Chapter - 1

INTRODUCTION

We are living in momentous times. These are the days of the communications explosion. This is the age of information, and the whole world is passing through a period of “Information Explosion”. Communication can be defined as “social interaction through messages”. Messages are formally coded, symbolic, or presentational events of some shared significance in a culture, produced for the purposes of evoking significance (Gerbner, 1958). The ongoing Communication Revolution has opened up new possibilities of accelerating development. In India it represents the extension of the scientific and technological revolution to the sphere of communication. We have not yet appraised the full implications of this communication revolution in terms of possibilities and dangers. The media of communication are the means of vehicles, capable of assuming forms that have characteristics of messages. These media include Radio, Television, Internet, Telephone including Mobile and Fax, Video Conferencing, Social Networking, etc. The latest technological applications used for information communication are grouped under Information and Communication Technology that include Internet, Telephone, Mobile, Fax, Video Conferencing etc.

The electronic media, particularly satellite channels have completely changed the media scenario. All information has now been reaching to every home in any remote area. With the revolution in communication technology, any information can reach in every part of the world within no time. The information revolution has changed the thinking process throughout the world. The labour process, according to some social thinkers, played the most important role in the transformation from ape to man. Probing deeper into this phenomenon of the origin of man we discover that communication has played an equally critical role in the transformation from ape to man and also in man’s transition from lower to higher levels of economic and social development. The growth in the social cohesion of human communities and their capacity for more and more effective action as a collectively has depended on two
factors. First is the sophistication of the technology of speedy transmission of messages in terms of reducing time and distance. Second is the innovation of language and of more subtle and suggestive meaning systems, symbols and images, for interpersonal, inter-group and inter-community communication. Thus the development of communication systems has two separate but complementary and inter-related dimensions—one relating to the medium or technique of transmitting the message, and the other relating to the message itself, its quality content and meaning. The first involves a technological challenge and the latter a cultural challenge. The communication revolution involves both a technological revolution and a cultural revolution. It encompasses a revolution in hardware as well as creativity of software. The first concerns the engineer and the technocrat working with material tools and the latter the creative artist and the writer working with the aid of images, sounds and words.

In designing its own version of the Communication Revolution in the contemporary world, a developing country like India has to give as much importance to the artistic and the cultural dimensions as to the engineering and the technological dimensions. This is because the extension of the modern communication to a developing country opens it up in a massive way to the techno-cultural influences and stimuli from the developed countries. This contact between the technologically under-developed and the developed countries has a positive role to play in stimulating developmental consciousness and indigenous creativity in the latter. Such a contact can potentially contribute to growth of national cultures within the framework of international co-operation.

Communication is essential for social change and development. It permeates every process of human life and this characteristic of pervasiveness makes it vital for the growth and development of the society. Conceptually, the mass media are technological agencies and corporate organization, engaged in the creation, selection, processing and distribution of message that are produced at speeds and in quantities possible only with mass-production methods. Today the society is more complex than it was before, making the process of communication more complex and indirect. Mass media, therefore, are the broadcast common currencies of public interactions in a
society. Thus, the mass media are the organised means of reaching large number of
diverse kinds of people quickly and efficiently. This view could be further
strengthened by the research findings of Lerner (1958) who successfully established
that the quickest way to change the ‘mind set’ of the traditional society was through
the use of mass media. In other words one can say that we are living in an era which
has frequently been characterized as “the age of communication revolution” a cycle of
profound and accelerating social and cultural change often attributed to the impact of
new media technologies. This communication revolution is, in fact, a succession of
three overlapping technological stages that have taken place during the last 150 years.

Among developing countries India is one of the few countries having the
cultural talent and technological knowhow to generate software relevant to its own
needs and requirements. But these potentialities still remain largely untapped. India
has been moving ahead much faster in hardware and has been lagging far behind in
software production. The Indian Communication Revolution is still predominantly an
eengineer-led revolution. It has yet to become a cultural worker-led revolution. This
vast gap between hardware and software has created avoid which results in inundation
of the communication system by low–quality entertainment programmes produced by
commercial agencies and by dry and didactic and sometimes crudely propagandist
programmes by government–controlled media. To provide entertainment is one of the
principal functions of all the media. Thus, whoever enjoys freedom has certain
obligations to society and, therefore, the media, which are guaranteed freedom in a
democratic society, are obliged to perform certain essential functions of mass
communication. The speaker must also remember that actions speak louder that his
words. A silence, and nod, a wink, a handshake, grimace themselves speak. The main
role and responsibility of media is to transmit message to inform the receiver of
messages. Mass media endeavours to send information to the public at large. Mass
media not only perform but persuade. Media are used for entertainment and
commercial as well as non-commercial. Without mass media there would be no
social, economic and political system.

It is widely accepted in Liberal democracy that when the media help to put
information at the disposition of the people, they will be able to formally or
informally control the state. The mass media are essential for democracy. By keeping
people on top of current issues, the media enable people to participate intelligently in public policy discussion and decision making. In a democracy the principal role of the media is to act as a check on the state and fearlessly expose abuses of official authorities. This watchdog role is said to override in importance all other functions of the media and dictate the form in which the media system should be organized.

The Communication Revolution exposes the developing countries to international demonstration effect; this means the dissemination of the values and outlook of consumerism from the rich to the poor countries. The full significance of this menace from the consumerism in the wake of the communication revolution has not been adequately appreciated either by the ruling elite or the people. Attention must be drawn to the fact that perceptive social thinkers from the West itself have regarded the link-up between communication revolution and consumerism as the most conspicuous feature of the post-industrial society. Communication has been converted into a powerful means of promoting consumerist values. Over the years, the growth in the field of communication has been phenomenal and the reach and influence of mass media on their users has increased substantially. Now, mass media are powerful instruments of social change. They inform and influence people almost on every aspect of life. In this background, the main challenge before developing countries is that of creating their own non-consumerist version of the communication revolution.

It is necessary that the communication planners and policy-makers realise the full implications of the extension of the modern communication to the rural areas and to remote regions of the country. No doubt the rural masses and the people in the remote regions need to be pulled out of their socio-cultural and economic isolation. The modern society is supported and sustained by modern means of communication system. Consequently, the rapid scientific and technological advancement in the last 200 years of human history have altered the mass media scene significantly. Today, mass media have been able to penetrate every section of the society bringing ‘information from every corner of the globe’. This development has been so extensive that it has made communication scientists to describe the present world as a “global village”.

Those left need to be drawn into the mainstream of development and social transformation. But putting an end to their (rural masses and the people in remote regions) isolation and their joining the mainstream should mean neither violent uprooting from their cultural moorings nor elimination of their cultural identity. It must be noted that in tribal and peasant communities, less exposed, if not unexposed, to modernisation, women have enjoyed a certain degree of independence, dignity and respect derived from their being equal partners of men in the processes of work and the sharing of the fruits of work. They also have participated as equal partners of men in cultural life, in community singing and dancing associated with processes of labour in the fields and in farms or with rituals, ceremonies and festivals celebrated all round the year. Women also enjoy social independence as reflected in widow remarriage, annulment of marriage as a sequel to maltreatment by the husband and right to remarriage with a suitable partner.

The impact of modernisation on tribals, peasants and artisans has often resulted in, what Srinivasas called, Sanskritisation, that is, adoption of the beliefs, practices and ways of life of the upper castes. Aping the upper castes means being re-oriented to treating women not as equal partners of man in work and song and dance. On the contrary, search for higher status involves woman’s degradation brought about by loss of economic and social independence arising from withdrawal from work and from singing and dancing with men in community celebrations. It also means giving up the practice of widow remarriage and the woman’s right to leave a male partner who maltreats her. Such Brahmanisation of the way of life of the lower castes is a retrograde step associated with pseudo-modernisation. The last few decades have seen tremendous changes in the lifestyles of men and women across all over the globe and particularly so in India. Globalization, market economics and above all, fast strides in technology have affected virtually all facets of life be it religion and education, politics or employment, fashion or healthcare. With the advent of computers and telecommunications, media has also undergone a sea of change. Media in India, which until a few years back used to comprise of the morning newspaper, the radio broadcasts and the sole television network screen images of “Doordarshan”, comprises today of a dazzling and at times mind boggling array of
communication devices. The media, which was earlier merely a reporting device, is today a vibrant means of shaping, moulding and influencing public opinion.

The Information Explosion has changed the look, content and presentation of newspapers. The television has helped people in making their opinion after seeing events on the screen. This has affected their thinking process and approach towards life. Television has today become a powerful medium of communication. Thus, its role has become very important. The information explosion has brought more openness. This has also affected the political and social systems and the market. No government can now keep its people in the dark or in any illusion. People can see the happenings in any corner of the world with the help of electronic media and they can form their own opinion. Due to information explosion all types of controls on the flow of information have become almost impossible. The flow of information has also been responsible for changes in the society. This has also accelerated the pace of technological development and economic progress. The Information Technology Revolution has greater impact on Agricultural and Industrial Revolution. Both the revolutions have affected man’s life and living. All the three have also been major civilization revolutions.

The history of television in India dates back to September 1959, when with modest beginning of two hours per day, television in India has assumed immense importance and significant place in electronic media during the last four decades. Presently, the Indian television network has grown as one of the biggest television networks in the world and other than state owned Doordarshan, many new satellite channels are also coming up.

In November 1956, a conference under canopy of the United Nations Educational and Scientific and Cultural Organization (UNESCO) was held in New Delhi. At this conference a proposal to set up a pilot television centre for the purpose of educational and community development was submitted by the Indian delegation. This proposal got favourable response and finally in August 1959, a television transmitter, and a studio was installed at All India Radio, New Delhi. On 15th September 1959, the then President of India, Dr. Rajendra Prasad inaugurated the experimental television service with prime objective to provide educational
programme to the citizens of Delhi. The experimental television service continued illustrated talks, interviews, discussion, documentary films and other kind of entertainment programmes. An experimental service of Delhi centre ended and regular television service was started in 1965. On 26th January, 1967, an instructional service for farmers and women was inaugurated under a pilot rural agricultural television project called “Krishi Darshan” and regular weekly transmission of 20 minutes programme started on 2nd February, 1967. The frequency of the telecast was raised to twice a week on March 01, 1967; 3 days a week on July 15,1970; 4 days a week on August 09, 1976; and 5 days a week on October 14, 1977.

During last couple of decades a new revolution has started in the area of telecasting. Since 1950s the television in India was controlled by the government and the viewers had no choice but to see the programmes of state controlled Doordarshan. But since the inception of the satellite channels like Zee Television, Sony Television, Star Plus, and so many other satellite channels, now the viewers have choice in their hand and also, there is lot of competition in the area of telecasting and as a result of which the programmes of state controlled Doordarshan have also improved a lot.

No doubt, television has been globally acclaimed as a very powerful media for mass communication. It provides audio-visual sound effect like cinema. It surpasses the later by its high intimacy and the capacity to reach the largest number of people in the shortest possible time. The population, land mass and natural resources are now no more big power potential. These are the old concepts. In the modern world, technology quality has greater and prominent role than even Industrial Revolution. The Industrial Revolution, and the Information and Communication Technology (ICT) are now playing a bigger role. As such major boon of the globalization is the Information and Communication Technology applications to each and every part of human life including education at different levels. The revolution in ICTs has profound implications for economic and social development. It has pervaded every aspect of human life whether it is health, education, economics, governance, entertainment etc. Dissemination, propagation and accessibility of these technologies are viewed to be integral to a country’s development strategy. The most important benefit associated with the access to the new technologies is the increase in the supply of information. Information is shared and disseminated in the supply of information.
Although, radio is equally capable, but the visuals in television has a distinct advantage over the radio. Television can deal with typical problems and depict persons known for their expertise and professional excellence. People learn through eyes and ears both, thus leaving distinct impact on the person watching the television. Further, the television on one side does not demand the strain and discipline which on the contrary is very much required in reading print media.

The importance of television as a medium of information, education and entertainment can hardly be over emphasised. The advantages of television are numerous and it is not possible to depict each of them. Though the medium is comparatively recent in our society, we have experienced its powerful effects. Gerbner (1977) sees the effect of mass media in the capacity to take over the cultivation of images, ideas, and consciousness. He refers to main process of mass media as that of “publication” in the literal sense of making public. The truly revolutionary significance of modern mass communication is the ability to form historically new base of collective thought and action quickly, continuously across the previous boundaries of the time, space, and status. But the unfortunate state of affair is that, in a poor country like India, it is still taken as a luxury for an average Indian to own a television set. Under these circumstances, the Government of India have installed a large number of sets in school, colleges, and at community centres for community viewing so that at least a good number of those who cannot afford to own a television set could also find an access to the telecast.

Thus mass media like television are cultural forces which do not simply reflect, but subtly and indirectly help in shaping social reality. Social attitudes and behaviour are adopted through a complex process of imitation and comparison with the attitude and behaviour presented by mass media. The films and television added the new function of entertainment to it. But there is very thin line between entertainment and proper communication as the market forces have started dominating the media, particularly the television. As there are large number of satellites and television channels, they try to attract advertisers. The manufacturers have found television to be the most effective media to sell their goods by the help of advertisements and sponsored serials. To make their programmes attractive and popular they attach glamour to it. With the arrival of foreign media on large scale, it is
said, that there is cultural invasion. This has changed the life style and also food habits of the people. Consumerism and commercialization have also changed their living habits. It is often alleged that we are drifting away from our own culture and identity. Western culture has been dominating the lifestyle. Thus, sometimes it is felt that people lose respect for their own culture.

Television as a mass media is also being used extensively for bringing the knowledge at door step of women through various programmes. Scientists and experts participating in these programmes are from some of the premier institutes of the country. They deal with the problems which are not only location specific but are also time specific. Universal applicability of recommendation is neither feasible nor logical. India is a large and diverse country, with an equally sizeable and varied media. Radio reaches out, to 97.2 percent of the population and is followed by television which has a reach of 85.4 percent. The print media, while much smaller and unlike radio and television, predominantly private, nonetheless has its own importance and legitimacy. Today, with the globalization of media, India is at the receiving end of a number of foreign television channels via satellite. In addition, local cable networks provide a wide range of programmes for different kinds of audience.

Women and children form the most vulnerable sections of the society. In the earlier times whenever they were in any type of difficulty, the joint family, by and large, came to their rescue. With the breakdown of the joint family system and the emergence of the nuclear family, the voluntary organizations came forward to provide that relief to the needy women and children which were no longer available in the family. The voluntary organizations have played a pioneering role in organizing welfare services in various fields.

A planned approach, however, was initiated only in the First Five Year Plan when the Planning Commission decided to give priority to the needs of women and children. The plan did not suggest any specific measures but it enabled the existing voluntary organizations to carry on the work by providing necessary financial and technical assistance through the Central Social Welfare Board. From the Second Plan onwards, several programmes were initiated and expanded by the Central and State
Governments. Upto the *Fourth Plan*, the stress was on the development of curative and administrative services. From the *Fifth Plan*, the emphasis has been on the preventive and developmental aspects which are effective and economical in the long run. Institutional services are being provided, wherever necessary, through the voluntary organizations.

Today, every nation, developed or developing, links its future with the present status of the child. India like other developing nations of the world is very much alive to the pivotal importance of the child in its efforts towards achieving the goals of development. Development not merely socio-economic development but human resource development— is a major concern of all nations. The full development of human resources is an absolute necessity for nation–building. The foundations for this are built in the early years of life. Thus, it is childhood that holds the potential and sets the limits of future development of a society. The contemporary social scenario in India presents a rather gloomy and depressing picture of the child during the most critical period of his life, *i.e.* early childhood. Millions of children subsist in conditions of abject poverty wherein even basic necessities are lacking. Malnourishment is a chronic problem. Deprived of minimum health care the children fall a prey to many debilitating diseases. Child neglect and abuse are widespread. Children undergo severe hardships as they are compelled to join the labour force at a tender age. Their access to intellectual influences, whether in the form of knowledgeable parents/elders, books or *mass media* is greatly limited. The general atmosphere in which a vast majority of our children grow is least conducive to their physical, emotional and intellectual growth. A major source of problems in the way of normal development and functioning of children is the failure of the family to meet the child’s basic needs, because of abject poverty and ignorance.

Women on the other side constitute half of the population in India, as indeed in most other countries of the world. Women are also among the most undeveloped, illiterate and exploited segments of the society. Material and technological development has made marginal difference as far as their status is concerned. Their role in the nation’s economy is ignored not just in India and other developing countries but even in developed and advanced countries. Women remain backward educationally, economically and socially. However, women are slowly emerging out
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of their centuries-old darkness, shaking off their shackles of tradition and man-
determined and man-imposed roles and are increasingly raising their voice to demand
their rightful place in society and their due from it in economic, political and social
life. Women have become one of the most potent forces of change, causing upheavals
in the staid, in still waters of a smug male-oriented society.

The ripples of these upheavals are being felt in India. But to carry the simile
forward, a lot more crest would ride equality. ‘A lot more’ would include efforts to
bring about change in public attitudes and perceptions regarding the role of women. A
task so immense both in magnitude and significance that only the mass media, given
the size of the country, could attempt to undertake. The mass media exert a strong
influence on shaping the public attitudes. The mass media are so powerful and all
pervasive that it is within their power to either stimulate or retard change
significantly.

The National Perspective Plan for Women (1988) pinpointed three dominant
stereotype images of women: that of less competent human beings, instruments for
exploitation by men and key to commercial success. This stereotyping was further
established in a number of studies. The Press Commission found the coverage given
to women’s issues as mere four to five percent in the English Press, six to seven
percent in the language and ten percent in the Urdu Press. The Indian Association of
Women’s Studies (1993) observed that the mainstream media covered women’s
issues in ‘short, superficial and palatable form’ whereas magazines like Manushi and
Asmita gave a consistent gender sensitive and independent perspective.

In any developing country, one of the prime strategies for development is the
dissemination of information. While communication support is essential in the entire
development process, nowhere it is more vital than in the area of women’s
development. The Information and Broadcasting Ministry, lists a number of
objectives of the State owned Electronic Media. Some of these include- to act as
catalyst for change, to spread the message of family planning and to highlight the
welfare of women and children, among others. Various research findings consistently
support the fact that mass media’s performance over the years has not matched these
promises. A global review of the portrayal and participation of women in the media
(UNESCO, 1981) concluded that overall media presentation of women was ‘unrealistic, demeaning, and damaging’. An update of the study did not report any radical change (UNESCO, 1989). The well-known feminist, Margaret Gallagher in her two studies (1983, 1987) established that media has offered unequal opportunities to women in their career, development and management. The Report on the Committee on the status of Women in India emphasised: “The contents of communication at any given time reflect the pattern of values of a society. The way subjects dealing with women are treated indicate to a great extent, the prevailing attitudes of that society towards its women. This could work both ways, to improve or lower women’s status in society, by introducing new or reinterpreting new ideas”.

A number of programmes in the Social Welfare Sectors have been taken up to cater to the special needs of the women who, because of some social, economic, physical or mental handicaps, are unable to avail of the general benefits and services available to the needy at large. During the International Year of Women, a national plan of action for their development was prepared. This Plan identified areas of health, family planning, nutrition, education, employment, legal provisions and social welfare for formulating and implementing action programmes for women. In accordance with the guidelines provided by this plan, an inter-ministerial co-ordination committee has been setup to co-ordinate the development strategies and programmes of different Ministries. The States are also required to set-up such committees. Thus the need to implement the women’s programmes in various sectors of development in a co-ordinated and integrated manner had been realised at the time of the formulation of the Sixth Five Year Plan. The basic strategy adopted for the development of women in the Sixth Five Year Plan had a three-pronged thrust, namely, education, employment and health. The basic approach was the development of family as a unit; the woman being the vital but vulnerable member of the unit deserved special attention. Hence, the economic emancipation of the family with specific attention to women, education of children and family planning was the major operational aspect of the development strategy for women. The need to strengthen the grass-root level organisations was realised and efforts were directed at creating channels for women to participate effectively in socio-economic programmes. The Central Social Welfare Board continued to be largely responsible for extending
support, both technical and financial, to voluntary agencies, particularly in the backward areas.

The Women’s Welfare and Development Bureau in the Ministry of Social Welfare was setup with the nodal responsibility of coordinating women’s welfare and development programmes. A number of steps have been taken up by the Bureau to activise different ministries and departments dealing with women’s programmes in the Government of India, particularly the Ministries of Education and Culture, Health, Industry, Rural Development and such of the voluntary organizations which contribute substantially towards collection of information regarding the relevant programmes of these ministries. The Bureau, besides playing the nodal role, also implements schemes for the welfare and development of women.

The Ministry of Social Welfare carried out a number of programmes to supplement the requirements of women which are not met under the general development programmes. These programmes included assistance for construction or expansion of working women’s hostels, condensed courses of education for adult women and vocational training courses enabling them to qualify for the middle school or the high school as also to impart training –cum-production centres for women, training programme for rehabilitation for women in distress, aids for short stay homes for women immoral danger, socio-economic programmes for destitute and physically handicapped women, organizational assistance to major voluntary and social welfare organizations, and so on.

The Committee on the Status of Women in India (1974) viewed health as both an important factor in the achievement of status as well as an indicator of social status. It has been argued that health is not merely a state of non-illness but the entire life spectrum from conception to death should engage our attention in order to improve the quality of life at all levels. It is believed that what makes good health is as much a matter of scientific understanding of nutrition, hygiene and causation of disease as of cultural orientation to health and illness. Gandhi and Shah (1992) included class, caste, political and social factors as integral to an assessment of an individual’s or group’s health status. Health according to them is not only survival but also a positive relationship with one’s own body. Naik (1985) found that for a
common man health is a fifth priority, which comes after food, shelter, clothing and employment. In the condition of sickness and accident when survival is in danger, people think of health as a priority.

The examination of India’s health situation points unequivocally to two large population groups who are especially vulnerable to disease and death: ‘women’ and ‘children’. The health of these two is inextricably linked both biologically and sociologically. From the moment of conception to the time of weaning, the child is physically dependent on one’s mother and many aspects of a woman’s health, her nutrition and infection status directly affect the health of the child. Besides biological effects, women also determine their children’s health through practices relating to feeding, health care, and children’s work and so on. In turn, the survival and health of children and their number have profound effect on the physical and psychological health of women. According to Haxton (1985), ‘In developmental terms, as well as biologically, it is useful to consider the mother and the growing child as a single unit’. Thus, if progress is to be made towards improving their health, attention must be paid to women’s health status and to their health related behaviour.

1.1 The Role of Television in Disseminating Information on the Above

Television, which had its birth in yesteryears and whose growth has been phenomenal in recent times, has now a firm grip on everyone. From the Nipkow disk of 1884 to the Video disc of 1984 is exactly one hundred years of hard human toil. The hundredth TV transmitter has been installed in India coinciding with exactly one century of Nipkow’s disk, the precursor of Television. During this period we have seen how the phenomenon called Television has shaped and has in turn been shaped by our culture and social systems. Nipkow’s device had been “the basis for experiments in the transmission of images”, the Video disc has been the culmination of Nipkow’s dreams. Television is comparatively a transitional arrival in the field of communication. However, once it comes to a country, it stays. The beginnings are small and modest. But no matter what the beginnings are, it grows into a giant and needs feeding and feeding in a big way. It is not content with small morsels of programmes. It needs big helpings of a variety of programme cuisine. It creates a world which seems very real and viewers are unable to differentiate between the
contrived world and the real one. Impact of television is more on the young children and adolescents, who sit in front of the television, and for hours, succession of pictures is watched by eyes that are only just opening onto the world, and it becomes imprinted on minds that are still impressionable. The availability of cable and satellite television exposes them to new information about the outside world; reinforces stereotypes and beliefs which may affect individual attitudes and behaviours. It’s also a known fact that children’s gender development occur through observation and imitation of gender behaviour.

The official policy stressed that television was to be used as a medium for social education as well as an instrument to support programmes of social and economic development. Specifically, it was stated that television would be used as a weapon against illiteracy and ignorance; it would bring about awareness among the people of sociological problems and make them conscious of national goals; it would create a sense of participation in India’s efforts to usher in a new social order; it would play a vital in cultivating civic consciousness and respect for law and order, public mortality and so forth and, in the field of entertainment, it would mould public taste to higher aesthetic levels. Over the years it has become a central dimension of our everyday lives, and in India it has grown at a phenomenal pace. Ever since the introduction of television in India in 1959, the expansion of television network has been phenomenal. An UNESCO funded pilot television project was commissioned in Delhi in September 1959 for carrying out studies in the use of this medium for imparting social education. In August 1961, educational programme for Delhi schools was introduced with the prime objective of imparting education. As the next step, television service for general public was introduced on 15th August 1965 which marked the beginning of entertainment oriented programme through television. Two years later in January 1967, ‘Krishidarshan’ programme was started.

