# ROLE OF MASS MEDIA IN CREATING AWARENESS ABOUT HEALTH PROGRAMMES AMONG RURAL WOMEN OF AGRA DISTRICT (U.P.)

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Rural development has always been a prime concern of all governments in India. The Mass media is a convenient tool with the government to reach out to a very large population. As an important agent of development services, media has found wide inroads into rural life style.

In context of sources of awareness one study report said,

"Combined channels of interpersonal communication were more often the sources of awareness about the schemes and programme than the combined mass media".

Several national health programmes are being implemented as centrally sponsored schemes-aimed mainly at reduction of morbidly and mortality by major diseases.

**1. Family Welfare Programme and MCH Programme**–The maternal and Child Health care is an integrated part of the family welfare programme. This programme as such tries to ensure the health of matter and children to achieve a small family norm.

**2. Reproductive and Child Health Programme**–Is a comprehensive package of services for family planning, maternal and child health and management of reproductive tract infections.The objective of the RCH programme are fulfilled with other 4 mother and child health programmes, which are implemented by the government. Therefore, these health programmes are included in RCH programme. These are :

(i) Prevention of prenatal sex determination.
(ii) Prevention of unwanted pregnancies.
(iii) Tetanus Vaccination Programme.
(iv) National Immunization Programme.

**3. AIDS Eradication Programme**–The government of India established an AIDS cell in the directorate general of health services, strategy planned for AIDS control is, identification of high risk groups and their screening, promoting use of nirodh etc.

**4. Tuberculosis Control Programme**–Was launched with a long term goal to reduce the problem of tuberculosis in the community to a level where it ceases to be a public health problem.

**5. Programme for control of Blindness**–Was launched as a hundred percent centrally sponsored programme.It has been pointed out that in a family and community, management of health remains the prime concern and duty of the women from conception to adulthood. Therefore, it is important that women should be aware about various issues and programmes related with health. Since mass media seems to be an important source to reach masses for dissemination of information. The present study undertaken with the following objectives;

1. To ascertain reach of health programme through mass media in the selected rural areas.

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2. To assess the knowledge of rural women about health programmes.
3. To find out the impact of knowledge about health programmes in adoption of health practices.

## METHODOLOGY :

For the purpose of study Multistage random sampling was used. The study was carried out in Agra district of Uttar Pradesh. The villages Jagner Dehat and Bhara of Jagner block of Agra District were selected by random sampling. 50 married women (between the age of 18 to 45 years) from each village, were selected randomly. Thus a total number of 100 respondents were identified for the study.

For the present study the structured interview schedule was prepared. Interview schedule was divided into 2 main parts. Part-1 consists of general information about respondent and her family and part-2 consists of specific information. Specific information was further classified into 5 selected health programmes and each health programme was categorized into 3 sections : first, for general information about the health programme, second, information regarding knowledge and practice of the respondents about health programmes and third section consists of information regarding sources of communication from which the respondents get knowledge about health programmes. During the course of preliminary survey, it was observed that in the selected area along with mass media, there were many other important sources of communication, therefore, in the present study other sources of communication were also included and were categorized as under :

1. **Mass media sources** consists of folk media, print media and electronic media.
2. **Personal localite sources** consists of family members, friends, gram pradh etc.
3. **Personal cosmopolite sources** cons doctor, village development officer etc.

With the help of pretested and structured interview schedule, the data collected personally from the respondents the related village at their household. T collected data was classified and tabulat to ascertain the relationship betwe independent and dependent variables. Simp mean score percentage and chi-square table were important statistical tool f interpretation of data.

