

Media and Communication Policies in Post-Independence India: (Special Reference to Health Communication)

Mass Media in India

In the advanced western countries, the Communication Revolution had not preceded but followed the industrial Revolution.¹ Western societies had become advanced industrial and urban societies when the communication revolution happened. This revolution was symbolized by the Radio and Television and other new ways of “passing ideas, information, attitudes, images from person to person”²

The importance of the role of communication for national development was underscored in India even prior to her independence. The Indian National Congress while formulating policies for National Development for Independent India set up a Sub-committee on Communication under the National Planning Committee to offer recommendations for development of communication for independent India. After independence of the country in 1947, the new Indian government announced a development-oriented agenda of governance dedicated to the amelioration of the economic, educational, and health conditions of the people. With the target of Development Communication, the new government adopted the recommendations of the erstwhile National Planning Committee as the mainstay of its communication policies. “The issue of using modern communication acquired high priority as a developmental resource during the Nehru era when the planners explored the prospects of using *radio* as a development agent, that is, for information and enlightening the people in the countryside and towns on developmental issue”³

Nehru was hesitant of introducing television in India as he was apprehensive that it will be monopolized by the middle class rather than be of use for the development of the masses. Nehru believed that a poor country like India could ill afford the *extravagance* of television.

But post Nehruvian era, the thrust began to change, visionary scientists like Vikram Sarabhai argued that India needs all possible technological know-how to educe all round development. Sarabhai famously said: “Our national goals involve leap-frogging from a state of

¹ P.C. Joshi, 2004. Pg xxiv

² Raymond Williams, 1966

³ Ibid.

economic backwardness and social disabilities attempting to achieve in a few decades a change which was incidentally taken centuries in other countries and in other lands. This involves innovation at all levels.”⁴

Sarabhai argued on this premise that *television* be given special priority for accelerating national development. He believed that technology can help set a national agenda for “implementing schemes of economic and social development.....it is of particular significance for population living in isolated rural countries”⁵

Indira Gandhi, the then Prime Minister of India was supportive of Sarabhai’s ideas and it culminated in the launching of the momentous Satellite Instructional Television Experiment in 1975-76 from the Space Application Centre located at Ahmedabad. It started beaming development oriented programmes to 2400 Indian Villages, the software were designed according to the socio cultural specificities of the areas concerned. It was a path breaking experiment in the field of development communication not only in India but also for the whole world. Till then Radio and television was considered an instrument of entertainment for the elite. And this was a new effort in utilizing both the media for Development Support Communication. These experiments were revolutionary in character as “market forces would never have taken TV sets to many of these villages and most certainly not to the houses of the poor and the marginalised--- the most information needy. This means was high technology (a direct broadcast satellite and a direct reception system) and the configuration was need-based.”⁶ Accepting that the western world used the new technology and innovation to spread consumer culture, Nehru urged upon the scientists and the technologists to bend the same technology to achieve the Gandhian task of “ending of poverty and ignorance and disease and inequality of opportunity.” During the days of Indira Gandhi the infrastructure for television communication received a major boost. Between the years 1984-85 over 120 television transmitters were installed in India.

But as is a typical Indian trait, the SITE experiment in the Kheda district died a silent death with Sarabhai. “The Kheda Project itself was wound up under tremendous pressure of the new rural middle class which was carried away by the glitter and glamour of the new television software...”⁷

⁴ Vikram Sarabhai and Kamla Chaudhury, 1974

⁵ *ibid*

⁶ Kiran Karnik, 1987 pg 88.

⁷ *Ibid* P. C. Joshi pg, xxviii

With the impending globalization of the media the question of ownership pattern and issues became a very important topic of deliberation. In fact this issue was much thought about even during the days of Nehru. Nehru showed an unambiguous indication of predilection towards the BBC style of autonomy. On a speech delivered on “freedom of information” on March 5, 1962 Nehru said “The mass media which are very useful have an element of danger in them in that they may be distorted for private aim. The rich group (inside) or the rich nation (outside) can flood the country and the world through the mass media with its own view of things which may or may not be correct view.” These words had turned out to be ominously true in the present world.

Because after India adopted neo-liberal economic policies in early 1990s, the communication policies underwent a drastic change. The state-controlled media agencies, viz., All India Radio and Doordarshan (national television network), till then dedicated more to the objective of public welfare, were asked to generate their own revenue. Both Radio and Television were laid open to private players. TRP and RAM started dictating the terms of popularity and hence advertisement revenue. Television was the major victim of this market-oriented media policy. Slowly, the villages started disappearing from the visual media. So did the issues inflicting the marginalized rural population. Whatever rural flavour was left in Radio was the run of the mill, very stale and unimaginative. However, it is not that urban India was realistically represented; it was more of a conjecture with no specific geographical root.

Role of the state controlled Media in Health Communication:

All India Radio had been the forerunner in the process of implementing Communication strategy being adopted by the government. The Radio Rural Forum experiment was conducted by the All India Radio at Poona during 1956. The project covered 156 villages where listening and discussion groups were organized in each of the selected villages. A programme of thirty minutes duration was broadcast on two days in a week covering agriculture and allied subjects to help promote rural development. Prof. Paul Neurath on behalf of the Tata Institute of Social Sciences conducted an evaluation study, and came out with interesting results: (1) The radio is very suitable medium to communicate with rural audience and to spread the message of development. (2) A majority of the listeners appreciated the value of the messages.

