Chapter -1
INTRODUCTION

Communication is probably the first activity a human being undertakes as soon as he comes on to this earth. The very first cry of a new born baby communicates its struggle to adjust itself to the new environment which is entirely different from the one immediately preceding the birth.

Communication is a process that is integral to all sciences. It finds its roots from the very existence of life, currently, developed as a vital allied discipline for the development of all other disciplines. Without communication no knowledge can be transferred from one being to the other or from one point to another. Thus it plays a very essential role in existence itself (Schramm:967:1). While identification of the process of communication and realisation of its importance, had been as old as the human existence, development of the concept, its categorisation and the analysis of the phenomenon for application is only about a century old.

1.1. COMMUNICATION AND OTHER DISCIPLINES: Communication, of course, has not yet become an academic discipline, like physics or economics, but it has become an extraordinarily lively area of research and theory. It is one of the busiest cross-roads in the study of human behaviour, which is understandable because communication is, perhaps, the most fundamental social process. Without communication, human groups and societies would not exist. One can hardly make theory or design research in any field of human behaviour without making some assumptions about human communication. Communication theory and research have,
therefore, attracted the interest of psychologists, sociologists, anthropologists, political scientists, economists, mathematicians, historians and linguists, and men from all these fields and more have made contributions to our understanding of it (Schramm:1967:1).

1.2. COMMUNICATION AND ANTHROPOLOGY: As mentioned above communication has been of interest to the Anthropologists. While diffusion is a social phenomenon of communication, Modern anthropology was born out of the controversy between those who conceived of the evolution as a major dynamic process of change and those, called 'diffusionists', who were trying to reconstruct history in terms of the itinerary of ideas or artifacts as they moved through time and space. Social Anthropologists even today are giving much of their attention to the study of the changes due to diffusion in underdeveloped areas (Katz:1967:70-71).

1.3. COMMUNICATION-DEFINITION AND THE CONCEPT: The term communication has been defined by various people in different ways. Ansari (1989:193) informs that 'communication' has been defined in a number of ways:

a. "as the process of transmitting meaning from sender to receiver (Altman, Valerzi, Hodgetle: 1985)"

b. "as the transmission of information between and among people (Du. Brin: 1978)" or simply

c. "as bridge of meaning among people (Davis: 1981)".
According to Denis McQuail (1981:3) communication has been defined as:

a. "the transmission of information, ideas, attitudes, or emotion from one person or group to another (or others) primarily through symbols (Theodorson and Theodorson: 1969),"

b. "Social interaction through messages (Gerbner: 1967)."

c. "In the most general ways, we have communication wherever one system, a source, influences another, the destination, by manipulation of alternative symbols, which can be transmitted over the channel connecting them (Os good et al: 1957)."

As per Anderson (1987:48) communication is "if the natural sciences are all physics, then the social sciences are all communication."

According to Aujoulat (1969:89) "Communication, in other words, someone transmitting a message to someone else for his welfare and his improvement."

Thus, communication, in its broader sense, includes all that behaviour and works of the individuals that convey an intelligible message to the receiver.

A systematic analysis shows that any complete process of communication includes five fundamental factors: an initiator (the source or communication); a recipient (observer); a mode or vehicle; a message (content); and an effect. Thus a communication study basically tries to understand the 5 components, viz., WHO said WHAT, to WHOM, through WHAT CHANNEL; and with WHAT EFFECT, of a particular piece of behavioural manifestation (Bhende: 1992:95).
While there are alternative ways, Denis McQuail (1987:6) suggests that one way of categorising this phenomenon is based on the nature of the five components; in other words the level of social organisation at which communication takes place, i.e., the number of communicators and receivers participating in a single behavioural manifestation at a time. Thus the processes of communication are divided into six strata and are arranged in an hierarchical order shown in the form of a pyramid with mass communication at the apex and intra-personal communication at the base (Diagram-1).

