Chapter 1
General Overview

1.1. Introduction

Health policy analysis is a diminutive but growing field of study. It is increasingly recognized as an important area within health policy and systems since nineties. The importance of health policy analysis is widely acknowledged and viewed as an instrument to act more effectively to combat health problems and improve life conditions\(^1\). Health policy analysis helps in understanding how policy makers set objectives, make decisions on health priorities & take actions\(^2\). It also explains how policy context (political, economic and socio-cultural) influences the health policy process and its outcomes\(^3\). Furthermore, health policy analysis can help in understanding important stages of the health policy process such as agenda building and policy formulating, planning, monitoring and evaluation and which factors as well as actors affect the process. In many developing countries, various international health programs including Health for All (HFA) and Primary Health Care (PHC) did not achieve their targets during the last three decades\(^4\). International agencies tried to improve health conditions by integrating international health programs and strategies with national health policies but did not succeed due to various factors related to health policy content, context and process. More recently World Health Organization has emphasized the importance of economic development, i.e. reduction of poverty, as the basis of health promotion and vice versa the economic benefits of investment in effective health policy. However, it is not easy to prove the effectiveness of health policy on a general level\(^5\).
There are various approaches available to analyze health policy formulation. Among these approaches, policy analysis experts have frequently used rationalistic and behavioral models. The health policy analysis approaches or models will be used to analyze the health communication policy too because communication policy (Media Policy) or a health policy is a public policy which may be described as a continuous flow of more or less independent policies which deals with many different activities. Public policy may be compared to a great river drawing from various tributaries, the innumerable component parts of which it is constituted. In a democracy or more so in a complex world policy cannot be made by one person or even persons at highest levels, public policy involves a large number of individuals and institutions-ministers, public servants, parliamentarian, politicians, interest and pressure groups, professional & experts.6

The purpose of this study is not to demonstrate direct links between health policy and implementation of health communication policies and its outcome on health indicators. The aim is to demonstrate how various factors and processes in the Assamese society and political system influence the health policy process specially health communication. The health policy formulation gives the similar impression about health communication policy formulation as health communication policy formulation comes under the orbit of health policy formulation.

This introductory chapter will explain why health communication policy analysis is important and which model is used to analyze health communication policy in Assam. Next, research questions will be formulated, concentrating on health communication policy analysis in Assam during the last decade. To execute this
analysis we have used various data sources and methods, which will be explained at the end of this chapter, followed by an overview of the chapters. But first we explain why Assam was chosen as a case to analyze health communication policy.

1.2. Communication & Health Communication

Communication is the process of transferring information from sender to receiver with the use of a medium in which the communicated information is understood by both sender and receiver. In this process all the components such as information, sender, coding, medium, decoding, receiver and feedback are very important. There are various types of communication such as mass communication, individual communication, written, verbal and non-verbal etc. But communication has two functions of exchanging information & signification of symbolic capability reflect what James Carey characterized as the transmission and ritual views of communication respectively. Carey recognized that communication serves an instrumental role (e.g. it helps one acquire knowledge) but it also fulfils a ritualistic function, one that reflects humans as members of a social community (James Carey). Thus, communication can be defined as the symbolic exchange of shared meaning and all communicative acts have both a transmission and a ritualistic component.

Health communication is not different from communication if and when the concept of communicating information to the general public is concerned. Therefore it can be mentioned here that health communication uses the same strategy while conceptualizing & while decoding meaning of something for which communication is being made. It is the key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. Within the health communication field, communication is conceptualized as the central social process in
the provision of health care delivery and the promotion of public health. The centrality of the process of communication is based upon the pervasive roles communication which performs in creating, gathering, and sharing "health information". In its literal form, it links the domains of communication and health and is increasingly recognized as a necessary element of efforts to look up personal and public in the form of health professional-patient relations, individuals exposure to search for and use of health information, individuals’ adherence to clinical recommendations and regimens, the construction of public health messages and campaigns, the dissemination of individual and population health risk information.