The Farm and Home units were subsequently established at many AIR stations to provide wider support to the Integrated Agriculture Development Programme (IADP). The contribution of the radio is widely acknowledged by farm scientists in increasing agriculture production and achieving a green revolution. Similar attempt was taken in respect of the Family Welfare programme. Till date All India Radio has its Family welfare programmes broadcast everyday focusing on the various government schemes.

The government controlled media has been more or less toeing a centralized form of communication. AIR (All India Radio) during its initial days formulated its communication policies in Delhi and got it translated to the various languages for dissemination. The irony was that it never even looked at the regional variations of the problems. To cite an example, every year, the government observes the first week of August as “Breast Feeding week” to emphasise on the importance of Breast Feeding for the new born as well as the lactating mother. The government media goes overboard with the campaign. Whereas, in India the people of the North-eastern part needs no campaign as all mothers breast feed their babies instinctively. Hence spending so much of valuable transmission time on such campaigns for these areas could never elicit any result. However no such knowledge level is decipherable in the annual orders that are sent to all the AIR stations about such campaigns. The state controlled television, Doordarshan, which has a very wide coverage area too has its programmes designed for health and family welfare too suffer from the same affliction.

The most tragic development is that, such a huge public service broadcasting infrastructure right now is almost redundant and non- functional. “The ministries of the central and state governments engaged in nation building and development tasks seem to create neither any communication apparatus within their own ministries nor do they make demands on the Ministry of Information and Broadcasting (MIB) for information and communication support adequate to the needs of policy formulation or implementation. The MIB is far from playing the role of a true *communicating link* within the government and between the government and the people in nation-building activities”⁸

Health Communication Policies in India Vis-A-Vis the International Perspective

⁸ Ibid P. C. Joshi pg 26

Soon after the Second World War, health came to be regarded as one of the most important indicators of development. It was clearly spelt out in the *Universal Declaration of Human Rights*, 1948, adopted and proclaimed by the UN General Assembly in *Article 25* wherein it was clearly stated thus:

(1) Health is both a public and merit good. Public health, sanitation, and the eradication of communicable diseases have to be provided by a collective basis that is as items of collective consumption, since they can not be feasibly supplied or consumed, or paid for at an individual level. They will not be provided at all if left to the market mechanism;

(2) Secondly, health care being so basic to the well-being and productivity of society, access to it needs to be universal. It cannot be constrained by affordability, and cannot, therefore, be left to the market. This is the sense in which primary health care, like primary education, qualifies as merit good for the provision of which the state has to bear a special responsibility. .⁹

India after attaining independence resorted to Five years planning for development, which aimed at both long term and short term planning. The first five year plan (1952-1957) brought in this realization to the policy makers that the geometrically progressing population growth was the real culprit behind the failure of the plans. In the case of Health communication, the threat of the ever bulging population was the first issue that was addressed by the media experts. In fact, India was the first country in the world to announce an official Family Planning Programme.

During the inter plan period of 1966-1969, Family Planning department carved out a unit in the form of Mass Education and Media Unit in 1966 and the first tirade against population growth was launched. "Simultaneously, the media units of Information and Broadcasting Ministry were strengthened for Family Planning communication. The objective was to evolve a differential communication strategy. Simple messages with simple pictures were selected for wider dissemination and through media which were easily visible and audible"¹⁰.

The scheme started with the concept of a small family and the raging slogan was, *Hum do Hamare do* (Literally translated, 'we two and our two'). The symbol propagated was that of the

⁹ Akhil Ranjan Dutta in Neo-Liberal State And Human Security A Study On Health Security, Unpublished Ph.D thesis, Gauhati University.

¹⁰ Information education Communication, Department of Family Welfare. http://www.mohwf.nic.in/dofw_website/.../iec.htm

red inverted triangle. This triangle was conceived during the Fourth Five year plan and a national campaign launched. Similarly, social messages such as ‘Small family is a happy family’, ‘*Agla bachcha abhi nahin, do ke bad kabhi nahin*’ (The next child not now after the second never ever) and ‘*Beti ho ya beta, do ya teen hi achche*’ (A Girl or a boy two or three are enough), became very popular among the people in the country. No doubt these messages have been successful in sensitising the people, but their impact is comparatively not had been envisaged primarily because the benefits in built in these messages were intangible and could only be realized at a later stage of time unlike the commercial messages promoting commodities. Not much was achieved and the population still continued to grow alarmingly.

Review conducted in 1973 proved that the problem did not lie only in the mind set of the population; rather it was much deeper than that. The child mortality rate (CMR) at that time was quite high as was the mother’s mortality rate (MMR). According to World Bank data, India stood in the following perspective as far as CMR of under- 5 children are concerned:

In 1960 it was 234 per thousand

In 1970 it was 190 per thousand

And in 1975 it was 172 per thousand.¹¹

Whatever development was perceived was not only almost negligible but also was symptomatic of the hurdles persisting in the national Family Planning programme. The people who were questioned about why they did not go for a small family replied that they needed more hands to bring in money for the family and also said that as there was no surety of a child living beyond the 5th year, they could not take the risk of limiting their family to only two children. There were other issues like the preference for the male child and more number of children meaning more hands as labour, which also determined the big family size. Fortunately it also deemed on the policy makers at that time that the Communication policies need to be designed according to the socio-economic and geographical specificities of the area. Ironically however it is yet to be translated into reality.

