Chapter 4

Health policies & Health Communication Policies and Plans in India & Assam

In this chapter, we propose to discuss various Health policies & Health communication policies formulated during planning period starting from first 5 year plan to now and also propose to include policies & plans regarding National Health Mission (NHM) & other state level policies. But the analysis will be strict to the Health Communication perspective only. It is also important to mention why all the five year plans are also included in the policy analysis, because planning is broadly termed as coordination of policies and practices. Policies are seen as temporal conceptual structure coordinating knowledge & power which indicates coherent decisions with a long term purpose rather than ad hoc announcement. The plan is structured management action broadly defined as coordination of policies & practices. Therefore to analyses Health communication policies we need to consider both plans and the policy. We are also trying to extract the health communication policy part from the main Health policy document and discuss in general of its affordability, accessibility, availability, feasibility and adequacy etc. Here, we plan to treat the planning period first at the macro level and then go to the micro level for empirical reality of changes of trend in Health communication policies in various plan periods.

4.1. Nature of Health communication policies of India & Assam:

In Assam, health care is based on the Indian model which is based on purely biomedical model as developed in the Western world in the last century and on
traditional (folk) medicine as in many developing countries. The delivery of health care is based on the Beveridge model, inherited from the British in the early years where health care is provided and financed by government through tax payments, just like the police force or the public library. This is mainly because the financial allocation of the resources is determined by the central government and this is done through plan schemes or programs that are usually uniform across states. That is why the overall policy formulation of health policies and health communication policies has been done centrally; but with autonomy to the state to take state unambiguous innovations if any along with the central plan as Indian constitution regards health as a state subject. Here we will try to analyze various policies and committees for health system reform of government of India as well as Assam with given importance to health communication policies.

4.1.1. Bhore Committee:

Structured health policy making and health planning in India is not a post-independence phenomena. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. This was the 'Health Survey and Development Committee Report' popularly referred to as the Bhore Committee. This Committee prepared a detailed plan of a National Health Service for the country, which provided a universal coverage to the entire population free of charges through a comprehensive state run salaried health service. In other terms, it was guided by lofty principals as ‘nobody should be denied access to health services for his inability to pay’ and that the focus should be on rural areas. The committee made a broad survey of the present position in regard to health conditions and health organization in British India, and provided recommendations for future...
development. By keeping the high hope of the Government of India that such plans should be based on a comprehensive review of the health problem and with assumptions that unlimited funds would be available for recurring on health sector, the Bhore committee planned it boldly, avoiding on the one hand extravagant programs which are obviously incapable of fulfillment and on the other hand halting and inadequate schemes which could have no effect on general health standards and which, would bring little return for the expenditure involved sets with defined objectives”.

In formulating its plan for a National Health Service the Bhore Committee set itself the following objectives:

- The services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;

- These services should be placed as close to the people as possible, in order to ensure their maximum use by the community, which they are meant to serve;

- The health organization should provide for the widest possible basis of cooperation between the health personnel and the people;

- In order to promote the development of the health program on sound lines the support of the medical and auxiliary professions, such as those of dentists, pharmacists and nurses, is essential; provisions should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;
In view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute “group” practice, should be made available;

Special provision will be required for certain sections of the population, e.g. mothers, children, the mentally deficient etc. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it.

The creation and maintenance of healthy environments as possible in the homes of the people as well as in all places where they congregate for work, amusement recreation, are essential.

The Bhore Committee further recognized the vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. The district health scheme, also called the three million plans, which represented an average districts population, was to be organized in a 3-tier system in an ascending scale of efficiency from the point of view of staffing and equipment. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organization which will include, within its scope, all the facilities that are necessary for modern medical practice as well as the supervisory staff who will be responsible for the health administration of the district in its various specialized types of service. This health organization would provide
integrated health services - curative, preventive and promotive - to the entire population. The health organization is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on a system of hospitals of varying size and of differing technical efficiency. “The institutions will play the dual role of providing medical relief & taking an active part in the preventive campaign.”  

Bhore committee also recommended the ratio to a standard unit of population the minimum requirement as 567 hospital beds per 100,000 population; 62.3 doctors per 100,000 population; 150.8 nurses per 100,000 populations on the basis of the existing at that time in India (1942) which was: 24 beds per 100,000 population; 15.87 doctors per 100,000 population; 2.32 nurses per 100,000 populations.

In addition to this basic infrastructure the Committee recommended a wide range of other health programs, which were malaria, tuberculosis, small pox, cholera, plague, leprosy, venereal diseases, hookworm disease, filariasis, guinea-worm disease, cancer, mental diseases and mental deficiency and diseases of the eye and blindness. For all these diseases the Committee found that facilities are grossly inadequate and need urgent attention - proper sanitation and other public health measures are the key to eradicate or control such diseases.

The Committee also made special recommendation in the area of environmental hygiene, public health engineering, housing, health education, health services for mothers and children, health services for school children, industrial health service, the population problem, medical education and research and vital statistics.

All this shows that the Bhore Committee plan was not only well studied and argued but also comprehensive and suited to the Indian situation. It recommended that
all services provided by the health organization should be free to the population without distinction and it should be financed through tax revenues. It further recommended that the health service should be a salaried service with whole-time doctors who should be prohibited from private practice. The recommendations also stated that large-scale provision for the training of health personnel forms an essential part of the scheme, because the organization of a trained army of fighters is the first requisite for the successful prosecution of the campaign against diseases. Side by side with such training of personnel, the committee recommended for the establishment of a health organization which will bring remedial and preventive services within the reach of the people, particularly of that vast sections of the community which lies scattered over the rural areas and which has, in the past, been largely neglected from the point of view of health protection on modern lines. These are that curative and preventive work should dovetail into each other and that, in the provision of such a combined service to the people, institutional and domiciliary treatment facilities should be so integrated as to provide the maximum benefit to the community. There should also be provision in the health organization for such consultant and laboratory services as are necessary to facilitate correct diagnosis and treatment.

Health communication is duly mentioned by Bhore committee report especially for the promotive & preventive component by saying that the health organization would provide integrated health services -curative, preventive and promotive - to the entire population. The committee mentioned the need of preventive services, reaching the services to the needy at their doorsteps, health education and other public health measures without which universal health coverage with equity will
be a distant dream. The Health communication was termed as Health education in the Bhore committee report\(^8\).

### 4.1.2. Five year planning in India/Assam

In the early years after independence the Indian state was engrossed in helping and supporting the process of accumulation of capital in the private sector through large scale investments in capital goods industry, infrastructure and financial services. The social sectors like health, water supply and education were low priority areas. Industrial growth was the keyword. It is evident from the five year plans that the Economic Services have right through from plan one to plan nine been allocated over four-fifths of the resources and the social sectors like health, education, water supply and housing have received only residual resources. Over nearly fifty years this is by no means a fantastic growth considering the increase in expenditure of 416-fold for agriculture and rural development between the first and ninth five year plans. Rural Development Programs (earlier called community development programs) have seen a quantum jump, especially since the introduction of the minimum needs program with the fourth five year plan to give a boost to rural infrastructure and provide some places to the small and marginal peasantry. However, these efforts at programming have not contributed in any significant manner in reducing rural poverty or in enhancing rural purchasing power\(^9\). In fact, it is clearly evident that over the years investment in the health sector has declined sharply in terms of the share it gets in the plan kitty. Though the social sector has been given low priority but still we will look at the health sector constituted plans in various Five Year Plans.
4.1.2.1. First five year Plan

The 1st planning commission depicted health in the following manner

“Health is fundamental to national progress in any sphere. In terms of resources for economic development, nothing can be considered of higher importance than the health of the people which is a measure of their energy and capacity as well as of the potential of man-hours for productive work in relation to the total number of persons maintained by the nation. For the efficiency of industry- and of agriculture, the health of the worker is an essential consideration.”

So, Health is given the priority for the efficiency of agriculture and health. In the fifties and sixties the entire focus of the health sector in India was to manage epidemics. Mass campaigns were started to eradicate the various diseases. These separate countrywide campaigns with a technocentric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. Cadres of workers were trained in each of the vertical programs. The National Malaria Eradication Programme (NMEP) alone required the training of 150,000 workers spread over in 400 units in the prevention and curative aspects of malaria control. The policy of going in for mass campaigns was in continuation of the policy of colonialists who subscribed to the percepts of modern medicine that health could be looked after if the germs which were causing it were removed. But the basic cause of the various diseases is social, i.e. inadequate nutrition, clothing, and housing, and the lack of a proper environment. These were ignored. The tuberculosis program involved vaccination with BCG, T.B. clinics, and domiciliary services and after care. The emphasis however was on prevention through BCG. These programs depended on
international agencies like UNICEF, WHO and the Rockefeller Foundation for supplies of necessary chemicals and vaccines.

