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Achieving Health Goals in India: The Role of Community Engagement and Communication

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Abstract India is committed to achieving the Sustainable Development Goals (SDGs) set up by United Nations. Community engagement (CE) and communicating health is the key aspect for achieving the desired results. Goal setting for health sector in India has long history. This systematic review aims to examine the evidence on community engagement and communication from studies that report on program outcomes in India. To our knowledge, there are limited reviews available that examine outcomes of CE in achieving health goals. This review seeks to fill this knowledge gap. We describe role of CE and communication in achieving the SDG health goals in India. The lessons learned this review may be useful in any developing country setting and may be utilized for planning and implementation for achieving the SDG by 2030. As methodology a systematic and realistic review of literature and Meta analysis is involved in this review paper. The review of literature includes program reports, documents, guidelines, research papers. Nationwide public health strategy, process of developing public health structures and achievements helping in improving status of health in India. Increasing capacity of the health care system, availability of trained human resources, efforts to improve the health care expenditure, and positive changes in demographic indicators shows that India is moving in right direction towards achieving SDGs. Based on various research and findings it has been derived that Engaging Community and adopting strategic path of communication can help in achieving the goals of SDG particularly in health sector in India.

Keywords: communication; community action for health; community engagement; healthgoals; health and wellness; Universal Health Coverage.

1. Introduction

Government of India is committed to achieve the Sustainable Development Goals (SDGs) set up by United Nations (United Nations, 2015). In September 2015, the United Nations General Assembly established the Sustainable Development Goals (SDGs) which specify 17 universal goals, 169 targets, and 230 indicators to be achieved up to 2030. Although the SDGs have been accepted in principle, they have also been criticized for being too large in number and too wide in their scope. It is a challenge to create and maintain public awareness, mobilization, advocacy,

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and continuity for these goals and targets enshrined in SDGs as compared to Millennium Development Goals (MDGs) (Singh, 2016).

Over the remaining eight and half years, with these goals that universally apply to our country will mobilize efforts to end all forms of poverty, fight inequalities and tackle climate change, while ensuring that no one is left behind in access to health care and basic sanitation and nutrition services. India has aligned its National Health Policy 2017 (Ministry of Health and Family Welfare, 2017), to achieve these goals. India's key developmental program, policy focus and resource allocation align with the SDGs. For instance, Ayushman Bharat (Pradhan Mantri Jan Arogya Yojana), which covers 500 million persons and is the largest health protection scheme in the world, closely aligns with SDG 3 (health and well-being) and SDG 10 (reduced inequalities). India's comprehensive climate action agenda and leadership in International Solar Alliance aim to achieve the same outcomes which SDG 7 (clean and affordable energy) envisions.

A health assurance scheme launched on 25th September 2018 to cover the health expenses of secondary and tertiary care of over 500 million poor beneficiaries and Jana Aushdhalaya's chain of pharmacies to improve the access to essential drugs at an affordable cost. Both these initiatives confirm the commitment of Government towards achieving the health goals as part of SDGs. As a confirmation of its commitment, the Indian government has raised its healthcare spending after worldwide pandemic challenge of COVID 19. The Union Budget 2021-22 proposed an outlay of Rs 2.23 lakh crore towards health and well-being. That is a 137 percent increase over the Rs 94,452-crore budgeted expenditure on healthcare in the ongoing fiscal year. The spending on the Prime Minister (PM) Atmanirbhar Swasth Bharat Yojana—to strengthen the health infrastructure of the country includes in this increased budget.

Goal setting for health sector in India has long history which we attempt in this paper with respect to review of some selected time bound goals which were decided in policies, programs and strategies in India. We identified the missing link of community engagement and communication in these programs and policies for achieving the formulated Health goals. Our effort is to analyze the need for and importance of community engagament (CE) and communication initiatives in achieving the health goals.

