Role of Communication for Improving the Health of Rural Women: Analysis and Implementation Strategies Used

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ABSTRACT

This study is an attempt to provide lucid and perhaps comprehensive information on the role of communication for improving the health of rural women. It was planned to focus the study on patrons of women health. We all need a communication plan that improves knowledge and raises awareness of rural women. Government Health programmes is essential to a health screening. Secondly, reaching some of the target women may be challenging due to transportation, low literacy levels, and religious constraints, which present barriers for health behavior in general. The purpose of this study is to understand and map the health communication practices of rural women and assess the current state of women health programme knowledge and attitudes toward the disease, and evaluate potential barriers to screening.

Keywords-- Communication, Women Health, Awareness, Mobilisation, Rural Culture, Rural Society, Marginalization, National Rural Health Mission (NRHM)

I. INTRODUCTION

Health is wealth. Without the good health of the general population, a nation can't well build up in socially and fiscally. Sashi Rani Agrawal, stated that "In the Alma Ata Revelation, embraced by the Universal Conference on primary Health Care in 1978, it is expressed that in any event the accompanying segments ought to be incorporated into primary Health Care”. Only good health can fight against deceased. Hence, India gave most importance to the good health to its peoples in its primary years of independence. Presently, India gave a huge preference in health of the people and opened “Health Section”, Health Education, Nutritional Education, Birth control project etc. Women in the developing World including India generally neglect the health problems and tend to go without medical attention for prolonged period of time. Women face complicated pregnancies and related poor reproductive health, abortion and chronic iron deficiency, which pre-dispose them to the need for blood transfusion. In India, Women’s are neglected regarding their health in respect to men. Kiran Prasad, "Women in the developing world including India generally neglect health issues and have a tendency to abandon therapeutic consideration for delayed timeframe. Women confront entangled pregnancies and related poor conceptive health, fetus removal and endless iron lack, which incline them to the requirement for blood transfusion. Therefore, a communication plan that improves knowledge and raises awareness of rural women, health programmes are essential to a health screening program. Secondly, reaching some of the target women may be challenging due to transportation, low literacy levels, and religious constraints, which present barriers for health behavior in general.

II. RATIONALE OF THE STUDY

India, the seventh largest country of the world is inhabited by 16 percent of the world’s population. India, which is inhabited by almost 121crores of people and among which female population was 586.5 million and male population was 623.7 million. In this context the extent to which India’s health system can provide for this large and growing rural based population will determine the country’s success in achieving universal health coverage and improved national health indices. Recognizing the seriousness of the health problem the government took up rural health as a thrust area.

The purpose of this study is to understand and map the health communication practices of rural women, assess the current state of women health screening knowledge and attitudes toward the disease, and evaluate potential barriers to screening. Thus, the researcher must look at the specific communication practices to find fundamental health narratives from different participants. A second contribution of this study is the application of Communication for women health to the Indian context, which allows researchers to evaluate the personal networks, local resources, geographic constraints, and
media outlets that impact information dissemination and behavioral changes in low-resource countries.

III. REVIEW OF LITERATURE

Megan A. Prilutski (2010) stated that there has been a couple of studies conducted trying to discover the best communication channels to reach Ghanaians. In the study on the implementation of a vitamin regimen in a Ghanaian village, a huge result of the research was the determination of the best manner to communicate with rural Ghanaians. In addition, “town criers, radio, posters, church, mosque and market announcements, loudspeaker vans and a song” were more popular and effective channels of health communication than community groups, television, movies, videos, healthcare personnel, billboards, newspapers and schools.

Nandita Kapadia-Kundu, Tara M. Sullivan (2012) Stated that India’s information technology sector is developing rapidly and expanding to access information, though health personnel in India still lack relevant and actionable information. In the face of the health challenges in India, health care provider’s need relevant and actionable information. In 2005, India launched the National Rural Health Mission (NRHM) nationwide to improve the health system in rural areas, where 72% of the population resides. India has a large number of health care workers at the village, block, district, and state levels. In such a large organization, the flow of formal and informal information plays a keyhole in informed decision making and coordination throughout the health system.

Margaret D’Adamo a, Madeleine Short Fabric (2012) stated that internet access is reportedly much more available and reliable at the national level than at the district and community levels in all of the countries surveyed. Mobile phone ownership, in contrast, is the norm even at the community level. Community-based health workers in many of the study areas already use low-cost mobile phones to share and exchange essential information, such as reports of emergencies and contraceptive stock outs. Although data from the assessments show that well-established oral communication channels such as meetings are preferred by many health workers, information tends to degrade, it further moves from the source. Researchers think that efforts to strengthen knowledge exchange should equip such intermediaries with the tools, training and support that will enable them to better support sharing of relevant and evidence-based information and knowledge across the health system.