National Malaria Eradication program has very few points regarding information, education & communication as such as the program basically covers the resistance and clinical part through spraying DDT and treatment of Malaria where Health communication part was rarely used in India whereas World Malaria Eradication program launched by WHO used various Health communication techniques including posters, wall writing, public service messages in the newspapers & magazines etc. Of course India had used the community mobilization techniques by selecting peer educators from the malaria affected areas to intervene mass malaria campaign which is true to Assam as well. The peer educators are those who are either political interpreter or an individual from the village who helps in creating awareness and counsel people for malaria.

There was no use of leaflets, posters, wall writings etc from the Indian’s intervention but the plan mentioned about Health education as the key priorities by saying “All progress in public health depends ultimately on the willing assent and co-operation of the people and their active participation in measures intended for individual and community health protection. Considering how much illness is the result of ignorance of simple hygienic laws or indifference to their application in practice, no single measure is productive of greater returns in proportion to outlay than health education”¹¹.

The plan also envisages that health education should be addressed to the different sections of the public through all available modern methods of publicity i.e. Audio-visual aids, the radio, the cinema, Gramophone records, cinema films, film
strips, lantern slides, picture posters, leaflets, book marks and picture cards and the press but with suitable messages as possible and intelligible to the large section that are not literate. Even the plan informed that the material prepared for imparting health knowledge to the people should draw upon all available sources, including the traditional practices and Ayurveda texts. The plan also stressed the need to have health publicity bureaus in the Centre as well as the States. They should be properly staffed and equipped with aid of a good library service as well as a museum and units for the production of the requisite educational aids and materials. Health publicity should form an integral part of the district health organization’s work.

4.1.2.2. 2nd Five year Plan:

During the 2nd Five Year Plan the basic structural framework of the public health care delivery system remained unchanged & urban areas continued to get over three-fourth of the medical care resources whereas rural areas received "special attention" under the Community Development Program (CDP). Within CDP the social sectors received very scant attention while agricultural & rural development programs got priority; but impact on food production & rural development programs has been limited. “The numbers of poor keep rising each year while economists and planning commission experts keep fighting on proportions over and under the poverty line. For the politicians, the investment in rural development is critical to their survival and they use it as appeasement to seek favor from the electorate”.

The health sector organization under CDP was to have a primary health unit (a very much diluted form from what was suggested by the Bhore Committee) per development Block (in the fifties this was about 70,000 population spread over 100 villages) supported by a Secondary health unit (hospital with mobile dispensary) for
every three such primary health units. The aim of this health organization was the improvement of environmental hygiene, including provision and protection of water supply; proper disposal of human and animal wastes; control of epidemic diseases such as malaria, cholera, smallpox, TB etc.; provision of medical aid along with appropriate preventive measures, and education of the population in hygienic living and in improved nutrition. The 2nd plan mentioned about health communication as mentioned below:

The primary object of health education is to help the people to achieve health by their own action and efforts. It therefore begins with the interest of the people in improving their conditions of living and aims at developing a sense of responsibility for their own health betterment as individuals and as members of local communities. The interests, needs and aspirations of the people themselves provide the starting point and the main motive force for enlisting their good-will and participation in local planning as well as in action. The guidance and help of experts is of course necessary. Health education bureau which are being established at the Centre and at the State Health Departments will attempt to provide in service training for health workers, educational aids and consultative services in educational methodology as well as improved interpretation of health services.

To evaluate the progress made in the 1st & 2nd plans and to make recommendation for the future path of development of health services the Mudaliar Committee was set up in 1959. The report of the committee recorded that the disease control programs had some substantial achievements in controlling certain virulent epidemic diseases. Deaths due to malaria, cholera, smallpox etc. were halved or sharply reduced and the overall morbidity and mortality rates had declined & the
expectation of life at birth had risen. However, the tuberculosis program lagged behind as a million and half estimated open cases of tuberculosis there were not more than 30,000 beds available. The Mudaliar Committee further admitted that basic health facilities had not reached at least half the nation. The PHC programme was not given the importance. There were only 2800 PHCs existing by the end of 1961. Instead of the "irreducible minimum in staff" recommended by the Bhore Committee, most of the PHC's were understaffed, large numbers of them were being run by ANM's or public health nurses in charge. The report mentioned the doctors were going into private practice after training at public expense and the majority of the beds and various facilities were located in the urban areas. The Committee recommended that the expansion of PHC's upgradation should take place in a phased manner & equipping of the district hospitals for treatment of non-PHC population. The committee makes a mention that except for the substantial increase in the number of doctors, number of other categories of health personnel was still woefully short of the requirement. The committee insisted that medical education should get a large share of public health resources with a belief that improvement in the technical excellence of medical care. But the Mudaliar committee does not have any mention about how to improve the Health Education arena.

4.1.2.3. 3rd Five year Plan:

With recommendations of Mudaliar committee the 3rd Plan period, launched in 1961, improvement of the technical excellence was the key word through - allocations for training of doctors, especially specialists, increased. This was reflected in a large increase in medical college seats. The provision of PHCs, and directed attention to the shortage of health personnel, delays in the construction of PHCs, buildings and staff
quarters and inadequate training facilities for the different categories of staff required in the rural areas were the key points. While the plan gave serious consideration for more auxiliary personnel but no mention was made of any specific steps to reach this goal; even health communication was completely ignored. On the other hand, the proposed outlays for new Medical Colleges, establishment of preventive and social medicine and psychiatric departments, completion of the All India Institute of Medical Sciences and schemes for upgrading departments in Medical Colleges for post graduate training and research continued to be high. But the allocation patterns continued to belie the stated objectives and goals of the overall policy in the plans. The urban health structure continued to grow and its sophisticated services and specialties continued to multiply. Ignoring the Mudaliar Committee’s recommendation of consolidation of PHC's, this plan period witnessed a rapid increase in their numbers but their condition was the same as the Committee had found at the end of the plan period. In case of the disease program due to their vertical nature we find a huge army of workers by uni-purpose health workers. Therefore we find that in the same geographical area there was overlapping and duplication of work.

In 1963 the Chadha Committee had recommended the integration of health and family planning services and its delivery through one male and one female multipurpose worker per 10,000 populations and India became the first country in the world to adopt a policy of reducing population. Faced with a rising birth rate and a falling death rate the 3rd plan stated that "the objective of stabilizing the growth of population over a reasonable period must therefore be at the very center of planned development". It was during this period that the camp approach was tried out and government agencies began to actively participate in pushing population control. This
was also the time when family planning became an independent department in the Ministry of health. This was a fundamental change in India's health policy. This policy change, though it had its own inner compulsions, was more so due to the recommendations of 1966 U.N. advisory mission visiting India\(^{21}\).

To endorse this strategy the Special Committee to review the Staffing Pattern and Financial Provision under Family Planning was appointed named as **Mukherjee Committee**. This committee indicated that the camp approach had failed to give the family planning program a mass character and hence the coming in of IUCD (loop) was a great opportunity. This committee also recommended introduction of target fixation, payments for motivation and incentives to acceptors. It suggested reorganization of the FP program into a vertical program like malaria and recommended addition of one more Health visitor per PHC who would specifically supervise the ANMs for the targets of this program. Also the Committee recommended retaining of private practitioners with minimal fees\(^{22}\).

**4.1.2.4. 4th Five Year Plan:**

The **4th Plan** which began in 1969 with a 3 year term continued on the same line as the 3rd plan. It lamented on the poor progress made in the PHC program and stresses the need for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of PHCs by providing them with staff, equipment and other facilities. For the first time PHCs were given a separate allocation. It was reiterated that the PHC's base would be strengthened along with, sub divisional and district hospitals, which would be referral centers for the PHCs. The importance of PHCs was stressed to consolidate the maintenance phase of the communicable diseases program due to the reverse epidemiological trend in 1966 as
incidence of malaria rose from 100,000 cases annually in 1963-65, to 149,102 cases. This was admitted by the planning commission²³.

FP continued to get even a greater emphasis with 42% of health sector (Health + FP) plan allocation going to it ²⁴. It especially highlighted population growth as the central problem and used phrases like "crippling handicap", "very serious challenge" and an anti-population growth policy as an "essential condition of success" ²⁵ to focus the government's attention to accord fertility reduction "as a program of the highest priority" ²⁶. It was also during this period that water supply and sanitation was separated and allocations were made separately under the sector of Housing and Regional development. About Health education or Health communication the plan reiterated only specific to family planning, the same line as the 3rd plan;

Mass education activities will be strengthened in rural areas and small towns. Traditional and cultural media like song, drama and folk entertainment will be effectively used. Extension education will be strengthened and population education will be introduced. The strategy will be to bridge the gap between knowledge and adoption of family planning by couples in reproductive age-group.²⁷ Except that nothing much about Health Education was explained in the plan.

