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## ROLE OF MEDIA AND NRHM IN IMPROVING THE HEALTH OF RURAL POOR WOMEN: AN ANALYSIS OF IMPLEMENTATION AND COMMUNICATION STRATEGIES IN HYDERABAD KARNATAKA REGION

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### ABSTRACT:

Health is an important indicator of individual's development and wellbeing. Irrespective of enormous investments in the sector, subsidies, and free treatment facilities by both government and NGOs, the health profile of an average Indian shows a poor status of affairs. The best way to improve the health profile is to increase the health awareness accomplished by health communication. The central government had implemented National Rural Health Mission (NRHM) as part of National Health Mission keeping urban poor in view to improve their health condition. The

present study would throw light upon Programme Implementation Plans of NRHM with specific reference to information dissemination and programme promotion strategies. This study grounded on theories such as health belief model, theory of reasoned action, social cognitive and agenda setting. The study aims to analyze the objectives of NRHM and its implementation plans with special reference to communication aspects incorporated in program execution. Research will look into "how communication strategies are made and implemented in NRHM and how does it help in effective implementation?" It is a qualitative research. Data is collected using interview and secondary data analysis. Research found that NRHM has the potential to improve the rural women health in all perspectives. It had contributed to the betterment of infrastructure and better staffing for women. The communication is meticulously planned on paper but the execution lacks at all levels. Communication training would improve the quality of service provided under NRHM and it will accelerate the achievement of NRHM goals.

**KEYWORDS:** NUHM, Rural Poor Women, Health communication, Media, Awareness and Programme.

### I. INTRODUCTION

There has been considerable growth in urbanization in India since last decade. Census 2011 shows that there is increase in urban population with 377 million. As per UN projection if India's urban population grows at this rate then 36% of the

population will be living in rural areas by 2030. Due to rapid urbanization, there is influx in migration, expansion of city boundaries and parallel rise in slum population and urban poverty. Out of 377 million urban population, about 100 million are living in slums facing variety of health problems due to improper sanitation and unhygienic conditions and prone to communicable and non-communicable diseases. Out of

more than 2 million births among Rural population, 56% of the delivery takes place at home. Over 60% of the rural poor children do not receive complete immunization. 47.1% of the urban children are underweight, 59% of the women are anemic, and several other health indicators are poor compared to that of rural population. Health indicators measure different aspects of health. Each indicator is like a piece of a

puzzle contributing to an overall picture. When indicators are tracked over time, they allow us to see how the health of population is changing. This paper provides a broad overview on the incidence and prevalence of common communicable and non-communicable diseases, morbidity & associated mortality, health risks and performance of related national health programmes in the country. The common reasons cited by the officials for poor health condition among urban poor are social exclusion, lack of information and assistance, expensive private health care facilities, perceived unfriendly treatment at government hospitals, non-availability of caretakers, ineffective outreach, and weak referral system, lack of basic health infrastructure etc.

Malaria has been a problem in India for centuries. At one time a rural disease, diversified under the pressure of developments into various ecotypes. These ecotypes have been identified as forest malaria, urban malaria, rural malaria, industrial malaria, border malaria and migration malaria; the latter cutting across boundaries of various epidemiological types. In 2017, maximum number of Malaria cases have been reported in Odisha (3,52,140 cases) and maximum number of deaths have been reported in West Bengal (29 deaths). Dengue and Chikungunya transmitted by Aedes mosquitoes, are a cause of great concern to public health in India. Every year, thousands of individuals are affected and contribute to the burden of health care. Dengue outbreaks have continued since the 1950s but severity of disease has increased in the last two decades. There has been considerable decrease in the number of swine flu cases/ deaths in the year 2014 as compared with 2012 & 2013. However, the number of cases and deaths has been drastically increased in the year 2015. In 2016, the cases have been decreased to 1786 and again increased to 38811 in 2017.

