CHAPTER – 2
Chapter 2: Literature Review

In this chapter, it has been attempted to understand the previous researchers’ work, which are relevant to this subject of study. This chapter gives a snapshot of the whole thesis in such a way that the future reader will have a notion of research area and work.

2.1 The Purpose of Literature Review:

Studying background information and knowledge of the research theme is the main aim of the literature review. The literature review helps us in knowing the appropriate research methodology, research design, potential variables and relationship between themselves and other concepts associated with it. Literature Review gives direction to the Researcher to meet and accomplish the definite ends. (O.R Krishnaswami, 1998).

2.2. Literature Review with reference to India:

Communication and development is the major domain of human endeavour, which are intimately linked with each other. The process of development calls for a strategy of communication, which is aimed at altering the targeted persons from mere recipients of information to seekers of information. This is achieved by the design of communication systems, as per the needs and purposes of the targeted persons. The triple “M” theory of the emergence of mass society, mass culture and mass communication links, mass communication to the formation of nations and societies as a result of geographical, social and psychic mobility. Mass communication can best serve in the process of change, if it is treated as a science, art and indeed as subject matter. The main function or purpose of communication is to change or guide other people’s behavior towards positive change of life.
Many people have defined communication in different ways. The issues about effects and effectiveness of mass communication have attracted the attention of the social scientists from the very beginning. The role of the mass media in development activity was very clearly implied in the dominant paradigm of development.

According to Chitambar (1990), defined “Community refers to a group of mutually dependent people, living in a more or less compact geographical area, having a sense of belonging and sharing common values, norms with some common interests and acting collectively in an organized manner to satisfy their needs through a common set of organization and situation”.

Roy and Loha Choudhury (1998) hinted at the importance of utilizing communication for universalization of elementary education in India. Building up their proposal on the analysis of lapses of total literacy mission, they called for a shift from campaign mode to sustainable communication mode even for any development program. The components of sustainable communication mode would make improving the primary health care improvement program a participatory and cost effective programme, they concluded.

Barua (2001) defined “Mobilization as both a process of change (in the control of structure) and a changing process. Mobilization is also conceived as the process by which potentials are brought closer to actualization, the raw material is processed to provide the social energy to fuel the pursuit of social goals and energy looked in other entities is made available”. Can we then think of mobilization as a process of communication?

R.R.Prasad of NIRD, Hyderabad finds out in his study (2003) that in development focus shifted to development activities of locally rooted participatory, micro development organization. The core element, which
emerges from the success cases on the ground, is participation. In the past ten to fifteen years, a sufficient body of experience has emerged, which demonstrates that where the poor participates as subject and not object of the development process, it is possible to generate growth, human development and equity. The strategy for empowering the poor should be embedded in the grassroots, where the underdeveloped masses, so far reliant, are provided with formal access to the state through their own organization. Community mobilization provided a suitable framework for holism in development, first by catering to the needs and aspiration of the poor and second by seeking to engineer social change based on self-reliance. Prasad supported Cohen’s viewpoint from his observations in Indian context. He talked about few stages in community mobilization for participatory empowerment, which demands the communication efficiency in successfully doing community mobilization to make any programme successful.

A study was undertaken on ‘Shame or subsidy revisited: social mobilization for sanitation in Orissa, India (2009)’. An inadequate water and sanitation infrastructure and unhygienic practices facilitate the transmission of pathogens that cause diarrhoea, which accounts for 2 million children death annually in the world, about half of them in India. In light of the strong interaction between sanitation and health, education, malnutrition and poverty, and to improve sanitation, 2008 was declared the International Year of Sanitation. The Government of India started nationwide “Total Sanitation Campaign (TSC)” that seeks to change attitudes about latrines. The campaign is designed as a demand-driven community-led programme and is implemented by state government. It targets all rural households, includes a range of community partners, provides economic incentives to meet programme objectives, and empowers individuals and communities to define and achieve their own goals. There is currently an emphasis on developing information, education and communication (IEC) plan to improve attitudes & knowledge about how sanitation, safe water and hygiene is related to health.
This paper, which contributes to the “shame” versus “subsidy” debate, examines the effects in Orissa of an intensified version of the IEC campaign that draws on a promising but untested “community-led total sanitation” model initiated in Bangladesh and subsequently implemented in some Indian states. The resulting IEC campaign seeks to generate strong emotional responses at the community level that will culminate in a community-wide resolve to end open defecation. The study followed a cluster-randomized design, with villages randomly assigned to treatment or control groups. On the heels of the International Year of Sanitation, the study delivers timely evidence on how to promote sanitation, a technology that some refer to as the most important medical advance of the past 150 years.

Mass Communication Research aims to find out the audience behaviour and uses of the media by the users etc. Since the establishment of the Indian Institute of Mass Communication (IIMC), New Delhi in 1965 by Government of India. Since August 1975, through the Satellite Instructional Television Experiment (SITE), development programmes were shown in 2400 villages of six states. A team of social scientists was employed by SITE to test the efficiency of television in improving agricultural practices and population control in upgrading and expanding education in promoting better health hygiene for a better life in rural areas.

