ROLE OF TELEVISION IN HEALTH AWARENESS : A SOCIOLOGICAL ANALYSIS

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Certified that the dissertation entitled: "Role of Television in Health Awareness: A Sociological Analysis" submitted by Mahendra Kumar Dubey is in partial fulfilment of the six credits for the degree of Master of Philosophy of this University. This dissertation has not been submitted for any other degree of this University and it is his own work. I recommend that this dissertation be placed before the examiners for evaluation.

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INTRODUCTION

Communication is the breath of community. Community without communication is a contradiction in terms. Communication between and among people is possible only when there is communion. It is through communication that communion develops in a society. However, not all typesof communication can give rise to communion. Certain types of communications may deliberately lead to conflict or disharmony or cessation of the existing communion. Sometimes they may even kill the humanity of man. The objectives of communication therefore differ depending upon the interests of the communicators. How do people communicate, depends upon how and in what sense they understand and accept others. In the final analysis, it is one's view of man and reality in its totality that determines the nature and objective of communication. Human life, on the whole, is treated in different ways. Some times man is considered as sacred and hence all human beings are treated as equally sacred. In some other cultures man's value is judged on the basis of economic power and hence the less privileged are viewed as the object of exploitation. In some other societies, man's standing is assessed on the basis of the birth if not previous birth. Here man is treated on the basis of social standing. Communication is made either for self-protection, or perpetuation of power; or for exploiting humanity or for the over-all progress of the humanity at large.

India has entered with dramatic speed the era of modern communication in recent years. This is partly as a

result of exposure to the Communication Revolution of the developed countries. This is also partly due to major policy decisions in favour of introducing modern communication technology in the Indian sub-continent.[1] Social scientists are not yet adequately focussed on the social consequences of introducing modern communication in a country like India. For a country which is still struggling with problems of economic transition from a pre-industrial to the industrial stage, the acceptance of the communication technology of the post industrial societies offers unperceived possibilities as well as dangers. Considering this above framework this study was conceptualized to examine the role of TV in health awareness.

With the development of new techniques in communication, India with some other developing countries, witnessed rapid expansion of mass media. Television, a young child of mass media, is growing fast as it is nourished by political will and, apparently, favourable governmental planning. Television, now frequently addressed by media planners as development tool, may be an instrument for socio-cultural upliftment of the people and therefore it, according to media policy of government, has to be made more responsive to the needs of the people "and... the media should be made more relevant for instructional purposes". It may play a major role in communication revolution to promote awakening among people regarding democratization, community participation in developmental tool, health, hygiene and family welfare

programmes, education, agricultural development etc. Therefore, television has a wide ranging role as information and education agents in all these fields.

Mass media, specially television and radio, are penetrating urban and rural communities' socio-cultural structure and seek to flow a package of entertainment, information and education among them. Demographically, country is divided into many linguistic population areas and the television is the only media which can cross the language barriers to provide message and information simultaneously and uniformaly.

Although, the programmes on television are not limited to any special field but health, hygiene and family welfare are given a sizeable coverage in it. However, communities, more or less, retain its own values regarding health but the force-ful mass-media like TV may effect and mould these values in to desired direction.

Poverty, illiteracy, poor sanitary conditions etc. are the fundamental causes of ill health but health status of the people may also be improved by giving them a positive awareness of health. Significance of television as a measure of information and education is particularly great in a vast and developing country like India where the reach of printed word is neither wide nor deep. For the country like India, where literacy percentage is still in poor condition, TV may be proved as a powerful weapon to disseminate the acquaintance and general awareness regarding primary education, health, hygiene, family welfare programme etc. Although, radio, fulfils all

these requirements fully or partially but TV becomes more useful and effective as it provides both audio and video to viewers for their easy understanding of the programme. Lastly, importance of television can be envisaged as in the words of P.C. Joshi:

"Television is the product of the most advanced stage of modern communication revolution. It has perhaps a much greater influence on perception, emotions and out look of the people than any other media. It has the effect of eroding old values and attitudes in favour of new ones"[2]

Purpose of the study:

Doordarshan has been expanded rapidly and it has now about 180 transmitters all over the country. However, it is claimed that existing Doordarshan network covers about seventy percent of the population of the country. Therefore, impact-study of television programme has become the prime requirement in the field of sociology of communication.

Some studies mostly sponsored by governmental agencies i.e. Indian Institute of Mass Communication, Indian Space Research Organisation, and Doordarshan etc. are claiming that the TV programmes related to health and family welfare are enhancing the knowledge of viewers and they are receiving these with acquisitive mind and interest. However, some social scientists agree upon television's role only for reinforcement and renewal of audience's existing knowledge already acquired by inherited health culture or by inter

personal communication and not for dissemination of new information among them.

Hence, it became immediate purpose and objective of researcher to investigate into the matter while undertaking the study on health awareness by the mass medium-television. Although, the degree of adoption and rejection of health programmes could not be perfectly assessed due to the time constraint and also fear of deviation from the actual objective of the research, but, however, the causes of rejection were evaluated. Thus, objectives underlying in the study are categorised into primary and secondary one and given as here under.

(a) Primary Objectives:

(i) Did the health programmes on TV cause viewer's acquaintance with diseases, its symptoms, preventive and lastly, curative measures?

(ii) Were the health programmes filling the awareness gap regarding health, and affecting viewer's own health culture?

(iii) Had these programmes benefitted or were benefitting to their individual health problems or to their families and peergroups?

Secondary Objectives

i) Did they face any difficulty or difficulties in understanding the programme's message and information?

ii) Had they any suggestion or suggestions about inclusion and modification of the items to be shown in health programmes?

iii) Did they watch the health programmes, if not, what were the reasons?

iv) If they watched the health programmes, which programme they liked most and why?

v) Did they watch TV, if not, what were the reasons?

Scheme of Chapterization

This whole work is devoted into five sections out of which first section is given to introduction and rest are the four chapters of the study. In the first chapter, growth and development of communication is reviewed and it includes the meaning of communication, development of mass media communication and television and its relation with the development of health. Second chapter is given to the review of available literature, attributed to the communication, specially television impact studies on rural development, agriculture and finally on health and family welfare. Third chapter contains an exploratory study in Mayapuri - Delhi, on TV health programmes. In the fourth chapter a discussion has been made on the basis of findings of the study and issues raised in the second chapter while reviewing the literature. And, finally a perspective of this problem has been worked out.

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CHAPTER - I

GROWTH AND DEVELOPMENT OF COMMUNICATION

Communication and its Development

1.11 Meaning and definition of Communication

Process of modernisation sought dramatic speed with the development of communication system. New technologies in communication system has become the means to revolutionise the all aspects of human life and prevailing social conditions. The word communication comes from the word 'Communico' - meaning share or impart, partake. It is also taken to mean the act or action of imparting or transmitting the fact or information.[1] "Communication is the exchange of meaning between individual through a common system of symbols"[2] It is social process which includes implicit acceptance of the message and also recognition of meanings associated with the message. Communication is that process whereby encapsulated particles of meaning are transmitted between individual organisms by means of specialised sending or receiving devices".[3] It is also defined as "a variety of behaviour, processes and technologies by which meaning is transmitted or derived from information.[4]

French sociologist Lapierre viewed communication as "the process by which one organism conveys through space and time or both, its feeling, sentiments, ideas or knowledge to another organism". Men can convey a wide variety of complex feeling, desire, ideas etc. with considerable accuracy and communicate with one another symbolically.[5] It must be recognised that "it is through communication that people can learn about new ideas, can be stimulated by change which is conveyed to them or be cognizant of change and what it means, and can understand what is going around them".[6]

Through communication people control one another's behaviour and unite themselves in groups. Thus, 'Communication is a means for breaking down the barriers to human interaction. It is means for achieving mutual understanding. Three elements i.e. (a) scarce (b) the message and (c) the destination are always required by communication.[7] Communication, according to Desai (1974), is the fabric on which all progress is woven. A progressive nation is one that seeks to give the people an effective voice in the process of decision making on question of economic growth, social equality and exercise of political authority.[8]

Communication's influence may be seen as instrument of reinforcement rather than change. And, the reinforcement may be helped by (1) predisposition and the related process of selective exposure, selective perception, and selective retention (2) the groups and the norms of the groups to which the audience members belong (3) the interpersonal dissemination of the content of communication, (4) the exercise of opinion leadership and (5) the nature of mass media in free enter-prise society.[9]

1.12 Development of Communication :

Communication which started with vocal sound, signals and body language, evolved through the spectrum of media channels of signs, symbols, picto graphy, notations, inscription etc. The content was centering mainly around food, shelter, natural forces and human relations. While moving in search of food,

people left their imprint on stones, caves, walls etc. "The development of tribal dialects continuing through the nomadic, acul-turist and agriculturist stage was a natural offshoot of primitive communication on modes." Gradually, the nature and structure of communication were changing while society moved towards industrialisation. According to Chaudhari (1984)[10] with the development of human societies, interaction which started with vocal sound, which can not be called dialect, signs, signals etc. went through the entire structure of traditional communication, modes, body language, through language and script, with industrialization, was absorbed and over shadowed by electrical and electronic channels". Dube (1955)[12] opined that primitive humans lived in small groups with interpersonal communication. Millions of years were spent in developing the technology, from cave engraving to the discovery of paper and press, to make it accessible to the people. While communication become easy after the development of transport routes like roads, waterways, bridges, sea routes, rivers and canals, it, in the words of Marshal Mcluhan, became totally" transformed into information movement in the electric age.[13] The invention of electricity was yet another milestone in man's progress on this earth. There came the printing press another take off stage for the era of mass communication, which again made the world a much smaller place to live in. The next break-through came in the shape of silent movies and later talkie movies for mass comminication entertainement and education and television is an audio-

visual extension of the film from mass audience to individual homes. On the basis of his study of two Indian villages, Lakshamana Rao (1966)[14] came up with the theory that "communication helps people find new norms and achieve a balance during a period of rapid change. Communication though appears to originally stimulate and create stress, later on acts as a balm and reduces tension". Schramm wrote (1967)[15] whenever change impends, wherever change occurs in human society, these communication flows".

Kuppuswamy (1972)[16] asserted the role of communication in all spheres of development in the life and condition of the people. He wrote "It is in the ninteenth century that a revolution took place in the world with respect to media of communication with the application of science and technology. It is also in the ninteenth century that there was a transformation in the political and economic structure in India giving rise to new attitudes, new outlook and new behaviour from one end of the country to the other. This has to a great extent helped in the unification of the people with diverse outlook and interests on account of rural urban difference, caste, religion and language difference, all of which tend to disintegrate the society unless the mass are exposed to new ways of thinking and develop new attitudes, there is little hope of economic development social equality, social mobility and political maturity. These changes now possible because of the development in modern medium of communication. To put in other words, without adequate and

effective communication economic and social development will be inevitably retorted.

Mass Media Communication

1.21 Meaning of Mass Media-Communication

Contemporary society is too complex to function only through direct communication between one individual and another. For instance, one message, can be delivered to thousands of people simultaneously through the mediums like radio and Television. A national important news can be read in the daily newspaper by millions of newsreaders at a time. Thus these communication media give more result in less time, money and labour than that of direct communication. This is mass communication - the process of delivering information, ideas, and attitudes to a sizeable and diversified audience through use of media developed for that purpose".[17] It is utilized to disseminate the message to large masses of different geographical regions, culture and socio-economic condition at a same time. Hence, mass communication seeks to cross all the barriers and conditions which happen frequently in the way of interpersonal communication. "Mass communication comprises the institutions and techniques by which specialized social groups employ technological devices (press, radio, film etc.) to disseminate symbolic content to large heterogeneous and widely dispersed audience".[18]

Mass media, means of communication, such as newspapers, magazines, television, radio and motion pictures designed to reach and influence very large numbers of people.[19] Every

channel of communication has its own function and characteristics, for example the cinema is concerned with providing entertainment and education and is capable of creating high emotional involvement. The print media, especially the modern press is involved in creating increase in political awareness and deals with advertising. The radio on the other hand has an implicit quality of immediately and sociability and able to command a large area coverage. The television and all other technical appliances have in common audiovisual display, entertainment, information, education and a persuative quality.[20] The mass media have made us instantly aware of the outside world. We are used to knowing what happens hundreds of thousands of miles away within moments of its happening ...... The mass media are seen as tools to reconstruct society.[21]

1.22 <u>Development of mass media communication</u>:

The development of mass media communication could be seen in sprectrum of the development of means of transportation of message from early days till today. The mass media are the resultant of the forces set in motion when groups of men like animals first huddled together against the cold and dangers of primitive times. The tool of language came even before recorded history and the alphabet came at the very dawn of history. Sometimes, between the beginning of language and the invention of the alphabet man developed highly ingenious ways of storing knowledge and transmitting information. Smoke singals and drum beats were the first broadcast and the collection of cut stone tablets, first libraries.[22] Thus the development of mass communication run through the same steps as of the communication.

Ancient India also developed mass media communication through the various ways of folk media and interpersonal communication media.

Parmar (1976)[23] suggested that in ancient India only folk media of communication of information and ideas were existed rather than modern mass media. The technology - based mass media appeared on the Indian scene only after the establishment of British rule. Media of communication in ancient India was inter-personal communication and conversation. According to Olive (1971)[24] it is strange phenomenon that in India from the oldest time upto the present day the spoken word and not writing has been the basis of literary even more definitely the social, political and commercial needs of the people.

With the onset and entrenchment of industrialization in Western Europe and England, the powers of its technologies of steam, mechanisation and electricity were extended to the colonies within their empires.[25] Rapid communication of complete and elaborate message became possible and after the invention of electricity and later, telegraph was invented as the first tool of electric system of communication in the 19th century. Just after telegraph message system, telephonic communication system was developed by Alexander Graham Bell. Radio, as the media available to common men entered into the field of mass media communication and become an instrument of communication revolution.

Development of communication in India may be traced back from initiation of regular postal service in Bengal in 1766 by

Robert Clive. In 1774, Warren Hastings made available the postal service to general public. In 1837, East India Co. established its monopoly on postal services and abolished those of private owned. Postal stamps, parcel, service, money orders and postal saving banks were introduced. In 1852, telegraph line was started in Calcutta. Telephone was introduced by some private enterprises in 1875. First telephone exchange was set up in Simla in 1913-14 and first railway line was opened in Calcutta in 1852.[26]

Starting gradually with roadways, printing press, steam navigation, locomotive railways, photography, postal services and newspapers, India before long was over-whelmed with the import of ever accelerating developing technologies of the big media: telegraph, newspapers, telephones, radio, phonographs, and movie photography .... The pace of development accelerated with the introduction of television, computers, and micro-electronics, and finally leap - frogged with the technological combinations of telematics, informatics and the satellite systems - all within the span of barely half a century.[27] Now, television and radio has become the central focus of the growth in mass media technology. And again, we are witnessing tremendous innovations in the use of television such as the development of video, cable and satellite systems.