In 1945, Bhore committee the recommendations laid the foundations of the health services goals in the country (Bhore, 1945). These included both short-term and a long-term program for a distant future. Creating health care infrastructure and service provision was focused of the health system in India in first 2 decades in post-independence era. Demand generation and community engagement was the missing part in initial stage of health programs. Target based

family planning approaches adopted a stringent control rather than welfare strategy, and community need, and choices were not focused till 1978. The 1978 Alma Ata declaration first time advocate the importance of Community participation, which framed the community as central to the planning, organizing, operation and control of primary health care (World Health Organization, 1978). New initiatives of achieving Sustainable Development Goals again focused on importance of community engagement globally. In line with the SDGs, integrated people-centered health services are key to achieving universal health coverage and attaining this goal requires participatory approaches (Marston et al., 2016). Over the decades, there has been much exploration, and debate on ways to conceptualize meaningful community engagement in health sector (Rifkin, 2009).

To promote the effectiveness of health programs implemented, engaging communities effectively is believed to have a positive impact on social capital, leading to enhanced community empowerment, and ultimately improved health status and reduced health inequalities (Morgan, 2001). Much of the research done on community participation has also focused on low- and middle-income countries despite evidence of its universal utility in improving health (Milton et al., 2012). To address this gap, this systematic review aims to examine the evidence on community engagement and communication from studies that report on program outcomes in India. To our knowledge, there are limited reviews of the existing systematic approaches that examine outcomes of community engagement in achieving health goals. This review seeks to fill this knowledge gap.

This article aims to address this gap by undertaking an analysis. We describe how community engagement and communication can played a meaning role in achieving the SDG health goals in India. The literature demonstrates the benefits of participatory and empowering approaches for community engagement in health. Studies indicate that community engagement can improve health care services/initiatives (George et al., 2015; Haldane et al., 2019; Hoon Chuah et al., 2018; Luisi & Hämel, 2021; Rifkin,2009).

The research analyzes this against the background of the characteristics of the regional health care system and previous developments in strengthening community engagement in India. This paper is an attempt to review the importance community engagement and role of communication towards achieving the health goals in India. In this paper issues, context and process of community engagement for health with the background of communicating health in India has been analyzed. It is an assessment and analysis to find out whether India's approaches, strategies and ways of action are correct and appropriate to achieve the sustainable development

goals. The lessons learned this review may be useful in any developing country setting and may be utilized for planning and implementation for achieving the SDG by 2030.

2. Methods

This review study uses a thorough and realistic review of literature as well as meta-analysis as approach. The literature review includes program reports, documents, guidelines, research papers, related websites, and training modules. “Sustainable development Goals,” “Community Engagement,” “Communication,” and “Universal Health Coverage” were key search words. About 110 documents, published from 1943 to 2021, were reviewed and out of these about 40 documents were found relevant for the subject. Relevant research work on the subject for over two decades in India and abroad was consulted and referred to in the analysis. These methods provided metadata to inform this attempt. Key concepts, ideas, themes, and implications for practice were analyzed.

3. Results and discussion

Health-related SDG indicators are health services, health outcomes, and environmental, occupational, behavioral and metabolic risks with well-established causal connections to health (Suresh, 2019). SDG index is used as a powerful tool to communicate to the public the merits of investing in health by showing gains evidenced by simple numbers though the global priorities over-ride local concerns and priorities (Agyepong et al., 2021). Today due to poor public health infrastructure in India, the healthcare service is burdened with firefighting of preventable diseases outbreaks, crowded hospital beds, poor diagnostic potentials and overworked healthcare workers. Public health is a long-term investment that is yet to be constructed and expanded in India (Ministry of Health and Family Welfare, 2017). Nationwide public health strategy is essential for achieving equity in health in near future. Public health structures are visible to the public eye, but their achievements need to follow as seen in eradication of smallpox, guinea worm and polio in past decades.

3.1. Status of health in India

India is the Seventh-largest country by area (3,287,240 sq. km) and is the second most populous country in the world with 1.39 billion (mid-year 2021). It has an annual growth rate of 1.19 percent with a population density of 382 per sq. km. The population comprises 51.5 percent males and 48.5 percent females and a sex ratio of 940 females for every 1000 males as per 2011 Census (Registrar General of India, 2011). India has a Crude Birth Rate of 21.6 & Crude

Death Rate of 7.0/ 1000 population as per Sample Registration Scheme (SRS) of Registrar General of India (RGI) in 2017.