The second television station in India came into existence in Bombay on 2nd October, 1972. In 1973, the Bombay station began relaying programmes to Pune and later, the television stations were established at Srinagar and Amritsar. In 1975, the Satellite Instructional Television Experiment (SITE) was undertaken for a period of one year to cover 2400 villages in six states. In 1977, terrestrial transmitters were setup at Jaipur, Hyderabad, Raichur, Gulbarga and Sambhalpur. Since, then a number
of television centres have been installed all over the country by expanding its network on campaign basis, particularly during 1984-85. Parliament in 1990 passed the ‘Prasar Bharti’ (Broadcasting Corporation of India) bill to give autonomy to Doordarshan. All Doordarshan Kendra’s through their five hundred and fifty three television transmitters telecast programmes regularly in their service areas. These programmes occasionally include entertainment as well as various aspects of development like family welfare schemes, community development, functional literacy, agriculture etc.

Television is now reaching every nook and cranny of the country. It is necessary that television producers evolve a new production style for programmes in general and for women’s programmes in particular. This style should be based on a close and continuing interaction of the producers with women to ensure their participation in the production process. It is also important that the programmes are area-specific and have a local flavour and colour. The question of language/dialect must also be taken into account and it should further be ensured that the language spoken is understood by the viewers and is unambiguous and un-esoteric.

Ever since the start of the “Decade for Women” under the auspices of the United Nations, efforts have been made all over the world to involve women in various tastes, particularly in those which have a direct bearing on the development and progress. In India also the story is no different. A decade internationally acclaimed as the Women’s Decade within which, coincidentally, television came of age in this country, it might well have been hoped that this powerful communication tool, totally in the government’s control, would have a prime responsibility to redressal the women’s situation; the need for redressal of women’s condition had been felt at the nation’s very birth but has remained so unfulfilled more than half centuries. Shaping the strategy for the nations Sixth Five Year Plan at a time that was midpoint in the Women’s decade, the policy makers has noted: “Despite development measures and the constitutional legal guarantees women have lagged behind men in all sectors”. It was analysed that the reality of development and raised fundamental questions about development processes and their intended and unintended effects on the lives of the people for whose benefit these measures are supposed to be initiated. But perhaps the most devastating evidence of the distortions of development, it is now recognised, comes from the female experience. It is evident that women have had unequal access
to the fruits of development and have often borne the brunt of its unintended backlash. An examination of the female “lag” throws up searing statistics which show that for the Indian female the discrimination and disadvantages of her condition have added up to an unequal struggle for survival itself.

There is extensive research documenting that the differentials in survival are paralleled by differentials in all important aspects of life itself – poorer nutrition, lesser health care despite higher levels of morbidity, lower education and skill formation. The problem of universal education has been long identified as one mainly of women, scheduled castes and tribes. There is a distinct polarization of classes in our country which has created all manner of disparities. And this has resulted in an unhealthy struggle in which women are certainly at a great disadvantage. Women belonging to the higher strata are able to secure spectacular jobs. And those who are below the poverty line are able to secure work as labourers, farm hands and domestic servants. The problem is that of the middle class women who victims of anxiety neuroses are. There is, for them, on the one hand, a paucity of jobs and on the other, the continuing awful fear of losing the jobs they do have, on one pretext or another and then not being able to find another. Then there is the constant nauseating fear of how to make two ends meet.

Women, particularly in our country, are living in a commercial civilization. As some has rightly observed: “The security of today is being shattered by the insecurity of tomorrow”. The Indian woman of today finds herself in a peculiar socio economic-cultural situation. There are many forces working simultaneously on her. There is the great heritage of our tradition which she is expected to preserve. There is the almost fossilized social order which works as a deadweight on the process of modernization. There is a regular inflow of ideas from the West which cannot be accepted blindly but have to be put to the test. Then there is the exposure to film and the print media-newspaper, books, magazines, documented records, posters, advertisements and above all the electronic media— radio and television and of late the Internet. Thus the woman of today has a tremendous exposure to concepts, persons, places and things.

The Indian Constitution has pledged the country to the creation of a new social order based on equality, freedom, justice and the dignity of the individual. To that end
it is dedicated to the elimination of poverty, ignorance, ill health, and gender inequality. The Constitution further empowers the state to make special provisions for women and children. The colossal investment in an expensive electronic medium such as television has been officially justified as a part of the effort to redeem these pledges which have, at best, remained pious hopes for so many. The argument as to whether television can sub-serve this purpose has now conclusively passed into the realm of rhetoric. The reality of today is that a vast investment is being made in this medium in the name of the poor and the vulnerable segments of Indian society. The need of the hour is to ensure that the medium begins to truly sub-serve that cause.

Many distinguished speakers have already highlighted the anomaly between television’s stated objectives and the actuality. The very fact that special efforts have to be made to draw attention to television’s utilization for the development of women and children is itself a reflection of that anomaly. For, given the context that women and children make two-thirds of the total population a medium that has been encouraged for the laudable aims mentioned earlier should be automatically catering predominantly to the requirements of those segments who form the majority and are widely recognized as the most vulnerable sections of the Indian society. It is only through serving the interests of women and children that television would be able to fulfil its role as a development tool. Therefore, women and children cannot be thought of as special segments to which the medium must cater through occasional or even regular programmes. Rather, its overall philosophy and approach have to be determined in a way that accords these two categories the overriding importance that their numbers and needs deserve. Their betterment is central to the social transformation television seeks. Programme ideas taken up on an adhoc basis will only lose their power in the welter of conflicting messages presently beamed and end up serving little more than the purpose of politicians and administrators wanting to claim achievements that don’t actually add up to anything in the field.

There is, therefore, need to press the government to announce that it considers the improvement of women’s condition, status and image a primary objective of television telecast channels. Towards this end, it must formulate clear-cut guidelines regarding the positive portrayal of women on television which take note of women in all facets of their lives, but particularly as workers and significant contributors
to family survival and the national economy so that respect for the women’s individual worth, understanding of her special problems and the need to promote the integration of women in terms of equality in all sectors of national life and development process is built up. Further, there is need for these guidelines to emphasise that the women’s dimension forms an integral part of all satellite programmes as far as possible and does not remain confined to isolated attempts to focus on women’s issues and within the women’s programme. Further these guidelines must enunciate the need for a portrayal of men that highlights and applauds them as caring, sensitive and self-sacrificing individuals, particularly showing them as co-operating in and taking on household, children and other family responsibilities. The implementation of these guidelines cannot be left to good intentions. Alongside, a careful evaluation and monitoring system needs to be setup. Channels should be made accountable and its performance ought to be open to public scrutiny.

Further, in order to promote a positive ideology that is sensitive and constructive about women’s needs and ensure that it permeates all programming and that there is a co-ordinated, consistent policy on the subject, there is need for all channels policy-makers, programmers and producers to have an orientation that sensitises them to the dimensions of the women’s question within a framework of general social issues. Similarly, a special committee should carefully scrutinise all advertisements to ensure that they do not portray women in derogatory and stereotyped ways. The purchase of foreign programmes should be limited to those that educate or promote a shared understanding of problems, particularly with reference to the roles, lives and struggles of women in other Third World countries. The reality of the ordinary Indian woman’s life needs to be explored through more field-based documentaries that rectify the myopia of the media’s middle class vision of women, but which also, through a creative search for solutions, offer an energizing, mobilizing experience that can motivate viewers to seek improvements. There is a general need to make the programmes more participatory and to draw in women and men, who are knowledgeable about women’s issues, to develop the programmes.

On the other side of the coin, we turn to the subject of television programmes for children. At the outset, one can recount a clause from the Declaration adopted by the United Nation General Assembly in 1959, which refers to the Rights of the Child.
It states that the child has: the right to affection, love, and understanding, adequate nutrition and medical care, free education; full opportunity for play and recreation, a name and nationality, special care, if handicapped; be among the first to receive relief in times of disaster, learn to be a useful member of society and to develop individual abilities; be brought up in a spirit of a peace and universal brotherhood to enjoy these rights, regardless of race, colour, sex, religious, national or social origin. The preamble of this Declaration says: “Mankind owes to the child the best it has to give”.

The contemporary social scenario in India presents a rather gloomy and depressing picture of the child during the most critical period of his life, that is, early childhood. Millions of children subsist in conditions of abject poverty wherein even basic necessities are lacking. Malnourishment is a choric problem. Deprived of minimum health care the children fall a prey to many debilitating diseases. Child neglect and abuse are widespread. Children undergo severe hardships as they are compelled to join the labour force at a tender age. Their access to intellectual influences, whether in the form of knowledgeable parents/elders, books or mass media is greatly limited. The general atmosphere in which a vast majority of our children grow is least conducive to their physical, emotional and intellectual growth. A major source of problems in the way of normal development and functioning of children is the failure of the family to meet the child’s basic needs, because of abject poverty and ignorance. According to Bettye Galdwell, children all over the world have the same needs and hopefully are entitled to the same rights, though there may be differences in the extent to which different cultures meet these needs and these rights.

In 1979 which was declared as the International Year of the Child, a list of children’s rights revised from the original United Nations document was circulated and became indicative of goals to be striven for throughout the world. Ensuring that all children have an opportunity to have all these rights fulfilled will depend on the mediators. The rights which fall under the mediating influence of the parental values and behaviour, though few, are far broader and, much more pervasive in terms of psychological meaning and development impact. The home is the basic educational institution for the child. It should provide the basic physical and psychological needs such as food, clothing, shelter and security and a sense of belonging and sense of self-worth. The family members are the child’s first caregivers/educators. The child’s
entire early development is a result of his experience within the family context, though it is subject to modifications as he grows older and interacts with more and more people outside the family. Unless the parents and the larger community in which they live feel concerned about the lack of a facilitating environment for their children, noconcerted and lasting actions will be taken and this will result in stunted and retarded growth and development of the children.

Mobilization of all organized sources is essential for substantial improvement in the health and well-being of children. A great barrier to overcome is the lack of awareness among parents, communities, opinion leaders, and even some professionals working with children and mothers about means available to them for nurturing life and fostering development. Overcoming that lack of awareness requires the involvement of a myriad of social, political and professional groups which can act as channels of support and communication to help parents use present knowledge and new techniques to ensure the survival, growth and development of their children.

In this, the media can make an indispensable contribution if we can plan for its effective utilization. It is through the media that we can reach millions of people, catch their imagination and enlist their commitment to the cause of children. A judicious selection and use of the media for highlighting the appropriate needs of children to specific target audiences will have to be planned jointly by the child development, communication and media specialist. The media can not only propagate and disseminate information and thus create public consciousness but can also provide specific directions for necessary actions and for the development of competence in the actual implementation of programmes by the different groups whose mediating influence determines whether the needs of children are met or not.

In India, children have been found to be most devoted and faithful viewers of television. The phrase “Television for Children” has two fairly distinct connotations. On the one hand, it includes television programmes that are specially designed for child audiences; and on the other, programmes that are designed for adults but are related to the various needs of children (i.e. child–related programmes). Children in India, like many other countries, enjoy watching television programmes not only those made specifically for them but those for general adult viewing. We, therefore,
have an obligation not only to produce what is meant for them but to see that our general programme take cognisance of them. Perhaps till today, very little research has been done to assess the overall impact of television on children. A large proportion of the children belong to disadvantaged sections of society and therefore, lack access to several vital services such as education, healthcare and nutrition. Television could provide an effective and far-reaching support to the existing educational system to which many children all over the country get little or no access to. Television can help such children not just to develop concepts such as those taught in school, but can also help to provide information on a variety of subjects including healthcare and nutrition. Television which has the power to reach such a vast number of people at one time can help tremendously in fostering the development of desirable values and habits in our country’s children. Child-related programmes can help greatly to improve the quality of child-rearing practices in the country. Programmes related to child-rearing would be directed primarily at parents of children between the ages of 0-6 years, as this age group of children is almost totally dependent on adults for all their needs. These programmes would focus on the characteristics and needs of children of different age groups in all areas—health, nutrition, intellectual development, language, social and emotional development—as well as an appropriate methods which can be used to foster development in each of these areas. Apart from informing parents about their children’s needs, television can also help to ensure that communities are aware of existing services that are available to them, and that there is a maximal utilization of these services.

Children should be able to enjoy television programmes, understand them and be enriched by them. Television should present to the child the larger world beyond the text books and the walls of his home and school. The programmes should stimulate them and help them to actualize their potential.

1.2 The Power and Promise of Health Communication

Communication for Social and Behavioural change has been accepted as one of the critical strategies for improving health status and performance of the health programmes. The power and potential of the communication has long been understood since early days by the Government of India in its plans and actions.
Although, a lot has been achieved over the years in a number of health programs (e.g. polio, small pox) and interventions but even today, India faces huge challenges as far as key health status and indicator are connected. There are several factors for the current situation which are related to “supply side” including inadequate infrastructure, gaps in human resources, challenges to funding release and utilization quality of services, access, and managerial and operational challenges and health being a state subject. The challenges from “demand side” have also been enormous which includes a very large and diverse population, tradition and customs, myths and misconceptions, beliefs, and perceptions, habits and attitudes, values and norms, and of course, gaps in information and knowledge and awareness issues. With the new Health Policy under consideration as well with the advent of SDGs, it is useful to explore the journey of health communication efforts from awareness to behaviour change and try to locate the key challenges in both supply and as well as demand side and proposes a road map and way forward that could make a real and big differences and real fast.

For a very long time since their inception in early fifties, the health communication programs were focussed on awareness, i.e. increasing knowledge, information and education without perhaps clearly and specially looking at or understanding that there are other factors sometime even much stronger than “knowing” that prevented or restricted people from “doing” or changing behaviour. This journey from “knowing” and“doing” in the crux of communication for Social and Behaviour change. Although the statement of the health communication problem has been realized but understanding the dimensions and layers in the Indian context has not been understood properly and that misalignment has occurred because we have applied the theories of change as it is, as it came from the west or from the developed economies. The basic distinction of individualism vs social being was not factored in the earlier models and frameworks which focussed on Health education and Health promotion constructs. The supply side “knew” and the people did not, so the flow of communication was one way—from the system to the people.
1.3 Objectives of the Study

1- To find out the health related problems in Varanasi district.
2- To study television’s accessibility and acceptability on the health care of women and children.
3- To analyze the effectiveness of television programmes on healthcare of women & children.
4- To observe how the health care programme presented on television motivate viewers (women & children) regarding their health care.
5- To calculate the impact of television on health care on different classes in the study area.

1.4 Hypotheses of the Study

H₁ – Impact of television on healthcare of women and children is not effective.
H₂ – The accessibility& acceptability of television on health care is not uniform for study area.
H₃ – The motivational behaviour of the television viewers through health care programme is negligible.

1.5 Methodology

In context to the above stated global issues, study was conducted on 401 women (reproductive and adolescent girls) to assess the impact of mass media especially television on the gender health by using Multiple Regression Model. (Reproductive was below 45 years of age and adolescent girls were above 18 years).
Chapter - II

REVIEW OF LITERATURE

Every research should base on the proper thinking and views which act the base for further research. It is essential because without sufficient knowledge and understanding of previous literature relating to the problem in hand, direction of the work may be vitiated and conclusion drawn may not appropriate. Thus a literature reviews pertinent to the problem chosen for analysis and interpretation provide a deep insight of what occurred, know are studied and yet what has not been done so far. Further with a view to ascertaining the gap, literature review is much essential.

Dietz and Gortmaker, (1985), “Do we fatten our children at the television set? Obesity and television viewing in children and adolescents”, reported that each additional hour of TV viewing per week increased the risk of obesity by 2%. The experimental study by Robinson found strong evidence of a causal link between TV viewing and children being overweight. In India, this association has also been emphasized.

Huston, A. C., J. C. Wright, M. L. Rice, D. Kerkman, & St. M. Peters, (1990), “Development of television viewing patterns in early childhood: A longitudinal investigation” they founded that in a two-year longitudinal study of children’s viewing habits, multiple one-week television viewing diaries were completed for 326 children in two cohorts (three- to five- and five- to seven-years old). Children’s viewing patterns changed very little over the course of the study. While results showed that as children aged they viewed more cognitively demanding programs, the researchers concluded that family characteristics were the strongest contributors to viewing patterns.

Crum, J. E., (1994), “What determines young children’s reactions to media violence”?analysed that viewing frightening television, even programming deemed appropriate for pre-schoolers, raised children’s heart rates and caused symptoms of
post-traumatic stress disorder (PTSD). In a survey study of 116 parents of three- to five-year-olds, 40% of parents reported at least one symptom of PTSD that occurred after a child viewed a scary event on television and that lasted at least a month. Sleep difficulties were one of the most common symptoms.

**DuRant, R. H., T. Baranowski, M. Johnson, & W.O. Thompson, (1994), “The relationship among television watching, physical activity, and body composition of young children”** in their study of physical activity, the behaviours of 191 three- to four-year-olds were directly observed for up to four days a year for four years. Researchers found that the more time children spent watching television, the less likely they were to engage in physical activity. Television viewing, however, was not related to measures of children’s obesity.

**Eron, L.D., (1995), “Media violence”** found that television is one of the major source of promoting violence. Violence on media is frequent, usually inconsequential and often rewarded. People are exposed to violence daily on television in a greater amount. Latest technologies bring on-the-screen coverage of firearms, rifle shots and other bodily violence directly into homes. Television amuses its viewers with realistic and bloody performances of killings, whippings and torture.

**Lowery, S.A., & M.L. DeFleur, (1995),** in their study “Milestones in Mass Communication Research: Media Effects” founded from religious leader’s viewpoint, media could be considered as risk factors for the youth by instilling an attitude of crime and violence amongst them. The aim to view the media in different perspectives is important in today’s world as it is playing a significant role not only in everyone’s life but also in the formation of the key social foundations.

**Gauntlett, D., (1998), “Ten things wrong with the effects model”,** Critics of studies that hold the media responsible for risky behaviour in young people have called particular attention to the problems of inferring too much from statistical correlations. Further, they argue that the “media effects theories” treat young people as helpless victims of the media, failing to recognize them as active and savvy audiences who can tell the difference between fictional events and reality.
Anderson, D. R., J. Bryant, A. Wilder, A. Santomero, M. Williams, & A. M. Crawley, (2000), “Researching Blue’s Clues: Viewing behaviour and impact” discussed that children who regularly watched Blue’s Clues, a curriculum-based interactive TV program for pre-schoolers, scored higher on standardized measures of problem solving and flexible thinking than children who did not watch Blue’s Clues, even though both groups of children had scored equivalently on a pre-test prior to Blue’s Clues exposure.

American Academy of Pediatrics, (2001), “Children, Adolescents, and Television” described the possible negative health effects of television viewing on children and adolescents, such as violent or aggressive behaviour, substance use, sexual activity, obesity, poor body image, and decreased school performance. In addition to the television ratings system and the v-chip (electronic device to block programming), media education is an effective approach to mitigating these potential problems. The Television Viewing and Adolescent Behaviour”: In the early 1980s, Anderson and his colleagues installed time-lapse video cameras in the homes of 106 Massachusetts families for a ten-day period and recorded their television viewing and interactions in front of the set. An additional 228 families in Massachusetts and 326 families in Kansas (in addition to the 106 families with video cameras installed in their homes) completed TV viewing diaries. Five hundred and seventy of the 660 initial families were able to be recontacted by telephone when the children were adolescents, and their high school transcripts were obtained. Pre-schoolers who viewed educational TV programs had higher grades and read more books in high school. Among girls, viewing violent programs in pre-school was associated with lower high school grades.

Anderson, Huston, Schmitt, Linebarger, and Wright’s, (2001), “Early Childhood A very large proportion of viewers absorbed the information that was provided in Grey’s Anatomy, and many of them had retained that knowledge six weeks later. American Academy of Pediatrics offers a list of recommendations on this issue for pediatricians and for parents, the federal government, and the entertainment industry.
Anuradha, et al., (2001), “TV viewing and children’s academic achievement with reference to punishment patterns exercised by the parents” reported significant difference in children’s amount of TV watching depending on the type of negative reinforcement and consequences exercised by the parents. The study also showed that parental disciplinary practices significantly affected children’s academic achievement. So, parents need to be educated about the negative effects of media, but it is not clear how to target messages in such a way that parents will feel that they have the power to make changes within the home. Pediatricians should encourage the development of media literacy, but studies indicate that few primary care physicians have the time or the inclination to address such matters in office visits because their time is limited and they believe that their efforts in this realm would be futile.

Anderson, D. R., A. C. Huston, K. L. Schmitt, D. L. Linebarger, & J. C. Wright, (2001), “Early childhood television viewing and adolescent behaviour: The recontact study” Pediatricians, educators, researchers, and policy-makers have raised particular concerns about electronic media use among very young children. Developmental science suggests that children may be the most vulnerable between birth and school age to certain negative effects of media use such as obesity, aggression, fear, and sleep disturbances. Paralleling this vulnerability is a unique responsiveness to educational programming that has been linked to both immediate and long range educational benefits.

Kulkarni, M.S., (2003), in the paper “Exposure to mass media and its impact on the use of family planning methods by women in Goa” to study the impact of women's exposure to television, radio and newspapers and its influence on their use of family planning with the help of a pre-designed and tested questionnaire was used to collect data from married non-pregnant women aged 15-45 years in a Northern Goa District. The samples were selected using a two-stage stratified random sampling method. The data were analyzed using chi-square and odds ratio (OR) test. The multivariate logistic regression analysis was used to study the effect of socio demographic variables for women's exposure to mass media in the use of family planning methods. The findings represented that the practice of family planning methods was significantly higher among the women who were exposed to television. The odds ratio
analysis indicates that the married women who were exposed to family planning messages in television were 2.44 times more likely to use the family planning methods compared to the women who were not exposed to these programmes.

**Rideout, V. J., E. A. Vandewater, & E. A. Wartella, (2003),** “Zero to six: Electronic media in the lives of infants, toddlers and preschoolers” observed that the Zero to Six study found that 74% of children under the age of two have watched television and 59% watch television on a typical day for an average of two hours and five minutes. Thirty percent of children zero to three years old and 43% of children four to six years old have televisions in their bedrooms. Those with screen media in their bedrooms use media for more time each day, and children in “heavy television” homes read less and learn to read later than those in other homes. Despite these data, more parents believe that television “mostly helps” rather than “mostly hurts” their children’s learning (43% vs. 27%).

**Christakis, D. A., F.J. Zimmerman, D.L. DiGiuseppe, & C. A. McCarty, (2004),** “Early television exposure and subsequent attentional problems in children” with the help of Data from the National Longitudinal Survey of Youth indicated that TV viewing at age one and three was associated with parental reports of attention disorder symptoms at age seven. Attention disorder symptoms were indicated by parent response to the five-item hyperactivity subscale of the Behavioural Problems Index (BPI), which assesses concentration, impulsivity, and restlessness. For every additional 2.9 hours of TV viewed per week at age one, a child was 28% more likely to exhibit attention disorder symptoms at age seven.

**Fuchs, T., and L. Woessmann, (2004),** “Computers and student learning: bivariate and multivariate evidence on the availability and use of computers at home and at school”, CESifo Working Paper no. 1321. Analysis of OECD’s Programme for International Student Assessment (PISA), 24 November Politicians, parents and schools are under increasing pressure to incorporate more screen technology in education. Yet few people are aware of large, well-controlled studies that fail to support a presumption of benefit. For example, a European based study of 15-year-old students in 31 countries concluded that those using computers at school several times
a week performed ‘sizeably and statistically significantly worse’ in both maths and reading than those who used them less often.

Gopinathan, P. R., et al., (2004), in their working paper “Kerala Research Programme on Local Level Development Centre for Development Studies Thiruvananthapuram”. Detailed analysis of programmes and the responses of viewers, especially women viewers, have been attempted. For the survey, they selected 100 houses each from a rural area and an urban area in Thiruvananthapuram district. The poor ward of the Sreekaryampanchayats situated on the outskirts of Thiruvananthapuram city formed the rural sample. The final findings of the study represents that in the Malayalam small screen woman has a ubiquitous presence, but her own voice is not heard much. Though formally educated, she is depicted as a docile and meek person. On the screen, as well as beyond, in the society, she gets little opportunity even to form her views, leave alone to air them. Her role on screen and off-screen is passive and undefined. In her insecurity and inhibition, she often forgets even the fact that she could have an opinion of her own and the ability to voice it, in public or in private. In a sense, she becomes the other, the societal requirement, the stereotyped version of her real self, in her haste to conform to its demands.

Halford, Jason C.G., et al, (2004), “Effect of television advertisements for foodson food consumption in children” The impact of television (TV) advertisements (commercials) on children’s eating behaviour and health is of critical interest. In a preliminary study we examined lean, over-weighted and obese children’s ability to recognise eight food and eight non-food related adverts in a repeated measures design. Their consumption of sweet and savoury, high and low fat snack foods were measured after both sessions. Whilst there was no significant difference in the number of non-food adverts recognised between the lean and obese children, the obese children did recognise significantly more of the food adverts. The ability to recognise the food adverts significantly correlated with the amount of food eaten after exposure to them. The overall snack food intake of the obese and over-weighted children was significantly higher than the lean children in the control (non-food advert) condition. The consumption of all the food offered increased post food advert with the exception of the low-fat savoury snack. These data demonstrate obese children have heightened
alertness to food related cues. Moreover, exposure to such cues induce increased food intake in all children. As suggested the relationship between TV viewing and childhood obesity appears not merely a matter of excessive sedentary activity. Exposure to food adverts promotes consumption.

