Chapter - 1

HEALTH COMMUNICATION - IMPORTANCE AND NEED

Communication plays an important role in addressing development issues as it involves bringing change in knowledge, attitudes and practices through information dissemination. Health is a major development issue and health issues which are preventive in nature need communication support. Nakajima, H. (Director General world Health Organization 1988) says we must recognize that most of the world’s major health problems and pre-mature deaths are preventable through changes in human behaviour and at low cost. We have the know-how and technology but these have to be transformed into effective action at the community level.

There are considerable differences among the health concerns between developing and developed countries. Health issues in developing countries are mostly influenced by factors such as illiteracy, poverty, a largely rural population with low access to health care facilities and other adverse socio-cultural factors necessitating more emphasis on preventive health care. Health education and communication occupies a major role in preventive health care and all agencies involved in health communication have a responsibility on par with the service providers in meeting the health challenges. As stated by Piotrow et al (1997) who emphasized the need for systematic communication strategies which can improve health behaviour, the power of communication today stems from two recent developments; the rapid growth of communication media and the notable increase in our understanding of communication processes. The issue is no longer whether health communication can influence behaviour. Now the issue is how to sharpen our understanding of communication to do a better job. This understanding will grow quickly as more health professionals recognize that communication is an investment and not an extravagance.

Some of the factors influencing the availability, accessibility and utilization of preventive health care services in any developing country are, the status of public health in that country, programmes for population stabilization and reproductive and child
health, availability of adequate drinking water and sanitation facilities in all the urban and rural habitations of the country, levels of literacy particularly among the female population of the country, etc. While innumerable other public health issues also demand attention reproductive and child health particularly is a matter of serious concern. As Piotrow et al. (1997, p. 1) observe “human reproduction is the key not only to human survival but also to the continuing health of billions of men and women and their present and future children. Yet human reproduction has always been among the most sensitive and challenging areas of public health. The issues relating to reproduction are becoming increasingly prominent on the public health agenda. In matters of reproduction and sexual behaviour, private behaviour has public consequences. Those consequences are important. Especially when individual private behaviour may be multiplied by the number of men and women of reproductive age in the world today – What an individual or couple may consider “nobody’s business but my own” becomes every one’s concern”.

**Role of Mass Media**

Planning and implementation of programmes aimed at covering large geographical areas and population need a large amount of mass media support. Mass media are powerful communication tools and are capable of contributing to rural development through informing the target population of their need for certain critical services from long term point of view of individual and familial socio-economic development, and of the availability and accessibility of such services to the population. The geographical reach and population coverage of mass media is extensive and unparalleled. Mass media have been credited for information dissemination and awareness creation among masses for many years, and now they have become an intrinsic and inseparable part of individual’s social life. Mass media transmits information, influences opinions and attitudes, and moulds the population’s perspectives on most socio-politico-economic issues concerning people significantly. Education, Information and Entertainment are the main objectives of media networks. Here, State owned media and private media differ in their approach in presentation of programmes. While the former attach more weightage to “educating the masses”, the later, mostly concentrates
on mass entertainment. Yet, both provide “Infotainment” a term widely used in media circles. Radio, in particular, the major development communication medium in India, has been devoting significant amount of time for health programmes and serving health information needs of the people over the past 45 years. The medium has already proved to be effective in addressing major health issues such as malaria, TB, family planning and pulse polio in the past few decades.

**Health Indicators**

Despite reasonably good efforts of the implementing agencies and the mass media globally accepted indicators of the effectiveness of health and family welfare programs show only moderate levels of success of such programmes in India. To quote few statistics the Maternal Mortality Ratio (MMR) (number of women dying during pregnancy or up to 42 days after delivery per 100000 live births) as per Sample Registration Survey (SRS) data (Government of India, 2007-2009) in India is 212, and in Andhra Pradesh (AP) it is 134 (Karnataka 178, Kerala 81 and Tamilnadu 97).

IMR (Infant Mortality Rate) (number of infants dying from the time of birth, till completing one year of age per 1000 live births) as per NFHS-3 (National Family Health Survey-2005-2006), is - India 57 and AP 53 (Karnataka 43, Kerala 15 and TN 31). Percentage of institutional deliveries as per NFHS-3 are - India 41% and AP 69% (Karnataka 67, Kerala 100 and TN 90). The percentage of children immunized against vaccine preventable diseases as per the same survey (NFHS-3) in India 44 and in AP 46.