The research in the field to mass communication has gained momentum in developing countries in the decade of fifties and sixties. Dube (1958) studied the importance of communication in community development programme in India. Wilbur Schramm (1964) emphasized on the role of communication in the process of social change by saying that the development of mass media is one of the requisites for and signs of a modernizing society. Chauhan (2004) pointed out that what is the most essential message, which “must” reach the people through the mass media.
Mass Media Campaigns, Public information campaigns are the common form of intentional use of the mass media for public purposes. Effective health-oriented campaigns typically are similar to campaigns for commercial products as they use a number of media channels and are designed to generate specific effects in a relatively large number of people within a specified period of time. One of the most promising ways of reaching the public is to develop entertaining programming for radio, television, movies, or music that features socially responsible messages. Entertainment education, also known as enter-educate, pro-social entertainment, or edutainment, is used throughout the world to put educational content into entertaining formats to increase knowledge, create favorable attitudes, and change overt behaviour concerning and educational issue. Building on Bandura's (1986) social learning theory, this approach presents an idea-such as family planning-through drama, and provides lesson on the rewards of a new behaviour and the disadvantages of an old one. Today entertainment education is used to promote reproductive health in more than 20 countries and at least six U.S funded agencies are actively involved.

Social problems of women leprosy patients: A study of Delhi has been completed under the Department of Social Work, Jamia Milia Islamia, Delhi. The study explored the social bindings and different problems always faced by the women leprosy patients. The study also analyzed the responsibility of our society and the people living in the society towards the women leprosy patients. This study has played a vital role to find out an ultimate picture of the problems of women leprosy patient of our society.

The other research works on health have been conducted in this Department are Changing Doctor patient relationship with special reference to Consumer Protection Act-1986, Role of Communication in AIDS Prevention. A research paper of Deepak Kem (2004) on Adolescent and mass media was presented in the Indian Academy of Pediatrics Training programme. The main focus of this study was on Adolescent Health.
The Tuberculosis (TB) Health System Research Network, Orissa, India studied the knowledge, perceptions and the health-seeking behaviour of three tribal districts of Orissa regarding chest symptoms (TB) and to assess local sources of information on health and disease. This study analyzed the utilization of research for IEC development. The findings revealed that blood in sputum was the main distinctive symptom of TB. Causes of TB were perceived to be alcohol, tobacco and hereditary disposition, while at the same time TB could spread through direct social interaction. These results pointed to develop IEC Activities that could effectively make appropriate TB information available to illiterate populations. With the involvement of local artists and communities, IEC materials were developed in participatory workshops with participants. Activities developed including Street Drama, Puppet show, Pictorial Pamphlets made by tribal artist and organization of interaction meetings with patients and providers to discuss issues and challenges for treatment and follow-up sputum testing together.


Archana Rakesh Singh (2006) in her study on role of mass communication in prevention and control of AIDS: Mass Media strategies for Adolescents observed the role of mass media in AIDS prevention and control by assessing the AIDS awareness levels and the media exposure amongst the target group of school going adolescents in Delhi and Ghaziabad. The media habits of the target group and the awareness levels have been seen. The study was successful in finding out the most suitable medium and method for AIDS awareness messages for the target group of adolescents. It reveals that mass media has a fairly good reach among the school going adolescents. With access to communication, literacy and educated set of parent, the school going adolescent is obviously more informed than his less privileged counterpart. It provides relevant information regarding the gravity of AIDS situation in the world as well as in our country.

The review and content analysis of the media, provides an insight into the quality and quantity of media messages about AIDS. The IEC strategies outlined in this study can help in designing interventions for HIV/AIDS. This study explored the role played by the Indian media in disseminating information regarding AIDS and whether the message is within the reach of the target audiences in physical and psychological terms. The study viewed that inadequate knowledge about the AIDS amongst our teenagers leads the society to believe that mass media should take up the cudgels of the awareness campaign. The study suggested that Inter-personal methods are necessary to reach the less privileged section of the society. This study has a significant role in the health sector in creating interventions for the target group of adolescents, planning mass media strategies, designing activities and choosing appropriate media for awareness campaigning.
T. Mathiyazhagan, Deoki Nandan, M.P.Meshram, Ramesh Chand and Lakhan Lal Meena (2007) in their paper on a study of utilization of communication channels and information seeking behaviour by the tribals for improving their health care practices observed the followings, likely: i) tribals tend to believe in interpersonal communication as compared to other modes of communication; (ii) availability of electronic media viz. radio and television with the tribals is limited, (iii) IPC followed by traditional media is the choice of combination of channels preferred by the tribals; and (iv) tribals prefer to watch television or listen to radio only in the evening hours but information seeking behaviour among them from various sources is casual.

Deoki Nandan, T. Mathiyazhagan, M.P.Meshram, Ramesh Chand and Lakhan Lal Meena (2007) conducted a study in Mandla, one of the tribal dominated districts of Madhya Pradesh, in 2005 for their paper on knowledge, perceptions and sources of information for tribals about common diseases prevailing in Mandla District of Madhya Pradesh. In this study, an attempt was made to (i) study the knowledge of tribals about various common diseases prevailing in Mandla District; (ii) identify the sources of information for tribals about various common diseases; and (iii) understand the beliefs and perceptions of tribals about the health care delivery system operating in the district. The findings reveal that, (i) the tribals have knowledge about malaria and diarrhoea as compared to other diseases viz.; sexual transmitted diseases, anaemia, worm infestation, tuberculosis and leprosy; (ii) the major source of information for tribals in the study area has been the health functionaries followed by the relatives; and (iii) the tribals tend to believe in traditional healers as compared to allopathic doctors.

C.T. Vinitha, Saudan Singh and A.K.Rajendran (2007) conducted a study on level of reproductive health awareness and factors affecting it in a rural community to examine the level of awareness and the different factors affecting awareness on reproductive health issues like safe sex, reproductive tract infection, safe age to bear children and types of family planning methods.
Enhancing health awareness among women in India is a challenging task. A cross-sectional study was conducted of 624 women aged 13-49 years from 532 households belonging to two health sub-centre areas in North Tamil Nadu. Only 9.5 per cent of the adolescents interviewed had knowledge on safe sex. Adolescents age 15 years and above, belonging to an extended family with educational status of above 5th grade, working outside home and having a high standard of living had significantly more awareness on safe sex. 79.5 per cent women aged 13-49 years knew it was unsafe to bear children before 20 years. Age, marital status and place of residence were significantly associated with awareness. Hence, this study shows that adolescents (<19 years), women who are illiterate or educated less than grade 10 and living away from basic health care services are less aware of reproductive health issues and need targeted interventions for reproductive health messages.