4.1.2.5. 5th Five Year Plan:

It was in the 5th Plan that the government ruefully acknowledged that though infant mortality rate going down, life expectancy going up, increase in the number of medical institutions, functionaries, beds, health facilities etc, were still inadequate in the rural areas. This shows that the government acknowledged that the urban health structure had expanded at the cost of the rural sectors. Therefore, the plan reflected
about increasing the accessibility of health services to rural areas through the **Minimum Needs Programme (MNP)**, to develop a sound referral services by removing deficiencies in district and sub-division hospitals, intensification of the control and eradication of communicable diseases, quality improvement in the education and training of health personnel and development of referral services by providing specialists attention to common diseases in rural areas. The MNP which would "receive the highest priority and will be the first charge on the development outlays under the health sector especially to the rural areas. The plan further envisaged a new category of health personnel to be specially trained as multi-purpose health assistants to deliver services but the infrastructure target still remained one PHC per CDP Block (as in the FYPI but the average Block’s population was now 125000)\(^28\)

The plan envisaged the need for health communication in a very skeptical manner. The plan mentioned, “*Health education has an important role in promoting concepts of health. And to prevent the diseases health education would be included in the curriculum or school education. It would also be made part of informal systems of education such as workers' education program, farmers' education program, etc. Education Bureau in States and at the Centre would effectively coordinate health education promotion activities. Even the plan also mentioned that Mass education activities will be strengthened in rural areas and small towns. Traditional and cultural media like song, drama and folk entertainment will be effectively used. Extension education will be strengthened and population education will be introduced. The strategy will be to bridge the gap between knowledge and adoption of family planning by couples in reproductive age-groups*\(^29\)."
The Kartar Singh Committee in 1973 recommended the conversion of unipurpose workers, including ANMs, into multi-purpose male and female workers and recommended that each pair of such worker should serve a population of 10,000 to 12,000. Hence the multi-purpose worker scheme was launched with the objective to retrain the existing cadre of vertical program workers and the various vertical programs were to be fully integrated into the primary health care package for rural areas. Another committee, named Shrivastava Committee was appointed to look into medical education & support manpower. As per the recommendations of the committee, a cadre of village based health auxiliaries called the Community Health workers was created. The CHWs were part time workers selected by the village, trained for 3 months in simple promotive and curative skills both in allopather and indigenous systems of medicine to be supervised by MPWs and to work as a link between the MPW at the sub-centers and the community. With regard to medical education the committee cried for a halt to opening of new medical colleges. The committee emphasized that there was no point in thinking that doctors would go to rural areas because there were a number of socio-economic dimensions to this issue hence option for rural areas was the CHW. This attitude was clearly supportive of the historical paradigm that rural and urban areas had different health care needs – that urban populations need curative care and rural populations preventive. This also is discriminatory since inherent in this paradigm is deprivation for the rural masses.

Earlier, in 1967 the Jain Committee report on Medical Care Services had made an attempt to devolve medical care by recommending strengthening of such care at the PHC and block/taluka level as well as further strengthening district hospital facilities. But recommendations of this Committee, which is the only
committee since Independence to look at medical care and also for the first time talked about strengthening curative services in rural areas, were not considered seriously\(^\text{32}\). In the middle of the 5th Plan a State of National Emergency was proclaimed and during this period (1975-77) population control activities were stepped up with compulsion, force and violence now characterizing the Family planning program.

4.1.2.6. National Population Policy 1976:

In the midst of all this the National Population Policy was announced whose core aim was a direct assault on the problem of population rise as a national commitment. One of the recommendations included was legislation by state governments for compulsory sterilization. With the end of the Emergency and a new government in power this policy was sent to the freezer. Family Planning, which started with an insignificant outlay in the 1\(^{st}\) plan, was now taking the single largest share in the health sector outlay. The policy draft maintained that poverty is the real enemy of the country and the Fifth Five Year Plan (1974-79) aimed to remove the widespread abject poverty by including Minimum Needs Program with an integrated package of health, family planning and nutrition as components. The plan reiterates its thirst on medical education so as to strengthen the community medicine and rural health aspects, and to restructure the health care delivery system on a three-tier basis going down to the most far-flung rural areas where the majority of our people reside and where child mortality and morbidity are the highest. The policy also stressed for education & Health as the key priority, bringing down the birth rate from 35 to 25 per thousand, increase the age of marriage & girls’ education up to the middle level and child nutrition\(^\text{33}\).
For the first time government has moved from somewhat urban-elitist approaches of the past into a much more imaginative and vigorous rural-oriented approach. In order to spread the message of family planning throughout the nation, the National population policy stressed for a new health communication policy focusing on multi-media motivational strategy to be evolved which would utilize all the available media channels including the radio, television (specially program aimed directly at rural audiences), the press, films, visual displays and also include traditional folk media such as the jatra, puppet show, folk songs and folk dances. The policy also mentioned that the government is working in close coordination with the Ministry of Information and Broadcasting and is also trying to draw the best media talent available in the country into the structuring of the new program\textsuperscript{34}.

4.1.2.7. National Water Supply and Sanitation Committee (Simon Committee):

To alleviate the problem of safe water supply & basic sanitation as diarrhea, amoebic dysentery, cholera, typhoid and jaundice is water borne, 1960 the National Water Supply and Sanitation Committee (Simon Committee) was formed. The report stressed the need to obtain correct data on the existing conditions both in urban and rural areas on which future planning and implementation could be based. It strongly recommended that the end of the 3rd plan must provide minimum drinking water to all villages in the country (Simon, 1960). This did not happen even till the end of the 5th Five Year Plan. The drought of 1979-80 (and the subsequent droughts experienced in many districts of different states) which was accentuated by an acute scarcity of drinking water due to the drying-up of wells, tanks and other sources added urgency to the problem\textsuperscript{35}. 
4.1.2.8. 6th Five Year Plan:

The Sixth Plan was to a great extent influenced by the Alma Ata declaration of Health for All by 2000 AD (WHO, 1978) and the ICSSR-ICMR report (1980). The plan conceded that "there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of mostly by the well to do classes. It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services. The plan emphasized the development of a community based health system with provision of health services to the rural areas on a priority basis, training of a large cadre of first level health workers selected from the community and supervised by MPWs and medical officers of the PHCs, no further linear expansion of curative facilities in urban areas; this would be permitted only in exceptional cases dictated by real felt need or priority and community participation and people's involvement in the program being of critical importance, program involving active participation of voluntary organizations and the mounting of a massive health education movement would be accorded priority. The plan emphasized that horizontal and vertical linkages had to be established among all the interrelated programs, like water supply, environmental sanitation, hygiene, nutrition, education, family planning and MCH. The 6th plan clearly stated the need to promote health education with strengthening of health education bureaus, training of medical and paramedical personnel in health education etc. The efforts were basically directed to develop and strengthen health education as an essential component of health services, with adequate budgetary provision. The health education were to be initiated to actively
involve social and preventive medicine as well as community medicine departments of the medical colleges, to strengthen health education training program for medical teachers, Para-medical personnel etc. School Health Education activities as an integral part of formal and non-formal education were proposed to be developed through appropriate measures. Efforts were to be made for the use of different types of media to create awareness among the people and motivate them to utilize health services and to adopt healthful practices. Behavioral sciences research (to study human behavior) for wider expansion of health education, has also encouraged.

4.1.2.9. Alma Ata Declaration & Health for All 2000:

The Alma Ata declaration in 1978 led the launch of Health for all by 2000 signed by 137 countries including India. The declaration advocated the provision of first contact services and basic medical care within the framework of integrated health services. It was declared that PHC is essential health care based on practical and scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families through participation. It called for strong community participation in all the phases, from planning and implementation to evaluation with special attention to the education of the community concerning prevailing health problems and the methods of preventing and controlling them. The concept of Health for all refers to community involvement rather than community participation, as the latter implies a passive rather than active role in health-related activities. This collaborative approach requires communication and knowledge to be multidirectional, not unidirectional as is common in the dominant health delivery system, and the forgoing of a horizontal partnership in place of the top-down, vertical approach pervasive in the mainstream health care delivery system.
4.1.2.10. The National Health Policy of 1983:

It has been observed that with the advent of planning the levels of health care, as recommended by the Bhore Committee, were diluted by subsequent committees and the Planning Commission. In fact, until 1983 there was no formal health policy. As a consequence of the global debate on alternative strategies during the seventies, the signing of the Alma Ata Declaration on primary health care and the recommendations of the ICMR-ICSSR Joint Panel, the government decided for a new approach in the name of National Health policy 1983.

It was announced during the Sixth plan period by jumbling up the concept of Alma Ata Declaration and principle of ICMR-ICSSR Report's (1981) recommendations as is evidenced from the large number of paragraphs that are common to both documents. But beyond stating the policy there was no subsequent effort at trying to change the health situation for the better. The NHP in light of the Directive Principles of the constitution of India recommends for a Universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford\(^\text{40}\). The policy stressed the need of creation of an infrastructure for primary healthcare; close co-ordination with health-related services and activities (like nutrition, drinking water supply and sanitation); the active involvement and participation of voluntary organizations; the provision of essential drugs and vaccines; qualitative improvement in health and family planning services; the provision of adequate training; and medical research aimed at the common health problems of the people\(^\text{41}\).