## RESULTS AND DISCUSSION :

**General profile of the Respondents**

Analysis of the data collected indicates tha respondents were mostly (70%) in the ag group between 18 to 30 years. Almost all the respondents (99%) belonged to Hindu religion, out of which 89% belonged to genera category and rest (11%) were from other caste (SC/ST and OBC). Majority of the respondents (67%) were literate followed by illiterate respondents (33%)

Family type of the respondents were almost equal (47% nuclear and 53% joint families). Family size of 6 to 10 members was more common in the villages (56%). Majority of the respondents (55%) belonged to business class families followed by farming (31%). Respondents belonging to low income group were in majority (62%).

**Sources of communication and their use in dissemination of information about health programmes :**

Table 1(A) shows the reach of health programmes through mass media sources. It indicates that television was used by the majority (70%) followed by newspaper, magazines (17%)

**Table 1.(A) Mass Media Sources**

| S.No. | Mass Media Sources | Respondent (N=100) | |
|---|---|---|---|
| | | Number | (1%) |
| 1. | Drama/nukkad | 0 | - |
| 2. | Camps | 7 | 7 |
| 3. | Poster/banners | 5 | 5 |
| 4. | Wall paintings | 14 | 14 |
| 5. | Pamphlet | 1 | 1 |
| 6. | Newspaper | 17 | 17 |
| 7. | Books/ Magazines | 17 | 17 |
| 8. | Public Address System | 2 | 2 |
| 9. | Radio | 7 | 7 |
| 10. | Television | 70 | 70 |

Table 1 (B) indicates that among personal localite sources majority of the respondents (90%) generally used family members followed by neighbouers and relatives (74% and 72% respectively).

**Table 1.(B) Personal localite sources**

| S.No. | Personal Localite Sources | Respondent (N=100) | |
|---|---|---|---|
| | | Number | (%) |
| 1. | Family members | 90 | 90 |
| 2. | Relatives | 72 | 72 |
| 3. | Friends | 12 | 12 |
| 4. | Neighbours | 74 | 74 |
| 5. | Gram pradhan | 00 | - |
| 6. | Local leader | 00 | - |

Table 1(C) indicates that among personal comopolite sources, doctor was used as a source of information by the majority followed by nurse (39%).

**Table 1.(C) Personal cosmopolite sources**

| S.No. | Personal cosmopolite | Respondent (N=100) | |
|---|---|---|---|
| | | Number | (%) |
| 1. | Doctors | 65 | 65 |
| 2. | Nurse (ANM) | 39 | 39 |
| 3. | Anganwadi worker (AWW) | 3 | 3 |
| 4. | Teacher | 1 | 1 |
| 5. | Village Development officer (V.D.O.) | 00 | - |
| 6. | Hospital/clinics | 6 | 6 |

Overall reviews of the table 1A, 1B and 1C shows that among the various sources of communication personal localite like family members, neighbours and relatives were used by the majority (90%, 74% and 72% respectively) followed by mass media sources television (70%) and cosmopolite sources doctor (65%) and ANM (39%). The findings are also supported by Kumar et al (2001).

The data presented in table 2. clearly indicate that out of 6 socio economic variables, caste, education and income were significantly associated with the knowledge of the respondents.

**Table 2. Association between socio economic characteristics of the respondents and knowledge regarding health programmes.** N=100

| Socio-Economic characteristics | Chi-square Value |
|---|---|
| Age | 0.928 |
| Caste | 6.38* |
| Education | 27.425** |
| Type of Family | 3.100 |
| Family size | 0.374 |
| Family income (Percapita per annum) | 7.221* |

* Significant at 0.05 level of significance

** Significant at 0.01 level of significance.

Further analysis of the data shows that majority of the respondents belonging to the low income group were illiliterate. Respondents from other caste (SCs and OBCs) were mostly illiterate and belonged to low income group. This could be the reason why caste, education and income of the respondents were significantly associated with the knowledge

Table 3. clearly indicates that education and family income were significantly associated with practice score of the respondents.

economic characteristics of the respondents and practices regarding health programmes N=100

| ocio-economic characteristics | Chi-square value |
|---|---|
| ge | 1.366 |
| aste | 0.200 |
| ducation | 13.120** |
| ype of family | 0.221 |
| amily Size | 1.620 |
| amily Income | 6.456* |