N. Sharma, R. Malhotra, D.K. Taneja, R. Saha and G.K. Ingle (2006) in their paper on reach of various communication methods (IEC) for Revised National Tuberculosis Control Programme (RNTCP) in Delhi observed that the main sources cited by the respondents for TB campaigns were TV (41.3%), messages displayed on buses (37.6%) hoardings (35.2%), wall paintings (24.6%), newspapers (13.5%) and radio (13.4%). Differences in the reach of various media were observed with reference to the gender, literacy status and place of residence of the respondents. A majority of them preferred TV (85.6%) followed by radio (49.6%), newspapers (28.1%) and posters (14.6%) for transmission of messages regarding TB in future. The authors suggest multi-media methods for IEC campaigns on Tuberculosis.

Ruchi Sagarwal and Damodar Bachani (2009) conducted a study for their paper on awareness of women about sexual transmitted diseases, HIV and AIDS and condom use in India: lessons for preventive programmes. The study examines the relative importance of awareness level of STD, HIV/AIDS and condom use with socio-economic variables in India. Data collected in the third round of the National Family Health Survey 2005-06, have been used to
purse the objective of the paper. A total of 124385 ever married women of in
the age group of 15-49 years from 29 major states of India were included in
the study. Logistic regression model was adopted to understand the
significance of HIV awareness on condom use. Analyses reveal that
awareness among women about STD excluding HIV was as low as 3.2 per
cent. Only 4.8 per cent of the women reported condom use at the last sexual
intercourse (p<0.05). 42-50 per cent of the ever married women from four
states of India namely Rajasthan, Jharkhand, Chhattisgarh and Uttar Pradesh
are not aware of any STD and HIV/AIDS. Socio-economic characteristics
such as domicile, education and wealth index of household are found to be
significantly associated with the level of HIV awareness and condom use at
the last sexual intercourse especially among poorer, rural and uneducated
women. The study highlights the need for integrated prevention programmes
that emphasize on the use of condom for HIV prevention as well as STDs.

Subhash Barman (2006) evaluated the knowledge, attitude and
participation of the gram panchayat members in health and family welfare
programmes in Hooghly district of West Bengal for his research paper. It was
observed that 80 per cent of the respondents had the knowledge of the
educational institutions and public and private health care facilities. The study
further revealed that the health committee members were involved in
promoting health awareness among the people about child immunization, safe
drinking water, acceptance of family planning methods, government-run
health care programmes and arrangements for the treatment of the rural
people. The gram panchayat members also assist in launching campaign on
different health related programmes such as immunization, maternal and child
health, public health and sanitation, eradication of communicable diseases,
and registration of births and deaths, the study revealed. The author
advocates to regularly conducting meetings of the health sub-committee to
help the workers to perform their jobs more efficiently in the community.
B. Reshmi, N. Sreekumaran Nair, K.M. Sabu and B. Unnikrishnan (2007) conducted a study for their paper on awareness of health insurance in a south Indian population – a community based study to find out the awareness of health insurance in an urban population in south India. A total number of 242 respondents from 242 households (male 38.4%; female 61.6%) were interviewed by using a pretested pro-forma after obtaining informed consent from the participants. The awareness of health insurance was found to be 64.0 per cent. Around 45.0 per cent of the respondents came to know about health insurance from the media, which played an important role in the dissemination of information. The mean premium amount agreeable to be paid by the respondents for health insurance was found to be Rs 1804.00, even the low socio-economic group of people was also willing to part with a reasonable amount of Rs. 697.00 annually for health insurance. The middle and low socio-economic groups favoured government health insurance compared to private health insurance. The findings indicate that government should come out with a policy, where the public can be made to contribute to a health insurance scheme to ensure unnecessary out-of-pocket expenditures and better utilization of health care facilities.

M. Hemanta Meitei, Latashori K and Ksh. Gopal (2005) conducted a study for their paper on awareness and prevalence of Reproductive Tract Infections (RTI) in North East Districts of India. Reproductive tract infection is a generic term used to cover three types of infections viz. sexually transmitted disease (and infection), endogenous vaginal infections and infections related to reproductive tract. The current study revealed that (i) the awareness level among both males and females regarding Reproductive Tract Infections is relatively low in majority of the districts in northeastern part of India; (ii) electronic media and newspapers were the main sources of information regarding Reproductive Tract Infections for both males and females in the districts of Arunachal Pradesh, Assam and Sikkim; (iii) sexual intercourse was reported to be the main mode of transmission of Reproductive Tract Infections by more number of males than females in most of the districts; (iv) a higher proportion of male respondents from Cachar, Jorhat and Nalbari in Assam,
Imphal and Senapati in Manipur, and Jaintia Hills and West Khasi in Meghalaya, Makokchung and Wokha in Nagaland and East Siang in Arunachal Pradesh reported lack of personal hygiene as one of the means of Reproductive Tract Infections transmission; and (v) a wide gap between knowledge and prevalence of Reproductive Tract Infections in both males and females was observed which was higher among females.