Intra-personal communication may be identified as a phenomenon synonymous to the cognitive process of perception. The sender and receiver may even be the same person when an individual
thinks or communicates to himself (Schramm:1967:6). Severity and scope of the same experience varies from person to person depending on what one communicates to oneself.

Inter-personal communication takes place between two individuals— the sender and the receiver. The mutual exchange of the roles is within the process. “The message may be merely written on the paper (as a printed book), or a series of condensations and rare factions in the air (as in the spoken word), or reflected light waves (as in communication by picture)” (Schramm:1967:6-7). By feedback, we mean the information that comes back from the receiver to the sender and tells him how well he is going. There is a great deal of feedback in personal communication, very little in mass media communication; that is the reason why it is easier to explain something and convince a person face to face (Schramm:1967:11).

Communication within society is made of complicated networks and long chains of senders and receivers. One very important characteristic of that chain is that every person on the chain, except the first and the last is a gate keeper. He can pass on the message, prevent it totally, or a part of it, or add something more to it. He has great control over the message and on the knowledge of everybody after him along the chain (Schramm:1967:11). Despite, communicating the feelings, to near and far away community members and seeking and receiving assistance to solve problems is an age-old process and an integral part of human life.
At interpersonal and intra-group level, the main problems claiming attention are concerning the forms of discourse, patterns of interaction, questions of affiliation, control and hierarchy, the setting of norms, the marking of boundaries, influence and diffusion. In formal organisations there is more attention to control and to the efficiency of information transmission and questions on voluntary attachment, interaction, co-operation and formation of norms and standards take precedence (Denis 1987:7).

1.4. COMMUNICATION AND BEHAVIOUR CHANGE: While any sort of communication is likely to have an effect on the receiver, the programmed process intended to control or influence the effect of communication on the receiver is known as persuasive communication. Teaching sessions in formal education, sermons of the preachers, television, radio, conversation between the counsellor and the client, etc., are the examples of persuasive communication. Persuasive communication can bring out any one or more of the following (Krishnan: 1989: 2C5):

a. A cognitive change followed by a behavioural change.

b. A cognitive change alone without a corresponding behavioural change.

c. A behavioural change followed by a cognitive change.

d. A behavioural change alone without a cognitive change.

Any change can always be considered to be in a positive direction. In other words, “the improvement and ‘normalisation’ of the behaviour of a man and the community” may be termed as behavioural change”. (Aujoulat:1969:89). For promoting the
positive behavioural change with reference to health, it is necessary to change the cognition of the community. "Anthropologists have often pointed out the pervasive importance of cultural beliefs, customs, values etc., in determining health behaviour. It is simplistically inter-health behaviour necessarily requires that first the beliefs, values and customs should be changed" (Kochar : 1992 :126).

1. 5. INTER-PERSONAL COMMUNICATION AND HEALTH SEEKING BEHAVIOUR: Communication between the doctor and the patient, the counsellor and the client, the patient and his family members, etc., are some examples of persuasive communication at interpersonal level. In these instances, the change could be in any direction, either desired or undesired, depending on the characteristics or the factors of the communication process. According to Schramm:1954 (quoted by Behende : 1992:98), it is often possible that the communicator encodes the messages according to his own field of experiences. When the fields of experiences differ, there is much distortion of the messages and they do not have the intended effect. For example in the instruction given by a doctor to his patient, the doctor uses technical medical terms while encoding his messages (instructions) and these are decoded by the patients based on their own understanding, experience and knowledge; the result of which is likely to be a distortion of the messages and may not have the effect the doctor had intended to, perhaps suggesting a need for using professional communicators in health programs, as there is an established notion with reference to general health that the
inter-personal communication effected by professionals has better impact than that of the non-professionals. Kochar (1992:119-120)

