

Health Communication and Public Health Campaigns in India: A Critical Examination of IEC Strategies in the Swachh Bharat–Swasth Bharat Abhiyan

Ashutosh Kumar Singh^{1*}, Dr. Rajesh Kumar Shukla²

¹PhD Scholar Department of Journalism & Mass Communication School of Education and Humanities
IFTM University, Moradabad, U.P.

Email ID: ashutoshinmedia@gmail.com

²Head Department of Journalism & Mass Communication School of Education and Humanities IFTM
University, Moradabad, U.P.

Email ID: drrajeshkumarshukla@iftmuniversity.ac.in

***Corresponding Author**

Ashutosh Kumar Singh

PhD Scholar Department of Journalism & Mass Communication School of Education and Humanities
IFTM University, Moradabad, U.P.

Email ID: ashutoshinmedia@gmail.com

ABSTRACT

The Swachh Bharat Abhiyan (SBA), launched by the Government of India in October 2014, remains among the largest behaviour-change communication exercises attempted anywhere in the world, seeking to link sanitation infrastructure with a broader vision of public health captured in the allied discourse of a "Swasth Bharat" (Healthy India). This paper undertakes a critical examination of the Information, Education, and Communication (IEC) strategies deployed under the campaign, situating them within established health communication theory, including the Health Belief Model, Social Cognitive Theory, and the Diffusion of Innovations framework. Drawing on secondary data, government reports, and existing scholarship, the paper argues that while the SBA achieved significant success in constructing sanitation infrastructure and shifting public discourse on open defecation, its IEC strategies exhibited a persistent gap between behavioural messaging and sustained behaviour change, particularly in rural and tribal contexts. The paper further examines the campaign's use of celebrity endorsement, mass media saturation, interpersonal communication through frontline workers, and digital media, and considers the limitations of a top-down, target-driven communication model in addressing deeply embedded socio-cultural practices. The paper concludes with recommendations for a more participatory, community-anchored model of health communication for future public health campaigns in India.

Keywords: Health Communication, IEC Strategies, Health Belief Model, Sanitation Behaviour, Communication for Development (C4D)

1. INTRODUCTION

Public health communication in India occupies a distinctive position at the intersection of state policy, mass media, and deeply layered socio-cultural practice. Unlike health systems where clinical intervention alone can address disease burden, India's major public health challenges — open defecation, waterborne disease, malnutrition, and vector-borne illness — are inseparable from questions of behaviour, habit, and social norm. It is in this context that the Swachh Bharat Abhiyan (SBA), launched on 2 October 2014, must be understood not merely as an infrastructure programme but as a vast experiment in Information, Education, and Communication (IEC), one of the largest behaviour-change campaigns undertaken by any government in the world.

The stated ambition of the SBA extended well beyond toilet construction. Official discourse consistently framed sanitation as a determinant of health, positioning the mission as a foundation for a "Swasth Bharat" — a healthy India — in which reduced open defecation would translate into lower rates of diarrhoeal disease, improved child nutrition, and reduced maternal and infant mortality. This paper is concerned with a critical examination of the IEC strategies through which this framing was communicated to the Indian public, and with an assessment of how far communication design matched the scale of behavioural transformation the mission required.

The paper proceeds in seven parts. It first outlines the theoretical frameworks relevant to health communication and behaviour change, and then sets out the document-based methodology used for the analysis. It then describes the architecture of IEC activity under the SBA, covering mass media, interpersonal communication, and community mobilisation. The following section offers a critical assessment of these strategies against the campaign's own targets and against independent survey data on sanitation behaviour, including a comparative analysis of reported coverage figures. A further section considers the specific challenges of rural and tribal contexts, including the Nashik region, where sanitation communication intersects with distinct social structures. The paper concludes with recommendations and an assessment of what the SBA's communication experience suggests for the design of future Indian public health campaigns.