Dipali Nemade, Seema Anjenaya, Rupali Gujar (2009) conducted a study on impact of health education on knowledge and practices about menstruation among adolescent school girls of Kalamboli, Navi Mumbai to assess the impact of health education on knowledge regarding menstruation and sources of information, misconceptions, restrictions, status of menstrual hygiene and practices among adolescent school girls. A community based intervention study was undertaken among 217 adolescents of Kalamboli. A pre-tested questionnaire was administered and later health education regarding menstruation and healthy menstrual practices was imparted to the girls. Post test was done after 3 months to assess the impact of health education. The study has revealed unhealthy menstrual practices, low level of knowledge and various misconceptions among adolescent school girls reading menstruation. The study also clearly brings out the impact of health education in improving their knowledge and practices. Taking into account the health implications and prevailing socio-cultural and economic factors, there is an urgent need for identifying effective strategies to persuade the adolescent school girls to adopt healthy menstrual practices. A well-informed continuous school education programme should be imparted to the students. Further, emphasis also needs to be given through workshops and seminars on ‘Adolescent Reproductive Health’.
2.3 Literature Review with reference to Abroad:

Most of the models of development communication were developed in the context of the western countries. The First World War can be considered to be a watershed in mass communication theory and research, Harold Lasswell (1927) came up with an innovative conceptualization of mass media effects. His model of communication was strongly influenced by Freudian theory and was in direct contradiction to liberation philosophy. Denis Macquail (1969) identified three main stages in the history of mass communication research. The initial phase started from the turn of 20th Century to the outbreak of the Second World War. During this phase, mass media were attributed with considerable power to shape opinion and beliefs.

In the second phase, from 1940s to early 1960s, mass media were believed to be largely important to initiate opinion and attitude change. At the current stage, the question of media effects is one where new thinking and new evidences are accumulating regarding the influences of mass communication. The second stage, extending from about 1940 to the early 1960s strongly shaped by growth of mass communication research in the United States and the application of empirical method to specific questions about the effects and effectiveness of mass communication. The earliest studies of Presidential elections in 1940 and 1948 conducted by Lazarsfield (1944) and Berelson (1954) respectively and the programme of research on the use of films for training of American service men undertaken by Carl Hovland (1949) concluded that the exposure to mass media primarily press, radio, television were unlikely to be major contributors to direct change of individual opinions, attitudes or behaviour or to be a direct cause of crime, aggression or other disapproved social phenomenon.

Zenter (1964) points out three aspects of communities. First, community is a group structure, whether formally or informally organized; in which members play roles, which are integrated, around goals associated with
the problems from collective occupation and utilization of habitational space. Second, members of the community have some degree of collective identification with the occupied space.

According to Jenkins (1983), “Mobilization is the process by which a group seems collective control over the resources needed for collective action”. The major issues therefore are the resources controlled by the group prior to mobilization effects, the process by which the group pools resources and direct these resources towards social change and the extent to which outsiders increase the pool of resources”.


A study by Dr. Emmanuel Nwala and Dr. Miriam O Ajuba (2011) of Health Policy Research Group, Dept. of Pharmacology and Therapeutics, University of Nigeria on “community mobilization and consent seeking for public health Action” has shown that community mobilization and consent seeking are effective tools in ensuring ownership of community health programs. Most studies, which have employed these approaches effectively, have often led to sustained behavior change while others have not. Two approaches were used to generate data: a review of relevant literature and the authors experiences in the consent seeking and mobilization process.

Findings showed that different authors employed different methods for community mobilization, which include group mobilization approaches, group discussion meetings, training workshops, community member peer data collection, phone calls, financial incentives etc. Most authors combined these
methods. Consent seeking methods were mainly oral, written or proxy and most of the studies had an ethical approval from a Research and Ethical review Board. There is still need to harmonize these approaches especially for ethical purposes. Single or independent approaches to mobilization and consent seeking may not only be efficient if expected results are to be achieved but are crucial. However, whichever approach is adopted should consider the context, content and actors involved in any given project.

In 2010, Health Communication Partnership (HCP), a project implemented by Johns Hopkins University and funded by USAID, supported Ministry of Health, Uganda to bring together Paediatric ART partners to develop an updated communication strategy aimed at increasing both uptake of Paediatric ART services, as well as promoting adherence for children and adolescents on treatment. Community mobilization was the main strategy.

The key results presented in this report provide evidence that the intensive community mobilization efforts carried out improved the capacity of radio hosts across the country to deliver relevant information on Paediatric HIV, and contributed to a significant increase in the number of children, who are tested for HIV and enrolled for care. The findings also highlight that it is challenging to monitor community mobilization efforts unless there is a standardized method of data collection at the health facilities to collect information about sources of referral. The intensive community mobilization efforts produced positive results, yet the campaign was implemented for a short period in specific locations. Moreover, results indicate that the demand for Paediatric HIV information and services among community members remains very high. The campaign needs to be scaled up with a stronger monitoring and follow-up system.
There is indeed overwhelming evidence that the measured net changes in attitudes or opinion as a result of persuasive material presented on radio, film, television or the press are likely to be small. Klapper (1960) suggested that people exposed themselves to messages selectively. There was a tendency for individuals to expose themselves relatively more to those items of communication that were consonant with their belief, ideas, values, etc. Regardless of exposure to communication, an individual's perception of a certain event, issue, person, or place could be influenced by his/her latent beliefs, attitudes, wants, need or other factors. Thus, two individuals exposed to the same message could go away with diametrically different perceptions about it. Research showed that even recall of information was influenced by factors such as an individual's needs, wants, moods, perceptions and so on. However, Klapper (1960) argued that "Mass Communication ordinarily does not serve as a necessary and sufficient cause of audience effects, but rather function among and through a nexus of mediating influences." Although, research had not shown the different media to be without effects, but it had established the primary of other social facts and showed the power of the media to be located within the existing structure of social relationships and systems of culture and belief. The research evidence of Rogers and Shoemaker (1971) led to the realization of the facts that social structure and social institutions intervene powerfully in the process of media effects. But, a number of social scientists expressed their doubt about it. They paid more attention to people in their social context, rather than at their attitudes and opinions. They looked at the account of the uses and motives of the audience members as mediating and effect. They looked at the structure of belief and opinion and social behavior rather than individual cases. They also took more notice of the content whose effects are being studied.