**Hancox Robert J., Barry J. Milne,& Richie Poulton, (2004),** 
*Association between child and adolescent television viewing and adult health: a longitudinal birth cohort study* they found moderate correlations between reported television viewing at different ages. These data indicate that viewing habits established in childhood might persist into early adulthood. This in itself is a cause for concern. However, it suggests that child and adolescent viewing might be associated with poor adult health because it is correlated with viewing in adulthood. Because we did not obtain information on television viewing at age 26 years, we could not test this hypothesis directly. However, controlling for television viewing at 21 years of age did not eliminate the association between earlier viewing and age-26 outcomes. Indeed, age-26 health was better predicted by television viewing in childhood and adolescence than at age 21 years. Although viewing time estimates at age 21 years might have been less accurate than the composite measure at age 5 to 15 years, this finding suggests that television viewing during childhood and adolescence is associated with long-lasting detrimental effects.

**Stroebele, N., J. M. de Castro, (2004),** 
*Television viewing is associated with an increase in meal frequency in humans* concluded that watching television also makes us eat significantly more, even if we are not physically hungry. A recent US study found that even children who watched a below average amount of television (less than three hours a day for an average of 2.7 days a week) ate roughly the equivalent of an extra meal a day more than those who watched none. **Bickham, et al., (2006),** 
*Is television viewing associated with social isolation? Roles of exposure time, viewing context, and violent content* investigated the relationship between TV viewing time, content, context, and peer integration. As children spend more total time watching TV, they spend a significantly shorter amount of time with friends as compared to those who don’t. Thus, viewing television causes poor peer relationships and thereby
increases the risk for social isolation, anxiety disorder, agoraphobia, and anti-social behaviour, including aggression and gang involvement.

Christenson, Peter, (2006), “The Reality of Health; Reality Television and the Public Health” purpose of this paper is to describe the nature of these shows, provide an overview of the messages they convey about health and medicine, and explore some possible implications of these shows for audience awareness and knowledge. In addition to the shows where health is the primary focus, many other reality shows are tangentially related to health issues, or have an occasional focus on a health topic. The implications of these shows are also discussed. The final findings represented that the health implications of reality television are obviously quite mixed. On the positive side of the ledger, reality TV can generate awareness and visibility for health issues, some very common — such as smoking or obesity — and others less so. Programs such as Miracle Workers can bring attention to the plight of patients with specific, less common conditions, perhaps stimulating research funding, or simply generating compassion for those who suffer. Health:

Myers, D., and others, (2006), ‘Multitasking and task switching’, Brain, Cognition and Action Laboratory. Studying with a television on makes learning less efficient, and renders what you manage to learn less useful. Homework can take 50 per cent longer to complete. Neuroscientists behind this research are describing the benefits of modern multi-tasking as ‘a myth. … The toll in terms of slowdown is extremely large – amazingly so … you will never, ever be able to overcome the inherent limitations in the brain for processing information during multitasking’.

Sargent, J.D., T.A. Wills, M. Stoolmiller, et al., (2006), “Alcohol use in motion pictures and its relation with early-onset teen drinking,” concluded among recent studies linking media portrayals of alcohol use to drinking onset among adolescents is a study which demonstrates a strong and statistically significant relationship between viewing alcohol use in films and drinking among teens in the US, even after controlling for a number of potential covariates; the relationship held for both cross-sectional and longitudinal analyses.
Chaput, J.P., & A. Tremblay, (2007), “Acute effects of knowledge-based work on feeding Behaviour and energy intake” The journal Physiology & Behaviour reported the findings of an experiment whereby one group of female students was placed in front of a computer and asked to read a document and write a summary of 350 words on-screen, while another group was asked to simply relax for 45 minutes in a chair. Those doing the computer-based task burnt just three more calories than the others, but ate much more food when given access to a buffet afterwards: an extra 230 calories. The researchers describe screen media as “obesogenic”.

Pardee, E., et al., (2007), “Television Viewing and Hypertension in Obese Children” A previous study in the American Journal of Preventive Medicine looked at children who were already overweight and found that the severity of obesity and daily TV time were significant independent predictors of high blood pressure in these children. Children watching 2 to 4 hours of TV a day had 2.5 times the likelihood of having high blood pressure compared with children watching 0 to less than 2 hours. While those children watching 4 or more hours of TV were 3.3 times more likely to have high blood pressure.

Frank, B. Hu, (2008), “Television Watching and Other Sedentary Behaviours in Relation to Risk of Obesity and Type 2 Diabetes Mellitus in Women” their findings could have important public health implications. The prevalence of obesity and type 2 diabetes has increased dramatically in the past several decades in the United States. Although leisure-time physical activity levels are generally low in the United States, there is no evidence that recreational physical activity has declined in recent decades. However, sedentary lifestyle has become more prevalent and pervasive as reflected by the large numbers of TV sets, VCRs, and remote controls per household and increasing time spent watching TV in the past several decades. They speculated that increasing sedentary behaviours, especially TV watching, may have contributed to the obesity epidemic in the United States. Given the strong relationship observed between sedentary lifestyle and obesity and diabetes risk, public health campaigns to reduce obesity and diabetes should not only promote increasing exercise levels, but also decreasing sedentary behaviours, especially prolonged TV watching. Substantial health benefits can be gained by even light to moderate activity such as doing
household chores and by engaging in simple and convenient activities such as walking.

**Jensen, Robert, (2008)**, in the article “*The power of TV: cable television and women's status in India*” explores the effect of the introduction of cable television on women's status in rural India. Primary dataset is the Survey of Ageing in Rural India (SARI), a panel survey of 2,700 households, each containing a person aged 50 or older, conducted in 2001, 2002 and 2003 in four states (Bihar, Goa, Haryana and Tamil Nadu), and the capital, Delhi. And basic empirical strategy is to compare changes in our measures of women's status for villages that add cable over the course of the panel relative to those that do not. They run individual-level fixed effects regressions of each outcome on cable availability (measured at the village-level). And the final findings are several mechanisms through which cable television may affect women's status.

**NRC Report, (2008)**, “*TV and Kids: The Good, the Bad, and the Ugly*” Then find out which TV habits seem to go along with better or worse behaviours, and if watching certain programs tends to be followed by certain behaviours. They find that kids who watch more TV and more violent programs are more likely to have problems, according to their teachers. When parents supervise their children’s TV viewing, they can increase the good things kids learn and decrease the bad things they learn. That is one reason why you should watch TV with your kids when possible, and why kids should watch TV in a room that you or other adults spend a lot of time in. All parents should care what their kids watch on TV and how much they watch – and if you do, TVs do not belong in children’s bedrooms — no matter how old your kids are. On the key fact presented in the show—that an HIV-positive pregnant woman who gets the proper treatment has more than a 90% chance of having a healthy baby—the proportion of viewers who were aware of that fact quadrupled, from 15% before the show to 61% after it aired, an increase of 46 percentage points.

**Rideout, Victoria, (2008)**, in the article “*Television as a health educator: a case study of grey’s anatomy*” having the objective to study that television working good as a health educators, and using the three national telephone surveys that were designed to measure the impact of a storyline featured in the popular ABC television show
Grey’s Anatomy. The first survey was conducted just before the target episode aired, the second was conducted during the week after the episode aired, and the third survey was conducted six weeks later. This study documents the enormous potential of popular entertainment television to serve as a health educator—even on a show that has a “soap-opera”-like feel and a comedic bent.

Bhojani, U., (2009), “Study of tobacco use and perceptions about tobacco use and related factors among the pre-university students in Bangalore city,” More recently, data from a global youth tobacco survey covering 13–15 year olds from 23 states in India found that tobacco advertising was highly correlated with smoking behaviour. A cross-sectional survey on tobacco use among pre-university students in Bangalore city found that nearly one out of every five male students (18%) and about one out of every 20 female students (6%) reported wanting to use tobacco after watching movie/TV stars using it on screen; combined with peer pressure, films and TV were seen to be a powerful influence on smoking behaviours.

Heatherton, T.F., and J.D. Sargent, (2009), “Does Watching Smoking in Movies Promote Teenage Smoking?” evaluated that the impact of the media on smoking among young people is another area that has received the attention of researchers. Indeed, available research evidence has led the National Cancer Institute to declare a causal relationship between exposure to smoking in films and initiation of smoking among youth. More recently, a US study, using nationally representative samples and cross-sectional and longitudinal designs, observed that adolescents with high exposure to smoking in films were about three times more likely to try smoking or become smokers than those with low exposure to media smoking; the effect remained significant after controlling for a number of risk factors including personality, parenting style and socio-demographics.

Higgs, S., M. Woodward, (2009), “Television watching during lunch increases afternoon snack intake of young women” founded that the effects on increased appetite may continue long after the screen is turned off and viewing stops. A study in the journal Appetite of females in late adolescence found that the “effects of television watching on food intake extend beyond the time of television watching to affect subsequent consumption … [TV] increases afternoon snack intake of young women.”
Immordino-Yang, M.H., et al., (2009), “Neural Correlates of Admiration and Compassion” A study published in Proceedings of the National Academy of Sciences (2009) examined the brain function and development which underlie qualities such as empathy. The scientists drew specific attention to the effects of electronic media: ‘The rapidity and parallel processing of attention requiring information, which hallmark the digital age, might reduce the frequency of full experience of such emotions, with potentially negative consequences.’ One of the authors explained the possible interference with this process by the speed of today’s media: ‘For some kinds of thought, especially moral decision-making about other people’s social and psychological situations, we need to allow for adequate time and reflection. If things are happening too fast, you may not ever fully experience emotions about other people’s psychological states’.

Ophir, E., et al., (2009), “Cognitive control in media multitaskers”, Proceedings of the National Academy of Sciences, compared groups of young people assessed as being either ‘heavy’ or ‘light media multitaskers’. Ironically, they reported ‘the surprising result that heavy media multitaskers performed worse’. One of the researchers commented, ‘The shocking discovery of this research is that [high multitaskers] are lousy at everything that’s necessary for multitasking’.

Sigman, A., (2009), “The biological implications of social networking” concluded that each and every Muslim is aware that television can have a harmful effect on children. Most parents will openly accept that if allowed, television quickly becomes almost a third parent to children. And so the scene of children sat mesmerised in front of the television watching the latest cartoons or movies.

Small, G.A., et al., (2009), “Your Brain on Google: Patterns of Cerebral Activation During Internet Searching” Although the media often crow about internet and computer use increasing people’s ability to make quick decisions and filter large amounts of information, new research is finding that this may come at the cost of the social and emotional skills central to civilised behaviour. In particular, there seems to be a decline in the subtle skills of reading the nuances of other’s emotions. A study of brain function in adults found that when using the internet, the areas of the brain associated with empathy showed virtually no increase in stimulation. ‘Young people
are growing up immersed in this technology and their brains are more malleable, more plastic and changing than with older brains . . . As the brain evolves and shifts its focus towards new technological skills, it drifts away from fundamental social skills.'

Martinez-Gomez, D., et al., (2010), “Research article Excessive TV viewing and cardiovascular disease risk factors in adolescents” The Spanish National Research Council has found a link between TV viewing and Cardiovascular Disease Risk Factors in Adolescents. After analysing blood tests, those adolescents watching more than 3 hours per day were found to have 'significantly less favourable' levels of HDL-cholesterol, glucose, apolipoprotein A1, and overall cardiovascular disease risk scores. The researchers also observed a 'negative influence of TV viewing on waist circumference.

Ray, Munni, and Kana Ram Jat, (2010), “Effect of Electronic Media on Children” calculating that radio, television (TV), movies, video games, cell phones, and computer networks have assumed central roles in our children’s daily lives. The media has demonstrated potentially profound effects, both positive and negative, on children’s cognitive, social, and behavioural development. Considering the increasing exposure of children to newer forms of media, we decided to review the current literature on the effects of media on child health both in the Western countries and India. It is widely accepted that media has profound influence on child health, including violence, obesity, tobacco and alcohol use, and risky sexual behaviours. Simultaneously, media may have some positive effects on child health. We need to find ways to optimize the role of media in our society, taking advantage of their positive attributes and minimizing their negative ones. We need to understand better how to reverse the negative impact of media and make it more positive.

Irwin, Mary, (2011), “What women want on television? Doreenstephens and BBC television programmes for women, 1953–64”. It is in the first article that Stephens puts her case for the importance of providing television specifically for the needs and interests of the women who were watching at home. She points out that, factually, the women who were predominantly involved with managing home and family life made for ‘the largest occupational group in the country’, continuing, ‘It is fair enough that
the BBC Television Service should appoint someone to take care of their interests’ (1954a, 7). She is, however, conscious of the needs of working women. In her second piece she asks, ‘But what to the needs of the women who go out to work? Is there [sic] to be no evening programmes for them?’ (1954b, 7). She cites the experimental two and a half hours that her department was to receive in January and February 1955 as a possible solution. The additional factor of women’s programmes being placed in an afternoon slot, rather than being broadcast along with what was seen as important and prestigious material in the evening, may well have meant that the programmes were largely judged on the criteria of being lightweight, disposable afternoon fare, and that the category of ‘women’s programmes’ was very much a secondary classification. That is, they were not archived simply because they were made for women, but were seen as part of a more general category of expendable, ephemeral television programming.

Veerman, J.L., et al., (2011), “Television viewing time and reduced life expectancy: a life table analysis” study observed to their potential outcome, several new studies have found a link between TV viewing time and life expectancy. In a new study ‘Television viewing time and reduced life expectancy’, researchers concluded that ‘TV viewing time may be associated with a loss of life that is comparable to other major chronic disease risk factors such as physical inactivity and obesity’.

Walker, Adam Hani, (2011), “make sure that our children get a childhood: the impact of television and television advertising on children” A factor which parents should keep in mind is that studies have revealed that children, particularly those aged 0–5 years, are increasingly vulnerable when confronted with television advertising. A key factor in this is that they are not able to distinguish between ordinary television content and adverts, seeing both as one in the same. And so their minds cannot yet comprehend that the advert is designed to persuade them to purchase or pester their parents to purchase the product being advertised. When children surveyed were asked to retell the content or story of a program they were watching they incorporated the advert into the wider story narrative. This effect is compounded by a practice known as “host selling” in which advertisements include the same, or similar, characters which are found in the programme they are watching. The effect of this is to
strengthen a child’s belief that the advertisement and main programme content are a single narrative and build up brand loyalty.

Westoff, Charles F., Koffman, A. Dawn, Moreau, Caroline, (2011), in the paper “The Impact of Television and Radio on Reproductive Behaviour and on HIV/AIDS Knowledge and Behaviour” is a study of the association of radio and television exposure with different aspects of reproductive behaviour and with knowledge, attitudes, and behaviour in connection with HIV/AIDS. The measures of mass media are limited to the frequency that women and men report listening to the radio and watching television, which are standard questions in the Demographic and Health Surveys (DHS). Only the frequency is assessed; the DHS does not obtain information on programmatic content. Television viewing in particular is found to be strongly associated with the use of modern contraception and with a smaller number of children desired and fewer births in the recent past. These associations generally persist after adjustment for the amount of schooling, wealth, urban residence, and other covariates. In this part of the study, the main assumption is that the media provide valuable information on the sources of infection, how to avoid it, where to get tested, the importance of condom use, and various other related subjects. In general, radio exposure appears to be more important than television as a conduct of such information.

Wendel Brunner, MD, PhD, Kate Fowlie, BA, Julie Freestone, MS, (2011), in their paper “Using Media to Advance Public Health Agendas” discussed that Media Advocacy is a strategy that changes the frame for health from individual responsibility to focus on environmental causes of ill health, and proposes specific policy solutions. It often uses a “news hook” as an opportunity to promote a policy agenda. Media Advocacy is generally aimed at policymakers. “Media Advocacy,” says Lori Dorfman of the Berkeley Media Study Group, “is a public conversation between the advocates and the policymakers held in the media.” Effective media advocacy frames issues in fundamental community values that motivate people, like justice, fairness or family. LHDs, generally perceived as protecting the community welfare, have particular credibility in their communities to use these frames, and so can be especially effective in conducting media advocacy campaigns.
Jahangir, SyedaFarhana, and Nazia, Nawaz, (2014), In the current study “Effects of Media (Television) on Mental Health” the effects of television have been investigated as an information source with special reference to mental health of its audience. A sample of 470 individuals of both genders was approached conveniently of ages 18-60 years. An exploratory survey approach was designed for preliminary investigation regarding the effects of media on its audience. The results were compiled through frequency counting, percentages and content analysis techniques. Findings revealed that media contents are portraying an unhelpful role by promoting Violence (41%), Vulgarity (46%), and Chaos (65%) while the smaller proportion (22%) of the sample reported media as entertaining. Moreover the most devastating effect of media is its key role as a contributor to stress and tension (97%), which is waning the mental and psychological health of its audience. It has been concluded that media is producing adverse effects on the psychological well-being of its audience.

Meti, Vijaykumar, (2014), in his paper “Impact of Television Health Programmes on Women: A Study on Gulbarga Television Viewers” explore and study the consumption pattern in regards to the health programmes on television for women ages above 20. The study also include women’s rationale for watching health-related shows, their perception of the situations portrayed on these shows and also the impact on them based on the sample of 120 respondents in selected areas of Gulbarga city of Karnataka state. The results are discussed and have been observed the types of television programmes are viewed, popularity of different channels and their contents among women and the opinion of health programmes among viewers. The objective of research was to understand the relationship between viewer motives for watching television and interpersonal relationship perceptions. The interpersonal relationship perceptions that were examined included: attachment styles, love styles, and Machiavellianism. This research used both quantitative surveys and focus group interviews as data. The quantitative data analysis produced support of genre specific media effects. First, motives were examined in relation to the television. Watching for positive outcomes was positively related to television viewing and watching for interpersonal outcomes was negatively related. Second, the relationship between television exposure and perceptions was examined. Respondents discussed how health programmes on television made them to be aware of their health condition and also
how to remedy for common disease including personal health care. Finally, respondents agreed that health programmes are very helpful for providing information and remedies about certain common disease.

**Sahai, Devina, et al, (2014), “Impact of Excessive Watching Television on Health and Nutritional Status among Suburban Children”**: find status of excessive watching television impact on health and nutrition among children of suburban town. The study was prepared at Deva Sub-urban town of Barabanki district state Uttar Pradesh (India). A-100 families purposively selected those having the child/children 03-12 years of age. Their recorded views in face to face situation through interview schedule method. The parameter used RDA and RDI, weight and height etc. The main findings of the paper were; the most-liked TV programme; 39% cartoon film followed by 34% film show, 10% educational programme, 9% social serials, 5% others and least 3% news. The time spent on programmes was approx. 8 hours-39%, 6 hours-23%, 4 hours-14%, and 2 hours and less than two hours: 24%. The obesity status; 38% overweight or obese; 42% healthy and rest 20% underweight. The intake of snacks and meal during watching TV was observed among 62% subjects not taking healthy food, only 38% subjects intake healthy food. The liking of food; fast and junk food; 68%, milk 10% and rest 22%. Therefore, it was observed that approx. 68% subjects were found unbalanced and unhealthy nutritional status that was watching excessive television programmes.
References


Gauntlett, D., (1998), “Ten things wrong with the effects model”, in Approaches to


Wendel, Brunner, M. D., Kate Fowlie, Julie Freestone, (2011), “Using Media to Advance Public Health Agendas”, Available at Wendel.Brunner@hsd.cccounty.us

HEALTH RELATED PROBLEMS IN INDIA WITH RESPECT TO VARANASI DISTRICT

Health status of the population is one of the significant indicators of social and economic well-being and is rightly defined by WHO as, “a state of complete physical, mental and social well-being and not merely absence of disease or infirmity.” In India ‘health’ as fundamental human right and its importance as the ‘engine of growth’ had long been recognized. It is an important ingredient for development. Health supports development process; it spurs economic growth and is a good measure of human well-being. Enhancement of health of the people is one of the major objectives of development. Health improves the productivity and skills of the people and reduces absenteeism from. It thus increases income of poor people. Health directly improves the socio-economic conditions of people in many ways. Improving health status of people is one of the basic goals of development. Health is not only an end product but it is also a major contributor for economic development. Health gives capability and brings the capacity for personal development, with economic well being; health is a critical input for poverty reduction and economic development.

Unfortunately, India presents a gloomy picture of health and healthcare in terms of human resource development. The history of health era is very old which can be classified in four phases(Biswas, Somak, 2015)

1. Phase One: Pre- Agricultural Age
2. Phase Two: Primitive Agricultural Age
3. Phase Three: Age of National & International Trade Practices
4. Phase Four: Modern Age

3.1. Phase One: Pre-Agricultural Age

It has been presumed that during pre-agricultural era when human beings did not have a settled life, even then, health economics was in practice. This period was relatively characterized by good health. High protein diet was available. Movement
from one place to another solved two basic problems, finding food and disposing excreta. Infectious and nutritional diseases were rare and life expectancy was long.

3.2. Phase Two: Primitive Agricultural Age

The second period was characterized by settled human life, an agrarian society. Food habits changed from protein–rich nuts and berries to cereal-grain products. Dental caries and abscesses increased due to poorly ground grain and greater sugar content in cereals. With settled life, exposure to pathogens increased leading to an increase in infectious diseases. By this time, people started to develop an understanding about the nature of different diseases, their causes and cures.

3.3. Phase Three: Age of National & International Trade Practices

The third era was categorized by the growth of cities and nations. Importance of health as a pre-requisite to socio-economic development was started to be recognised. Europe, Greece and Rome were the forerunners in advancement of medical science. Greeks made the subject of medicine and medical care more scientific; gave the doctor modern professional status; defined an ethic for the relationship between doctor and patient; and advocated free medical service to sick poor. This was also a phase when trade in Europe began. Independent, isolated economic units began to lose their identity. Their interaction with heterogeneous economic units of other nations led to introduction of new health influences, positive and negative.

The medical philosophy of Greece and Rome was conserved and advanced by Arabs in 12th century. There was a remarkable expansion of medical care facilities, between 12th and 18th centuries, mainly due to an increasing demand for better health facilities, sustained increase in understanding of diseases and development of the idea of disease-prevention.

Late 18th and early 19th centuries were characterised by reduction in mortality, due to improvement in medicine. It was a phase when quinine was introduced; vaccination against small pox was invented and effective treatment for diseases such as diphtheria and syphilis were started. However, as a result of industrial revolution, there was rapid industrialization and urbanization, which led to introduction of several
urban health hazards, such as problems of sanitation, inefficient garbage and sewage service, and inadequate and unsanitary water supply. Questions regarding funding of programmes to eradicate different diseases as well as solution to problems associated with urbanization were raised. Individual action was expensive. Collective action by joint agreements between different private parties was almost impossible because of conflicting economic interests. It was thus observed that government action was needed.

By the mid-nineteenth century, harmful externalities related with poverty, unhygienic environment and infectious and epidemic diseases was recognised. Modern medical professionalism emerged which believed that health can be improved at a cost. British Medical Association was formed in 1832, American Medical Association in 1847, and General Association of French Physicians in 1858. The need to increase public expenditure for fulfilment of socio-economic needs including poverty alleviation, employment opportunities, garbage collection, sewage disposal and clean water provision along with expenditure on health care was acknowledged. By late 19th century, health came to be redefined as a social good. Various public health measures such as construction of clean water and sewage systems were started. To cover the costs of such measures, new taxes were introduced.

3.4. Phase Four: Modern Age and Post-Globalisation Phase

By early 20th century, there were great advances in healthcare industry marking the beginning of fourth phase in history of health and healthcare. Health and economic growth interacted endogenously. There was rampant growth of national and per capita income. Increasing wealth led to an increasing demand for medical care making it a consumer good. At the same time, medical industry started to be professionalized with increasing competence among medical practitioners, scientifically defined standards of medical education and training, and issuance of practicing license. There was an increase in the number of hospitals based on commercial lines in contrast with charitable institutions of medieval period. Hospitals grew into a place for treatment of diseases, surgical operations, training of doctors, nurses and other paramedical staffs, along with a centre for wide range of medical research.
During the inner-war period, Soviet Union introduced an alternative model of socialized medicine, in which medical personnel worked as an employee of the State. After World War II, following the Russian example, hospitals were nationalised in many countries with an intention to reduce costs associated with health care, and use general tax revenue to pay for the health care system.

In the last sixty years, volume of medical care has tremendously expanded. There has been an all-round growth in number of hospitals, dispensaries, and clinics, along with qualified doctors and supporting staff, dentists, and nurses. Medicine and diagnostics have become economically more paying. The practice of health care as an economic activity has been radically transformed. Medical Industry has become professional by adjusting to changing demand and supply of healthcare and making demand for health care supply-induced.