Infant Mortality Rate (IMR) in 2017 was 42 per 1000 live births. According to the World Health Organization (WHO), India has made considerable progress in recent years in reducing the Maternal Mortality Ratio (MMR) by 77 percent, from 556 per 100,000 live births in 1990 to 130 per 100, 000 live births in 2016. India's present MMR is below the Millennium Development Goal (MDG) target and puts the country on track to achieve the Sustainable Development Goal (SDG) target of an MMR below 70 by 2030. Total fertility rate has declined to 2.6. Life expectancy at birth provides an indication of overall mortality of a country's population. In India, from 2000 (62.5 years) to 2016 (68.8 years), the life expectancy at birth has improved by 6.3 years (Registrar General of India, 2016).

In a global context, SDG 3 addresses all major health priorities, including reproductive, maternal, and child health, communicable, non-communicable, and environmental diseases, universal health coverage, and access of all to safe, effective, quality, and affordable medicines and vaccines. It also calls for more research and development, increased health financing, and strengthened the capacity of all countries in health risk reduction and management. Commendable progress has been achieved in several areas—improving child and maternal health and reducing mortality, rising life expectancy, and improving the defense against several major communicable diseases.

Maternal mortality has fallen by almost 50 percent since 1990. Measles vaccines have averted nearly 15.6 million deaths since 2000. The under-5 mortality rate has significantly come down to 39 deaths per 1,000 live births in 2017; there is a 6.7 percent reduction since 2015, and an overall reduction of 49 percent since 2000 in the under-5 mortality rate (Ministry of Health and Family Welfare, 2020). The global neonatal mortality rate has also undergone a substantial decline of 41 percent during the same period. On the other hand, the chance of dying from non-communicable diseases (such as cardiovascular disease, cancer, diabetes, and chronic respiratory disease) remained high at 18 percent. The dangers of dying as a result of traffic accidents and air pollution are increasing.

The capacity of the health care system needs to increase. The availability of trained human resources is one of the most important challenges facing India. The skilled health workforce in India does not meet WHO criteria of 44.5 doctors, nurses, and midwives per 10,000 population. As per the National Health Workforce Account, the doctor's density is 8.8 and that of nurses/midwives 17.7 per 10,000, while the National Sample Survey Office (NSSO) data pegs doctor density at 6.1 and nurses/midwives at 10.6. Of the 156,231 sub-centers in India

(Ministry of Health and Family Welfare, 2019), 78,569 were without male health workers, 6,371 without auxiliary nurse midwives, and 4,263 without either, according to Rural Health Statistics 2017. Public Health Centers (PHCs) require 25,650 doctors across India to tend to a minimum of 40 patients per doctor per day for outpatient care, as per Indian Public Health Standards (IPHS). If these standards are met, 1 million patients could be benefiting every day. But with a shortage of 3027 doctors, 1974 PHCs are without doctors. This means that 12%, or 121,080 patients, go without access to primary health care every day (Central Bureau of Health Intelligence, 2018).

As per an estimate, around 97 million people of India are aged 60 or older, so people suffering from lifestyle diseases, such as hypertension and diabetes are expected to increase. The number of diabetic cases is expected to increase (60 million in 2011) to 100 million by 2030. There is a wide divergence in the achievements across states and inequities continue based on rural, tribal, and urban divides, gender imbalances, and economic conditions of families, literacy, and the caste patterns (Animaw & Seyoum 2017).

3.2. Health care expenditure in India

According to the National Health Account (2018) report, households spend roughly 68.1 percent, with State Governments (15.8%), the Government of India (8.7%), local authorities (0.8%), social insurance from employers and enterprises (4.5%), and Non-Governmental Organization (NGOs), others accounting for the rest (2.1%). An analysis of the pattern of spending indicates attributed to inpatient curative care (35.3%), outpatient curative care (17.1%), patient transportation (4.3%), laboratory and imaging services (4.4%), prescribed medicines (26.8%), over the counter (OTC) medicines (0.3%), therapeutic appliances and medical goods (0.2%), preventive care (6.8%), and others (1.5%). About 3.4% is attributed to Governance and Health System Administration (Ministry of Health and Family Welfare, 2017).