Therefore it is to be mentioned here that ‘Health communication’ not only examines the pragmatic influences of human communication on the provision of health care and the promotion of public health but also enhances the quality of health care delivery and health promotion. To this end, health communication is usually problem-based, focusing on identifying, examining, and solving health care and health promotion problems. Health communication encompasses numerous communication strategies including edutainment or enter-education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing. It can also take forms of traditional and culture-specific communication such as storytelling, puppet shows and songs etc. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas.
It uses the mass (such as public service announcements on advertisements, billboards, radio and television) and educational messages in printed materials (such as pamphlets, leaflets etc) media tools to deliver health messages. Many campaigns have used social marketing techniques. Even health improvement activities are taking advantage of digital technologies, such as CD-ROM (Compact Disc Read only Memory) and the World Wide Web (WWW) that can target audiences, adapt messages, and slot in people in interactive, ongoing exchanges about health. An emerging area is health communication to support community-centered prevention. Community-centered prevention shifts attention from the individual to group-level change and emphasizes the empowerment of individuals and communities to effect change on multiple levels. The commonly used techniques for delivering the health communication is mass media but recently the behavior change communication is taking the place of mass media as in changes to bring out through providing information, communication and education. The behavior change communication includes interpersonal communication or organizing counseling session, group discussions, video & audio shows, women’s meet etc.

### 1.3. The case of 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. That is why the overall organizational and
management structure in Assam is quite similar to the management structure followed across India, despite health being a state subject. This is mainly because the financial allocation of the resources is determined by the central government and this is done through plan schemes or programmes that are usually uniform across states. But still there are few hospitals and clinics which are not owned by government; some doctors are government employees but there are also private doctors who collect their fees from the government. It also to be mentioned the existence of multiple systems, various types of ownership patterns and different kinds of delivery structures i.e. Allopath, Ayurvedic, homoeopathy, Unani, Siddha, among others which makes up a complex plurality for the development of an organized system in Assam and across India. However, Allopath is the dominant system of medicine. Its domineering influence is evidenced by the fact that practitioners of other systems of medicine are now also primarily practicing Allopath.

As, per the National Health Policy 2002, there are 17,000 hospitals (34 percent rural), 25,670 dispensaries (40 percent rural) and about one million beds (23 percent rural) at present in India. In addition, the rural areas have 24,000 PHCs (Primary Health Centre) and 140,000 sub-centers (henceforth SC). However, the comparison between urban and rural areas show that urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 urban population in sharp contrast to rural areas which have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 rural population. Thus, the urban-rural disparity is striking in spite of the fact that 70 percent of the population comprises rural areas and only 30 percent comprises the urban areas. The shortfalls of the system are mentioned in National Health Policy 2002. Applying current norms to the population program for the current year, it is
estimated that the shortfall in the number of SC/PHC/CHC is of the order of 16 percent. However, this shortage is as high as 58 percent when disaggregated for CHCs (Community Health Centre) only. In terms of availability of medical manpower for the country as a whole shows that for every 1,00,000 populations there are 70 doctors. Across rural areas, the public health manpower include 28,930 nurse midwives, 1,33,194 ANMs (Auxiliary Nurse-Midwife), 61,907 male MPWs (Multi Purpose worker), 17,708 pharmacists and 58,752 paramedical staff in addition to non technical staff.

In Assam still not all the villages have a health care services provider from the health department. The Auxiliary Nurse-Midwife (henceforth ANM) is located in one out of 4 to 6 villages. In many parts of the state, ANMs do not stay at sub-centres because of security reasons, lack of residential quarters, family constraints and at times for no genuine reason at all and one can imagine the situation in the state. In the frontier state, a very limited rural health infrastructure already exists but it needs to be improved both quantitatively as well as qualitatively. On the one hand, the number of Primary Health Centres (henceforth PHC) and Community Health Centres (henceforth CHC) are much below the required norms and on the other hand, many of them are not fully functional. PHCs in the remote areas are grossly understaffed or may be maintained by an AYUSH MO (Medical officer) or many are run by only an ANM or a Pharmacist. It is a callous waste of resources that only a small fraction of the existing infrastructure is being used. Due to disuse and neglect, the buildings are in a state of dilapidation and decay. Equipments are also not fit for use due to lack of regular maintenance. In the absence of doctors, the skeleton paramedical staff
provides the services which obviously are of substandard quality. This situation has given rise to rampant quackery and corruption\textsuperscript{13}.