On the other hand, the profounder of the 'theory of mass society' have examined the question of media effects on culture and society. In their view, mass media encourage and make viable a rootless, alienated form of social organization in which we are increasingly within the control of powerful and
distant institutions. The Marxist accounted the effects of mass media as a powerful ideological weapon for holding the mass of people in voluntary submission to capitalism. They argued that the mass media are both a force for integration and for dispersion of individualization of society. It suggests that mass media do have important consequences for individuals for institutions, for society and culture.

The diffusion of innovations theory has important theoretical links with communication effects research. The emphasis was on communication effects: the ability of media message and opinion leaders to create knowledge of new practices and ideas and persuade the target to adopt the exogenously introduced innovations. There was disagreement on the question of whether ideas were independently developed in different cultures, or whether an idea was invented in one culture and borrowed by or diffused into another. Evidence indicated that in most cultures there was a predominance of borrowed or diffused elements over those that developed from within a particular culture (Linon, 1936, Kroeber 1944). In the dominant paradigm, communication was visualized as the important link through which exogenous ideas entered the local communities. Deniel Lerner’s “The Passing of the Traditional Society (1958)” points out that the mass media were both an index and agent of modernization. In Lerner’s model, there was a close reciprocal relationship between literacy and mass media exposure. The literate developed the media, which in turn accelerated the spread of literacy.

Aghinotram Ramanakumar V of Department of Social and Preventive Medicine, University of Montreal, Canada has shown his interest in occupational health research in India. The study analyzed the health inequalities between indigenous and non-indigenous groups across four different outcomes: mortality, smoking tobacco use, chewing tobacco use and alcohol consumption. All four outcomes were measured at the level of individuals were analyzed separately; the lowest unit of observation for this study was the individual. S.V.Subramanian, Geoge Davey Smith of Harvard
School of Public Health, Boston and Malavika Subramanyam from University of Bristol analyzed Indigenous Health and socio-economic status in India. Systematic evidence on the patterns of health deprivation among indigenous peoples remains scant in developing countries like India. Socio-economic status differentials substantially account for the health inequalities between indigenous and non-indigenous groups in India. However, a strong socio-economic gradient in health is also evident within indigenous populations, reiterating the overall importance of socio-economic status for reducing population-level health disparities, regardless of indignity.

In fact, not all communities have played a passive role in improving the primary health care delivery system. For instance, Williams (1994) stresses that until the middle of the last century, responsibility for improving the primary health care rested with the community. Although there still are places where communities came forward to support government initiative in constructing health institutions, especially sub centres, where community donates space and government gives the construction cost. Community participation in health has neither been fully recognized nor extended systematically to a wider practice to improve the primary health care scenario.

Mass media campaigns can be highly effective and successful in changing the social context within which individuals operate. This role has not been sufficiently considered in media evaluation and appropriate outcome indicators must be chosen which reflect this goal. (Hertog, 1995) Chinai also argues for the role of the media in influencing social attitudes rather than individual behaviour, especially in developing countries. Nevertheless, mass media can play an important role in generating the awareness and shaping the public opinion in the case of the developed societies as well as in the ease of a developing society. In case of generating awareness, control and prevention of different diseases mass media can play a vital role in society.
2.4 Literature Review on Health & Community Mobilization:

Health is defined by the World Health Organization (WHO), as a state of complete physical, mental, social well-being and not merely the absence of diseases or infirmity. Health is one of the vital elements that determine human development and progress. Health care delivery system is confronting various challenges today posed by rapid developments worldwide, the need for containment and focus on effectiveness and efficiency of the delivery mechanism. Different strategies are formulated for providing better health care services in India. Under the constitution, Health is a State subject, but, in the present context, Central Government’s intervention through assisting State Government is needed in the areas of control of major communicable and non-communicable diseases, broad policy formulation and awareness activities for prevention of diseases. Several National Health Programmes are being implemented as centrally sponsored schemes, which are aimed mainly at reduction of mortality and morbidity causes by major diseases. The major Health schemes include the National programmes for eradication of malaria, blindness, leprosy, tuberculosis, AIDS, Cancer Control. National Rural Health Mission was launched in April 2005 throughout the country for bringing improvement in the health care delivery system, particularly in the unprivileged marginalized population. An Information Education Communication (IEC) package for prevention and control of diseases is developed and catered at all levels of health care delivery system.

Communication is a process in which ideas, thoughts and words are transferred from one person to another. The process of transmission of ideas can be said as Communication. Research according to dictionary meaning is to make a detailed enquiry into, researcher is someone who makes a detailed enquiry into a subject. Research in the field of communication started only in the late fifties and early sixties. Mass Communication Research can be either simple or complex based on the objective of undertaking the research and the scope and what we intended to find out.
Health and Family Welfare are an integral part of development programmes, but the use of mass media has not succeeded in persuading people to adopt certain measures. The main factors identified in the past few research are paucity of resources, vastness of Indian traditional ethos, low education and literacy profile, diversity of languages and lack of coordination between communicators and policy planners and the overall resistance to change. Health communication contributes to actions and organizations in the development process. Further, health development is important in mobilizing people’s efforts in social and economic life. Communication in that sense is the product of the society and also the effective tool to change the society.