emphasizes the notion by saying that “health communication at inter-personal level requires far greater skills and understanding, requiring the involvement of professionals” As a matter of fact, the inter-personal communication effected by professional counsellors has been proved to be a very effective technique in case of some of the social deviation profiles like drug abuse, delinquency, etc.
1.6. FAMILY COMMUNICATION AND HEALTH SEEKING BEHAVIOUR:
The un-programmed and informal process of interaction of the family members, that communicates feelings to one another is often termed as family communication. According to Cubbin and Patterson's, ‘Family Adjustment and Adaptation Response Model’, “how a family defines and interprets stressful situations, how family members decide a course of action, how members stabilise meaning and implement solutions, all are constituted by family communication” (Egbert:1987:88). And most of the family theories posit the family communication as the central facilitating dimension between stress and health (Epstuein, Bishop and Baldwin, 1984, Olson, Russel and Prenkle, 1984 quoted by Eggert:1987:80).

1.7. COMMUNICATION IN SOCIAL NETWORKS AND HEALTH SEEKING BEHAVIOUR: Means of communication that operate among groups and communities influence the health seeking behaviour of the community. Berkman (1984:29) informs that “groups or networks have the potential to be either health-promoting or not, and this may influence the health status of individuals”. Kochar (1992:118) argues that “health education that aims at knowledge transfer is often poorly related to health behaviour as a determinant (Quarry:1991). It is common place that change in knowledge occurs without health education. It usually occurs through autonomous endogenous communication process within the communities (Fieldman:1966). Some of these, endogenous indigenous processes of informal communication are far more powerful in spreading information or influencing health
behaviour than are the formal exogenous methods of health education (Rogers: 1973:315) communication Networks”.

1.8. COMMUNICATION AND SOCIAL SUPPORT: Communication of social support gain compelling appeal in treating chronic illness. “Social support refers to verbal and non-verbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception or personal control in one’s life experience” (Albrecht: 1987:19). It has become an important issue with reference to both non infectious diseases like coronary heart disease, stroke, cancer of various sites, mental illness, arthritis and infectious diseases where variations in host susceptibility are of critical etiological significance (Cohen: 1985:4).

1.9. PROBLEM STATEMENT: Health has been one of the areas where the style of communicator, the media, the message (content), and types of communication matter a lot in terms of influencing the patient’s health, prevention of diseases, patients’ compliance and conviction towards the treatment, etc. In view of that, the proposed study attempts to examine the above discussed communication processes and their role in changing the behaviour of the people with reference to leprosy. Before entering into the details of the design of the study it is worthwhile to know the salient features of leprosy as a psycho-social concern.

1.9.1. LEPROSY A GLOBAL PROBLEM: Leprosy is a chronic and stigmatised disease evoking revulsion, disgust and sympathy. It is believed to have been originated in India and spread to other countries. The earliest reference to different types of leprosy was
found in Indian literature. Sushruta Samhita, a treatise on Indian medicine of 600 BC, describes this disease as “Kushta” a Sanskrit word for leprosy. Early references were also found in China and Japan. It is widely prevalent in tropical and sub-tropical regions of the world (Kurup : 1991b:8-9).

It is estimated that there were 5.5 million leprosy cases against 3.1 million registered in the world in 1991 (IJL : 64(4) : 1992) which declined to 828803 cases registered in the World by 1998 (WHO : 1998:6). Table 1.1 to 1.5 present the information on the no. of cases, prevalence rate, present no. of cases on MDT and cumulative no. of cured cases with MDT in each country with more than 100 cases by WHO region. It is significant to note that out of a total of 10,724,229 cases in the world cured with MDT by 1998, 9,052,000 cured cases are from India, and out of 828,803 registered cases in the world during 1998, 518,163 are from India (WHO : 1998 : 11).