3.3. Health care system in India

The health care system in India comprises a mix of complex multiple systems. Different systems of medical practices with a wide range starting from illiterate unregistered medical practitioners (RMPs/quacks) to super-specialist, states and national systems like railways, employees state insurance scheme (ESIS), and defense, each of which makes demands and offers resources to the other levels.

3.4. Response for achieving SDGs & Universal Health Coverage (UHC) in India

In response to its commitment, Government of India has put up a National Health Policy 2017 (Ministry of Health and Family Welfare, 2017) to address the challenges of SDGs and Universal Health Care in particular. The analysis inferred that the power of health systems to deliver the power of health interventions to those in greatest need, in a comprehensive way, and on an adequate scale was not matched.

Hence, Ministry of Health and Family Welfare (2017) has incorporated seven key policy shifts such as: a) Ensuring Comprehensive Primary Health Care (CPHC) with appropriate referral mechanism, b) Changing the resource allocation from an input oriented to an output-based financing and focus on need based strategic purchasing of services from secondary and tertiary care from private facilities c) free, diagnostic and emergency services to all seeking care in public health facilities, d) targeted Infrastructure and human resource development to reach under-serviced areas throughout the country. e) scale up health services in urban areas with a focus on urban poor f) Integrate national health programs with health systems for better effectiveness g) A three-dimensional mainstreaming of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH) system of medicine for better cafeteria approach of service provision key focus areas.

The private sector is the dominant healthcare provider in India, characterized by lack of regulation and consequent variation in quality and costs of services. The public sector offers healthcare at low or no cost but is perceived as being unreliable and of sub-optimal generally is not the first choice unless one cannot afford private care. Public intervention in healthcare delivery needs to include the Commitment of Ministry of Health and Family Welfare (2017) to achieve the Universal Health Coverage (UHC) and SDG goals. This policy envisages as its goal the attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality, and lowering the cost of healthcare delivery. Key principles of National Health policy 2017 includes: Professionalism, Integrity and Ethics, Equity, Affordability, Universality, Patient-Centered & Quality of Care, Accountability, Inclusive Partnerships, Pluralism, Decentralization showing the intention and commitment of government to put the efforts to achieve and ensure universal coverage of health services and goals.

The domains of Health-related SDGs included in National Health Policy 2017 are Mortality Reduction Targets. The country aims to reduce its MMR to less than 70 Maternal

Mortality Ratio (MMR) which stands at 122 per 100,000 live births. The United Nations (UN) target is to reduce it to 70 per 100,000 live births by 2030. The states of Kerala, Maharashtra, and Tamil Nadu have achieved this, but Uttar Pradesh, Rajasthan, Madhya Pradesh, Orissa and other Empowered Action Group (EAG) states are far behind the target.

Institutional Deliveries: Approximately 54.7 per cent of estimated deliveries happen in a health institution in India. The target is to increase it to 100 per cent. Under 5 Mortality Rate: For every thousand live births in India, 50 children die before completing 5 years of age, according to NFHS-4. The UN target is to bring it down to 25 per 1,000 live births. As per SRS data report 2017, the under-five mortality rate is estimated at 37 and it varies from 42 in rural areas to 25 in urban areas. Among the bigger States, it varies from 12 in Kerala to 55 in Madhya Pradesh. On an average, the Under-five mortality rates of female are higher than that of male except in some states.

Health needs of communities at state and national level to move beyond assessing individual health-related SDGs to investigating the links between different goals. Notable improvements were observed in maternal and child health and maternal health in India over the period 2005–06 to 2015–16, and if the trends continue the country can achieve the SDG target in maternal health by 2030. However, progress in nutrition and other health indicators has been slow and uneven (Panda & Mohanty, 2019). A high-quality health system is one that optimizes health care in a given context by consistently delivering care that improves or maintains health outcomes, by being valued and trusted by all people, and by responding to changing population needs (Kruk et al., 2018).