Rukhsana Ahmed and Benjamin R. Bates (2013) in his book “In today’s Media Saturated Environment” and within a global context of bioterrorism, infectious disease threats, and natural disasters, traditional one-way delivery of messages from a central source can be usefully complemented by more interactive platforms that allow people to engage with health issues, help them find acceptable and appropriate solutions to health problems, and encourage them to play a central role in self-care. The second part of this book is concerned with integration of theory and application of health communication in the online media context. The third part of this book deals with integration of theory and application of health communication in mobile media contexts.

Vinalini Mathrani (2011) in his thesis conducted a study in Karnataka, on Women Health in 2011 for this research work; the researcher said that this section provides an overview of Boohalli village. Boohalli is located at a distance of 70 km from Bangalore. The Primary Health Centre (PHC) at Sathnur is 5km from Boohalli. There is a tarred access road to these destinations but it is of poor quality and sometimes it becomes unusable in the monsoons. Women’s health status is closely associated with their social status; it reflects their self-worth and their social, economic and political value in the community to which they belong. The consequences of women’s unfavorable status include discrimination in the allocation of household resources, such as food and access to health care. This study reveals that the social network has a key role to play enabling women to secure health care despite multiple barriers.

Megan A. Prilutski (2010) stated that there has been a couple of studies conducted trying to discover the best communication channels to reach Ghanaians. In the study of the implementation of a vitamin regimen in a Ghanaian village, a huge result of the research was the determination of the best manner to communicate with rural Ghanaians. Overall Kit was determined that radio is the best way to communicate because, although many Ghanaians do not personally own a radio, most have access to one. In addition, “town criers, church, mosque and market announcements, loudspeaker vans and a song” were more popular and effective channels of health communication than community groups, television, movies, videos, healthcare personnel, billboards, newspapers and schools.

IV. OBJECTIVE OF THE STUDY

The study aims to analyse the objectives of women health 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 improving women health and how does communication help in effective implementation. It will also look into the effectiveness of communication for women health in Rural Society of West Bengal and its localized implementation strategies.

1. To find out the health facilities available under NRHM and use of these facilities.
2. To evaluate the impact and the effective reach of various communication in rural society.
3. To know the use of various media in impacting health knowledge and attitude.
4. To examine the implementation of communication strategies to involve communities.

V. THEORETICAL FRAMEWORK

Denis McQuail (1983) propounded the Democratic Participant Theory. McQuail summarized the main features of the theory: Media should subsist principally for the audience, not for the media organizations or their clients. Individually the society and the marginal groups have the right to access the media and how the media will serve the society that is determined by the society according to their own need and want. The state bureaucratic and the political leaders should not control the content of the media and the media as an organization. Media which is controlled by the people themselves is expected to work without any political or bureaucratic pressure. Different forms of media like Small-scale, interactive and participative media are better than large-scale, professional media. The concept of narrowcasting also intensely opposes the commercialization of mass media. With the help of the ‘right to communicate’ and by democratic individual participation the empowerment issues of the marginalized rural women can obtain sustainable development.

The Development Communication Theory, specifically, discuss about the habit of scientific application of strategies and doctrines of communication to establish a positive notion of social change. In the ‘Development Communication Theory’, media has taken the role of bringing forth positive and developmental programmes for the state and accepting restrictions and receiving instructions from state. It is an undisputed fact that there can be no foundation of Empowerment without communication and this concept provides the basis for the Development Communication Theory. Communication for empowerment, as it is called, means the press has taken the responsibility of bringing out constructive empowerment programmes, accepting limitations and directives from the state. Communication can become the best tool for empowerment as it is an effective medium.

According to Health Belief Model individual health behavior is determined by the individual belief system including perceived susceptibility, perceived severity, perceived benefit, perceived self-efficacy and perceived barriers with cues to action. Gender, age, ethnicity, personality, socioeconomic and knowledge are the modifying factors. The Theory of Reasoned Action (TRA) and the Theory of Planned Behavior (TPB) focus on theoretical constructs concerned with individual motivational factors as determinants of the likelihood of performing a specific behavior. It assumes the best predictor of a behavior is behavioral intention, which in turn is determined by attitude toward the behavior and social normative perceptions regarding it. The Social Cognitive theory emphasizes reciprocal determinism in the interaction between people and their environments. SCT post it’s that human behavior is the product of the dynamic interplay of personal, behavioral, and environmental influences. This statement emphasizes the significance of non-medical interventions. Therefore, health is one of the prime research areas for social scientists. The focus of the present research is to find out the existing state of communication strategy usage in NUHM and its significance in effective implementation of NUHM.