India alone accounts for more than 10% Global HIV/AIDS (Human Immune-deficiency Virus/Acquired Immune Deficiency Syndrome) cases and is currently living with approximately 2.5 million HIV/AIDS positive victims and many more lakhs with STIs (Sexually Transmitted Infections) (National AIDS Control Organization, 2014). Andhra Pradesh is among the six high HIV/AIDS prevalence states in the country. Out of 2.5 million estimated cases of HIV/AIDS in India about 10% are from Andhra Pradesh (Andhra Pradesh AIDS Control Society, 2014).
The high number of child marriages is an alarming issue in the state. As per NFHS 3 (2005-2006) among the women in 22-24 age group, as many as 54.7% are married by 18 years age (which at the time of NFHS-2 (1998-99) was 64.3% and NFHS-1 (1992-93) was 68.6%. The latest data (NFHS-3) also show considerable number (18.1%) are already mothers at the time of survey among the women between the age group 15-19 years. The figures in respect of child marriages in the state are higher than the national level situation (44.5%) and demand immediate attention. When compared to north India and certain other parts of the country AP has relatively been more effective in implementation of Health and Family Welfare programmes but not so when compared to the states of Kerala and Tamilnadu.

Maternal and child mortality is a matter of serious concern in rural India. Poverty, illiteracy, superstitions, vulnerability to adverse health outcomes, poor access to health care facilities etc., are the major factors contributing to high rate of MMR and IMR in India. Literacy level of AP is 67% lower than the national average of 74.04% (Andhra Pradesh Population Census-2011). Government has been implementing many programmes and schemes to improve the status of maternal and child health in the country. A complete reorientation of the Family welfare programmes in the country focusing more on RCH areas is a major initiative in this direction. A detailed explanation on RCH programme/policy is provided below.

**Reproductive and Child Health (RCH) - Focus of the study**

The International Conference on Population and Development (ICPD) 1994 had established an International consensus on a new approach to policies to achieve population stabilization (NIHFW-2007). Under this approach, it was broadly agreed that fertility reduction should be addressed at the level of broad social policy, including reduction of gender discrimination in access to education, health care facilities and opportunities for income generation. It was further agreed that Reproductive health programmes should focus on the needs of actual and potential clients not only for limiting births and for reducing the size of one’s family, but also for healthy sexuality and child
bearing. In India, the implications of the reproductive health approach would be to shift the focus from the use of family planning as a tool intended essentially for population stabilization, to using family planning as one among a constellation of interventions that enable women and men achieve their personal reproductive goals without being subjected to additional burdens of disease associated with their reproductive phase of life.

Reproductive health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes (UNFPA-1995). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed about and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The Reproductive and Child Health (n.d.) (RCH) Programme was launched throughout the country on 15th October 1997 (IPHA workshop report, p.4). The RCH approach consists of need-based, client-oriented, demand-driven and high quality integrated services which include: maternal health services, child health services, prevention of unwanted pregnancies etc. There was fragmented attention in the decade of 1980s & earlier. The National Family Welfare Program has undergone a paradigm shift, from the past, with its focus on Reproductive and Child Health and major changes in approach.

There is a close relationship between the fertility behaviour of women and population stabilization programme. Factors such as marriage at an appropriate age, good ante-natal care during pregnancy, institutional delivery, post natal care, mother and child nutrition, neo-natal care, immunization, child survival strategies, cafeteria approach for
making available various services for family planning, availability, accessibility and affordability of comprehensive preventive and curative health care services for reproductive and sexually transmitted diseases etc., all have a clear and strong bearing on population stabilization. There is therefore a need to attend all these health issues effectively to be able to achieve the goal of health for all in general and addressing the RCH concerns of women in particular, as well as achieving an overall higher acceptance of the small family norm and there by the population stabilization. Considering the importance of these issues and also the need to explore suitable health communication strategies in influencing the health seeking behaviour of people the present study has identified reproductive and child health issues as focus for the study.