The geographical structure though easy for movement but there are a large number of swamp and the terrain is crisscrossed by numerous rivers, making it flood-prone. This makes movement very difficult, especially during the rainy season. Even in the PHCs which function, facilities are not adequate and available facilities are not fully utilized. There seem to be several underlying reasons for this malady. Firstly, the PHCs are overcrowded and have to cater to a larger population than they are supposed to attend. Consequently, doctors are not able to give attention and time to the patients. Secondly, proper storage facilities are not available and supply of medicines is irregular and insufficient. But it is the frustration and demoralization among doctors from the lack of opportunities for promotion and harassment by petty bureaucrats which debase the medical services. The situation is further compounded by a growing trend wherein doctors go to their own private clinics and nursing homes refer a large number of patients who can be treated at the PHCs. The CHCs are also of the same situation. Except few it is functioning in the name of CHC only. Literally, it can be termed as PHCs. The CHCs are supposed to staff resident specialists. They are generally not available as they are “attached” to some hospital or dispensary in the city areas or commute between the CHC and the nearby town where they have private hospital. Another factor which makes the situation in Assam relatively unique is its low economic growth rate unequal to national level and shoddier law and order situation due to insurgencies.

The most important observation which led to this study is the observations of NFHS-3 (National Family Health Survey) data on media exposure. It is observed
from the data that the media exposure on health policies/strategies is less; women age group 15-49 years has 85 \% & from 49 years to above has 88\% media exposure in urban areas while 56 \& 73 \% in rural areas respectively. It has also been observed from the DLHS-3(District Level Household survey) data that the awareness about the government health programs especially DOTS, Leprosy, Malaria, Dengue, prevention of sex selection is not very encouraging which is 58.4, 35.7, 90.4, 28.7\% respectively. The awareness level about any methods of family planning is less than 50\%. Even the coverage of ANC (Ante Natal check up), Institutional delivery, Full Immunization is 74.8\%, 35.3\%, 50.9\% respectively which indicates the messages or the information on health issues and subjects has not been disseminated widely. Or the health policy formulation was incorrect hence people were not ready to accept the messages. Or the communication policies to spread the health messages were not given due importance. But the state has more than 20 daily newspapers in various languages, 10 or more no of 24x7 news channels and other regional channels which is on air at present. In the city areas above all TVs more than 10 FM radio channels are on air. In spite of that also the awareness level is not so encouraging.

Therefore the pertinent question arises how the health policy is designed in this dominant system. In the process of health policy development & design how does the state treat the people living far away from the centre of power? Do they have right to health? Under what circumstances the health communication policies are designed? Who participates in the policy making? Do the policies have political goal/objectives? Do the policies really achieve the coveted goals/target? Do the policy makers have the requisite knowledge about the new communication strategies? Are the policies people friendly? These are some of the crucial issues to be looked into in a triad of people,
state and the larger society. For this we are attempting to know how the health communication policies are designed & developed in Assam in larger context so that the health messages may be spread equally to all the nook and corner of the state.

1.4. Importance of Health communication policy analysis

Modern health archetypes assert that all public policies should take into account the health rights and interests of the public by making healthy choices easier and unhealthy choices more difficult \(^{16}\). In this regard, health policy helps to set the parameters for the mode and character of industrial and agricultural production, corporate management and individual behavior and to influence the environment in the direction of modern health paradigms \(^{17}\). It denotes new ecological perspective of disease prevention and health promotion in policy making by paying attention to all determinants of health such as human biology, lifestyles, environment (Physical, political, economic and socio-cultural) and health care organization. The modern concept of public health also mentions it all by the following way,

"Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease \(^{18}\). That is why to ensure the public health, the health policy and health communication policies are one of the most important components.

But due importance on the Policy analysis in developing countries has been limited and health communication sector in particular appears to have been neglected.
This is all more surprising because of the growing crisis in health systems. The initial optimism of PHC (primary health care) revolution of late 1970s has been challenged by a number of trends; escalating costs but lower public health budgets because of economic recessions, the emergence of AIDS (Acquired Immune deficiency Syndrome), the increase in the number of large scale and complex disasters, the prevalence of chronic diseases side by side with persisting communicable diseases, worsening inequalities in access to services, demoralized health staff and emerging drug resistance to some diseases. In the face of severe economic constraints and shifts towards neo-liberal values, many countries have introduced structural adjustment programs which led to cut public health services, introduction of or increased charges for health sector and liberalization of the health sector to promote private sector development. This crisis in Health is well recognized and prescriptions of what countries should do abound. However there is very little attention to how countries should carry out reforms, much less who is likely to favor or resist such policies. Even the health policies wrongly focuses attention on the content of the reform and neglects the actors involved in the policy reform (at the international, national and sub national level), the process contingent on developing and implementing change and the context which policy is developed. Therefore the Health Policy analysis specifically should describe the contextual factors including political, economic, socio-cultural and demographic aspects which affect the health outcomes directly or indirectly.