A look back to the above economic history reveals that the concept of health and health care has been transforming over ages. However, the most important change has been the recognition of the importance of health as a prerogative to socio-economic development. There has been a rising recognition to preventive social action against diseases. The idea of public responsibility for the sick has been acknowledged. There is no further debate on the issue of whether healthcare is a responsibility of the state or not. The debate about health care has now changed from the discussion about the responsibility to the discussion about efficiency in the provision and management of healthcare.

3.5 Health Sector in India

The healthcare sector in India is at the crossroads. This is partly due to an interesting relationship between development and health, which is known as the Preston Curve. In 1975, Samuel Preston showed that if the health of nations as measured by Life expectancy is plotted against the wealth of nations as measured by Gross Domestic Product (GDP) per capita, then up to a point, there is a sharp increase in life expectancy for even the modest increase in GDP per capita. Then the curve suddenly flattens out—and after this point, large increases in public health expenditure are required for modest increase in life expectancy (Deaton 2013). In his book “The Great Escape” explains that even after the bend in the Preston curve, there
is a sustained correlation between health outcomes with growth—only that now it is a logarithmic relationship—for the same degree of increase one requires a four-fold increase of the GDP per capita. He also points out that it is a two way relationship—that not only is economic growth related to better health, this bend in the curve also represents the point of epidemiological transition—when non-communicable diseases start becoming the main cause of death, increasingly dwarfing persistent contributions from the declining deaths due to maternal and common childhood diseases.

In the 2010 version of the Preston Curve, India today is at or near the bend on the curve, and this has major implications for policy. At the bend in the curve, the past problems of reproductive and child health and of communicable disease persist, but new problems have got added on. If public investment in health care does not increase, private investment would, but there is no certainty that this would lead to better health outcomes. If public investment increases, a choice has to be made between deploying it to strengthen public health system and purchasing care from private sector. If the case is latter then one needs to be ready to impose a strong regulatory regime and also increase public expenditure far above the 2.5 percent of GDP that the current national health policy draft calls for (Sundararaman, Maraleedharan, and Mukhopadhyay, 2016).

The very conception of ‘Health for All’ (HFA) is based on a ‘holistic paradigm of social development’ where human wellness (more than well being) is accorded priority. Even the concept of human development, which is far less comprehensive and transformative than social development, comprises of three components: (i) growth in personal income (ii) improvement in education, and (iii) health (more longevity). It is not only broader and more comprehensive than ‘Universal Health Coverage’ (UHC), but also differs from the latter in quality and depth because in UHC, the focus is more on ‘coverage’ while in HFA, focus is on wellness and care. Second, UHC emphasizes more on a health financing system based on the pooling of funds from public, private and joint sectors in order to provide health coverage to all people of a country (implying some personal contribution from people too), while conception of ‘health of all’ implies public financing (by state) for health care of all. Third, UHC presumes a ‘package’ of primary health services through insurance companies, mainly private (through competition in open market)
but sometimes both public and private, while HFA implies delivery through government facilities at different administrative levels.

To put the conception of ‘Health for All’ in a historical perspective, United Nation envisaged a comprehensive and integrated primary health care for all in Alma Ata Declaration in 1978 to promote equity and was driven by the community needs.

The constitution of World Health Organisation (WHO) mentions ‘that health, well-being, standard of living, medical care, right to security in case of sickness as well as special care and assistance for mothers and children are quite significant and notable in the context of HFA. In addition, Article 3 of Universal Declaration of Human Rights (UDHR) clearly provides that everyone has ‘the right to life, liberty and security of person’. Obviously, right to life includes right to food and health (as interpreted by Supreme Court of India). The Alma Ata Declaration in 1978 was thus, in consonance with UDHR and WHO’s constitution. In fact, at Alma Ata (now Almati in Kazakhstan) International Conference on ‘primary health care’ expressed the need for ‘urgent action by all governments, all health and development workers, and the world community to protect and promote the health for all the people of the world’. Its main resolutions are follows:

i. Health, which is ‘a state of complete physical, mental and social well-being’, not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the ‘highest possible level of health’ is a most important worldwide social goal;

ii. The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable;

iii. Economic and social development is of basic important to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries;

iv. People have the right and duty to participate individually and collectively in the planning and implementation of their healthcare;

v. Government have a responsibility for adequate health of their people, to be attained by 2000;
vi. Primary health care is key and essential, to be made available at a cost that community and country can afford;

vii. Primary health care provides *promotive, preventive, curative* and *rehabilitative* services, and promotes maximum community and individual self-reliance and participation in planning, organization, operation and control of primary health care, making the fullest use of local, national and other available resources;

viii. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as a part of comprehensive national health system;

ix. All countries should cooperate in a spirit of partnership and service to insure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country;

x. An acceptable level of ‘health for all’ for the people of the world by 2000 can be attained through a fuller and better use of world’s resources, a considerable part of which is now spent on armaments and military conflicts; a genuine policy of independence, peace, detente and disarmament could and should release additional resources, to be used for socio-economic development including primary health care.

WHO time and again reiterated for *Health for All*, especially in 2005 and 2011 too, though it used ‘Universal Health Coverage’ with health financing system including a method for prepayment of financial contributions for health care, with a view to share risk among the people, under the influence of World Bank in particular and the process of *liberalization, privatisation* and *globalisation* in general. United Nation (UN) resolution in December 2012 further emphasized it for overall human development and to be included in post-2015 development agenda. However, World Bank in its World Development Report(1993) ranked common health care interventions according to *cost-effectiveness*; its minimum health package for low income countries considered to avert one-third of estimated disease burden and one-fifth of that in middle income countries. But, unfortunately, many common ailments (moderately severe injuries and chronic conditions like diabetes, cataract, hypertension, mental illness and cervical cancer) were excluded from public funding in low income countries (as found by *M.Segall* in 2003). Consequently due to
‘Structural adjustment’ or economic reforms during 1980’s in the poorest 37 nations, public spending on health per head the declined by half due to cuts—e.g. in Mexico, it declined up to 60 percent during 1982-87.

Due to the adverse impact of liberalisation, privatisation and globalisation in 1980’s and 1990’s, most of the developing countries having faced following problems regarding health:

a) Since state retreated from development interventions, there was a massive decline in public investment in health sector like other social subsectors (education, welfare of the deprived sections, etc.); e.g. In 1991, Peru spent $12 per capita on health and education while in 1980, it spent about $50 per capita and in 1991, it paid $25 per head to Western banks as dept repayment;

b) There accrued a huge shortage of doctors and supporting medical staff, hence availability of doctors and staff decreased, leading to patients bound to go to private clinics;

c) There was a shortage of medical equipment, drugs and pathological facilities in public health institutions- hospitals were reduced to mere writing of prescriptions and patients were compelled to buy medicines from the open market and to get pathological tests done at private labs at higher costs;

d) Private doctors not only indulged in charging exorbitant fees but also prescribed unnecessarily more and costlier medicines as well as avoidable pathological tests;

e) Due to laxity of the state apparatuses, even government doctors and supporting staff started giving more time at their private clinics, even during official duty hours, with the profit and commercial motive.

f) Due to the retreat of state in providing subsidized food, nutrition, safe drinking water and sanitation facilities, there was a rise in communicable and non-communicable disease among the poor people who are unable to afford the required medical treatment, leading to long duration of morbidity and finally death;

g) The phenomenon of free market (invisible hand) was based on the ‘individual care’, considered as a ‘private’ good but in most of Latin American countries like Chile and Colombia, there was no improvement in quality of health care,
equity and efficiency for the local people while the private insurance companies, consultancy firms, private pharmaceutical companies and private hospitals earned great profits.

Nowadays, public-private partnership, modernization, value of money, health insurance etc. are the buzzwords in most of developed and developing countries. However, there are some alternatives health systems in Cuba, China, Costa Rica, Malaysia, Sri Lanka, Rwanda, Venezuela and Thailand. Since 2002, there is Universal Health care Coverage in Thailand for all people without any charge and now 77 percent of all hospital beds in that country are in public sectors (2012). Cuba has been famous for a long and sustained drive to ensure cataract operation of all old people at public facilities. There is equitable health service delivery with regulations like three years of compulsory rural service for doctors and nurses, and a radical shift in funding away from urban hospitals to primary care across Thailand. Health expenditure there increased from 1.7 percent of GDP in 2001 to 2.7 percent in 2008 but is still quite low; and there are only three physicians for every 10,000 patients compared to 9.4 in Malaysia, 11.5 in the Philippines, 12.2 in Vietnam and 18.3 in Singapore. There is also shortage of nurses due to less salary (and attractive salary results in their flight to Singapore).

Consequently, Millennium Development Goals (MDGs) were declared by member-nations of UN unanimously of which following relate to health:

(a) To halve, between 1990 and 2015, the proportion of people who suffer from hunger;
(b) To reduce by two-thirds, between 1990 and 2015, the under five mortality rate;
(c) To reduce by three -fourths, between 1990 and 2015, the maternal mortality ratio;
(d) To achieve, by 2015, universal access to reproductive health;
(e) To have halted by 2015 and begun to reverse the spread of HIV/AIDS;
(f) To have halted by 2015 and begun to reverse the incidence of malaria and other major diseases;
(g) To halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation.

According to World Health Organization (2015), under–nutrition or malnutrition is the major cause of death in 45 percent of all deaths among children below 5 years. During 1990-2013, the proportion of underweight children in developing country declined from 28 percent to 17 percent and expected to be 16 percent in 2015 (globally declined from 25 percent in 1990 to 15 percent in 2013) against the target of halving the proportion of people suffering from hunger. The MDG target for this indicator was met in WHO’s North and South Americas, European region and Western Pacific region but not in Eastern Mediterranean region, South-East Asian region and African region. In India, about 47 per cent children are underweight. Similarly during 1990-2013, the number of stunted children declined globally from 257 million to 161 million, a decrease of 37 percent. We could not achieve this target (Sharma, Shubhash, 2016).

Second, during 1990-2013 under-five child mortality rates declined by 49 percent (against the target of reducing by two-thirds), falling from 90 deaths per 1000 live birth to 46 per 1000 live births (it was 42 in 2013 in India)- that is globally 17,000 fewer children died daily in 2013 than in 1990. Globally, total number of neo-natal deaths decreased from 4.7 million in 1990 to 2.8 million in 2013 and neo-natal mortality rates per 1000 live births declined from 33 to 22 during that period (39 percent). Looking at the achievement regarding under-five mortality rate by region, it transpires that till 2013 in African region (comprising of 47 countries), 6 countries achieves the target of reduction by two-third and 2 countries are on track while 25 countries are at least halfway and 14 countries are less than halfway. In both Americas (35 countries), 5 countries achieved the target and 3 countries are on track, while 24 countries are atleast halfway and 3 countries are less than halfway. In South-East Asia region (11 countries), 5 countries achieved the target and 2 are on track while 4 are at least halfway and none in less than halfway. In European region (53 countries), 23 achieved the target and 4 are on track while 26 countries are at least halfway and none less than halfway. In Eastern Mediterranean region (21 countries), 6 achieved target and 2 are on track while 12 are atleast halfway and 1 is less than halfway. In Western Pacific region (27 countries), 3 achieved target and none on track
while 18 are at least halfway and 6 are less than halfway. Globally (194 countries), 48 (25 percent) achieved the target and 13 (7 percent) are on track while 109 (56 percent) are at least halfway and 24 (12 percent) are less than halfway, thus most of the countries (133) could not achieve the target of reducing under-five mortality by two-third by 2015. Major causes of under-five mortality are: (a) preterm birth complications (17 percent), (b) pneumonia (15 percent), (c) birth asphyxia (11 percent), (d) diarrhoea (9 percent), (e) malaria (7 percent), (f) congenital anomalies (7 percent) and (g) neo-natal infections (7 percent). In fact, ‘neo-natal period’ (first 28 days) is the most vulnerable period for child’s survival. In 2013, about 44 percent of under-five deaths took place during neo-natal period, up from 37 percent in 1990. Yet immunization has increased considerably all over the world, e.g. during 2000-2013 incidence of measles decreased by 72 percent (from 146 to 40 cases per million population). During 2000-2013, global number of measles deaths in children below 5 years decreased by 74 percent (from 4,81,000 to 1,24,000).

Third, during 1990-2013 the maternal mortality ratio per lakh live births declined globally by 45 percent (from 5, 23,000 to 2, 89,000) against the target of two-third reduction— thus, it has lagged behind the target. Unfortunately in 89 countries, with the highest maternal mortality ratio in 1990 (100 or more), 13 have made insufficient or no progress at all, with an average annual decline of less than 2 percent. Major cases of maternal deaths are haemorrhage (27 percent), hypertensive diseases of pregnancy (14 percent) and sepsis (11 percent). Thus, we have not achieved this target.

Fourth, regarding universal access to reproductive health during 1990-2012, prevalence of contraceptive use of women (15-49 years) increased globally from 55 percent to 64 percent and ‘unmet need’ (not using contraceptive) declined from 15 percent to 12 percent—but African region has the highest level of unmet need at 24 per cent. Further, 83 percent of pregnant women globally received antenatal care at least once during pregnancy but only 64 percent pregnant women received minimum four antenatal care visits. In African region and low-income countries, only 51 percent pregnant women received services of skilled nursing staff during delivery. Thus, we have not achieved this target.
Fifth, in 2013, about 12.9 million people with HIV/AIDS received anti-retroviral therapy (ART) globally (of these 11.7 million lived in low and middle income countries) against 32.6 million affected with HIV/AIDS. Due to such treatment, HIV mortality declined from 2.4 million in 2005 to 1.5 million in 2013. Thus, we could not achieve the target of halting spread of HIV by 2015 nor could we achieve the target of universal access to treatment of HIV/AIDS.

Sixth, globally 3.20 billion people are at risk of being infected with malaria and other major diseases, with 1.2 billion at high risk. In 2013, 198 million cases of malaria occurred globally (against 227 million in 2000) leading to 5,84,000 deaths—of which 90 percent in African region and 78 percent malaria deaths occur in children below five years. During 2000-2013 malaria mortality rates decreased by 47 percent globally, and decreased by 54 percent in African region, and by 53 percent globally in children below 5 years. In sub-Saharan Africa, 44 percent of population at risk were sleeping under insecticide- treated net in 2013 compared to only 2 percent in 2004. In total, 64 countries have met MDG target of reversing the incidence of malaria. Further during 2000-2013, globally the number of new cases of tuberculosis (incidence) has fallen at an average annual rate of 1.5 percent and during 1990-2013; global tuberculosis prevalence rate fell by 41 percent with a decline of 45 percent in mortality rate. Since 2007, high global treatment success note (85 percent) has been sustained but in 2013, about 1.5 million people died from tuberculosis globally. Thus, MDG target of halting incidence of malaria and tuberculosis by 2015 has been achieved globally. Regarding elimination of leprosy by 2020, 75 percent reduction in incident cases is recorded since the launch of the programme in 2005. Regarding lymphatic filariasis, since 2000, more than 5 billion treatments have been delivered to stop its spread and of 73 endemic countries 39 are on track to achieve its elimination by 2020.

Seventh, MDG target of having the proportion of population without sustainable access to safe drinking water by 2015 was achieved globally in 2010 but at national level, only 116 countries met the target and 45 countries are still not on track. In 2012, 748 million people still lacked it and there was inequality among different regions, between rural and urban areas, and between different socio-
economic classes. On the other hand, MDG target of halving the proportion of population without basic sanitation could not be achieved. About one billion people (14 percent of world population) have no toilets, hence go for open defecation. In India, about 55 percent people go for open defecation. This results into high level of environmental contamination and exposure to microbial infections, cholera, trachoma, hepatitis and schistosomiasis. About 90 percent of people globally going for open defecation live in rural areas.

Eighth, we have not achieved the MDG target of providing access to affordable essential drugs in developing countries because selected essential (generic) medicines in 21 low-and middle- income countries were available only in 55 percent of public sector facilities. The common patients in low- and middle –income countries were available only in 55 percent of public sector facilities. The common patients in low-and middle-income countries are paying two to three times the international reference prices. In developing countries like India, many medical practitioners, mostly private (but also many government ones), connive with medical representatives of various pharmaceutical companies and, therefore, prescribe costly and unnecessary more medicines and pathological tests, often combined with negligence, hence there are many cases in consumer courts in this regard.

We may safely state that all the developing countries (including India) should accord topmost priority to ‘health for all’ in letter and spirit because it ensures not only human resource development, but also the well being of our future generations, without any restriction on caste, class, gender, religion or area basis, whose interests cannot be compromised at all. Therefore, developing nations have to increase their budget on health (as proportion of gross domestic product, and as share of public expenditure to total expenditure per capita on health). In India, we spend just about 1 percent of GDP on health and our public expenditure is 30 percent whereas Japan spend 82 percent, OECD (average) 73 percent, Canada 70 percent, Switzerland 65 percent, US 48 percent and even Thailand 72 percent. Consequently, the life expectancy at birth in Japan (82.7 years), OECD (80.1), Canada (80.4), Switzerland (82.8), US (78.7) and Thailand (74.3) is much higher than that in India (66.3 years).
On the other hand, infant mortality rate in India (43.8 per thousand is 20 times that in Japan (2.3 per thousand), ten times in OECD and Canada (4.1 and 4.4 per thousand respectively), 11 times that in Switzerland (3.8), 7.5 times that US (6.1) and 4.5 times that in Thailand (9.9). Kerala has achieved the level of many developed countries both in health and education due to its priority to social sector over the years.

3.6 Health Status of Indian population

India is passing through demographic and environmental transition which is adding to burden of diseases. The first half of the twentieth century witnessed a large number of communicable disease epidemics. There have been major improvements in public health since 1950s. Affordable medicines and tools are now available which are highly effective, when used appropriately. Examples are: Anti-tubercular medicines Anti-malarial, Insecticide-treated bednets, and condoms (to prevent HIV infection). However, there have also been health consequences of urbanization and industrialization. There is persisting inequality in health status due to varying economic, social and political causes.

India currently faces three types of diseases namely:

1. Unfinished agenda of Communicable Diseases.
2. Emerging Non-communicable disease related to lifestyles, and
3. Emerging Infectious Diseases.

This high burden of disease, disability and death can only be addressed through an effective public health system. Ever increasing population with increasing geriatric population and changing lifestyle with more urbanization is putting pressure on environmental as well as on nutritional requirement resulting in nutritional deficiency, poor sanitation increasing communicable and non-communicable diseases etc.

3.7 Disease Burden

India has the highest number of tuberculosis(TB) cases in the world. Out of 9.2 million cases of TB that occur in the world every year, nearly 1.9 million occurs
in India which accounts for one-fifth of the global TB cases. Experts estimate that about 2.5 million persons have HIV infection in India (Chauhan, L.S., 2011). This is nearly 7.6 % of the global burden of 33 million cases. More than 1.5 million persons are affected with malaria every year. Almost half of them suffer from falciparum malaria. One-third of global cases infected with filarial disease live in India. Nearly half of leprosy cases detected in the world in 2007 were contributed by India. More than 300 million episodes of acute diarrhoea occur every year in India in children below 5 years of age. Although data are limited, perhaps more than 35 million persons are carriers of viral Hepatitis B.

Emerging infection diseases are a major public health problem in developing countries like India. Because of the exiting environmental, socio-economic and demographic factors, developing countries like India are vulnerable to rapidly evolving micro-organisms. During the past three and a half decades more than 30 new organisms have been identified worldwide including HIV, Vibrio Cholera 0139, SARS, Corona virus, highly pathogenic avian influenza virus A, and novel H1N1 influenza virus. Many of these organisms emerged in the developing countries of Asia.

Infectious diseases, especially the new emerging and re-emerging diseases, results in high morbidity and mortality and affect the public health and economy adversely. For example, plague which was not reported from any part of India for almost a quarter of the century, caused a major outbreak in Beed district in Maharashtra and Surat in Gujarat in 1994 and resulted in huge economic loss to the country.

In the recent times, avian influenza virus AH5N1 created pandemic scare by affecting birds/poultry in more than 60 countries including India and affecting human beings in 15 countries. But pandemic finally occurred due to novel H1N1 virus in 2009. As of November 20, 2009, more than 0.5 million cases and 6770 deaths due to lab confirmed novel H1N1 infections have been reported to WHO by more than 206 countries, although countries are no longer required to test and report all cases. During previous pandemics, influenza viruses took more than 6 months to spread as
widely as the new influenza A H1N1 pandemic virus did in less than 6 weeks since the first cases started in Mexico in April 2009. Infection, first confirmed in India on 16th of May 2009 in a traveller, has spread to 30 states in 6 months causing more than 46,460 labs confirmed cases and 2735 deaths till March 2011.

Burden of non-communicable diseases is not less. Overall non-communicable diseases are the leading causes of death in the country, constituting 42 % of all deaths. Communicable, maternal, perinatal and nutritional conditions constitute another 38 percent of deaths. Injuries and ill-defined causes are at older ages (70 or higher years) and most of ill-defined deaths are likely to be from non-communicable diseases.

Rural areas report more deaths due to communicable, maternal, perinatal and nutritional conditions (41%). The urban areas have a lower number of deaths from communicable, maternal, perinatal and nutritional conditions but a higher proportion from non-communicable diseases (56%). Their proportion is less in rural area (40%). Injuries constitute about the same proportion in both rural and urban areas; however, the specific causes of injury vary.

Overall, the leading cause of death is cardio vascular disease (19%), followed by respiratory diseases (namely chronic obstructive pulmonary disease or COPD, asthma, other respiratory diseases; 09%), diarrhoeal diseases (8%), perinatal conditions (6.3%), respiratory infections such as acute pneumonia (6.2%), tuberculosis (6%), malignant and other neoplasms (5.7%), senility (5.1 %-which is concentrated at ages 70 and higher), unintentional injuries; others (4.9%), and symptoms, signs and ill-define conditions (4.8 %).

Besides, India has the highest number of blind persons in the world. An estimated 2.0-2.5 million persons in India have cancers at any given point of time. More than 7 lakh cases of cancer occur every year. National Family Health Survey – III has revealed that more than 56% of the women in India have some degree of anaemia and about one-third are under-nourished. Similarly, three-fourths of young children are also anaemic.
Despite high disease burden and shortage of funds, the country has achieved noteworthy successes. Smallpox and guineaworm have been eradicated; their vast cases occurred in the country in May 1975 and July 1996 respectively. Yaws, which mainly occurs in remote tribal areas, has been eliminated. Prospects of polio eradication in the near future are very bright. Last case of Polio occurred in January 2011 in West Bengal. Uttar Pradesh and Bihar, the traditional pockets of Polio, have not reported a case for a long time. Malaria which used to cause 75 million cases in early 1950s has been reduced to less than 2 million cases every year. Revised national tuberculosis control programme, launched in 1997, presently covers the entire country and detects over 70 % of new sputum cases with treatment success rate of 87%. TB mortality has decreased from over 5 lakh deaths every year at the beginning of programme to about 2.8 lakh deaths presently despite growth in population. Leprosy has been eliminated as a public health problem from most of the states.

Life expectancy has increased from 36.5 years in 1951 to more than 66.3 years. While Crude Birth Rate declined from 40.8 in 1951 to 21.6 in 2012, Crude Death Rate declined from 25.1 in 1951 to 7.0 in 2012, Infant Mortality Rate (IMR) declined from 146 per 1000 live birth in 1951 to 39 per 1,000 live births in 2014. Maternal Mortality Ratio (MMR) declined from 398 per 1,00,000 live birth in 1997-98 to 109 per 1,00,000 live births in 2014-15 (MDGs- India Country Report, 2015). However, India has a long way to go in further reducing mortality among infants, mothers and the people in the most productive age –groups (15-45 years).

3.8 TOP TEN Health Concerns of the Decade

In the last 10 to 15 years, innumerable diseases and conditions have plagued mankind from the recent Ebola & SARS to Cancer, AIDS and Obesity in children.

Heart Diseases: Heart disease is the number one killer of both men and women. India is likely to account for 60 percent of heart disease patients worldwide. A study among Asian Indian men showed that half of all heart attacks in this population occur under the age of 50 years and 25 per cent under the age of 40, according to Indian organization, Medwin Heart Foundation (times of india.indiatimes.com). Although
more men die of heart disease than women, females tend to be under-diagnosed, often to the point that it’s too late to help them once the conditioned is discovered.

**Cancer:** The good news is that survival rates have improved for many types of cancers in recent years. But one can lower the risk by adopting a healthy lifestyle. Screening also can help find some cancers early, when they are most treatable. Skin, lung, prostate, colon and testicular cancers are the ones that worry most men, while women feel anxious about breast cancer. It is second to lung cancer as the leading cause of death for women. Experts say the fear of breast cancer can sometimes be exaggerated, stopping women from going to their doctors for screening, or pushing women to make rash decisions about mastectomy, when it may not be necessary.