All India Radio - The Public Service Broadcaster

The historical background of mass media in India is diverse to a considerable extent. Since their inception, in India, press has been under private ownership and radio and TV have been under state control. Broadcasting in India was started in 1927 by the Indian Broadcast Company (IBC). Indian State Broadcasting Service became All India Radio (AIR) in 1936. Prasar Bharati was established in India on November 23, 1997 following a demand that the state owned broadcasters in India should be given autonomy such as similar to those in many other countries. The Indian Parliament had passed an Act to grant this autonomy in 1990, but it was not implemented until September 15, 1997 on which date the Prasar Bharati came in to existence (Prasar Bharati, Annual Report 2004 pp12-14). Prasar Bharati is India’s first autonomous public service broadcaster. It is an autonomous corporation of the Ministry of Information and Broadcasting, Government of India. Today, Prasar Bharati through Akashvani (All India Radio) and Doordarshan networks provides maximum coverage of the population and is one of the largest terrestrial networks in the world.

Public service broadcasting is the broadcasting made, financed and controlled by the public, for the public. Tracy, M. (1998) considers public broadcasting as the single most important social, cultural, and journalistic institution of the twentieth century.
Claiming social responsibility as the main principle of public service broadcasting, Chhetri, R. (2011) believes that public service broadcasting can serve as a keystone of democracy when it is guaranteed with pluralism, programming diversity, editorial independence, appropriate funding, accountability and transparency. Public service broadcasting has the responsibility to provide services to the general public comprising many individuals and groups with linguistic cultures, languages, wide ranging differences and broad similarities.

The roots of public service broadcasting are generally traced to documents prepared in support of the establishment of British Broadcasting Corporation (BBC) by a Royal Charter on January 1, 1927 (Chhetri, R. 2011). This corporation grew out of recommendations of the Crawford Committee appointed by the British Postmaster General in August 1925. These recommendations included the creation of a public corporation, which would serve as a trustee for the national interest in broadcasting. It was expected that as a public trustee, the corporation would emphasize serious, educational and cultural programming that would elevate the level of intellectual and artistic tastes of audience.

Many countries have adopted public service broadcasting systems. British Broadcasting Corporation (BBC) particularly is considered as a model in this context. In the United Kingdom, the term public service broadcasting (PSB) refers to broadcasting intended for public benefit rather than for purely commercial concerns. (Public service Broadcasting in the United Kingdom-2014). The communications regulator Ofcom (The Office of Communications - commonly known as Ofcom, is the government-approved regulatory and competition authority for the broadcasting, telecommunications and postal industries of the United Kingdom) requires that certain television and radio broadcasters fulfil certain requirements as part of their license to broadcast. All the BBC’s television and radio stations have a public service remit, including those that broadcast digitally. Additionally, all stations that broadcast on terrestrial analogue television are obligated to provide public service programming as they can be viewed freely almost anywhere nationwide. The Community Radio Services are also specifically recognized by OFCOM.
as being providers of public service broadcasting output, delivered under the terms of the Community Radio Order 2004. Commercial radio also has nominal public service obligations. However, the requirements imposed for commercial radio are generally fewer, normally requiring only a minimum level of news.

As the term indicates PSB is meant for the cause of the public and has been successful in serving the people for quite long time. However, changes in political, economic and technological spheres in recent times have influenced the ideology of PSB, making it a “struggle for existence” in recent times. Worldwide PSBs are facing critical challenges though the nature of such challenges may marginally vary depending on the socio, cultural, economic and political conditions of a particular country.

Indian broadcasting network is no exception to the global situation. For quite a long time AIR did not introduce commercials. Only in 1967 commercial broadcasting service came into existence with a restriction of commercials not exceeding 10-15% of the total transmission hours. Later in 2003 marketing divisions were established all over the country giving more emphasis to revenue generation (Prasar Bharati, 2014). Fixing targets for stations, efforts to market programmes and review of income generation, are some of the new features in programme administration in AIR and DD. In spite of these initiatives Radio and Doordarshan have not yet lost their public service character. But, slowly market culture is penetrating into public broadcast media in India also. Presently the Indian PSB network is functioning in a conflicted environment. Explaining the uncertain future of PSBs, Brown, A. (1996, pp 3-15) says, “The traditional rationale for the production and transmission of public service broadcasting (PSB) arises from the perceived social importance of the broadcasting media and their potential influence on values, attitudes, and beliefs. There are also strong arguments for the provision of PSB arising from the economic analysis of broadcasting markets. Economic theory indicates that an unregulated, fully commercial system of broadcasting would result in market failure. This supports the case for some form of government intervention in broadcasting to ensure the provision of PSB programming. The empirical literature provides insights into the economic characteristics of PSB organization. Provision of PSB by state-
sponsored, non-commercial broadcasters is currently under considerable pressure, particularly from new broadcasting technologies. The traditional providers of PSB thus face an uncertain future”.

