Family Welfare Program in Rajasthan: Present Marketing State and Problems

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Abstract: - **The Indian Government is indulging with the welfare, social Justice and empowerment of each segment of the society. Basic purpose of the policies, programmes, law and institution of the Indian welfare system is to bring the target groups into the mainstream of growth development by making them self-reliant and independent. Indian family welfare program is a centrally sponsored scheme, implemented by the State governments within the framework of detailed guidelines and norms developed by the Central Government. Marketing is the process of communicating the values of a service to potential customers. Due to ineffective approach of marketing public services are often slow to respond to users' demands about what services should be available, about when and where they should be provided, and about what standards of staff behavior, information provision, accommodation and service outcomes are acceptable to the public. Social Marketing is considered the marketing practice dealing with social problems and potential solutions in the commercial sphere. Those works that do so are frequently quite uncritical of existing marketing practice, tending to assume that public services should be promoted as commercial marketing practice rather than to communicate it.**

Therefore, it is a sincere attempt to explore and to focus the present state of marketing of family welfare programmes in Rajasthan and hurdles faced by the health functionaries and health workers in the provision of health and family welfare services in Rajasthan.

Key Words: **Marketing-Service Marketing-Social Marketing-Family Welfare Program(FWP)-Marketing of FWP-Problems**

I. INTRODUCTION

The marketing refers that transforming the information of public welfare and to circulate the plans and policies through various welfare schemes for social cause. The government has launched various schemes and plans for up-gradation of welfare structure, with objective to provide the social benefits without aiming to earn from it. As Government serves towards the society with the aim of welfare therefore in broader sense, all those activities to inform the actual beneficiaries about these programmes covered under the social marketing. Social marketing is the systematic application of marketing, along with other concepts and techniques, to achieve specific behavioral goals for a social good¨ **Services** are activities, benefits or satisfaction. Services can be defined as action(s) of organization(s) that maintains and improves the well-being and functioning of people. The perception of services marketing gives emphasis on selling the services in the best interest of users. It is concerned with scientific and well planned management of services which makes possible a fine fusion of providers and users interests.

Social marketing, as the concept evolved, acquired two different dimensions (Luck 19741)[1] in one dimension of it related to social responsibilities of marketers mainly in response to consumer advocacy movement and also the pressure of government regulations. It was "born" as a discipline in the 1970s, when Philip Kotler and Gerald Zaltman realized that the same marketing principles that were being used to sell products to consumers could be used to "sell" ideas, attitudes and behaviors.[2] *Kotler and Andreasen* defined social marketing as "differing from other areas of marketing only with respect to the objectives of the marketer and his or her organization. Social marketing seeks to influence social behaviors not to benefit the marketer, but to benefit the target audience and the general society." In other words, social marketing is nothing but adaption of the methodology of marketing to social imperatives with the objective of achieving social change. Social marketing needs not to perceived and rewards are not seen. This technique has been used extensively in international health programs, especially for contraceptives and oral rehydration therapy (ORT), and is being used with more frequency in the United States for such diverse topics as drug abuse, heart disease and organ donation. It has persuasion to make providers and influencers learn, adapt and change.

Indian family welfare program is a centrally sponsored scheme, implemented by the State governments within the framework of elaborate guidelines and norms developed by the Central Government. Public sector bodies can use standard marketing approaches to improve the promotion of their relevant services and social aims. This can be very important but should not be confused with social marketing where the focus is on achieving specific behavioral goals with specific audiences in relation to topics relevant to social good. Although each State is encouraged to introduce innovative approaches within these policy parameters, in practice, the family welfare program in the country has been macro in approach, sectoral in coverage, and highly centered. It has, therefore, failed to achieve the desired results. The strategy adopted so far has created a wide gap between the provider and the client, and the lack of involvement of people has led to the failure of the program. Thus, there is a growing concern among policy makers and implementers that the

centralized standardized nature of the scheme gives local program managers insufficient flexibility to meet varying local needs. This one dimensional focus on awareness creation for leading programmes and policies with excessive emphasis on 'information transmission'. The knowledge-behavior gap had shown that higher awareness does not always result in behavioral change. At the outset it must be stated that 'family welfare' has not been accepted in its true spirit as the entire effort of the concerned department was primarily family planning. Other concerns like child immunization, ante-natal care, abortions, deliveries, post-natal care etc are only marginal; occasional spurts of activity like universal immunization using a mission approach did change things temporarily but as routine set in, it could not be sustained and has again been marginalized.