1.23 Mass Media Communication and Social Change

The rapid growth of mass media and their influence in modern times led people to consider the actual role of mass media in social life and behaviour. According to Schramm,[28] "mass media are essentially agents of social change and the specific kind of social change they are expected to help accomplish in the transition

to new customs and practices, and in some cases, to different social relationships. Behind such change in behaviour must necessarily present substantial alterations in attitudes, beliefs, skills and social norms".

There are two theories about the effect of man communication. According to first theory, media are extremely potent. And, in the hands of advertisers, political propagandists and mass educatiors, they can be used as instruments for the manipulation or conditioning of man's mind against his will.[29] On the other hand second theory argues that the mass media tend to make people to be conservative, status quoist and opposed to any change. Klapper (1960) concluded that media have little or no effect on people, rather, they tend to reinforce attitude and behaviours that people already possess.[30]

It is often recognised by sociologists and media experts that mass media are very powerful in society and determine the thought and actions of people to a substantial degree. But, this view is not universally accepted, that is why a third world journalist communicator Altaf Gauhar rejects this view. According to him, among the natural human urges are: the will to servive and the will to express. People become one on the basis of identity and they remain one in pursuit of a common destiny. Any social or political order which militates against the identity and destiny of a community alienates itself from the people. Gauhar expresses strong belief in the self sufficiency and self protecting capacity of media - process, against the domination of vested interests. When vested interests within the community try to dominate this (communication) process, redical forces are released,

which somtimes gather enough strength to liquidate those interests and the process in reactivated.[31]

Melvin L.DeFleur and Sandra Ball Rokeach enunciated that the action media message reception of the people has been effectively instrumental in charging individual needs, psychological and social characteristics. And in some cases they flow back to alter the nature of social itself."[32]

Mass Media, have become an agent of mobilising the human resources requiring great deal of national development. It especially encourage the attitudes, customs and knowledge which will be favourable to the development. According to Wilber Schramm, the task, creating and encouraging attitudes mobilising human resources and providing adequate information is being increasingly entrusted to mass media. For unless there is enough information designed to encourage productive attitudes, social patterns and customs, the development process is bound to suffer and be blocked".[33]

Particular mode of communication can influence and also be influenced by the structure of society. The existing behaviour pattern, value system, belief and custom are all important ingredients of communication system and they all need careful study for the communication to be effective. Communication affects the value, attitude and beliefs and in turn being affected by it".[34] and it is always structured by and function in relation to a social nexus, so it is viewed as one of the factors bearing on individual and social behaviours.[35]

John K.Davies discussed that mass media could play the role of modification of behaviour. In his words, "it has a powerful influence on the topics people discuss in both formal and informal gatherings. It influences what people talk about and raises their

consciousness of issues. It is most effective where changes of opinion have no social consequences where the receipient has little knowledge and no firm opinion of the facts"..... "There is widespread evidence from communications research that the persuative power of the media and its ability to directly influence its audience is very limited, Behaviour change depends on the extent to which the media is supported and facilitated by the social and physical environment. Social reinforcement is crucial. The audience should be seen as playing an interactive role with the media."[36]

However, for positive and better effect of mass media in moulding the social and physical behaviour of the people in desired direction possible only when the message to be communicated is accepted by specific culture. According to Foster "if communication is to advocate behaviour change, it had better advocated one that is feasible in the culture. Innovation are found to have gone wrong because they were illadapted to the situations."[37]

On the other hand, Merton[38] theorises that communication media help in transforming the custom, practices and social relationships. But, the functions of transformation are of two types namely manifest (intended by participants) and latent (not intended by participants) functions. Thus, however, the role of mass media communication is accepted in changing the socio-cultural structure of society, may be completely or partially.

"Social change is a multidimensional concept. The concept is against the strangle hold of status quo. However, in social systems which have regional disparities, cultural diversities, imbalance as between the urban elite and a vast majority of people who live in rural areas with overall, low literacy

percentage aften without one common language for the entire people, is a complex task. In such situations the role of mass media is also both important and challenging. But then, in these prevailing conditions, the electronic media alone can accept the challenge.[39] Modern Mass Media's role in disseminating message and information may easily be evaluated but only after the development of printing press. The American war of independence, the industrial revolution and the various liberation struggles including independence of India depended to a large extent on print media-the leaflets, the hand bills and the underground press. Power of the printed words grew in its potential to change the hearts and minds of suppressed multitudes. The radio entered the arena as a new and powerful tool of social change.[40]

In India, after independence, radio played a significant role in bringing about social and educational awakening, in spreading awareness in the fields like agricultural development family welfare, eradication of communicable diseases etc. Electronic media of communication like television reinforced the efforts of other media in propagating and disseminating the message and information of mostly of governmental and non-governmental agencies to the people.

1.24 <u>Television as mass medium:</u>

It is universally agreed that being an audio video medium television is more effective than any other medium to give impact on audiences. However, radio has larger network and more accesibility than TV but it could not cross the language

barrier which television did. Innovation of this electronic media, television facilitated its large audience to watch the event happened at any place in the world. In the word of Mcluhan[41] "with television the world has become a global village where any event happening any where can be witnessed by every one in this earth at the same time simultaneously." Today, audience of TV are more than any other modern mass media even cinema. Serials, documentaries, chitrahar, News, films etc. are the programmes which are viewed by mostly, audience of middle and lower middle socio-economic statuses.

Television can play a significant role in developing countries like India, as Agashe[42] has observed, both in the development of socially-useful and adequate human attitudes to various issues and in the presentation of previous culture of India.

P.C.Joshi[43] viewed television as "the product of the most advanced stages of modern communication revolution. It has perhaps a much greater influence on the perceptions, emotions, and outlook of the people than any other media. It has the effect of eroding old values and attitudes in favour of new ones'.

Thus, it may be concluded that television has become today's most effective and powerful medium of communication. Contrary to some western communication experts and sociologists, who are suspicious of the effect of mass media expecially television on people, their counter parts in India unanimously agree that television can bring social change if the programmes

of television are planned ingeniously ie. according to need of the people and their culture.

1.3 Growth of Television

1.31 History of Development of Television

Television as mass medium is a recent development in communication technology. While describing its growth and development in India it is worth while to examine the situation in the world causing its development. The first public television service was established by the British Broad-casting Corporation in 1936. In 1954, the Independent Television Authority was setup by an act of British Parliament. This authority, which ended the monopoly of BBC, owns its means of transmission but has contract for provision of programmes with a number of companies. While the BBC draws its revenue from licence fees, the Independent Television authority is maintained through payments by companies with which it has programme contracts. The companies earned their revenue by selling advertising time.[44]

When a transmitters was offered for sale to the Government of India by Phillips (India) at a reduced price after they demonstrated its use at an exhibition in New Delhi, it was decided to use it for an experimental service partly to train personnel, and partly to discover what TV could achieve in community development and formal education. UNESCO made grant of $20,000 for this purpose and US government helped by providing some equipment.[45]

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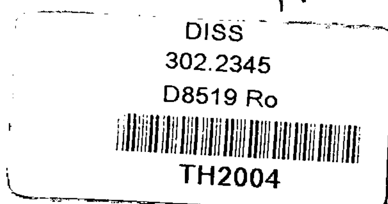
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Television services was introduced with range of 40 km. as a pilot centre at Delhi on 15th September 1959. A pilot project was proposed to be set up to study the use of television as means of education, rural upliftment and community development. In the beginning emphasis was on education. Programmes were telecast two times in a week only for 20 minutes. The project was decribed as an experiment for assessing the value of different types of educational television programmes for group viewing in rural and urban countries in such a way that the results of such an assessment may be useful not only for India, but also for other Asian countries. These production of series of educative programmes include such subjects as would improve urban and rural conditions, adult and health education.

Programmes were telecast two times in a week only for 20 minutes for teleclubs which were organised for viewing the programmes and discussing their contents. UNESCO provided the fund for TV sets for teleclubs and "sponsored a study in 1961 which indicated that teleclub programmes had made some impact".[46] The subjects in the test programmes were traffic, road sense, languages, health of community, adulteration, encroachment of public property, good manners and town planning.[47]

According to the Report of the Ministry of information and Broadcasting for the year 1960-61 the Indian Adult Education Association and National Fundamental Education Centre of Education Ministry were entrusted the work of evaluation of these programmes. But according to Awasthy, "no report, however, has as yet been published". A agreement for four years was made with the Ford Foundation of United States for launching a regular television

programme for schools in Delhi.[48]

In 1963 Paul Neurath conducted a study of the impact of Delhi's school TV broadcasts and made several recommendations based on his findings. This study was financed by Ford Foundation schools with TV set were supposed to send their reactions but only one percent of the schools with TV sets did so. A study conducted by NCERT in 1980 of School TV broadcasts in Delhi showed that at any given time only 38% of the schools were watching TV programmes.[49]

Regular television broadcasting service started in Delhi in 1965 and entertainment was mingled with the programme of social education. Duration of daily service was increased to three hours including the two weekly programmes of equal duration entitled "Krishi Darshan" for farmers in 1970 in about eighty villages in which farm tele club was organised. With the result of the programmes, farmers acquainted with improved practices in agriculture. On 2nd October 1972, Bombay was brought into TV map and relay station was opened at Pune. Television centres established in Srinagar and Amritsar in 1973 and Calcutta, Madras and lucknow were included in the list of TV centres in 1975.[50]

On 1st April 1976, Doordarshan was established under a separate Directorate in the Ministry of Information and Broadcasting.

1.32 <u>Programme Content</u>

Concerning programme content, a seminar was organised by AIR in 1973, the software objectives of Indian TV were clearly

defined. The seminar recommended that (a) TV must be utilised in the developmental process as an instrument of social change and national cohesion (b) it should cater both to in-school and out of—school education, (c) TV should disseminate information on specific aspects of science and technology, agriculture, health, Family Planning etc. with assistance from supporting units in the departments concerned. Special emphasis has been laid on using cultural programmes to foster national pride and national integration. Folk culture encompassing all its facets like music, dance, painting, craft, folklore, have also been adequately represented in the programmes specially in those serving the rural areas, like TV programming all over world, Indian TV also included feature films and films documentries in its programmes. Thus major section of programmes produced and telecast were (a) primary education (b) krishi darshan or programme for farm telecast (c) programme for children, (e) youth programme, (f) drama, (g) music and dance and (h) News and current affairs.[51]

1.33 Planning of expansion of television services

On 18th November 1969, the Indian Department of Atomic Energy signed a memorandum of under standing with America's National Aeronautics and space Administration (NASA) to cooperate in a joint venture in a instructional television experiment using the application Technology Setellite ATS-6. This agreement was known as the Indo-US ITV satellite experiment project". Programme management teams were set up in both couhtries to

coordinate the preparation for the programme which had been named, by this time, as Satellite Instructional Television Experiment (SITE). India accelerated SITE - related activities from 1973 and NASA launched ATS - 6 into space on 30 May 1974. The actual experiment (SITE) commenced on 1 August 1975 for a period of one year.[52]

The experiment (SITE) conducted in 2,400 villages of six states viz. Andhra Pradesh, Bihar, Karnataka, Madhya Pradesh, Orissa and Rajasthan. Apart from these in Kheda district, Gujarat 504 conventional television sets have installed in 335 villages. The basic objective while planning production of programme for SITE were to ensure that TV was utilised for social change and national cohesion. Programmes focussed specially on primary education agricultural information, Animal husbandry, Health, Hygience, Family planning nutrition etc. SITE researcher supplied regularly that feed back after each programme to evaluate its acceptance, popularity and social impact.[53]

Fallowing the success of the SITE 1975-76 Government approved a proposal for multipurpose Indian Satellite (INSAT). One of the objectives of the INSAT system was to provide nation wide direct TV broadcasting the rural communication in the field of education, social awareness, health and family welfare.

After INSAT - 1A had to be abondoned for having developed some technical snag in 1982, INSAT - 1B was made fully operational by October 1983. Besides television it is being utilised for radio, telecommunication, meterological forecasts etc. In case

of television, INSAT - 1B is used to carry television to rural and tribal areas in the remote parts of India. Under this project, three districts each in six states (Andhra Pradesh Orissa, Maharashtra, Uttar Pradesh, Bihar and Gujarat) have been selected to provide at government cost, community—viewing facilities".[54] These programmes are 'instructional' in nature. These can broadly be divided into two categories (1) Area-specific items, and (2) educational for age groups of 5 to 8 and 9 to 11 among the primary school going children. The area - specific programmes have a thrust on agriculture, animal husbandry, health and hygiene, family welfare, adult education social awareness, national integration, weather forecasts, topical hints for farmers etc.[55]

During its silver Jubilee year (1984) Doordarshan carried out an expansion of its 45 transmitters in the network covering 28 percent of population in the beginning of the year to 172 transmitters in the net—work, providing TV service to 52 percent of the population presently. This was the result of Government's special plan for TV expantion at an outlay of Rs.68 crore, in July 1983. The plan envisaged establishment of high power transmitters and low power transmitters in various parts of the country, so as to raise the total number of transmitters in the network to 180 by the end of the Sixth plan.

In the same year (1984) multi channel TV services in the country was also started. On September 17, 1984, the then Prime Minister Smt(Late) Indira Gandhi inaugurated the second TV Channel of Doordarshan Kendra, Delhi, which provide to viewers of Delhi two hours service in every evening.

Seventh Plan is also looking further to develop TV service net work. The basic thrust of Doordarshan's seventh Plan proposals is to provide a three tier TV service comprising (1) primary service in each major state to be available throughout the state in the language of the state (ii) national service to be available throughout the country based on programmes produced at Delhi as well as programmes of national relevance orginating from other centres and (iii) local service for a limited duration from the primary service transmitters with provision for separate channels at the metropolitan centre.

The Seventh Plan proposals, interalia, also envisage wider availability of facilities for local programme production in each state/Union territory as well as more intensive TV coverage of the broader areas.[56]

1.4 Health and Television

Relevance of health with television in India can be traced back to SITE when extension programmes on health were evaluated most popular and people watched the health programmes with keen interest. Television as a potent tool of mass media to influence the beliefs, values and customs of a society, is however, recognised by many sociologists and media experts. Health promotion is a major component of the effort of socio-economic development of the community.

1.41 Concept of Health

Meaning and concept of health may vary according to culture and, moreover, degree of industrial development of communication. Perception of a community is, however, shaped by its socio-cultural determinants i.e. traditions, taboos, beliefs, norms etc. and economic condition. Hence meaning of health and health problem is more social than individual in nature. WHO defines "health as a state of complete physical mental and social well being and nor merely an absence of disease or infirmity". Recently, Qadeer[57] eloquently described her approach towards health and health problem while criticising the definition of health given by WHO as follows:

This definition tends to focus on the ideal rather than actual, since it assumes the notion of an absolute, i.e. the complete well being of an individual rather than examine the relationship of the individual with his social environment. It also ignores the fact that health or well being has a range and cannot be an absolute quantity (or quality!) Health is reality, then, is a social concept

evolved and determined by the perception of a group or community and therefore, differs from community to community.... In other words, health of individual and groups is largely determined by the socio-economic political and technological force' Health and well being, therefore, can not be static concepts. Concept of health, therefore, apart from specifying the physical and mental status of individuals, should have an inbuilt social dimension reflecting the exploitation of one class by the other, the struggle of exploited against this exploitation, and their conscious, collective effort to rebuild society.