1.9.2. LEPROSY A NATIONAL PROBLEM: In 1991 there were nearly 20 lakh registered leprosy patients in India, and about 5-15 percent of them are deformed (Mittal:1992A). Nearly 25 percent of them are of infectious type and the remaining 75 percent of them are of non-infectious type. 15-20 percent of them are child patients. The prevalence of leprosy varies from state to state and region to region within the state. As per the statistics of 1995, states with high prevalence rates are Bihar (P.R. 5.36), Orissa (P.R.5.08), Tamil Nadu (P.R.3.72), Andhra Pradesh (P.R.3.23) etc. Similarly, Lakshdweep (P.R.3.92) and Andaman and Nicobar Islands (P.R. 3.60) are among the union territories having the highest prevalence.
of leprosy (Kurup:1995:12). State-wise situation of leprosy as in 1999 is presented in Table-1.6.

1.9.3. LEPROSY- A SOCIAL PROBLEM: Leprosy is perhaps the most stigmatized of all diseases because of the horrifying morphological deformities it causes to the patient. "The general image of leprosy even today in the common man's mind is that of a deformed and disfigured person who has ulcers, swollen face, shining nodular skin, depressed nose, shortened fingers and toes, without eyebrows and so on. People identify a leprosy beggar in the street exhibiting his disease, as a classical example of vice incarnate" (Mutatkar: 1979:72). There are a lot of misconceptions about its etiology, transmission, treatment and cure. Because of fear, the leprosy patients have been subjected to inhuman treatment and discarded by the society throughout the recorded history whether in Europe, Asia, Africa or the New World (Dols:1983). Such behaviour is strongly associated with the belief that the disease is a divine punishment and that only most heinous sins, such as unspeakable sexual excesses, exploitation of the poor would have earned such a fearful punishment (Brody: 1974; Skinsnes: 1985; Waxler: 1981). In antiquity, people believed to have contracted leprosy were forcibly thrown out of home and family and castigated as a threat to rest of the society (Goldman et al: 1966; Varren: 1989; Richards: 1978). In medieval Europe, accused leprosy victims were executed by burning, crowning, or live burial (Browne: 1975; Dharmendra: 1960).

For fear of stigma and the resultant problems, suspected cases will not disclose their disease to family members, friends, villagers, etc.
or consult any doctor. As a consequence, the disease gets deteriorated manifesting in deformities and disabilities. (the situation of disabilities in high and low endemic districts in India is presented in Table-1.7 & 1.8). Once the deformities set in, the disease will get known to the family and community leading to ostracism, marginalisation, dehabilitation and destitution. The patient suffers loss or change of occupation, denial of participation in the community, marital disharmony, lack of diminished prospects for marriage, etc. In addition to the suffering of the patient, the family also suffers from economic, social and psychological problems. The problems were not limited to patients or their immediate families alone but were also extended to their relatives (Kant: 1984). The acceptance of leprosy patients in the family is generally low (Kurup: 1991) and more so if the patients are deformed and cause social and economic problems to the family (Kopparty: 1993). Sometimes, the leprosy patients are not allowed by the community to use public utilities such as wells (Kant: 1984).

1.9.4. LEPROSY CONTROL IN INDIA: Efforts to control leprosy were made by the philanthropic institutions in earlier times. Prominent among them are Hind Kusht Nivaran Samgh (HKNS), Leprosy Mission, Acworth Leprosy Hospital, German Leprosy Relief Association (GLRA), Damien Foundation, Foona District Leprosy Committee, Bombay Leprosy Project, Gandhi Memorial Leprosy Foundation, etc. The Government of India launched National Leprosy Control Program (NCLP), in 1955, to organize anti-leprosy activities on an all-India level. The primary objective was to control leprosy through mass domiciliary treatment with sulphones. Later, in 1982, it was designated as the National
Leprosy Eradication Program (NLEP) on recommendations of the Swaminathan Committee. A target was fixed to eliminate leprosy as a public health problem by the year 2000 AD.