3.5. Health Initiatives to contribute towards achieving the Health Goals are

First, Pradhan Mantri Bhartiya Jan Aushadhi Pariyojana Kendra (PMBJPK) A countrywide sample survey on healthcare, in 2014, indicated that the medicines emerged as a principal component of total health expenses—72 percent in rural areas and 68 percent in urban areas**.** To address the problem of the availability of quality medicines at affordable prices to the common man, a campaign called Pradhan Mantri Bhartiya Jan Aushadhi Pariyojana (PMBJP) was launched by the Department of Pharmaceuticals of the Government of India. The scheme envisaged making available basic essential medicine through special centers known as PMBJPK, which were set up to provide generic drugs, at lower prices but are equivalent in quality and efficacy as expensive branded drugs.

Second, Swachh Bharat Abhiyanin the year 2014, only 31 percent of Indians had access to toilets. Swachh Bharat Mission was launched in 2014. Today, sanitation coverage is well over

90%, putting the country on track to eliminate open-air defecation (ODF). According to the World Health Organization, the Swachh Bharat Mission will save the lives of 300,000 children.

Third, National Health Protection Scheme. The National Health Protection Scheme (Ayushman Bharat-The NHPS) is a government-sponsored health insurance program. The coverage has enabled expansion to include tertiary care making provision for purchasing it from the private sector where such services are not available in the public sector. In Rajasthan Mukhyamantri Chiranjivi Swasthay BimaYojna has been initiated in addition to Ayushman Bharat Mahatma Gandhi Rajasthan Swasthay BeemaYojna.

3.6. Mode of health services provision in India

Home-based and outreach care by Accredited Social Health Activist (ASHA's), Anganwadi Worker (AWWs) and Auxiliary Nurse Midwife (ANMs), *Outreach Services* are delivered at the community level on a periodical basis during Village Health Nutrition Day (VHND) or Maternal Child Health and Nutrition (MCHN) Day. *Individual Care* is the most critical delivered at the above by paramedical workers and at the facilities starting from PHC to the tertiary level care institutes. The National Health Policy (NHP) 2017 envisages Comprehensive primary health care at a sub-center level (Ministry of Health and Family Welfare, 2017). The basic doubt is about the quality of services and human behavior of the service providers and of course irritants like long waiting time, restrict the use of the services. In the strategic (bottleneck) analysis for investment in health across India by UNICEF, five policy steps are important to achieve the UHC and other states' equity in health services (UNICEF, 2016).

1) Identify the most deprived population and invest in improving their health,
2) Invest in proven, cost-effective interventions,
3) Overcome implementation bottlenecks,
4) Partner with communities, and
5) Make the most of available resources.

All these have been incorporated in NHP 2017 and will pave the way for achieving UHC. Attention on strengthening and delivering comprehensive primary health care services through health and wellness centers, the effectiveness and success will be dependent upon a rapid transition from policy to implementation stage; focus on the engagement of community and other stakeholders (Lahariya, 2020).There is a strong need to synchronize services such as sanitation, hygiene, nutrition, and drinking water with health services (Ved et al., 2019).

3.7. Community engagement and health goals

A community is a social unit with commonalities, such as norms, religion, values, practices and customs, or similarities. Communities may share a sense of neighborhood in each geographical area (e.g., a country, village, town,). Communities may have common intent, faith and beliefs, priorities of needs and requirements, threats, or risks in common, affecting the identity of the people and their degree of cohesiveness.

Engaging the community in health-related problems and solutions is one of the fundamental principles of public health. The most effective strategy to achieve public health goals, particularly the eradication of health disparities, is to actively involve those who are affected in every element of the solution. Community engagement means involving community members/groups in all activities from identifying the relevant issues and making decisions about how to address them, to evaluating and sharing the results with the community.