The national Health policy mentions that to achieve universal health coverage 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 Blindness Program), but also as part of the effort to bring about a behavioral change to prevent HIV/AIDS and other life-style diseases. *The policy too mentions that “Public health program, 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. It is widely accepted that school and college students are the most impressionable targets for imparting information relating to the basic principles of preventive health care. The policy will attempt to target this group to improve the general level of awareness in regard to ‘health-promoting’ behavior* 42.

For the first time, it has been observed that the term IEC (Information, Education & communication” was used in India’s planning process which would lead to much desired behavioral change in the society. Even the concept of health promoting behavior had widened.

### 4.1.2.11. 7th Five Year Plan:

As per the recommendations of National Health Policy 1983, the 7th Five Year Plan recommended that "development of specialties and super-specialties need to be pursued with proper attention to regional distribution" and such *development of specialized and training in super specialties would be encouraged in the public and the private sectors*, the plan also talks of improvement and further support for urban health services, biotechnology and medical electronics and non-communicable diseases & population control. Special attention was also provided to AIDS, cancer & coronary heart diseases 43.
The plan stressed that health communication in terms of promotion of health education need to be strengthened with added emphasis. Measures would be initiated to actively involve social and preventive medicine as well as community medicine departments of the medical colleges, to strengthen health education training programs 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. It also added that efforts will be made for the active use of different types of media to create awareness among the people and motivate them to utilize health services and to adopt healthful practices. Behavioral sciences research (to study human behavior) for wider expansion of health education, will be encouraged.

The similar IEC policy of the sixth plan has been made which is mentioned in the WHO bulletin also. For quite some time the health communication has been restricted to more of an academic exercise or executive routine. So, an insider’s perspective or “emic” approach to see health issues and conceptualize them into programs has been almost missing. Most of the time, the planners have designed programs in view of the so called ‘Experts’ approach. Hence, a deviation to this is felt necessary to bring all the potential stakeholders to a common platform and understand issues in Health Communication in its totality. This may lead to a holistic approach of understanding the issues and may incorporate both emic as well as etic approaches. At community level, health communication can be used to influence the public agenda, advocate for policies and programs, promote positive changes in the socioeconomic and physical environments, improve the delivery of public health and health care services, and encourage social norms that benefit health and quality of life.
The World Health Organization (WHO) in its revised explanation has included Spiritual and Social wellbeing and not merely the physical and mental wellbeing in the definition of “Health”. The definition was updated in the 1986 WHO "Ottawa Charter for Health Promotion" to say health is a resource for everyday life, not the objective of living”, and "health is a positive concept emphasizing social and personal resources, as well as physical capacities.\textsuperscript{46}

\textbf{4.1.2.12. Eighth Five Year Plan:}

On the eve of the Eighth Five Year Plan the country went through a massive economic crisis and the Plan got pushed forward by two years. But despite this, no new thinking went into this plan. In fact, keeping with the selective health care approach the eighth plan adopted a new slogan –instead of Health for All by 2000 AD it chose to emphasize the Health for the Underprivileged. Simultaneously it continued the support to privatization in accordance with the new policy of the government to encourage private initiatives, private hospitals and clinics will be supported subject to maintenance of minimum standards and suitable returns for the tax incentives.\textsuperscript{47} The plan also suggested forming Education Commission for Health Sciences, and a few states have even set up the University for Health Sciences as per the recommendations of the Bajaj committee report of 1987. During the 8th Plan period a committee to review public health was set up. It was called the Expert Committee on Public Health Systems. This committee made a thorough appraisal of public health programs and found that we were facing a resurgence of most communicable diseases and there was need to drastically improve disease surveillance.
The Health communication plan choose to emphasize that Information, Education and Communication, which are critical inputs will be further strengthened and expanded. The IEC activities of the health and the family welfare sector will be integrated. Greater use of the mass media will be made to disseminate the message of family planning to the remotest corner of the country. The entire system of pricing the media time vis-a-vis its social responsibility has to be given a fresh look, different from the commercial angle. Area specific IEC material will be developed and produced. At the viewers' level, efforts will be made to pool resources of various social sectors and to provide community TV/ radio sets, besides maintaining them. The backbone of the IEC efforts will, however, remain the inter-personal communication for which the grass-root level female worker will have to be trained and effectively utilized\textsuperscript{48}.

4.1.2.13. 9th Five Year Plan:

The 9th Five Year Plan was a good review of all plans and has made an effort to strategize on achievements hitherto and learn from them in order to move forward. The main theme of the plan is to create \textit{Basic Minimum Services program (BMSP)} \textit{through which the government try to post physicians in PHCs and CHCs by creating part time positions either local qualified private practitioners. It also suggested provisions to set up at district level a strong detection cum response system for rapid containment of any outbreaks that may occur. The plan also stresses on the poor quality of data management and recommends drastic changes to develop district level databases so that more relevant planning is possible}\textsuperscript{49}.

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. The entire thrust of Health Communication strategy emanating from the deliberation of RCH 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.

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).


In the midst of all this the National Population Policy (NPP 2000) was announced with a lot of fanfare in the middle of 2000. It affirmed the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services. The NPP 2000 provides a policy framework for advancing goals and prioritizing strategies during the next decade, to
meet the reproductive and child health needs of the people of India, and to achieve net replacement levels (TFR) by 2010. It is based upon the need to simultaneously address issues of child survival, maternal health, and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child health services by government, industry and the voluntary non-government sector, working in partnership.

In regards to Health communication, it stresses that 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 need 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 mobilized 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.

4.1.2.15. 10th Five year plan:

The focus during the 10th plan was reorganization and restructuring the existing government health care system including the ISM&H infrastructure at the primary, secondary and tertiary care levels with appropriate referral linkages. These institutions have the responsibility of taking care of all the health problems (communicable, non-communicable diseases) and deliver reproductive and child health (RCH) services for people residing in a well-defined geographic urban and rural area. The another area of focus were to the development of appropriate two-way
referral systems utilizing information technology (IT) tools to improve communication, consultation and referral right from primary care to tertiary care level and building up an efficient and effective logistics system for the supply of drugs, vaccines and consumables based on need and utilization. The plan also envisages for horizontal integration of all aspects of the current vertical programs including supplies, monitoring, information education communication and motivation (IECM), training, administrative arrangements and implementation for a progressive convergence of funding, implementation and monitoring of all health and family welfare programs under a single field of administration at state as well as district & below district level. The plan stressed the need for devolution of responsibilities and funds to Panchayat raj institutions (PRIs); besides participating in area-specific planning and monitoring, PRIs can help in improving the accountability of the public health care providers, sort out problems such as absenteeism and improve inter-sectoral coordination and convergence of services.

The plan also commented that an aware and informed population, actively participating in programs aimed at promoting health, preventing illness, accessing health care at appropriate level is an essential prerequisite for improvement in health status of the country. Health education, which is the major tool for achieving this objective, had received a lot of attention in the 1950s and 1960s. During the development of various centrally sponsored vertical programs for disease control, family welfare program and state’s efforts to build up state specific program, health education efforts got fragmented. Currently, health education efforts are mostly limited to information being provided through mass media and health functionaries regarding Family Welfare services and disease control programs. These efforts have
resulted in improved awareness of the population who accessed these programs. However, active participatory health education aimed at motivating the population on lifestyle changes and preventive and promotive health care programs have not received due attention. Lack of readily available information at household and community level on where to go & whom to access for various health problems continue to remain a major barrier for seeking appropriate care. During the Tenth Plan, attempts were made to review existing training programs on health promotion/health education and make them more relevant; integrate the various health education programs under different vertical programs so that health personnel at each level of care provide comprehensive IEC to the population; involve PRIs and NGOs in health promotion/education and IEC&M; and ensure the involvement of non-formal leaders in the community in order to make health promotion/education/IEC&M a people’s movement.

4.1.2.16. National Health Policy 2002:

After the 1st National Health Policy in 1983, several major developments in the polices impacting the health sector came up & was revised during 2002 to achieve an acceptable standard of good health among the general population of the country and has set goals 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 country.

It 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 program would set specific targets for the association of PRIs/NGOs/Trusts in such activities. In several public health programs, 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 program will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programs 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\textsuperscript{53}.

4.1.2.17. 11\textsuperscript{th} Five year Plan:

The Eleventh Five Year Plan would provide an opportunity to restructure policies to achieve a New Vision based on faster, broad-based, and inclusive growth. One objective of the Eleventh Five Year Plan is to achieve good health for people, especially the poor and the underprivileged. In order to do this, a comprehensive approach is needed that encompasses individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices. The Plan facilitates convergence and development of public health systems and services that are responsive to health needs and aspirations of people. Importance will be given to reducing disparities in health across regions and communities by ensuring access to affordable health care.

During the tenth & eleventh five year plan, the RCH II program launched from 1\textsuperscript{st} April 2005 and Millennium Development Goal (MDG) also lay down during 2000 by focusing on eight important goals. 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.

