Role of NUHM in Improving the Health of Urban Poor: Analysis of Implementation and Communication Strategies Used

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Abstract

Health is an important indicator of individual's development and well-being. 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 surest way to improve the health profile is to increase the health awareness accomplished by health communication. The central government had implemented National Urban Health Mission (NUHM) 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 NUHM 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 NUHM 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 NUHM 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 NUHM has the potential to improve the urban health in all perspectives. It had contributed to the betterment of infrastructure and better staffing. The communication is meticulously planned on paper but the execution lacks at all levels. Communication training would improve the quality of service provided under NUHM and it will accelerate the achievement of NUHM goals.

Keywords: NUHM, Urban Poor, Health communication, Awareness, Programme Implementation Plans.

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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 46% of the population will be living in urban 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 urban population, 56% of the delivery takes place at home. Over 60% of the urban 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. 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.

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 and National Urban Health Mission (NUHM) under NHM. NUHM was launched in May 2013 with the objective of meeting the health care needs of the urban 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. NUHM 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 NUHM 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.

LITERATURE REVIEW

Provision of good health care to the people is an essential component of the health strategy adopted by the state. The public expenditure of health is about 0.9 percent of GSDP during 11th plan period. The 12th Five Year Plan (2012-17) is aimed at controlling population and reducing infant and maternal mortality through strengthening health services. Karnataka has performed relatively better in population control with total fertility rate 1.9 by reaching 12th Five Year Plan target in 2013 itself. Infant mortality rate is reduced to 32 per 1000 live births in 2013 from about 50 in 2004 (SRS, 20014). Karnataka has more than one-third of its women (35.5%) with Body Mass Index (BMI) less than 18.5 kg/m2, indicating high prevalence of nutritional deficiency. There is also high prevalence of anemia among women (51.5%) and children (70%) (DLHS-4, 2014).

Gochman (1997) defined health behavior as "those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including effective and emotional states and traits; and overt behaviour patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement".

Socioeconomic status has been linked with both health status and health behaviour, with less affluent persons consistently experiencing higher morbidity and mortality (Berkman & Kawachi, 2000). The study done on effectiveness of behaviour change communication (BCC) for increasing immunization coverage by Nair & Nair (2012) concluded that use of BCC as an effective strategy for scaling up coverage of immunization is successful. Communication messages and tools for different interpersonal and mass media communication channels are carefully planned for BCC, designed and pretested based on the local situations through appropriate audience segmentation (Pencheon et. al., 2005). 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.

The programme based on adolescent health titled 'I need to know', has been successful in Nigeria in bridging the gap between parent and child, while encouraging open dialogue on adolescent sexual health issues as well as encouraging policy makers to provide adolescents access to information and youth friendly services.

A radio talk show 'Window of Love' was used in Vietnam to educate adolescents on sensitive aspects of reproductive health. It was popular among adolescents than other programmes. Health communication programs in developing countries often face great barriers due to the target audience's lower levels of education, restricted individual agency, immediate concerns that take precedence over health, and resource constraints at the individual and community levels.

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. In health communication, messages affect attitudes only when people understand, process, and remember them (Krauss & Fussell, 1996) and feel motivated to apply them in their everyday life. Knowledge and attitude change are also influenced by the way information is presented. Establishing open and trusting communication is often the first step in creating a receptive environment in which information can be perceived as reliable and worthy of consideration. All successful communications and interactions usually require a reasonably good understanding of the other person's point of view (Brown, 1965).

Interpersonal behaviour and communications are highly influenced by cultural, social, age, and gender related aspects, as well as literacy levels and individual factors and attitudes. 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 results. It is also revealed that health communication should incorporate the audience centric treatment for the messages. Human values, aspirations and economic and social background, environment essentially influences the reception and interpretation of health messages.