Therefore, concept of health and health is not limited to a restricted meaning but it should only be visualised in broader perspective i.e. socio-economic perspective. Hence, effort towards health promotion should be preventive and community oriented not the curative and individualistic one.

1.42 Health Culture and mass media communication:

Concept of health culture was firstly used, in India, by Banerji[58] who wrote "to cover an equally wide range of consideration, which intimately interact with one another to form a sub-cultural complex. Cultural perception of health problems, their cultural meaning and the cultural response to these problems, both in terms of formation of various institutions to deal with various health problems and actual (health) behaviour of individuals or groups, form this sub cultural complex. Because of its cultural connotation, health culture is subjected to change as a result of cultural innovation, cultural diffusions and

purposive intervention from outside to bring about a desired change in health culture". He further writes that "health problems form a key factor in the shaping of the health culture of a population.

Banerji (1985) has analysed how health culture had developed in India historically. He has described elaborately the condition and situation regarding health from very ancient period (Indus vally period) to modern one. According to him, "In ancient and medieval India, there was an established system of public health facilities and indigenous medicine consequently which formed the specific health culture. After decline of Mughal Empire, British conquered India and disturbed the ecological balance by upsetting political, social and economic conditions in Indian society. As a part of colonial exploitation Indian were deprived their health practices and they were denied the benefits of Western medical science". Thus, due to adverse environmental conditions created by colonial exploitation, health problems were increased, access to Western medicine was denied and consequently condition of masses was more vulnerable to exploitation. Lastly, he concludes that "health services thus became yet another powerful weapon for the perpetuation of colonial rule".[59] In this way, the health culture of India had to face many ups and down but still today, Indian people mostly have specific assumptions for health which are certainly influenced by traditional health culture.

Later, Sahu (1980)[60] has in his study "Health Culture of Oraons of Rourkela and its Hinterland"., writes, "The concept

of health culture as a dynamic entity, which is influenced by number of factors, was used to explore how the health culture of a tribe undergoes change with changes related to the concerned factors". He further adds that the culture of a community also directly influences its health culture because certain cultural practices such as child rearing, food and drinking habits, pregnency and child birth practices are directly related to the generation of some community health problems.

Therefore, the package of information and message by mass media communication should be in coherence with the culture of the community where it is given. Schramm[61] pointed out that if any innovation is suggested "it has to be explained in terms that are acceptable to the culture where change is expected to occure. Otherwise it becomes ineffective and counter productive". one must have sufficiently knowledge about the audience and the culture for whom the message is meant for. According to Rogers and Shoemaker[62] the communication media programme must be organised with the help of people who have thorough understanding of local culture with whom they are constantly in interaction.

Thus, health culture of Indian community is prerequisite to formulate the health programmes to make it more effective and meaningful and moreover, to meet the felt needs of the masses.

1.43 National Health Policy

The Ministry of Health and Family Welfare has evolved a National Health Policy[63] keeping in view the national commitment to attain the goal of Health for All by the year 2000. The policy lays stress on the preventive, promotive, public

health and rehabilitative aspects of health care and points to the need of establishing comprehensive, primary health care services to reach the population in the remotest areas of the country, the need to view health and human development as a vital component of over all, integrated socio-economic development, decentralised system of health care delivery with maximum community and individual self reliance and participation. The policy also lays stress on ensuring adequate nutrition, safe drinking water supply and improved sanitation for all segments of the population. Emphasis is also placed on health education.

Thus, to attain the goal of Health for All by the year 2000 AD motivation and encouragement by providing information and message to promote health awareness, is indispensable. As Seventh Five Year Plan envisages, effort is to be made "for the active use of different types of media to create awareness among the people and to motivate them to utilise health services and to adopt healthful practices".[64] Therefore, for this purpose, mass media especially television may work as powerful instrument to disseminate the message regarding health promotion and to enhance health awareness in the community to let them become self reliance with participation in community development and touch the ideal target of National Health Policy - Health for all by the year 2000 AD.

1.44 Health Education and Television

'Health for all' strategy of WHO and member nations means a basic change in health policy and in approaches to

positive health care. This change can be achieved with full knowledge and consent of all the people. In 1978 the need for effective communication was emphasized at the Alma - Ata Conference on Primary Health Care. Health for All can only be achieved if public opinion understands its purpose and key issues. For attaining optimum result of health promotion endeavour, there should be effective health education programme by inter personal and impersonal communication. Mass media communication is impersonal communication system and therefore the message and information to be thrust upon the masses should be wisely appraised. As Schramm[65], Rogers and Shoemaker[66] and Foster[67] theorise, communicators and health educators should be acquainted with the local culture while pouring the fluid of information and knowledge to motivate health and family welfare promotion programme. In this regard, an instance given by Foster may be illustrated. An American colour film about transmission of typhus by lice was shown to the Indian workers and their families to get themselves rid of plague by lice. A week after demonstration, audience were asked questions how effective the health education project had been. It was found that they did not get message. They said they have never seen lice in fly model on the pacific island and they had never seen sick people like those shown in film so they didn't see any connection with that giant lice and people of white colour and therefore they speculated this was the disease that afflicted other kinds of people.

Health Communication is yet, one way process this should be developed as two way process by allowing the masses to come up and to take the responsibility of communication among each other by mass media. Therefore, health educators and communicator's effort should be firstly, to teach the community leaders as they could teach the remained population by themselves. As Banerji[68] fairly remarked, "Health education and mass communication become two way process : far from merely seeking cooperation of communities in carrying out plans already made the new approach to health education aims at encouraging people to be actively involved in the planning and maintenance of their health and that of their communities". Television may be strongest weapon of mass media to penetrate the mass by its package of message and information prepared and planned by careful communicators, health educators and also the people from community to be provided information.

Lastly, goal of mass media communication is to be twisted towards developmental sectors. In this regard, seventh plan has made the provision which is laid down as follows:

"The modern media of communication would be used extensively for the education of the masses and for promoting programmes of health, family planning education and culture".[69]

1.45 Health Programmes on Television

About all the main TV centres produce and telecast the health programmes once or twice in a week. These programmes are of 20 to 30 minutes' duration. The programmes formats include interviews with medical experts, discussions, on the spot inter-

views, TV reports, music, plays, poetry, question and answers, reply to viewers' letters etc. The main thrust of the programme is (i) primary prevention and secondary prevention (ii) Nutrition and Immunization. Delhi Doordarshan Kendra is producing and telecasting four regular health programmes viz. (i) Jaan Hai Jahan hai (ii) Gharelu Nuskhe (iii) Aap Ka Pariwar (iv) Yoga Aur Swasthya. 'Jaan hai Jahan hai' is telecast twice in a week i.e. Monday and Saturday and all other three programmes are telecast once in a week at definite day and time. i.e.Gharelu Nuskhe on Thursday at between 6 to 6.30 p.m. 'Aap ka Parivar' on Friday at the same time, 'Yoga Aur Swasthya' at 9.45 a.m. on Sunday 'Jaan hai Jahan hai' is telecast on Monday at between 6.00 p.m. to 6.30 p.m. but on Saturday at 7.55 p.m. (recently fixed) Telecast time may have little variation according to the administrative requirement of the TV centre.

'Jaan hai Jahan hai' programme is informative and educative regarding diseases, their symptoms prevention and cure, etc. 'Gharelu Naskhe' is based on Ayurvedic and domestic treatment, structured in interview form in which a physician of Ayurveda is interviewed by a compere. 'Aap ka pariwar' is based on Health and Family Welfare message directly or indirectly. 'Yoga aur Swasthya', is the popular programme presented by an expert on Yoga practices and two demonstrators.

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CHAPTER - II

COMMUNICATION, DEVELOPMENT AND HEALTH; A REVIEW

Communication as a latest technique of modern development has not been studied in a proper perspective, taking care of the key variables in a well designed research in the different fields situation. Considering this fact, before reviewing the impact of communication on health, which is one of the component of overall development of the society at large, it has been logical for us to review the impact of communication on the other sector of development like agriculture, social problem and rural development. It is true that lot of scholars have attempted to develop body of knowledge on the impact of communication in various fields but less attention has been given to health because communication in family planning (welfare) programme got the maximum attention and national as well as inter national importance to make the programme a success. As a result of this, social scientists and the other scholars could not give much thought to studying the role of television as an advanced tool of mass media on health. There are only few studies on the impact of impersonal communication especially television in India. Although outside the country, sociologists conducted many studies on role and impact of communication media but most of them were limited to specific culture and region. Scholar like Schramm tried to develop impact study of television but mostly, restricted only to American viewers. However, he entered into every aspect of the television and its effects and theorises the relation between television and socio-political development i.e. change in attitudes, social patterns and customs, the voting

behaviour etc. of the audience.

Malvin L Defleur (1970)[1] in his article "Mass Communication and Social Change" has described that process of cultural diffusion and adoption of innovation fostered with the growth of mass media. He has taken into account about all important mass media like newspapers, motion pictures, radio, television etc. This study was based on growth and development of American society. He writes, television was a new item which fitted remarkably well within the personality, social and cultural systems of the society to which it was presented. Finally, no political or economic upheaval prevented its rapid acquisition". In one other essay The Impact of Television on the Audience for National Newspapers, 1945-68, "James Curran[2] negated the earlier theory that circulation of newspapers is reduced after advent to television. He critically concluded that "the notion that television viewing has displaced the press merely derives from a deep rooted statistical fallacy about the significance of newspaper circulation statistics . ...In fact, gross newspaper consumption in the United Kingdom has risen very substantially during the age of television.

In "Threat or Promise" Colin cherry[3] opined the immense potentialities of the electronic explosion and what wonders the TV Screen can do to enrich the quality of life of modern man. According to winnick,[4] mass medium can act as vehicle for dissemination of ideas about a particular kind of deviant behaviour.

Television watching was experienced as the best challenging activity and involving the least amount of skill "according to

Michaly Csikszentmihali and Robert Kubey[5] They have also came to conclusion that among the leisure time activities, TV matching have been observed to be most relaxing.

James Lull[6] thinks that audience use of mass media (TV) can be categorised into four components (1) diversion - the use of TV and other media for escaping routine problem of emotional release (2) personal relationship, social utility comparison ship (3) personal identify personal reference reality, exploration, value reinforcement (4) Surveillance social use of TV in the home are of two main primary types - structural and relational, the structural portion mediating as a behavioral regulator - television punctuates time and family activity. Television audience use TV to create practical social arrangements in four major divisions of behaviour typology. The four relational functions are communication, facilitation affiliation/avoidence/ social learning, competence/dominance.

Lionberger (1958)[7] viewed TV as an effective instrument to change the former's attitude for purchasing of farm supplies. According to Dale (1963)[8] television's 10 minutes programme on agricultural practice is more effective than putting an extension man for a week. Hach (1967)[9] reported that television is very useful for service training of staff members in agricultural unit.

Denis Mc Quail (1970)[10] conducted a study in Britain examining the "Audience for Television Plays' and found that social class and education play relatively better part in determining response to TV plays. Difference of socio-economic

background were seen to be almost unrelated to differences of behaviour in the use of television.

Dennis Howitt (1982)[11] did effort to encompas the social problems and relate them with mass media. Basically, his socio-psychological analysis consists five parts and fourteen chapters including one for Health, illhealth and the mass media. He had critically examined both positive and negative aspects of media inrespect of voilence, sex, race, crime, education, health and welfare. He focussed attention on two possible aspects of media affects the health and the mass media promote health. He concludes "several ways have been presented by which the media may be a help or hindrance to promoting health. Little emerged that was indicative of an enoymous role for the mass media. One can speculate about a mass communication system which promotes illhealth more actively and effectively than at present; one can equally see a mass communication system which meticulously teaches good health practices; enhances patient-doctor communications aids in preventive medicine, and which recruits those needing medical help readily. There is little doubt that a mass media system designed around the needs of medicine and health could do some good. However, such a system would be expensive we have already seen that some attempts to utilize the mass media to promote public health have been ineffective on a cost benefit basis. The temptation to look to mass media to solve problems which affect the mass of the people may be overwhelming but careful evaluation and costing is needed".

Communication research in the field of sociology and social anthropology and health is new in India and therefore, studies on communication impact are very scarce. To some extent, reason behind the paucity of the communication study may be assumed as due to the late modernisation in communication like radio, television etc.

Damle's[12] article (1956-57) in the public opinion Quarterly under the title "Communication of modern Ideas: knowledge in Indian villages, can be regarded as the first major work in the field of sociology of communication in India. In his research Damle studies the diffusion of modern ideas and knowledge in seven villages near Pune, Maharastra. The villages selected for the study difered not only in distance from Pune but also in relative amenability to communication of ideas and knowledge. It was equally affected by the social structure of the community which determined the qualitative and quantitative context of the communications. Information relevant to the needs and interests of the people is more widespread than awareness of less functional matters.

Y.V. Lakshamana Rao (1966)[13] in his book based on the study of two villages of Andhra Pradesh, concluded that the development of communication and the resulting flow of information is followed by or goes hand in hand with, development in other areas, information of certain kinds, one released, awakens appetite for new things or for new ways of doing things. He theorises that communication helps people find new norms and achieve a

balance during a period of rapid change.

A study was conducted by B.N.Berlhaker (1970)[14] to evaluate the influence of communication in the rural population with special reference to media and news papers. According to his findings, radio and newspapers followed by cinema were adopted as main media of communication by the younger generation. Mass media change the social institutions and social relations and adoption of improved agricultural methods and health practices in village.

Pradepto Roy et al (1969)[15] studied the three types of specific communication treatment: radio forums, literacy cum reading forums and animation leadership training. Radio forums were found to be superior in the adoptation of agricultural and health programmes for forum participants and non-participants. Literacy classes did better in bringing about increased agricultural knowledge for forum participants and increased health knowledge for non participants. Participants were involved in forum sessions and in two way communication whereas non-participants were passive and were engaged in one way communication. Impact of communication on family planning was studied by many social scientists.T. Pofenberger (1961)[16] in collaboration with other colleagues conducted a survey to examine motivational determinants for high and low fertility attitudes. The authors examined husband-wife communication and its impact on adoption of fertility control method. The study was carried out in a villages of south Gujarat revealed that due to the

traditional social set up effective husband-wife communication in general was difficult. It was even more difficult in the case of F.P. communication. It was found that in the traditional joint family the young wife could talk to her husband only about what was necessary for conducting the daily activities. The people felt guilty in or ashamed of violating the expected behaviour pattern. The outhers believed that the gradual weakening of the joint family might result in closer husband-wife relationship and improve communication between them which would promote more effective fertility control.

Although, many studies have been conducted in India to evaluate the impact of television on development, but for the first time, study in holistic nature was performed during SITE period.