However, in India, PSB has played an important role in development sectors such as education, health, agriculture etc. In particular AIR’s contribution to health sector has been extensive. Both All India Radio and the Health department of state governments, are largely under government’s control and have been functioning in synergy since decades. The health broadcasts are planned as per the health policy of Government of India and implemented in coordination with the health departments at central and state levels.

**All India Radio - Health and Family Welfare**

All India Radio (AIR) has a national network of 261 broadcasting centers with 406 Transmitters (AIR, Citizen Charter - Dec. 2011). AIR has coverage of 91.85% of the geographical area, and 99.18% of the population of India. AIR broadcasts in 24 Languages and 146 dialects in home services. It has total 4 tiers of services; national, regional, local and external Services. In external services, AIR broadcasts in 27 languages; 17 national and 10 foreign languages. AIR has also Direct-to-Home (DTH) Radio services (21 channels) and has planned for internet based radio services round the clock. AIR follows international and national level social and cultural values and service standards in broadcasting.

Issues relating to health and family welfare have always been given special focus in AIR since inception. However, broadcasts, which were occasional in nature, became regular from 1967 onwards. At national level Family Planning Units (each consisting of an extension officer, a field reporter and a scriptwriter) were set up initially at 22 AIR stations. Later this was extended to several other centres also, and 14 small units with one field reporter and a special unit at Akashvani headquarters, Delhi were also established (Luthra, H.R., 1986).
Broadcasting Centres - State Level

There are 12 radio stations in Andhra Pradesh, four major stations and eight district local radio stations (DLRs). Few more stations were initiated at important regional centres, such as Mahaboobnagar, Karimnagar, Srikakulam etc. but they are not fully established units and mostly relay programmes from the nearby main stations. These stations located at important regional centres allot a considerable amount of broadcast time for health and family welfare programmes. While major AIR stations have fixed time slots of varied durations for different programmes, the DLRs are more area-specific and flexible, reflecting the needs of the people of the areas they cater to. They provide an opportunity for artistic expression and communication skills of the local talent. To realize these objectives, field-based programmes are given more importance. In addition, commercial channels (two in number) and youth entertainment channels (three) which have higher listening rate and popularity among audience, also broadcast Health and Family Welfare programmes regularly.

Advisory committee

At station level, Health and Family Welfare broadcasts are planned based on the suggestions from advisory committees. Representatives of audiences, subject experts, veteran broadcasters and one official from the department of health and family welfare constitute the membership of this committee. In addition, they receive guidelines from the ministry of health and family welfare, Government of India (GOI.). Other agencies such as UNICEF and WHO also provide information and expert inputs for these health broadcasts. AIR follows foolproof methods in designing, production and presentation of the programmes. In view of the need to give importance to field recordings and provide instant coverage to topical issues which significantly affect the local population, programme planning at district level is relatively flexible.
Training

AIR has training institutes at national and regional levels. In-service training is provided to the staff in both institutions. However, health and family welfare is one among the many topics covered and they are discussed only occasionally. In addition to these trainings, organizations such as National Institute of Health and Family Welfare (NIH&FW) Delhi and Indian Institute of Mass Communications (IIMC) Delhi, occasionally plan training programmes on development broadcasting as a part of their training calendar which includes health contents.

A one-day workshop for the personnel of AIR conducted by Health and Family Welfare Department of Andhra Pradesh during 1994-95 brought out the need to provide information on health issues to the media and also regular orientation to the personnel involved in the production of health programmes. Similarly, the AIDS Control Project of Andhra Pradesh has organized a few orientation programmes for the staff of AIR.