II. FAMILY WELFARE PROGRAM IN RAJASTHAN

There are long-term causes underlying the poor performance of the family welfare promegram in the country, some of which are structural in nature. The family welfare programme is a centralized program with all major decisions percolating downward from the top with little or no participation of the people for whom the program is meant. Therefore, the willingness and commitment of people has not been harnessed. Besides, an area specific approach and marketing strategies have not been adopted, in spite of the fact that in a continental country like ours where wide variations exist in term of population density, degree of development, socio-economic conditions, topography, expectations of the masses, etc. targets are set and guidelines to achieve these are given by the center. The major family welfare programmes run by Government of Rajasthan are-

1) Reproductive and Child Health (RCH) - The overall goal of RCH programme is to reduce infant and maternal morbidity and mortality in the state. These goals will be achieved through improvement in quality, enhancing accessibility and availability, and coverage with the reproductive and child health services, including family welfare. The programme emphasizes empowerment of women and communities for enhancing health service utilization to achieve reproductive goals and population stabilization.

2) Immunization - Complete immunization of a child is an important step towards the good health status of the child, hence Immunization has been kept as a major strategy. The complete Immunization in Rajasthan is poor as reported from independent surveys.

3) Disease Control Programmes - The National Disease Control Programmes are being implemented in state under NRHM with a view to achieve the MDG goals to halt the spread of major diseases and reverse the trend by 2015 so as to reduce the mortality and morbidity and increase life expectancy and quality of life. The NDCP encompasses: Revised National TB Control Programme (RNTCP), National Vector Borne Disease Control Programme (NVBDCP), and National Programme for control of Blindness (NPCB), The National Leprosy Eradication Programme (NLEP), Integrated Disease Surveillance Programme (IDSP), and Iodine Deficiency Disorder Control Programme (IDDCP).

4) Additional Interventions under NRHM ASHA - Accredited Social Health Activity (ASHA), The Government of India and Government of Rajasthan have launched a National Rural Health Mission to address the health needs of rural population, especially the vulnerable sections of the society. The sub center is the most peripheral level of contact with the community under the public health infrastructure. This caters to the population norm of 3000 - 5000. The worker in sub center is an ANM who is directly involved in all the health issues of this population, which is spreaded over the wide area of many kilometers and covering 5 to 8 villages. Many a times the villages are not connected by public or private transport system making it more difficult to achieve the objectives and goals of providing quality health care for the poor and oppressed sections of the society. So the new band of community based functionaries, named as Accredited Social Health Activist (ASHA) is proposed in the NRHM who will serve the population of 1000 and 500 in hilly and desert terrene. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women, children, old aged, sick and disabled people. She is the link between the community and the health care provider.

5) Janani Surakha Yojna (JSY) - Janani Surakha Yojana(JSY) is a centrally sponsored scheme under NRHM umbrella to benefit pregnant women & certified poor families. The objective is to decrease maternal mortality rate & infant mortality rate and to increase Institutional deliveries amongst BPL & poor families. The beneficiary are women of BPL / APL families and the duties of ASHA - Sahyogini: Registration of eligible beneficiary, Antenatal checkup (3 times) Arrange referral transport, Escort her to health facility & facilitate cash assistance from PHC/CHC/DH. Post natal checkup (2 times). A Nodal officer has been appointed in each district to implement this scheme effectively.

6) Indian public health standards (IPHS) - Under National Rural Health Mission Strengthening of CHCs as per the norms of Indian Public Health Standards (IPHS) is an important component. Under this component all the CHCs of the State will be up graded in phases. Under this component 64 CHCs have been selected for up gradation in the year 2005-6. In the year 2006-07, 64 more CHCs has been selected for up gradation. Now total number of CHCs selected for up gradate the IPHS by 305.