Polio Communication campaign design identified the need for developing separate communication strategies by considering social reasons for the refusal of vaccination at different levels. As it is mentioned in Polio Communication Quarterly of WHO (2011) "Despite meeting a milestone, work may still remain to meet the needs of the country specific context; classification of risk has therefore been determined using both a quantitative as well as a qualitative lens."

THEORETICAL FRAMEWORK

According to Health Belief Model individual health behaviour 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, socioeconomics and knowledge are the modifying factors.

The Theory of Reasoned Action (TRA) and the Theory of Planned Behaviour (TPB) focus on theoretical constructs concerned with individual motivational factors as determinants of the likelihood of performing a specific behaviour. It assumes the best predictor of a behaviour is behavioural intention, which in turn is determined by attitude toward the behaviour and social normative perceptions regarding it.

The Social Cognitive theory emphasizes reciprocal determinism in the interaction between people and their environments. SCT posits that human behaviour is the product of the dynamic interplay of personal, behavioural, and environmental influences.

Sir Douglas Black from London said "The main determinants of health and diseases lie outside the realm of direct medical competency". This statement emphasizes the significance of nonmedical 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 .

OBJECTIVES

The study aims to analyse the objectives of NUHM 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 NUHM and how does it help in effective implementation?" It will also look into the effectiveness of NUHM in Bangalore city and its localized implementation strategies. Further study specifically seeks to ;

1. find out the health facilities available under NUHM and use of these facilities
2. know the use of various media in impacting health knowledge and attitude,
3. examine the implementation of communication strategies to involve communities
4. assess the program implementation plans (PIP),

5. study strengths and lacunae of health information dissemination system under NUHM.

METHODOLOGY

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

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 Bangalore City for the period of 2014 to 2016 were analysed.

Challenges of Urbanization

Urbanization has posed many challenges due to migration, leading to increased growth of slums that lack infrastructure, basic amenities like safe drinking water, sanitation, housing etc, increasing the risk of both communicable and non-communicable diseases etc. The challenges of urban health exist in terms of administrative issues, policy issues, operational issues, and large size of the population. The possible solutions can be ensuring adequate and reliable health related data, inter-sectoral co-ordination, sharing

of successful experiences and best practice models, reducing the financial burden of health care through improved financing techniques, strengthening public private partnerships and strengthening public health care facilities. Migration among urban poor resulted in overcrowding, unhygienic living condition, illiteracy, communicable diseases, life style modification, non-communicable diseases, crimes, stress and mental illness etc. The key elements of health among urban poor are marriage and fertility, maternal health, child survival, family planning, environmental conditions, infectious diseases and access to health care. The NUHM is one of the flagship programmes of Central government to address urban health challenges. The ground realities illustrate that comprehensive health policy and programmes are required to address these challenges.

Health facilities available under NUHM and use of these facilities

National Urban Health Mission (NUHM) aims to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections, 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 Urban Local Bodies (ULBs). NUHM covers all the district headquarters and other cities/towns with a population of 50,000 and above in a phased manner. The emphasis will be to improve existing public health delivery system with a thrust on making available adequate health human 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 health care centers, establishing new primary health care centers wherever appropriately needed. Further, special outreach camps are conducted by Auxiliary Nurse Midwives (ANM) and Urban-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 U-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 slum pockets, urban poor concentration areas and other vulnerable population.

Service delivery infrastructure is developed by establishing Urban Primary Health Centers (U-PHC), mobile PHCs, referral hospitals. The execution of program plans is done by city program management units and zonal 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 NUHM. Due to NUHM implementation, the maternity homes are called as Urban 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 urban poor, NUHM had developed the referral system. Big hospitals are linked with specialists care. Panel of specialists is appointed and their service is provided across Bangalore city. NUHM 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.

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.