New paradigms of health policy analysis began to emerge in the 1990s, focusing less on technical content of health policy (the ‘what’ of policy – for example whether to recommend user fees or insurance as more equitable and efficient in financing health care) and more on the actors, power and processes involved in
developing and implementing policy, and the contexts within which decisions are made. These paradigms surfaced as demand grew to understand how and why certain policies do well or do not succeed and how such understanding could help policymakers make strategic decisions about future policies and their implementation. The Health policy analysis contributes to understand how policy makers set priorities in health care and plan actions in order to address increasing health problems. It analyzes important stages of the health policy process - including agenda building and policy formulation, planning, monitoring and evaluation - to determine which factors and actors affect the process. This knowledge can help in finding effective ways of policy formulation, planning, implementation, monitoring and evaluation. Health policy analysis can also help in understanding the role of actors and interest groups involved in the health policy process. In other words, the study of health policy needs to take into consideration factors such as the role of the state, the interests of various actors and the manner in which they wield power, the nature of political systems and their mechanisms for participation, and the rules of the game in so far as the informal and formal policy processes are concerned. Moreover, policy analysis must also examine the role of culture and values systems and how they are expressed as beliefs, ideas and argument, as well as international factors which are increasing inter-dependence between states and affecting state sovereignty over policy processes.

With the introduction of new health paradigm as mentioned earlier, health policy analysis should try to achieve the mandate to reach to its goal to provide the best health care to the people and try to develop the health seeking behavior of the people for a better health of the community in the state. The mandate of new health paradigm is prevent disease, promote health and prolong life and this may be achieved
through better health communication policy in the state which is part of Health policy making process only 20.

1.5. Different Approaches in Health & Health Communication Policy Analysis

Policy analysis means different things to different people. For some, policy analysis mainly concerns policy content, while others argue it is more concerned with policy context and process. Traditionally, there are two approaches to policy analysis: the "rationalist" and the "behaviorist” approach 21. Within these two approaches again the variety is large and accents may differ. During the study we will be using both the approaches to analyze the health communication policies; here we describe few main approaches.

The rationalist or idealistic approach or ‘linear model’ tends to focus more on the content of the policy and is more value oriented - since it analyses how policy-making should be undertaken. Policy making is seen as a problem solving process where decisions are made on sequential phases i.e. problem definition, alternative approaches to solve the problem, choosing the best approach and implementing it. Rationalists believe that the focus upon content analysis adds significantly to the breadth, significance, and reliability of the discipline’s special body of knowledge 22. Accordingly, clear goals can be formulated, based on the analysis of health needs, health hazards and their determinants. This approach enables analysts to evaluate past and present policies more objectively and offers a prescriptive and ideal model of how policy-making ought to be undertaken. It offers a way of improving the effectiveness of policy-making by explicitly identifying values and goals before making policy choices and selecting the best policy options based on comprehensive information
about the costs and consequences of each. The rationalist approach is also linked to various scientific and technical tools, such as Program Evaluation Review Technique (PERT), Management by Objectives (MBO) and Program Planning and Budgeting (PPB).

Unlike rationalism, the **behaviorism approach (also called instrumentalism)** argues that it is essential to pay more attention to the process and the context within which policies are formed and implemented. According to this approach analysis of policy process helps in understanding why many health problems are not solved, why policies are not implemented effectively and why health policies do not achieve their targets. It is among others a ‘political process’ which outcomes are ‘evolutionary’ and not rational or ‘logical’. Therefore, for behaviorists the understandings of contextual factors, including political, socio-cultural and economic ones are critical in any policy analysis. Understanding such factors should lead to the best choice of strategies for implementation in a specific community.

