Leveraging Mobile Phone Technology to Improve Community and Public Health Interventions in India: A Review of Current Initiatives and Directions for Future Innovation

Jena Nicols Curtis¹, Richard Thailer², and Vincent Mascarenhas³

Abstract - Around the globe mHealth initiatives are being implemented to increase the reach of public and community health programs. This paper provides an introduction to mHealth, an overview of current programs, and an analysis of the ways in which IT and public health program developers could partner to further advance the scope and impact of mHealth programs in India. To illustrate these key points, it describes a study conducted in India to offer a solution to the basic source of health related issues.

Keywords – mHealth, Endemic Disease, LMIC, Mobile Phones

I. INTRODUCTION

With the exponential spread of mobile phones, even into more remote and rural areas of the globe, the technology originally developed to connect people for conversation and commerce is being repurposed to address many pressing needs. The emerging field of mHealth is focused on using the mobile phones, personal digital assistants (PDAs), and other wireless devices to support patients and providers in the delivery of clinical and public health services[1]. mHealth interventions are increasingly being used around the world in public and community health arenas to improve maternal and child health outcomes, show and track the spread of endemic diseases like HIV/AIDS, malaria, and tuberculosis, and to address health disparities that tend to be exacerbated by both poverty and remote location[1]. mHealth programs are also being developed to assist clinicians in providing direct medical care by facilitating diagnosis, managing drug shortages, and increasing providers’ own clinical education and capabilities[1].

Although the adoption of mHealth initiatives holds great promise for health programs in India, they are not a panacea. As with any new technology, the desire for innovation cannot outpace the

---

¹ State University of New York, College at Cortland
² State University of New York, College at Stonybrook
³ St Aloysius Institute of Management and Information Technology
need for thoughtful and deliberate development. Emerging initiatives need to be subjected to careful evaluation[2]. Developing programs should complement existing national health programs, and would ideally be based upon programs already in use for related health issues[2] that, following best practices, would have a demonstrated history of both success and sustainability.

The World Health Organization has identified five different ways in which mHealth is being used around the globe to improve health[1]. These include:

1. Facilitating communications between individuals and health services (for instance, helplines that allow patients to call to receive advice with symptoms and treatment);
2. Enabling communications between health services and individuals (for instance, sending reminders to patients to keep medical appointments or take medications);

... Corresponding authors ...

3. Allowing consultation between health professionals (for instance, using telemedicine to teach innovative medical procedures to doctors in remote areas);
4. Permitting for emergency communications between medical facilities and providers in times of crisis (such as during flooding of cities or villages);
5. Providing a mechanism for the surveillance of disease and illness—especially in remote locations;
6. Supporting access to essential information for health professionals[1].

Given the vast scope of these different types of interventions, the authors will focus in this article on the first two modes of mHealth delivery. Specifically, it will address the facilitation of bilateral communication between patients and providers, since this is *sine qua non* in the provision of public and community health interventions. Although all of these uses of mHealth warrant further exploration and development, it is the first two modalities that offer the most immediate promise for community and public health interventions.

II. mHealth Initiatives in Low and Middle Income Countries

A global study of 112 member countries conducted by the Global Observatory of eHealth Services in conjunction with the World Health Organization found that the most frequently reported mHealth interventions among all reporting nations were health call-centers or health care telephone help lines (which had been implemented in 59% of participating countries) and emergency toll-free telephone services (implemented in 55% of participating countries). Low-income countries were significantly less likely to have adopted mHealth services (77% of participating countries) as compared to high-income countries (87% of participating countries)[1].

Although lower income countries have been shown to be less likely to implement mHealth initiatives, and have typically implemented fewer initiatives than their higher income counterparts,[1] this does not mean that such initiatives cannot be successful in less affluent regions of the world. Globally, there have been a number of interventions that have been both conducted and evaluated in low and middle-income countries (LMICs) and contribute to a growing body of literature that suggests that mHealth interventions can improve patients’ adherence to various treatments and attendance at clinical appointments[4]. If anything, mHealth programs may offer more promise for low-income countries, because in these regions the
coverage of mobile phone networks often far exceeds other infrastructure including paved roads, electricity, and wired Internet[1]. This reality makes mHealth a more cost-effective and immediate way of reaching remote areas.

### III. mHEALTH IN INDIA

The potential of mHealth is especially rich in India, most obviously because India has the one of the fastest growing mobile phone markets in the world[5]. According to 2014 data, 62.5% of the population, or a total of 893.3 million people in India, have mobile phones[6]. This number most likely under-represents true access to mobile phone technology since research has shown that Indian family members often share phones[7]. For instance, one study in Rajasthan found that 72-92% of participants had access to mobile phones that were either personally owned or shared between family members[6]. This widespread sharing of phones suggests that the real-world penetration of mobile technology may actually be much more vast than documented phone ownership rates depict.