Programme Pattern

In Andhra Pradesh, all major radio stations broadcast programmes on health and family welfare. While the Telugu programmes are on the main channel commercial service centres also include public service announcements on subjects such as proper age at marriage, need for comprehensive antenatal care for pregnant women, importance of institutional deliveries, and family planning concepts including the small family norm, spacing methods, contraceptives, sterilization, immediate benefits of the above for the health of the mother, long term benefits for the well-being of the family as a whole, etc. in the form of jingles or sponsored programmes. AIR Hyderabad broadcasts programmes in six languages: Telugu, Urdu, English, Hindi, Marathi and Kannada. All these programmes include topics on health and family welfare. The other sections such as women and youth also contribute to health programmes through discussions on health issues related to the specific audience.
All India Radio makes use of solicited and unsolicited scripts. Many health workers at district and mandal (a sub-district unit of administration; the same has replaced ‘Taloks’ which existed till about 1985; each erstwhile taluk has been replaced by about five to six mandals with a view to take administration closer to the people) levels are able to participate in the programmes of local radio stations. Others at village level are also covered by local radio stations in their field-based programmes. There are no restrictions (such as age, religion, education etc) to participate in local radio programmes. AIR does not follow any caste, creed and community restrictions in inviting people to participate in its programmes that are produced for the purpose of broadcast. Talent, communication skills/abilities, subject expertise and experience in the respective field are the criteria. Health staff at different levels are encouraged to contact the programme officer of the closest AIR station and convey their area of interest and seek opportunity to participate in any appropriate programme. However, a minimum time gap is maintained between one programme and another by the same person in order to encourage more people to participate. Health workers can also bring to the notice of media any public campaign or event related to health sector they consider important.

**Staff-pattern and programme production**

As mentioned earlier, to educate the public on health and population issues, exclusive units of health and family welfare have been set up in some major AIR stations in the country. Earlier, these units were headed by an extension officer deputed from the health and family welfare department of the state. Now, the programme executives of AIR who generally monitor the programmes are given Health and Family Welfare section also. A field reporter-cum-production assistant helps the programme executive in the programme designing and preparation.

The programme executive in-charge of the Health and Family welfare section in AIR periodically prepares a layout of health topics to be considered for inclusion in broadcasts in consultation with health experts. After obtaining the approval of the AIR
station director for the layout, the programme schedule is prepared for a three month period and the contracts sent to different resource persons.

AIR makes payment to the artistes/resource persons for their contribution. Those invited from interior areas within the coverage zone are also paid for their travel and incidental expenses. The recording of programmes are planned accordingly. The schedule is by and large flexible and topical issues which need immediate publicity get attention.

Content

The contents of the programmes produced for broadcasts include all health issues especially in the areas of priorities set by the government. These are usually of concern to a large segment of population of the state. The programmes cover family planning, disease control and preventive measures, population, nutrition, mother and child care, AIDS, sex education etc. Apart from covering programmes organized by health department at various places, field-based programmes such as interview with beneficiaries (members of the general public who have utilized the services) are also broadcast. Programmes focussing on prevention of illnesses are given preference.

Importance given to broadcasts on family welfare is evident from the fact that the topic is included as a special category in the Akashvani national annual awards competitions. AIR Vijayawada in Andhra Pradesh had received two such awards in the past. All AIR stations arrange invited audience programmes on different subjects which also include topics such as AIDS.

The programmes broadly reflect the national health policy. Family planning, mother and childcare, antenatal and post-natal care, age of marriage etc are subjects dealt with usually. But they are not often based on the demographic profile of the state/area that is covered by the broadcast.
Scripts and Materials for broadcasts

All India Radio mostly depends on health experts for scripts. While producers enjoy the freedom of selecting the formats and techniques of their own choice, the subject-matter for the broadcasts is decided in consultation with the experts. Further, such experts themselves, often doctors, policy makers, and others, are invited to the studio to broadcast the messages. This is done with a view to ensuring the authenticity of the contents of the messages broadcast. Health broadcasters take adequate precautions both in treatment of the content and also the production work. A majority of experts are good communicators. AIR regularly receives voluntary feedback from listeners about these programmes in the form of letters. Sometimes, the producers themselves solicit the feedback.

Programme format

The family welfare units of AIR put considerable efforts to make the programmes interesting. Eminent writers and other creative talent are drawn to prepare the scripts which are made into audio programmes. The formats for these programmes include talks, interviews, discussion/dialogue, symposium, play features, poetry, short story, outdoor broadcasts, quiz, phone in, listeners’ questions and answers, newsletters, songs, announcements, messages on special occasions, jingles, slogans, folk ballads etc. The programmes are of different types such as, studio-based programmes, outdoor broadcasts detailed features and documentaries.