Within the behaviorism, various processes or factors may be seen as crucial in understanding the outcome and various theories are developed. Few of the scholars Jenkins-Smith & Sabatier\(^\text{23}\) demonstrate the usefulness of the advocacy coalition framework (ACF) for understanding the factors which influence the policy process at least in western policy making. The ACF has generated considerable interest because it emerged out of a search for an alternative to the heuristic stages that was then dominating policy studies, a desire to synthesize the best features of the ‘top-down’ and ‘bottom-up’ approaches to policy implementation and a commitment to incorporate technical information into a more prominent role in theories on policy
processes. The goal of the ACF was to provide a coherent understanding of the major factors and processes affecting the overall policy process. In the mid eighties, Sabatier interested in the role of technical information and Jenkins-Smith, who had quite independently developed a similar conception of the role of scientific information in public policy, revised the framework of the ACF several times together with other scholars.

Another theory has developed named the ‘theory of streams’ by Kingdon by opining that the policy process moves through a number of distinct phases but not in an orderly way. Interaction between policy makers and executive officers is an important aspect. This theory considers three streams of agenda building i.e. a problem stream, a political stream and a policy stream where each stream has its own typical process rather independent from each other. In the problem stream the process is characterized by problem recognition. Various factors focus the attention on a problem or issue of concern and its importance. In the political stream the process is determined by fluctuations in politics through the influence by people, political parties and ideologies of politicians that can either include or exclude certain issues from the agenda. In the policy stream the process includes the presentation of ideas and the development of alternatives. Proposals are selected on the basis of criteria like feasibility, harmonization with dominant norms and susceptibility of politicians. Another scholar Leeuw de opined that the policy process is complex because policy making is increasingly a matter of (exchange of) information and communication. The opportunities and abilities of participants in a policy network to communicate and to exchange information, expertise and other resources determine whether policy is made and what is its content. Other policy scientists take an even more extreme view.
by characterizing the policy process as complex, disordered & coincidental and hardly open to analysis.\textsuperscript{26}

There is also some debate about ‘models’ and ‘theories’ whose usability again might be related with infrastructure and circumstances of the place/context of the investigation. Some believe that a model is a representation of a specific situation whereas a theory provides a “denser” and more logically coherent set of relationships. A theory considers a connection and pattern between a set of variables and usually specifies how relationships may vary depending upon the values of critical variables. For example, the work of Sabatier (1993), (1998) and (1999) presented how theories can be used in analyzing policy process in developed countries. In developing countries, the policy process is different; for example the relationship and interaction between policy makers and executive officers influences the implementation process considerably and may change the goals and outcomes. In developed countries the role of well organized interest groups and stakeholders is more pronounced.

We believe that in analyzing health policies in India and other developing countries many theories and models (like of Kingdon and Sabatier) are not appropriate because political, economic and socio-cultural context in which policy process takes place in the developed world is different than developing countries. In developed countries interest groups are better organized, various processes like in problem stream and policy stream are less connected with each other and mechanism to ‘defend’ the interests are based on formalized procedures and democratic embedded. In case of developing countries in analyzing health policies problem stream and policy stream are strongly connected, procedures are not established and interest groups are absent and/or not organized. Even more important may be to pay
attention upon the policy content in developing countries because health policy content indicates what outcomes may be expected for the health status of the population, where health status are bad. It makes clear which priorities are set, which policy tools and programs are believed to achieve the policy’s goals and objectives.

In analyzing health policies developing countries need a comprehensive approach but not a detailed set of connected concepts (theory) because their problems have to be solved within a more unfavorable policy context, within an often centralized system and with lack of procedures and resources. We believe that the model of Walt & Gilson (1994) can be a helpful tool to analyze health policies to know who the actors are and what the contextual factors are that affecting policy decisions. This model will apply as well to health communication policies in Assam because the model has been specifically designed for analyzing health policies.