2. THEORETICAL FRAMEWORK

Health communication scholarship offers several frameworks through which the IEC strategy of the SBA can be read. The Health Belief Model (HBM) proposes that individuals adopt health behaviours based on their perceived susceptibility to a health threat, the perceived severity of that threat, the perceived benefits of action, and the perceived barriers to it. Applied to sanitation, the HBM suggests that a household's decision to construct and use a toilet depends less on the availability of subsidy than on whether open defecation is genuinely perceived as a health risk, and whether the barriers — cost, water availability, social habit — are outweighed by perceived benefit.

Albert Bandura's Social Cognitive Theory (SCT) is equally relevant, given the campaign's heavy reliance on celebrity endorsement and modelling. SCT holds that behaviour change is mediated by observational learning and self-efficacy: individuals are more likely to adopt a behaviour when they see it modelled by figures they respect, and when they believe themselves capable of performing it. The SBA's use of prominent public figures pledging to promote sanitation, and its "Darwaza Band" (Close the Door) messaging built around social shaming of open defecation, drew directly, if not always explicitly, on this logic.

Everett Rogers' Diffusion of Innovations framework, meanwhile, is useful for understanding the campaign's uneven geographic and social spread. Rogers identifies adopter categories — innovators, early adopters, early majority, late majority, and laggards — and stresses that an innovation's rate of adoption depends on its perceived relative advantage, compatibility with existing values, complexity, trialability, and observability. Toilet construction and use, as an "innovation" in this sense, faced significant compatibility barriers in regions where open defecation carried no strong social stigma, or where existing beliefs about purity and pollution complicated the placement and use of toilets within or near the home.

A fourth relevant strand is the Communication for Development (C4D) tradition, associated with UNICEF and other multilateral agencies, which emphasises participatory processes over top-down message delivery. C4D scholarship distinguishes between diffusion models of communication, in which a centrally designed message is transmitted outward to a passive audience, and participatory models, in which communities are engaged as co-producers of meaning and solutions. Much of the critical scholarship on the SBA's IEC approach turns on precisely this distinction.

3. METHODOLOGY

This paper adopts a qualitative, document-based methodology suited to a critical policy and communication analysis rather than a primary field investigation. It draws on three categories of secondary source. The first consists of official government material: guidelines and progress reports issued by the Ministry of Drinking Water and Sanitation (renamed the Department of Drinking Water and Sanitation), Swachh Bharat Mission portal data, and the government's own National Annual Rural Sanitation Survey (NARSS). The second consists of large-scale independent household survey data, principally the National Family Health Survey (NFHS-4, 2015–16, and NFHS-5, 2019–21) conducted by the International Institute for Population Sciences, and the National Sample Survey Office's 76th Round (July–December 2018) survey on drinking water, sanitation, hygiene, and housing conditions. The third consists of peer-reviewed and grey literature evaluating the implementation, communication design, and behavioural outcomes of the SBA.

These three source categories are read against one another rather than in isolation. Where government-reported coverage figures and independent survey figures diverge, as they frequently do, that divergence is treated as analytically significant rather than as noise to be reconciled: it is read as evidence of the gap between administrative reporting incentives and field-level behaviour that forms a central argument of this paper. Figures drawn from different surveys are not strictly comparable in method, sample frame, or the precise indicator measured — coverage, access, and regular use are related but distinct constructs — and the analysis in Section 5 makes this comparability limitation explicit rather than treating the figures as a single continuous series.

This approach has a clear limitation: a document-based comparative analysis of existing survey data cannot establish causal attribution in the way a controlled field evaluation might, and it cannot capture the qualitative texture of household decision-making that primary ethnographic fieldwork would reveal. Its purpose is instead interpretive and evaluative — to synthesise available quantitative and qualitative evidence and to read it through the lens of established health communication theory set out in Section 2, in order to assess the SBA's IEC strategy on its own terms and against comparable communication campaigns.