There are some key benefits of community engagement. It leads towards equity and social justice, help provide health care services which are culturally accepted, and meet the specific needs of the community. Involving community in the planning process will help to demonstrate participatory values and this can help to build trust, increase communication, and create openness to utilizing services and improve outreach. The rationale for community-engaged health promotion is largely rooted in the recognition that lifestyles, behaviors, and the incidence of illness are all shaped by social determinants (Singh & Chauhan, 2021).

Health inequalities have their roots in larger socioeconomic conditions; thus, health issues are best addressed by engaging community partners who can bring their own perspectives and understandings of community life and health issues. Health care is the key to the attainment of the goal of Health for All. It reflects the values of social justice, where every person has the right to make choices regarding their lives, and participation, where every individual has a voice to make such choices. The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health promotion and collective action as important tools. It was expected that such empowerment where people take charge of their own lives and act to change their own life situations would result in improved health (World Health Organization, 1978).

In the past 70 years, governments and political leaders are quoting and reaped the soul sense and recommendations of Bhore committee made in 1945. India's Health Survey and Development Committee, under the leadership of Sir Joseph Bhore, recommended that for health care to become accessible to all people, greater and more active involvement of the

community was required. As per the comments of the Bhore committee community health cannot be attained until

> "… individual has learned to realize that his neighbor's health is a matter of as much concern to himself as his own, that it is his own effort which must help to decide the health pattern of the community circle in which he lives and that only a combined cooperative endeavor on the part of all workers in the many fields of activity in that circle can yield results that are worth achieving …" (Bhore, 1945).

The mechanisms for the engagement of civil society NGOs in the health sector in India were initiated in the second phase of the National AIDS Control Program in 1999. This engagement has continued and matured other initiatives, such as vaccination hesitancy.NRHM Framework for Implementation clearly articulated that communities must be "empowered to take leadership in health matters". Communitization was one of the components of the NRHM and included the creation of a new cadre of female community health workers – accredited social health activists (ASHA). The Village Health Sanitation and Nutrition Committees (VHSNC) set up under the NRHM are

> "… envisaged as being central to 'local level community action, which would gradually develop to support the process of decentralized health planning. Thus, VHSNCs are expected to act as leadership platforms for improving awareness and access of community for health services, support the ASHA, develop village health plans, specific to the local needs, and serve as a mechanism to promote community action for health, particularly for social determinants of health …" (National Rural Health Mission, 2013)

The National Health Policy (India) 2017 stressed in its goal about the attainment of the highest possible level of health and well-being for all, at all ages, and includes universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery (Gaitonde et al., 1993). Without ensuring the active role of community in health, whether it is a matter of planning or execution or the monitoring, it is very difficult to achieve the goal of universal coverage of health.

The increasing popularity of the term "community action for health" responds to many of the conceptual and operational limitations inherent in the term "community involvement, not only does it imply a partnership between the community and the health sector, it goes further and also denotes a pro-active role for the community and the implicit objective and obligation of the formal sector to share power rather than merely to foster cooperation. In the context of community action for health, the community is an agent for health and development rather than a passive beneficiary of health and development programs (Peter et al., 2021).

To address health in a meaningful way it is redefined in relationship between wellness and working environments. “In many cases, solutions to our health challenges can be mounted at the local level, with people and communities taking the lead.... It is within communities where collaboration can occur most effectively, where resources can be pooled most efficiently’ and where the results of positive action and change are most manifestly recognized” (National Rural Health Mission, 2013).

The policymakers and health care providers have always appeared to have remained skeptical about the benefits of the community engaging itself in health care activities. They have been even more hesitant about the community's role in defining health problems, prioritizing them and contributing to their solution. Community Action for Health (CAH) is one of the pillars of the National Health Mission (NHM) in India, which places people at the Centre of the process of ensuring that the health needs and rights of the community are being fulfilled (Singh et al., 2010).