Significant at 0.05 level of significance
* Significant at 0.01 level of significance

**Table 4 Association between use of ources of communication and knowledge egarding health programmes among ural women :**

**able 4 (A) Association between sources f communication and knowledge.** N=100

| .No. | Health Programmes | Chi-square Value |
|---|---|---|
| 1. | Family Welfare programmes | 13.228** |
| 2 | RCH programmes | 4.361 |
| 3. | AIDS Eradication programme | 0.34 |
| 4. | TB control Programme | 4.503 |
| 5. | Programme for control of Blindness | 8.988* |

Significant at 0.05 level.
* Significant at 0.01 level.

Scores have been given according to umber of sources used by the respondents.

Table 4(A) indicates that use of sources f communication is significantly associated ith family welfare programme and rogramme for control of blindness. While remaining 3 health programmes multiplicity f communication sources does not affect the vel of knowledge, reason being, RCH rogramme : As far as the RCH programme concerned, the complete information could e obtained mainly from single inter personal sources like family members or the doctor etc.

AIDS control programme: Out of 100 respondents only 41 knew about the disease AIDS and 59 did not know even about the word 'AIDS'. It was observed that respondents use only TV and family members. It does not matter how many sources of communication used for dissemination of information.

TB control programme : It was seen that in rural areas, from every third family 1 or 2 persons were suffering from TB and the same becamethe sources of communication.

**Table 4(B) Association between use of mass media sources only and knowledge regarding health programmes** N=100

| Mass Media Sources | Knowledge score | | Total |
|---|---|---|---|
| | Below mean | Above mean | |
| Nill | 24 | 4 | 28 |
| 1 | 16 | 17 | 33 |
| 2 | 2 | 17 | 19 |
| 3 | 4 | 6 | 10 |
| 4 and above | 0 | 10 | 10 |
| **Total** | **46** | **54** | **100** |

X2=36.149**
** Significant at 0.01 level with 4 d.f.

Table 4(B) Indicates that there was highly significant association between use of mass media sources and knowledge regarding health programmes. Similar findings were also reported by Bhardwaj (1981), and Pushpa and Sheela (1997).

Therefore, it can be said that if one mass media is supplemented with other medias or a combination of media is used, knowledge level increases.

Table 5. Indicates the association between knowledge and practices regarding health programmes among respondents. Table shows that there was significant association between knowledge and practice of respondents regarding health programmes.

| S.No. | Health Programmes | Chi-squar value |
|---|---|---|
| 1. | Family Welfare Programme | 6.952** |
| 2. | RCH Programme | |
| | (i) Prenatal sex determination and Unwanted pregnancies | 5.11* |
| | (ii) Tetanus Vaccination | 7.97** |
| | (iii) Immunization | 33.408** |

* Significant at 5% level with 1d.f.
** Significant at 1% level with 1d.f.
1. Practice could be assessed only in family welfare and RCH programme.

## CONCLUSION :

It is concluded from the study that out of all the mass media sources, television play the most important role in dissemination of information. Since the community in the rural areas is very close knit, along with mass media sources other communication sources such as family members, relatives and neighbours become very important sources of communication for creating awareness. Also it is important to note that during the study, it was found that these members of the the block and services are regularly provided by doctors and ANM, they come at the next place as a source of communication.

Out of all the socio economic variables, it is found that education plays most important role in affecting knowledge and practice of the rural women regarding health programmes.

To conclude it is suggested that for dissemination of the information for rural masses TV should be given utmost importance as it was found to be most powerful source of communication.

Doctor and ANM become very important source in the sense that whatever Information rural people gather from them, along with mass media, they communicate to the other members of the community and since they are found playing second most important role in dissemination of information. They should be provided with correct and sufficient information, so that they can be used as a channel of communication.

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