components should [18]:

- Be technically sound, but also culturally appropriate
- Be relevant and feasible for communities to act upon
- Include online and offline channels of communication
- Include a feedback mechanism to understand what is working and what needs to change.

All the above reinforced the community's need for a sense of autonomy, competence, and relatedness. The latter also arose from the long period of trust already built among community members by *SNEHA* over two decades of its work on maternal and child health.

Competence: Supporting People to Feel Empowered

Sakan et al. in a survey of the psychological needs of individuals during the COVID-19 lockdown found that "when the sense of competence was thwarted within the environment, distress was more pronounced" [27]. Most COVID-19 communications placed restrictions on people's access to work and other activities which gave them a sense of self-efficacy. However, in marked contrast to this general pattern, communication outreach undertaken by *SNEHA* through the lockdown included the innovative '*Gharwalli Diwali*' (*Diwali* at home) campaign which encouraged the community to celebrate the festival of lights (*Diwali*, the New Year as per the *Hindu* calendar for some communities) by spending time with the family and celebrating indoors [18]. With a seemingly simple tagline, the underlying message that went out was that the outreach team cared for the sentiments of the community and their desire to celebrate an important festival. Most important, in an environment marked by constraints and 'don'ts', it shared with them what they can do.

Initiatives like the above validate the learning that reinforces that a sense of competence and agency is important in order to encourage adherence to behavior change. Porat et al. state that "…understanding what people can do in addition to what they cannot do is important. It is useful to advise people to be proactive and do things that are constructive and directly relate to the crisis they are facing. Taking action and being proactive during a crisis can help to develop a sense of control and overcome emotions of helplessness and hopelessness. Helping the public feel in control and empowered in some parts of their lives may also decrease fear" [28].

When it came to the broad-based communication that the authorities put out in India, however, this important aspect of communicating 'what people can do in addition to what they cannot do' was largely absent. Menon observed that "… we have (not) done enough to emphasize that open ventilated areas are probably ten times safer than any enclosed space. And perhaps this should have been done to give people an alternative earlier on." Adding that "the psychological impact of the pandemic has been such that people have been told there are many things they cannot do. But they have not been told about things that they can do. And allowing for low density public spaces, I think would have been a bit of positive messaging while preventing crowding in enclosed and badly ventilated, air-conditioned spaces" [12].

Box 1

The 'Corona *Gaya Nahin* (Corona has not gone) campaign' used a 360degree approach, using digital media, bulk short message service (SMS), mid- media such as displays and loudspeakers mounted on auto rickshaws, cable TV, and interpersonal communications, spearheaded by a large team of community volunteers (a part of the Community Action Groups that *SNEHA* had facilitated over the years, that served as a link between the community and the public health system) who were designated as COVID *Yoddhas* (COVID warriors).

Phase 1: created curiosity in the community with the question Corona Gaya Nahi? The outreach team triggered discussions at community-level around this teaser question *'Corona Gaya Nahi? Jald Hi Pata Chalega. Sathark Rahe'.* (Hasn't Corona gone? We will know soon. Stay Aware.)

Phase 2: emphatically announced that corona has in fact not gone away. A mascot was launched and was accompanied by multiple campaign products including films, road show events, and others.

Phase 3: reinforced key campaign messages including on modes of transmission, use of masks, distancing, hand wash, spitting, stigma and discrimination, and safety measures to be followed. In particular, boys and men were targeted as field insights indicated they were less particular about following COVID appropriate behavior. Communications also incorporated information on vaccination including the process of registration, details of centers, and such like.

Key findings from the study to evaluate the campaign (*SNEHA*'s End of Project Report):

Television (90–94%), friends/family (56–70%), and social media (34–53%) were the most commonly reported sources of information on COVID-19. However, community health workers (98–97%), *SNEHA's* community organizers (COs) (98–97%), doctors (94–97%), and COVID *Yoddhas* (98–98%) were the most trusted sources of information.