**HIV/AIDS:** The HIV/AIDS epidemic will affect women’s health incoming years. Rates of infection are found in population groups with certain high risk behaviours (*i.e.* sex workers, intravenous drug users, and sexually transmitted disease patients). However, this infection is also increasing in the general population. Despite the alarming growth of the epidemic, most women in India have very little knowledge of AIDS. Even among those who had heard of the disease, there were many misconceptions about modes of transmission.

**Swine Flu:** Soon after the outbreak of H1N1 virus in the United States and Mexico in March 2009, the Government of India started screening people coming from the affected countries at airports for swine flu symptoms. Till date there have been 852 confirmed H1N1 deaths in the county confirms the Health Ministry. What begins with sudden chills, cough, sore throat headache and fatigue, worsen and lead to death if not detected on time.

**Reproductive Health:** Many of the health problems of Indian women are related to exacerbate by high levels of fertility. Research has shown that numerous pregnancies and closely spaced birth erode a mother’s nutritional status, which can negatively affect the pregnancy outcome. Unwanted pregnancies terminated by unsafe abortions also have negative consequences for women’s health.
Osteoporosis: A largely preventable disease, the behaviours that women develop in their childhood, in their adolescence, and in their early adult years really play a significant role in the development of osteoporosis. That’s because bodies build up most of bone mass until age 30. Then new bone stops forming and the focus is on maintenance of old bone. It is never too late to keep bones strong and avoid fractures.

Depression: Depression appears to affect more women than men. Research has proved that women need a connection with others in their lives. They need that sustenance and if they don’t have it, they tend to get depressed.

Unintentional Injuries: Accidents, also called unintentional injuries, are the third leading cause of death around the world. They account for 1 of every 4 people treated in an emergency department. Death can result from motor vehicle accidents, falls and fires.

Diabetes: More than 9 out of 10 people with diabetes have type II diabetes. Many men don’t even know they have it until they develop problems such as erectile dysfunction, vision loss, or kindly disease.

Obesity: A difficult condition to treat, obesity and overweight rates for children and teens have been steadily rising. Children who are obese face serious health problems, including asthma, joint pain, high blood pressure, and type II diabetes. In the poll parents reported that they discuss at length limiting junk food and physical activity. However, most do not curtail television time.

3.9 Health Status in Uttar Pradesh

Uttar Pradesh’s performance has always been poorer than All–India averages with regard to most of the vital statistics. The birth rate, death rate and infant mortality rate trends of Uttar Pradesh has always been higher than the All–India figure, a glance of which can be had from the table below:
## Table: 3.1 Vital Statistics Indicators, 2014

<table>
<thead>
<tr>
<th>India/States/Union Territories</th>
<th>Birth Rate</th>
<th>Death Rate</th>
<th>Natural Growth Rate</th>
<th>Infant Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Rural</td>
<td>Urban</td>
<td>Total</td>
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<tr>
<td>India</td>
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<td>22.7</td>
<td>17.4</td>
<td>6.7</td>
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<td>1. Andhra Pradesh</td>
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<td>17.3</td>
<td>16.3</td>
<td>7.3</td>
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<tr>
<td>2. Assam</td>
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<td>23.6</td>
<td>15.5</td>
<td>7.2</td>
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<td>3. Bihar</td>
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<td>26.9</td>
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<td>6.2</td>
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<td>4. Chhattisgarh</td>
<td>23.4</td>
<td>25.0</td>
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<td>21. West Bengal</td>
<td>15.6</td>
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**Source:** SRS Bulletin Vol., 50, No.1, Registrar General of India, July 2016

Uttar Pradesh is the most populated state of India. Medical and health facilities are continuously expanding by the mutual co-operation between the government sector and the private sectors of the state. The Birth Rate, Death Rate, Neo-natal Mortality Rate and Maternal Mortality Rate etc. is decreasing at a fast rate because of the better medical and health facilities provided to the public. Any how the rates are higher in comparison to the national average level. For the improvement in health and demographic indexes, the state government is compelled /committed. The expansion
and improvement in health services is one of the most important agenda of the government.

Among the states, Uttar Pradesh’s health care system presents a unique picture on account of its mission and vision that all people in the state should have access to quality healthcare. In order to accomplish this mission it is felt urgent to eliminate diseases like Polio, Leprosy, Kala Azar, Malaria, Filaria apart from reducing incidence of HIV/AIDS to zero, reducing mortality form vector borne and respiratory diseases, as well as achieving significant reductions in MMR, TFR (Total Fertility Rate), IMR and under-5 IMR along underweight birth rate.

Birth Rate: Birth Rate is ‘annual number of live births per 1000 population’. It is an item of concern and policy for a number of national governments. High birth rates are associated with health impairments and low life expectancy, low living standards, low status of women, and low levels of education. There are claims that as countries go through economic development and social change, birth rate declines. Birth Rate ranging from 10-20 births per 1000 is considered low, while rates from 40-50 births per 1000 are considered high. There are problems associated with both an extremely high BR an extremely low Birth Rate. High birth rate can cause stress on the government welfare and family programmes to support a young population. Additional problems faced by a country with high birth rate include educating a growing number of children creating jobs for these children when they enter the workforce, and dealing with the environmental effects that a large population can produce. Low Birth Rate can put stress on the government to provide adequate welfare systems for seniors and also the stress on the families to support the elders themselves. There will be less children or working age population to support the constantly growing aging population.

Inter-state comparison put Uttar Pradesh at the topmost position among the major 21 states as far as vital statistics are concerned. In respect of Crude Birth Rate (CBR), UP stands 21st with a value of 27.0 with the top slot occupied by Kerala at 14.8 according to 2014 SRS data. As such, regarding Birth Rate, Uttar Pradesh tops
the list followed by Bihar, Madhya Pradesh and Rajasthan. The birth rate in rural region with 28.3 is higher than urban region with 23.3.

**Death Rate:** Death Rate (annual number of deaths per 1000 population) is high in Uttar Pradesh at 7.4 in comparison to All–India figure. In absence of indicators of morbidity, affliction of deadly diseases and the impact of curative systems, Death Rate is an important indicator. Inspite of advanced medical facilities, the high death rate in UP is worrisome. Diseases like cancer have been killing many in UP. Besides, death rate due to heart and other recently emerging diseases related to lifestyle have also gone up. Even diseases like dengue have tolled lives of many. Besides diseases, road accidents have also become big killers.

**Infant Mortality Rate:** Infant Mortality Rate (number of infants dying under one year of age per 1000 live births in a year) is regarded as one of the important indicators of health status of a country. It is seen as a sentinel indicator of child health and the well–being of the society over time. The causes of infant mortality are strongly correlated to structural factors like economic development, general living condition, social well-being and the quality of the environment, that affect the health of entire population. IMR is widely accepted as good indicators of health status by government and also international organizations like World Health Organization (WHO). It is one of the most telling indicators on the health services, health awareness and satisfactory health practices.

Reduction of IMR has been accorded high priority in improving the health situation of the population. The National Population Policy, 2000 aimed at a reduction of IMR to less than 30 by 2010-11. The Millennium Declaration aims to reduce infant mortality by two–third from its current level. Total Infant Mortality Rate in Uttar Pradesh is 48, and just fourth to the topmost states Madhya Pradesh (52) along with Assam and Odisha with 49 each. It is much higher in comparison to All- India average of 39. Urban IMR (37) is quiet lower than Rural IMR (51), but higher than All- India average with 26 and 43 respectively.
Health related problems in India...

Table: 3.2 IMR during the 1997-2013 for All Major States

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<td></td>
</tr>
</tbody>
</table>

Source: SRS, Registrar General, India.

Uttar Pradesh ranks 17th in India with respect to IMR. In terms of reduction overtime, 1997-2014, during the period UP appears to have improved and done much better than earlier record but is far behind in comparison to All-India average point of 39. It clearly suggests that a gradual improvement in health facilities over the years in the states is inadequate. This is also the case when IMR for boys and girls are considered separately; indeed, the gap between Uttar Pradesh and India is especially high for female IMR, indicating that UP has a poor record of ensuring the lives of girl infants than India as a whole. Since within aggregate infant mortality, nearly 42 percent of the deaths occur within the first week, the control of early neo-natal mortality would lead to a much improved IMR.
Table: 3.3 Fertility and Mortality Indicators

<table>
<thead>
<tr>
<th>Bigger States</th>
<th>TFR (total fertility rate) – 2012</th>
<th>NNMR (neo-natal mortality rate) – 2012</th>
<th>MMR (maternal mortality ratio) 2011-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>India</td>
<td>2.4</td>
<td>2.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>1.8</td>
<td>1.9</td>
<td>1.7</td>
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<tr>
<td>Assam</td>
<td>2.4</td>
<td>2.5</td>
<td>1.5</td>
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<tr>
<td>Bihar</td>
<td>3.5</td>
<td>3.6</td>
<td>2.5</td>
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<tr>
<td>Chhattisgarh</td>
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<td>2.9</td>
<td>1.8</td>
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<td>Gujarat</td>
<td>2.3</td>
<td>2.5</td>
<td>2.0</td>
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<td>Haryana</td>
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<td>2.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>2.8</td>
<td>3.0</td>
<td>2.0</td>
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<td>2.0</td>
<td>1.7</td>
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<td>1.8</td>
<td>1.9</td>
<td>1.8</td>
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<td>Madhya Pradesh</td>
<td>2.9</td>
<td>3.1</td>
<td>2.0</td>
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<td>1.6</td>
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<td>2.2</td>
<td>1.5</td>
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<tr>
<td>Punjab</td>
<td>1.7</td>
<td>1.7</td>
<td>1.6</td>
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<tr>
<td>Rajasthan</td>
<td>2.9</td>
<td>3.1</td>
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<tr>
<td>Tamil Nadu</td>
<td>1.7</td>
<td>1.7</td>
<td>1.7</td>
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<tr>
<td>Uttar Pradesh</td>
<td>3.3</td>
<td>3.4</td>
<td>2.5</td>
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<tr>
<td>West Bengal</td>
<td>1.7</td>
<td>1.8</td>
<td>1.2</td>
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</tbody>
</table>


3.10 Fertility and Mortality Indicators

Total Fertility Rate (TFR) is defined as “Average number of children that would be born to a woman if she experiences the current fertility pattern throughout the reproductive span”. It is obtained by summing the single-year-age specific rates at a given time. High fertility is associated with increased risk of maternal morbidity and mortality. In most settings, women who have several children find it difficult to work outside the home, thus having fewer opportunities to improve their economic and social status and that of their families. Low income household with many children, often find it more difficult to get out of poverty than those with less children, and high fertility societies face greater demand from their youthful populations. The changes in the population age distribution resulting from declining fertility rate are for a period, beneficial for economic growth. As fertility declines, the proportion of children in the
population falls and the proportion of populations of working age increases, resulting in a lower dependency ratio. Provided jobs are available for the increasing population of working age, a country can reap the benefits of increased production and lower the costs associated with the decreasing proportion of dependents. This “demographic bonus” can thus contribute significantly to economic growth and poverty reduction. TFR for the country remained stationary at 2.4 during 2011 to 2012. Bihar reported the highest TFR (3.5) while Punjab, West Bengal and Tamil Nadu, the lowest (1.7). Uttar Pradesh is second to Bihar having a TFR of 3.3. In comparison to All-India average of 2.4, the TFR of Uttar Pradesh is too high. At present, on an average a rural woman (having a TFR of 2.6) at the national level would have about one child more than an urban woman (having a TFR of 1.8). TFR for the country declined by 1.2 points (down by more than a child), rural TFR also by 1.2 points and urban TFR by 0.8 point over last 20 years.

**Neo-natal Mortality Rate:** Neo Natal Mortality Rate is the number of resident newborns in a specified geographic area (country, state, etc.) dying at less than 28 days of age divided by the number of resident live births for the same geographic area (for a specified time period, usually a calendar year) and multiplied by 1000. Neo-natal survival is a very sensitive indicator of population growth and socio-economic development. Each year in India over million newborns die before they complete their first month of life, accounting for 30% of the world’s neo-natal deaths.

India’s current neo-natal mortality rate of 29 per 1000 live births represents almost 1.2 million children who die each year. Neo-natal mortality is very distinctly higher in rural areas (33) compared to urban (16). The neo-natal mortality rate also varies considerably among Indian States. Odisha, Uttar Pradesh and Madhya Pradesh have the highest neo-natal mortality rate of 39, (rural 41, urban 27), 37 (rural 40, urban 21), and 39 (rural 42, urban 23) per 1000 live births respectively. Kerala has the lowest neo-natal mortality of 7 per 1000 (rural 8, urban 3), followed by Tamil Nadu 15 per 1000 (rural 18, urban 11). Along with a reduction in infant mortality, the Government of India is committed to reducing the neo-natal mortality rate to approximately 20 per 1000 live birth by 2015. However, this aim requires the consideration of many contributing elements. Maternal factors that contribute to neo-natal mortality have their origin long before the baby is born.
Death due to pregnancy and during the child birth is common among women in the reproductive age groups. Reduction of mortality of women has thus been an area of concern and the governments across the globe have set time bound targets to achieve it. The International Conference on Population and Development in 1994 had recommended reduction in maternal mortality by at least 50 percent of the 1990 level by the year 2000 and further one- half by the years 2015. The Millennium Development Goals (MDGs) has set the target of achieving 200 maternal deaths per lakh of live birth by 2007 and 109 per lakh of live birth by 2015.

According to the SRS Bulletin of Government of India, Birth Rate, Death Rate and Neo-natal Mortality Rate was 32.8, 10.3 and 83 respectively in the year 2000, which continuously fell to 27.4; 7.7 and 37 respectively in 2012. At the national level, it was 21.6, 7.0 and 29 respectively in 2012. A comparison can be studied through the given table 3.4.

### Table: 3.4 No. of BR, DR and NNMR related data

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2010</th>
<th>2012</th>
<th>2014</th>
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<tr>
<td><strong>Birth Rate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UP</td>
<td>32.8</td>
<td>25.8</td>
<td>28.3</td>
<td>22.1</td>
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<tr>
<td>INDIA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Death Rate</strong></td>
<td>10.3</td>
<td>08.5</td>
<td>08.1</td>
<td>07.2</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Neo-natal Mortality Rate</strong></td>
<td>83.0</td>
<td>68.0</td>
<td>61.0</td>
<td>47.0</td>
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<tr>
<td></td>
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</table>

Source : SRS Bulletin, Registrar General, India.

### 3.11 Maternal Mortality Rate

The health of children and the family is one of the most important issues related to the health of mother. A healthy mother only can give birth to a healthy child. One of the major objectives of complete health system is to decrease the rate of maternal mortality. Maternal Mortality Ratio (MMR) measures the number of woman aged 15-49 years dying due to maternal causes per 1,00,000 live births. According to SRS Bulletin’s data, the MMR for the state level was 606 in 1997-98, 539 in 1999-2001, 517 in 2001-2003, and 440 in 2004-06, and decreased to 359 in 2007-2009. At the national level, the rate was 398, 327, 301, 254, and 212 respectively. Here its clear from the above data that MMR of state is higher than the national level.
Presently too, the babies are delivered / born at home under the supervision of untrained people. For the safety of baby and mother during delivery as well as after delivery, it is utmost necessary that the delivery of the child takes place under the supervision of skilled doctors and safe/clean environment. The programmes such as ‘Janani Suraksha Yojana’ etc. run by the government encouraged pregnant women for delivery in institutions / hospitals. The table 3.5 clearly shows the picture.

Table: 3.5 Condition of Institutional Delivery in the State

<table>
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<th>2010-11</th>
<th>2011-12</th>
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<td>Institutional Delivery</td>
<td>28.07</td>
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<tr>
<td>Delivery under Trained People</td>
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<tr>
<td>Delivery by Other People</td>
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<td>02.24</td>
</tr>
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</table>


It is clear from the above table 3.5 that the institutional delivery has decreased from 28.07 lakh in 2010-11 to 27.55 lakh in 2011-12. Delivery under trained people has also decreased from 14.31 in 2010-11 to 12.25 in 2011-12.

3.12 Morbidity Status of Uttar Pradesh

Uttar Pradesh ranks much lower in comparison to the states like Kerala, Punjab, Maharashtra, Andhra Pradesh, West Bengal etc. for a relatively high rate of PAP (Proportion of Ailing Person). PAP means number per 1000 for persons reporting ailment during a period of 15 days. In both rural and urban areas, the states of Kerala, Punjab, West Bengal, and Andhra Pradesh were at one extreme reporting high levels of morbidity while at the other extreme were Jharkhand.

Uttarakhand, Bihar and Rajasthan with low levels of morbidity reporting (NSSO, 60th Survey Report). Data on morbidity sometimes pose problems of interpretation. A high morbidity rate of the state is mainly because of better, reporting of illness by literate and aware population or because of high prevalence of diseases. With decline in mortality, sickness prevalence rates go up, as observed in a study of four developed countries USA, UK, Japan and Germany. Scholars have argued that low morbidity rates in Uttar Pradesh are a result of lower decline in mortality rates. It is usually observed that with an increase in the level of development, prevalence of
communicable diseases come down and that of chronic illness goes up. In Uttar Pradesh, the prevalence of Group I diseases (that includes prenatal, acute respiratory infection, diarrhoeal diseases, Tuberculosis, protein-energy malnutrition, measles and Polio) with non-communicable disease-Group II Ischemic heart disease, Cerebro-vascular disease, congenital abnormalities, Neuro Psychiatric and Cirrhosis of Liver), and Group III disease (like injuries and accidents) taking the next two slots. Many factors contribute to the poor health status including poverty, poor infrastructure, and highly morbidity. Poverty associated with communicable diseases like tuberculosis and malaria, along with maternal mortality and morbidity, comprise a major portion of the disease burden. Malaria is endemic with frequent epidemic outbreaks of Plasmodium falciparum malaria (about 50%). Over 60,000 deaths occur every year due to tuberculosis. Prevalence of leprosy is 10 per 10,000. HIV/ AIDS pose another rising threat and lifestyle disease too.

3.13 Health Status in Varanasi

There have been very few attempts to analyse the performance of health systems in Varanasi where the disparities in health attainments of different areas are quite severe. One of the government report access to high levels of intra-sectoral differences in health attainments and the report also pointed out that the foremost problem in the health system is the persistent gaps in the man power and infrastructure availability especially at the primary healthcare level.

3.14 Public Healthcare in Varanasi

Public healthcare has been a major component of social welfare policy in India since Independence. Primary and secondary healthcare services at district level are now provided through a decentralized referral chain, which is extended vertically from the health sub-centres at the rural base to the district hospitals at the apex. The National Health Policy 1983 has universalized primary healthcare services, which is known as the cornerstone of public health policy during the Sixth Five Year Plan. Since primary healthcare is included in the State List of Indian Constitution, the onus for mobilizing adequate resources to achieve the ambitious target of ‘Health for All’ by the year 2000 fell largely to the lot of State Government. However, serious gaps had emerged within the healthcare system by the time the revised National Health
Policy 2002 was announced, because of inadequate public investment in the health sector. The principal problems that currently confront the public healthcare system in Varanasi included-

- Persisting inadequacies in public health infra-structure.
- Insufficient investment on outdoor medical facilities.
- Overcrowding of the medical facilities.
- Shortages in medical schools and essential medical equipments.
- Inadequate staffing by medical and para-medical personnel, and
- Inadequate provision of essential generic drugs.

All of these problems have led to sharp deterioration in the quality of public healthcare systems. Recognizing such persisting difficulties, the National Health Policy, 2002 stressed that substantial recourses would have to be committed by the Central Government to the public health system in a phased manner, in order to ensure equitable access to healthcare services. The reworked healthcare strategy formulated under NHP 2002 thus envisaged.

a. Creation of a well distributed network of primary health care services closely interlinked with health education and extension.

b. Health intermediation through the agency of trained health volunteers who would form an essential link between the community and the healthcare institutions.

c. Establishment and strengthening of the decentralized referral healthcare system to reduce excess patient loads on secondary and tertiary facilities by ensuring that most basic healthcare services were accessible as required at the nearest referral units.

d. More even dispersal of speciality and super-speciality services, with the involvement of private investment for meeting the needs of paying patients, so that free public facilities could be increasingly availed by poorer users.

3.15 Maternal and Child Care and Role of Media

As already discussed earlier there is a high mortality rate of infants and as well as of pregnant women in rural areas of Uttar Pradesh which is mainly because of
poverty, lack of awareness, illiteracy, poor communication and transport system, delivery of the child by untrained attendants at home, etc. In Uttar Pradesh, there are 907 family welfare centres, 248 community health centres, and 20,153 sub-centres where women may have safe delivery. But because of the cultural barriers and illiteracy they prefer to deliver the child at home by untrained an attendant which increases the death rate of pregnant women or causes death at the time of delivery. According to the news published in *Hindustan* (2003), 5000 children lose their mothers within six weeks of their birth.

Television has brought tremendous change regarding the place of delivery. Now nearly 70 % of village women use the facility of the health centres. They are also aware of keeping adequate gap between programmes. Television has also increased their knowledge regarding different methods of family planning and has eradicated their fear regarding the use of family planning methods. They also believe in the small family norm but it is not very effective to the ideal of gender equality in opportunities and treatment that a truly egalitarian system should aspire to have.

### 3.16 Health Status in Varanasi District

An official Census 2011 detail of Varanasi (Varanasi), a district of Uttar Pradesh has been released by Directorate of Census Operations in Uttar Pradesh. Enumeration of key persons was also done by census officials in Varanasi District of Uttar Pradesh.

In 2011, Varanasi had population of 3,676,841 of which male and female were 1,921,857 and 1,754,984 respectively. In 2001 census, Varanasi had a population of 3,138,671 of which males were 1,649,187 and remaining 1,489,484 were females. Varanasi District population constituted 1.84 percent of total Maharashtra population. In 2001 census, this figure for Varanasi District was at 1.89 percent of Maharashtra population.

There was a change of 17.15 percent in the population compared to population as per 2001. In the previous census of India 2001, Varanasi District recorded increase of 25.14 percent to its population compared to 1991.
Table 3.6 Comparative Population and Demographical Status of Varanasi District

<table>
<thead>
<tr>
<th>Description</th>
<th>2011</th>
<th>2001</th>
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</thead>
<tbody>
<tr>
<td>Actual Population</td>
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<td>3,138,671</td>
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<tr>
<td>Male</td>
<td>1,921,857</td>
<td>1,649,187</td>
</tr>
<tr>
<td>Female</td>
<td>1,754,984</td>
<td>1,489,484</td>
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<tr>
<td>Population Growth</td>
<td>17.15%</td>
<td>25.14%</td>
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<tr>
<td>Area Sq. Km</td>
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<td>Density/km2</td>
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<tr>
<td>Proportion to Uttar Pradesh Population</td>
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<td>1.89%</td>
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<td>Sex Ratio (Per 1000)</td>
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<td>903</td>
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<tr>
<td>Child Sex Ratio (0-6 Age)</td>
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<td>Average Literacy</td>
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<tr>
<td>Total Child Population (0-6 Age)</td>
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<tr>
<td>Female Population (0-6 Age)</td>
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<td>Female Literates</td>
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<td>18.35%</td>
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<tr>
<td>Boys Proportion (0-6 Age)</td>
<td>13.72%</td>
<td>18.19%</td>
</tr>
<tr>
<td>Girls Proportion (0-6 Age)</td>
<td>13.30%</td>
<td>18.52%</td>
</tr>
</tbody>
</table>

Source: http://www.census2011.co.in/census/district/568-varanasi

3.17 Varanasi District Density\(^1\) 2011

The initial provisional data released by census India 2011, shows that density of Varanasi district for 2011 is 2,395 people per sq. km. In 2001, Varanasi district

\(^1\)http://www.census2011.co.in/census/district/568-varanasi.html
density was at 2,045 people per sq. km. Varanasi district administers 1,535 square kilometres of areas.

### 3.18 Varanasi Literacy Rate 2011

Average literacy rate of Varanasi in 2011 were 75.60 compared to 66.12 of 2001. If things are looked out at gender wise, male and female literacy were 83.78 and 66.69 respectively. For 2001 census, same figures stood at 77.87 and 53.05 in Varanasi District. Total literate in Varanasi District were 2,403,903 of which male and female were 1,389,116 and 1,014,787 respectively. In 2001, Varanasi District had 1,694,405 in its district.

### 3.19 Varanasi Sex Ratio 2011

With regards to Sex Ratio in Varanasi, it stood at 913 per 1000 male compared to 2001 census figure of 903. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate. In 2011 census, child sex ratio is 885 girls per 1000 boys compared to figure of 919 girls per 1000 boys of 2001 census data.

### 3.20 Varanasi Child Population 2011

In census enumeration, data regarding child under 0-6 age were also collected for all districts including Varanasi. There were total 497,151 children under age of 0-6 against 575,882 of 2001 census. Of total 497,151 male and female were 263,762 and 233,389 respectively. Child Sex Ratio as per census 2011 was 885 compared to 919 of census 2001. In 2011, Children under 0-6 formed 13.52 percent of Varanasi District compared to 18.35 percent of 2001. There was net change of -4.83 percent in this compared to previous census of India.