Bhatia and Chauhan (1977)[17] while studying 'SITE utilization' evaluated the comperative effectiveness of different media as follows:

(i) Television's effect and penetration on former population was greater than any media or village level worker.

(ii) Radio was used for entertainment more than that of television.

(iii) Health and sanitation programmes was more popular than family planning programmes.

(iv) More percentage of forums become encouraged for first trial stage than any other medium.

(v) Village level worker was more important at trial stage to discuss before trying than their own family members and progressive formers.

They indicated that the conduct of utilization activity like group discussion, field demonstrations etc. were contributing for the gain in knowledge of a farmer. It was found that the small farmers has gained the meximum, big farmer came next whereas the medium farmer's gain in knowledge was the least. For utilization study villages were grouped into two categories viz. experimental and control groups and letter one registered more gain than former. The knowledge of agricultural practices in each tested area increased more in utilization villages as compared to 'TV only villages'.

Thus, it was evaluated by the study that the process of knowledge boosting could be positively stimulated by conduct of utilization activities viz. group discussion, field demonstration etc.

Agricultural programmes on TV and radio were evaluated by P.K. Dey (1968)[18] while studying relative effectiveness of Radio and Television in Three village teleclubs and three village rural forums. This study found that television is superior medium in respect of gain and retention of knowledge and developing favourable attitude towards the recommended practices than that of radio.

In another similar study Chahil (1969)[19] found television more effective than both radio and pamphlets in informing the farmers. He conducted his study in three villages of Shahdara Block (Delhi) and selected farmers were exposed to all three media for similar specific cultivation information. It was revealed that gain and retention of knowledge through television was more than other two media-radio and pamphlets.

An impact study of 'Krishi Darshan' programmes on television telecast was conducted by NCERT[20] Eight programmes of Krishi Darshan were selected to measure the gain in knowledge of the viewers who watched these programmes. Two groups of respondents in equal numbers were chosen from experimental (TV viewers) and control (non-TV viewers) areas. It was revealed that the experimental group gained more knowledge about the recommended practices of cultivation than the control group.

Mishra (1967)[21] measured farmers' knowledge about particular practices. The study was conducted before and after the telecast of five selected agricultural programmes telecast during March 1967. The initial level of the knowledge of the farmers about the particular practices were measured before the actual telecast. Fifty respondents (farmers) were taken at random from five teleclub villages (each teleclub village comprised fifteen respondents). The same respondents were interviewed three times after each telecast. Firstly, just after the telecast, secondly after fifteen days, and finally thirty days after the telecast. A significant gain in knowledge was reported as a result of watching the telecast of all the five programmes. However, the extent of knowledge acquired through television programmes varied according the content and presentation of programmes i.e. new items in content caused of more gain in knowledge, but whereas difficult and technical morals lowered the extent of gain in knowledge of

the respondents. They retained on an average 79.01 and 67.44 percent of the gained knowledge after fifteen and thirty days of telecast respectively.

Arvind K. Sinha (1985)[22] in his book has analysed the change after viewers watched the SITE programmes in the community sets. He has under taken the study in a village (Ismailpur) in Muzaffarpur district in Bihar and has evaluated the process of socio-cultural changes triggered the introduction of satellite televisions as a new medium of communication. Existing infrastructure of cultural communication and development communication has been taken into account while studying the television impact on the overall existing communication structure i.e. communication for education, development-instruction and integration and upliftment lastly, Investigator concludes:

"The study clearly reflects a positive role that a medium like television can play in rural development, the process through which a society move to acquire capability of enhancing the quality of life of the people, primarily through the solution of its economic problems or increasing the per capita income".

He further analysed the television impact on different rural classes and the perception of the viewers according to their socio-economic status. "For landless labourers, the moving pictures were like fairytales, not helping towards a better living. They remained high sounding ideas without any

practical consequence. For the small cultivators in the village, most of agricultural practices and innovations were capital incentive, ment for rich and large cultivation. For them it was state of helplessness in which the new knowledge could not be used due to lack of required finances and support from the developmental studies". But rich cultivation viewed television as an instrument of instigation of the poor against them and its message destroying the existing status quo and the so called harmony of the village".

Prakash M.Shingi and Bella Modi[23] in his study revealed the nature of agricultural information distribution and its correlation in television villages as against no television villages. They also studied the nature and extent of distortion and loss of information in knowledge of agricultural television programmes. For this, they selected three teleclub villages of Najafgarh block of Delhi. In pretest sample 80 farmers were interviewed who attended the telecasts of Krishi Darshan. Post test sample size was reduced to 48 due to certain reasons. Farmers from control sample were not reinterviewed. In control sample there were not TV viewers.

Analysis indicated the literacy was related to the level of ignorance about agricultural information of farmers in "No TV villages"whereas cultivation from the Krishi Darshan villages literacy has lost its importance for information acquisition as TV message was accssible and understandable to the illiterate too. Telecast performed much better in

providing knowledge of logic and principles (eg. how to use urea for the potato crop) About half of the televised information was already known by respondents. Half of the viewers using two televised practices said the programmes interested them. Whereas more than half of viewers thought "programmes are boring, those have technical words produced in the direct speaking and have non-visual radio-lecture style."

Farmers background variables eg. education, social and economic position were found to be related to the degree of knowledge absorbtion from the two programmes. Medium and viewing situations (noise seating arrangements) also had significant affect on televised information loss and distortion".

"Television and social development - A study of a city of Haryana" by Mehra, Sharma and Nagar (1985)[24] evaluated the level of exposure and effect of various television programmes with suggestions to improve them. One hundred eighty heads of the family possessing television sets for more than one year were randomly selected from selected colonies of Hissar. They studied different programmes and its awareness degree separately. Evaluation of the programmes on general knowledge depicted that more than half of the viewers increased their knowledge and about half of them were aware of social problem through the programmes on social problems. Analysis revealed that 42.78 percent got knowledge while 21.11 percent felt it practically useful. Data revealed that majority of respondents (86.11%) were satisfied with news programmes followed by

Krishi Darshan (57.22%) entertaining programmes (20.56%) and Children programmes (20.56%), large proportion of respondents remained neutral towards various programmes like youth programmes rural development programmes, Mahilaon ke liye etc. Because, they said they could not get time to see all these programmes frequently.

In conclusion they write, on the whole, analysis depicted that television has been exploring on adequate flow of information to the masses and is making substantial contribution in the sphere of social, economic, political and cultural development of the society. It has also been enhancing the cultural, intellectual and educational standards of the society. Majority of their devote long time on television viewing".

An attempt to study the impact of television on Indian families, was done by Smt. Andal Narayanan (1984)[25] This study was performed by Bombay Television viewers. Representative sample was made enumerating about all the sectors and subdivisions of the metropoliton city. She thought it was necessary to evaluate the actual impact of television of Indian family because it has been acknowledged that television is a powerful tool of social change in the hands of communicators who want to educate, inform or entertain". She has drawn the inference as follows:

Television has to certain extent affected the life style of the families and changed certain house hold routines. It was found that there was a great change in the respondents

habits in visiting their friends, going to temples clubs, libraries, meeting music concerts, social contact etc, during the transmission times.

- Television, however, has affected the study of children.
- It has reduced the boredom very much as respondents spent their leisure time in viewing television.
- Respondents admitted that while they were watching, it helped them to feel relieved of their tension after days's streneous work is over and afforded the viewers a brief escape from reality.

B.S. Bhatia (1980)[26] noted the findings of the SITE studies as follows:

1. The overall knowledge of agricultural practices increases significantly more in utilization villages as compared to "TV only" villages.
2. The gain in knowledge due to attending group discussions was much greater than the gain to knowledge due to increased TV using frequency.
3. The penetration of TV in the farmer population within a short span of one year was greater than that of Radio print media, or village level workers".

Srinivasan's[27] project started in 1974 using television for social-education in Bombay. A series of programmes was produced on slides, film and half inch video taps on health hygiene, community living and other topics in Marathi. The

Bombay city social Education Committee (BCSEC) agreed to having TV introduced into its educational scheme. Doordarshan Kendra Bombay produced and transmitted the programmes for the literacy classes for working class adults in the chanels and the topics were generated by thirty five years old literacy text book of the BCSEC.

The first phase of study was experimental basis. Evaluation of five phases revealed that it was uncertain how much had been absorbed of its educational purpose. Irrelevant programming and indifferent performance of the teachers were concluded to be among the obstacles in the use of TV as an instrument of "social education" in the first phase. Besides, some mechanical problems eg. mal-functioning of TV sets, absenteeism of watchman of the school who held the key, absenteeism of adults etc were other causes of failure of the objective of social education by television.

Second phase was launched in January 1975 with the objective of shifting from literacy to problem oriented education and to realise the potentiality of TV as medium of non-formal education and mass communication.

Agrawal (1980)[28] noted the holistic study for evaluation of SITE. It was undertaken to provide a microlevel, indepth, qualitative understanding of the process of satellite TV-a new medium of communication in village India. Besides agriculture and Anumal Husbandary,

Health Hygiene and Nutrition have been given a major thrust in the study. Information received from TV helped in crystallising the ideas in changing the existing beliefs, reinforcing the existing beliefs, adding new knowledge, and adoption of new health innovation".

In two programmes telecast, it was suggested that gruel separation while cooking rice is not good for health. It was in contrast of the belief prevalent in Kamadpalley that unseparated gruel rice causes flatulence in the body. It was observed that two young viewers, brother and sister, literate aged 18 and 27, viewed the programme and they told their mother to follow the suggestion of TV not separating gruel from cooking rice. Mother was not persuaded and daughter has to enter the kitchen and cooked rice as shown in TV. A number of similar incidents were observed in which TV helped to modify the existing cultural belief. It was concluded that programmes shown first time did not register on the viewers but second viewing reinforced the new idea which was followed by discussion and final adoption. Adoption took place because, it was only a modification in the practice without incurring additional expenditures. A similar process was observed in the adoption of green vegetable by the same house hold after TV viewing.

V. Ramdas Murthy and M. Mohanram(1985)[29] described different studies based on field-surveys related with health and nutrition communication. The study conducted by NIN in Hayatnagar Block (Andhra Pradesh) revealed the

appalingly low exposure of women to telecasts such as those on weaning foods, breast feeding and cooking. Their comprehension of the concepts was very low. School children, however, scored well on some topics. Other points were the inadequate preparation of people to the new medium, absence of infrastructure for fellow up action and poor production technique arising mostly from lack of liasion between producers and subject specialists. The SITE study in Chattisgarh (MP) and Mahabubnagar (AP) by NIRD revealed the viewers did not favour by programme preferences and comprehension to the programmes of health and nutrition. The exposure of women to the medium was very low. At last, they conclude that health and nutrition education programmes cannot be successful unless all the prerequisites for effective communication are fulfilled.

In a report prepared by Prabha (1984)[30] while describing the fundamentals of health, mass media and television, narrated the existing health and family planning programme and their achievements. She enumerated the achievements as followes: (i) Considerable progress has been made in the promotion of the health status of our people. (ii) There has been a definite decline in the infant mortality rate and increase in the adult longevity (iii) Mass media, specially, Doordarshan have been able to increase awareness about the importance of health, hygiene, nutrition among the rural and urban masses. (iv) It has been able to

discriminate the fundamental concepts of health promotion and disease prevention among the masses and extending support to the prevailing ancient knowledge about medical sciences from being lost." According to her, "Doordarshan is handicapped by the absence of adequate number of TV channels and has limited transmission time. Diversity of multi-subject and multilingual programmes required to be compressed into these limited parameters, lessens its impact and emphasis on health and family welfare in the mind of the people, ... concerted efforts are being to create awareness among the masses and encourage and motivate them to avail themselves of health proctices and family welfare methods in order to lead happier and healthier life. However, the report exhibits only the structure and achievements of the Doordarshan but, certainly, it reflects apparent intention and media policy of government.

One of the studies on SITE related to health and hygiene practices was undertaken by Chaudhari (1981)[31] in Madhya Pradesh. Total ninety respondents were interviewed and variable of the sample were economic status, sex, age etc. PHC's doctors and health extension workers were also interviewed. For the sample, approximately 206 community viewing centres and 29 villages were selected. It was attempted to extract out the information from villagers about existing health practices, prevalent diseases and concept of hygiene to them. PHC staff were asked for

prevalent diseases and villagers attitudes towards these diseases.

At last, after general findings of health situation, villagers were asked for suggestions to improve TV health programmes. Out of total, only fifty percent of respondents suggested as followes:

(i) Programme should be in local dialect (Chhatisgarhi)

(ii) Indigenous methods of diagnosis and medicine should be emphasised.

(iii) Health programmes should be given more time,

(iv) Making aware about good health habits, only the rural health problems should be the topics for health telecast.

(v) Televised health programmes should be based on day-to-day health problems.

(vi) Statistical display should be avoided

(vii) The programmes should be simple as to comprehend easily.

Indian Institute of Mass Communication undertaken a research project "Communication - Experimental Studies of Programme Impact and Family Planning Motivational Development". This project was led by Dr. Sumati Mulay (1974)[32] as project Director. Part of the study was "communication and satiation in message reception in Family Planning". This study was to enlist the current communication strategy with regard to repeated message. The general objective of the study was to investigate whether the eligible married couples for

family planning have reached to the point of satiation due to the repetition of message reception of family planning through different channels of communication. Data was collected by interviewing the selected respondents after random sampling for this study conducted in U.P. Radio was found quite popular and respondents told that they listened to programme on Family Planning on Radio either through advertisements in Vividh Bharati or through other broadcasts like talk, discussion, dramas etc". Lastly, it was concluded that (i) there was no evidence of satiation towards reception of message on family planning, (ii) various communication channels should be used to dessiminate the message (iii) mass media in family planning succeeded in completing the awareness task (iv) local influential leaders should be involved in educating the masses and local clinics did not utilize certain local persons as motivators in the community.

A study[33], 'Media Reach and Effectiveness' was conducted by National Institute of Health and Family Welfare, in 1980. Three villages of Ajmer district (PHC Pisangari) of Rajasthan were chosen for this purpose with broad objectives to assess the role of various communication media in promoting family welfare programme and their impact on the target groups. In each selected villages, 30 house-holds were selected by systematic sampling. Only one currently remained person either male or female from each selected household, was

interviewed. Different socio-economic characteristics viz. Religion, occupation and age were taken into account for the representative sampling. Various media like Radio, Films, Newspapers, poster, wall paintings, Pamphlets, leaf lets, Family Planning Exhibition, and group meeting were assessed separately for awareness and effectiveness of communication media. For Radio, it was concluded that among the respondents more than 50 percent are listening the radio broadcast and among the listeners, 50 percent are listening the family planning programmes and understand the message broadcast easily. Therefore, it was evaluated that radio as a mass media is effective among family planning listeners. To know the awareness and knowledge of family planning the respondents were asked question with multiple choice answers. It was found that almost all the respondents were aware of family planning. The respondents were asked question about misconception in respect of loop, vascctomy and condom and it was observed that misconception about vasceetomy was significantly high in nearest village from PHC.