Research Methodology: This paper is basically descriptive and analytical in nature. The main focus of this study is to find out how Communication for Improving the Health of Marginalized Rural Women in West Bengal.
Research method: This study uses conjoining both qualitative and quantitative methods. The qualitative methods used were adopted among the Marginalized Rural Women to find out the pattern of communication and how it could be improved.
Methods of data collection: Methods play a major role in every research. The study used primary and secondary source for data collection.

Primary Source: The primary data are collected through two methods viz interview and observation. Information was collected through interviews of the beneficiaries are conducted through an interview schedule.

Secondary Source: Secondary data was collected from books, journals, periodicals, articles and Past Study records and web-based materials and internet. And other published sources of the State Government, Central Government and International Organization.

The Universe: The study was conducted in two districts of West Bengal. The districts were so selected that they were representative of the state of West Bengal.

Selection of sampling: The primary data for the study have been collected through a multi stage stratified random sampling method.

Selection of District: In the first stage, in twenty district of West Bengal namely Burdwan, Hooghly, have been selected purposively to cover the entire Burdwan Division. The study conducted in two district of West Bengal has been purposively selected for the present study.

Selection of Blocks: In the second stage, two blocks from each district has been selected randomly. From each district four blocks were randomly selected. From each district two blocks were randomly selected. Out of two districts, four blocks i.e. four blocks from each district has been chosen randomly.

Selection of Villages: In the third stage from each block 2 villages have been selected randomly. Two villages from each block i.e. 8 villages in all were selected. Apart from logistical advantages, two criteria have been used to
influence choice: 1) Large percentage of poor in the population of the village. (2) Majority of the SC, ST population live in the village.

Selection of Household's: In the fourth stage, the list of households of eight selected villages has been collected and eventually 5 percent of the households of these villages suitable to different size, classes have been selected randomly. From each village 80 respondents in total 640 households have been selected as sample unit of this study.

Sample Size: The total sample was taken out of the eight villages, and from there 80 women were randomly selected for the present study. The sample was designed to have a total of 640 respondents. All women respondents were marginalized rural women.

VI. DATA PRESENTATION, ANALYSIS AND INTERPRETATION

Under this section, I tried to analyse the health activity and awareness, communication habits and exposure of respondents to mass media. For this purpose five communication media namely, print media, Broadcast media, Multimedia, Human and Government Organizational Communication are taken into consideration. The women health seeking habits and exposure and communication pattern of the respondents has been analyzed as below.

Source: Data collected through Field Survey
A perusal of table 1 indicates the place of health checkup among the respondent. 28.75% people knows about Public Health Centre, 19.37% knows about Private Health Centre, 21.87% knows about private practitioner, 5% knows about Asha foundation and 35% knows about Anganwaadi in rural areas of Burdwan-1 Blocks district. The table shows that knowledge about Anganwaadi is maximum (36.09%) in all these four Blocks. No respondent from Monteswar Blocks knows about Asha foundation. After Anganwaadi maximum respondents (26.87%) go for Public health centers and then they (20.78%) go for Private Practitioners. 10.15% of total respondents from these four Blocks go for private health centers.

The table 2 clearly indicates that 73.43% of total respondents from these Blocks are aware about NRHM program. Monteswar the majority percentage of respondents (77.50%) in this case. 20.93% of total respondents from these four Blocks have no awareness about NRHM programmes. 0% from Monteswar, 8.75% from Burdwan-1, 7.50% from Chinsura Blocks has said nothing about NRHM programmes and in total it is 5.62%. A perusal of table 3 indicates the most of the respondents (85.46%) are aware about ASHA workers. 86.25% knows about ASHA, 8.75% don’t know about ASHA and 5% are not sure about ASHA in the rural areas of Burdwan Blocks. In Chinsurah Blocks 84.37% knows about ASHA, 9.37% does not have any idea about ASHA and 12.5% are not sure. Monteswar Blocks has maximum number of respondents (88.75%) who knows about Asha workers followed by Chinsurah Blocks (82.50%). 12.5% from Arambagh Block 7.50% from Chinsura Blocks and 3.75% from Monteswar Blocks are not sure about Asha workers.