Total number of cases and deaths due to Chicken Pox were 74,035 and 92 respectively in 2017. Kerala has accounted for maximum number of cases (30,941) and West Bengal has accounted for maximum number of Deaths (53) due to Chicken Pox in 2017. Total number of Cases and Deaths due to Encephalitis were 12,485 and 626 in India during 2017 respectively. Assam has reported maximum numbers of Cases (5525) and Odisha has reported maximum number of deaths (246). Total number of Cases and Deaths due to Viral Meningitis were 7,559 and 121 respectively in 2017. Andhra Pradesh accounted for maximum number of Cases (1493) and maximum number of Deaths (33).

After completion of 70 years of independence, our country has witnessed remarkable progress in the health status of its population. However, over the past few decades, there has been major transitions in the country that have serious impact on health. Changes have been seen in economic development, nutritional status, fertility and mortality rates and consequently, the disease profile has changed considerably. Though there have been substantial achievements in controlling communicable diseases, still they contribute significantly to disease burden of the country. Decline in morbidity and mortality from communicable diseases have been accompanied by a gradual shift to, and accelerated rise in the prevalence of, chronic non-communicable diseases (NCDs) such as cardiovascular disease (CVD), diabetes, chronic obstructive pulmonary disease (COPD), cancers, mental health disorders and injuries.

## II. RATIONALE FOR THE STUDY

The extent to which India's health system can provide for this large and growing city based population will determine the country's success in achieving universal health coverage and improved national health indices. During 11th plan the Crude Birth Rate (per 1000) is 19.1, Crude Death Rate (per 1000) is 6.0, IMR (per 1000 live births) is 40.0, Prevalence of Anemia among Children (6 -35 months) is 72.7%, and Prevalence of Anemia among Pregnant Women is 54.6 %.

Recognizing the seriousness of the health problem the government took up urban health as a thrust area in 12th five-year plan. In 2005, the Prime Minister Manmohan Singh launched the National Rural Health Mission (NRHM) to improve the health care among rural population. Later in order to cater to the health needs of the urban poor government made a broad umbrella called National Health Mission (NHM). Government brought NRHM under NHM. NRHM was launched in May 2013 with the objective of meeting the health care needs of the Rural Women population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of

pocket expenses for treatment. NRHM planned to cater to the health needs of urban poor, homeless, rag pickers, rickshaw pullers, street children, sex workers, construction workers, and temporary migrants. The goals of NRHM is to facilitate equitable access to quality health care through a revamped public health system consisting of partnership with NGO's, community based risk pooling and insurance mechanism, active involvement of local urban bodies and synergizing the existing system.

### III. OBJECTIVES

The study aims to analyse the objectives of NRHM and its implementation plans with special reference to communication aspects incorporated in program execution. Research will look into "how communication strategies are made and implemented in NRHM and how does it help in effective implementation?" It will also look into the effectiveness of NRHM in Kalaburagi district of H K Region and its localized implementation strategies. Further study specifically seeks to ;

- 1) To find out the health facilities available under NUHM and use of these facilities
- 2) To know the use of various media in impacting health knowledge and attitude,
- 3) To examine the implementation of communication strategies to involve communities
- 4) To study strengths and lacunae of health information dissemination system under NRHM.

### IV. METHODOLOGY

It is a qualitative research using interview and secondary data analysis techniques. The interview was conducted among state and health department officials who are involved in implementation of NRHM particularly women. A total of 20 officers working for NRHM and doctors were interviewed. The policy documents and PIPs are analyzed for their relevance and to know the strategies particularly for women. The implementation pattern and monitoring system was examined by evaluating organization structure. The previous research findings are referred to know the effectiveness of various media in bringing health awareness and positive influence on health practices in rural area. The documents such as NRHM implementation guidelines, PIP 2014-15 and 2015-16, NRHM framework and quality standards for urban PHCs 2015 formed the basic secondary data for this study.

### V. ANALYSIS AND DISCUSSION

The data compiled through secondary data analysis and interviews are presented in narrative manner. The documents' evaluation was done with specific focus on communication strategies adopted by these agencies. The Programme Implementation Plans of in Hyderabad Karnataka area of Kalaburagi district for the period of 2018 to 2019 were analyzed.