“During the Fifth Five year Plan, the Government of India executed an agreement with the Advertising Agency Association of India to design a communication strategy for the states of Uttar Pradesh, Andhra Pradesh and West Bengal and this agreement is still considered a landmark in evolving communication strategies in Family Planning programme. The objectives

¹¹ World Bank, World Development indicators. <http://www.google.com/publicdata?ds...>

of the strategy were to provide appropriate knowledge about methods of contraception, allay fears among the people, provide accurate information as to where one can have family planning services, and finally stimulate inter-personal contacts”¹².

However, despite the huge amount of investment and repeated persuasion, and during the time of the infamous internal emergency (1975-77) even an amount of coercion, failed to yield the expected result. Rather than empowering the people to take informed decision, family planning became more of propaganda. After this lapse was recognised it was felt that, the Family Planning Programme needs to be more inclusive and participatory. It was acknowledged that only an overall welfare of the population can lead to population control. It was realised that the information gap would not be possible to be bridged by mass media alone. So emphasis was laid on direct communication. It also became obvious that media access was directly proportionate to economic condition of the population in question.

Taking all these into consideration, in the 6th five year plan (1980-85) the Population Control Programme was rechristened as Family Welfare Programme. It widened its scope from mere population control and vasectomy to embrace issues like Maternal Mortality Rate (MMR) and Child health. It was also emphasized that the decision of family planning should be a spontaneous and informed decision taken by the parents. The communication planning was undertaken so as to incorporate Information and Education in the process.

In the meantime, India launched its coloured television in the 1980s. It resulted in a paradigmatic change in the whole communication process. Communication experts, Media Professionals and Practitioners started focusing towards this new attractive medium. Mexico had already successfully broadcast a tele-serial promoting family planning, the success of this programme inspired India to broadcast *Hum log* (‘we people’) from 1985-85 addressing issues like gender inequality, health, alcoholism and family planning¹³. “Most *Hum log* viewers reported learning positive attitudes and behaviour about an equal status for women, national integration, health and smaller family-size norms”¹⁴

In the meantime the Alma Ata declaration of 1978 came as reiteration of the international pledge of better health condition. It stated that: “Governments have a special responsibility for the health of their people which can be fulfilled only by the provision of adequate health and

¹² Ibid. mohfw/nic/dofw website/.../iec.htm

¹³ Singhal, A., & Rogers, E. M. (1989). pg.331-350.

¹⁴ Everett M. Rogers & Arvind Singhal, (1990). pg 176-181.

social measures. A main social target of Governments, International Organizations and the whole world community should be the attainment by all people's of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." The conference went so far as to address the economic and political steps needed to fund the initiative:

*An acceptable level of health for all people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.*¹⁵

"This declaration formally adopted primary health care (PHC) as the means for providing a comprehensive, universal, equitable and affordable healthcare service for all countries... The emphasis changed from the larger hospital to that of community-based delivery of services with a balance of cost-effective preventive and curative programs. The approach was intersectoral, involving agriculture extension officers, schoolteachers, women's groups. Youth groups and ministers of religions etc"¹⁶

In fact almost all the nations in the world accepted the declaration of the Alma-Ata and pledged themselves to achieving health for all by 2000 including India. India formulated its National Health Policy 1983 keeping the following objectives as target:

"India is committed to attaining the goal of "Health for All by the Year 2000 A.D." through the universal provision of comprehensive primary health care services. The attainment of this goal requires a thorough overhaul of the existing approaches to the education and training of medical and health personnel and the re organisation of the health services infrastructure.

The National Health policy 1983 re-emphasised IEC as the core communication strategy. The Ministry of Health & Family Welfare realized that IEC needs to be used for improvement of Health care facilities and as well as creating a positive notion about the health care providers.

¹⁵ Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Available at http://www.euro.who.int/AboutWHO/Policy/20010827_1.

¹⁶ John J Hall and Richard Taylor 2003, pg 178 (1): 17-20

The necessity to create a sustainable demand for health care was recognised as the elementary responsibility of IEC. In brief, IEC was given a special focus in the document.

The 1980s saw a new international stance which became very obvious through the diktat of the World Bank. This developed country regulated bank put up the following agenda for the states to be followed:

- (1) Cuts in public spending in the health services including tertiary level medical care and shifts to strengthen population control;*
- (2) Shifting curative care to the private sectors;*
- (3) Introducing cost-recovery mechanisms in public hospitals;*
- (4) Defining “essential” clinical and public health packages;*
- (5) Tackling poverty through structural adjustment policies, education and women empowerment.¹⁷*

“Changes in political and economic philosophy in the late 1980s and 1990s marked a major change in how government services were delivered throughout the world. These reforms had their roots in the economic reforms of North America and Europe. Emphasis was placed on reducing government involvement in all aspects of society. Market forces became the dominant model for service delivery”¹⁸

This target of Entertainment- Education received the same attention in the seventh five year plan (1985-1989). A lot of academic material was generated on the importance of Entertainment Education strategy. At that time it was believed that “the mixture of Entertainment and educational message content can serve to attract large audiences to the media and thus earn high profits from advertising and/or sales.”¹⁹

Critiquing the IEC process of the Sixth Five year plan, the Seventh Five year plan laid down clearly the objective of IEC in the following words:

“Progress made so far in the promotion of health education is far from satisfactory. Schemes to strengthen health education bureaus, training of medical and paramedical personnel in health education etc., would continue to be implemented with added emphasis. Efforts in the Seventh Plan would be basically directed to develop and strengthen health education as an essential component of health services in the country. This will be supported by adequate budgetary provision. Measures would be initiated to actively involve social and preventive

¹⁷ Imrana Qadeer (1999) pg 55

¹⁸ ibid John J Hall and Richard Taylor.