The baseline-endline comparison indicated a marked increase in awareness about fever (88–96%) and breathing difficulty (53–71%) as symptoms of COVID-19. There was an increase in awareness (41–64%) of at least one of the uncommon symptoms (loss of taste, diarrhea, conjunctivitis, fatigue, muscle ache, chest pain, and skin rash).

The proportion of respondents reporting the combined practice of three protective behaviors (hand-washing, use of masks, and social distancing) increased from 78 to 83%.

The proportion of respondents who perceived medium or high risk of contracting COVID-19 infection increased from 20 to 27%.

Among those who had not taken the vaccine, 63% reported willingness to take the vaccine when made available to them. However, 37% reported hesitance to take the vaccine. Vaccine hesitancy was more among women (46%) than men (27%). Vaccine safety (19%) and the side-effects after administration (20%) emerged as major concerns related to the vaccine.

One of the important elements to note is that through the period of the campaign, which is now moving into the phase of addressing vaccine hesitancy, the fundamental 'basic' messages around the three preventive behaviors remained a consistent thread throughout. This was an important learning that India had also derived from the campaigns on HIV and AIDS that moved from messaging around prevention to testing, treatment, stigma reduction, and other

issues. In India, as in many other countries, as reported by the Kaiser Family Foundation 'even after more than three decades into the HIV epidemic, we still see a need to cover fundamentals, like how HIV is—and is *not*—transmitted and that testing is the only way to know if you (or someone else) has it. As the COVID-19 conversation shifts to testing, treatment, and vaccines, there will still be a need for reinforcing messaging about frequent hand washing, not touching your face, and physical distancing'.

Enhancing Credibility: Engaging Community Leaders and Champions

The outbreak of a new disease and especially the havoc caused by a pandemic such as COVID-19 can lead to a situation of uncertainty and confusion among the public. A feeling of helplessness is more acutely felt by communities that are more vulnerable either in terms of their economic status, relative lack of access to healthcare and facilities, and inability to access credible sources of information, including digital and mass media. The void in information is often filled by rumors, misconceptions, and myths that take on a momentum of their own and sometimes outpace the sharing of evidence–based scientific knowledge. Communities such as migrants, refugees, and internally displaced persons are known to be at higher risk of being left out of shared credible information and messaging. Recognizing this special vulnerability, seven organizations including United Nations Children's Fund (UNICEF) and World Health Organization (WHO) came together during the COVID-19 pandemic to issue a set of joint guidelines that provided recommendations on how to address this challenge [29]. Two recommendations that emerged are noteworthy:

> When direct community engagement is not possible, communicate remotely with community leaders and/or other members to ensure continuous provision of information and mobilize people who have recovered from COVID-19 to act as community champions to build social trust and hope.

The first, the engagement of community leaders, was an important component of India's successful polio eradication communication strategy. The second, engaging with those with 'lived experience', was a strong element of India's HIV/AIDS communication strategy and action plan. In both cases, in-country experience proved the soundness of the approach.

In 2001, when the Social Mobilization Network (SM Net) was set up to address the polio communication challenge in the highly endemic regions of India, community members who were identified and trained as social mobilizers faced formidable barriers when it came to the acceptance of the oral polio vaccine in resistant pockets. These included fears and apprehensions about the side-effects, lack of faith in the efficacy of the vaccine, lack of conviction pertaining to the need to give children

the vaccine repeatedly, and several others [30]. One of the main barriers among minority populations in particular was fueled by strong rumors that the vaccine caused impotence. There was also resistance stemming from hostility towards so much emphasis on one issue when other more immediate problems being faced by disadvantaged communities were seen to be neglected. Wasan notes that "a lot of brainstorming ensued and the final conclusion was that it would be wise if religious leaders could be taken on board because enlisting the support of religious leaders meant gaining allies to influence families. By building bonds and partnerships with religious leaders, who are widely respected within the community, it was hoped that grassroots networks and support systems could be developed" [31].