#### A. Health facilities available under NUHM and use of these facilities

National Rural Health Mission (NUHM) aims to improve the health status of the rural poor women, by facilitating equitable access to quality health care through a revamped and reoriented public health delivery system, partnerships with community and with the active involvement of the Rural Local Bodies (RLBs). NRHM covers all the district headquarters and other areas with a population of 5,000 and above in a phased manner. The emphasis will be to improve existing public health delivery system with a thrust on making available adequate women health resources, upgrading the existing health facilities in terms of infrastructure and equipment, and establishing new health facilities wherever necessary by providing specialist care as well as strengthening emergency response systems

The strategy will comprise of strengthening the existing primary healthcare centers, establishing primary health care centers wherever appropriately needed. Further, special outreach camps are conducted by Auxiliary Nurse Midwives (ANM) and Rural-Accredited Social Health Activists to ensure health care delivery at the doorstep. Community participation will be facilitated by the Mahila Arogya Samithis (MAS) which will act as a bridge between the communities and the nearest health facility. The ASHAs will play the role of provider of first contact care and generate community awareness with regard to various health issues, sanitation, and nutrition. Special care is taken to ensure

that MAS would be constituted by drawing people from local population by ensuring adequate representation to the SC, ST and minorities. A comprehensive baseline survey and mapping has been undertaken to gain insight into the dynamics of health needs of existing listed and unlisted household, rural poor women concentration areas and other vulnerable population.

Service delivery infrastructure is developed by establishing Rural Primary Health Centers (R-PHC), referral hospitals. The execution of program plans is done by village program management units. ANMs are assigned to conduct one outreach camp once a month in her area. The health officials have appreciated the facility provisions under NRHM. Due to NRHM implementation, the maternity homes are called as Rural Population Welfare Health Centers. It works as 24 hours maternity centers and provides facilities given under PHCs. It is considered as first referral unit. As specialists care is not affordable by the rural poor women, NRHM had developed the referral system. Big hospitals are linked with specialists care. Panel of specialists is appointed and their service is provided across H K Region. NRHM has made the provision to hire more human resources from appointing ASHAs, ANMs and doctors. It has reduced the burden on existing staff and has improved the quality of service.

### **B. Use of media to influence health knowledge and attitude**

Media bring change and shape social interaction, influencing people's thinking and opinion. They undermine traditional values and bring new values in the system. All over the world, it is observed that individuals and villages that welcomed modern media have more modern attitudes, are more progressive, and moved to modern roles faster than those who didn't (Pool 1996).

The dissemination and utilization of any idea depend not only on the mass media but also on interpersonal communication between people. However, mass media have a tremendous impact on the attitudes, taste, and worldviews of people. Through reading, watching movies, listening to radio, and viewing television, people in the villages and impoverished cities discovered a land of their hearts' desire and came to know different ways of life that were different to their inherited rut (Pool 1996).

In the 1970s, the idea of using television as an instructional/ development medium appealed to both administrators and development experts because of its immense potentials in propagating useful ideas and practices. Singhal and Rogers (1999) points out that entertainment-education programs either directly or indirectly facilitate social change:

- ❖ At the individual level by influencing awareness, attention, and behavior toward a socially desirable objective;
- ❖ At the larger community level of the individual audience member by serving as an agenda setter, or influencing public and policy initiative in a socially desirable direction;

In this approach, educational contents are embedded in entertainment programs in media such as radio, television, records, videos and Folk Theater. Effects tend to be mostly cognitive changes, though some changes have been recorded that require behavior and value shifts.

The research done in Cambodia using survey method concluded that complete immunization had increased 20 percent in one year and sharp reductions in measles are the result of increased educational efforts and different communication channels for community mobilization. In this research BCC activities involved local NGOs and religious leaders along with extensive use of mass media and other interpersonal communication (IPC) tools (Soeung et al., 2007).

The study done during 2004-05 at five districts of Tanzania on acceptance of Malaria vaccine found that 96 percent mothers and their spouse agreed for vaccination post intervention. The BCC material developed using community champions and they were found to be highly effective.