4.1.2. National Rural Health Mission (NRHM)

To address the gap in Health scenario, the National Rural Health Mission (NRHM) was set up in 12 April, 2005. A generic public health delivery system envisioned under NRHM from the village level to the state. The National Rural
Health Mission (2005-2012) is a major undertaking by United Progressive Alliance Government to honor its commitments under Common Minimum Program (henceforth CMP). The political commitment to rural health and access to primary health care that the CMP articulated was itself a matter of considerable cheer. NRHM is also strategic framework to implement the National Health Policy 2002. It has adopted key guidelines given in National Health Policy 2002, e.g. equity, decentralization, involving Panchayat Raj Institutions (henceforth PRIs) and local bodies in owning primary health care management, strengthening primary health care institutions and suggestions for generating alternate source of financing.

On the 12th April 2005 the Prime Minister of India, Dr. Manmohan Singh, launched “The National Rural Health Mission” with a budget outlay of Rs. 6500 crores for 2005-06, and a commitment of the government to raise the public health expenditure from 0.9 % to 2-3 % of the GDP. The goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children, with initial focus on 18 “high focus” states. NRHM lists a set of core and supplementary strategies to meet its goals of reduction in IMR and MMR; universal access of public health services such as women health, child health, water, sanitation and hygiene, immunization and nutrition; prevention and control of communicable and non communicable diseases; access to integrated comprehensive primary health care; population stabilization; revitalization of local health tradition and mainstreaming AYUSH; and promotion of healthy lifestyles. The Mission seeks to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services,
strengthening public health systems for efficient service delivery, enhancing equality and accountability and promoting decentralized health plan. The Plan of Action includes determinants of good health like nutrition, sanitation, hygiene and safe-drinking water, increasing public expenditure on health, mainstreaming the Indian systems of medicine, reducing regional imbalance in health infrastructures, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health program, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing the community health centers into functional hospitals meeting Indian Public Health Standards (henceforth IPHS) in each block of the Country.

The main goals of NRHM to achieve are as under:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women’s health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles
The NRHM lists a set of core and supplementary strategies to meet its goals as follows:

A. Core Strategies:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programs at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
× Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

× Formulation of transparent policies for deployment and career development of Human Resources for health.

× Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.

× Promoting non-profit sector particularly in under-served areas.

B. Supplementary Strategies:

× Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.

× Promotion of Public Private Partnerships for achieving public health goals.

× Mainstreaming AYUSH – revitalizing local health traditions.

× Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics

× Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

The plan of action is divided into ten categories to achieve its goal which is depicted below:

❖ Accredited Social Health Activist

❖ Strengthening of Sub-Centre
- Strengthening of Primary Health Centre
- Strengthening of Community Health Centre For First Referral Care
- District Health Action Plan (DHAP)
- Converging Sanitation & Hygiene Under NRHM
- Strengthening of Disease Control Programs
- Public-Private Partnerships for Public Health Goals, including regulation of Private sector.
- New Health Financing Mechanism.
- Reorienting health/ medical education to support rural issues.

4.2 Planning Process; How Policies & Plans were designed in India as well as in Assam:

4.2.1. Planning Process of Five year Plans in India as well as Assam:

Indian planning is an open process. Much of the controversy and the debates that accompany the preparation of the plans are public. The initial aggregate calculations and assumptions are either explicitly stated or readily deducible, and the makers of the plans are not only sensitive but responsive to criticism and suggestions from a wide variety of national and international sources. From original formulation through successive modifications to parliamentary presentation, plan making in India has evolved as a responsive democratic political process and the culmination of the same in the final document is an impressive manifestation of the workings of an open society. But by its very nature it also generates many problems from the point of view of mapping an optimal strategy for economic development. It has adopted a "top
down” approach in planning of course nullifying the decisions of the bottom level as state has few issues to be raised in matters of planning.

Since 1947, the Indian economy has been premised on the concept of planning. This has been carried through the **Five-Year Plans**, developed, executed, and monitored by the Planning Commission (NITI Aayog after 2014). With the Prime Minister as the ex-officio Chairman, the commission has a nominated Deputy Chairman, who holds the rank of a Cabinet Minister. Prior to the Fourth Plan, the allocation of state resources was based on schematic patterns rather than a transparent and objective mechanism, which led to the adoption of the Gadgil formula in 1969. Revised versions of the formula have been used since then to determine the allocation of central assistance for state plans\textsuperscript{56}.

The new government led by Narendra Modi, elected in 2014 has announced the dissolution of the Planning Commission, and its replacement by a think tank called the NITI Aayog (an acronym for National Institution for Transforming India). The stated aim for NITI Aayog’s creation is to foster involvement & participation in the economic policy-making process by the State Governments. It has adopted a "bottom-up" approach in planning which is a remarkable contrast to the Planning Commission's tradition of "top-down" decision-making. One of the important mandates of NITI Aayog is to bring cooperative competitive federalism and to improve centre state relation. NITI Aayog will provide opportunities, that the previous Planning Commission structure lacked, to represent the economic interests of the State Governments and Union Territories of India. India’s finance Minister Arun Jaitley made a remark on the necessity of reformation of planning commission which is as under: *The 65-year-old Planning Commission had become a redundant...*
organization. It was relevant in a command economy structure, but not any longer. India is a diversified country and its states are in various phases of economic development along with their own strengths and weaknesses. In this context, a 'one size fits all' approach to planning is obsolete. It cannot make India competitive in today's global economy.

4.2.2. National Rural Health Mission planning process:

The planning process as described in the NRHM guideline and practices in India as well as in Assam is unique as it follows the system of planning through a bottom up approach. The first planning will happen at the village level and all the subsequent village plans will be merged into a cluster or block level plan for the respective year. All the blocks under the district will be compiled and accordingly shapes the District Health Action Plan. The State Health Action Plan or called State program implementation Plan (SPIP) is a congregation of all the district plans submitted to the state by the districts. The following is the brief detail of the State, District & block planning team

- The State Level Health Mission has a State Health monitoring and planning committee for overall guidance to the planning process. The state Planning Cell proposes the draft plans, streamlines the plans with guidance & directives from ministry. The Planning Cell has to supervise the work of all the District Health Missions by scrutinizing and providing feedback on the plans to ensure quality. The State team also finalizes various survey formats and formats for preparation of plans at various levels. The state planning team consists of Secy (Health), Mission Director, NHM, Nodal officer & SPOs (State Program officers) of
various programs, NGO representatives, a few health experts and State program manager etc. In simple terms, State plan is blend of all the district plans.

- The District Level Health Mission has a Health monitoring and planning committee responsible of providing overall guidance and support to the planning process. A draft plan formulates by the District Health Team and presented for discussion to the broader committee. After relevant discussion and modifications in the committee, the district plan is finalized by the District health team, which besides a few existing government functionaries; have NGO representatives & a few professionals. The team is responsible for household Surveys and Health facility surveys. The Zila Parishad Adhyaksha, the District Medical Officer, the District Magistrate will be key functionaries of the District Team. In nutshell, District plan is blend of all the block plans.

- The Block/CHC level monitoring and planning committee reviews the Block Health Plan. The Adhyaksha (President) of the Block Panchayat Samiti, the Block Medical Officer, the Block Development Officer, NGO/CBO representative, head of the CHC level Rogi Kalyan Samiti are the key members of this team. Additional social mobilization professionals and planning resource persons is contracted at the Block level to develop a good Resource team at that level. The Team finalizes the Block Health Plans. In simple terms, Block plan is blend of all the cluster level plans.

- Village level Health, Sanitation and Nutrition Committee (VHSNC) will be responsible for the Village Health Plans e.g. ASHA, the AWW, the Panchayat representative, the SHG leader & the CBO representative. The household survey,
the Village Health Register (VHR) and the Village Health Plan (VHAP) are done by VHSNC.

(Diagrammatic Representation of Planning process under NRHM Source: NRHM implementation Framework 2005)

4.3. Various Health Communication plans under NRHM in Assam:

Health Communication plans are termed as IEC/BCC (Information, Education & Communication/ Behavior Change Communication) plans as per NRHM implementation framework, 2005. The “IEC/BCC activities play a very important and strategic role in the area of public health. Strategic IEC/BCC programs use a
systematic process to understand people’s behavior and influences. In other words, a successful IEC/BCC plan would help in refuting myths and misunderstandings prevalent in the society and will lead to a demand for the various health services being provided, thus bringing about a behavioral change among individuals and the community at large. It has been observed that though importance of Health communication /Health Education or IEC/BCC was felt during the post independence but due importance was not justified till NRHM comes into place. Assam is also not peculiar from the rest of India and very few importance were given for health communication in Assam; The State since inception of NRHM has taken up IEC/ BCC activities to reach out to the people. Different strategies have been worked out for the different communities. The State IEC team is responsible for overseeing the planning, implementation, monitoring, and evaluation of IEC activities, special campaigns, and health education in emergency, monitoring of activities and capacity building of staff at the districts and block levels, and front line health service providers in communication. Even during NRHM, it has been ushered that integration of the IEC activities would improve overall coordination, more cost effective and timely utilization of funds, avoid duplication of resources, and strengthen planning, implementation and feedback. In the tea garden areas where anemia and hypertension during pregnancy and diarrhea in children are high, specific IEC and BCC activities are being planned. The state has utilized diverse media like print, Radio and TV to reach out to mass people. In Doordarshan and local Cable network short films on pregnancy care, importance of Hospital delivery, immunization of children and family planning are screened. The State has developed radio jingles on antenatal care, Institutional delivery, immunization, child care practices and family planning which
are aired through All India Radio & FM Channels. Through print media, the state regularly gives information about different health facilities, the service delivery schemes and packages. The State has also started ASHA Radio program where the health related issues are discussed where ASHAs also participate. The program is aired twice a week through All India Radio. From the year 2010-11, the State has started Folk Media campaign where health care delivery service messages are given to the local communities through folk media.

