ABSTRACT

News media can influence the decision and pressure the governmental agencies to undertake adequate measures to improve the health conditions in peripheral regions. Considering the efforts from United Nations governmental agencies through its Sustainable Development Goals (SDG) 2030 have significantly focused on improving health and promoting well-being. However, despite several initiatives to ensure healthy lives and well-being in India, the National Health surveys reflect an entirely different picture. There has been a significant gap in the health outcome of rural and urban areas. In addition, women and children have been at the receiving end of inequality in health outcomes. The inequalities also persist concerning the accessibility, availability, and utilisation of healthcare services among the population. Different Social Determinants of Health create disparities in healthcare among people (SDH) compounded by gaps in health governance. For instance, the unavailability of adequate healthcare workers and resources can significantly affect an individual's healthcare services, resulting in a substantial difference in health outcomes.

Healthcare professionals have an essential role in bridging the health gap backed by news media professionals towards a more equitable healthcare ecosystem. This study provides an array of instances of women and child health inequalities in bordering rural areas, the action healthcare professionals and news media practitioners undertake to advance health equity goals. Furthermore, it is essential to observe how health and media professionals can jointly improve healthcare services' availability, accessibility, and utilisation for better health outcomes. Taking the relevant cues from the data on individual's health from the community, healthcare professionals view improving health and news media observation on advancing equity in healthcare among the marginalised community in the peripheral region.

The research problem is approached through the mixed method, as the study has multiple categories of participants. This study is guided by *the embedded experimental model* with a two-phased approach, where a quantitative dataset establishes the study, and qualitative data is subservient within the methodology. The study is based on primary data sources collected through questionnaires and structured interviews from three major category participants: community members, healthcare professionals, and media practitioners.

The study population is categorised based on participants: community members, healthcare workforce, and media personnel. For the quantitative part of the study, the data were collected from community members and the healthcare workforce in the borderland region. The community population are women between the age group of 15-49 from the districts adjacent to the international borderland. In the healthcare workforce, every healthcare worker employed in PHCs, BPHCs, and SCs in the bordering communities is considered for the study. For the qualitative part of the study, the population is defined as journalists and correspondents from print and electronic news media engaged in local news agencies in Assam.

For the community, out of 33 districts of Assam, three districts were selected based on their health status. The least performing districts in the health parameters are also adjacent to the India Bangladesh border. The three districts, namely Karimganj, Dhubri, and South Salmara, have seven, thirteen, and two development blocks. Blocks were later selected based on their proximity to the international border. Four development blocks were chosen within the range of 15 kilometres from the border fence. From the four development blocks, 24 villages were selected that falls under 15 kilometres from the international fence. The sampling frame was prepared from the NRHM centre of each district, where 26,757 women aged 15-49 from the 24 villages were selected for the survey.

A representative sample of 355 was drawn using Cochran Formula. Likewise, a similar sampling technique was used to identify samples for the healthcare workforce. A sample of

109 was drawn from the 162 health workers engaged in 23 health centres. For qualitative data, journalists were selected using a convenient sampling technique. Sixteen journalists were selected to participate in in-depth and structured interviews. Three different tools were used to measure the variables involved in the study. Structure interviews were conducted with the respondents from the community. The structured interview tool was adopted the NFHS-round four questionnaire. Further, the adopted tool was tailored into *Household Questionnaire* and *Individual Response Questionnaire* to collect information from the community.

Similarly, a self-constructed tool was used to identify the factors affecting the functions of the healthcare workforce. The reliability of the tool was computed, which came out to be 0.73. The value indicates the level of reliability to be satisfactory. A structured in-depth interview guide was prepared to collect information from respondents, which contains seven open-ended questions.

The data analysis for individual and household response questionnaires are pre-coded and closed-ended. Descriptive and inferential statistics were used to analyse the dataset. The wealth index and housing index were also calculated through the Principal Component Analysis. The study measured its variable with Binary and Multinomial Logistic regression. Factor analyses were conducted to extract factors from the items. Pearson correlation and multiple regression analysis were used to interpret the effect of predictor variables on the outcome variable. In the case of in-depth analysis, the crystallisation method was used to analyse the qualitative data from the interviews with media professionals.