India's polio communication strategy thus evolved to include a strategic mix of mass media, frontline communicators, and a strong group of identified local influencers including religious leaders. The latter worked closely with the program to address community fears and misgivings and also made relevant announcements at religious congregations such as mosques. Gitanjali Chaturvedi, who documented India's experience with polio communication, remarked on this 360 degree approach to communication by noting "…pasting banners, posters, and distributing leaflets would not work. People followed by example. If some influential members of their community appealed to them to immunize children against polio, they could be convinced. If their doubts were clarified by community volunteers recruited exclusively to change behavior towards immunization, a significant improvement could be registered. In other words, an intense combination of social mobilization and interpersonal communication was the answer" [30].

The engagement of a variety of stakeholders and local influencers, including teachers, traditional birth attendants, *anganwadi* (nutrition) workers, and others, led to an intensive on-the-ground effort that addressed concerns and information gaps on polio. When the COVID-19 outbreak took place, Chaturvedi highlighted lessons from the polio communication experience that could be harnessed for COVID-19 communication plans [30]. It was not just India that successfully engaged with religious leaders and community influencers, other countries such as Nigeria also achieved success through this approach. Ms. Chaturvedi highlights an important point "however, rather than as an afterthought, this engagement has to be done carefully and upfront. For instance, in several low-income settings, explaining lockdowns that impact people economically will have to be accompanied with a response plan involving communities and their leaders. Liberia shut down completely during the Ebola crisis. But this was done in consultation with community leaders and detailed micro-plans were prepared assessing rations and other essential requirements of communities" [32].

The lack of strategic planning of the kind detailed above when it came to announcing the lockdown in India led to the unfortunate events that followed, and these have been documented and analyzed extensively—the plight of the dispossessed migrants walking thousands of miles to reach home and the anxiety and fear generated by the evident lack of an on-the-ground response plan that could have been put in place with consultation with community leaders and civil society organizations. Reporting on the migrants, Yadav and Priya noted that "In haste to control

the situation created by pandemic, the State considered little about these people while implementing a nationwide lockdown. The employers and intermediaries who were the last hope had also turned their backs on these pitiable people. The migrant workers' class, which largely depends on their daily earning, had literally nothing to fall back on" [33]. In a study undertaken by the Stranded Workers Action Network (2020) of the 11,159 migrant workers interviewed, a high proportion (72%) had food supplies for only the next two days.

The experience gained from engaging local influencers in polio communications can be brought to bear on important components of COVID-19 communications as we go forward. One of the key areas that have similarities has to do with COVID vaccine hesitancy. Communication strategies to address this can build on the learnings of how to leverage influencers to address fears and misconceptions.

One of the recommendations pertaining to risk communications in the context of vulnerable populations and COVID-19 refers to the guidance to 'mobilize people who have recovered from COVID-19 to act as community champions to build social trust and hope' [29].

Engagement of people with 'lived experience' in the planning and implementation of programs is an approach that has been used in a variety of ways across sectors. Notable among these is the involvement of people who experienced mental health challenges in the design and roll-out of programs addressing such issues. Other sectors include TB prevention and treatment, for example in India, where 'TB Champions' were featured in campaigns to inspire others on the importance of non-stigmatizing behaviors, on the need to ensure adherence to medication, and other such issues [34]. India's experience with campaigns on HIV and AIDS include the involvement of PLHIV (People living with HIV) to 'normalize' the virus and reduce the fear and stigma surrounding it [35]. People living with HIV not only participated in campaigns on broadcast media but they also personally addressed large forums including the press, the corporate sector, educational institutions, and elected representatives through their training as 'Positive Speakers' [36].

The engagement of PLHIV in program and communication efforts provided valuable insights on how the use of terminology and language can fuel stigma and trigger discrimination. These are useful lessons that may be applied while designing public health communications around COVID-19. As advised by UNAIDS, "Words matter. The way governments, communities, and the media speak about an epidemic, its modes of transmission, and people who have the virus can all shape the way people and communities are perceived and treated. Avoiding phrases such as 'super-spreader' or choosing neutral phrases like 'acquired' rather than 'infected' can make a difference as to whether people feel empowered and willing to be tested and self-isolate and to provide help to others in need" [6].