The NLEP adopted a multi-pronged strategy for controlling the disease by regular and continuous treatment of leprosy patients to arrest active transmission of the disease and thus bring down the prevalence and incidence of the disease. The strategy is mainly based upon:

1. Early detection, particularly of multibacillary (MB) and potentially disabling forms, of leprosy,
2. Prompt and regular treatment with multi drug therapy (MDT) of all cases of leprosy on domiciliary basis,
3. Education of the patients for ensuring regular treatment and prevention of disabilities, and
4. Education of the families and the community to extend their support to leprosy patients for their regular treatment and their social and economic rehabilitation (Mittal: 1992 B).

NLEP is a vertical programme with its own infrastructure and training facilities. At the grassroots level, in high endemic areas (P.R. 5+), there is a leprosy control unit (LCU) for a population of 4-5 lakhs and urban leprosy centres (ULC) covering a population of 30-70 thousand catering to the needs of rural areas and urban centres respectively. The LCU is manned by a medical officer (MO) supported by four non-medical supervisors (NMS), 20 paramedical workers (PMW), one lab technician (LT), one health educator (HE), one Physiotherapist (PT) and other staff while the ULC is manned by a non-medical supervisor functioning along with other supporting staff.
staff, under the supervision of a medical officer in charge of a dispensary or hospital to which it is attached.

In low endemic areas, a different organisational set up is provided. Survey, Education and Treatment (SET) Centres are provided for a population of 25,000 which is attached to a PHC or a dispensary or hospital located in the area. One para-medical worker (PMW) or a non-medical assistant (NMA) is attached to each in-charge of the PHC. A limited number of institutions were developed also with facilities for re-constructive surgery. As per the NLEP position in 1991 there were 719 LCUs, 894 ULCs, 60597 SET Centres, 291 Temporary Hospitalisation Wards, 75 re-constructive surgery units, 244 district leprosy units, 49 leprosy training centres, 39 sample survey cum assessment units and 287 voluntary organisation projects (Mittal: 1991).

1.9.5. NEED FOR BEHAVIOURAL INTERVENTIONS IN LEPROSY CONTROL WORK: So far leprosy has been approached from a biomedical model ignoring the psycho-social and economic aspects altogether. Leprosy needs to be treated as a whole dealing with all the three aspects - medical, public health and socio-economic (Dharmendra: 1985). A hospital cannot fulfill the function of providing medical treatment without giving guidance with regard to social needs of the patients. There is a great need to have a blending of medical as well as social pathology to diagnosis to achieve the maximum benefit for the patient while they are in hospital.

The major problems in leprosy are dehabilitation and rehabilitation. Dehabilitation is a process of destabilisation, dislocation and
displacement of the leprosy patients from socio-economic and cultural anchors such as family, neighbourhood, community, society, peer groups, employment, etc. The process starts with the diagnosis of leprosy. Psychological disturbances such as fear, anxiety, loneliness, guilt, etc., culminate in the hampering of homeostasis (Gokhale:1994). Deformity and disabilities further aggravate the problem. On the other hand, rehabilitation means restoring of handicapped persons to the fullest possible physical, mental, social, vocational and economic usefulness of which they are capable. Both these problems are closely linked to the knowledge of the patient and his family about the disease, attitude, social support and economic resourcefulness of the family.

In order to overcome these problems and to prevent the affected from dehabilitation and to rehabilitate the affected, the patients and their family need to be counselled about the disease, the treatment, problems, and opportunities for rehabilitation so that they develop a right perspective about the disease, treatment and the affected. This would help the patient for treatment compliance leading to early 'release from treatment' (RFT), prevention of deformities and disabilities and to maintain homeostasis.

1.10. LEPROSY CONTROL PROGRAMME AND COMMUNICATION:
Keeping in view the unique nature of the problems, as mentioned earlier, the National Leprosy Eradication Programme (NLEP) had adopted the SET pattern - Survey (S) to identify the cases, Education (E) to educate the patients and the society and also Treatment (T) to the patients. While the basic pattern adopted by the NELP still remains the same (SET), for health communication in
the general health sphere, the NLEP also has been changing its approach from health knowledge transmission to appealing communication. There is an increasing awareness about health communication in leprosy that “the manner in which leprosy workers handle the patients with detachment, non-affection and unsympathetic attitude; and the manner in which workers dispense medicines, or the manner in which they attend to the complaints and problems of the patients is far more important than health education. The behaviour of health personnel creates strong impressions it communicates and educates” (Kochar : 1992 : 131). Thus behavioural aspects along with treatment procedures are emphasised to communicate motivation, social support, knowledge and conviction, etc.