III. STRENGTHENING OF PUBLIC INSTITUTIONS FOR HEALTH DELIVERY

The Rural Health Care System forms an integral part of the National Health Care System. Provision of Primary Health

Care is the foundation of the rural health care system. For developing vast public health infrastructure and human resources of the country, accelerating the socio-economic development and attaining improved quality of life, the Primary health care is accepted as one of the main instrument of action. Primary health care is the essential health care made universally available and accessible to individuals and acceptable to them through their full participation and at a cost the community and the country can afford. Although vast network of this infrastructure looks impressive, accessibility, availability of manpower and quality of services, and their utilization have been major issues in the Public health care delivery system. Adequacy of coverage is an important issue.

IV. MARKETING OF FAMILY WELFARE PROGRAM IN RAJASTHAN

The marketing concern in Rajasthan for family welfare programmes first, the ambience in the clinic was deliberately de-medical- zed, secondly, personalized attention was given to each customer for which staff was instructed time and again, and thirdly, the policy of not asking questions from the customer was followed. All these measures helped in creating an atmosphere which was friendly. The marketing campaign tried to create mouth publicity and as the result, or more specifically the impact, of the above measures is reflected in the extent of acceptance of these programmes.[1] The different kinds of communication strategy was adopted to create awareness about 'disease' and educate people on how it can be prevented with the use of condoms. He aim was to convert the negative attitude into an opportunity for a large coverage. The distribution strategy was to supply of condoms to the larger at different approachable places at lowest prices gives the speed to these programmes. The TV commercials were telecasted to educate people. The wall posters, wall paintings, primary centers, health centers were developed to promote these programmes at larger level[2]

V. PROBLEMS

There are ample numbers of problems faced by the health functionaries during the marketing of family welfare program in Rajasthan. The major problems are following-

1) Regulation and enforcement in public health

A good system of regulation is fundamental to successful public health outcomes. It reduces exposure to disease through enforcement of sanitary codes, e.g., water quality monitoring, slaughterhouse hygiene and food safety. Wide gaps exist in the enforcement, monitoring and evaluation, resulting in a weak public health system. This is partly due to poor financing for public health, lack of leadership and commitment of public health functionaries and lack of community involvement. Revival of public health regulation through concerted efforts by the government is possible through updation and implementation of public health laws, consulting stakeholders and increasing public awareness of existing laws and their enforcement procedures.

2) Health information system

The Integrated Disease Surveillance Project was set up to establish a dedicated highway of information relating to disease occurrence required for prevention and containment at the community level, but the slow pace of implementation is due to poor efforts in involving critical actors outside the public sector. Health profiles published by the government should be used to help communities prioritize their health problems and to inform local decision making. Public health laboratories have a good capacity to support the government's diagnostic and research activities on health risks and threats, but are not being utilized efficiently. Mechanisms to monitor epidemiological challenges like mental health, occupational health and other environment risks are yet to be put in place.

There is a need for strengthening research infrastructure in the departments of community medicine in various institutes and to foster their partnerships with state health services.

3) Health promotion

Stopping the spread of STDs and HIV/AIDS, helping youth recognize the dangers of tobacco smoking and promoting physical activity. These are a few examples of behavior change communication that focus on ways that encourage people to make healthy choices. Development of community-wide education programs and other health promotion activities need to be strengthened. Much can be done to improve the effectiveness of health promotion by extending it to rural areas as well; observing days like "Diabetes day" and "Heart day" even in villages will help create awareness at the grassroot level.

4) Human resource development and capacity building

There are several shortfalls that need to be addressed in the development of human resources for public health services. There is a dire need to establish training facilities for public health specialists along with identifying the scope for their contribution in the field. The Public Health Foundation of India is a positive step to redress the limited institutional capacity in India by strengthening training, research and policy development in public health. Preservice training is essential to train the medical workforce in public health leadership and to impart skills required for the practice of public health. Changes in the undergraduate curriculum are vital for capacity building in emerging issues like geriatric care, adolescent health and mental health. Inservice training for medical officers is essential for imparting management skills and leadership qualities. Equally important is the need to increase the number of paramedical workers and training institutes in India.