¹⁹ Ibid Singhal, A., & Rogers, E. M. (1989) (pp.331-350)

*medicine as well as community medicine departments of the medical colleges, to strengthen health education training programmes for medical teachers, para-medical personnel etc. Organization of School Health Education activities as an integral part of formal and non-formal education would need to be developed through appropriate measures.”*²⁰

In the planning process of the Eight Five year plan (1990-1995), an analysis of the functioning of IEC in the Seventh Five year plan was done, and it was felt that the performance of IEC was not as effective as it had been expected and lot of gap remained in the process. It was also observed that the content of the programmes were far removed from the geographical reality. And it was also felt that, there remained a yawning gap between target group and the policy implementing personnels. The 8th Five year plan document stated:

“Due to inadequacy of Information, Education and Communication (IEC) activities the knowledge of the community about the contraceptives, their availability, safety, etc. are at a low level. Adoption of the small family norm and use of appropriate measures for birth control are matters of personal choice and decision. The IEC activities have to take this into account. However, till recently, the IEC activities have been directed more towards national issues rather than personal issues. Undoubtedly, this incongruity of perception between the people and the providers of services has cost the programme dearly. The document further added “Containment of population growth is not merely a function of couple protection or contraception but is directly correlated with female literacy, age at marriage of the girls, status of women in the community, IMR, quality and outreach of health and family planning services and other socio-economic parameters.”

And that

*“The Information, Education and Communication (IEC) activities within each programme would be given special attention for enlisting community participation, which constitutes one of the weakest links, for carrying out the disease control programmes.”*²¹

Realising the importance of Information Education Communication (IEC), The Ministry of Health and Family Welfare in collaboration with USAID (United States Agency for International Development) and ORG (Operational Research Group) and assistance from John Hopkins University Population Communication Services (JHU/PCS), developed a detailed

²⁰ www.planningcommission.gov.in

²¹ *ibid*

report. The Health Communication strategy that was charted in the report laid stress on the generation of sustainable demand for holistic health for the family. In concurrence with the document it was decided to formulate the IEC strategy with the help of field study, direct and indirect data etc. For this purpose, the states of Uttar Pradesh, Rajasthan, Madhya Pradesh, Bihar, Gujarat, Andhra Pradesh and West Bengal was selected. Extensive study went into the formulation of IEC strategy. But somehow the report seems to have been relegated to the cold storage and never consulted at all, because the IEC strategies which were formulated in health communication even after that bore no sign of such introspections.

The World Development Report, 1993, titled *Investing in Health* was crucial in the perspective of the new economic order which was imminent regard. The Report replaced the term 'primary health care' by 'essential and clinical services,' omitted communicable diseases from the category of essential public health activities and outlined the treatment of diabetes, cardio-vascular diseases, cataract, schizophrenia etc. as priorities for the government. Critics have pointed out these as attempts to cater health care to an exclusive class.²² Interestingly countries like India followed these in total, in the form of budget cuts, a new drug policy with decontrols and privatization of medical care etc. This World Bank approach came to be known as Health Sector reforms. It has been criticized as being driven by economic and political ideology.²³

The International Conference on Population and Development held in Cairo in 1994 took a different look at the issue of population explosion. It was realised that the road to population control lies through better Reproductive Child Health and elimination of gender discrimination. The IEC focus changed with this, and in India, United Nations Population Fund Agency (UNFPA) offered help to formulate the strategy. UNFPA had realised at the outset that for the target to be achieved, a whole new approach for IEC, based on various other indicators, like people's concept of development, traditional views on population growth, gender sensitivity of the people, and opinion of the people regarding the concept of family welfare needs to be studied. With the help of Mode Research UNFPA did an extensive study in the states of Tamilnadu, West Bengal, Rajasthan and Madhya Pradesh. The outcome of that study resulted in the formulation of a new policy and was implemented nationwide. Financial aid too came to the

²² ibid Akhil Ranjan Dutta ch 1

²³ Werner D. 2001; 31 (Jan): 22-23

government from various international agencies for implementation of the scheme. This was called RCH (Reproductive Child Health) scheme which came as the challenge for the IEC campaign. “In order to effectively improve the health status of women and children and fulfil the unmet need for Family Welfare services in the country, especially the poor and under served by reducing infant child and maternal mortality and morbidity, Government of India during 1997-98 launched the RCH Programme for implementation during the 9th plan period by integrating Child Survival and Safe Motherhood (CSSM) Programme with other reproductive and child health (RCH) services.”²⁴

RCH was an amalgamation of various schemes with a long term thrust on quality improvement of the general population. Issues like, prevention of unwanted pregnancy, universalisation of immunisation, questions related to safe abortion, importance of safe motherhood, prevention of sexually transmitted infections, decreasing Child Mortality Rate (CMR), positive change in the views regarding good health and gender, etc., gained immense importance in the IEC of RCH.