### 3.21 Varanasi Houseless Census

In 2011, total 1,513 families live on footpath or without any roof cover in Varanasi district of Uttar Pradesh. Total Population of all who lived without roof at the time of Census 2011 numbers to 5,689. This approx 0.15% of total population of Varanasi district.
Table 3.7 Religious Population of Varanasi District

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindu</td>
<td>3,107,681</td>
<td>84.52 %</td>
</tr>
<tr>
<td>Muslims</td>
<td>546,987</td>
<td>14.88 %</td>
</tr>
<tr>
<td>Christian</td>
<td>7,696</td>
<td>0.21 %</td>
</tr>
<tr>
<td>Sikh</td>
<td>3,309</td>
<td>0.09 %</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1,146</td>
<td>0.03 %</td>
</tr>
<tr>
<td>Jain</td>
<td>1,898</td>
<td>0.05 %</td>
</tr>
<tr>
<td>Others</td>
<td>298</td>
<td>0.01 %</td>
</tr>
</tbody>
</table>

Source: http://www.census2011.co.in/census/district/568-varanasi

3.22 Varanasi Population 2015

What is the population of Varanasi in 2015? The fact is, last census for Varanasi district was done only in 2011 and next such census would only be in 2021. There is no actual figure for population of Varanasi district situated in Uttar Pradesh. As per 2011, Varanasi population is 3,676,841.

3.23 Varanasi District Urban/Rural 2011

Out of the total Varanasi population for 2011 census, 43.44 percent lives in urban regions of the district. In total 1,597,051 people lives in urban areas of which males are 845,331 and females are 751,720. Sex Ratio in urban region of Varanasi district is 889 as per 2011 census data. Similarly child sex ratio in Varanasi district was 881 in 2011 census. Child population (0-6) in urban region was 190,725 of which males and females were 101,422 and 89,303 respectively. This child population figure of Varanasi district is 12.00 % of total urban population. Average literacy rate of urban regions in Varanasi district as per census 2011 is 78.41 % of which males and females are 83.30 % and 72.92 % literates respectively. In actual number 1,102,671 people are literate in urban region of which males and females are 619,660 and 483,011 respectively.
As per 2011 census, 56.56 % population of Varanasi districts lives in rural areas of villages. The total Varanasi district population living in rural areas is 2,079,790 of which males and females are 1,076,526 and 1,003,264 respectively. In rural areas of Varanasi district, sex ratio is 932 females per 1000 males. If child sex ratio data of Varanasi district is considered, figure is 888 girls per 1000 boys. Child population in the age 0-6 is 306,426 in rural areas of which males were 162,340 and females were 144,086. The child population comprises 15.08% of total rural population of Varanasi district. Literacy rate in rural areas of Varanasi district is 73.38% as per census data 2011. Gender wise, male and female literacy stood at 84.17 and 61.89 percent respectively. In total, 1,301,232 people were literate of which males and females were 769,456 and 531,776 respectively.

All details regarding Varanasi District have been processed by us after receiving from Govt. of India. We are not responsible for errors to population census details of Varanasi District.

Table 3.8 Rural and Urban Population of the Varanasi District

<table>
<thead>
<tr>
<th>Description</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Percentage (0-6)</td>
<td>14.73 %</td>
<td>11.94 %</td>
</tr>
<tr>
<td>Male Child Percentage</td>
<td>15.08 %</td>
<td>12.00 %</td>
</tr>
<tr>
<td>Female Child Percentage</td>
<td>14.36 %</td>
<td>11.88 %</td>
</tr>
<tr>
<td>Literates</td>
<td>1,301,232</td>
<td>1,102,671</td>
</tr>
<tr>
<td>Male Literates</td>
<td>769,456</td>
<td>619,660</td>
</tr>
<tr>
<td>Female Literates</td>
<td>531,776</td>
<td>483,011</td>
</tr>
<tr>
<td>Average Literacy</td>
<td>73.38 %</td>
<td>78.41 %</td>
</tr>
<tr>
<td>Male Literacy</td>
<td>84.17 %</td>
<td>83.30 %</td>
</tr>
<tr>
<td>Female Literacy</td>
<td>61.89 %</td>
<td>72.92 %</td>
</tr>
</tbody>
</table>

Source: http://www.census2011.co.in/census/district/568-varanasi
Most of the population live in rural region in Varanasi District. Total General Category population is 3161266 out of total population 3676841 along with the number of the children is 497151, SC is 486958, and ST population is 28617.
ACCESSIBILITY AND ACCEPTABILITY OF TELEVISION AND ITS EFFECTIVENESS ON HEALTHCARE

“Life is not merely being alive but well being”

-Martial, 66 AD, Epigrams

“Health is Wealth” may be an oft quoted dictum. But, it is also a reality that a healthy person is more able to take care of himself/herself and his/her family, as also, the nation. A Nation with a healthy population is more capable of contributing to and achieving its development goals and making India vivid and vibrant. India has had a tradition of health care, with many notable physicians like Dhanvantari, Jivika, Charaka and Susruta. This has been carried on through various government schemes and programmes over the years. Both the Millennium Development Goals (MDGs) and later the new set of Sustainable Development Goals (SDGs) had appreciated this fact and integrated Health Goals into their agenda. India, as a signatory to the SDGs needs now to gear up its policies and work out its health priorities to achieve those targets.

Of the world’s 7.5 billion population in 2015, as many as 1.2 billion people live in India. Around 18 percent of global deaths and 20 percent of loss of global disability—adjusted life years occur here, making it a country with one of the highest disease burdens in the world. Health-care in India is provided by 1.5 million practitioners registered with Medical Council of India of which 0.7 million are trained in modern medicine and 0.8 million in alternative forms of medicine. It has been found that not all the sick visit a doctor, which means the burden of sick people in India, is much higher. More males visited a doctor than females and this difference was greater in the paediatrics or child age group, suggesting gender bias. Also, only 8% of the patients who visited a doctor were aged over 65, suggesting that old people do not visit a doctor as much as they should.

According to the analyses done by Anuradha Mascarehnas, it was found that a doctor saw 25 patients on an average daily, which means around 40 million patients
visit a doctor every day. Over 50 percent of patients visited a doctor for a respiratory problem and half of them had symptoms suggestive of respiratory tract infections. The remaining half had presence of chronic respiratory symptoms. 61 percent of paediatric patients visited a doctor for a respiratory problem, making respiratory ailments the biggest health burden in India. 21 percent of patients visited the doctor for a gastrointestinal problem and 15 percent for a circulatory problem. Only 40 percent of patients who visited a doctor were labelled to have a specific diagnosis. The most common diagnosis reported was hypertension (12.5%). 21 percent of those labelled to have hypertension were aged under 40, indicating that a large number of young people suffer from hypertension.

In winning the sprint for economic growth, most of the developing nations seem to have failed in assessing the size of the pool of their latent energy and visualising whether they have enough strength to achieve their coveted target. It has now been universally acknowledged that a healthy society is a better bet for a country’s development than a wealthy society comprising only a small fraction of its population. The history of the developed nations of the world gives enough testimony to the fact that creating healthy people is fundamental to the well-being of a nation and economic prosperity would follow if it is supported by growing size of human capital. The less developed nations are yet to identify the role of public health in the march towards their overall development. In common parlance, health care means diagnosis and cure of any disease, but, as the World Health Organization holds, it encompasses the preventives which eliminate or at least minimise the possibilities of the occurrence of diseases, the curatives which imply diagnosing the ailment and curing the patient, and also the rehabilitative measures aimed at rehabilitating the victims of some fierce diseases.

Health infrastructure is an important indicator for understanding the healthcare policy and welfare mechanism in a country. It signifies the investment priority with regards to the creation of healthcare facilities. But it has been disappointing to find that the health care, has always failed to find a place in the India’s Schema of economic development, which was prevaricated to care for social concerns on the lines of the concept of basic minimum services which the Approach Paper of the Ninth Plan announced, included “universal pre-education, primary healthcare, safe
drinking water and shelter for all.” It was also promised that the state would address these social issues by allocating sufficient funds for them from its Exchequer. The health care services are divided under State List and Concurrent List in India. While some items such as public health and hospitals fall in the State List, others such as population control and family welfare, medical education, and quality control of drugs are included in the Concurrent List. The Union Ministry of Health and Family Welfare (UMHFW) is the central authority responsible for implementation of various programs and schemes in areas of family welfare, prevention, and control of major diseases. But in practice, of all these areas, the health sector was never placed on priority of the Indian Political agenda. It might have perhaps been non-pragmatic and illogical for the government to acknowledge the fact that a healthy society can contribute to economic growth many more times than a community which a devoid of the endowment of sound health. Besides, a more noticeable fact, which our governments kept ignoring, is that despite enjoying an emerging economic super power status, India can’t claim to be really developed country if it continues to fare badly in reference to the Human Development Index (HDI) which is indicative of its tacit apathy towards the fulfilment of the primary needs of the society including healthcare. It is also appropriate to comprehend that the level of economic prosperity of a country, howsoever fast growing it is, turns out to be of earning insignificant amount of social sanction and credibility, if it is not being shared by the majority of its people, and hence, what is really desirable here is that the people be made capable of sharing the fruits of economic growth, and health is obviously the most potent factor which built up – this capability, as the two pronged strategy for poverty reduction evolved by the World Development Report, 1990, reveals, “countries that have been most successful in attacking poverty have encouraged a pattern of growth that makes efficient use of labour and have invested in human capital for the poor. Both elements are essential. The first provides the poor with opportunities to use their most abundant asset–labour. The second improves their immediate well-being and increases their capacity to take advantage of the newly created possibilities. Together, they can improve the lives of most of the world’s poor.”

India has been at the forefront of policy discourse and has done some background work and seems to be ready to take a giant leap towards UHC (Universal Health Coverage), and contribute to achieve the Sustainable Development Goal-3 and
other Sustainable Development Goals (SDGs) both at national and global level. UHC aims that ‘all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services, UHC received global attention as an idea and aspiration with the World Health Assembly (WHA) 2005 resolution urging member states to develop their health financing systems for transitioning to UHC. UHC continued to receive attention at global fora and was well supplemented by additional resolution on UHC by WHA in 2011 and then United Nation General Assembly (UNGA) discussed about UHC and passed a resolution on UHC on 12th December, 2012. The UNGA resolution was a landmark step as it broadened the scope of UHC agenda from the ambit of health ministers to the heads of state and ministers of foreign affairs. To commemorate UNGA resolution on UHC, since 2014, 12th December is used as a day to organize commemorative events on UHC and 12th December, 2014 was the first ever Universal Health Coverage Day or UHC Day.

UHC has three dimensions- population coverage, health services coverage and financial protection coverage- and is often represented by a cube, referred as ‘UHC Cube’ or ‘UHC Coverage Box’.

The ‘inside cube’ reflects the existing status in the countries, where only a proportion of the population has access to health services, only a few services are available and not all who receive services can afford the cost. The ‘outer cube’ is the aspirational goal for the countries, as defined by UHC, and proposes that all countries...
should strive to fill the box by extending coverage of quality services with affordable cost. Interestingly, as the services provided leads to improved health outcomes, which in turn leads to a change in disease pattern in the countries, and availability of newer technologies would affect service need and utilization.

The Sustainable Development Goals (SDGs) were endorsed on 25 September, 2015 at the UN Sustainable Development Summit, attended by the heads of state and governments, to carry the work done under Millennium Development Goals (MDGs) forward and to guide global development over the next 15 years. The UNGA formally adopted the universal, integrated and transformative 2030 Agenda for Sustainable Development, along with a set of 17 Sustainable Development Goals and 169 associated targets. The 17 SDGs focuses upon poverty, hunger, health education, gender equality, water and sanitation, energy, work, and economic growth, industry and infrastructure, inequalities, cities, responsible consumption, climate, life below water, life on land, peace and strong institutions, and the partnership.

The final text of the 2030 agenda for sustainable development in its preamble states: “To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind” and that signifies the relevance of health in overall development agenda. One of the goals in SDGs, the goal 3 (or SDG-3) addresses health challenges and aims to “ensure healthy lives and promote well-being for all in all ages.” The SDGs and UHC together provide another and perhaps bigger than ever, opportunity to bring public discourse on health to a level of critical threshold to accelerated health system reforms and strengthening. It is possible that UHC becomes a shining star in SDG period when global leaders reconvene to take stoke of SDGs achievements in 2030.

The possibility for the power of communication to liberate the minds and potential of people through critical awareness is present in every field linked to human development, be it women’s emancipation, family planning, environmental sanity, or functional literacy. New social possibilities are opened up by strengthening the link between communication and education. Communication generates an educational environment, far beyond the education system. This becomes particularly
hopeful in a situation where female literacy is too low. At the same time expansion of education provides a basis for deeper and wider communication.

Many developing countries have attempted to use mass media to educate and to inform, and thereby to promote economic and social development. Most of them have access to the tools of mass communication. The reach of different media varies with the level of development and size of the populations. The use to which different media are put also varies, according to priorities and policies. In India, the communication network is evidently one of largest functioning in the world today. To realise its full potential for people’s development is an exciting challenge before us.

Experience shows that different media have different effects and often they have to be used jointly for optimum effect. For example, broadcasts for carefully identified audiences are an effective and economical means of influencing actions of large numbers of persons at great distances—provided these become the basis for later discussion among local groups, these are supplemented by printed reading or graphic materials and personal contacts by extension workers. The one-way flow and short lived nature of the message broadcast by radio or television have thus to be consciously overcome by planned use of complementary methods, media and messages. This principle of a harmonious blend of communication channels towards a common purpose is related to the limitations as well as the potential of different media, and is relevant to enhancing the capability of women-in-child-rearing or income generation, family planning or participation in community life.

4.1 Accessibility and Acceptability of Television

Accessibility is a complex notion, as evidenced by the heterogeneity of definitions and conceptualizations in the literature and almost interchangeable use of the terms “access”, “accessibility” and “utilization of healthcare services”. The Canadian Oxford Dictionary (1998) defines accessibility as the “condition of being readily approached”. In this sense, accessibility is a characteristic of something that can readily be reached, entered or used.

Donabedian (1973) describes accessibility as characteristic of health systems that impede or promote service utilization. Thus, health services are accessible if their
specific characteristics—geographic availability, organization, price, acceptability and so on—allow a broad range of persons to reach, enter and use them (Bashshur et al. 1971; Donabedian 1972; Penchansky and Thomas 1981). From this perspective evaluation of accessibility is amenable to both objective and subjective assessment of the geographic and temporal availability of services, their organizational availability, their costs and their social and cultural acceptability (Levesque 2006).

4.2 Evaluating the accessibility of primary health care services

In a consensus consultation of primary health care (PHC) experts across Canada to formulate operational definitions of PHC attributes to be evaluated (Haggerty et al. 2007), two distinct definitions of accessibility emerged. The First, labelled first-contact accessibility, is “The ease with which a person can obtain needed care (including advice and support) from the practitioner of choice within a time frame appropriate to the urgency of the problem.” This is specific to primary health care and is one of its essential functions. The Second, accommodation, is applicable to all levels of health care: “The way health care resources are organized to accommodate a wide range of patients abilities to contact healthcare providers and reach healthcare services, that is to say telephone services, flexible appointment systems, hours of operation and walk-in periods”.

Accessibility has four overlapping dimensions:

(1) Non-Discrimination
(2) Physical Accessibility
(3) Economic Accessibility (Affordability)
(4) Information Accessibility

Acceptability: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.

4.3 Status of Women in India

Today, women are less than half of Indian population and their numbers are decreasing alarmingly. As per census 2011 of India, the population of males were 6237 lakh (51.5%) and females were 5864 lakh (48.5%). A sex ratio of 950 is
considered normal sex ratio but it is below normal right from the year 1941 when it was 945 and decreased from 950 in the year 1931.

**Table 4.1: Census-wise Sex Ratio of India**

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Year</th>
<th>Sex Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1901</td>
<td>972</td>
</tr>
<tr>
<td>2</td>
<td>1911</td>
<td>964</td>
</tr>
<tr>
<td>3</td>
<td>1921</td>
<td>955</td>
</tr>
<tr>
<td>4</td>
<td>1931</td>
<td>950</td>
</tr>
<tr>
<td>5</td>
<td>1941</td>
<td>945</td>
</tr>
<tr>
<td>6</td>
<td>1951</td>
<td>946</td>
</tr>
<tr>
<td>7</td>
<td>1961</td>
<td>941</td>
</tr>
<tr>
<td>8</td>
<td>1971</td>
<td>930</td>
</tr>
<tr>
<td>9</td>
<td>1981</td>
<td>934</td>
</tr>
<tr>
<td>10</td>
<td>1991</td>
<td>926</td>
</tr>
<tr>
<td>11</td>
<td>2001</td>
<td>933</td>
</tr>
<tr>
<td>12</td>
<td>2011</td>
<td>940</td>
</tr>
</tbody>
</table>

**Source:** Registrar General of India, Census 2011.

Table 4.1 given above shows that the sex ratios are decreasing. However, in the census 2011, a slighter improvement in sex ratio is visible, but when we see the child sex ratio, we observe that in the year 2011, it was 914 where as earlier it was 927 in the year 2001.

**4.4 Social Status**

Indian society is a patriarchal society, in which important rights and power to decisions are ought to be taken by man. *Manu* in 200 B.C. said, “By a young girl, by a young woman, or even by an aged one, nothing must be done independent, even in her own house.” This quotation of Manu forces us to accept that Sex and Gender are two different concepts related to women. The Universal validity of Simone de Beauvoir’s famous observation that “One is not born but rather becomes, a woman...” is reinforced in the light of the methods through which a girl is socialized into feminine submissiveness. What Simone wants to establish is that woman is a cultural construction. It is a known fact that biologically, there are some differences between man and woman and God has given different strength to both of them and we know that each has a different function to perform, so to pronounce one inferior or superior
is stereotype that pollutes and corrupts the psychology of society. It is the add-on of cultural norms to this biological categorization that becomes subversive and results in gender discrimination.

Sociologically, the word gender refers to the social-cultural definition of man and woman, the way societies distinguish men and women and assign them social roles. The distinction between sex and gender was introduced to deal with the general tendency to attribute women’s subordination to their anatomy. For ages it was believed that the different characteristics, roles and status accorded to women and men in the society are determined by sex, that they are natural and therefore not changeable. As soon as a child is born, families and society begin the process of gendering. The birth of a son is celebrated, the birth of a daughter is filled with pain; sons are showered with love, respect, better food, and proper healthcare. Boys are encouraged to be tough and outgoing; and girls to be homebound and shy. All these differences are gender differences and they are created by the society. Gender inequality is therefore a form of inequality and stems from pre-existing gendered social norms and social perceptions. Gender inequity has adverse impact on development goals as reduces economic growth. It hampers the overall well-being because blocking women from participation in social, political and economic activities can adversely affect the whole society. Many developing countries including India have displayed gender inequality in education, employment and health. It is common to find girls and women suffering from high mortality rates and vast differences in educational level.

India has witnessed gender inequality from its early history due to its socioeconomic and religious practices resulting in a wide disparity between the position of men and women in the society. In spite of India’s reputation for respecting women, including treating her as a Goddess, history tells us that women were also ill-treated. There are no equality between men and women. This is true of ancient, medieval and early modern times. Women in Indian society are considered as a citizen of secondary status. In the patriarchal society of the country, girls and women face lots of discrimination and hurdles. The decrease in the status of women has been due to the prevalence of patriarchal society in the country. Due to this, girls are not allowed to perform various rituals which can be performed only by the male child.
They are treated as the property of the family in which she lives as Manu said, “In childhood a female must be subject to her father, in youth to her husband, when her lord is dead to her sons; a woman must never be independent.” So woman is never given freedom and she is always subjected to exploitation of various kinds. As a result one can perceive as difference in the cognitive, connotative, and consumption patterns of women residing in various spheres of social and economic layers. The victims of exploitation and oppression have been largely women of the third world countries in general and lower sections among them in particular.

Socially and culturally, the types of discrimination can be understood as follows:

- Gender Specific Specialization (Work);
- Cultural Definition of Appropriate Sex Roles;
- Expectation of role within relationship;
- Belief in the Inherent Superiority of Males;
- Customs of Marriage (Bride price / Dowry);
- Notion of the family as the Private Sphere and Under Male Control; and
- Value that give Proprietary Right over Women and Girls.

Man is supposed to earn livelihood and women is expected to raise children and look after house-hold jobs. Woman is treated as a fairied sex, weaker sex, and she is expected not to do hard and difficult work. Family of women are generally expected to give dowry to the family of man and have to bear the cost of giving birth to a girl as if they have committed some crime. Women are also not given property rights as she is not treated as head of the family and as they have to go to some other family and some other place.

4.5 Economic Status

The socialisation of girls take place in such a manner and atmosphere that they are supposed to be conditioned to bear exploitations. As a result of the cultural and economic factors, women face discrimination right from the childhood. If there are two siblings in a family and one of them is a male, then the girl is expected to give due respect to the likes and dislikes of her brother, is given food after the male sibling has his share and also expected to do household chorus. It is held that both in
childhood and adulthood males are fed first and better. According to one estimate, even as adult women consume approximately 1000 calories less per day than men. This discrimination continues even after she gets mature and even after gets married. Her contribution to the house-hold chorus is not given importance at all and even not counted in the National Income because work done without taking anything in return/ remuneration is not treated as income.

Former President Bill Clinton while addressing the annual meeting of the Clinton Global Initiative (September, 2009) rightly said that, "Women perform 66 percent of the world's work, and produce 50 percent of the food, yet earn only 10 percent of the income and own 1 percent of the property. Whether the issue is improving education in the developing world, or fighting global climate change, or addressing nearly any other challenge we face, empowering women is a critical part of the equation."

There is discrimination against women in the economic activities which can be understood with the help of the following points:

- Limited Access to Cash and Credit
- Limited Access to Employment in Formal and Informal Sector
- Limited Access to Education

As per the latest economic survey of the country, only 49 percent of the Indian population have bank account whereas only 18 percent of women have bank accounts in their name. This show the women's low level of accessibility to banking services in the country which pose hindrance in their economic development and led to low levels. As per the National Sample Survey Organization (NSSO) data reveals that women account for just 22 percent of work force in India. According to the International Labour Organization (ILO), out of 131 countries for which data was available, India ranks 11th from the bottom in Female Labour Force Participation (FLFP). In fact, the National Sample Survey Organization (NSSO) data reveals falling FLFP from over 40 percent in the mid – 1990s, to 29 percent in 2004-05, to 23 percent in 2009-10 and 22.5 percent by 2011-12. This shows that female participation is decreasing continuously from mid- 1990s.
The disadvantages facing women and girls are a major source of inequality. All too often, women and girls are discriminated against in health, education, and labour market – with negative repercussions for their freedoms. India’s gender gap index was 0.655 in the year 2013 on a 0 to 1 scale, with 0 denoting inequality and 1 equality. Gender Inequality Index increased to 0.553 in 2001. The World Economic Forum has placed India in the 101st position among 136 countries in the 2013 annual report that makes a global assessment of the progress made in bridging the gender gap. India was at 124th position out of 136 countries when it comes to the economic participation and opportunity.

Table 4.2: Gender Gap Sub-Indexes – INDIA

<table>
<thead>
<tr>
<th>Sub-Indexes</th>
<th>Rank</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Economic participation and opportunity</strong></td>
<td>124</td>
<td>0.446</td>
</tr>
<tr>
<td>Labour force participation</td>
<td>124</td>
<td>0.36</td>
</tr>
<tr>
<td>Wage equality for similar work (survey)</td>
<td>86</td>
<td>0.62</td>
</tr>
<tr>
<td>Estimated earned income (PPP US$)</td>
<td>125</td>
<td>0.27</td>
</tr>
<tr>
<td>Legislators, senior officials and managers</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Professional and technical workers</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Professional and technical workers</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td><strong>Educational Attainment</strong></td>
<td>120</td>
<td>0.857</td>
</tr>
<tr>
<td>Literacy rate</td>
<td>123</td>
<td>0.68</td>
</tr>
<tr>
<td>Enrolment in primary education</td>
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<td>1.00</td>
</tr>
<tr>
<td>Enrolment in secondary education</td>
<td>111</td>
<td>0.79</td>
</tr>
<tr>
<td>Enrolment in tertiary education</td>
<td>107</td>
<td>0.73</td>
</tr>
<tr>
<td><strong>Health and Survival</strong></td>
<td>135</td>
<td>0.931</td>
</tr>
<tr>
<td>Sex ratio at birth (female/male)</td>
<td>133</td>
<td>0.89</td>
</tr>
<tr>
<td>Healthy life expectancy</td>
<td>112</td>
<td>1.02</td>
</tr>
<tr>
<td><strong>Political Empowerment</strong></td>
<td>9</td>
<td>0.385</td>
</tr>
<tr>
<td>Women in parliament</td>
<td>106</td>
<td>0.12</td>
</tr>
<tr>
<td>Women in ministerial positions</td>
<td>100</td>
<td>0.11</td>
</tr>
<tr>
<td>Years with female head of state (last 50)</td>
<td>1</td>
<td>0.75</td>
</tr>
</tbody>
</table>

**Source:** *World Economic Forum Report, 2013.*
The rankings are based on four of sub-indices that measure economic participation and opportunity, educational attainment, health and survival, and political empowerment. It is in the political empowerment arena that India has scored strong, being ranked 9th.