1.11. COMMUNICATION IN NLEP: As such, the whole process of interaction between NLEP staff members and the community is a process of communication. The NLEP staff (Medical Officer/Paramedical worker/Physiotherapist/Health Educator etc.), who perform their tasks are communicators whereas the patient/patient's family member/members of the patient's social network are the receivers of the message. The media used by them depend on the nature of their profession and context.

Apart from the above, in few instances, though not as a part of NLEP, trained professionals like Medical Social Workers and Psychologists, to promote effective inter-personal communication, have been employed as counsellors who communicate knowledge, motivation, social support, in an individualised and personalised
way as per the needs of the receiver and the process of communication has been referred to as 'counselling'.

1.12. COMMUNICATION AND COUNSELLING: The definitions given below may better explain such phenomenon of communication. Here the patient is the receiver and the counsellor is the communicator, who sends messages as per the needs of the receiver. Counselling is a scientific process of assistance extended by an expert in an individual situation to a needy person (Dave: 1984:1). It is a behaviour change strategy involving direct contact with a client. Essentially, it involves an attempt to help the individual marshal his own resources and utilise them to resolve certain difficulties which confront him (Brown: 1973:xii). It is a remedial and an individual focused process.

To merit as a scientific process, such communication needs to fulfil certain requirements. The first criterion is the reliability and validity of data about the individual receiver and his needs and should be ascertained before proceeding to communicate anything. Data about the counselee's (a person receiving counselling) environment is fundamental to the process of counselling. Environment plays an important role in shaping the nature of an individual's needs and the proposed modes of his meeting these needs. Accurate knowledge of the counselee's environment in terms of his socio-cultural and economic background, home environment, is essential for counselling. This would greatly facilitate the communication process between the counsellor (a person providing counselling) and the counselee. It is desirable if both the counsellor and counselee share a common culture environment, the counselling process will be
more effective. In the absence of such an environment, there is every scope for miscommunication and misunderstanding.

The next step is determination of activities and functions to be performed in a scientific manner. Each function or activity needs to be systematically planned in terms of specified goals of counselling, should be objectively conducted according to standard norms of science, and should be pursued with the open minded flexibility of a scientist.

The third step is a continuous evaluation and follow up of functions performed in the programme leading to, if needed, a revision, restructuring or even re-conducting at any stage of the entire process.

Thus, counselling is best understood as a process including assessment and counselling per se. Assessment includes the systematic collection, organisation and interpretation of information about a person and his situation. Counselling is the process in which a professionally trained person and his client relate the materials brought to light by the assessment process to the choices and decisions confronting the client in his formation of goals and life-plan providing a learning and problem solving setting for a client (Tayler:1953).


With reference to communication to patients with chronic illness and their families in general, a variety of work has been published some of which are the following. Some of these studies indicated the desirability of interpersonal communication through counselling for effective treatment compliance and psychosocial adjustment of leprosy patients.

Ramanathan et al (1991) conducted a study on psycho-social aspects of patients undergoing surgical correction in JALMA Institute of leprosy research, Agra and found that pre-operative counselling of the patients would help them develop realistic post-operative expectations and better psychological adjustment.
Mull et al (1989) in their study of culture and compliance among leprosy patients in Pakistan suggested that to make the treatment of leprosy truly effective, it should include counselling of families, education of public at large and enhanced communication with the patients.

Gokhale et al (1994) in their study of social aspects of dehabilitation of leprosy patients suggested to include counselling as one of the key activities in the control programme. This would help patients to overcome stress, anxiety, etc., and to integrate well in the family.