The entire thrust of Health Communication strategy emanating from the deliberation was based on the three premises: i) Stratification of the population on the basis of qualitative and geographical characteristics and then attempting to elicit behavioural change by devising special schemes of IEC. ii) Information dissemination will be necessity driven. iii) Use of media to be decided after studying the media consumption pattern of the people to be communicated. It was further decided that the planning of all schemes will be done in the district level and implementation in the village or local level. Central government would only help in the facilitation of the scheme. This obviously needed a more region specific IEC policy. But interestingly again these were never reflected in the reality. And ironically the IEC component was given to the functionaries of *Total Literacy Mission* (a literacy drive meant to ensure total literacy, which was a very strong movement initially but fizzled down due to various reasons). The official website of Department of Health and Family Welfare offers the explanation thus: “An important initiative of the new IEC strategy is to decentralised IEC efforts to the level of district, so that every district is able to plan and implement local specific IEC keeping in view the cultural, ethnic, linguistic requirements. IEC through Zila Shaksharta Samitis (part of the National Literacy Mission) are new thrust areas aimed at for integrating education with Family

²⁴ <http://www.mohfw.nic.in/dofw%20website/Child%20healthrti.pdf>

Welfare by utilizing the already existing network. Under the ZSS scheme, the concerned districts are to plan and implement their IEC plans, with a thrust on the folk media, design and display of posters, wall writing and paintings and specific cultural medium in their respective areas.”

However it never helped, in fact it acted as a deterrent to the smooth take off of the IEC drive. It also became quite a herculean task to coordinate between the government departments of Health and Education and it is easily imaginable knowing their reputation.

The end result was that, no new innovation was visible in the IEC activities. The familiar usage of All India Radio and Doordarshan was visible, the all too repeated usage of poster, banners, and meetings were rampant.

The National Health Policy 2002 was formulated with the following objectives to be achieved by the year 2015:

NHP-1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had hoped to provide ‘Health for All by the year 2000 AD’, through the universal provision of comprehensive primary health care services. In retrospect, it is observed that the financial resources and public health administrative capacity which it was possible to marshal, was far short of that necessary to achieve such an ambitious and holistic goal. Against this backdrop, it is felt that it would be appropriate to pitch NHP-2002 at a level consistent with our realistic expectations about financial resources, and about the likely increase in Public Health administrative capacity. The recommendations of NHP-2002 will, therefore, attempt to maximize the broad-based availability of health services to the citizenry of the country on the basis of realistic considerations of capacity. The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which it is now necessary to review the field, and to formulate a new policy framework as the National Health Policy-2002. NHP- 2002 will attempt to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country²⁵

Reiterating the importance of IEC the document commented:

A substantial component of primary health care consists of initiatives for disseminating to the citizenry, public health-related information. IEC initiatives are adopted not only for disseminating curative guidelines (for the TB, Malaria, Leprosy, Cataract

²⁵ <http://mohfw.nic.in/np2002.htm> pg 5.

Blindness Programmes), but also as part of the effort to bring about a behavioural change to prevent HIV/AIDS and other life-style diseases. Public health programmes, particularly, need high visibility at the decentralized level in order to have an impact. This task is difficult as 35 percent of our country's population is illiterate. The present IEC strategy is too fragmented, relies too heavily on the mass media and does not address the needs of this segment of the population. It is often felt that the effectiveness of IEC programmes is difficult to judge; and consequently it is often asserted that accountability, in regard to the productive use of such funds, is doubtful. The Policy, while projecting an IEC strategy, will fully address the inherent problems encountered in any IEC programme designed for improving awareness and bringing about a behavioural change in the general population.²⁶

The NHP 2002 planned IEC in the following manner:

NHP-2002 envisages an IEC policy, which maximizes the dissemination of information to those population groups which cannot be effectively approached by using only the mass media. The focus would therefore be on the inter-personal communication of information and on folk and other traditional media to bring about behavioural change. The IEC programme would set specific targets for the association of PRIs/NGOs/Trusts in such activities. In several public health programmes, where behavioural change is an essential component, the success of the initiatives is crucially dependent on dispelling myths and misconceptions pertaining to religious and ethical issues. The community leaders, particularly religious leaders, are effective in imparting knowledge which facilitates such behavioural change. The programme will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmes on the targeted groups. The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups, who do not normally benefit from the more common media forms.²⁷

It is clear from the above statement that in spite of realising the necessity of IEC for information dissemination it was also accepted that too much of dependence on Mass communication eliminates a sizable number of target audience. However not much new initiatives were visible in practice.

²⁶ Ibid pg12

²⁷ Ibid pg 27-28

The second phase of RCH program i.e. RCH – II was launched from 1st April, 2005 the five year file 2010. *“The main objective of the program was to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realizing the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India”*²⁸. When RCH-II was launched, IEC was rechristened as Behavioural Change Communication. It was decided in October 2000 that in those states where the scheme was being carried out through external financial assistance, 10 districts would be selected in each of those states and the first phase of community mobilisation would be launched in those districts. European Commission also pledged some support in the process. But nothing really came out of it. The same run of the mill communication strategies were used and implemented.

In the process of the mid term review of after the ICPD declaration by UNFPA held in Bangladesh along with the civil society a critical evaluation of IEC was done and was felt:

Governments and civil society should strengthen and intensify their social and resource mobilization efforts as well as formulate IEC and advocacy strategies which are bolder and more innovative, based on socio cultural and economic research, and designed to reach specific audiences within a broader spectrum of civil society. The following actions would advance this process:

- *Communicate directly and clearly.*
- *Use media more effectively.*
- *Develop new strategic alliances.*
- *Engage ICPD critics and adversaries.*
- *Address controversial topics and cultural taboos.*
- *Mobilize resources.*²⁹

As stated above, India took the path of neo-liberal economic reforms in the 1991. Governments changed but the road to reform was pushed in the same way. “Although the BJP led National Democratic Alliance (NDA) government enacted the National Health Policy (2002)

²⁸ <http://mohfw.nic.in/index.htm>

²⁹ (Report on the Round table meeting on “Partnership with Civil Society to Implement the Programme of Action, International Conference on Population and Development” held in Dhaka Bangladesh from 27-30 July 2008 held by the technical division of UNFPA pg xii)

and promised to increase allocation of public fund in health care sector, the promise did not materialize³⁰.