4. THE ARCHITECTURE OF IEC STRATEGY UNDER THE SWACHH BHARAT ABHIYAN

The SBA's communication architecture combined several distinct strands. At the apex was mass media saturation: television advertisements, radio jingles, print media, and hoardings carried a consistent visual identity built around the broom as a symbol of collective cleansing action, and around the Prime Minister's own visible participation in cleanliness drives. The campaign's launch was itself a communication event, with public figures across film, sport, and industry photographed holding brooms and nominating others to do the same, a device that mimicked

the structure of a viral social media challenge and extended the campaign's visibility well beyond conventional government messaging.

A second strand consisted of interpersonal communication carried out by frontline functionaries — Accredited Social Health Activists (ASHAs), Swachhagrahis, anganwadi workers, and school teachers — who were tasked with door-to-door motivation, community meetings, and the organisation of local events such as Swachhata rallies. This strand was intended to compensate for the limitations of mass media by providing a channel for two-way dialogue, addressing specific household objections, and modelling toilet construction and use within trusted local relationships.

A third strand involved community-level social mobilisation techniques, most notably adaptations of Community-Led Total Sanitation (CLTS), in which facilitators used exercises such as transect walks and mapping of defecation areas to provoke collective disgust and shame as triggers for behaviour change. This approach, borrowed from earlier rural sanitation programmes, sought to generate what its proponents describe as "collective efficacy" — a shared community commitment to ending open defecation rather than a series of individual household decisions. A fourth strand, increasingly significant over the campaign's later phases, involved digital and social media. Hashtag campaigns, short-form video content, and mobile applications for reporting sanitation grievances positioned the SBA within a broader shift in Indian governance communication toward digital citizen engagement, particularly aimed at urban and younger demographics.

Finally, the campaign's messaging architecture evolved over time to more explicitly foreground the health rationale for sanitation. Early phases emphasised dignity, particularly the safety and dignity of women, and national pride ahead of the 150th anniversary of Mahatma Gandhi's birth in 2019, which served as the campaign's initial target date for achieving open-defecation-free (ODF) status nationwide. Later phases, under Swachh Bharat Mission-Gramin Phase II and the urban mission's later iterations, shifted emphasis toward ODF-Plus objectives, solid and liquid waste management, and more explicit linkage to health outcomes, aligning more closely with the Swasth Bharat framing.

5. CRITICAL ASSESSMENT: GAPS BETWEEN MESSAGE AND BEHAVIOUR

A critical reading of the SBA's IEC strategy must begin by acknowledging genuine achievements. The campaign succeeded in making sanitation a subject of everyday public conversation to a degree unmatched by earlier Indian sanitation programmes, and it constructed toilets at a scale that materially altered the physical landscape of rural India. The visibility strategy, in particular the mobilisation of celebrity and political leadership, achieved a rare feat in Indian public communication: sustained national attention to a subject long considered too indelicate for open discussion.

However, independent research conducted during and after the campaign's principal phases has repeatedly identified a gap between toilet construction figures and consistent toilet use, sometimes referred to in the literature as the "access-use gap." Household surveys conducted by independent researchers in several states found that a meaningful proportion of households with a functional toilet continued to practise some open defecation, particularly among adult men and older residents whose habits predated the campaign. This gap suggests that the IEC strategy, for all its visibility, was more successful at generating awareness and even social pressure than at achieving what health communication scholars term durable behaviour maintenance — the continuation of a behaviour after external monitoring or incentive is withdrawn.

Several explanations for this gap emerge from the theoretical frameworks discussed earlier. First, the campaign's dominant communication register was shame and disgust rather than health risk perception in the terms specified by the Health Belief Model. While shame-based triggering can be effective in initiating behaviour, as CLTS theorists themselves acknowledge, it is less reliably effective in sustaining behaviour once the intensity of community monitoring recedes. Where messaging failed to substantively build household-level understanding of the causal link between open defecation, faecal-oral disease transmission, and child health, the perceived benefit of toilet use in HBM terms remained comparatively weak relative to the perceived barriers of cost, water scarcity, or the physical inconvenience of some constructed toilets.