The implementation of communication strategies to involve communities

Under NUHM All the IEC / BCC activities will be planned at Urban Primary Health Centers (Urban-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 NUHM emphasized on creating awareness about prevention of malnutrition and control of communicable and non communicable diseases in slums. As per NUHM implementation plan information will be provided through Group Inter Personal Communication (IPC) and discussions at the ward level to inform the public about U-PHCs and facilities offered including health and nutrition day observances at the UPHC 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, Slum Associations and 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. Girls are collectively given a platform at slum level to visit the U-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 groups such as auto drivers, vegetable vendors, guards/security personnel, maid servants, coolies, manual labourers, unorganized labourers, and daily wagers are identified through local NGOs, *Mahila Arogya Samithis* for awareness programmes. The NUHM programme is supported for developing web based HMIS component. A grant of Rs. 50,000 is allocated per UPHC

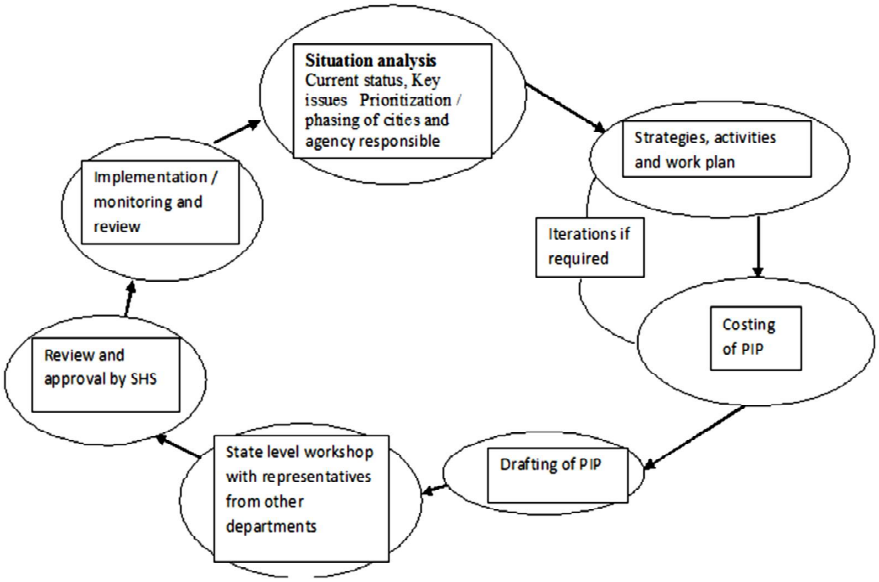
for procurement of computers and accessories for implementation of HMIS.

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 BBMP community building can be declared as a Health Kiosk in Bangalore city. There are 35 such kiosks in Bangalore. Under the NUHM, provision of Mobile Medical Unit (MMU) is one of the strategies to improve access. NUHM has IEC Material production provisions on health including personal hygiene, proper nutrition, use of tobacco, diseases, PNDT Act, RT/STI and HIV/AIDS.

Assessment of the Programme Implementation Plans

Overall operationalzing of the scheme is the responsibility of the District Collector/District Magistrate who is the chairperson of the District Health Society. States/UTs need to prepare City Health Plans (CHP) for the identified cities/ towns. The CHP would consist of a situation analysis, key issues, strategies (including identification of facilities to be upgraded / location of new facilities, PPPs/ innovations, etc.), activities, work plan, program management arrangements including monitoring indicators/ results frame work and proposed budget.

Figure 1-Program implementation plan preparation process



State need to constitute a planning team including representatives from other departments, in particular Urban Development Department / Directorate of Municipal Affairs/ Slum Board, etc. The State NUHM Plan needs to be presented and approved by the State Health Society prior to submission to Ministry of Health and Family Welfare. The interview with officers revealed that the meticulous planning and target group's involvement had made the PIP more target oriented. Need assessment is done with bottom up approach. There is relaxation in the PIP to adopt to local needs. Supplementary PIP can be made in September of every year. PIP has specific budgetary allocation for implementation. PIP has provided budget for data gathering, mapping, human resources, mobility support, office expenses, orientation of urban local bodies, training of ANM/paramedical staff, training of medical officers, orientation of specialists, constitution and training of MAS, selection and training of ASHA, strengthening of health services, drug procurement, outreach services/camps, renovation of upgradation of existing facilities, operating cost, school health programme, ASHA intensive, baseline/end line survey, research studies in urban public, and IT based monitoring initiatives etc.