The researcher has used Inter personal communication (IPC) through community health workers, mothers and community own resource persons, branding posters (Mushi, 2008).

A research conducted during 1990-94 in 56 countries marked increase in the vaccination coverage post intervention using different communication channels addressing adverse reaction of



vaccination. It used BCC to improve knowledge through public health intervention, address concerns of people regarding vaccination through mass media and other communication tools (Atkinson, 1994).

A survey research done in Africa by Cutts et al. (1991) used mixed approach of addressing the low motivation level of health worker using BCC material and better planning of vaccination program resulted in coverage of measles vaccine increased from 16 percent in 1983 to 45 percent in 1988. The researches on the role of BCC in the health sector has proved that multiple communication strategies considering all the stakeholders of the health system along with the support of technology would bring in behaviour change. Several studies done in India, Pakistan, USA, Canada and African countries related to immunization efforts have tried BCC with the help of telephonic reminders, post card reminders, automated phone message followed by letters, IEC activities addressing barriers at individual and community level, parents education, mobile vaccination units and computer based telephone client reminders.

Health communication partnership (HCP) programme of USAID had reinforced the notion that successful evidence-based communication programs can influence the public agenda, advocate for policies and programs, promote positive changes in the socio-economic and physical environment, improve the effectiveness of service delivery systems, stimulate debate and dialogue for health, and encourage social norms that benefit health and quality of life. Health communication experiments in India have proved that the localized, need based, relevant health messages framed with the socio-cultural and economic consideration would yield better result.

### **C. The implementation of communication strategies to involve communities**

Under NRHM All the IEC / BCC activities will be planned at Rural Primary Health Centers (Rural-PHC). It is mentioned that IEC and BCC have an important role especially in urban areas where the influence of media and advertising needs to be countered effectively, especially against use of junk food, aerated drinks, tobacco and alcohol consumption, etc. Provision of Rs. 5 per capita for IEC/BCC has been allocated. Since PHCs are present in slums/ underserved areas in addition to the above activities NRHM emphasized on creating awareness about prevention of malnutrition and control of communicable and non communicable diseases in slums. As per NRHM implementation plan information will be provided through Group Inter Personal Communication (IPC) and discussions at the ward level to inform the public about R-PHCs and facilities offered including health and nutrition day observances at the RPHC level to improve immunization compliance, adequate nutritional knowledge and encourage neonatal checkups. According to strategy Awareness programs at ward level for reducing the prevalence of communicable diseases such as Tuberculosis, diarrheal diseases, Vector-borne diseases such as Dengue, Malaria and Chikungunya and other communicable diseases, information is provided through Group IPC and discussions held at the ward level to inform the public. Increased participation of NGOs, local bodies will ensure better prevention and control of these diseases. Awareness program at ward level is focused on reducing unhygienic practices, garbage disposal, waste management and encouragement of good sanitation practices, creating demand for safe drinking water facilities, demand for toilets and their usage. Women are collectively given a platform at area to visit the R-PHC to share their concerns and discuss good health measures.

Mahila Arogya Samithis are engaged in creating awareness on non-communicable diseases through group communication activities. Vulnerable women groups such as vegetable vendors, maid servants, coolies, manual labourers, unorganized labourers, and daily wagers are identified through local NGOs, Mahila Arogya Samithis for awareness programmes. The NRHM programme is supported for developing web based HMIS component. A grant of Rs. 50,000 is allocated per RPHC for procurement of computers and accessories for implementation of NHRMS.

In order to provide primary health care to the population living in clusters and where it is not possible to construct urban Primary Health Centres an existing unused H K Region community building can be declared as a Health Kiosk in Kalabuaragi city. NRHM has IEC Material production provisions on health including personal hygiene, proper nutrition, use of tobacco, diseases, PNDT Act, RT/STI.