Second, the target-driven administrative structure of the campaign, in which district and block officials were evaluated against ODF declaration timelines, created incentives for what several researchers have described as premature or symbolic ODF declarations, in which toilets were counted as constructed or households as compliant ahead of verified, sustained behaviour change on the ground. This dynamic reflects a broader tension in Indian public administration between the communicative logic of a mission with fixed deadlines and the slower, non-linear logic of genuine social norm change.

Third, the campaign's reliance on mass media and celebrity modelling, while effective for agenda-setting, does not straightforwardly translate into the kind of self-efficacy that Social Cognitive Theory identifies as necessary for behaviour change among structurally disadvantaged households. A celebrity photographed holding a broom communicates the desirability of cleanliness as a value, but offers limited practical guidance to a household lacking secure land tenure, water access, or the money for even a subsidised toilet. Communication strategies

aimed at aspiration and national pride, in other words, addressed motivation more effectively than they addressed capability or opportunity, the other two components of the widely used COM-B (Capability, Opportunity, Motivation – Behaviour) model of behaviour change.

Fourth, the interpersonal communication strand, though theoretically well positioned to close these gaps, was constrained in practice by the workload already carried by ASHAs and anganwadi workers, who were assigned sanitation motivation duties in addition to extensive existing responsibilities in maternal and child health. Frontline communication of the depth required for genuine dialogic engagement — addressing specific household objections, negotiating with elder family members, revisiting resistant households multiple times — is time-intensive, and evidence from field-level studies suggests that in many blocks this activity was compressed into brief, transactional visits rather than sustained relationship-based engagement.

5.1 Data Analysis: Divergence in Reported Sanitation Coverage

The access-use gap discussed above can be illustrated concretely by comparing the coverage and usage figures reported by different sources across the life of the campaign. Table 1 sets out rural sanitation figures from six sources between the campaign's 2014 baseline and 2022, drawn from government reporting, the government's own household survey (NARSS), and independent surveys (NSS, NFHS).

Source	Period	Reported Coverage / Access	Nature of Indicator
MDWS baseline	2014	38.7%	Government-reported toilet coverage at campaign launch
NFHS-4	2015–16	~52% (national)	Independent household survey; improved sanitation access
NSS 76th Round	2018	71.3% (rural)	Independent household survey; latrine access
NARSS	2018–19	93.1% access; 93.3% of these using regularly	Government-commissioned rural sanitation survey
SBM(G) self-declaration	Oct 2019	100%	Administrative ODF declaration based on toilet coverage, not independently verified usage
NFHS-5	2019–21	~65–70% (rural, national)	Independent household survey; improved sanitation access
Swachh Survekshan Grameen	2022	95.4% access; 95.4% of these using regularly	Government-commissioned rural sanitation survey

Table 1. Comparative rural sanitation coverage and access figures, 2014–2022 (compiled from Ministry of Drinking Water and Sanitation / Jal Shakti data, NARSS, NSS 76th Round, NFHS-4, NFHS-5, and Swachh Survekshan Grameen reports).

The pattern in Table 1 is visualised in Figure 1, which plots the reported coverage figure from each source against the year in which it was recorded.