AIR continuously broadcasts short messages supplied by the state health and family welfare departments in the form of live announcements or recorded programmes during campaigns and other major health events Many consider these to be more effective.
**Frequency and Repeat broadcasts**

At state level as well as at major stations’ level there is a health broadcast almost every day. At local level, the frequency is usually twice a week. For paid programmes on the subject of health and family welfare, there is no limit. AIR repeats many of the health broadcasts. The criteria for repetition are topicality, production value and potential benefit it is likely to cause to the listeners. While no specific guidelines are followed in selecting the topics for repeat broadcasts, repetition is common feature on electronic media as it helps to reinforce the message.

**Budget**

AIR Directorate allots budget to different stations spread all over the country. At state level for major stations where the programmes are scheduled every day, budget for H&FW units varies between Rs.1 to 2 lakhs. This allotment is a part of stations’ overall budget and not exclusive. For local stations with twice a week frequency of broadcast this would be around Rs.50 thousands. In addition, many commercial or sponsored programmes which are related to health topics are broadcast on regular basis. Phone-in programmes with doctors and sponsored programmes by corporate hospitals is a common feature at present.

**Audience research**

AIR has audience research units at national and state levels to provide feedback on programmes from time to time. However, evaluation studies on health programmes are limited. Further, the studies conducted by these audience research units concentrate more on gathering opinions from audience on certain general aspects and techniques of the programme production rather than the content.

The above is a brief description of different aspects pertaining to health broadcasts in AIR. The data from the records of AIR shows a gradual increase in number
of health programmes broadcast over the years. As per the data available country wide about 20,000 Family Planning programmes were broadcast during the year 1971-72 from AIR Stations. In 1973-74 this increased to about 27,000. In 1979, over 52,000 items were broadcast during January to November, and it was stated that this represented a two-fold increase over the programmes broadcast during the corresponding period in the previous year. About 60,000 programmes were put over in the calendar year 1980 (Luthra HR 1986). The figure for 1985 is 58,856. If one also considers all the other publicity themes and adds to these a very large number of ‘days’, ‘weeks’ and ‘fortnights’ devoted to annual events like Health Day, Literacy Week, Leprosy Day, Fire Prevention Week, Cleanliness Week, Savings Fortnight, Vanamahotsava, etc., the number of programmes generated perhaps runs to several.

While the above data represents the past, the detailed explanation given in the preceding paragraphs on the functioning of the system of health broadcasts in AIR stations in Andhra Pradesh provides the present status. Technological social economic and political changes in society have invariably been leading to greater transformation both in media in general and the health sector in particular. At present, the use of media in health sector has increased substantially when compared to the past. A good example of this phenomenon is the relentless radio campaign that has been taken up particularly to combat HIV/AIDS for which media support was sought since prevention is the only choice to contain the problem of HIV/AIDS. Since 1990s use of media by health sector is prominently visible. Use of media has increased mostly from year 2000 onwards consequent to the increasing need to spread messages for prevention of HIV/AIDS and Pulse Polio campaigns. Emerging dynamic leadership in health sector in most states of the country, as a result of the initiatives taken by the Government of India under the RCH program had also helped increased media programmes. Radio has been providing dedicated service to health sector with specialized units as explained earlier.

Though radio is considered as an important development communication media in the country, its potential has not been tapped adequately by the health sector. All India Radio had been broadcasting programmes in the areas of maternal and child health for
many decades using different techniques and formats. It adopts sound methodologies and practices in health broadcasts. However, these efforts have been more on delivering the messages i.e., transmitting health content: yet a system of critical review of the initiatives was not developed since the inception of such programmes. The need for introspection and critical review in any programme implemented for relatively long periods of time requires no emphasis. Hence, the present study made an attempt to study the health broadcasts with special reference to reproductive and child health, as well as explore suitable alternate approaches for application in health communication process. The study is titled *Radio Campaigns on Reproductive and Child Health in Andhra Pradesh - Emerging approaches*. The long time contribution of AIR to maternal and child health is examined in terms of content, dissemination and reception and efforts are made to explore suitable approaches for future programming.

**Need for the study**

The perceived gaps in the existing system of health broadcasts for the above mentioned aspects i.e., content, dissemination and reception, are further explained as given below.

Radio has been broadcasting health programmes since many decades with full-fledged Family Welfare units, in coordination with health sector both at central and state level. However, it has taken a long time to reflect the paradigm shift in health programme policy (focus on reproductive and child health) in tune with the decisions/agreement made in the Cairo conference (The International Conference on Population and Development (ICPD) 1994). Coverage of RCH concepts is observed to be random and needs focus (Sharada, et.al, 2001).