5) Public health policy

Identification of health objectives and targets is one of the more visible strategies to direct the activities of the health sector, e.g. in the United States, the "Healthy People 2010" offers a simple but powerful idea by providing health objectives in a format that enables diverse groups to combine their efforts and work as a team. Similarly, in India, we need a road map to "better health for all" that can be used by states, communities, professional organizations and all sectors. It will also facilitate changes in resource allocation for public health interventions and a platform for concerted intersectoral action, thereby enabling policy coherence.

6) Inadequate Financial Resource

Inadequate financial resources for the health sector and inefficient utilization result in inequalities in health. As issues such as Trade-Related aspects of Intellectual Property Rights continue to be debated in international forums, the health systems will face new pressures.

The causes of health inequalities lie in the social, economic and political mechanisms that lead to social stratification according to income, education, occupation, gender and race or ethnicity.[3] Lack of adequate progress on these underlying social determinants of health has been acknowledged as a glaring failure of public health.

Important issues that the health systems must confront are lack of financial and material resources, health workforce issues and the stewardship challenge of implementing pro-equity health policies in a pluralistic environment.[5] The National Rural Health Mission (NRHM) launched by the Government of India is a leap forward in establishing effective integration and convergence of health services and affecting architectural correction in the health care delivery system in India

7) Lack of Skilled health workers

A drawback in the implementation of the family welfare programme was the shortage of skilled and dedicated health workers at the sub-centre level followed by non-availability of a lady doctor at the PHC level. In most of the PHCs, male health workers were not available because of non-recruitment of vacancies during the last several years, as either they were retired or promoted. This has been happening at a crucial time when male involvement in family welfare is required

8) Gender Misconception

It is generally believed that the family welfare programme is for women, male sterilization would make them weak and impotent and as such they would loose their sexual libido. It was opined that these misconceptions can be removed with the community participation approach. Many MOICs and district level officials also felt that the involvement of ISM&H could be effective in increasing community participation in family welfare programme.

9) Less Community Participation

Community participation and lack of involvement of community leaders along with religious and political leaders was another reason given for the poor implementation of the family welfare programme, especially among Muslim communities. They attributed the success of the pulse polio programme to community participation.

Treatment seeking behavior and utilization of services at PHCs shows that family planning was not an important concern for clients who visited the PHC for availing services. Also, reproductive health care seeking is almost negligible at the PHC level. This shows that demand for family planning and reproductive health services from the government sources is not high.

10) Low Level of Awareness

It is very difficult to implement the family welfare programme, particularly the family planning programme as the constraints ensue both from the communities as well as supplies. People are mostly illiterate and do not understand the benefits of small family. Further, they emphasized the need to have quality family planning programme in view of the State having high infant and child mortality. They also emphasized that unless child survival is ensured couples would not want to opt for sterilization. This can be ensured by providing quality services. They acknowledged that there is a dearth of lady doctors in the State, and that failure of laparoscopic sterilization has had a negative effect

VI. ROLE OF SUPERVISORS

The role of the health supervisors is extremely important in supervision and monitoring at the SC level. Staff was also found to be under-utilized due to lack of proper supervision and monitoring. The only mode of monitoring was by conducting weekly meetings by MOICs on the work of the health workers. Similarly, MOICs attend monthly meetings with the CMOs. Generally, at the meetings, reporting is from the lower to the higher levels.

The doctors did not discuss family planning issues. This indicates that family planning is not an important issue to be discussed by the doctor or that it is to be dealt with either by ANMs at the subcentre or at the PHC during camps.

They received services like check ups, medicines and injections; and reported that Although the management information system is being modernized through computerization, statistical information on family planning and immunization was found to be poorly maintained especially at lower levels.

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