1.6. The model of Walt and Gilson Health Policy Analysis

Walt & Gilson (1994) considered the work of many scientists in developing their analytical model. The model plays more attention to social context and considers a balance of power between state and society. Similarly the model stresses that the health policy context includes the political system, the power structure, the role of government and its institutions, socio-cultural and economic environments, demographic characteristics, the health status of the population and the role of community. The model of Walt & Gilson (1994) does not reject nor fully support either of the traditional approaches (rationalism and behavioralism). It juxtaposes both the approaches and incorporates their views by arguing the importance of policy content, context, and process. Furthermore, this model argues to include the role of
actors (or interest groups) in analyzing policies (see Figure 1). The model explains the policy making process as cited under:

1.6.1. Actor Analysis:

In every (Public) policy, actors play various roles in all stages of policy process such as agenda building, policy formulation, planning, implementation, monitoring & evaluation. Some refer to actors as policy elites and decision makers. Sabatier (1998) has developed a framework in which the role of individual actors and interest groups play a central role. This framework applies to situations where “some degree of coordinated dissent from the policies of the dominant coalition” is possible

27. In analyzing the role of actors, some scientist tends to limit their focus of attention only to the actors within government. Others argue that actors outside the government should also be included because many actors outside the governmental hierarchies directly and indirectly influence health policy process

28. Walt & Gilson (1994) include the role of actors in health policy analysis and consider the work of many scientists highlighting the role of actors like civil servants, political leaders, tribal & religious leaders, foreign donors in different regions of the world in analyzing the role of actors in various countries. Scientists like Berry (1990), Brown(1989), Mukandala(1992) and Panday(1989) suggest that relationship between various actors should also be considered in analyzing the role of actors. In summing up, Walt & Gibson mentioned that for analyzing the role of actors as Individuals and as members of Groups within and outside the government should also be considered.
International agencies and donors such as the World Bank, IMF, WHO and many others also influence overall policy environment, health policy and health in various ways. They constitute an important part of the actor analysis. Donors contribute resources for health in developing countries and put extensive pressure upon those countries to implement changes. For example, WHO’s Health for All (HFA) strategies provided the policy basis for the main social target of governments and a better understanding of appropriate policy mechanisms for effective implementation. The World Bank has taken on an important global role in health policy process by its efforts in alleviating poverty, improving nutrition and providing external funding for the health sector in developing countries. The year 2000 AD has come and gone but ‘Health for All’ remains a distant dream to most countries in the world. As a response to the situation, various People’s Organizations around the world came together in 2000 AD in Dhaka, Bangladesh and organized the first People’s Health Assembly demanding “Health for All Now”. People’s Health
Movement (henceforth PHM) was born at the end of the assembly to address health care issues at all levels. People’s Health Movement known as Jan Swasthaya Abhiyan (henceforth JSA) in India launched the Right to Health Care Campaign to establish health care as a basic human right in 2003, the silver jubilee year of the “Health for All” declaration. The JSA proposed organizing Jansunwais’ (public hearings) on denial of access to health care as one of the ways for achieving the objectives.

1.6.2. Content Analysis

Policy content refers to a particular policy goal or set of goals and the particular actions planned to achieve those goals. Focusing on content helps policy makers in identifying, comparing and evaluating competing policy proposals as well as in building agenda, making policy decisions and fixing health goals. Content analysis helps in finding solutions for health problems by considering not only health care services but also other determinants of health which can be influenced particularly environment and lifestyle. Furthermore, it improves understanding of policy outcomes and provides information for policy makers regarding the technical skill, reliability & effectiveness of various means and the interrelations between different goals.

Modern health paradigms require that attention to be paid to health policy content in promoting health systematically and effectively. For example, in 1978 the WHO initiated its Health for All (HFA) strategy by recommending that new policy directions and specific health targets to be added to the policy content. It helps in setting a systematic relationship between the content of the policy and the responsibilities of government and stakeholders. However, whether the content of
health policy does contribute to better health outcomes is a much more complicated question and not easy to answer \(^{35}\).