In a collaborative study on media Reach and effectiveness was organised by National Institute of Health and Family Welfare (1985)[34] From seven states (Gujarat, Orissa, Bihar, Uttar Pradesh, Maharashtra, Tamil Nadu and Karnataka) only two states were undertaken by NIHFW to collect the data while other research centres were to collect data from their respective states. Various mass media viz Radio, TV, Film,

Exhibition, Poster, Wall-painting, Pamphlet/leaflet, Newspaper, Magazine, Telephone were assessed for its reach and effectiveness for family welfare programme. The study covered 14,000 respondents of which 7,250 were males and 6,750 females. Only findings for radio and television for family planning message are worth describing. Radio was assessed very high for its family planning reach. Three-forth of respondents favoured the use of radio for disseminating family planning information. About 96 percent of the respondents reported that the language used was simple and easy to understand. Among the TV viewers about 48 percent respondents stated that they had watched some family planning programmes. Proportionately more female respondents received family planning message than male. Acceptability of TV as a media is less compared to radio, might be because it is a home and family bound medium and large number of people are still out of the reach of TV. Among the viewers of programmes, understandabilit of the message was quite high (74%) while acceptability was moderate (48%) less than a half of the respondents favoured using television for promoting small family norm, use of family planning methods' and information about place of services.

Helen Parris[35] in an experimental study, in twenty villages near Delhi, assessed the impact of different types of television sources used in importing a family planning message to adults in the experimental village. Same family planning programme contents was presented on TV by a village

opinion leader and an urban medical expert. Relative effectiveness of both Television sources were measured in terms of change in knowledge, attitude and motivation to seek additional information among viewers. The village opinion leader was received by viewers with much interest and apprehension than that of the urban medical expert viewer got more knowledge of family planning by the programmes presented by village leader.

B.C. Agrawal and J.B. Ambedkar[36] in a SITE evaluation, analysed the effect of family planning programme on television in the viewers in a Karnataka village. Out of the fifty programmes on family planning ,twenty three were in Kannada and twenty seven in Telugu. These programmes were of two categories (1) Small family related norms and (2) general information on primary health centre, ideal family and operation camps. In the first category, there were 12 Kannad programmes and 20 Telugu programmes. Nine programmes were in the form of song in the format which is locally very popular. Such songs served as intertainment and also conveyed the message of the importance of small family. They were generally understood and liked. There were 9 programmes in Kannad and 7 programmes in Telugu relating to primary health centre, ideal family and operation camps. The viewers were disinterested in the interview, talk and discussion programmes even if they were in Kannada, such programmes even forced viewers to leave the place. Those programmes which focussed

on hospital scenes, interviews of patients who got operated and they like, were very formal, and often the literate viewers made fun of the style of asking questions and considered the answers to be artificial. The reaction of the illiterate viewers was that, in the television "they show nothing but family planning".

Thus, after reviewing the literature attributed to communication impact and especially television's role on development and health and family welfare, purpose of study was ascertained and consequently hypothesis was developed as follows:

1. Television is the potent mass medium to influence the existing health culture.
2. Health programmes on television are enhancing the awareness regarding general health.

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CHAPTER III

- HEALTH PROGRAMMES ON TELEVISION :

A Study in Delhi

INTRODUCTION:

After reviewing the literatures concerning communication, specially TV impact studies it was decided to undertake a study to examine the hypothesis developed. Delhi was chosen as the place of study considering the factors like approachibility and availability of the regular TV viewers.

The union territory of Delhi is bounded on the north, west and south by Haryana and on the east by Uttar Pradesh. The grace and beauty of the city is enhanced by yamuna river flows by the side of its eastern border in a north - south direction.

For this short time study, a small area having all desirable considerations was to be selected. Lastly, this difficult task was completed with the selection of 'Mayapuri' as the area of the study. It is located at a corner of south Delhi and situated beside the main ring road. The area, in which 'Mayapuri' is situated, is called industrial area for having installed here many big and small industries.

This study was undertaken while observing the current pattern and inclination of sociological studies.

Hence, perceiving the urgent need to scale the real impact of mass media, this study had been formulated. Television - one of the communication tool in shaping the conventional culture into dynamic innovative and developed one, as some social scientists, media experts and ruling agencies of India have been proclaiming, was to be studied. Hence, impact of television is proved only for health - one significant aspect of socio -

economic development. Therefore, this investigation seeks revealing real penetration of information pertaining health into awareness structure of urban viewers empirically. Thus, in this study, television programme from Delhi TV Centre giving information on health were taken into considerations. The attempt was made to evaluate how far the viewers of such health programmes have been benefitted in terms of their health needs. Further, the health awareness of these viewers have been assessed in terms of their benefits and knowledge gained after viewing such programmes.

RESEARCH DESIGN

Selection of the area: Criteria of selecting 'Mayapuri' as the area of study were as under here:

1. Mayapuri is located at the one corner of the city, therefore it possesses sub-urban culture and subsequently accomplishes the need of the study by providing heterogeniety in socio-cultural heritage. The population of this area provides us a different types of health cultures.
2. Migrant labourers, big and petty business men, employees of industries and government servants are residing in the area. This helps in providing a representative sample for the study.

Study population:

Many variables were taken into account to made the sample representative. These variables comprised in the study were occupation, economic group, educational level, age, sex, mother

toungue, religion and family size etc. Out of these variables, some viz. occupation, age, sex, economic group and educational level, have been given more thrust and considered important to extract out general findings.

Three hundred households were taken into account for the purpose of study. From every household, one respondent was selected. In this way, out of 300 respondents, only 265 were television viewers whereas health programme viewers again limited to 236. Thus, there were 35 non-viewer respondents in general and 29 non viewers of health programmes specifically.

Sampling :

Purposive Selection was the method of sampling. Primarily, strata were based mainly on occupational groups and again on their per ratio distribution in study population. It was tried that share of one occupational group was to be given for study only according to viewing habits of the televiewers, e.g. house wives were given more importance and also therefore, more number of interviews were administered as they used to stay at home and viewed the programmes thoroughly which, subsequently affected as to make them aware about health problems. Occupational groups were restratified into three income groups i.e. lower middle and upper income group. Again, these strata consisted of all other variables (e.g. age, sex, education level etc.) undertaken in the study. In this way, socio demographic profile of sample was prepared.

Socio-demographic profile of study population:

Different socio-demographic groups as variables were considered in the study to make its finding representative.

These variables were as under:

1. Age : Respondents were asked for their age which was grouped into three categories viz. (i) 13 years to 30 years (ii) 31 years to 50 years (iii) 51 years and above.
2. Sex : Both male and female were included in the sample.
3. Mother toungue : Respondents' mother toungue was enquired to examine the influence of language on programme's viewing.
4. Educational Level : Five educational levels viz. Illiterate, literate to under matric, matric to undergraduate, graduate, post-graduate and professionals (e.g. doctor, engineer etc.) were counted in the study to assess the impact of education in programme's viewing and consequently, in health awareness.
5. Religion : Four major religions were comprised in the sample to reveal out influence of religion in health awareness.
6. Television possession: Respondents were enquired about their television owning. If they did not own then they were asked were whether they visited neighbour's place or community television sets.
7. Family size: Three categories were made for family size i.e. (i) one to three members (ii) four to seven members (iii) eight and more members. Respondents were enquired for which category they belonged.
8. Income group: Respondents were divided into three income groups viz. (i) more than two thousand rupees,

(ii) between two thousand and one thousand rupees and (iii) below one thousand rupees.

9. Occupation: All possible occupational groups in a urban population were considered i.e. service, house wife, student, business, labour and unemployed person.

Data Collection:

(a) Techniques used:

Both, quanititative and qualitative data were collected. For quantitative data, a tentative interview schedule was prepared covering about all the aspects of television viewing and health programmes on television. Interview schedule was constructed of a set of questions divided into eight sections. Except first question which was prepared for preliminary information about respondents other seven consisted of all sorts of questions about television viewing in general and regular health programmes' viewing specifically. Interview schedule was administered for all three hundred respondents. The schedule consisted of both structured and open ended questions according to the requirement of the objective of the study.

To elicit the proper responses, it became a challenging task for the investigator because, most often, respondents blended their answers in a unsystematic or haphazard manner. Therefore, investigator had to be careful enough to filter out the information required in the study. Interview schedule was so designed as the questions were arranged in such a way that every next question was more deeper and explorable than its preceeding one.

For qualitative data, direct observation of benefits of health programmes' message was performed during several visits to respondents. Investigator sometimes observed the current television viewing situation. Investigator used to visit regularly the respondents at the time when they should be viewing health programme. We tried to enquire also their immediate reaction for the same. Those informations either noted down at once or after the interview. For the purpose, investigator always kept diary to follow up the respondents regularly.

(b) Pilot study:

Pilot study was conducted for ten days in the selected area to test the suitability of the interview schedule. About field problems observed and modification in the schedule, investigator discussed with his supervisor. Schedule was rearranged and modified according to the field experiences. Before, fulfledged study was started, investigator got himself acquainted with the regular health programmes telecast for Delhi televiewers. He attempted to analyse pros and cons of the programme and developed some assumptions for further probing through field work. A list of subjects and presenters was made for the health programmes telecast in December, January and February 1985-86. Besides, he had the details of current week's health programmes already telecast which helped him while asking whether they watched this or that programme or what benefits they gained after using the certain health programmes or what were their opinion regarding this particular programme.

Final data collection:

Final study was started only after 15th January 1986 and data gathering was completed by 15th of April 1986. Investigator had to face problem of establishing rapport and administering the interview with the respondents. In the study area, as in other parts of Delhi, it has become routine practice of knocking the door by the stranger convincing the residents for purchasing certain products or surveyor of family planning, census department etc. to perform their survey. Therefore, the residents were reluctant to give proper response just at the first appearance. Investigator had, anyhow, to convince the people that he was research scholar and collecting the research data for his own study purposes. After wastage of about 5 days in convincing the people they were somehow agreed to fully cooperate and allowed to interview themselves or their family members.

Fortunately, the subject of the study was related with television. So the curiosity, towards it, of the people, specially young, helped in gathering the information. Help of local influencial people were also solicited during primary visits of investigator in the study area. Sometimes, chaukidar and other deputed person for general security, objected to visit the house without permission of proper authority. Then, inspite of going to higher authority for permission investigator tried to solve the problem by utilizing community leader's influence. Hence, local influencil persons were interviewed firstly and with frequent visits the respondents truly responded to the queries of the investigator.

Firstly, the colonies of government and other agencies in the area were visited. The flats in the above colonies were rackoned into different economic groups viz. higher (HIGS), middle (MIGs) and lower income groups (LIGs) and janta flats. Mostly respondents of a particular income group were found in the flats for same income groups. Thus, it facilitated the investigator to approach the households and respondents according to the need of the study. But, sometimes it did not occur and the residents had the income group differing from their "residential status". This problem was negociated only after asking the monthly income of the respondents of their parents or gaurdian if he or she is unemployed or student.

Sample was distributed into various occupations and the data gathered for the particular occupation was accommodated according its TV viewing frequency and strength among the television viewers. In this way, investigator had to be always careful for not including the respondents of a particular variable in bigger proportion than it was justified (i.e. according to its viewing frequency and strength among total of the television viewers). Thus, housewife occupation accorded top position by its number of interviewer followed by servicemen, labour, student, business-men and unemployed persons. Both male and female included in the study population but percentage of female become higher apparently due to one large occupational group (housewife) belongs female sex exclusively and moreover, it also had larger share in total study population because of its television viewing habits (i.e. stayed at home and viewed most of the programmes) and, also good strength among television viewers.

The questions in the schedule were framed and asked under eight broad headings, a brief description of which is given below;

1. Personal information: This portion mostly included questions on demographic features viz. name, sex, age, education, occupation, income, religion, mother toungue, family size, besides, one question was added to enquire about owning of their television set.
2. TV viewing: The respondents were asked whether they watched TV or not, if yes, then what was the viewing frequency and if not, then what were the reasons for not viewing.
3. Viewing of the health programme: They were asked for viewing the health programmes. They were told to name the programmes which they viewed and to give the reasons of not viewing if they did not view any one of the health programmes.
4. Freqnency of viewing the health programmes: It was enquired in terms of regularly, frequently and occasionally. Never viewing could already be noted in previous question.
5. Benefits of the health programmes. Respondents were asked for the benefits to them by health programmes. They were also told to describe the benefits. For negative response by them, they were asked to say that why they did not get the benefits.
6. Understanding of the health programmes: Respondents were asked whether they faced any difficulty in understanding the health programmes. They were told to describe the reasons if they faced the same.
7. Suggestions of the viewers: Regarding health programmes, suggestions of viewers were asked for including, excluding

and changing the items or topics in the health programmes to make the programmes more beneficial to the viewers.

8. Lastly, they were told to say any special events, information, or suggestions regarding health programmes or any other related TV programmes. If any information, reaction and suggestion could not be given by him under above purposive questions they were free to tell in this head 'special information (if any)'.

Gathered information were cross checked automatically during other interviews performed at the next household and thereby the data were refined for the study.

Analysis of data:

After completion of final data the analysis was started. Data were tabulated after information were collected, properly checked and codified. Tables were drawn to facilitate the analysis by organising specific data in systematic manner. Various variables were taken into account while tabulating and analysing the data. Firstly, all filled schedules were arranged according to respective occupation of the respondents. To make analysis convenient, inter-relationships among different variables were evaluated on the basis of the table prepared by occupation wise. Detail chart, for suggestions of television viewing was prepared.

Besides, for qualitative data, information gathered by observation were arranged systematically and analysed with quantitative results.

Limitations of the Study:

The limitation of the study can not be ignored. First of all for proper sample, specific census of study population is required. Although, investigator selected the households and respondents made the sample a representative one. But, it might be better if the census of the study population would have been done before sampling. Lack of resources i.e. time, money and manpower, were the apparent reasons for not having prior census of the study population. Furthermore, this study was only confined to a limited area and therefore, findings of the study can not be claimed forcefully for having its applicability to all television viewers in India, because of its urban character. Four regular health programmes telecast in every week in Delhi and nearby areas have been accounted for the evaluation of health awareness among the television viewers in this study. Because of this, the finding of this study were limited in its applicability to the other areas (coming under different TV centre's coverage where different health programmes are produced and telecast).

The qualitative data could not be strengthened for total sample households properly because of the urban based occupational group. Inspite of these above short comings and limitations, the data gathered in this study has helped as to strengthened our hypothesis on the basis of qualitative data strengthened by quantative one.

Findings

The findings were drawn on the basis of interviews and observation. This study was based on four regular health programmes. Viewer's knowledge of the health programmes, their contents and subsequent gain through these programmes were evaluating measures for this study.

While recording the findings for four health programmes, observation was made to assess the general health status of study population. Health condition of the residents of the study area were observed during study as a requirement for the qualitative data. It became evident the certain problems which occured mainly due to the density of population like bad sanitation, unhygienic dwellings, lack of open field/grounds etc. was not seen in remarkable degree.