The results of the study were categorised into two major phases, each phase presenting the objective-wise results. The phase one address objective one and two, whereas phase two offers the objective three and four. Objective one estimates the level of inequality among the community residing near India's border region. The wealth-based inequality is computed

through the Gini Coefficient value, laid graphically through the Lorenz curve. The level of wealth-based inequality is 0.267 points below the line of perfect equality.

The data revealed a disproportionate concentration of healthcare services among the population. The utilisation of services is significantly high among the poorer section except for the utilisation of ambulance services. The data also revealed that the populations from relatively wealthy households mostly prefer private care for their health needs. On the other hand, the concentration of diseases is high among households that lack improved housing conditions.

In addition, the study also presented the effect of socioeconomic conditions on the accessibility of healthcare services. It is revealed that age, education qualification of women, and household wealth have a significant association with treatment choice at the public healthcare centre. Older women with higher education qualifications from the wealthier household are more likely to visit public healthcare centres than women from the lowest quintile without any formal education. Similarly, wealthier women of younger age are more likely to seek institutional delivery, and the education qualification of women has no significant association with institutional delivery. Likewise, accessibility of postnatal services increases roughly two times more, women from mid-level wealthy households than women from the poorest section.

The study's second phase identified three primary factors: community service and engagement, competency and skills, and advocacy associated with the healthcare professionals. The study also presents the effect of sociodemographic factors of the healthcare workforce on their functioning. The data revealed that the gender of the healthcare workforce plays a significant role in addressing health equity. In addition, phase two of the study presents qualitative data from in-depth structured interviews of the media professionals. Three themes have emerged from the interviews with local reporters, journalists, and editors: the perspective of media professionals, factors considered for selection of health stories, challenges, and barriers in

covering health-related stories. The themes have substantiated the quantitative data from the responses by the community and healthcare professionals.

The level of wealth-based inequality is significantly high in the rural regions bordering the international border with Bangladesh. The households close to the border fence are more downtrodden than the communities close to the district's centre. The survey revealed that communities with less wealth lack improved housing facilities such as safe drinking water, hygiene toilet, and better housing conditions. The housing conditions of the community directly correlate with the wealth of individual households. Existing literature stated that housing condition has a direct impact on the health status of the individual. Thereby, housing conditions and wealth of a particular household directly influence the health outcome, which increases morbidity and mortality rate.

It is also pertinent to examine the effect of socioeconomic and demographic factors on individuals' health outcomes, resulting in under-utilisation and inaccessibility of healthcare resources. The data revealed that wealthier households are less likely to utilise public healthcare facilities than the population from the more impoverished household. On the other hand, the beneficiaries for most healthcare schemes are the wealthier household rather than the household in need. Furthermore, healthcare facilities are more in poorer household members, but more impoverished families have limited access to it to access health deliverables. The gap in utilisation and accessibility of services has significantly impacted the health outcome, reflected from the National Family and Health Survey round four data. Hence, it is the responsibility healthcare workforce to ensure equitable distribution and bridge the gap in utilisation and accessibility of healthcare resources across the population.

The study identified three primary factors influencing the functioning of the healthcare workforce engaged in the public healthcare centre in rural peripheral India. The three factors are Community Service and Engagement, Competency and skills, and working for advocacy

to address the existing inequity in access and utilisation of healthcare resources. The data revealed that *Community service and engagement* factors affect 38 per cent of the healthcare professionals functioning. It is reported that the gender of healthcare professionals has a role to play in engagement with the community members. Engagement involves activities to improve social and economic conditions, community building, emphasising doctor-patient relationships, and helping patients make informed health decisions. Furthermore, it is being observed that healthcare providers practice facilitation and representational advocacy while engaging with the community.

Media is an essential factor that influences all the stakeholders for better functioning healthcare machinery in the rural peripheral region. Effective reporting mechanisms of the health news will positively change the communities' approach towards the public healthcare system. Furthermore, media significantly plays an essential role in engaging healthcare professionals in advocacy programmes. It is pertinent for healthcare professionals and media practitioners to work in sync to communicate to the audience the importance of utilising services. The health executive and administrative bodies should attempt to integrate the implication to cater to the community's health needs in the peripheral region.