1.6.3. Context Analysis

Health policy does not take place in a political vacuum but is embedded within a political, administrative, economic, socio-cultural, and demographic context. Contextual factors are considered critical elements influencing the policy process and the overall health of a population directly and indirectly \(^{36}\). For example, many developing countries suffered high mortality and morbidity as a consequence of violent political divergences, communal wars and repeated alteration of government priorities and less importance on social sector policies specially health, education etc. The economic context significantly influences the health policy process and health outcomes \(^{37}\). A well-functioning health care system and successful health policy implementation need a regular flow of resources. If a country is very poor, its resources for health care will inevitably be very restricted. The economical context also influences health in other ways. For instance, developing countries often suffer from serious nutrition problems, which are a direct consequence of poverty and strongly influence the health status of the population. Socio-cultural factors such as the status of women, religious and cultural values, literacy level and corruption pervade the health policy environment and influence behavior \(^{38}\). There are obvious relationships and clear links (positive or negative) between health and culture because lifestyles are significantly influenced by cultural values. Culture also influences the attitude of people in playing their role in the collective efforts of society to prevent disease and promote health. A low status of women and illiteracy has been identified as contributing factors to high mortality and morbidity in developing countries.
Several organizations, including the World Bank, the IMF, and Transparency International, have highlighted corruption and its impacts upon the policy process in developing countries. The problem of corruption in the health sector makes health policies ineffective and contributes to mortality and morbidity in developing countries\(^39\).

1.6.4. **Process Analysis**

Through health policy process a government, society, institutions and/or professionals set their activities and allocate their resources. Generally, the policy process is divided into different stages or segments such as agenda building, planning, implementation, monitoring & evaluation and feedback \(^40\). Policy processes in the developing countries are often characterized by many weaknesses and failures. Policy elites in developing countries often build the health agenda and formulate health policies without recognizing important health problems \(^41\). Consequently, many health problems do not effectively get on the policy agenda. In some countries, policymakers even seem to deny the existence of serious health problems or the multiple factors determining the health problem \(^42\). In developing countries, health planning repeatedly leads to health plans that appear to be implemented not at all or only partly. Planning documents often offer health objectives without providing enough details on how objectives will be realized. Health planning is often not flexible, participative or integrated with other decision-making processes. The links between planning and implementation are weak. Many health policies in developing countries are not implemented properly due to power conflicts, lack of political support, lack of resources and lack of reliable data \(^43\). For example the much discussed model for better health communication policy designing as suggested by World Health Organization in
2000 and THCU (The Health Communication Unit, University of Harvard) roadmap for health communication policy development clearly shows that the various stages for policy formulations are not entirely followed in developing countries while developing health communication policies.

1.7. Aims & Objective:

The central objective of the research is to study the development & designing of Health policies particularly health communication policies for Assam. It is to know how the health communication policies are being designed during the last decade in Assam and how the contextual factors played a major role in formulating this policy.

The following are the specific research objectives:

- To study the process how the health communication policies are designed (i.e. agenda building, planning, implementation, monitoring and evaluation).

- To study how the contextual factors (political, economic and socio-cultural) influence the health policy process in Assam.

- To understand the trend of health communication in Assam especially after the market liberalization.

- To make suggestions for designing better health communication policy.

As the objectives reveal, the study aims at documenting and understanding the health communication policy making process for the state of Assam. The study aims to bring out the extent of policy making process as a public health problem solving tool. In the process it will also be necessary to study the norms, culture, beliefs and
values of the community from the existing literature available. Another broad goal of this study is to know various health communication policies since planning period and analyze the change of priority in policy making process.

1.8. Hypothesis of the study:

- Consider communication to be a psychological event and emphasize that ‘when’ (time) is an important component of communication in addition to ‘how’ and ‘with what ways’ as 3 major characteristics of communication. All the 3 is lacking in Assam.

- Modern health paradigms denote new ecological perspectives of disease prevention and health promotion in policy making by paying attention to all important determinants of health such as human biology, lifestyles, environment (physical, political, economic and socio-cultural) and health care organization which is missing in Assam context.

- Generally, national health policies in developing countries suffer from various weaknesses and do not offer appropriate solutions to many health problems in accordance with the comprehensive principles of modern health paradigms.

- Health communication revealed that the message designed was based on agenda setting theory.

1.9. Study Design & Methodology:

The study makes use of various data sources and methods. The strength of such a research method is its ability to deal with a broad variety of evidence, documents, data and observations. Given the aims, scope and research objective,
quantitative and qualitative research methods is used to gain insight into the health policy content, context and process in Assam.

- Quantitative data has been derived from available health statistics, nationally and internationally (The year 2012-13 is considered as the 1st phase of NRHM; hence we consider citing relevant information within 2012-13). The content analysis is based mainly on secondary data in the form of previous studies on health policy analysis, official reports/records of health ministries and departments/facilities in Assam, India and international agencies, reports of seminars and conferences and assessment and evaluations by ministry on the improvement in Health during the period in the country.