The media therefore have an essential function in social learning- to provide the information that will empower ordinary people and to transmit the idea that will structure peoples thinking and make up the row material of what we identify as public opinion. A more considerable body of research has demonstrated that whilst information provision is a first step, it has limited impact on individual behaviour change. This may in part be due to the tendency to true out information not in line with peoples existing beliefs. It is generally agreed that the most effective way of motivating individual behaviour change appears to be interpersonal communication, including interactive face-to-face educational and counseling where “messages are tailored to the specific need of individuals”.

The mass media represents the most readily available and potentially most economical means of imparting information about health awareness and prevention of various diseases. Along with other forms of communication, the mass media can effectively raise public awareness and concern on health issues. Mass media are generally defined as those channels of communication, which are capable of reaching heterogeneous audiences simultaneously with uniform messages. These include radio, television, the press and cinema. Despite the overwhelming evidence of mass media effectiveness in raising awareness, increasing knowledge and changing
behaviour, doubts remain among non-specialists and media critics. These may be due to a failure to realize that there are two distinctive ways of media utilization. The first being the usual media coverage of news events, regular programmes and entertainment material, and the second is the use of mass media in the context of a planned and systematic process for the clear purpose of influencing attitudes and behaviour.

Community Mobilization is something new in the health care delivery system but it did not suddenly appear as panacea to solve complex problems related to health. Many research studies have identified various ways of community mobilization in health sector. NRHM is a new flagship programme, aiming to provide affordable, accessible, quality health care especially to the rural masses within a fixed period. NRHM is trying to achieve its goal of ensuring community demand through active community participation in managing a health facility. It tries to understand concept, meaning and approaches of community mobilization so that community mobilization can yield expected result in increasing the habit of community demand generation.

2.5 Literature Review on Primary Health Care in India:

Health is the topmost priority in every individual's life. Its importance is evident in old saying “Health is Wealth”. Health is not only basic to lead a happy life for an individual but also necessary for all productive activities. The development cycle of a person depends upon his intellectual caliber, curiosity and constructive thinking but all these qualities depend upon on good health. Therefore, to meet this need of the healthy citizens of a healthy society health services are sine-qua- non-for the government.

Phisek Ponrattana Wanrom, in his article “Health is Development” rightly says “Good Health is a pre-requisite to human productivity and the "development" process. It is essential to economic and technological development. A healthy community is the infrastructure upon which to build an
economically viable society. The progress of the society greatly depends on the quality of its people. Unhealthy people can hardly be expected to make any valid contribution towards development programs. Charaka, the renowned Ayurvedic Physician, is known to have said, “Health is vital for ethical, artistic, material and spiritual development of man”. Ramesh Kanbargi in his article “Health & Development in India: Trends and Prospects” has rightly said “Health is a function of the overall integrated development of the society and the health status is one of the indicators of the quality of life”. Buddha has said that of all the gains, the gains of health are the highest and the best. Who would deny that a soldier who is not keeping good health cannot be expected to defend the frontiers of his country, even when he provided with the latest sophisticated weapons? Similarly, who would deny that unhealthy farmer with the best possible technological know-how would not succeed in producing the best that can be expected of him. Obviously, what is true of an unhealthy soldier or an unhealthy farmer is also true for other categories of workers. Thus, no industry can expect the optimum output, if it does not employ healthy workers or does not make and provide adequate facilities for proper maintenance of their health. It has been accepted by the World Health Assembly that good health is a fundamental human right. World Health organization defines health as “a state of complete physical, mental, social and spiritual well being and not merely absence of any disease or physical infirmity”. This is the holistic concept of health.

Studies in Primary Health Care:

Public health has developed as a vital area of interest for study and research. The literature on the administration of health services in fact has been enriched by numerous research studies undertaken under the auspices of (i) Union and State Governments, (ii) International specialized Agencies, (iii) Institutional Efforts and (iv) Individual Scholars.
(i) **Union and State Government:**

Government of India has shown its concern for Public Health both during British and during post independence era. The health of the nation (British India), reviewed by Bhore Committee under the Chairmanship of Sir Joseph Bhore (GOI, 1946) observed that no individual shall fail to secure adequate medical care because of inability to pay for it. After independence, a number of research studies were carried out to meet the growing challenges of Public health under the welfare state. Prominent among the specialized studies are the reports of Health Survey and planning Committee – Chairman Laxman Swami Mudiliar (GOI, 1962), Group of Medical Education and Support Manpower – Chairman, J. B. Srivastava (GOI, 1975), Five year plan documents, Central Council of health reports etc. Since the genesis, evolution, growth and diversification of Primary Health Care System in India is the outcome of these expert committees, it would be useful and fruitful to analyze the recommendations of these committees.

I. **Bhore Committee (1943-46):**

Taking into consideration the findings of interim report of National Planning Committee on Health (1940) and being dissatisfied with the then health care system in meeting the health problems of the community, particularly the rural population, in 1943 the then British government appointed the “Health Survey and Development Committee”, with Sir Joseph Bhore as Chairman, to make a survey of the existing health conditions and health organizations and to make recommendations for future. The recommendation and guidance provided by the Bhore Committee formed the basis for organization of Basic Health Services in India. The report was submitted to Government in 1946.

The Bhore Committee made two types of recommendations:
(a) A comprehensive blue print for the distant future (20 to 40 years) the smallest service unit was to be Primary Health Unit, serving a population of 10,000 to 20,000;

(b) A short – term scheme covering 2 to 5 years period – the emphasis would be on setting up 30-bedded hospitals, one for every two Primary Health Units.