Today for many members of the general public, press, radio and television are some of the main sources of information on health. As observed by Simbra, M. (2005), a medical reporter and a practicing physician in US, reporters are surpassing doctors as a source of health information. In India, radio is fulfilling the responsibility of
disseminating development information of which health is a major component. When compared to interpersonal communication broadcast media has many advantages. Messages are disseminated to millions of people through many channels instantly. Use of creative formats and techniques make the broadcasts interesting and draw the attention of listeners. These and many other aspects pertaining to dissemination of messages needs to be evaluated on regular basis to understand the effectiveness of the same.

Media organizations focus more on functional issues than feedback collection. This is more so in radio programmes in the areas of social and economic development where broadcasters think of providing the message dissemination service as a major responsibility. Media activity is time bound and broadcasters’ energies day and night are spent mostly on feeding content to the transmitters. Usually people take more care in designing and implementing the campaign and neglect evaluation exercise. Sometimes evaluation is put aside deliberately for the fear of getting unpalatable results or for the fear of criticism. Sometimes even if evaluation is conducted the results are not made public if the outcome causes embarrassment to the implementing agency. In situations where people do not want to indulge in self-criticism avoiding evaluation is felt to be safer. Discussing the lack of evaluation/research efforts in health communication campaigns particularly using mass media Backer et.al. (1992) say, until recently, the body of empirical evidence on successful health campaigns that include a mass media component was too limited and scattered to permit cross-comparison. Now, there is much more evidence and experience to study but most campaign scholar’s deal with one or a limited number of specific health topics in their studies.

Discussing the study of the characteristics of organizations involved in health communication campaigns, and how these organizations work together to either facilitate or inhibit the success of mass media campaigns (Backer, et.al., 1992) further observe that the organizational and inter organizational dynamics of mass media health campaigns—which tend to be complex, highly interdependent enterprises have a significant bearing on campaign outcome, but these factors are virtually virgin territory in research on campaigns. About the use of radio in public health communication campaigns they say,
“Radio as a medium for campaigns is underutilized. There certainly is not enough research being done on its effects today. Follow-up seems to be more difficult with radio, and this might be another reason for its underutilization”.

The discussion clearly shows the need for research on the effects of campaign particularly using radio, and the proposed study is expected to make significant contribution to the field of Health broadcasting.

Few major studies which are conducted on regular basis both in media and health sector concentrate only on certain broad aspects pertaining to health broadcasts. India Readership and Indian News Papers Survey which are considered as standard research data among media organizations include few questions on reach and coverage of electronic media in a routine manner. Similarly, the National Family Health Survey (NFHS) which is considered to be a standard survey in health circles also includes only a very few questions particularly on the source of media for health information. As Carriere (1990) says we require behavioural information that is hard and based on ground level experiences, empirical, scientifically gathered and generalizable. Stressing the need for professional approach to communication and creative message design and skilful use of many mass media and person-to-person channels now at our disposal he further says unless an enlightened public health leadership invites and mobilizes the market and audience researchers, the message designers and the media planners, our approaches at behaviour change will remain fragmentary, ineffective and amateurish. The real need is to demystify health knowledge in communication.

Routine programming does not allow for detailed study of various specific issues (content, dissemination and feedback). There are special efforts made periodically with better planning. It is the objective of this study to look at a selection of such special efforts and to discover the best practices used in them for developing content, dissemination strategies used, the modes of feedback collection, and incentives for better audience participation.
The plan of this study is explained below.

Organization of the Study

Chapter - 2 follows this introduction chapter. It provides an overview of the research available on health broadcasting with special reference to reproductive and child health.

Chapter - 3 that follows will explain the objectives and the methodology selected for the study. The theoretical framework used for the study is detailed in the chapter.

Chapter - 4 present the detailed reports on 5 campaigns (cases) chosen for the study.

Chapter - 5 Data presentation and Analysis includes, (1) Basic details of all five campaign cases and (2) Comparative analysis of five campaign cases (Content, Dissemination & Reception). A brief report on the ‘Listening Sessions’ is also presented in this chapter.

Chapter - 6 deals with Multivariate Cluster Analysis.

Chapter - 7 describes Best practices and emerging approaches from the study.

Chapter - 8 will present the major findings from the study.

The next chapter provides a detailed review of literature pertaining to health broadcasts special reference to reproductive and child health.