Strengths and lacunae of health information dissemination system under NUHM

The IEC officer said "NUHM 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. NUHM has established City Health Society. A doctor who is actively involved in programme implementation said, that "the lessons learnt in Polio campaigns are integrated in implementation of NUHM. 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 Bangalore. Through NUHM measures are taken to upgrade the infrastructure. NUHM 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 NUHM, 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, disigns 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.

NUHM expects to decrease the disease prevalence in urban areas, more institutional deliveries, positive health behavior change etc. But the implementation limitations are still curtailing the objectives of NUHM. The plans and policies are well worked and prepared. However, the result is not so glossy.

The infrastructural growth in 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 BBMP. 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 BBMP frequently. Hospital employees' behavior with patients matters a lot for continuation of service utilization, but such trainings are not provided.

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 Bangalore. Though health awareness and education is key strategy in NUHM it has failed to deliver.

The urban poor's priority is to earn rather to attend outreach programmes. It is major challenge for the workers to reach those people according to their convenience. The multi lingual set up has become major barrier in communication. Urban slums are cosmopolitan in nature, which requires specific plans. There is lack of *Anganawadi* centers, day care centers that is not included in NUHM. Unhygienic conditions, unclean water, and shifting of people due to rapid urbanization are the other challenges.

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.

CONCLUSION

Research found that health had close connection with the socio-cultural, economic and environmental aspects of the community. The NUHM 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 NUHM for the betterment of urban health. However, the execution is still far behind even after 2 years of implementation. The NUHM 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.

REFERENCES

1. Atkinson S.J. (1994). Immunization in urban areas: Issues and strategies. In. *WHO Bulletin* No. 72. Pp.183-194.
2. Berkman, L. F. & Kawachi, I. (2000). *Social epidemiology*. New York: Oxford University Press.
3. Brown, R. (1965). *Social psychology*. New York: The Free Press.
4. Cutts F.T. (1991). Strategies to improve immunization services in urban Africa. In. *Bulletin of WHO.* Vol. 69: 407-414.
5. DLHS-4. (2014). Anaemia Status by Haemoglobin Level (%). Open Government Data Platform India. Available at https://data.gov.in/catalog/district-level-household-and-facility-survey-dlhs-4. Accessed on October 20th 2016.
6. Gochman, D. S. (1997). Health behaviour research: Definitions and diversity.

In. D. S. Gochman (ed.), *Handbook of health behaviour research: Personal and social determinants*. Vol. 1.New York: Plenum Press.

7. Krauss, R. M. & Fussell, S. R. (1996). Social psychological models of interpersonal communication. In. E. T. Higgins & A. Kruglanski (Ed.), *Social psychology: A handbook of basic principles* (pp. 655-701). New York: Guilford.
8. Mushi, A. K. et al. (2008). Development of behavior change communication strategy for a vaccination-linked malaria control tool in Southern Tanzania. *International Malaria journal.* Pp. 191.
9. Nair, S.S. & Nair, R. (2012). Is Behavior change communication an effective strategy for increasing immunization coverage? In. *Advance Tropical Medicine and Public Health International*. 2(2), 40 - 60.
10. Pencheon D. et al. (2005). *Oxford handbook of public health*. Oxford University Press, U.K.
11. Pool, S.I. (1966). *Communication and development*. Basic Book Inc.
12. Roger,M.E. & Sighal, A. (1999). *India's Communication revolution: From Bullock carts to cyber marts*. Sage publication. New Delhi, India.
13. Soeung S, et al. (2007). Developments in immunization planning in Cambodia-rethinking the culture and organization of national program planning. *Rural and remote health Journal*. http://www.rrh.org.au. Accessed on September 18th 2016.

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