In addition to those who have survived COVID-19 and can participate in public health campaigns, thereby allaying fears and reducing stigmatizing attitudes, the featuring of other stories and narratives is important too. There is a need to go beyond dry statistics and share stories of hope, adoption of COVID appropriate behaviors, and resilience as these relate to family caregivers, frontline workers, the medical staff, and others. Explaining the value of 'role modelling through narratives', the authors

state that "the use of role models to teach social behavior through narratives can be implemented during disease outbreaks or pandemics as well. During the COVID-19 pandemic, for instance, narratives using positive role models can demonstrate the advantages of following the guidelines, thus strengthening people's self-efficacy" [37].

A similar approach has been used by advocates of 'positive deviance' such as Arvind Singhal [38]. Positive deviance is based on the premise that communities have within them individuals who by the practices they adopt and the behaviors they choose, demonstrate the doability of such actions and the benefits of the same. Campaigns featuring such positive deviants have been designed based on audience research in India on subjects where triggering behavior change has proved to be particularly challenging. For example, in convincing rural women to adopt the intra-uterine device (IUD). Field studies showed that women were likely to be more favorably disposed towards a family planning method if someone who had personally used it shared her story with them.

In the ultimate analysis, it is a sense of solidarity, empathy, and inclusion that would need to permeate all public health communication in the context of COVID-19. India's former Union Health Secretary, K Sujatha Rao, who successfully spearheaded the country's response to the HIV pandemic, emphatically believes that "more than the infection, we need to battle the fear that we seem to have got into our psyche and ensure that in so doing we do not become complacent… We have a chance only if we live with a sense of social solidarity and social responsibility" [39].

Conclusions

The COVID-19 pandemic has brought to the fore the importance of harnessing public health communications in a strategic and focused manner, not only to support essential preventive behaviors such as hand washing, the use of masks and physical distancing, but going beyond these to address the larger inter-related concerns that influence such behavior, including experiences of fear, stigma, anxiety, and isolation. Beyond the need to reinforce essential preventive behaviors, there is also a growing need to address concerns as the pandemic evolves, such as living with uncertainty, accepting a new normal, addressing vaccine hesitancy, and many more.

This chapter illustrates how such communications can be designed and implemented based on the well accepted theory of Self-determination (that outlines the three building blocks of relatedness, autonomy, and competence being fundamental to sustained behavior change). It also elaborates on how such an approach was applied in addressing two major public health challenges that India grappled with, the HIV/AIDS pandemic and the polio eradication program.

The theoretical foundation of the country's experience points to the significance of the following five inter-related principles that can serve as useful guidance going forward. These are (1) the importance of fostering a feeling of relatedness and solidarity; (2) generating trust between the sender and receiver of communication; (3)

engaging with communities to design interventions and messages that are appropriate and relevant to their life circumstances; (4) reinforcing a sense of competence by highlighting the 'doables' in an atmosphere of constraints and restrictions and finally; (5) leveraging the influence of community leaders and narratives of champions/survivors to enhance the credibility of the communications. These five inter-related components, tried and tested in the design of India's campaigns in HIV and Polio, can serve to guide the development of COVID-19 communications going forward.

Going forward means dealing with myriad issues that are not possible to touch upon in this chapter. The canvas of what needs to be done in public health communications around COVID-19 in India, as indeed in many other countries, is large and complex. To give some examples, communications would need to address the important aspect of mental health and engage with this issue in a manner that is nuanced, appreciative of the inter-sectionality of mental health with other issues and take into account the special needs of diverse vulnerable populations such as women, people with disabilities, the elderly, the *adivasis* (indigenous tribal communities), and others. As rural India grapples with the virus, communicators would need to explore channels for reaching out that are accessible and believed to be trustworthy to rural and tribal communities and importantly, in synch with service delivery and accessibility. Simultaneously, the need to harness the power of social media (that fosters heightened interactivity and participation, but comes with its pitfalls of being easily harnessed to fuel misinformation and rumors) would require careful planning and implementation. Underlying all this is the need to continue to gather a body of evidence on what works well in public health communications by investing necessary effort and time on documentation of good practices.

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