There are several factors that contribute to the exponential growth of mobile phone use within India. First and foremost may be the sense that mobile phones are portable yet personal devices that allow people to make both personal and business connections[8]. Mobile phones in India are also relatively affordable to even the poorest individuals since India has the second lowest mobile phone tariff in the world, after Bangladesh[8]. The cost of phone ownership is further reduced because one-quarter of all mobile phone handsets are recycled, allowing for the purchase of these second-hand phones at reduced prices[8]. This affordability is changing phone use and uptake. For many Indians, mobile phones are replacing wired telephone lines[8]. For others, mobile phones represent their first opportunity to have and use private, or semi-private, telephone and text services.

With the increasing adoption of mobile phones even in the more rural and remote areas of India, there has been a surge in mHealth interventions utilizing both text messages (SMS) and telephone calls. mHealth interventions have been developed and implemented throughout India to help people with mental illness,[6][7][9] improve maternal and child health outcomes,[10] encourage breast cancer screening[11], study tobacco use[12], increase HIV/AIDS treatment adherence[5][13], support behavioral interventions to prevent type-2 diabetes,[14] and improve dental health through both appointment reminders,[15] and oral health education programs for mothers of pre-school children[16].

This burgeoning body of research has found many potential benefits of mHealth initiatives. These interventions tend to be low-cost to implement and can be scaled to larger populations, should the initial pilot study show promising results[13]. Automated, mobile phone interventions have the ability to cross barriers of time and space to reach patients wherever they are and whenever they are available[13]. This is an especially important consideration for those programs targeting disadvantaged populations who may not have access to stable housing or employment. Traditionally, this insecurity meant that those individuals most in need of public health interventions were the most difficult populations with which to initiate and sustain programs. mHealth provides an opportunity to at least partially overcome this barrier. Additionally, mHealth interventions have the potential to be sustained at relatively low costs, for extended periods, or conversely, implemented quickly to meet a sudden demand or crisis[13].

Finally, research suggests that mHealth interventions are likely to be welcomed by Indian health consumers. One study found that the overwhelming majority of interviewees (99%) reported that they do not see health-related text messages on their mobile phones as an invasion of privacy - rather
they limited their own calls to the program for fear of inconveniencing the doctor providing the outreach[17]. Another study of young urban women with mental illness found that participants were reassured by having someone available via their phone who could text back or call them[7]. It is possible that mHealth interventions may increase participants’ sense of connection to caring others[7]. This connection has the potential to improve not only physical but also emotional and social health outcomes.

IV. ISSUES TO BE ADDRESSED

There are still logistical matters regarding mHealth development and delivery in India that need to be addressed. First and foremost is the fact that, although phones are in widespread use throughout India, they are not yet ubiquitous. This disparity is especially noticeable in rural areas; cell phone penetration in remote locations is less than a quarter of that in the urban regions of the country[8]. The adoption of mobile phones in rural areas and telecom manufacturing in India has been lower than had previously been predicted[8]. This is believed to be, in part, related to the difficulty in establishing right-of-way and purchasing land for fiber optic cables[8] but other barriers and avenues to developing infrastructure need to be explored and addressed. Currently there is a lack of skilled technologists within Indian health ministries to develop and direct these initiatives[1]. There is also a gender gap in mobile phone ownership. Less than 30% of women in India own mobile phones[8][18]. This disparity has especially significant implications for maternal and child health initiatives, in which sustained contact with mothers is essential. Poverty also presents special challenges for mHealth in India. The requirement to prepay phones can mean that disadvantaged people have intermittent service and patients or community members may be lost for follow-up with health programs[6]. Finally, less expensive phones are unlikely to have Internet connection or be able to download data[1][16]. This restricts the ways in which phones may be used for mHealth. Impoverished users are also less likely to use their phones’ text-messaging or SMS services[6], further limiting the scope of potential interventions in these populations.

V. NEXT STEPS TO LEVERAGE TECHNOLOGY AND mHEALTH

Innovative collaboration between public and community health personnel and university and college information technology (IT) programs is required by both fields for the budding potential of mHealth in India to bloom into full flower. Each side of this equation has an essential and unique role to play, since both partners have distinct skills and knowledge. IT developers understand not only what is present, but also what is possible with current and emerging technology. Public health providers understand the current and emerging threats to health and safety in both the general population and to those who are most disadvantaged. IT developers are essential to address issues of connectivity, and also provide analytics that will allow public health providers to better understand both patterns of disease and patterns of health behavior and health resource utilization[20].