By keeping in mind few priority areas the annual plan was prepared and accordingly submitted to government of India. National Program Coordination Committee (NPCC) through a discussion with the state approves the plans if properly justified. Now we will try a have a look into the various annual plans submitted to GOI by NRHM, Assam. Out of the plans, we will look at the IEC/BCC (Information, Education, Communication/Behavioral Change Communication) component only since 2007-08 to 5 years period (till 2012 the 1st phase of NRHM) to know the health communication policies & plans for Assam.

4.3.1. SPIP 2007-08:

Though National Rural Health Mission (NRHM) started in 2005 but actual planning process started since 2007-08 only in Assam because of structural problems (The draft guideline on NRHM, Broad Framework for preparation of District Plans issued to all the districts on August 2006)) and the state of Assam submitted the 1st plan during 2007-08 only. During the plan period, the state is focusing on the improvement of RCH services and to achieve that it first put its foot forward in the literacy rate among women and male too. The plan states,
“The literacy rate of female is 56.03% and that of male 71.93%. So, people are not aware of the various programs and activities being under taken by the government. Hence, IEC (Information, Education & Communication) as well as BCC (Behavior Change Communication) is one of the very important interventions for bringing socio-behavioral change among people towards the program. Awareness for RCH (Reproductive & Child Health) program, NRHM and various other vertical programs should be clear, focused and disseminated everywhere including to the remote corners of the country and in local dialects. Awareness messages need to be strengthened and their reach to be widened with locally relevant & locally comprehensible media & messages. The conventional methods like banners, posters, hoardings, TV/Radio broadcasting are of some help but some innovative ways like Focused Group Discussion, songs, drama, folk lore are also needed to carry out in addition to the conventional methods\(^5\).

To achieve that the state keeping objectives like increase awareness level among rural masses about NRHM & its components, New born & child care, advantages of contraceptives & small family, educate and raise awareness amongst the adolescent boys and girls about human physiology, HIV/AIDS, EC (Eligible Couple) and safe sex and on disease prevention activities on various diseases like Malaria, Dengue, Japanese Encelyphytis (JE), Diphtheria, Rabies, Drug addiction etc. To achieve the objectives the state proposes the list of various activities which includes\(^6\):

- To organize orientation program for the health workers on BCC/IEC;
- Publicity through pamphlets, radio spots on general health and hygiene;
• To hold an IEC session during health day on improving nutrition and to prevent various diseases;

• To organize dramas, orientation program on diseases like anemia, refractive error, hookworm infestation, malnutrition, dental caries to support School Health Program;

• To create awareness in the community through vernacular press advertisements, TV and radio spots to utilize the services of ASHA;

• To organize exhibitions during Health Melas;

• Publicity through leaflets, hoarding, posters, wall writings, banners, film slides, electronic media and press advertisements on JSY and various other NRHM activities;

• To inform the masses through vernacular press advertisements and about the infrastructural strengthening and of the facilities available in the health institutions;

• Communication activities will be developed to raise awareness about institutional delivery, and about facilities having comprehensive EmOC care.

• For Intra communication within the framework of NRHM, monthly newsletter will be published and NRHM Website will be developed.

• Communication activities i.e. Group discussions, interpersonal communication, hoardings, street plays will be developed laying emphasis on marriage after 18 years, first child after 20 years of age, need of ANC (Ante Natal Care), birth preparedness and importance of hospital delivery to increase
awareness amongst the mothers and communities about the need of ANC and exclusive breast feeding;

- Institutional delivery message display on rickshaws;

- Hoardings will be installed in important places like market, bus stands, etc.,

- TV/Radio and press advertisements will be developed on the need of ANC, birth preparedness and importance of hospital delivery to increase awareness amongst the mothers and communities about the need of ANC and exclusive breast feeding;

- Communication activities will be developed laying emphasis on symptoms of RTI (Reproductive Tract Infection) & STI (Sexual Tract Infection), myths and facilities available in the block area of diagnosis & treatment;

- The Mahila Mandalas (Women Group), ASHAs (Accredited Social Health Activist), and PRIs (Panchayat Raj Institutions) and Autonomous Councils will be oriented to motivate pregnant woman for institutional deliveries.

- Public Awareness campaign through print publicity / Outdoor publicity / Celebrity endorsement / PRIs / NGOs (Non Governmental Organisations) etc.

- Dissemination of information on certain diseases and other ‘health alerts’ through pamphlets, street plays, press and electronic media advertisements.

- Training ASHAs on BCC / IEC and Basic response to outbreaks.

### 4.3.2. SPIP 2008-09:

The plan states that, a *strategic IEC/BCC approach in Assam will focus in bridging the gap between knowledge and practice, which is a must for all BCC*
interventions. It is not realistic to expect one intervention alone to have significant impact on behavior; it is necessary to use a suitable mix of different interventions, through different channels over a long period of time. For rural and far-reached areas, more emphasis will be laid on alternative forms of communication – communication in the form of folk media and other mediums such as street plays, rallies, group discussions, local popular mobile theatres, etc. All these different channels shall be strategically used for behavior change communication. It has to be noted that with mainstream forms of communication such as print, electronic (including radio); almost 60 percent of the target audience is not catered to.

The changing population and demographic trends, environmental changes pose a new challenge for IEC/BCC planners in issues regarding health. While the population continues to grow, issues like sanitation, clean drinking water, eradication of malaria, polio and leprosy, affordable and accessible care for tuberculosis, maternal and child health, anemia, early age of marriage and HIV epidemic make new demands on behavior change communication interventions and campaigns as the previous year’s strategy and activities did not have much impact on the masses; and the problem remain unchanged. The NRHM, Assam again emphasizes on reduction of maternal mortality, meeting the reproductive health needs of men and women, including adolescents and youth and prevention of the spread of HIV/AIDS, reduction of infant mortality by way of improving the immunization coverage, promoting breast feeding, IMNCI (Integrated management of Neo natal & Childhood Illness), SNCU (Sick New born Care Unit), referral transport system, conducting of health days, formation of village health and nutrition committee, reducing total fertility rate by promoting family planning methods etc. To achieve this the state decided to have a
strategic IEC/BCC approach which should ideally focus in bridging the gap between knowledge and practice, which is a must for all BCC interventions. It is not realistic to expect one intervention alone to have significant impact on behavior; it is necessary to use a suitable mix of different interventions, through different channels over a long period of time. (SPIP 2008-09).

It is also emphasized that for rural and far-reached areas, more emphasis will be laid on alternative forms of communication – communication in the form of folk media and other mediums such as street plays, rallies, group discussions, local popular mobile theatres, etc. All these different channels shall be strategically used for behavior change communication. It has to be noted that with mainstream forms of communication such as print, electronic (including radio); almost 60 percent of the target audience is not catered to (SPIP 2008-09; Govt. of Assam).

**IEC/BCC for the year 2008/09 will be a two-fold process. One aspect of it will focus on more effective ways to reach out the target audience (including those residing in far-flung and remote areas) and the other is to focus on increasing the visibility of the services provided for the general mass under NRHM to a wider audience.**

For the reason the target audience can be sensibly divided into two viz the ‘media-haves’ or people who are accessible to media and the ‘media-have-nots’ or people who are not accessible to any form of mainstream media. It has to be noted that the target audience residing in far-flung areas cannot be penetrated through the use of mainstream communication forms such as Electronic and Print Media. The answer here is the use of alternative forms of communication in the form of Folk media, which the target audience is more receptive to.
To boost up the state decided that it is best to identify the Opinion Leaders. These opinion leaders should be used to sensibly influence the target audience to adopt health-seeking behavior. Along with this IPC or Inter-personal Communication can prove to be highly beneficial but as far as increasing the visibility of NRHM is concerned, the use of mainstream media will be continued, which will also enable NRHM to cater to the objectives. But Strategies will vary depending on the target group’s level of accessibility to various forms of communication. For groups residing in urban and semi-urban areas, messages will be disseminated using mainstream forms of communication. For target groups residing in remote locations and having no access to mainstream media, excessive use of alternative in the form of folk media, street plays etc will be made.63

4.3.3. SPIP 2009-10:

The IEC strategy for the year 2009-10 has focused more on making the communication strategies more comprehensive like 2008-09. While the mainstream media forms viz. Print, Electronic and Radio are included to cater to the general masses, there are new strategies proposed to reach out more effectively to the masses residing in remote and far-off areas. This will be achieved through Folk-media based presentations and through community screening of films based on health and health-related issues. The primary idea behind these new strategies is to blend information and entertainment (Info-entertainment) mainly in the audio-visual format which will help incarcerate the attention of the rural and the underprivileged audience for a maximum length of time. As for the masses residing in the urban and semi-urban areas, mainstream media forms such as the Print media, Television and Radio have been retained. Further, booklets featuring various health messages will be designed.
and printed and finally handed over to the ASHAs as supporting materials for conducting Inter-personal Communication (IPC).