As for housing condition and settlement pattern was concerned, there was remarkable difference between different income groups. It was observed that the population in lower income group was having less civic amenities with small congested, ill-ventilated and mostly rented rooms. Other sections (middle and high income groups) were having the government or private houses with civic amenities.

As far as the health condition was concerned it found that nearly 70 to 80 percent in lower income group were having complaints of different kinds of health problems. On further investigation it also found out the families in this particular

income group for alleviating the suffering from health problems, they used to visit the nearby health institutions run by private and governmental agencies. Nearly 50% respondents informed that type of the services which they were recurring from these institutions were of little value. Furthermore, the industrial labourers in this group were of the opinion that in case of their health problems neither they did receive any help from their employer nor did they get good health services from governmental agencies. Because of this, they were compelled to approach the private practitioners while they suffered from acute problems like severe dysentry accident, high fever in case of malaria etc. For the minor health problems they were adopting home remedies to get rid of suffering.

The middle and high income group respondents informed the investigator that they also, some times, had to run to the nearby private practitioners when they did not get adequate health measures from the government institutions, in case of their severe health problems. It has been observed that the family members of these two groups of study population took steps to approach the hospital,private clinic etc. according to their convenience. It was the home remedies which was adopted by them in most cases while they had minor health problems like headache, vomiting, stomachache.

The above observation revealed adequately on health culture of three categories of study population. This

qualitative information on health culture, helped the investigator to analyse the application of messages provided through television to the viewers.

The study revealed that almost all the respondents were well acquainted with television and its some programmes. However, it was also found that television has become a necessary item for urban households. There were a few households who could not own TV mostly because of their poor economic condition (e.g. labour in study area could not purchase the same).

Out of the total (300), 265 respondents watched the television programmes. Those respondents were distributed among three categories on the basis of the viewing habits viz. (1) total programmes viewers (ii) selected programmes viewers (iii) viewing 'only on sunday'. Highest percentage of the respondents (53.09%) watched the 'selective programmes' followed by total programmes viewers (22.66%) and viewers only on sundays (2.66%). About 12 percent (11.66%) of the respondents comprised of non-viewers, were asked for the reasons of non-viewing.

34.2 percent of students had viewed the total programmes on television whereas housewives and servicemen were counted respectively 27.36% and 20% for the same. In case of selective programme viewing, there were very thin differences among viewers among servicemen (76.66%) businessmen (72.72%) housewives (70.49) and students (60.52%). Very few

of the responsdnets (2.66%) reported that they watched programmes only on sunday, out of all of the respondents viewed the programmes only on sunday, fifty percent (4) were from business occupational group. Non viewers (11.66%) of the television programmes mostly came from labour.

Reasons for non-viewing the television programmes were also elicited out of the respondents. Non-possession of TV sets was the reason of non viewing for 83% non-viewers respondents, most of them were labourers. They told that they could not buy the costly television sets. They expressed that owning of TV was nothing but luxury at the cost of bread. Four respondents told that despite of owning television sets they could not watch due to their engagement in bosiness, service or any other work. Some of them (14.28%) felt that television programme was not interesting.

Respondents were asked whether they watched health programmes and what were the names of the programmes. For this purpose, in interview schedule four regular health programmes were included. Highest percentage (37.28%) of the respondents viewed three regular health programmes,21.5 percent were viewing of four health programmes and 22.88 percent were viewers of two programmes. Whereas the viewers of only one health programmes scored 15.69 percent. Quantitatively very less (only 4), but 50% of their total health programme viewers were the labourers who watched only one health programme. In the same way, 57.14% of unemployed watched three health programmes and

they were followed by housewifes (43.24%) students (42.42%) servicemen (29.41%) and businessmen (26.92%).

However, four health programmes were watched by 29.41% service men followed by labourers (25%) housewifes, (24.32%), students (21.21%)., Business men (19.29%) and unemployed(25%). Female viewers were naturally mone (67.34%) than the male because they were highest in the sample size. Respondents preferred to watch, "Jaan hai Jahan hai", "Gharelu Nuskhe", "Yoga aur Swasthya" and, lastly, "Aap ka Pariwar" respectively. "Jaan hai jahan hai" was viewed most, because of its telecast twice in a week and moreover, one of those two days happened to be Saturday - that was official holiday for government servicemen.

Reasons for non-viewing the health programme:

Out of 265 (two hundred sixty five) television viewers, 29 (10.94%) were not viewing the health programmes. Many reasons were reported and the all types of reasons told by respondents for non-viewing were clubed into three categories viz. (i) about 38 percent of the non-viewers of health programmes opined that they had no time to watch due to involvement in their business or office or domestic work or wage work etc. (ii) 34.94% of them told that they remained busy in their day to day routine work while the programme was telecast and (iii) health programmes were not as interesting as to watch, told by eight (27.58%) non-viewers respondents. More over,

they claimed that like film', 'chitrahar' and some TV serials, health programmes were not interesting to them as to spend time in viewing the same.

Frequency of viewing the health programmes:

It was analysed that housewives watched the health programmes more (92.5%) than other occupational groups but difference among other occupational groups for watching health programmes was not remarkable.

Table No.5 shows that labourers were least in number (28.2%) for television viewing.

Respondents reported that they watch the programmes only when they get convenient time. About half (49.57%) of the viewers of health programmes were occasional viewers (two or three programmes in a month). While the remaining viewers of the programmes could be grouped into frequent viewers (30.50%) and regular viewers (19.38%). Businessmen topped the score (65.38%), of occasional viewers, followed by students (54.54%), labourers (50%), servicemen 47.05%), housewives (45.94%) and unemployed (42.85%).

Among the frequent viewers, housewives scored slightly more (30.63%) than three other groups (service, student and business) but two unemployed and labour groups who were numerically poor, they scored 42.85%and 37.5 percent respectively among the frequent viewers of health programmes for their own occupational groups. About 20 percent of the viewers watched the health programmes regularly. Among the regular viewers

servicemen (23.52%) were counted slightly more than housewives (23.42%) whereas remaining groups of unemployed (14.28%) student (15.13%) labourers, (12.5%) and businessmen (7.69%) did not score good for regularity of the viewing of the health programmes.

Respondents who viewed health programmes were distributed into three income groups viz. (i) more than two thousands (ii) two thousand to one thousand and (iii) Below one thousand. Table 6 shows group first by income was assessed to include more viewers (90) than second (68) and third one (48) out of the total respondents viewing health programmes. Study revealed that in every income group occasional viewers were more than other two groups on frequency wise. It was revealed in the study, that the viewers of first income group watched more 87.37%) than others i.e. income group second (85.96%) and income group third (57.83%).

Occasional viewers were found more in every income group followed by frequent viewers and regular viewers. Percentage of occasional viewers was enumerated highest in income group first (56.66%) followed by income group second (45.91%) and income group third (43.75%). Table 7 shows that in all three income groups, frequency of viewing of health programmes were sloping down from occasionally to regularly. In income group first and second, business men were counted more for occasional viewing whereas for third income groups their counterparts were labourers.

It was observed that 48.03% of regular viewers and 41.66% of frequent viewers topped the frequency score in second income group but 43.85% of occasional viewers were, enumerated highest in first income group.

Service holders (45.09%) students (45.45%) and housewives (37.83%) were more in first income group. Unemployed (71.52%), Businessman (50%) and also Students (48.48%) were proportionately more in the second income group. Eleven labour had been enumurated as TV viewers in third income group and out of this, 8 were the viewers of health programmes.

Table 8 shows the educational background of the viewers. Graduates occupied the upper most position (35.15%) followed by the groups comprising of 'martic to undergraduate' (30.93%) 'literate to under matric' (19.09%) 'post graduate' (11.44%) and illiterates (3.38%) respectively. Group of post graduates also included professionals (e.g. doctors and engineers etc.) for convenience of study. From illiterate group not even single respondents had viewed that health programmes regularly while the viewers who had education 'matric to under graduate' scored maximum (38.29%) of the regular viewers of health programmes. Among the frequent viewers, 'graduates' scored more (33.33%) than other educational groups but according to the percentage of the viewers of one particular educational group post graduates acceeded all for 'frequent viewing' by scoring 44.44 percent of total post graduate viewers. Illiterate crossed other educational groups for occasional viewing frequency as (62.5%) among total 8 illiterate viewers watched the

health programmes occasionally. However, proportionately, 55.42% of graduates and 51.11% of 'literate to under matric' were occasional viewers.

However, 54.54% of the students viewing health programmes were graduates. Servicemen who had education 'from literate upto under matric level' all (4) viewed the health programmes regularly while in the same occupational group the viewers who were graduates (65.21%) viewed the health programmes occasionally.

This study revealed that the health programmes were viewed more by the middle aged group (31 year to 50 years) but the respondents (99.62%) of this age group reported that they watched the programmes occasionally. In 15 to 30 years of age group, respondents, (39.5%) watched the programmes regularly, 37.62%, occasionally and 22.88% of them viewed frequently. In third age group (51 years and above), 49.62% of them viewed the programme freqnently followed by 30.93% occasionally and 19.43% regularly.

Benefits of the health programmes to the viewers

Respondents were asked whether they gained any type of benefits after viewing the health programmes. All the responses were recorded in ten sections. One respondent had given more than one kind of benefits because of different health programmes. Thus 344 answers for benefits were recorded.

Table 9 shows that 37.71% viewers gained benefits in term of increasing knowledge about the diseases their symptoms and treatment.

Out of the total who viewed the health programmes as informative and promoter of knowledge about diseases, 52.94% were only servicemen. A sizeable number (62.5%) of the labourers-viewers asserted that by these programme they become acquainted with the health problems, symptoms of the diseases and, moreover, domestic and cheap curing method by the particular health programme 'Gharelu Nuskhe'.

Fifty five respondents told that advices of 'gharelu nuskhe' were beneficial to them as many minor and also some chronic diseases were cured after applying the package of medicines adviced in the programme. This programme was also praised for its useful information and advices by 17.39% of the viewers other than those who gained benefits in term of curing themselves and their family members. These viewers who only viewed and sometimes noted the advices, reported that they did not feel any need to apply those 'nuskhe' but dissiminated them to their friends, neighbours etc. for their relief. Viewers of the following occupations, who gained maximum benefit to relieve their suffering from minor and common ailments e.g. cough (khansi) cold (jukham), stomachache, dysentry, skin problems (phora-phunsi) etc., were housewives (29.72%) followed by unemployed (28.57%), servicemen (25.49%) and students (15.15%). Students (24.24%) and unemployed respondents (71.42%) who acclaimed the philosophi of 'Gharelu Nuskhe' and termed it beneficial, most of them had not applied the message televised in the programme. 19.49% respondents were,

virtually, not having any definite answers. However, they responded in very generalistic way i.e. 'these may be beneficial but I can not say the results as I have not applied so far: Among those who reluctantly accepted the usefulness of programmes, were mostly businessmen (26.92%), labour (25%), and students (24.24%). And those who liked "Gharelu Nuskhe" were mostly of middle aged group viewers (57.34%) and of third group of educational level (35.34%) i.e. 'matric to undergraduate level'.

"Yoga aur Swasthya" programme was liked by the viewers for its utility in maintaining the physical and mental health. Out of the total viewers of health programmes, 15.69% reported that 'Yoga aur Swasthya' was very good and beneficial programme but they had not applied it for their own benefit. Some of them told that they were thinking to practice Yoga and, however, they had already advised others to practice the yoga. Only 12.28% of the viewers of the health programmes accepted that they were practicing yoga to deminish or remove their certain problems e.g. short hight, obesity,loss of appetite etc. Out of the total viewers of the health programmes, 7.62% viewed "Yoga and Swasthya" exclusively. Among the viewers who thought yoga as beneficial to improve the health, unemployed persons were 71.42%, followed by students (36.36%)housewives (12.61%,)servicemen (7.84%)and business-men (7.69%.)

Surprisingly, as table 8 shows, not a single student, who vehemently pleaded the usefulness of yoga, was practicing the same. It might have some other reasons, as one student

said, "At the time when Dhirendra Brahmachary was demonstrating yoga most of the people practiced and followed the instruction but now a days 'yoga aur swasthya' has become dull and uninteresting to be viewed. Therefore, people do not practice according to the demonstration in the programme. He also observed that yoga practices which played on television are very difficult and complex as these could not be practiced easily.

About 57% of the viewers of health programmes were acquainted with 'Jaan hai Jahan hai' programme. Some of them (6.35%) told that they had known only 'Jaan hai Jahan hai'as a single programme related to health. However, 29 respondents (12.28%) asserted that 'Jaan hai Jahan hai' programme had increased the knowledge about symptoms, prevention and also curing against some diseases. Majority of the viewers (89.65%) who stated the above, were service men (15.88%), housewives (13.51%) and businessmen (11.53%). Some respondents (7.62%) denied to say any benefit after viewing the health programmes and told that they were not benefitted by the programmes. Although, the viewers who gave this statements were 72.22% of the housewives of which 33.89% were of third educational group and 36.13% were of second income group. (1000-2000). Seven of them reported that the programme 'Jaan Hai Jahan hai' created suspicion among them for particular disease after viewing the symptoms of the same disease televised in the programme. Three of them even stopped viewing the health programme due to the fear of being cought by disease e.g.Cancer, and leprosy.

The case study revealed that one respondent (18 years old girl) said her mother had instructed not to view this programme because of the fear of getting this particular disease i.e. cancer. She suspected her mother developed some psychological problems after viewing the programme 'Jaan hai Jahan hai'.

Two respondents admitted that after viewing the programme on heart and blood cancer they were forced to consult the specialists to examine them but such disease was not found.

Amazingly, not even single respondents among the viewers of health programmes reported about the usefulness of 'Aap ka pariwar', Basically, prepared for the propagation of the Family Welfare Programme and to motivate the 'Target Couples'. One lady revealed that the format and style of presentation of this programme should be changed to make it more meaningful by drama or story telling methods with hidden message of family planning.

Table 11 shows that there were maximum suggestions in favour of showing the health programmes on common problems like obesity, short hight, skin problems etc. Most of the respondents (64.14% out of the total) had not suggested any new and said, "programmes are alright" or 'I cannot say' or I have not any personal opinion. Mostly, the labourers suggested in favour of more programmes on women and children health problems. For this suggestion servicemen were counted more (43.3%) followed by businessmen (42.86%), housewives (28.9%) and students (13.33%).

Housewives have been counted highest (52.58%) for suggesting that more programme should be on common problems e.g. obesity, short height, skin problems, eye problems, ear problems, hair problems etc. It was observed that often, respondents told for the programmes on specific problems which they themselves had. Some respondents (8.88%) reported that there should be the programmes on cancer, infectious diseases and fatal diseases like AIDS, whereas 11.11 percent told that the programmes on Homeopathy, Sex Education, Seasonal diseases and Nutrition should be started.

Detail chart of suggestion and opinion shows that viewers wanted that health programme should be telecast later or at between 8.00 P.M. to 9.00 P.M. (before or just after Hindi News) and programmes detail should be announced before the telecast.