In September 2000, 189 heads of state adopted the UN Millennium Declaration and endorsed a framework for development. The plan was for countries and development partners to work together to increase access to the resources needed to reduce poverty and hunger, and tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.³¹

MDG lays down a time framework (i.e. within 2015) for the achievement of those goals, which are crucial for vital/basic security of every human being. MDG basically focuses on eight important goals.³²

- (1) Eradicate extreme poverty and hunger;
- (2) Achieve universal primary education;
- (3) Promote gender equality and empower women;
- (4) Reduce child mortality;
- (5) Improve maternal health;
- (6) Combat HIV/AIDS, malaria and other diseases;
- (7) Ensure environmental sustainability;
- (8) Develop global partnership for development.

In India in the year 2000, the National Population Policy was formulated which the following as its target:

*The **immediate objective** of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The **medium-term objective** is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The **long-term objective** is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.*³³

Reiterating the importance of the role of IEC in all schemes, it stated:

³⁰ ibid Akhil Ranjan Dutta ch 1

³¹ *Millennium Development Goals: A Compact Among Nations to End Human Poverty* (2003), UNDP Human Development Report, p 1.

³² Ibid pp 1-3

³³ National Population policy document. Pg 4

*Information, education and communication (IEC) of family welfare messages must be clear, focused and disseminated everywhere, including the remote corners of the country, and in local dialects. This will ensure that the messages are effectively conveyed. These needs to be strengthened and their outreach widened, with locally relevant, and locally comprehensible media and messages. On the model of the total literacy campaigns which have successfully mobilised local populations, there is need to undertake a massive national campaign on population related issues, via artists, popular film stars, doctors, vaidyas, hakims, nurses, local midwives, women's organizations, and youth organizations.*³⁴

The document drafted an elaborate plan to evolve the IEC process thus:

1. Converge IEC efforts across the social sectors. The two sectors of Family Welfare and Education have coordinated a mutually supportive IEC strategy. The Zila Saksharta Samitis design and deliver joint IEC campaigns in the local idiom, promoting the cause of literacy as well as family welfare. Optimal use of folk media has served to successfully mobilize local populations. The state of Tamil Nadu made exemplary use of the IEC strategy by spreading the message through every possible media, including public transport, on mile stones on national high ways as well as through advertisement and hoardings on roadsides, along city/rural roads, on billboards, and through processions, films, school dramas, public meetings, local theatre and folk songs.

2. Involve departments of rural development, social welfare, transport, cooperatives, education with special reference to schools, to improve clarity and focus of the IEC effort, and to extend coverage and outreach. Health and population education must be inculcated from the schoollevels.

3. Fund the nagar palikas, panchayats, NGOs and community organizations for interactive and participatory IEC activities.

4. Demonstration of support by elected leaders, opinion makers, and religious leaders with close involvement in the reproductive and child health programme greatly influences the behavior and response patterns of individuals and communities. This serves to enthuse communities to be attentive towards the quality and coverage of maternal and child health services, including referral care. Public leaders and film stars could spread widely the messages of the small family norm, female literacy, delayed marriages for women, fewer babies, healthier

³⁴ Ibid pg 13

babies, child immunization and so on. The involvement and enthusiastic participation of elected leaders will ensure dedicated involvement of administrators at district and sub-district levels. Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional, and religious leaders, media and film stars, sports personalities and opinion makers, will enhance its acceptance throughout society.

5. Utilise radio and television as the most powerful media for disseminating relevant sociodemographic messages. Government could explore the feasibility of appropriate regulations, and even legislation, if necessary, to mandate the broadcast of social messages during prime time.

6. Utilise dairy cooperatives, the public distribution systems, other established networks like the LIC at district and sub-district levels for IEC and for distribution of contraceptives and basic medicines to target infant/childhood diarrhoeas, anaemia and malnutrition among adolescent girls and pregnant mothers. This will widen outreach and coverage.

7. Sensitise the field level functionaries across diverse sectors (education, rural development, forest and environment, women and child development, drinking water mission, cooperatives) to the strategies, goals and objectives of the population stabilisation programmes.

8. Involve civil society for disseminating information, counseling and spreading education about the small family norm, the need for fewer but healthier babies, higher female literacy and later marriages for women. Civil society could also be of assistance in monitoring the availability of contraceptives, vaccines and drugs in rural areas and in urban slums.³⁵

In the midst of all these, the Central government in 2005 launched the ambitious National Rural Health Mission. In this process, the Mission planned to achieve goals set under the National Health Policy and the Millennium Development Goals. The mission document clearly states:

- *Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Budgetary allocation for health is 1.3% while the State's Budgetary allocation is 5.5%.*
- *Union Government contribution to public health expenditure is 15% while States contribution about 85%*

³⁵ Ibid pg 30-31

- *Vertical Health and Family Welfare Programmes have limited synergisation at operational levels.*
- *Lack of community ownership of public health programmes impacts levels of efficiency, accountability and effectiveness.*
- *Lack of integration of sanitation, hygiene, nutrition and drinking water issues.*
- *There are striking regional inequalities.*
- *Population Stabilization is still a challenge, especially in States with weak demographic indicators.*³⁶