The main objectives of the plan are Safe motherhood & balanced diet by reducing Maternal Mortality, Promoting Healthy Infant hood to reduce Infant Mortality Rate, decrease family size etc. And for the first time the state has included IEC as a separate & BCC as a separate part in the plan. The BCC is introduced to meet the informational need of the particular target audience groups, reduce barrier to behavior change to motivate audiences to seek appropriate reproductive and child health, family planning, adolescent health & other disease related to preventive and curative aspects. To achieve the objectives the state of Assam has proposed the following types of activities which are:

- Media based presentations will be carried out under the overall supervision of the DME (District Media Expert). These presentations will focus on the above outlined points and will be carried once twice a quarter in each of the 149 blocks of the state.

- A Docu-feature will be produced on Safe-motherhood practices. This film will be screened twice in a month in all 149 blocks of the state. CDs (Compact disc) of the film will be handed over to Mobile Medical Units (MMUs), and will be screened using their onboard audio-visual facilities during health camps

- TV spots will be shown in Mobile theatres

- Street plays will be carried out thrice-a-month in each block of the state. These street plays will feature the above mentioned objectives.
A booklet will be prepared on the Safe-Motherhood practices. This booklet will be distributed among all the ASHAs, who will use it as a supporting material to conduct Inter-Personal Communication (IPC).

Another Docu-feature will be produced incorporating the above mentioned points. This film will be screened twice a month in all schools under the SSA (Sarba Sikhsa Abhiyan) program.

A booklet on RH (Reproductive Health) knowledge for adolescents will be designed and printed.

IPC session on ANC, PNC, Safe delivery practices, PNC, complications during delivery, family planning and all the sessions will be organized and supervised by ASHA Facilitator during VHNDs, block PHCs/ CHCs/ SCs/Mini PHCs or a suitable place as decided by District Health society.

4.3.4. SPIP 2010-11:

There is nothing new in the IEC/BCC plan of 2010-11. It is replicating the previous goals, objectives and activities proposed in the previous years and tried to be more comprehensive. The IEC strategy for the year 2010-11 will focus more on making the communication strategies more comprehensive. While the mainstream media forms viz. Print, Electronic and Radio are included to cater to the general masses, there are new strategies proposed to reach out more effectively to the masses residing in remote and far-off areas. This will be achieved through Folk-media based presentations and through community screening of films based on health and health-related issues. As for the masses residing in the urban and semi-urban areas, mainstream media forms such as the Print media, Television and Radio have been
retained. Further, booklets featuring various health messages will be designed and printed and finally handed over to the ASHAs as supporting materials for conducting Inter-personal Communication\textsuperscript{64}.

4.3.5. SPIP 2011-12:

The IEC/BCC campaign of NRHM Assam is an interactive research based process to increase the knowledge level of particular audience group, reduce barriers to behavior change, to motivate audiences, to develop appropriate health seeking behavior in the field of Child Health, Adolescent Health, Family Planning, Maternal Health and other diseases like malaria, Japanese Encephalitis, Diarrhoea etc. The campaign shall also focus on generating demand for service deliveries. Advocacy at all levels including policy makers, service providers, community influencers etc, will be done related to preventive and curative aspects of health. Most of the planning is based on the following indicators but which are not new as repeated in the previous years. They are as follows:

- Infant mortality Rate- 61% out of 1000 live births (SRS, 2011)
- Findings say that more than 70% of the infant mortality death occurs within 1 month of birth of which again more than half dies within 48 hours of birth.
- Acute Respiratory Infection (0-2 years) - 14.6% (CES, 2009)
- Acute Diarrheal Infection (0-2 years)-7.8% (CES, 2009)
- Vitamin A Supplementation 2nd dose- 16.7% (CES-2009)
- Exclusive Breastfeeding till 6 months- 51.8% (CES-2009)
But there is nothing new; the same strategy and same activities are being continued and the same activities which has been continuing since the inception NRHM. The glimpses of plans & activities which are proposed and approved during the plan periods are Installation of Hoarding on six issues of Child Health, Print advertisement on the six issues of Child Health, Audio Visuals for TV and Radio, Workshop with ASHAs and ASHA Supervisors for IPC during VHND and Home Visit, Printing of IEC materials to support IPC, Folk Media (Street Plays, Mobile Theatre), Community Meetings, ASHA Radio Program, Social Mobilization campaign during Nutrition week and Breastfeeding Week, Campaign with special focus on Tea Garden and Riverine areas, Installation of Hoarding on anemia control, Print advertisement on anemia control, Workshop with ASHAs and ASHA Supervisors for IPC during VHND and Home Visit, Printing of IEC materials to support IPC, Folk Media (Street Plays, Mobile Theatre), Social Mobilization campaign during Nutrition week, Audio Visuals for TV and Radio.

4.3.6. SPIP 2012-13:

The IEC strategy for the year 2012-13 seeks to consolidate on the innovations introduced in the previous financial year. The plan explained that while the mainstream media forms viz. Print, Electronic and Radio are included to cater to the general masses, activities like Folk media communication through Jatras, Bhaonas (Theatre type of Assam) and Bengali Folk-theatre along with community film screening received impetus. The primary idea behind these activities is to blend information and entertainment, mainly in the audio-visual format, which will help arrest the attention of the rural and the underprivileged audience for the maximum
length of time. To consolidate these activities, IEC materials in the form of booklets, leaflets, posters, banners and hoardings in prominent locations has been planned.

The plan also introduced the Television News Reel initiative. The initiative mentions Documentaries and Docu-features on health to be telecasted on Doordarshan weekly (in the lines of the ASHA Radio Program). These films planned to focus on the activities and schemes under NRHM Assam- how these have benefited the masses and how the common people can avail the benefits of these. DVDs of these films panned to be distributed to the districts for screening of these films in the community. In the districts, shows are planned during evening hours, to provide the element of spectacle and to attract maximum audience. While selecting location for screening, the emphasis is to be given to far-off and remote places, where the reach of mass-media is limited. The DME along with the BPM should decide on the location where the show will be organized. For this purpose, a multimedia programmer and a DVD player has been planned to procure for each block.

4.3.7. SPIP 2013-14:

The SPIP shows a unique look without extensive write up on various activities. As per the new Program Implementation plan guideline issued by Govt. of India it stressed for planning up strategies and activities with annexure to be submitted with the SPIP. The Health Communication too does not have any write up except the filled in annexure. The government of Assam has filled in the annexure demarcated IEC/BCC part in various sections. The plan demarcated the concept of Health communication tools and planned various activities in the below format:
Mid-Media which includes community meeting & meeting with the focus group, institutional level block meeting for public, Street Play, folk media on various issues, information board for various subjects including JSSK, Public meeting, debate competition, rally etc. E-media which includes the production cost & broadcasting cost of various government, private news channels like NE TV, Rang, Ramdhenu, Newslive, DY 365, News time Assam & Door Darshan and various Red FM, Big FM, Gup chup FM and AIR. IPC tools for video screening, VHND meeting in the evening at ASHA Radio etc. Print advertisement which includes designing & publishing cost of advertisements or Public service messages regarding in various newspapers e.g. Asomiya Pratidin, Aamar Asom, and The Assam Tribune etc. 67.

4.3.8. Assam Public Health Bill 2010

During the planning period, the Assam Public Health Bill 2010 was introduced to provide for protection and fulfillment of rights in relation to health & well being, health equity and justice, including those related to the underlying departments of health as well as health care and for achieving the goal of health for all and for matters connected therewith or incidental thereto. Whereas every human being is entitled to enjoyment of the highest attainable standard of health and well being, conducive to living life in a dignity; and whereas right to health is an inclusive right extending not only to timely and appropriate Health Care but also to the underlying socio-economic, cultural and environmental determinants of health. And whereas the persisting inequities and denials in the matter of health in the state are concern to all; and whereas there is also a need to set a broad legal framework for providing essential services and functions, including powers to respond to public emergencies.
The Assam public Health Bill 2000 states that the act will extend to whole of Assam which will provide every person without reducing that persons’ capacity to acquire other essential goods and services including food, water, sanitation, housing, health services & education. The bill reiterates that Government in the Health & Family Welfare department will ensure appropriate and adequate budgetary measures to the extent possible as per the globally accepted norms, to satisfy, the obligations and rights for ensuring planning & rational allocation and distribution of resources for various health & health related issues & concerns for realization of health and well being of every person in the state.