The table 4 evidently shows that 90.31% respondents from these four districts know about I. C.D.S. workers. Very low percentage of respondents, that is 5.93%, has no idea about I.C.D.S workers whereas 3.75% of respondents have not commented on this. Among all the districts Monteswar Blocks (91.87%) and Burdwan -1 (91.87%) scores highest about knowing about I. C.D.S. workers and Chinsurah Blocks scores highest between four about not knowing about I. C.D.S. workers.

### Table 5

#### Availability of communication media in the villages

| Source: Data collected through Field Survey |

Table 5 shows that television plays a major role in communication among the rural women, in an average 82.18% of the respondents said that television has become one of the important parts in their daily life. Despite radio being the cheapest medium for the rural communities, only 7.18% of the respondents from these districts access the radio. 25.78% of the respondents have access to the newspapers and only 0.5% houses buy English newspapers and the rest prefer the regional dailies. 5.93% of the respondents who were college students have access to the Internet only in their educational institutions. Only 2.34% of respondents buy magazines. 66.25% of respondents have mobile for their personal use in the rural areas of these Blocks.
VII. DISCUSSION

This research, therefore, aimed at understanding the state of health communication practices in rural India, evaluating women health screening knowledge, and examining influencing factors toward screening using Communication. Our results indicate that, in areas where the collaborative led screenings, women were aware of the disease and those screened knew about it. In the areas where the collaborative had not fielded, women had no knowledge of women health or its screening. Therefore, it seems that communicating the need for screening in the local language, with clear terms, and by somebody local suffices for most women to understand the problem. To spread these critical messages about women health screening, community radio and health talks, combined with the dissemination of information through interpersonal networks, were found to be the most effective routes. Scholars working with health communication needs express the urgency to involve ethnic or local stakeholders in the community radio and community organizations. In turn, when residents are strongly connected to each other and to these local entities, knowledge about health issues travels faster and reaches more individuals. Our results suggest that those connections exist and should be promoted in prospective women health screening campaigns. In areas where residents are even harder to reach, for instance in villages where they remain isolated for part of the year due to road disrepair. In rural India, health talks have a strong potential and have been used successfully to inform and discuss health issues. Specifically, we found four ways First, community radio can be critical to announce upcoming health talks in the area. Community radio broadcasts in the many local languages, is listened to by virtually anyone, and offers the opportunity to deliver messages timely. Second, community radio is also used for interpersonal communication. The community hour offers the chance for residents to connect with friends or family that live far enough not to be reached face-to-face. Third, health talks deliver accurate, trustworthy information that can then circulate in the micro storytelling network. Finally, interpersonal networks connect residents at the micro-level that may have not heard the message in the community radio or health talk. The synergy and dynamism of these levels create a wide web that allows messages to disseminate relatively fast.

At the macro-level, opportunities are more challenging. We are not aware of any organization trying to demand stronger press freedom for the mass media, but they may exist. Even if improved, the mass media still present challenges: (1) the main language of mass media broadcasts are elitist Bengali, which the rural villagers do not understand; (2) not everyone can afford a television or to buy daily newspapers; (3) one still needs to have access to and afford electricity to watch TV since electricity does not reach the entire nation, nor does it provide service 24/7; finally, (4) newspapers require literacy, and only about 46% of the population can read and write. Given these constraints, the meso-level is better suited to disseminate mass information.

VIII. RECOMMENDATIONS FOR IMPROVING WOMEN HEALTH

The bulk of this study is concerned with understanding and mapping the health communication infrastructure in rural India. We have emphasized this aspect, rather than message design to persuade women of child bearing age, because without an understanding of the communication infrastructure, messages may never reach their intended audience. Thus, taking on the task to craft tailored messages ought to happen after we know how women communicate about health, how we can reach them in rural areas, and how we can communicate the concept of cervical cancer and its screening to a population that lacks the vocabulary to grasp the concept.

IX. CONCLUSION

Research found that health had close connection with the socio-cultural, economic and environmental aspects of the rural women community. The NRHM has improved the infrastructure in rural 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. Programmes Implementation Plans have provided budget head for communication and training. ICT is also incorporated for programmes monitoring. Substantial funds are provided for the grassroots research. The programmes are very strong according to policy. Adequate budget is also provided under NRHM for the betterment of rural women health. The NUHM planned to provide multi-speciality facilities to the public with preventive health care. The communication training for the health workers is major limitation of the programmes. Lack of motivated employees, reaching the target on their convenience and environment hurdles are major threats for rural health. A
good rural community health policy suffers due to bad implementation.

**REFERENCES**