The country-side was the focal point of these recommendations. Other recommendations were:

a) Formation of Village Health Committee to secure active cooperation and support in the development of health programme.

b) Provision for Doctor of future who should be a “Social Doctor” combining both curative and preventive measures.

c) Formation of a District Health Board for each district comprising of district health officials and representatives of the public.

d) To ensure suitable housing, sanitary surroundings, safe drinking water supply, elimination of unemployment and to lay special emphasis on preventive work.

e) Inter-sectoral approach to health services development.

II. Mudaliar Committee (1959-61):

The Government of India, in the Ministry of Health, set up a Committee on the 12th June 1959, under the Chairmanship of Dr. A. Lakshmanswami Mudailar. Detailed recommendations on these aspects were submitted in 1961. Their salient features were:

(a) Upgrading and strengthening of PHUs.

(b) Strengthening of District Hospitals.

(c) Mobile Service teams for Rural Areas.

(d) Levying of small fee for availing hospital facilities.

(e) Long range health insurance policy for all citizens.

(f) Formation of Central Health Cadre.
(g) Extension of the functions of UGC of education in the fields of the Medicine, Engineering, Agriculture and Veterinary Sciences.

(h) Institution of National Programmes for eradication of Malaria, Small Pox, Cholera, Leprosy, Tuberculosis and Filariasis.

(i) Director General of Health Services should enjoy the status of an Additional Secretary.

III. Chadha Committee (1963)

In April 1963, a special Committee was constituted by the Government of India under the Chairmanship of Director General of Health Services, Dr. M. S. Chadha, to go into the details of the requirements of primary health centres, their planning, the necessary priority required. According to the 'needs of the maintenance phase of Malaria Eradication Programme' and also for other health activities and the manner in which the technical and supervisory staff of the NMEP organization should be utilized after malaria eradication has been achieved. The Committee considered that the maintenance was the responsibility of the general health services, which should be adequately strengthened, particularly the rural health services. Multi-purpose domiciliary health services should be developed for all health programmes, including malaria, smallpox, control of other communicable diseases, health education etc.

IV. Mukherjee Committee (1966)

The central Council of Health, at its meeting on the 31\textsuperscript{st} December 1965, in Madras, appointed a Committee under the Chairmanship of Union Health Secretary to undertake the review of Family Planning Programme and its strategy. The Committee recommended strengthening of the administrative set-up at all levels from the Primary Health Units to the State Headquarters. It also recommended delinking of malaria maintenance activities from Family Planning Programme, so that latter could receive undivided attention and could be carried through as a crash mass programme.
V. Karter Singh Committee (1972-73)

In pursuance of the recommendations made by the Executive Committee of the Central Family Planning Council, the Government of India constituted a committee in October 1972, which recommended that:

(a) Multi-purpose workers for the delivery of health, family planning and nutrition services to the rural communities are both feasible and desirable.

(b) To begin with, one Male Health Worker (Multi-purpose) should be available for a population of six to seven thousands.

(c) At least one Female Health Worker (ANM) should be available for a population of ten to twelve thousands.

(d) Each PHC should ultimately serve 50,000 population and should have 16 sub-centres spread over its area.

(e) Training for all workers engaged in the field of health, family planning and nutrition should be integrated.

VI. Shrivastava Committee (1974-75)

The Government of India, in 1974, formed a Committee on ‘Medical Education and Support Manpower’ under the Chairmanship of Dr. J. B. Shrivastava. The Committee submitted its detailed report in 1975 and made specific recommendations for the initiation of the following major programmes for immediate action:

(a) Organization of the basic health services (including nutrition, health education and family planning) within the community itself and training the personnel needed for the purpose.

(b) Organization of an economic and efficient programme or health services to bridge the community with the first level referral centre, viz., the PHC (including the strengthening of the PHC)

(c) The creation of a National Referral Services Complex by the development of proper linkages between the PHC and higher level referral and service centres, and
(d) To create the necessary administrative and financial machinery for the re-organization of the entire programme of medical and health education from the point of view of the objectives and needs of the proposed programme of national health services.

VII. National Health Policy Document (1983)

The major directions laid down in the Seventh National Health Policy Document (1983) are:

a) Provision of universal and comprehensive primary health care services with special emphasis on the preventive, promotive and rehabilitative aspects.

b) Securing small family norms through efforts and moving towards the goal of population stabilization and enunciation of a national population policy.

c) To formulate a National Medical and Health Education Policy for health manpower development and to ensure that personnel at all levels are motivated to adopt community health approach.

d) To decentralize the primary health care system by restructuring the health care services to promote community participation and linking it with a systematic back up support of referral services at secondary and tertiary levels.

e) Integrally linking the health care knowledge, skills and appropriate technology to community, so that majority of common health actions could be handled by the community.

f) Mobilizing untapped health resources and encouraging investment by private sector, NGOs, voluntary bodies to establish curative services, wherein all affluent sectors could be looked after by paying for the services.

g) To remove the existing regional imbalances and to provide services within the reach of all, whether residing in the rural or the urban areas.
h) Assist in the enlargement of the services being provided by the
private voluntary organizations active in the health field,
especially those which seek to serve the needs of the rural
areas and the urban slums.

i) The entire approach to health manpower development should
ensure their functioning as a “Health Team”.

j) To integrate the services of Indian System of Medicine (ISM)
practitioners at the appropriate levels, within specified areas of
responsibility and functioning in the over-all promotive, and
public health care aspects.

VIII. National Health Policy—2002

The main objective of the policy is to achieve an acceptable standard
of good health amongst the general population of the country and increase
access to the decentralized public health system by establishing new
infrastructure in deficient areas, and by upgrading the infrastructure in the
existing institutions. Salient features of the policy are as follows:

I. Increase health sector expenditure to 6 percent of GDP with 2
percent of GDP being contributed as public health investment by
the year 2010.