The bill talks about the Establishment of a State & District Public Health Board by the state government and accordingly put forward various functions of the board which will be basically for implementation of the bill and monitoring of the activities as mentioned in the bill. The state Public Health Board will be chaired by Chief Secretary Govt. of Assam, Co chairman will be Principal Secretary Health & Family Welfare; Govt. of Assam, commissioner & Secretary of health & Family Welfare will be the Vice Chairperson and Director of health Services, Assam shall be the member secretary. The state public Health board will also consists of representatives/ nominees of all department’s secretaries, two members from Legislative Assembly, four non official members Public health Experts, Representatives of Medical associations, non government organization as nominated by government as members. The Board will carry out various functions which includes formulate and implement state level strategies and prepare plan of action, Identify state Health goals to be included in mandate of PRIs/ Autonomous Council. To get medical clinical audit carry out, confidential inquiry of deaths & failure of the
health system for systematic improvements, establish and implement performance standards, ensuring availability of drugs as per WHO model list of Essential Drugs, develop public health IEC infrastructure and programs for mass public health campaigns, formulate & implement human resource development plan, initiate mechanism for Public Private Partnerships in implementation of public health programs, empowering decentralized monitoring committee at all levels, ensure coordinating with other government departments, coordinating with central government, review the existing laws & policies of the state government and appoint committees and sub committees to address technical aspects of specific areas.

Regarding health Communication the main duties of the board will be as under:

*Develop public Health IEC infrastructure and programs for mass public Health campaigns and activities, with institutionalized involvement of educational institutions, no governmental organization, community based organizations, non-governmental organizations, association of medical providers, traditional health care practitioners, mass media including privately owned mass media and stakeholders in promotion of public Health.*

The district Public Health Board will be headed by Deputy Commissioner (DC) as the chairperson, CEO (Chief Executive Officer), Zila Parishad (District Council) in non XI schedule states and Chief Executive Member (CEM) in the XI schedule areas or his representatives will be Co-chairperson and Joint director Health Services of the concerned districts will be the member secretary of the board. The board will consists of senior most engineers from PHE department, President/Chairman Zila Parishad, District Social Welfare Officer, Program Director, DRDA
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(District Rural Development Agency), for members from NGOs and Health Experts. The main functions of the board is to organize hearing of beneficiaries coming to the hospital once in a year with a view to improve health care services, ensure coordination among all public health institutions of the district, coordinate with various departments to handle any emergencies & ensure availability and access to adequate and safe food, water, sanitation and housing, and carry out any activity entrusted by state health board.

Lastly the bill restates that despite anything contrary contained under the provisions of the act, neither the government nor the government personnel, experts or agents responsible for performance of any of the duties and functions under this act or any other NGO/Civil Society representatives/member especially authorized or entrusted by the government to act under this act, shall be held liable for death or any injury caused to any individual, or damage to the property, or violation of any kind, directly as a result of complying with or attempt to comply with this act or any rule made there under. Furthermore, nothing in this act shall be construed to impose liability on the state or the local public health agency for the acts or omissions of a private sector partner unless explicitly authorized by law.²⁹

4.3.9. Assam Health (Prohibition of Manufacturing Trade, Advertisement, Storage, Distribution, Sale and Consumption of Zarda, Gutkha, Panmasala etc. containing Tobacco) Act, 2013.

The Bill was introduced in Assam Assembly by the State Health Department for imposing ban on consumption, trading, manufacturing, distribution and advertising of a wide range of tobacco and tobacco products and other items containing tobacco as an ingredient. The main objective is to ‘improve public health
and prevent incidence of cancer and other health hazards and addiction among the people of the State.

4.4. Conclusion

It has been observed that most of the health policies, programs etc is designed by government of India since all the five year plans and the state was just a mere spectator or a follower of the health plans or policies. Only after the introduction of National health mission only the state government has been taking active part in preparation of policies and plans whether it is for health communication or health as a whole.
Notes & References

1. Dutta Indrani & Bawari Shailly, May 2007 Health & Health Care in Assam-a status report, Centre for Enquiry into Health and Allied Themes (CEHAT) and Omeo Kumar Das Institute of Social Change and Development, Mumbai P21
2. Ravi Duggal; Evolution of the Health Policies in India; Centre for Enquiry into Health and Allied Themes (CEHAT)); 18th April 2001 p23-25
3. Bhore Committee; Government of India; Report of the Health Survey and Development Committee (); Delhi, 1946: Manager of Publications p17
4. Bhore, 1946 p.22
5. Bhore, 1946 p30
10. Planning commission, Govt. of India, 11st five year Plan Planning Commission, p3
13. Ravi Duggal, Evolution of the Health Policies in India; Centre for Enquiry into Health and Allied Themes (CEHAT)); 18th April 2001 p 34-35
14. Govt. of India, 2nd five year Plan Planning Commission, Yojana Bhavan, New Delhi p227
15. Govt. of India, 2nd five year Plan, pp 278-79
17. Ravi Duggal; Evolution of the Health Policies in India;, Centre for Enquiry into Health and Allied Themes (CEHAT)); 18th April 2001p44-48Ibid p 235-240
18. Govt. of India, 3rd five year Plan Planning Commission, Yojana Bhavan, New Delhi p 657
19 Batliwala, Srilatha, 1978: The Historical Development of Health Services in India, FRCH, Bombay p 67
20 Ravi Duggal; Evolution of the Health Policies in India; Centre for Enquiry into Health and Allied Themes (CEHAT)); 18th April 2001 p44-48Ibid p 235-240 p 54
21 Chadha Committee, 1963: Special Committee for NMEP Maintenance Phase, MoHFW, GOI, New Delhi p34
23 Govt. of India, 3rd five year Plan Planning Commission, Yojana Bhavan, New Delhi p 56, 3rd five year plan p66
24 3rd five year plan pp 31-32
25 3rd five year plan p 391
26 Ravi Duggal & Leena V Gangoli, 2001 Review of Health care India, p 398-414
27 Ravi Duggal & L. Gagungli pp 213-214
28 Govt. of India, 5th five year Plan Planning Commission, Yojana Bhavan, New Delhi, p 294-295
29 Report of the committee on multipurpose workers under Health & Family planning programs 1974; Government of India pp 23-25
30 Report of the committee on multipurpose workers under Health & Family planning programs 1974 pp 87-89
31 Report of the committee on multipurpose workers under Health & Family planning programs 1974 pp 84-85
32 National Population Policy 1976, Govt. of India p 3-5
33 National Population Policy 1976 pp 78-80
34 Simon Committee, 1960: National Water Supply and Sanitation Committee, GOI, New Delhi p34
35 Govt. of India, 6th five year Plan, Planning Commission, Yojana Bhavan, New Delhi Vol. III, 1978, p 250
36 6th five year Plan 1978, p 368
37 6th five year Plan, 1978, p 378-380
38 Ravi Duggal 2001; Evolution of the Health Policies in India pp112-113
39 National Health Policy 1983 p26
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41 National Health Policy 1983 pp29-30
42 Nanda 2007; Reflecting on issues related to emic & etic approach Vol 15, No 2 (2014)
43 Seventh five year plan 1983 pp14-18
44 Seventh five year plan 1983 pp34-38
45 Ottawa charter for health promotion 1986 pp4-7, WHO, Ottawa
46 Ottawa charter for health promotion 1986 p13 WHO, Ottawa
47 Eight five year plan p345 Health communication, planning commission
48 Ravi Duggal 2001; Evolution of the Health Policies in India p154-55
49 National Population policy 2000 p87
50 Ninth five year plan, Planning commission, Govt of India 1997 p25
51 Ninth five year plan, Planning commission, Govt of India 1997 pp123-124
52 10th five year plan document; Planning Commission p349-357
53 National Health Policy 2002 Govt of India Ministry of Health & Family welfare pp 12-20
54 11th Five year Plan, planning commission page 345-347
55 National rural health mission program implementation plan page 12-14
56 Framework of implementation National Health Mission, 2005 Govt. of India page 32-36
57 www. niti.gov.in viewed on 15th march 2016
58 Framework of implementation National Health Mission, 2005 Govt. of India page 39-46
59 to 67 State program Implementation plan since 2006-07 onwards till 2012-13; IEC/BCC division
68, 69 Assam Public Health Bill 2000, Govt. of Assam, Page 1-5
70 Assam Health (Prohibition of Manufacturing Trade, Advertisement, Storage, Distribution, Sale and Consumption of Zarda, Gutkha, Panmasala etc. containing Tobacco) Act, 2013 pp2-3