The Mission in its document also ambitiously states “*The Mission is an articulation of the commitment of the Government to rise public spending on Health from 0.9% of GDP to 2-3% of GDP.*” However the reality belies the promise. If we look at the last union budget, we see ‘*the public health expenditure accounts for less than 1% of the gross domestic product (GDP) in contrast to private health expenditure of over 5% of the GDP*’³⁷

However the focus on IEC/BCC has apparently changed, it has become a more integrated approach rather than standing out as a component only and is now focusing more on interpersonal communication in the form the village level health activist called ASHA (Accredited Social Health Activist). She is supposed to be the guiding force behind the implementation of all the health schemes:

*ASHAs would also provide immediate and easy access for the rural population to essential health supplies like ORS, contraceptives, a set of ten basic drugs and she would have a health communication kit and other IEC materials developed for villages.*³⁸

However IEC activities were supposed to continue the way it had been except that it would be continued in a more “decentralized model”³⁹ Even fund allocation for IEC had been planned in a decentralized model:

*Allocations (will be) at national, state and district levels. Up to Rupees ten per capita which should be equally spent at the three levels (1/3, 1/3, 1/3).*⁴⁰

Interestingly a good amount of budget allocation is kept for the IEC/BCC component under the mission. For example we can look at the budget allocation for IEC for the state of

³⁶ NRHM Mission Document. www.mohfw.nic.in

³⁷ Ravi Duggal, August 15, 2009

³⁸ NRHM Framework. www.mohfw.nic.in

³⁹ Ibid.

⁴⁰ Ibid.

Assam. In the budget of 2007-08 had 2074.88 lakhs earmarked for IEC and for the year 2008-09 27 crores was proposed⁴¹. Similarly every state budget has an impressionable amount allocated for the IEC activities.

This had resulted in a huge communication industry striving emphatically in the country now. But the end result of really achieving the target of health education seems to be still quite far. In fact most of the time such communication seems more of a routine exercise rather than targeted. For example, a television advertisement set in the north Indian state is literally dubbed in a horrible way and broadcast in an eastern India state.

In the meantime MDG had reached halfway in 2008. An independent study for the appraisal of the achievement of MDGs in India states:

*“The Health MDGs are very narrow, focusing only on maternal and child health, contraception and selective disease surveillance. Their monitoring indicators are largely demographic. And what is intriguing is the fact that these are precisely the goals of India’s primary health programme, especially for rural areas. So the focus on MDGs is old hat for India’s health policy makers and planners. Thus for the Ministries of Health in India the MDGs are godsend as they coincide with their 2002 National Health Policy (NHP) of limiting the State’s role in healthcare, providing them an opportunity to debunk the goals of the 1982 NHP of comprehensive universal primary healthcare. This is very clear evidence that India follows the global agenda set in Washington or Geneva; post 1978/1979, that is HFA and ICESCR, India adopted a NHP which emphasised comprehensive universal primary healthcare and post 2000 MDGs, India adopts a NHP that follows the diluted agenda of MDGs”*⁴²

Conclusion

Health has become an industry now. It is catering to the ever bulging upwardly mobile Indian middle class than to the deprived section. Communication also relates to that market and has very limited knowledge to offer to the needy. The so called effort of the government media towards communication is riddled with stale communication whereas in the private media it is targeted towards the potential consumers.

In 1990 India invested 1.3 percent of its GDP in health. It was reduced to 0.9 percent in 2002. Besides, the new thrust area within health (family planning or non-communicable diseases

⁴¹ http://www.mohfw.nic.in/NRHM/NPCC_Presentation/Assam_NPCC_08_09.pps

⁴² *SECURING RIGHTS Citizens’ Report on MDGs*, an independent study by a group of citizen and organization.

etc.) at the cost of more dangerous and common diseases like T.B., malaria etc, have made the health care scenario more vulnerable. On the other, with the implementation of new drug/pharmaceutical policies (1985, 1994 & 2002) as well as with the enactment of new Patent Bill (2005) and its amendment in 2005, the government control of prices over the drugs once declared as essential has been withdrawn. The result has been constant price hike of drugs and the alarming increase in out of pocket expenditure on health care. The selective nature of the media regarding the diseases to be communicated about is also an outcome of the government communication policies. In a country where MMR, Malaria, Encephalitis, Malnutrition even diarrhoea kills so many thousands of people every year, the focus remains ironically only on HIV/AIDS or Swine Flu. Media goes all out to carry horror stories on these issues rather than make concerted effort on building consensus on the other diseases.⁴³

India has now left with the last two years of its NRHM project. With the target of achieving the MDGs too larking large, it would be worthwhile to assess the progress made at the end of the project. IEC had been a real guzzler of money as well as media space till now. It will remain so for the time to come. But IEC for the sake of IEC remains a threat to the achievement of the desired outcome. It really needs a through rethinking and redesigning at the local level. The social welfare schemes which started in the early 1990s and are still continuing, however, have not been accompanied by any new set of communication policies. The old and the much-trodden path of the old policies have been tried out without any special empathy. Even when the social scientists and economists of world repute kept on emphasizing the importance of well thought out and culture-specific communication policies, not much intellectual exercises could be felt in those being practiced.

As far as health is concerned, there has been a wide production and dissemination of information in India, related to various schemes. But most of them suffer from extreme transmission loss. A huge communication industry strives on health communication. The health communication policy of the government also suffers from the malaise of routine exercise. As a huge amount of fund has been earmarked for the communication exercise, it has been more deprived of the originality that is required to communicate to the uneducated and the marginalised. However, how much of the benefits actually percolate to the target is a matter of enquiry.