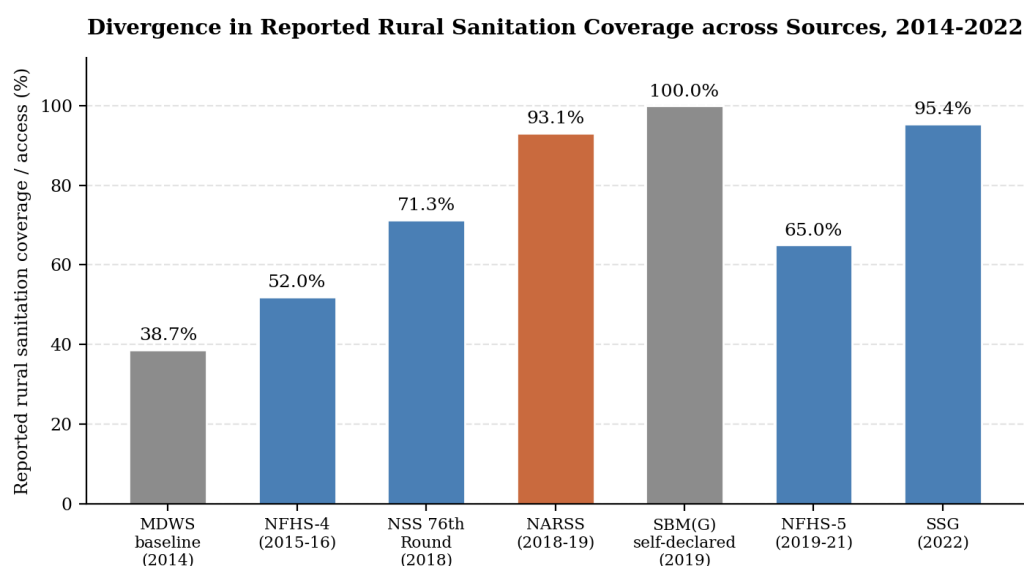


Figure 1. Divergence in reported rural sanitation coverage across government and independent sources, 2014–2022.

Two features of this comparison are analytically significant. First, the two administrative data points bracketing the campaign's official five-year window — the 2014 baseline of 38.7 per cent and the October 2019 self-declaration of 100 per cent — describe a linear, near-complete transformation that no independent survey conducted around the same date corroborates: NARSS (2018–19) recorded access several points below full coverage, and NFHS-5, fielded only slightly later, recorded rural access closer to two-thirds of households. Second, government-commissioned surveys (NARSS, Swachh Survekshan Grameen) consistently report higher coverage and usage than surveys conducted by independent statistical or demographic agencies (NSS, NFHS) for comparable periods, a pattern consistent with the concern, raised in the parliamentary and academic literature cited above, that administratively incentivised reporting tends to overstate behavioural achievement relative to independently measured outcomes. Read alongside the theoretical discussion in Section 2, this divergence is best understood not as a simple measurement discrepancy but as a symptom of the communication strategy's own design: a target-driven, declaration-based model of progress reporting generates strong incentives to register the desired behaviour rather than to verify its durability.

6. RURAL, TRIBAL, AND REGIONAL CONSIDERATIONS

The gap between message design and behavioural outcome is especially pronounced in tribal and rural taluka contexts, including areas of Maharashtra's Nashik district, where sanitation practice intersects with distinct patterns of settlement, water access, and existing relationships with forest and open land. In many tribal hamlets, distances to water sources, seasonal migration for agricultural labour, and lower baseline exposure to mass media meant that the campaign's urban-oriented and Hindi-dominant messaging register did not travel with equal force. Where local language adaptation and community-specific messaging were weaker, the campaign's reach depended disproportionately on the interpersonal strand, precisely the strand most constrained by frontline worker capacity. This regional unevenness points to a broader methodological weakness in the SBA's IEC design: a largely uniform national messaging architecture applied across an extraordinarily heterogeneous social landscape. Health communication scholarship has long emphasised the importance of message tailoring to specific audience segments, informed by formative research into local beliefs, practices, and communication channels. While the campaign did adapt some materials into regional languages and did draw on existing government cadres at state and district level, the core symbolic architecture — the broom, the Darwaza Band framing, the celebrity pledge chain — remained largely constant nationwide, limiting its capacity to address the specific barriers operative in particular social contexts.