It gives communities an opportunity to participate and provide regular feedback on the progress of the program interventions of national Health Mission in their areas, thus contributing to strengthening health services to put the “public” into public health, community engagement first came to prominence in the public health arena. It was expected that such empowerment where people take charge of their own lives and act to change their own life situations would result in improved health (McGinn & Lipsky, 2015). Governments have a duty to reduce health inequalities. This means giving special attention to the health needs of the disadvantaged and vulnerable. This idea is encompassed by the obligation of governments to ensure that health facilities, goods and services are accessible without discrimination to all.

The context of government interventions in this area is likely to vary significantly from state to state. Subsidized school lunches (MDM) and breakfasts for the children of low-income families (Community Kitchen schemes), the subsidized provision of pharmaceuticals (PM Jan Aushadhi Yojna) to aid smoking cessation, the provision of long-lasting insecticide treated mosquito nets to high-burden areas are some of the examples to address community health need through community engagements. One way that legislation can help to reduce health inequalities is by recognizing the right of individuals to challenge policies and actions that undermine the freedoms and entitlements that comprise the right to health.

Years back, Mahatma Gandhi said on issues of sanitation “If we only realize that the public is a part of us and that we in turn are part of it, our unsanitary conditions would become impossibility and by freeing ourselves of disease etc. would add to the nation's strength and

even its wealth". This is applicable on all aspects of development including health (World Health Organization, 1994).

3.8. Community engagement and universal health coverage

Universal access to health care is one sustainable development goal that India is committed to providing in all rural and urban areas. Aggregate national indicators do not highlight the huge disparities which exist across the states and districts of India. A baby girl born in Rajasthan, for example, isat a six-fold higher risk of dying before herfirstbirthdaythan a babygirlborn in Kerala. Across almost every health indicator; health inequity can be seen easily in the country. Rural, less educated and poorer section so four population including dalits have a worse health status than mor eaffluent, higher groups. Women too, are worse off in health status and access to principally we all are against the social exclusion of communities vulnerable from health entitlements but there is need to make more efforts to ensure social inclusion of certain people, abandoned from the services (Sharma et al., 2019).

The role of civil society and community-based organizations in advancing universal health coverage and meeting the targets of the 2030 Agenda for Sustainable Development has received renewed recognition from major global initiatives (Lahariya et al., 2020). There is a need to clearly define the role of different sectors in the Implementation and listed out an aggressive implementation and results in monitoring of SDGs at all levels (Suresh, 2019). The Pradhan Mantri Jan Arogya Yojana (PM-JAY) must be linked to a well-functioning and sufficiently staffed primary health care system that extends beyond curative care to include broader health promotion and prevention (Shroff et al., 2020).

'Universal coverage' refers to a scenario where everyone is covered for basic health care services. This is a scheme under which all citizens, regardless of their economic, social, or cultural background, will have the right to affordable, accountable, and appropriate health services and benefits (Singh, 2013). To have access to quality health care regardless of financial status, quality of health care, institutions, hospitals have to be improved**.** Implications of UHC will be seen in the reduction of poverty by reducing the risk of ill-health and achieving health equity. "Chief Minister Chiranjivi Swasthay Bima Yojna" by Rajasthan governments further moves toward achieving the goal of Universal Health Coverage. It provides coverage for more families by eliminating limits of the annual income of families to get insurance.

To achieve UHC in India's changing paradigm shift. Provision of essential to quality health care at the primary care level is on the anvil. Primary healthcare is focusing on systems beyond

medicine. Initiatives that influence the health of the poor, vulnerable, and underserved population have achieved excellent success in their respective domains (Garg, 2018).

3.9. Communication for Community Engagement

Communication is an enabler of individuals and society to achieve established developmental goals including health (Suresh, 2011). The science of communication is a process involving planning, design, and implementation of strategic interventions. An evidence-based strategic approach to communication is required to achieve the Health Goals.

Changing individual behavior to avoid health-related risk factors is the road to health improvement. Behavioral change may sometimes be achieved through interventions, such as health education and counseling. Efforts to change individual risk must consider the influence of community conditions and systems that affect the population in general.