⁴³ Ibid Akhil Ranjan Dutta, Chapter 4

Media also has become very selective in its presentation with regard to region, class, creed, and so on. It is not that such tendencies were totally absent before, but the degree of such selective discrimination has increased manifold today. The effect of this is adversely felt in the social sector. Commercial considerations, not social significance, have become the principal arbiter in deciding the 'value' of any news. For example, when swine flu broke out and 28 persons were dead in India in a month's time during July-August, 2009, media almost went hysteric. During the same period, on the other hand, Japanese encephalitis killed more than 40 people in one small district in the state of Assam which was not reported at all in the national media and its reporting was shadowed by the swine flu reporting in the Assamese regional media too. Every year several hundred persons die in epidemic outbreaks of each of the diseases like Japanese encephalitis, malaria, cholera and diarrhoea in the rural and backward areas like Assam. Despite huge expansion in the media network in recent times, its coverage of such news has witnessed a significant shrinkage. This becomes all the more conspicuous when one compares it with entertainment and metro-oriented news items. This disparity in information generation and dissemination as far as media is concerned has been reflected in the communication policies too.

The most important point as far as Communication policy in India is concerned is that the mass media has become quite insensitive towards the people. As mentioned earlier, the market oriented media has been deprived of its responsibility towards the marginalised and the underprivileged. Too many pulp and glitzy programme targeted towards the new upwardly mobile middle class has de-sensitized even the people towards their own apathy. The live coverage of the Miss World or such pageant holds a breathless nation to ransom as the media projects the win as a symbol of national pride. When there is coverage of more pro people issue, the presentation is either dull or more often verging towards negativity. For example, after each round of pulse polio immunization drive media gives space to such news as the death of a child after taking those *two drops of life* (do boond zindagi ki). This is mainly because the media which has become a 24x7 phenomenon (mostly the television media) has to *Break News* all the time to get their fair share of advertisement.

The innocent and unsuspecting victim of the whole process is the suffering people. Ethno culture sensitive communication might be able to elicit the desired result in terms of elevating the health condition of the populace. For that a thorough revamping of the communication

policies and close monitoring of the dissemination of information should be regarded as the earnest responsibility of the state.

REFERENCES:

1. Duggal, Ravi “*Sinking Flagships and Health Budgets in India*” in Economic and Political Weekly , 320-321, A to Z Industrial Estate, Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013. August 15, 2009 vol XLIV no.33,
2. Dutta Akhil Ranjan “*Neo-Liberal State And Human Security A Study On Health Security*”, Unpublished Ph.D thesis, Gauhati University 2003.
3. Hall John J and Taylor Richard “*Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries*” in The Medical Journal of Australia 2003 178 (1): 17-20 (e-version)
4. Karnik Kiran, “*Societal Implication of Communication Revolution,*” Mainstream, Twenty Fifth Annual Special, New Delhi, 1987.
5. P.C. Joshi, *Communication and National Development*, Anamika Publishers and Distributors (p) ltd, Delhi 2004
6. Qadeer Imrana in Rao Mohan (ed) *Disinvesting in Health: The World Bank's Prescriptions for Health* (1999)
7. Raymond Williams, *Communication's*, Penguin Books Ltd., 1966
8. Rogers Everett M. & Singhal Arvind, (1990). *The Academic Perspective*. In C. Atkin & L. Wallack (Eds). *Mass Communication and Public Health* (pp 176-181). Newbury Park, CA: Sage.
9. Sarabhai Vikram and Chaudhury, Kamla “*Television and Development*”, in *Scientific Policy and National Development*, South Asian Books, Macmillan, New Delhi, 1974
10. Singhal, A., & Rogers, E. M. (1989). *Prosocial television for development in India*. In R.E. Rice & C.K. Atkin (Eds), *Public Communication Campaigns* (pp.331-350). Newbury Park, CA: Sage.
11. Werner D. Health Hazard: user fees. *New Internationalist* 2001; 31 (Jan): 22-23

DOCUMENTS:

1. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.
2. Information education Communication, Department of Family Welfare.
3. World Bank, World Development indicators.
4. Report on the Round table meeting on “Partnership with Civil Society to Implement the Programme of Action, International Conference on Population and Development” held in Dhaka Bangladesh from 27-30 July 2008 held by the technical division of UNFPA pg xii
5. *Millennium Development Goals: A Compact Among Nations to End Human Poverty* (2003), UNDP Human Development Report, p 1.
6. National Population policy document
7. NRHM Mission Document
8. NRHM Framework
9. *SECURING RIGHTS Citizens’ Report on MDGs*, an independent study by a group of citizen and civil society organization

WEBSITES:

1. http://www.mohfw.nic.in/dofw_website/.../iec.htm
2. <http://www.google.com/publicdata?ds...>
3. http://www.euro.who.int/AboutWHO/Policy/20010827_1
4. www.planningcommission.gov.inhttp://www.mohfw.nic.in/dofw%20website/Child%20healthrti.pdf
5. <http://mohfw.nic.in/np2002.htm>
6. <http://mohfw.nic.in/index.htm>
7. http://www.mohfw.nic.in/NRHM/NPCC_Presentation/Assam_NPCC_08_09.pps

SHASHWATI GOSWAMI
Associate Professor
Indian Institute of Mass Communication
New Delhi, India
110067