7. TOWARDS A MORE PARTICIPATORY MODEL

The critical literature on the SBA converges on a set of recommendations relevant to the design of future Indian public health campaigns. First, health communication strategies benefit from grounding aspirational, shame-based, or pride-based messaging in clearly communicated causal health information, so that behaviour change is anchored in genuine risk perception rather than social pressure alone, which tends to be less durable. Second, campaigns require sustained investment in frontline interpersonal communication capacity, including realistic

workload allocation for community health functionaries, rather than treating interpersonal communication as a residual channel beneath mass media.

Third, greater reliance on participatory and community-led processes — in which communities themselves diagnose local barriers and design locally appropriate solutions — offers a more durable route to behaviour maintenance than nationally uniform messaging, even where the latter is more easily scaled and more visible in the short term. Fourth, monitoring frameworks should measure behaviour rather than infrastructure wherever feasible, since administrative incentives built around infrastructure counts predictably generate reporting distortions. Finally, future campaigns addressing health behaviours in India's diverse regional and tribal contexts would benefit from formative, audience-segmented research prior to message design, rather than the retrofitting of regional adaptation onto an already-finalised national communication architecture.

8. CONCLUSION

The Swachh Bharat Abhiyan represents a landmark in the history of Indian public health communication, both for its scale and for the degree to which it succeeded in making sanitation a matter of mainstream public discourse. Its IEC strategy drew, whether deliberately or intuitively, on established principles of health communication theory, particularly the mobilisation of social modelling and collective shame as triggers for behaviour change. Yet a critical examination of the campaign's communication design reveals a persistent gap between the generation of awareness and the achievement of durable behaviour change, a gap most visible in the well-documented disjuncture between toilet construction figures and consistent toilet use, and most acute in rural and tribal contexts where the campaign's largely uniform national messaging architecture met the greatest resistance. As India's public health agenda increasingly turns toward the more diffuse and long-term objectives implied by the Swachh Bharat framing — reduced disease burden, improved nutrition, and strengthened preventive health practice — the lessons of the SBA's communication experience suggest that future campaigns will require a more participatory, capability-oriented, and locally adapted model of health communication than the one the mission itself principally employed.

References

1. Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behavior*, 31(2), 143–164.
2. Centre for Economic Data and Analysis (CEDA), Ashoka University. (2021). Rural Sanitation: NFHS vs Other Surveys.
3. Chambers, R., & Myers, J. (2016). Norms, knowledge and usage. *Frontiers of CLTS: Innovations and Insights*, Issue 7. Institute of Development Studies.
4. Coffey, D., & Spears, D. (2017). *Where India Goes: Abandoned Toilets, Stunted Development and the Costs of Caste*. HarperCollins India.
5. Gani, A., et al. (2023). Effectiveness of the Swachh Bharat Mission and barriers to ending open defecation in India: a systematic review. *Frontiers in Environmental Science*.
6. International Institute for Population Sciences (IIPS) and ICF. (2021). *National Family Health Survey (NFHS-5), 2019–21: India Report*. Mumbai: IIPS.
7. Ministry of Drinking Water and Sanitation, Government of India. (2019). *Swachh Bharat Mission (Gramin): Guidelines*. New Delhi: Government of India.
8. National Sample Survey Office. (2018). *Drinking Water, Sanitation, Hygiene and Housing Condition in India (NSS 76th Round)*. Ministry of Statistics and Programme Implementation.
9. PRS Legislative Research. (2021). *Seven Years of Swachh Bharat Mission*.
10. Press Information Bureau, Government of India. (2022). *Over 11 Crore Toilets and 2.23 Lakh Community Sanitary Complexes Built across All States/UTs under Swachh Bharat Mission–Grameen*.
11. Rogers, E. M. (2003). *Diffusion of Innovations* (5th ed.). Free Press.
12. UNICEF. (2018). *Communication for Development (C4D): A Framework for Sustainable Behaviour and Social Change*. New York: UNICEF.
13. World Bank. (2020). *Swachh Bharat Mission: Progress and Challenges in Ending Open Defecation in India*. Washington, DC: World Bank Group