### 4.6 Educational Status

The World Economic Forum has placed India in the 120th position among 136 countries in the 2013 annual report in terms of educational attainment. As per 2011 census the total literacy rate of India was 74.04 whereas literacy rate for male was 82.14 and female was 65.46. It shows that almost 33% or one-fourth of Indian women are literate.

- Gross Enrolment Ratio (GER) of girls in primary stage was 48.2 whereas for upper-primary stage was 48.77 in 2013.
- GER in secondary education shows that there are 10% print gap between enrolment of boys and girls. As per available data of Gross Enrolment Ratio (GER) for Secondary Education for the year 2009-10, 52.39 percent of boys and 45.86 percent of girls combined at secondary and senior secondary level.
- The national GER for girls in higher education in 2011-12 was 18.9 percent. The national average of gender parity index in higher education, according to the AISHE report, was of 0.88 which shows that still there are 12 differences between the GER of boys and girls at the National Level. As per AISHE 2010-11, enrolment of women at UG level was 42.5 percent, at PG level was 42.7 percent whereas for Ph.D. level, it was 39.9 percent showing vast difference between enrolment of boys and girls at different levels of higher education.

- **Technical Status**

Technology has contributed a lot in the dwindling sex ratio in the country. Sex Ratio was 940 for females per 1000 males in the year 2011 which further decreased when we see the child sex-ratio. The child sex-ratio in the year 2011 was 914 whereas it was 927 in the year 2001. The situation is alarming in parts of Delhi, Punjab, Haryana, Uttar Pradesh and Maharashtra where the figure is less than 850 girls for every 1000 boys. Haryana tops the list with 830 girls for every 1000 boys. The maximum downfall in the sex-ratio has been in the states and districts which has developed economically and has good medical
infrastructure in place. Due to better health and medical facilities, parents easily got the sex of the foetus determined from the greedy and unethical medical practitioners and then able to abort them, if the foetus is going to be a girl.

4.7 Status of Women's Health in India

India with about 17.5 percent of the world population accounts for about 25 percent of the maternal death in the world. Every year about 1,25,000 Indian women die from pregnancy related causes many of which are preventable. Poor maternal health results in low birth weight and premature babies. Less than two-third of mothers received antenatal checkups. 58 percent received iron and folic supplements (1998-99). More than a third of women in the country had a Body Mass Index (BMI) of less than 18.5. Anaemia is a major health problem. The prevalence of anaemia for ever married women has increased from 52 percent in NFHS-II to 56 percent in NFHS-III. Pregnant women are much more likely than non-pregnant women to be moderately to severely anaemic. Not only that the overall health status of women in India is quite unimpressive, there are vast disparities in the achievements across the states of the country. Despite an increase in institutional deliveries, 60 percent of pregnant women still deliver their babies at home. The position of women is worse in "BIMARU" states. In India more than two-third of all maternal deaths occur in BIMARU states like Uttar Pradesh, Madhya Pradesh, Rajasthan, Orissa and Assam. There is an important link between women's status and population parameters such as fertility, infant child mortality, life-expectancy etc. High rates of fertility and infant child mortality deplete women's health. National Population Policy 2000, specifically identified the low status of women in India as an important barrier to the achievement of population and maternal and child welfare goals (Ministry of Health and Family Welfare, 2000). Nearly 50 percent women get married before they attain 18 years of age and 57.9 percent pregnant women and 56.2 percent married women suffer from anaemia. MMR is quite high at 301 maternal deaths per 1,00,000 live births in 2006. One-third of all malnourished children live in India and 46 percent of children under—3 years are under weight. Thus the status of women health is largely reflected by the indicators like female mortality and morbidity, disease burden, reproductive health and encompassing reproductive behaviour, maternal mortality and morbidity,
nutrition, poverty and violence against women, and its consequences for the healthcare system of women. Indian women have high mortality rates during childhood, reproductive years and particularly in pregnancy (Kateja, 2008) According to the report, 5.2 million people in the (15-49) age-group in India are suffered by HIV/AIDS, and among the affected 38 percent are women. Severity of malnutrition problem presents a serious threat to health of girls and women. It is important therefore to understand how women are particularly impacted and their health outcomes. There is a critical need to look at women's health holistically.

The study done on media accessibility, utilization and preference for food and nutritional information by rural women in India by Shweta Upadhyay et al. (2011) states that television and radio being at first and second position respectively in order of media preference poster and calendar places itself at third and fourth position respectively. Poster and calendar studies show that text accompanied by pictures is better remembered than text alone. This so-called 'pictorial superiority affect' is especially strong when people see pictures with an oral explanation and later see the same pictures to remind them of what they heard (Houts et al. 2006). As far as print media is concerned it lacks oral explanation this could be probable reason for giving print media a lower preference over electronic media. Muhammad and Garforth (2001) reported that radio was the major source followed by television in women farmers. In their study, electronic mass media appeared relatively more popular than any other method of communication among women farmers. Similarly, in my study also it was found that television and radio has been the two most preferred media for healthcare.

Lectures, audio cassettes, booklets, charts were given the 5th, 6th, 7th and 8th place. Newspaper emerged as least preferred media among women. It may be because of low subscription and poor newspaper reading habits of women. Audio cassettes, booklets, charts and newspaper were the four least preferred media among women. Reason for this may be that these involve non-interactive mode of communication and does not induce subjects to read it again and again. In one word, we can say that the potential of television as a mass communication medium in creating awareness, educating and motivating the people is unmatchable. The main reason of preferring television is because of its entertainment value. Research
demonstrates that people are more likely to pay attention to information that is accompanied by explanatory pictures (Katz et al. 2006; Levie 1987), this is particularly true for television.

The focus on consumer use of health care services combined with unprecedented access to health information through television highlights the need to better understand the effect of the use of health information on health services use. As examined the effect of exposure to multiple sources and types of health information on health care utilization in a general population of women shows higher median number of visits compared to other population-based studies. Broadcast and print health media were the two most commonly reported sources of information used. Along with these, computer-based resources were associated with a higher number of health care visits. The use of multiple sources of information was also associated with higher healthcare visits. The percentage of women who reported the use of computer-based resources (i.e. Internet) along with broadcast services of television and radio is consistent with the facilities availability and suggest that the Internet may be emerging as a viable, alternative source of health information for women. The explanation for the association between computer-based resources and higher visits may be similar to that of broadcast and print health media. Because the Internet comprises a vast amount of print health media, it may also contribute to the use of more health services.

Broadcast media (television and radio), print-health media, and computer-based resources are considered active sources of health information. Individuals who use these sources are generally described as adult women who actively seek health education and knowledge. However, these sources of information are not used equally among all populations of women of health information-seeking adults. There are differences in the use of television or computer-based sources, for example, within income, education, and racial groups. Older women and lower income women report less use of computer-based and television resources. A higher percentage of rural women report the use of passive information sources such as radio and organized health events, compared to urban women. Increased access to television and computer-based resources along with print health media among these populations might increase health care knowledge and improve long-term health. The effect of
use of television, radio and print health media along with computer-based sources on health services use has important policy implications for healthcare promotion among women who have not traditionally used these sources of information. First, for women who are less active information seekers, broadcast media (i.e. television and radio) may be a more effective method of health communication and promotion, particularly for health prevention campaigns that are aimed at educating women who do not actively seek health information. Second, the unintentional exposure of less active information seekers to health information, through broadcast media for example, could then prompt a higher intentional use of sources, such as computer-based sources or print media.

Several factors might explain the relationship between the use of multiple information sources and higher utilization. First, enhanced consumer knowledge through various information sources may translate into more healthcare service use. It is also possible that women's use of multiple sources of information and higher visits may reflect uncertainty or mis-interpretation of health information. Women may seek information from alternative sources because the information received from health care providers is incomplete or insufficient. Also, mis-interpretation of health information could exacerbate patient uncertainty and predispose women to make more visits.

4.8 Views on Children

Travelling by a train at speeding exceeding 400 kmph is a noteworthy technological advancement, and being able to find evidence of water on Mars is a significant scientific progress, but however, a truly global progress would be achieved when children of our society are ensured of basic rights like living healthy lives. For any nation, children are their most important asset and their development is as important as the development of other national resources.

Globally, more than 70 per cent of almost 1.1 crore children die every year due to diarrhoea, malaria, neo-natal infection, pneumonia, pre-term delivery or lack of oxygen at birth. A more notable fact is that these deaths occur mainly in developing countries. As per the latest statistics, India contributes to 21 per cent of the global burden of child deaths (Source: Progress for Children Report, UNICEF).
Over the last one and a half decade the daily experience of children has been transformed by developments in electronic media, including the computer, the Internet, and cell phones. Relative rarities only a generation ago, they are the daily tools of communication, information, and amusement for a majority of adolescents and children. Beyond access, content and capabilities have exploded. Even television, long a ubiquitous presence in Indian households, has seen content change and has grown dramatically. The growing children age is crucial to the development of child's body, brain, in respect of educational and psychological development. Their negative influence can have lifelong health effects. Even then, radio, television, movies, videogames, cell phones, and computer networks have assumed central role in our children's daily lives. The media has demonstrated potentially profound effects, both positive and negative, on children's cognitive, social, and behavioural development. It is widely accepted that media has profound influence on child health, including violence, obesity, tobacco and alcohol use, and risky sexual behaviours. Excessive television viewing among young children has been linked to negative impacts on early child brain development and life-long physical health. Repeated exposure to television can affect a child's mental and emotional development that often takes place of interactive experiences (for eg. play) that promotes healthy brain development. In other words, effects of the mass media have been found to be far reaching and potentially harmful in influencing the health-related behaviours of children and adolescents, many of whom are not yet mature enough to distinguish fantasy from reality, particularly when it is presented as "real life". This is particularly important for very young children who developmentally think concretely and are unable to distinguish fantasy from reality. Hence, time spent with media decreases the amount of time available for pursuing other more healthy activities such as sports, physical activity, community service, cultural pursuits, and family time.

Bickham et al. investigated the relationship between television viewing time, content, context, and peer integration. As children spend more total time watching television, they spend a significantly shorter amount of time with friends as compared to those who don't. Thus, viewing television causes poor peer relationships and thereby increases the risk for social isolation, anxiety disorder, agoraphobia, and antisocial behaviour, including aggression and gang involvement. Some authors found
that the more time children spent watching television, the less time they spent with their families. While television may isolate children, the reverse causal direction is also plausible—lonely children may turn to television for entertainment and companionship. Children who are marginalized by their peers use television to escape the stresses of their lives and meet the social needs. Conversely, children who are socially integrated spend less time watching television. Thus, it can be argued that it is social isolation that motivates excessive media use. Overall, it is most likely that both effects occur—children who watch more television become more socially isolated, which leads them to spend more time watching television. While television viewing is often perceived as an isolating activity, it frequently occurs in the company of friends. Because socializing builds interpersonal skills, television viewing with friends may provide a venue for these skills to develop. It is important to consider content whenever investigating the relationships between media use and behaviours. Violent television viewing may influence younger children to be more antisocial; resulting in their becoming socially isolated which, in turn, attracts them to more violent media. To optimize children's social development and long term mental health, parents, teachers, and pediatricians should discourage the viewing of violent television programs.

One can remark that television viewing is the third most time-consuming activity following work (study) and sleep among children. A typical child in the United States watches approximately 20 hours of television per week. Television is the largest single media source of messages about food. The vast majority of money spent on food advertising comes from branded food manufacturers and fast food chains, and television is primary medium used by these companies. The food product advertised most intensively on television also tend to be over consumed relative to federal dietary guidelines, whereas fruits and vegetables which are almost never advertised are under consumed. It is, therefore, of considerable importance to determine the relationship between use of television and children food consumption patterns. One of the most sedentary behaviours 'per se' in childhood is television viewing. This behaviour could replace more vigorous activities, and at the same time, could expose children to a large number of important unhealthy stimulations in terms of food intake. First of all, it has been recognized, that in the last few decades, obesity
prevalence has increased as a function of the number of hours that television networks devotes to target children populations. Television shows and cartoons programmes addressed to a very young audience are now aired everyday on both public/nation-wide and private/commercial channels. Most of the times the new way of approaching children with dedicated programmes are sponsored by companies producing toys and for unhealthy food, including high calories, high sugar and high-salt products. The negative consequences of the commercials can be analyzed as the higher the number of commercials watched the greater the number of purchase-influencing attempts directed at parents in the supermarket by children from 3 to 11 years of age. Television on during meals, worse eating pattern in the family. Among all the types of commercials, food advertising is the most frequent, especially when it comes to junk food in all of its forms; high fat, high sugar, high salt foods, sodas and sugared beverages, and of course, advertising for fast food restaurant and more recently, ready-to-eat frozen food, which is often nutritionally unbalanced.

For the past 15 years, the American Academy of Paediatrics (AAP) has also expressed its concerns about the amount of time children and adolescent spend viewing television and the content of what they view. According to recent Nielsen Media Research data, the average child or adolescent watches an average of nearly 3 hours of television per day. This figure does not include time spent watching videotapes or playing video games (a study found that children spend an average of 6 hours 32 minutes per day with various media combined). By the time the average person reaches age 70, he or she will have spent the equivalent of 7 to 10 years watching television. One recent study found that 32% of 2-to-7-year-olds and 65% of 8-to18-year-olds have television sets in their bedrooms.

4.9 The Effects of Electronic Media on Children Well-Being

Health and Safety

Health and safety concerns potentially related to the use of electronic media especially television by children and adolescents are wide-ranging and have inspired a growing body of research. Concerns include both behaviour-related maladies (obesity, violence, drug use) and threats to physical health (injury, cancer). In addition, some researchers have examined health benefits related to electronic media use.
Considerable evidence indicates that certain media influence violence and substance use.

**Violence**

During the past few decades, India has witnessed an alarming increase in the incidence of violence in the lives of children. There is a strong body of research exposure to violent television program content in childhood to violent behaviour both as children and later as young adults. On a daily basis, children in India are victims of violence, as witnesses to violent acts in their homes or communities, or as victims of abuse, neglect, or personal assault. The causes of violent behaviour in society are complex and interrelated. Among the significant contributors is poverty, racism, unemployment, illegal drugs, inadequate or abusive parenting practices, and real-life adult models of violent problem-solving behaviour. The nation's organization of early childhood professionals, is deeply concerned about the destructive effect of violent living conditions and experiences on many of our nation's children.

An analysis of studies found a medium effect of television violence on aggressive behaviour. The research linking playing violent video games to physical aggression is less extensive, but analysis of available research find effect sizes that are only slightly smaller than those found for violent television. At the same time there has been an increase in the number of reported violent acts directed at children, there has been an increase in the amount and severity of violent acts observed by children through the media, including television, movies, computer games, and videotapes, and an increase in the manufacture and distribution of weapon-like toys and other products directly linked to violent programming. It is believed that the trend toward increased depiction of violence in the media jeopardizes the healthy development of significant numbers of our nation's children. The organization also believes that television and other media have the potential to be very effective education tools for children. Research demonstrates that television viewing is a highly complex, cognitive activity, during which children are actively involved in learning. Therefore, it supports efforts to use media constructively to be positive social values, and condemns violent television programming, movies, videotapes, computer games, and other forms of media directed to children. The organization believes that it is the
responsibility of adults and of public policy to protect children from unnecessary and potentially harmful exposure to violence through the media and to protect children from television content and advertising practices that exploit their special vulnerability.

**Smoking**

Research has demonstrated a strong association between exposure to certain mass media messages and *smoking* in adolescents. For instance, more than half of adolescent smoking initiation has been linked to watching smoking in movies. Acknowledging the effects of mass media on attitudes and behaviour, media literacy may teach youth to understand, analyze, and evaluate advertising and other mass media messages, enabling them to actively process media messages rather than passively remaining targets of mass media. India faced a lot of controversy with the ban on on-screen smoking in films and television programs. Initially, ban was imposed from January 01, 2006, and then on January 23, 2009, Delhi High Court lifted the smoking ban in films and television. There is need for evidence based guidelines for such issues.

**4.10 Alcohol and Tobacco Consumption**

It has also been shown that exposure to alcohol advertising and television programming is associated with positive beliefs about alcohol consumption. Although such cross-sectional studies do not prove causation (only association), it is of interest that in a study done in 1990 found that 56% of students in grades 5 to 12 said that alcohol advertising encourages them to drink. Findings showed that girls who had watched more hours of television at ages 13 and 15 drank more wine and spirits at age 18 than those who had watched fewer hours of television. One study suggested independent associations between marijuana and alcohol use, and media exposure. In particular, music exposure is associated with marijuana use while movie exposure is related to alcohol use. Little research has been done to date relating exposure through video games or the Internet to adolescent smoking and drinking behaviours.
4.11 Sexual Activity

During early childhood, the foundation is laid for future social, emotional, cognitive, and physical development. During this formative period, young children are particularly vulnerable to negative influences. In most instances, children have no control over the environmental messages they receive. Up until age fourteen or fifteen, children have great difficulty distinguishing fantasy from reality, and their ability to comprehend nuances of behaviour, motivation, or moral complexity is limited. This special vulnerability of children necessitates increased vigilance to protect them from potentially negative influences. Parents are ultimately responsible for monitoring their children's viewing habits; however, parents cannot be omniscient and omnipresent in their children's lives. Parents need assistance in protecting their children from unhealthy exposure to sexual activity and risk of sexual initiation, or exposure to pornography. Surprisingly, and despite long-standing concerns over the influence of sexual media content on the behaviour of adolescents, there is very little relevant research in this area according to a recent review by Escobar-chavez and Andersson (2008). Several analyses have found that exposure to sexual content in television and videos was related to more positive attitudes towards pre-marital sex, and to being sexually active, but it was not clear if there was a causal connection.

Initiation of sexual intercourse by younger adolescents is associated with risky sexual behaviours and increased risk of multiple partners, unwanted pregnancy, sexually transmitted infections, and pelvic inflammatory disease. In the US, approximately 47% of high school students have had sexual intercourse. Of them, 7.4% report having sex before the age of 13 and 14% have had more than and equal to (≥) 4 sexual partners. One potential but largely unexplored factor that may contribute to sexual activity among adolescents is exposure to sexual content in the mass media. In India, there are reports of messaging of sexual contents through mobiles among school-going adolescents.

Survey research results demonstrate that television programs watched by adolescents contains high level of sexual content, include little information about sexual risks, and are an important source of information about sex. Almost 75% of 15 to 17 year olds believe that sexual content on television influences the behaviour of their peers "somewhat" or "a lot". Collins et al. reported that the amount of sexual
content viewed, but not hours of television watched, was a significant one year risk factor for sexual initiation. Ashby et al. used longitudinal data to examine the relationships between amount of television viewing and parental regulation of content on sexual initiation and observed that watching television 2 to more hours per day and lack of parental regulation of television programming were each associated with increased risk of initiating sexual intercourse within a year. Peterson et al. found that co-viewing television and discussing television with parents were related to decrease sexual initiation in certain adolescents.

4.12 Childhood Obesity and Eating Disorders

There is concern that excessive media use promotes obesity by reducing time developed to physical exercise and by increasing consumption of high calorie non-nutritious foods. Several studies have found a relationship between excessive television viewing and obesity among adolescents. Dietz and Gortmaker reported that each additional hour of television viewing per week increased the risk of obesity by 2%. The experimental study by Robinson found strong evidence of a causal link between television viewing and children being overweight. Settler, et al. showed a significant association between electronic game use and obesity, with nearly a 2-fold increased risk of obesity for every hour spent playing electronic games daily. An inverse relationship between time spent using video games and daily physical activity has also been observed. Thus, if playing of video games is used as a substitute for regular physical activity, the positive association between game play and obesity is certainly plausible; however, if it is used to replace time spent watching television or simply resting, video game play can serve to more positively affect energy expenditure. Thus, although video game play should not be considered a sedentary activity, it should in no way be considered a substitute for regular physical activities that significantly stress the metabolic pathways required for the enhancement of cardio-vascular conditioning.

The mechanism of effect of television exposure on overweight risk is undoubtedly multi-factorial. It appears to operate independently from reduced physical activity. Excessive television exposure may instead operate through the extensive advertising messages for unhealthy foods targeted at very young children or
from a tendency of children to snack while watching television. A randomized controlled trial found that increasing screen time resulted in reduced energy expenditure and increased energy intake. There is association between exposure to advertisements and children's requests for specific foods, food purchasing, and food consumption. Indeed, studies show that television viewing is inversely associated with intake of fruits and vegetables, which receive little air time despite their potential to promote health in various ways and protect against weight gain. Epstein et al. conducted a randomized trial and found that reducing television viewing and computer use may have an important role in preventing obesity and in lowering BMI (Body Mass Index) in young children, and these changes may be related more to changes in energy intake than to changes in physical activity.

It was also observed that the print media promotes an unrealistically thin body ideal that, in turn, is at least partially responsible for promoting eating disorders. One prospective study of thin ideal – promoting media use in young adolescent girls found that decreases in magazine reading over 16 months was associated with decrease in eating disordered symptoms. In a study done by Field and his colleagues observed that majority of the pre-adolescent and adolescent girls in their school-based study were unhappy with their body weight and shape. This discontentment was strongly related to the frequency of reading fashion magazines. The frequency of reading fashion magazines was positively associated with the prevalence of having dieted and exercised to lose weight and to improve body shape. Van den Berg et al. also found that frequent reading of magazine articles about dieting/weight loss strongly predicted unhealthy weight control behaviours in adolescent girls, but not boys, 5 years later. The result suggest that the print media aimed at young girls could serve a public health role by refraining from relying on models that are severely under weight and printing more articles on the benefits of physical activity.

The American Academy of Paediatrics has recommended that children under the age of two not watch any television. While many parents have some idea that television watching is not good, most parents are not aware of the detrimental effects television can have on young children. In fact, there are a number of researchers from different fields who have revealed mounting evidence that television can actually harm the child physically, mentally and emotionally as already discussed. A study by...
Dr. Jenn Berman suggests some top reasons to turn off the television before the child is exposed to it. They can be reframed as:

(1) ADD - Attention Deficit Disorder

There is a significant connection between infants exposed to television and the development of Attention Deficit Disorder (ADD). In a study published in April 2004 issue of "Paediatrics", researchers found that for every hour of television watched at ages one and three there was a 10% increased chance of developing attention problems that could be diagnosed as ADD by the age of seven. A recent review of the studies indicate that evidence linking electronic media use to Attention Deficit Hyperactivity Disorder (ADHD) is inconsistent. A number of researches find that children with ADHD watch more television than other children, though it is unclear whether the ADHD is a cause or consequence of more television viewing. One study has also linked excessive video game playing to attention problems, but again the direction of influence is unclear. The researchers hypothesize that exposing a baby's developing brain to the quick changing images of today's television may over stimulate it causing permanent changes in developing neural pathways.

(2) Metabolism

Television viewing actually slows down metabolic rates. Studies show that normal-weight children experience a 12% decline in metabolic rates while watching television and obese children experience a 16% decline. This metabolic slowing makes it more likely that a child who watches television will be overweight.

(3) Poor Eyesight

Permanent eye damage which was previously attributed to genetics is now strongly linked to television-screen exposure. The long periods of fixed attention required by viewers is now believed to be the cause of the increase in myopia or short sightedness.

(4) Development of Inner Speech

Even just listening to television can be harmful. It can prevent a child from the play and babbling that is so important to language development. The distraction
television provides can prevent a child from developing inner speech or an "inner voice". According to educational psychologist Jane Healy, inner speech is important in order to problem solve both academically and personally. In addition, as children get older they need inner language in order to sort out their thoughts and be able to listen to others.

(5) Autism

In a controversial new study titled "Does Television Cause Autism?" researchers discovered a connection between early childhood viewing and the onset of autism. In looking for environmental triggers they discovered television viewing as a potential contributing factor.

(6) Melatonin

Television viewing lowers melatonin production. Melatonin is responsible for immune system development, regulating circadian rhythm or sleep cycles, controlling hormone levels, helping learning and memory, and many other important bodily functions. Scientists at the University of Florence in Italy found that when children were deprived of television, computers, and videogames, their melatonin production increased by an average of 30 percent.

(7) Bad Sleep Habits

In the study "The Association Between Television Viewing and Irregular Sleep Schedules Among Children Less Than 3 Years of Age" published in the journal "Paediatrics", researchers found that the number of hours babies watched television was associated with irregular nap and bedtime schedules which, as one knows, often leads to poor quality sleep. In another study in "Paediatrics" called "Television-viewing Habits and Sleep Disturbance in School Children", researchers found that the more television viewing a child did the more likely he was to have difficulty falling asleep and staying asleep.