- Qualitative research methods is also used to obtain insight into health policy priority setting, context (political, economic, socio-cultural, and demographic) and policy process (agenda building, planning, implementation, monitoring and evaluation). Our research methods include observations, recordings through informal semi-structured interviews. Characteristics of this type of research are non-manipulation of variables and simply focusing on studying a phenomenon as it occurs in reality. Regarding the method of open-ended interviews, hundred twenty three actors are involved in health communication policy process at international, national, provincial and district (local) level has been personally interviewed & few are collected through questionnaires filled up and sent it by email.

- The review of the literature includes a review of modern health paradigms, international health programs and strategies including Health Care system
especially health communication in Assam and the norms, culture, beliefs and values of the community.

1.10. **Limitation of the study:**

The one-to-one interview proved to be very difficult because the officers/government servants are very busy with their works and difficult to find them in office in spite of pre appointment. As a result of these, few interviews were collected telephonically and few through emails and rest through face to face interviews.

The personal biases of the researcher in the interpretation of the data are also not to be overlooked and must therefore be taken into account while drawing any conclusions on the basis of the present study data.

Finally, it should be noted that since the study is area specific and the sample size being not very large, broad generalization would not be possible. Nevertheless, we hope that this study would highlight some aspects of the health communication policy design process that have neither been understood nor studied earlier.

1.11. **Chapter overview**

The first chapter deals with the meaning/significance of communication, what are the various types of communication/mass communication. It also deals with the difference between the health communications and how it differs from the other types of communication. It also tries to describe the need of health communication, the history of health communication and its present/ongoing trend in the world as well as India. Moreover the chapter analyzes the importance of health communication in
India especially Assam. Finally the chapter includes the aims & objectives and the methodology of research in detailed terms.

The 2\textsuperscript{nd} chapter deals with the literature review. The first part of the literature review will provide an overview of Health communication and its growth in the world, India and Assam and the second part will cover up the review of existing health policy research and Health communication policy research.

In the 3\textsuperscript{rd} chapter we propose to discuss briefly the general overview of Assam & North East, history of Assam, ethnic and religious composition, natural resources, interdependence and socio-economic profile of the community, presence of health care facility, history of the community, culture and religious festivals. Besides, we are also discussing about the traditions, customs, practices, socio cultural practices, social aspects, food habits and identity of the community. Here, we plan to treat the issues first at Assam as a whole and then go to the micro level empirical reality of the study areas. Then we try to relook/ analyze various mass communication tools used in Assam to aware the people so that a message related to health can be created and delivered to the common masses since the time of Independence. Then the chapter tries to give a brief idea about the existing health system of Assam & its structure.

In the 4\textsuperscript{th} chapter, we propose to discuss various Health communication policies formulated during planning period since 1\textsuperscript{st} five year plan to 12\textsuperscript{th} five year plan & include policies regarding National Health Mission (NHM) & other state level policies. But the analysis is strict to the Health Communication perspective only. Then a brief definition of plan and policy will be depicted. We are also trying to take out the health communication policy part from the main policy document to know the trend of health communication policy in general. 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.

The 5th chapter we propose to discuss the Health condition of Assam, various health indicators in spite of so many policies had been formulated by the government. Then try to relate whether the Health policies of India is a comprehensive health policy based on Health for All (HFA) strategy which may address increasing health problems in the country and whether the plans (Five year plans, Health Policies & National Rural Health Mission yearly plans) are made as per the policy goals to achieve HFA strategy. After that we will analyze the various respondents view in terms their understanding about the policy making process, socio-economic factors etc in the process of designing & development of Health communication policies by various subsequent governments.

The 6th Chapter tries to analyze the contextual factors such as political, economic and socio cultural factors from documents published by Government of Assam and other articles in state, national and international journals. The chapter also looks at the respondents view on contextual factors in accordance with Health for All strategy, WHO’s mandate for effective health communication policy.

The seventh chapter discusses the health policy process (i.e. agenda building, planning, implementation, monitoring and evaluation), describes the availability and use of resources, expertise and methods to realize the policy objectives. It answers the research questions briefly presenting the analysis of health policy content, context and process in Assam. Next the results are being discussed. This chapter also makes recommendations for changes in health communication policy in Assam.
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