Regardless of their area of expertise, mHealth program developers must have a clearer understanding of patterns of mobile phone use, barriers to this use, and the perceived needs of users[6]. In the language of public health this is a needs assessment; in the IT world it is a market analysis. For both realms it is essential for future program planning and development. The challenge of providing public health information and outreach in LMICs is enormous. Given India’s vast population, the task is even greater. Successful programs will require a partnership between those skilled in providing technology infrastructure support and software solutions, and experienced public health personnel responsible for content creation and ongoing support.
Successful programs must utilize existing communications networks, while at the same time forging new collaborations between healthcare and technology experts.

The transition of mHealth initiatives from a start-up phase to fully developed programs of national significance and impact has been one of the major barriers in mHealth development[19]. Community health programs have struggled to develop sustainable mHealth programs of lasting impact, but alliances between governmental, not-for-profit and for-profit entities have been shown to be both to have exceptional promise[20]. The potential of these partnerships is limited only by the vision and resources of the participants.

**V. STUDY AND ANALYSIS MADE WITHIN INDIA ON SANITATION ISSUES WITH FOCUS ON MHEALTH**

Given the progress in the incorporation and use of technology, India is still lagging far behind many countries in the field of environmental sanitation[3]. But what is more important is what is done about it, in terms of remedial measures. Things are getting better e.g. the fight malaria “The commitment of the Government of India to eliminate malaria by endorsing the Global Malaria Technical Strategy 2016-2030 and setting a national malaria elimination target of 2030 is a huge step forward that will have a major regional and global impact.[22]”.

In view of the above-mentioned initiative toward better health, the application of technology for resolving health issues via mHealth would achieve its anticipated effect only when that specific automated mechanism functions as intended. However, disorganized processes or broken social and civic systemic functions may result in inefficient implementations of that mechanism and may not justify the cost. The difficulty that could arise - first and foremost, is in the flawed thinking process - the wrong mind-set, the absence of basic hygiene, sanitation and rational thinking; lack of desire, adoption and retention of ideal environment as a precondition for general health and welfare. The source of this presumptive reasoning is a set of survey statistics gathered with relevance to monitoring the root cause of social and economic problems in two specific geographical locations in India, i.e. districts of Mangalore and Udupi in the state of Karnataka. Survey questionnaires were developed and used for collecting information on the most significant constituents of maintaining cleanliness in these two (Mangalore and Udupi) surroundings. The study provided ample evidence to believe that environmental cleanliness and hygiene could be well maintained if people were made aware of the negative impact caused by related environmental neglect. This study complements the concept of mHealth by way of setting the prerequisite of good health before mHealth could be fully deployed.

Factors such as air pollution, water contamination, food and material decomposition and decay could actively contribute as breeding ground for spread of various diseases. These are basic structural components that, if managed well, can lessen the onset of health crises. Pollution can manifest itself in many forms such as – unmanaged vehicular traffic with its uninhibited exhaust fumes, unhygienic open waste disposal, uncontrolled noise emission from vehicles, social pollution such as disruptive behavior that affects civility and/or the general indiscernible laxity and lack of accountability etched into the social structure due to the perception that any matter not of material personal benefit, is not worth anyone’s time. Ambiguous and indecisive municipal assistance, or rather the interference, only worsens the situation.

In the interest of the society and as a solution, apart from the initial fact-finding survey, the team also developed an application that could be used by the municipal authorities for monitoring and maintaining the general upkeep of the city. The general public could use this application to report issues (textual narrative with option for image-upload and geographic location indicator) that are
of public safety and health concerns. The information, received by the municipal monitoring squad could be used to rectify related issues by dispatching required personnel to the affected area. This may be applicable to most issues that affect the general public, within reason.

**VII. CONCLUSION**

A coalition between public health and IT programs would allow for the development of targeted pilot projects, based on a needs model that is scalable, tailored to specific user demographics in terms of language and other cultural considerations, and responsive to emerging crises. mHealth interventions have been shown to be adept at both delivering and collecting medical information, disseminating targeted healthcare interventions and content, and dispensing individualized behavioral change programs[21]. Public health and IT industry collaboration could dramatically increase the reach, depth and timeliness of public health programs in India. The authors intend that this paper will serve as a clarion call to both public health and IT professionals to join in a concerted effort to leverage mHealth innovation for the good of all in India.

**REFERENCES**


[3] Legal Control of Environmental Pollution – Mahesh Mathur – Department of Law


[22] India launches the National Framework to Eliminate Malaria – Dr. Henk Bekedam