Besides, they had given some other valuable suggestions e.g. more visuals should be shown in 'Jaan hai Jahan hai' programme, address of major hospitals and Medical Centres should be given, health programmes should be telecast daily or frequently, programme for handicap and mental patients should be started etc.

Table - I

Respondents' Profile
(Occupation wise)

Occupation	Age			Sex		Mother toungue				Education						Religion				TV Possession				Number of Family members			Income groups			Total	% of whole Total
	1	2	3	M	F	H	U	P	O	1	2	3	4	5	6	H	M	S	CH	own	comm.	Nb.	No.	1	2	3	1	2	3		
Service	19	35	6	43	17	39	-	6	15	-	5	15	23	10	7	51	-	4	5	56	-	4	-	16	38	6	27	23	10	60	20.00
House wife	38	71	13	-	122	77	-	32	13	6	25	42	34	15	-	107	-	12	3	120	-	-	2	30	87	5	46	50	26	122	40.66
Student	37	1	-	16	22	30	-	6	2	-	-	15	20	2	1	32	1	4	1	36	-	2	-	2	30	6	18	18	2	38	12.66
Busibess man	11	22	-	28	5	18	2	12	1	-	8	14	7	2	2	26	1	3	3	31	-	2	-	4	25	4	11	15	7	33	11.00
Labour	20	18	1	37	2	35	4	-	-	10	19	9	1	-	-	32	5	1	1	6	2	7	24	17	15	7	-	2	37	39	13.00
Unemployed	6	-	2	3	5	6	-	1	1	-	-	3	4	-	1	6	-	1	1	8	-	-	-	2	5	1	1	6	1	8	2.66
Total	131	147	22	127	173	205	6	57	32	16	57	98	89	29	11	254	7	25	14	257	2	15	26	71	200	29	103	114	83	300	100.00
(%)	43.7	49	7.3	42.3	57.7	68.3	2	19	10.7	5.3	19	32.7	29.7	9.7	3.7	84.7	2.3	8.3	4.6	85.7	0.6	5.0	8.7	23.7	66.7	9.7	34.3	38	27.6	100	

Age: 1=15-30yrs, 2=31-50yrs, 3=51 and above, Mother toungue: H=Hindi, U=Urdu, P=Punjabi, O=Others, Education: 1=Illiterate 2=literate under matric, 3= Matric to undergraduate, 4= graduate, 5= post graduate, 6=Technical/professional Religion: H= Hindu, M=Muslim, S=Sikh, CH=Christian, TV Possession: Comm=Community, Nb.Neighbour, Family members: 1=1-3members 2=4-7 members, 3=8members and above, Income Group: 1=More than Rs.2000, 2=Rs1000-2000, 3=Below Rs.1000.

Table - II

Frequency of TV Viewing by Occupation wise

Frequency of Viewing the Programmes	Service			Housewife			Student			Business			labour			Unemployed			Total		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Total Programmes	8	4	12	0	34	34	5	8	13	3	0	3	1	0	1	3	2	5	20	48	68
			20.5%			27.86%			34.21%			9.09%			2.56%			15.15%			22.66
Selective Programmes	32	14	46	0	86	86	11	12	23	7	0	7	19	5	24	0	3	3	69	120	189
			76.66%			70.49%			60.52%			72.72%			17.94%			9.09%			63.09
Programmes only on Sunday	0	0	0	0	0	0	1	0	1	3	1	4	2	1	3	0	0	0	6	2	8
			0%			0%			2.63%			12.12%			7.69%			0%			2.66
Never	2	0	2	0	2	2	1	0	1	2	0	2	26	2	28	0	0	0	31	4	35
			3.33%			1.63%			2.63%			6.06%			71.79%			0%			11.66
Total	42	18	60	0	122	122	18	20	38	27	6	33	36	3	39	3	5	8	126	174	300
			20.0%			40.6%			12.7%			11.0%			13.0%			2.66%			100%

Table - III

Reasons of non-viewing (in codes) by occupation wise

Occupation	Total respondents	Number of non-viewers	%	Reasons (in code) 1	2	3	Total TV Viewers	% of Total respondents
Service	60	2	3.33	0	2	0	58	96.66
House wife	122	2	1.63	0	2	0	120	98.36
Business	33	2	6.06	1	0	1	31	93.93
Student	38	1	2.63	1	0	1	37	94.87
Labour	39	28	71.79	2	25 (86.2%)	3	11	28.20
Unemployed	8	0	0.0	0	0	0	8	100.00
Total	300	35	11.66	4	29	5	265	

Code: 1: Own TV but have no time to watch due to business/service/any other engagements

2: Do not own TV and not like to watch at the place neighbours/community sets

3: Own TV but not interested in TV Programmes.

Table IV

Number of health Programmes Viewed by Occupation and Sex wise

Occupation	Only one programme			Two programmes			Three programmes			Four programmes			Total			% of health programmes viewers
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	
Service	8	5	13	5	3	8	10	5	15	10	5	15	33	18	81	21.61
			25.49%			15.68%			29.41%			29.41				
House wife	0	8	8	0	28	28	0	48	48	0	27	27	0	111	111	47.03
			9.09%			25.22%			43.24%			24.32%				
Student	3	3	6	2	4	6	6	8	14	4	3	7	15	18	33	13.98
			18.18%			18.18%			42.42%			21.21%				
Business	5	1	6	6	2	8	4	3	7	3	2	5	18	8	26	11.01
			18.18%			30.76%			26.92%			19.29%				
Labour	4	0	4	2	0	2	0	0	0	2	0	2	8	0	8	3.38
			50.0%			25.0%			0%			25.0%				
Unemployed	0	0	0	0	2	2	2	2	4	1	0	1	3	4	7	2.98
			0.0%			28.57%			57.14%			14.28%				
Total:	20	17	37	15	39	54	22	66	88	20	37	57	77	159	236	100.00
			15.69%			22.88%			37.28			24.15				

Table V

Reasons for non-viewing the health programmes by Occupation wise

Occupation	Total TV viewers	Non-viewirs	% of the total viewers	Reasons (in code) 1	2	3	Total Health programmes viewers	% of Total TV viewers
Service	58	7	12.06	3 42.85%	2 28.57%	2 28.57%	51	83.93
Housewife	120	9	7.5	2 22.22%	5 55.55%	2 22.22%	111	29.50
Student	37	4	10.81	1 25.0%	2 50.0%	1 25.0%	33	89.14
Business	31	5	16.12	3 60.0%	1 20.0%	1 20.0%	26	83.87
Labour	11	3	27.27	2 66.66%	0 0.0%	1 33.33%	8	72.72
Unemployed	8	1	12.5	0 0.0%	0 0.0%	1 100.0%	7	87.54
Total	265	29	10.94	11	10	8	236	78.66
				37.93%	34.38%	27.58%	89.05% of total TV viewers	

Code No: 1 = No time due to business/office/domestic wor/labour work etc.

2 = Time is not suitable/open TV only after hindi news in the evening

3 = Not interested in watching the health programme

Table VI

Frequency of Viewing the health programmes
by Occupation wise

Occupation	Total TV Viewers	Frequency of viewing the health programmes Regularly	Frequently	Occasionally	never	Total viewers of health prog.
Service	58	12 23.52%	15 29.41%	24 47.0%	7 13.72%	51 87.93% OF TTV
House wives	120	26 23.42%	34 32.63 %	51 45.94%	9 8.1%	111 92.5% of TTV
Student	37	5 15.15	10 30.30%	18 54.54%	4 12.12%	33 89.18% of TTV
Business	31	2 7.69%	7 26.92%	17 65.38%	5 19.2%	26 83.87% of TTV
Labour	11	1 12.5%	3 37.5%	4 50.00%	3 37.8%	8 72.72% of TTV
Unemployed	8	1 14.28%	3 42.85%	3 42.85%	1 14.28%	7 87.50 of TTV
Total	265 88.33% of TR	47 19.91% of THV	72 30.50% of THV	117 49.57% of THV	29 9.66% of TR & 10.94% of TTV	236 78.66% of TR 89.05% of TTV

Regularly = 3 to 4 programmes weekly
Frequently 1 to 2 programme in a week
Ocasionally 2 to 3 programmes in a month

TR = Total Respondents
TTV = Total TV viewers
THV = Total Health Programmes viewers

Table VII

Frequency of viewing the health programmes by income group and Occupation wise

Occupation	Total viewers of H.P.	Total Frequencies			1st I.G. Rs. 2000 +				2nd I.G. Rs. 1000 - 2000				3rd I.G. below Rs. 1000			
		R	F	O	R	F	O	T	R	F	O	T	R	F	O	T
Service	51	12	15	24	4	6	13	23 45.09%	5	6	9	20 39.21%	3	3	2	8 15.68%
House wife	111	26	36	51	7	16	19	42 37.83%	12	12	18	42 37.83%	7	6	14	27 24.32%
Student	33	5	10	18	2	3	10	15 45.45%	3	5	8	16 48.48%	0	2	0	2 6.06%
Business	26	2	7	17	0	1	7	8 30.76%	2	3	8	13 50.0%	0	3	2	5 19.23%
Labour	8	1	3	4	0	0	0	0 0.0%	0	1	1	2 25.0%	1	2	3	6 75.0%
Unemployed	7	1	3	3	0	0	2	2 28.57%	10	3	1	5 71.42%	0	0	0	0 0.0%
Total:	236	47	72	117	13	26	51	90* 38.13% of THV	23	30	45	98** 41.94% of THV	11	16	21	48 20.33% of THV
% of the viewers of one Income group					14.1	28.3	56.7		23.5	30.6	45.9		22.9	33.3	43.7	57.83% of Total viewers of 3rd I.G.
% of the viewers of one Frequency					27.6	36	43.6		48.9	41.7	38.4		23.4	22.2	17.9	

R= Regularly, F= Frequently, O= ocassionally, T= Total, I.G.=Income group
* = 87.37% of the total viewers of 1st I.G., ** 85.96% of the total viewers of 2nd I.G.
THV = Total Health programme viewers.

Table-8

Frequency of Viewing of the Health Programmes by Education and Occupation Wise

S.No.	Occupation	Total Viewers of Health Programmes	OCCUPATIONAL GROUPS: Illiterate					Literate to Undergraduate					Matric to Under-Graduate					Graduate					Post-Graduate + Professionals					Total		
			R	F	O	T	%	R	F	O	T	%	R	F	O	T	%	R	F	O	T	%	R	F	O	T	%	R	F	O
1.	Service	51	0	0	0	0	0	4	0	0	4	7.8	4	4	6	14	27.45	3	5	15	23	45.09	1	6	3	10	19.6	12	15	24
													(28.5)%	(28.5)%	(42.85)%			(13)%	(22)%	(65)%								(23.5)%	(28.5)%	(49)%
2.	Housewife	111	0	2	4	6	5.6	7	8	14	29	26.1	11	9	13	33	29.7	5	10	15	30	27.02	3	5	5	13	11.7	26	34	51
				(33%)	(67%)			(24%)	(27%)	(48%)			(33%)	(27%)	(39%)			(17%)	(33%)	(50%)			(23%)	(38%)	(38%)			(23%)	(30%)	(46%)
3.	Student	33	0	0	0	0	0	0	0	1	1	3.03	1	4	7	12	36	3	6	9	18	54.5	1	0	1	2	6	5	10	18
													(8%)	(33%)	(58%)			(17%)	(33%)	(50%)								(15%)	(30%)	(54%)
4.	Business	26	0	0	0	0	0	0	2	6	8	30.7	1	2	5	8	30.7	1	2	5	8	30.7	0	1	1	2	8	2	7	17
									(25%)	(75%)			(12%)	(25%)	(62%)			(12%)	(25%)	(62%)										
5.	Labour	8	0	1	1	2	25	0	1	2	3	37.5	1	1	1	3	37.5	0	0	0	0	0	0	0	0	0	0	1	3	4
									(33%)	(67%)																		(12%)	(37%)	(50%)
6.	Unemployed	7	0	0	0	0	0	0	0	0	0	0	0	2	1	3	43	1	1	2	4	57	0	0	0	0	0	1	3	3
														(67%)	(33%)			(25%)	(25%)	(50%)								(14%)	(43%)	(43%)
7.	Total	236	0	3	5	8	3.38	11	11	23	45	19.09	18	22	33	73	31	13	24	46	83	35	5	12	10	27	11.4	47	72	117
																												(20%)	(30%)	(49%)
8.	% of total viewers of one education group	-	0	37.5	62.5	100	-	24	24	51	100	-	25	30	45	100	-	16	29	55	100	-	19	44	37	100	-	-	-	-
9.	% of total viewers of one frequency	-	0	4	4	-	-	23.4	15	20	-	-	38	30.5	28	-	-	28	33	39	-	-	11	17	8	-	-	-	-	-

Table No.9 : BENEFITS OF THE HEALTH PROGRAMMES TO THE VIEWERS BY OCCUPATION WISE

BENEFITS TO THE VIEWERS (IN CODES)

S.No.	Occupation	1	2	3	4	5	6	7	8	9	10	Total Viewers
1.	Service	27	8	5	13	4	7	8	2	1	1	5% of total viewers
	% of total viewers	52.94%	15.68%	9.80%	25.49%	7.84%	13.72%	15.68%	3.92%	1.96%	1.96%	21.6
2.	House Wife	36	21	20	33	14	13	15	13	3	0	111
	% of total viewers	32,43%	18.91%	18.01%	29.72%	12.61%	11.71%	13.51%	11.71%	2.70%	0%	47.03
3.	Student	8	8	8	5	12	0	1	3	2	0	33
	% of total viewers	24.24%	24.24%	24.24%	15.15%	36.36%	0%	3.03%	9.09%	6.06%	0%	13.98
4.	Business	11	7	2	2	2	5	3	0	1	2	26
	% of total viewers	42.30%	26.92%	7.69%	7.69%	7.69%	19.97%	11.53%	0%	3.84%	7.69%	11.01
5.	Labour	5	2	1	0	0	0	0	0	0	0	8
	% of total viewers	62.5%	25%	12.5%	0%	0%	0%	0%	0%	0%	0%	3.38
6.	Unemployed	2	0	5	2	5	4	2	0	0	0	7
	% of total viewers	28.57%	0%	71.42%	28.57%	71.42%	57.14%	28.57%	0	0	0	296
7.	Total	89	46	41	55	37	29	2 9	18	7	3	236
	% of total viewers	37.71%	19.49%	17.37%	23.30%	15.69%	12.28%	12.28%	7.62%	2.96%	1.27%	100%

Decoding of Benefits told by respondents

Code No.		Description after decoding of the response
1	-	These programmes give information and increase the awareness about the diseases, their symptoms and treatment.
2	-	These may be beneficial but I cannot say reason as I have not applied so far.
3	-	'Gharelu Nuskhe' is useful programme as it provides knowledge about domestic treatment for common diseases (Khansi,Jukham etc) but I have not applied for my own only told and discussed with friends and neighbours.
4	-	After application of Nuskha of the programme 'Gharelu Nuskhe', I got relief from some disease of Khansi, Jukham, stomache etc.
5.	-	'Yoga and Swasthya' is very good and beneficial programme but I have not applied. I am thinking to practice/advised to practice by others.
6	-	Practicing Yoga for improving the health/increasing height/reducting fat/stimulating appetite etc.
7	-	'Jaan hai Jahan hai' increases the knowledge about symptoms, preventive and curative measures against disease of myself and others.
8	-	Not getting that as much of benefits as could be illustrated.
9	-	After watching the programme 'Jaan hai Jahan hai' suspected for particular disease as told the symptoms for the same and if needed connected to the doctor.
10	-	No, Not any. Can'nt say.