Mutatkar (1979) studied the process of communication between the NLEP workers and the community and its impact on the urban society, in terms of changing the behaviour. He further studied the process of communication by NLEP workers and its impact in changing the behaviour of the people in rural society (1987).

However, it seems there has been no attempt to systematically investigate the role of communication with regard to leprosy control activities considering all the patients taking leprosy treatment.

1.14. THE PRESENT STUDY: The studies of Mutatkar (1979 and 1987) emphasised on the routine activity of the prescribed NLEP staff (PMW/MO/HE/PT etc.) as the communication input and concludes that communication changes the behaviour of the people. However, they did not look into the communication inputs made by the professionals like Medical Social Workers and psychologists.
(often referred to as counsellors), who perform inter-personal communication.

In view of the fact that there are only a few organisations making efforts to promote behavioural changes through professionally effected counselling and there is very little literature on the subject, this present study is proposed to find out the relative advantages of such professional-inter-personal communication in quantitative terms. The study is intended to gauge the impact of communication effected by professional counsellors on an experimental group of leprosy patients and compare it with another similar group not receiving professional counselling. Both the groups are identical and are equally accessible to all other types of communications.

Mutatkar and Tare (1988) felt that the change that occurs is not always because of the communication interventions made by the programme. The extensive change taken place in the last decade in the coverage and impact of MDT programme and the occurrence of high proportion of their self-reported cases cannot be attributed to any health communicating activity performed by the SET workers, nor it can be attributed to any educational intervention targeted to change the beliefs, values and attitudes of the patients and the community. Kochar (1992:118) agrees with the above findings, when he referred to the findings of Quarry (1991) that- health education is poorly related to health behaviour as a determinant, and of Fieldmann (1966) that- change in knowledge occurs without health education, usually through autonomous endogenous communication processes within the community, and that of
Rogers (1973) that informal and endogenous communication processes within the family and community are more powerful than formal exogenous methods of health education.

As there is no literature within our knowledge on family communication and social network communication with special reference to leprosy, it is rewarding to understand the phenomenon and also investigate whether any other indigenous channels that are likely to change the behaviour of the people are in operation. It also helps in appreciating the role of such communication in adopting coping mechanisms at the cultural level. However, to maintain better objectivity of the study, it is proposed to carry out this investigation on the people who don’t receive professional counselling.

In other words, the proposed study tries to understand the impact of interpersonal communication between the professional counsellors and the patient and the patient’s community on the one hand, and their role in changing the behaviour of the people with reference to leprosy, on the other.
1.14. AIMS AND OBJECTIVES OF THE STUDY: The primary objective of the study is to understand the process and impact of communication in bringing about behavioural change among leprosy patients, in a psycho-social counselling centre. This study also attempts to fulfil the subsidiary objectives:

1. To understand the process of inter-personal communication between the patient/the members of the patients’ family/the community and the professional counsellors, in a leprosy counselling clinic.

2. To understand various types of psycho-social problems, the reasons, cause effect pattern of the problems and the communication needs of the patients and the members of patients’ social network.

3. To assess and compare the relative impact of communication in the psycho-social counselling clinic and other sources of information other than formal counselling affecting the behaviour of the patient/patient’s family members/members of the patient’s social new work. The latter is referred to as non-formal communication/ counselling for the purpose of the study. The non-formal communication also includes communication from family members, close friends and relatives.

4. To identify the other societal factors, if any, that play significant role in changing the coping pattern of the leprosy patients.
1.16. HYPOTHESES: It is proposed to test the following hypotheses:

1. Communication changes the behaviour of the leprosy patient, his family members and his social network.

2. Individualised inter-personal communication between the counsellors and the patient/patient’s family/his social network has better (positive) impact than the global impersonal communication used in the National Leprosy Eradication Programme for the control of the disease.

3. Social factors play a significant role in developing adoptive coping mechanisms which provide social support to the families of the leprosy affected.