II. Increased allocation of 55 per cent of the total public health
investment for the primary health sector; the secondary and
tertiary health sectors being targeted for 35 per cent and 10 per
cent respectively.

III. Key role for the Central Government in designing national
programmes with the active participation of the State
Governments. The Policy ensures the provisionining of financial
resources in addition to technical level by the centre.

IV. Apart from the exclusive staff in a vertical structure for the
disease control programs, all rural health staff would be
available for the entire gamut of public health activities at the de-
centralized level.
V. Expand the pool of medical practitioners to include a cadre of licentiates' of medical practice as also practitioner of Indian System of Medicine and Homoeopathy.

VI. Revival of the primary health system by providing some essential drugs under central government funding through the de-centralized health system. Provisioning of essential drugs at the public health service centre would create a demand for other professional services also from the local population.

VII. More frequent in service training of public health medical personnel at the level of medical officers as well as paramedics.

VIII. Implementation of public health programs through local self-government institutions and decentralize the implementation of the programs to such institutions by 2005.

IX. Minimal statutory norms for the deployment of doctors and nurses in medical institutions.

X. Setting up of a Medical Grants Commission for funding new Government Medical and Dental Colleges in different parts of the country.

XI. Modify the existing curriculum.

XII. Enable fresh graduates to contribute effectively to the providing of primary health services as the physician of 1st contact.

XIII. Raise the proportion of post graduate seats in public health and family medicine in medical training institutions to 114th of the earmarked seats.

XIV. Improvement in the ration of nurses vis-à-vis doctors / beds.

XV. Improving the skill level of nurses and increasing the ratio of degree holding nurses vis-à-vis diploma holding nurses.

XVI. Need for basic treatment regimens, in both the public and private domain on a limited number of essential drugs of a generic nature.

XVII. At least 50% of the requirement of vaccines / sera to be sourced from public sector institutions to ensure uninterrupted supply of vaccines at an affordable price.

XVIII. Setting up of an organized urban primary health care structure.
XIX. Funding for urban primary health system to be jointly borne by the local self-government institutions and state and central government.

XX. Established of fully – equipped “hub spoke” trauma care networks in large urban agglomerations to reduce accident mortality.

XXI. Interpersonal communication of information and folk and other traditional media to bring about behavioural change.

XXII. Association of PRIs/ NGOs/ Trusts in IEC activities.

XXIII. Increase in government funded health research to a level of 1% of the total health spending by 2005; and thereafter up to 2% by 2010.

XXIV. Enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishment/medical institutions by 2003;

XXV. Encourage setting up of private insurance institutions for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance package.

XXVI. Disease control programs should earmark at least 10% of the budget in respect of identified program components to be exclusively implemented through NGOs.

Government of India and State Government through their Health & Family Planning Ministries/Departments bring out annual reports and statistical analysis, which indicate the past reviews, current status and future projections of health status of the populations as well as administrative issues impinging on various programs.
2.6 Genesis of RCH program and NRHM program:

In 1994, the Cairo conference proposed "Reproductive and Child Health (RCH)" program, which introduced paradigm shift from "top down approach" to "target free bottom up" approach. Basically, the RCH underlines that "People have the ability to reproduce and regulate their fertility. Women should be able to go through pregnancy and childbirth safely.” As India was also a signatory of the conference, so India also started the RCH program in 1997. The concept of RCH program is to provide to the clients need based, client centred, demand driven, and high quality integrated RCH program. The RCH program incorporates all the components of the CSSM and family welfare program as well as two more interventions namely, Reproductive Tract Infection (RTI), Adolescents Reproductive Health (RH). From 2005, RCH II was started, which ended on 2010. Along with the RCH II program, GoI started another holistic umbrella program namely NRHM (National Rural Health Mission) in 12th April’ 2005 by Hon’ble Prime Minister of India taking RCH as one its major components among five components. The NRHM program tries to bring architectural correction in the health programs. It also wants to ensure affordable, accessible and quality health care for the rural masses.

Now, when we say about health sector then the functioning of NRHM comes into picture as the NRHM is now the umbrella program, which is catering the health needs of the people and even the NRHM has set convergence with the other line department so that the status of the other health determinants also starts progressing. Consequently, primary health care delivery system is now a shared responsibility of the state and people, who are the responsible parties. Hence, constituents of improving primary health care in this holistic approach may be perceived as are:

State

Access + Participation + Quality health care  →  Improved health,

Community
So, these pre requisites have to be fulfilled to ensure that the end result is citizens improved health. It is accepted worldwide that the basic primary health care has to be provided to all citizen as better health of citizens’ yields better productivity, which ensures nation’s progress. In other words, National Rural Health Mission is

A programme with clear **time frame** for improving mainly primary health care,
A response to the **demand for quality** basic health services over the country,
An opportunity for promoting **social Justice** through access to basic health care,
An effort at **effectively improving** the PRIs, Hospital Management Committees, Village Health Sanitation & Nutrition Committees (VHSNCs) and other structures in the management of hospitals.
An expression of **political will** for improving primary health care across the country.
A **partnership** between central, state and local government.
An opportunity for states to develop their **own vision** of health care delivery system.

**The Objectives of the National Rural Health Mission**

Reduction in child and maternal mortality.
Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women’s and children’s health and universal immunization.
Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
Access to integrated comprehensive primary health care.
Population stabilization, gender and demographic balance.
Revitalize local health traditions & mainstream AYUSH.
Promotion of healthy life styles.
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