TABLE 10 COMPREHENSION OF HEALTH PROGRAMMES BY OCCUPATION AND SEX WISE

S.No.	Comprehension (in codes)	DIFFERENT OCCUPATIONS: Service M	F	T	Housewife M	F	T	Student M	F	T	Business M	F	T	Labour M	F	T	Unemployed M	F	T	Total (% of total viewers of health programme)
1.	1. No	30	13	43	0	90	90	14	15	29	20	5	25	4	1	5	3	3	6	198
	% of Total			21.77			45.45			14.64			12.62			2.52			3.03	(83.89%)
2.	2. Yes: Technical words/ difficult action in Yoga/ Comparing/method of explaining is not comprehensive.	2	0	2	0	4	4	1	0	1	0	0	0	1	1	2	0	1	1	10
	% of Total			20			40			10			0			20			10%	(4.23%)
3.	3. Yes: Language problem to understand the programme	2	2	4	0	7	7	0	2	2	0	0	0	1	0	1	0	0	0	14
	% of Total			28.57			50			14.28			0%			7.14			0	(5.93%)
4.	4. Yes, but can not say reason.	1	1	2	0	10	10	0	1	1	0	1	1	0	0	0	0	0	0	14
	% of Total			14.28			71.42			7.14			7.14			0			0	(5.93%)
5.	Total	35	16	51	0	111	111	15	18	33	25	1	26	6	2	8	3	4	7	236
	% of Total			21.6			47.03			13.98			11.01			3.38			2.96	

TABLE 11 : SUGGESTIONS OF ITEMS AND TOPICS BY VIEWERS OF HEALTH PROGRAMMES BY OCCUPATION AND AGE GROUP WISE

S.No.	Occupation	Suggestions (in codes) by Viewers - Age group																								Total
		1				2				3				4				5				6				
		1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	1	2	3	T	
1.	Service	0	1	0	1	1	7	1	9	0	4	2	6	0	1	0	1	0	4	1	5	22	8	1	31	53
2.	Housewife	2	0	0	2	0	9	2	11	6	9	5	20	2	0	0	2	0	1	2	3	23	11	49	83	121
3.	Student	2	0	0	2	2	0	0	2	8	0	0	8	2	0	0	2	1	0	0	1	23	0	0	23	38
4.	Business	0	0	0	0	0	3	0	3	1	1	0	2	1	1	0	2	0	0	0	0	8	11	1	20	27
5.	Labour	0	0	0	0	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
6.	Unemployed	0	0	0	0	1	0	0	1	0	0	1	1	0	0	1	1	1	0	0	1	3	0	1	4	8
7.	Total	4	1	0	5	8	19	3	30	15	14	8	37	5	2	1	8	2	5	3	10	79	30	52	161	251
		30%	20%	0	100	26.66 %	63.33 %	10 %	100 %	40.54 %	37.83 %	21.62 %	100 %	62.5 %	25 %	12.5 %	100 %	20%	50%	30%	100%	49.06 %	18.63 %	32.29 %		

Decoding of suggestions by respondents

Code No.	Decoding of suggestions
1 -	Group of diseases of Blood/heart/ should be programmed frequently.
2 -	Coverage of Women/child disease/protection during pregnancy/Health Education preventive measures against diseases Immunization should be frequently telecast.
3 -	Health problems like obesity/short height/skin problem/eye problem/ear problem/ stomach ache/polio/ hair problem/Acidity/Diabitics/Brest pain/Khansi-jukam etc. should be highlighted.
4 -	Cancer/Bacterial and other infunction diseases/other fatal diseases e.g.AIDS should have more coverage.
5 -	Separate programmes on nutrition/sex-education/Homeopathy/seasonal disease should be started.
6 -	Not any/nothing special/can't say/programmes are alright.

DETAIL CHART OF SUGGESTIONS

Total Respondents suggested = 72

Kinds of suggestions = 41

Suggestions in chart = 10

SUGGESTIONS	SCORE
1. Time of programme should be later/ after 8 P.M./9.P.M.	10
2. Programme's detail should be properly informed before telecast	7
3. Time of the programmes should be increased	5
4. Address of various major hospitals/ Medical institutions should be given.	4
5. Programme on handicapped should be started	3
6. Programme on mental diseases should be started.	2
7. Children/women programmes should be shown frequently.	2
8. There should be enough time to note down the programmes Message	2
9. Expert doctors in the programme should give their name and address	2
10. There should be programme of health for youth	2
Total	39

CHAPTER IV

A DISCUSSION

DISCUSSION

After reviewing the existing literature and having the findings of the study conducted at Delhi it was essential for us to discuss the issues relating to the role of television as an important tool of mass media, in the improvement of health of the people in India. Health problems, health practices and population growth are closely linked with the ecological setting of a community. Health problems are in effect a function of the human ecology and the community's response to them is a function of its health culture. Thus, there exists a dynamic equilibrium between the ecological setting on one hand and the community's response to the health problems (arising out of the ecological setting) on the other.[1]

There has been a gross over estimation of the impact of public health measures on the fall in birth rates, and in this process, much more complex but significant ecological, biological and epidemiological issues which have promoted major shifts in the host - parasite equilibrium within the populations have not received due attention.

The very wide field of social, economic and political factors are responsible for the creation of the poor ecological conditions and correspondingly poor health services and the social and cultural implication of such condition.

Health is a subjective concept. It is obviously beyond mere absence of physical pain or illness. It is generally taken as a state of physical, psychological and socio-cultural well-being and

to that extent good health is an interrelated and transactional part of overall societal development. We, as a democratic and welfare polity, are said to be committed in principle to open out to the population opportunities for a "richer and more varied life" and providing better medical and public health facilities is a significant component of India's planning structure.

Media of communication are brought to India to help easy and efficient flow of information with different sections and subsections of the national populace in this vital task of distributing the fruits of socio-economic and socio-cultural growth and development.

"Traditionally, the purpose of mass communication in the field of community health is to ensure that people get the information they should have. It is usually a one- way process, with the masses of people remaining passive receiptients of what is handed down to them. Those who above decide what information people should have and choose the media to transmit that information. It is thus loaded with values and interests of the communicators and their employers and it is authoritarian in nature; telling people (the 'target' population) what is good for their health.[2]

Mass communication in health fiels is very often associated with another similarly value load approach, namely health Education. The emphasis were is on person to person contact. The common factor in both the approaches is an 'attack' on the target.

Here the 'target' was the 'Mayapuri' population. Thus we had to examine, how far the sample population were benefitted by the

so called "four health programmes" telecast regularly by the Delhi TV Centre. It was found out that out of the four programmes only two programmes (i.e. "Gharelu Nuske" and "Jaan Hai Jahan Hai") were of limited utility, that only to the higher and middle income group. Out of the other two programmes ("Yoga aur Swasthya" and "Aap Ka Parivar") "Yoga aur Swasthya" was preferred only by the students, business-men and housewives because this programme could give these elite viewers some benefits on health problems like obesity and loss of appetite etc. But 'Aap Ka Parivar' a programme on family welfare (Population control measures) was of little significance to the sample population. Here question arises that why these programmes were discriminately accepted by the study population. It was verified that the contents of "Jaan Hai Jahan Hai" was primarily on the prevalent diseases such as: Heart disease, leprosy, Viral fever, Jaundice, diseases of Ear, Nose and Throat, Diabetes, Cancer etc.

Besides, the viewers queries through letters were taken into account alternatively in this programme. This very process created two way communication in this programme. Because of this "Jaan Hai Jahan Hai" got a little success among the study viewers and had satisfied the need of their health culture to some extent, But this programme was of (less beneficial to the lower income group i.e.) labourers, class iv employees etc. because very often of medical experts and the comperes presented the programme mostly in technical terms in English language. Therefore, this programme was less meaningful to the needs of the lower income group of our study population. Banerji has already expressed that sometimes due to short comings in the messages

and/or in the transmission media, the messages fail to reach the "target" or they reach them in a distorted form. At times the messages lack credibility or they are counter productive because they sell the wrong product to the target.[3]

The programme "Aap Ka Parivar" was virtually misinterpreted in the first instance by the viewer, because the message was not clear and appealing. This was evident from the viewers also that they were already more or less aware of family planning vis-a-vis the welfare measures. But the question was of adopting the practices by the target couples. Because of this, already much awared viewers of higher and middle (urban area) income group were reluctent to give further importance to such out dated programmes. This programme could have been of some importance to the lower income group, in which mostly TV was not available in their houses (Table No.2).

In other case, the "Gharelu Nuskhe" programme was of some importance to mostly all viewers because the processes of taking care of the common minor ailments at house setup were advised in this programme. These urban viewers were also of the opinion that they were ignorant of these house remedies indigenous practices. This proved that the health culture of this urban study population was devoid of these practices in contrast to the rural households. The house remedies, telecast through "Gharelu Nuskhe" filled the gap of existing health facilities available to this urban population.

Further more, the felt needs of the viewers in the study population were available with suggestion chart. It was evident

from that, the telecast-timing of the health programmes should be convenient to the viewers. The content of the each health programme should be announced earlier to meet the felt need of target viewers.

Besides this, the language was found to be of mostly incomprehensive because the technical words in "English" were used frequently by the programme's experts and comperes. The efforts should be made to prepare the programmes in a common language giving sufficient pause to help viewers understand. Most of the viewers were of the opinion that the health programmes might be prepared taking into account the disease prevalent in the community and the programmes might cover the whole history of a disease (Natural history of a disease) as a result of which the viewers (patients) would be benefitted to take adequate steps with the proper health agencies or health experts.

Case Study:

In a case study it was found out that Mr.Narayana after watching a health programme on heart disease approached to the concerned doctor in the hospital but he could not get adequate help because of the particular doctor discussed without any proper examination. He could not afford to show his problem to any private practitioner because his dependency on the other family members.

This case study proved that after receiving the information on different health problems the viewers, when knocked the doors of the health services providers were kicked around as usual like the other active seekers of health services. In other

words, the success of the Role of TV in health promotion of the people is very limited in the existing situation prevailing in the urban privileged oriented, over mistified health services infrasturctures.

In this study it was also proved that the elite interests even in the area of medicare were promoted by giving much importance to the disease usually found among them e.g. heart attack, diabetes, obesity etc. Because of this very situation, the health programmes on TV even in urban area were less acceptable to this middle and lower middle class.

So the communication on TV, for a specific task, say family planning or communicable diseases, can hardly be effective in isolation as our previous experiences indicated in other studies, reviewed earlier. Such an information or code messages have to be a part of a package programme simultaneously addressing to closely related questions such as nutrition, child care, socio-economic upliftment, education, fighting fatalism, encouraging public participation, and so on. Moreover, mass media can be effective only when they are combined with interpersonal communication skills for the creation of general awareness to bring about changes in attitudes, values and, eventually, behaviour.

Health education campaign and mass communication package in case of promoting the use of sanitary latrine in rural areas, mass BCG compaign, SITE to instruct rural people about health, nutrition, and Family Planning and, also, compaign for adopting vitamins, tonics and baby foods etc. along with campaign against the use of alcohol narcotics etc. are some of the examples in which the success is yet a question. This study also proved the same about the four health programmes telecast in Delhi TV Centre,

because this above down approach of mass communication on health education is not a solution for health promotion of the target population.

There is wide spread evidence from communications research that the persuasive power of media and its ability to directly influence its audience is very limited. Behaviour change depends on the extent to which the media is supported and facilitated by the social and the physical environment. Social reinforcement is crucial. The audience should be seen as playing an interactive role with the media. Its effects are often assessed by what happens immediately after the reception of a media message. But it is also important to gauge what happens before (Health Culture study), during and after the message reception. We should be clearly aware of the difference between the short-term effects of a single programme and the long-term effects of the health programmes. Health promotion should counter-act the dangerous development whereby people's perceptions of reality could be replaced by a perception of reality as displayed by television programmes.

In health promotion we are not only dealing with health services, but also with health conditions and the environment in which people live. The mass media is only one system of communication, it can provide the backcloth, but it needs reinforcement by personal and more interactive techniques in order to bring about behaviour change. Mass media programme must be supplemented by community organization and other efforts to enhance the interpersonal reinforcement of the programmes'

objectives. We must consider the old style of just "attacking" a passive and unresponsive public. It is not enough to furnish knowledge, we need to check that people receive, accept and employ with the message as appropriate. Health promotion strategies must be pre-tested and evaluated. Part of this should include a communication planning process - a careful understanding the target audience, analysis of their media habits, their knowledge attitudes and behaviour. Systematic pretesting is needed for this.

The Alma Ata Declaration Health for all by 2000 AD has identified health education and community participation as the first of the major element of the concept of primary health care has led to a fundamental reappraisal of the concepts and methods of conventional health education and mass communication in health. These trends have been articulated by the WHO Expert Committee on New Approaches to Health Education for Primary Health Care. It has described the conventional approach as "patronising", paternalistic and victim blaming". It emphasises that people themselves need to fully understand the problems and to fully collaborate with their health care provides in their solution. For this purpose it is suggested that health care providers develop people oriented health programmes and use approaches of health education and mass communication to strengthened the involvement of the people. Health education and mass communication become two-way processes for from merely seeking co-operation of communities in carrying out plans already made, the new approach to health education aims at encouraging people to be actively involved in the planning and maintenance of their health and that of their communities.[4]

Understanding of response of the people should be the basis for choice of technology of organisational framework and management practices to deliver the chosen technology. Strategy for mass communication and health education has to be developed with the people oriented service delivery complex.[5]

Suitable strategy of communication and education should be drawn upto actively generate felt needs to cover the unreached portion of the epidemiologically assessed needs and to erase that portion of the felt-needs which does not cover the epidemiologically assessed needs.

Finally, the major elements of a conceptual framework for mass communication vis-a-vis the role of TV, in community health are summerised below. The conceptual framework needs further detail sociological analysis in a bigger representative sample.

1. Role of TV in community health is not an isolated approach: it is certainly not the only answer for health awareness on health promotion.

2. Understanding of the people - viewers forms the basis for the choice of technologies and for developing a service delivery system which is in consonance with the socio-cultural setting.

3. Communication and education programmes either follow the development of a people oriented service complex or they become its integral component, playing an advocacy or even an advisory role.

4. An optimum mix of communication package has to be developed in an interdisciplinary team to make the TV Health Programmes more meaningful in the existing Indian reality.

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