#### **D. Strengths and lacunae of health information dissemination system under NRHM**

The IEC officer said "NRHM has introduced the new information dissemination system by establishing Mahila Arogya Samithi. There is provision to train these people to handle emergencies in the community. ASHA will be the chairman of this Samithi. They are provided with Rs.5000 for emergency drug purchase. NRHM has established Rural Health Society. A doctor who is actively involved in programme implementation said, that "the lessons learnt in Polio campaigns are integrated in implementation of NRHM. For the inter departmental coordination the District Task Force, Taluk Task force and Block Level Task Force are constituted to achieve effective reach of programs and cooperation at all levels. These bodies meet once in month to review and plan the implementation".

Interviews with officials revealed that the demands and suggestions for health improvements by civic society are considered at the PHC while preparing and modifying PIPs, SHGs, Red Cross, Charan Seva Samaja, Lions and Rotary are also involved. The Civic bodies meet once every quarter in Kalaburagi District. Through NRHM measures are taken to upgrade the infrastructure. NRHM has added need based infrastructure and provided specialist care. The Outreach and community counseling are made compulsory for its employees. The State health department is taking care of IEC material production and distribution along production of radio jingles and television health programs. Under NRHM, IEC material production provision is provided to districts. Rs. 1.75 lakhs per year is allotted to every PHCs for local planning. Local planning committee, Rogi Kalyana Samithi and Mahila Arogya Samithis are constituted for undertaking publicity. The branding of government health services is done by introducing more attractive colors, designs and codes. Mission Indra Danush programme has been designed to improve the immunization system. This programme is run on the lines of polio programme campaign.

The infrastructural growth is not meeting the approved plan. As per the officers' opinion in 2014-15 Karnataka state received a huge grant of Rs. 1300 crore but it was not utilized. For the current year Rs. 1800 crore is allotted but concerned departments are not able to spend according to plan. However, there are repeated notifications on recruitments and the process has not begun in H K Region. ASHAs are the primary link between the community and the system. They are not well paid and they do not have fixed salary. Through the incentives they earn very meager amount. Therefore, there is discontinuation of work and ASHAs are doing their duty on part-time basis. The training of ASHAs are not conducted on fixed intervals and the discontinuation also poses challenge for training. The retraining and reviews are very essentials for effective communication and motivation, which is not happening in H K Region frequently.

The effective communication skills are not taught to the grassroots workers. The ASHAs are having less education and find it difficult to communicate health messages. Presently the IEC officers take one session of one hour once in 2 days or week to train ASHAs and ANMs. Supportive supervision is lacking in H K Region. Though health awareness and education is key strategy in NRHM it has failed to deliver. The communication training is very essential for health workers at all levels. The health department is focusing more on information dissemination rather than its format and impact. Training and retraining of the workers along with supportive supervision is required to meet the challenges. The electronic media penetration is very high in urban areas, which can be tapped as opportunity.

#### **VI. CONCLUSION**

Research found that health had close connection with the socio-cultural, economic and environmental aspects of the community. The NRHM has improved the infrastructure in urban areas and provided adequate staff. The communication plans are specifically focused on group communication. It has also emphasized the production of printed materials and usage of outdoor advertisements, radio and television to reach the target group. The outreach programmes are planned meticulously and the workers are given responsibilities. The community involvement is encouraged through community based action groups to motivate them to become opinion leaders in the community related to health.

The analysis of previous program evaluation reports and research studies reveal that behavior change communication should incorporate audience centered approach and it should be community specific. Television has greater role to play when the entertainment education programmes are produced and transmitted on health. Programme Implementation Plans have provided budget head for communication and training. ICT is also incorporated for programme monitoring. Substantial funds are provided for the grassroots research and data collection to conduct need assessment studies of the community.

The programme is very strong according to policy. Adequate budget is also provided under NRHM for the betterment of urban health. However, the execution is still far behind even after 2 years of implementation. The NRHM planned to provide multi specialty facilities to the public with preventive health care. The communication training for the health workers is major limitation of the programme. Lack of motivated employees, urban migration, multi lingual nature, reaching the target on their convenience and environment hurdles are major threats for urban health. A good urban community health policy suffers due to bad implementation.

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