CE has been regarded as a critical element of successful health programs to achieve "the health for all" goals (Yuan et al., 2021). Community involvement and communication are two critical tactics for ensuring active participation of all relevant stakeholders, information sharing, and dialogue at all levels. Both are critical for establishing trust with communities, mobilizing support and ownership, and spotting disputes while they are still manageable. Effective community engagement and communication are therefore highly critical to achieving the goals.

To achieve any health goal, communication and community engagement are essential components. With help of these two components, we can enhance the interaction between the people promoting change that will impact positively on improving the overall health status and living conditions of the people with whom they work to actualize their dream.

Role of community engagement and the communication initiatives with stakeholdersin achieving the health goals widely depended on strategies adopted by program planners (George et al., 2015; Haldane et al., 2019; Hoon Chuah et al., 2018; Luisi & Hämel, 2021; Rifkin,2009). Health communication is not only limited to the exchange of information between healthcare professionals, it is equally important to communicate the knowledge to the masses (Singh & Tomar, 2020). Civil society and Community-Based Organisations (CBOs) often employ a rights-based approach. There are some essential requirements to involve communities or civil society on a sustained and effective basis. The requirements can be summarized as a conclusion:

1) Community engagement and communication are mandatory for participatory planning. It requires identifying people's concerns, values and developing a broad consensus on

planned initiatives. Out of all issues, however, communication and community engagement are the most complex ones, because of their social-political aspects and unique context characteristics – there is no standard process, step-by-step guide or risk management. Yet, thorough planning and implementation of communication strategies and activities along with community engagement are the keys to navigate challenges and opportunities among key beneficiaries to achieve the health goals (Centers for Disease Control Atlanta, 2011)

2) Efforts of community engagement required strengthening of community platforms like Mahila Arogya Samitis (MAS) in urban slums through regular orientations, training, meetings, and handholding support of leadership (Lahariya, 2020).
3) Community Voices need to be considered during health care delivery services. Without considering the cultural competence and behavior in planning, execution of the program issues will be completely unacceptable; leading to health care encounters that lack basic communication and fail to empower or engage clients in addressing their own health needs— (Vaccine hesitancy is one of the important examples in tribal and minorities in various parts of India).
4) In terms of the domains of SDGs to be achieved, the mortality rates are achievable by the country as a whole. The goal of a total fertility rate (TFR) of 2.1 has already been achieved (NFHS-5, 2021). There are large inequities in under-five (U5) mortality across states and districts and between social and economic groups. The are some evidence of reduction of social and economic inequalities over the past two-three decades, but presence of several risk factors like low levels female education status, early childbearing and inadequate birth spacing that will impede the child mortality reduction in some pockets. Given the fact that MMR was 130 /100,000LB, IMR of 34/1000LB in 2016 (and estimated under-five mortality rate of 50) and the recent trends in annual reduction rate of MMR & IMR India can hope to achieve these goals.
5) The key challenges are connected regarding the lack of community engagement in planning, execution, and monitoring of services at ground level.Communication should be explored appropriately to reach the various segments of society. This will lead to the emergence of new ideas, opinions, and information that will ultimately promote the people-oriented community-owned health dialogue.

4. Conclusion

Based on various research and findings it has been derived that Engaging Community and adopting strategic path of communication can help in achieving the goals of SDG particularly in health sector in India. Recent results of National Family Health Survey -5 have provided us the boost towards this direction specially the increase in female sex ratio and decrease in Under-5 mortality.

Community participation is a fundamental element of an equitable and rights-based approach to health that is proven effective in optimizing health interventions for positive public health impact. This review adds to this evidence base supporting the utility of community participation in yielding positive outcomes at the organizational, community, and individual level across a wide range of health domains. Our findings present process and community outcomes as necessary to achieving robust health outcomes. This supports the notion that CE do not happen as a linear progression, but rather consists of complex processes influenced by an array of contextual factors. Overall, it is evident that community involvement is key in priority setting to drive healthcare improvement can benefit from a contextualizing learning phase. Our review highlights the need for more robust program evaluations of community engagement initiatives that measure long-term outcomes and cost-effectiveness, in more settings globally.

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Conflict of Interest

There is no conflict of interest for this manuscript.

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