(8) Cancer

According to Dr. Aric Sigman, author of "Remotely Controlled: How Television is Damaging Our Lives," reduced levels of melatonin result in a greater
chance that cellular DNA will produce cancer-causing mutations. A substantial amount of research has investigated whether the electromagnetic radiation emanating from cell phones causes brain and other forms of cancer. However, the US Centres for Disease Control and Prevention, after reviewing available research, has concluded that there is no evidence of a significant link. Even so, several major studies are ongoing, looking for possible long-term effects. Medical experts have speculated on a link between sleeplessness and cancer. A study in the journal "Brain, Behaviour, and Immunity" hypothesized that circadian disruptions form a "neuro endocrine-immune pathway from stress to disease".

(9) **Little Consumers**

In the study "Identifying Determinants of Young Children's Brand Awareness: Television, Parents, and Peers", it was found that children as young as two years old were able to recognize 8 out of 12 brands they were shown. The researchers found that the more television a child watched regularly the more likely he was to be able to recognize specific brands. Children, who don't understand advertising, are at the mercy of the messages that advertisers send them.

(10) **Alzheimer's Disease**

Babies who watch television become children who watch and later become adults who watch television. It is now believed that the risk of developing Alzheimer's disease increases with each extra daily hour of television viewing among people aged 20 to 60. By definition, television watchers are inactive. A study, published in the Proceedings of the National Academy of Sciences, suggested that people who were relatively inactive had a 250% increased risk of developing Alzheimer's.

**4.13 Positive Health Influences**

While most research has focused on the link to negative health outcomes some research has examined the potential health benefits related to electronic media use. A recent survey reveals that 28 per cent of adolescents ages 12-17 who use the Internet use it to access information on health, dieting, and physical exercise; however, the impact of that information on their health is unknown. In addition, there is some evidence that social marketing campaigns using electronic media have been
successful in positively affecting health behaviours of adolescents. For example, a recent rigorous, quasi-experimental evaluation found that the mass media campaign was successful in reducing the number of youth who took up smoking, accounting for 22 per cent of the total decline in teen smoking in last three years. Evaluations of state-funded anti-smoking campaigns targeting adolescents also found some evidence that such campaigns reduced teen smoking.

Social Development

Increased access to cell phones and the Internet has vastly expanded options to adolescents for interacting with their peers and, in the case of the Internet, with strangers. Options include texting, instant messaging, blogs, online gaming, email, and increasingly, social networking sites like Facebook and My Space. Subrahmanyam and Greenfield (2008) conclude that, where relationships with others are concerned, adolescents use the Internet primarily to strengthen existing "offline" relationships with friends and romantic interests. They also indicate that online interaction with strangers (strangers at least in terms of their offline lives) can help relieve social anxiety and social isolation for some.

4.14 Elements of a Good Children's Programme

Some programme elements that can help to increase the appeal and effectiveness of programmes for children include:

Combining Entertainment with Education

Recent experiments have shown that the elements of education and entertainment can be merged quite effectively. However, precautions must be taken to ensure that the two components are combined in harmonious proportions. The element of entertainment, for instance, must not become so prominent as to obscure the educational messages that are to be communicated alongside.

Some programme elements that have been commonly used to increase the entertainment value of a programme are:

Humour: Depending on the age of the target audience, different forms of humour may be incorporated into programmes, including slapstick, situational comedy, verbal humour, and so on.
Action and Drama: Fast paced action almost invariably helps to increase the child's interest in a programme.

Music: Apart from helping to attract and sustain the child's attention, music can often be used as an effective aid to memory; children are generally better able to memorize concepts or passages when they are set to a tune. Apart from the components of entertainment, other factors which contribute to the success of a programme are:

Variations in terms of contents as well as pace, to sustain the viewer's interest.

Repetition of important messages, to ensure they are assimilated and memorized.

Indirect instruction: Children can be helped to acquire desirable attitudes and habits through processes of modelling and limitation that is, through indentifying with a model on screen.

Use of child characters: Child viewers, naturally, identify much more strongly with child characters and therefore enjoy stories revolving around children like themselves. Whenever adult characters are used, they must communicate with the child at his level; with genuine warmth and enthusiasm and without affectation or condescension.

Formats

There are three major formats which may be used in children's programmes:

1. Use of live characters: This is often the most effective format, provided the child actors/characters featured are spontaneous and not self-conscious or affected.

2. Puppets of various kinds have been used successfully: shadow puppets, hand puppets, string puppets etc.

3. Animation: Children sometimes enjoy animation merely because it is "different" or unusual. Experiences during the SITE, however, have shown that messages conveyed through animation films are frequently not understood or assimilated. This is especially true for children who have had little or no experience with two-dimensional pictures and cartoons, and three-dimensional documentaries and movies.
4.15 An Overture

Programmes— in terms of contents, format, and style— must be designed with one age group kept in mind as the target audience. Since the abilities, needs and interests of children change rapidly as they grow older, it is often necessary to consider a range of only 2-3 years as forming a homogeneous group in terms of implications for programming planning.

It must be noted at this point, however, that designing a programme for a specific age group does not necessarily preclude enjoyment of the programme by all other age groups. The same programme can be enjoyed equally well by a preschooler and an adolescent provided it contains elements that each age group can appreciate. For instance, if within the same programme, slapstick as well as slick verbal humour were to be used, both age groups could be adequately provided for.

A related point in this context has to do with the kind of language that is used in contemporary television programmes. All too often producers tend to feel that if a programme is to be educative or informative, it must sound very erudite and somewhat complicated; it certainly must not be perceived as entertaining. Conversely, programmes for children often contain simplistic themes, presented in condescending "baby talk" fashions. Through such attitudes and practices, we are ensuring a gross under-utilization of television as an educating agent for children. We need to consider that children of all ages can benefit to some extent from programmes that are primarily "adult directed". Consider, as an example, the daily news bulletin. If this were presented in simple, easily understood language, children could pick up valuable bits of information every now and then, even though they might not assimilate all the contents of the programme. Conversely, programmes designed specifically for children must not contain condescension of any kind. Adults featured on children's programmes who "talk down" to their audiences in a sing-song, affected manner not just unnecessarily insult the intelligence of the child, but are also in conducive to processes of learning in children. Following the simple rule of simplicity (as distinguished from puerility or falseness) in all television programmes, then, we may have the beginnings of television being used almost constantly for educating children.

The Indian planners, appreciating the potential of television as an instrument of education and change, have whole-heartedly recommended its expansion which is underway. Television has come to stay in India as elsewhere in the world. With the
help of satellites and the experience gained and lessons learnt from SITE (Satellite Instructional Television Experiment), the government is expanding television to cover 90% of India's population by the end of 2015. The capacity of television to reach people more effectively than any other modern or traditional medium with the massage of development (apart from the messages of the party in power) makes the medium one of the most powerful. However, going by the performance of television programmes, it is doubtful that television in its present role can be a catalyst for social change. To bring about a change in attitudes and perceptions in tune with the changing needs of the present-day society the medium should project issues and problems in their perspective, being nearer to truth. This is particularly true with regard to portrayal of woman.

With the pace at which television expansion is taking place, television could well become the most powerful communication medium in India in a few years. The influence of television in shaping attitudes and concepts is unquestionable. Therefore, all care should be taken to see that television does not work in variance with the government's stated policy of equality for women. Doordarshan and other channels should ensure that the image of women presented on television screens does not have a negative impact on government effort for sexual equality. The commercialized, tasteless, stereotyped image of women on the television should give way to truthful and honest image, a dignified and positive image that will bring about changes in attitudes of both men and women, that will encourage women to discover their potential unhampered by prejudices unreal images and harmful stereotypes.

With its reach extended into rural areas, television can play a crucial role in instilling confidence and self-respect in rural women (and urban women) and help them in securing their dignified and rightful place in society.
Chapter - V

HEALTH CARE PROGRAMS ON TELEVISION : ITS ROLE AND IMPACT TO MOTIVATE VIEWERS

Women are among the most undeveloped, illiterate and exploited segments of the society even though constituting half of the population in the world. Material and technological development has made marginal difference as far as their status is concerned. Their role in the nation's economy is ignored not just in India and other developing countries but even in developed and advanced countries. Women remain backward educationally, economically and socially.

However, women are slowly emerging out of their centuries-old darkness, shaking off their shackles of tradition and man determined and man-imposed roles and are increasingly raising their voice to demand their rightful place in society and their due from it in economic, political and social life. Women have become one of the most potent forces of change, causing upheavals in the staid, in still waters of a smug male-oriented society.

The ripples of these upheavals are being felt in India. But, to carry the simile forward, a lot more needs to be done for these ripples to become waves on whose crest would ride equality. 'A lot more' would include efforts to bring about change in public attitudes and perceptions regarding the role of women. A task so immense both in magnitude and significance that only the mass media, given the size of the country, could attempt to undertake. The mass media exert a strong influence on shaping the public attitudes. The mass media are so powerful and all pervasive that it is within their power to either stimulate or retard change significantly.

The reach of the mass media among women is much less due to factors like illiteracy, inaccessibility, lack of respite from household chores, inconvenient programme timings in the case of radio and television, and traditionally imposed inhibitions restricting the movement of women (as in the case of film and television). The distance between women and media not only deprives the women of their right to
information and knowledge but also keeps the women in the dark regarding the blatant misuse of the female and the distortion of the truth.

The children also are in the same stream. One can recount a clause from the Declaration adopted by the UN General Assembly in 1959 which refers to Right of the Child. It states that the child has: the right to affection, love and understanding, adequate nutrition and medical care, free education; full opportunity for play and recreation, a name and nationality, special care, if handicapped; be among the first to receive relief in times of disaster, learn to be a useful member of society and to developed individual abilities; be brought up in a spirit of a peace and universal brotherhood to enjoy these rights, regardless of race, colour, sex, religions, national or social origin.

The preamble of this Declaration says: "Mankind owes to the child the best has to give". Prime Minister Indira Gandhi, has, therefore, rightly observed: "Child care must be the corner-stone of all our constructive activities." After we attained freedom, we started paying attention to be development of the personality of the child. Various schemes were drawn up for the well-being, betterment and integrated development of the child. Our Constitution also made special provision for children.

*Article 24* lays down: "No child below the age of 14 shall be employed to work in any factory or engaged in any other hazardous employment."

*Article 39* advises: "the State shall, in particular, direct its policy towards securing... that the tender age of children is not abused... that... children are given opportunities and facilities to develop in a healthy manner and in the conditions of freedom and dignity…"

*Article 45* enjoin upon the State "to provide... free and compulsory education for all children until they complete the age of 14 years." In the year 1972 the Minister of Planning recommended the establishment of child care services. The Government of India has formulated a National Policy for children, proclaiming in the National Policy Resolution, 1974, that "the nation's children are a supremely important asset and that their nurture and solicitude are our responsibility."
This shows that women and children are the greatest assets a country possesses and as such we should be proud of these assets. Doordarshan and other private channels should do everything possible to promote their health—physical and mental—their growth, progress and prosperity by doing effective, credible and meaningful television programmes. Therein lies our salvation!

The Indian planners, appreciating the potential of television as an instrument of education and change, have whole-heartedly recommended its expansion which is still underway. With the help of different satellite and the experience gained and lessons learnt from SITE (Satellite Instructional Television Experiment) the Government is expanding television to cover 90% of India's population. The capacity of television to reach people more effectively than any other modern or traditional medium with the message of development (apart from the messages of the party in power) makes the medium one of the most powerful. However, going by the performance of television programmes, it is doubtful if television in its present role can be a catalyst for social change. To bring about a change in attitudes and perceptions in tune with the changing needs of the present-day society the medium should project issues and problems in their perspective, being nearer to truth. This is particularly true with regard to portrayal of women.

With the pace at which television expansion is taking place, television could well become the most power communication medium in India in years to come, displacing other traditional medium along with commercial movies. The influence of television in shaping attitudes and concepts is unquestionable. Therefore, all care should be taken to see that television does not work in variance with the Government's stated policy of equality for women. Doordarshan along with other private channels should ensure that the image of women presented a television screens does not have a negative impact on governmental effort for sexual equality. The commercialized, tasteless, stereotyped image of women on the television should give way to truthful and honest image, a dignified and positive image that will bring about changes in attitudes of both men and women, that will encourage women to discover their potential unhampered by prejudices, unreal images and harmful stereotypes.
With its reach extended into rural areas, television can play a crucial role in instilling confidence and self-respect in rural women (as well as urban women) and help them in securing their dignified and rightful place in society. Hence, the purpose is to discuss and recommend how best a medium like television can be utilized for the development of women and children. This matter is of crucial importance at present for two obvious reasons:

(a) The television network in the country is spreading very fast due to the quick implementation of Special Expansion Plan. Consequently, the reach of television signals is going to increase from 70 percent to 90 percent of the population by the end of this decade through several High Power and Low Power Transmitters.

(b) The programmes from Doordarshan Kendras, and other private channels, in Hindi and English are being shown in the areas covered by these transmitters all over the country. Most of the people live in rural areas. These programmes which also include imported film and video material suit the urban needs and tastes and are quite irrelevant for the rural masses.

This defeats the main objective of television as defined by the Government, "to assist in the process of social and economic development and to act as an effective medium for specifically in the most important rural areas".

We all know that television was started with the main objective to accelerate the process of development. Despite so many changes in plans and priorities of government about the development and expansion of television during all these years of its existence, there is no shift in the policy of government as far as the development objective of television is concerned. However, if one reviews the performance of television during this period in an objective manner, it becomes quite evident that there is a shift in the original intention of applying this medium for education and development since it is dominated by low quality entertainment programmes with its focus on urban viewers. We can examine the reason for this widening gap between the policy and performance in the context of present project which has been conceived and implemented to accelerate the process of development, particularly in rural and remote areas of the country.
The utilization plan of television segment envisages the beaming of development-oriented television programmes in the target areas on the Pattern of SITE which remains the largest experiment in developmental communication ever conducted in the world. These programmes have to be specially made according to the specific needs of the target audience with the participation of the local people using their own language and dialect which is necessary to give it the credibility and image of the people's medium. To meet the needs of this kind of local programming it was found imperative to decentralize production facilities.

Even in the existing set-up of the Ministry and the Directorate, one found it feasible to change the structure and working system of the television stations responsive to the peculiar needs and problems of television programme production. One can hold the conviction that this is easily possible if one tries to introduce simple management concepts like planning, organizing, leading and controlling as the basis of functioning of the television stations at all levels. Needless to say that the television stations are the nerves center of Doordarshan and other private channels which transform the policies into realities by planning, producing and telecasting the desired types of programmes. The management of television stations on efficient lines to produce right type of quality programmes at minimum cost is the reefer of primary importance in the total task of development of television in the country.

As one of the valuable findings of SITE, now it is well recognized in all quarters that any programme produced with developmental objectives for target audience has to be research based in order to make it relevant and meaningful. The production of such programmes demands management system which can facilitate research and innovation by providing scope for:

(i) Multidisciplinary teams consisting of Producers, Researchers, Script Writers, Subject Experts etc.
(ii) Different production requirements for various types of programmes
(iii) Sufficient and varying lead time for every programme
(iv) Creative freedom to Producers
(v) Team Spirit
(vi) Technology developments
Hence, we can say that mass communication does not operate in a vacuum. It functions through both positive and negative mediating factors which need to be identified. Every society has established norms, practices and behaviours in dealing with women and children. It is important that strategies are developed which integrate mass communication with inter-personal and inter-societal perceptions of problems of women and children in a way which reinforce one another and bring about desired behavioural change.

Human development is our primary consideration and the goal of communication is communion. People relate to one another, through direct inter-personal conversation or through the media. In fact communication is a matter of human right which goes beyond information. By definition, communication is two-way. The existence of mass media and even their wide-scale use may not imply that communication is achieved in support of common development. The developmental challenge lies in opening up possibilities which exists in principle to extend communication from a minority to all of the population.

In developmental terms, as well as biologically, it is useful to consider the mother and the young child as a single unit. Nearly three-fourths of India's populations are women and children. About half the numbers of women and children (as well as men) live in conditions of poverty. And the effects of ignorance and ill-health may have spread even wider than the immediate effects of poverty like lack of food. Beneath this massive and complex situation lies the unmet need of economic support, access to nutrition, safe sanitation, and means to health, family planning awareness, educational opportunities and participative communication. Development experience shows that it is more productive, perhaps easier, to promote these complementing concerns together rather than separately. Before development can happen, the impediments in its way have to be removed; among them the very real threat to the survival of children, and the various factors that limit the potential of many of those who survive. Certain immediate interventions are required to remove dangers and obstacles of this kind. Luckily many of them are removable, easily, effectively, and economically—through communication.
For example, debility of a pregnant mother is a fact of life among the poor, which they perhaps take as inevitable. Yet they will be able to alleviate her condition, as well as that of her baby, despite the poverty, if they know that a marginal redistribution of the family diet will make a more than proportional difference to the health of both mother and child. The changes will be more dramatic if they are informed about, and also helped to gain better access to, new sources of nutrition. Providing material help is necessary, but in the absence of communication to activate people, it remains insufficient for durable change in their condition. To take another example, when epidemics like dysentery and jaundice come, as they still do, the usual social response is medical and limited to treatment which may happen to be too late for too many. But the deeper causes like unhygienic practices and harmful dietary habits remain to re-invite the disease. The preventive potential of relevant information is under-estimated and underused. This is one reason why the “provider approach” and the “dependency relation” continue.

Again poor families often assume their lack of control over infant deaths, caused in large numbers by preventable infections. But if they are aware that vaccines exist and they have a right of access to them, they will not resign themselves to their helplessness. The facilities to immunize children will be of little avail unless people are moved– by communication– to make eager use of them.

The possibility for the power of communication to liberate the minds and potential of people through critical awareness is present in every field linked to human development, be it women's emancipation, family planning, environmental sanity, or functional literacy. As communicators, we have to bring them to bear fruit.

New social possibilities are opened up by strengthening the link between communication and education. Communication generates an educational environment, far beyond the education system. This becomes particularly hopeful in a situation where female literacy is around 62%. At the same time expansion of education provides a basis for deeper and wider communication. And the familiar imbalances in communication are remediable through universal education.
Many developing countries have attempted to use mass media to educate and to inform, and thereby to promote economic and social development. Most of them have access to the tools of mass communication. The reach of different media varies with the level of development and size of the populations. The use to which different media are put also varies, according to priorities and policies. In India, the communication network is evidently one of the largest functioning in the world today. To realize its full potential for people's development is an exciting challenge before us. Experience shows that different media have different effects and often they have to be used jointly for optimum effect. For example, broadcasts for carefully identified audiences are an effective and economical means of influencing actions of large numbers of persons at great distances—provided these become the basis for later discussions among local groups; these are supplemented by printed reading or graphic materials and personal contacts by extension workers. The one-way flow and short-lived nature of the message broadcast by radio or television have thus to be consciously overcome by planned use of complementary methods, media and messages.

This principle of a harmonious blend of communication channels towards a common purpose is related to the limitations as well as the potential of different media, and is relevant to enhancing the capability of women in child-rearing or income generation, family planning or participation in community life.

It is good to remember the inference of experience, that mass media programmes have been successful in reaching large numbers of people and introducing them to the possibility of change, more than in effecting change. For instance, a successful mass communication campaign can increase the knowledge of the audience about nutrition, without achieving any discernible change in their health status. We have to use, on the one hand, the media conjointly with one another and, on the other; advocacy must be co-ordinated with action. Just as progress in one of the sectors of development without concurrent action in the others often leaves the human condition substantially unchanged, pre-occupation with radio or television to the
neglect of more traditional and more pervasive forms of communication, with peers and parents, school teachers, and community leaders, is unlikely to yield intended results.

Hence we can restate some of the fundamentals which we can ill-afford to ignore in promoting the developmental use of television:

- Television is not an autonomous or separate medium. There must therefore be a continuous and creative interaction between content specialists and communicators.
- Television must become participatory. Ways must be found to enable audiences of children as well as women to respond to the communication they receive.
- Television communication must outgrow uni-sectoral channels in and outside government. Mechanisms of effective co-ordination need to be developed to link sectors as well as link media.
- An independent, professional and multi-disciplinary evaluative system is necessary to test the relevance of programmes against the touchstone of life of the majority.
- And, the traditional and modern media must be made to be mutually supportive, to become a common resource of people's development.

5.1 Various Health Programmes Telecasted on Television

Despite the dominating and expansive role of the Internet, global reports on mass media still find television as the most popular source of information on health. Television news programmes are the most common source of health information. We can make an attempt to systematize the knowledge concerning television broadcast dedicated to the subject of health and illness, and aim to identify the benefits and limitations resulting from the use of the audiovisual means to convey information on health; diagnosing potential threats and explaining trends and possibilities of making use of the television to educate and improve health awareness of the viewers. In the light of the conducted review, the television presents itself as a promising source of
information on the topic of health and illness which, provided one maintains a cautious attitude as well as moderation, influences the level of knowledge of the viewers, identification of simple symptoms and constitutes an important source of education in terms of prevention and avoiding risk behaviours.

5.2 Health Show – Kalyani (Doordarshan)

*Kalyani* is a pioneering initiative in health communication in India with several innovations in project design, content creation and community engagement through television.

Launched in 2002, in 8 most backward states of India as a weekly programme in an entertaining & innovative format, Kalyani is India's longest running public health campaign on television demand, telecast on *Doordarshan*, India's public service broadcaster on popular the programme series was expanded to 21 states of India.

Kalyani's model of communication is need-based, participatory and interactive. It integrates inter-personal communication with mass-media. The programme combines education with entertainment. It delivers key messages on major communicable and non-communicable diseases such as malaria, TB, HIV/AIDS, Tobacco & Water-borne diseases, maternal and child health. It does so through song and dance, quiz and talk shows in 13 languages and 17 dialects.

The show has been produced at Doordarshan's stations in the state capitals. Over 9,009 episodes have been broadcast since May 2002. These episodes have touched millions of people and it is evident in the growing number of viewers participating in the programme's highly popular interactive medium– the *Kalyani clubs*. The success of the health campaign is partially due to its innovative strategy of involving viewers in spreading the programme's messages by encouraging them to form clubs or groups of support and deliver the messages. These clubs have empowered people to help themselves and others in their villages and communities.
Over 3,258 Kalyani clubs have been created where ordinary citizens mobilize support for community health care.

Kalyani has been produced in-house in Doordarshan, India's Public Service Broadcaster for Union Minister for Health and Family Welfare. Kalyani presents a model of collaboration between policy-makers, media, service providers, and Non-Governmental Organizations (NGOs).

Kalyani has established an army of Kalyani clubs that are like the foot soldiers of the effort. The Kalyani clubs mobilize the communities and make a difference on the ground. The combined efforts of the television show and the Kalyani Health clubs has resulted not only in awareness, but in behaviour and attitudinal change, to achieve the ultimate objective of empowering people.

5.3 Total Health Shows: DD NEWS

It is a Live Phone-in Show. A health based program where viewers can talk about their health related issues with a panel of doctors over the phone.

Air’s: Every Sunday, 8:30 a.m. – 9:30 a.m. on DD News.

Stay Fit in Two Minutes: ABP NEWS – Presented by Dr. Shikha Sharma, Daily (6:30 am, 7:30 am, 8:30 am, 9:30 am and 1:30 pm)

Jeena Shikho: ABP NEWS – Presented by Dr. Mukesh Jain, Daily (11:00 pm)

Health Wealth: ZEE NEWS – Every Sunday, 12:30 pm (Weekly Programme)

Topic Discussed in this show –

Fluid Intake, Vitiligo, Safe Holi, Safe Drugs, Cancer Prevention, Potbelly Obesity, Cancer Prevention, Vitamin D Health Wealth, Pneumonia, Sudden Cardiac Death, Depression, Can Alcohol be Prescribed as Medicine, Health Wealth: All about Paralysis.

Doctor NDTV: NDTV

Doctor on Call
Every Saturday, 9:00 am – 9:30 am

**Men’s Health and Women Health: HEADLINES TODAY**

Every Saturday, 9:30 am (Weekly Programme)

**Health Aaj Tak: AAJ TAK**

**Health Mantra: ETV BIHAR**

**Health TV Shows: JIVA TELEVISION**

Jiva's television shows on Ayurveda have been reaching out to over 50 million viewers across India through popular channels such as Care World, News 24, and India News.

Ayurveda, offer viewers the opportunity to call in and ask about their health related problems and find natural Ayurvedic solutions for them on a call-in shows featuring Dr. Partap Chauhan, Director of Jiva. Dr. Chauhan draws of 20+ years of Ayurvedic practice as the most widely travelled Ayurvedic doctor in the world to provide advice that can quickly guide to peak health.

Jiva's TV Shows are presently broadcast on:

- **Sanskar(Arogya Mantra) :** 9:05 am to 9:30 am
- **Care World (Eternal Health) :** 12:10 pm to 12:45 pm
- **News 24 (Sanjeevni) :** 2:30pm to 3:00 pm
- **India News National (Arogya Mantra) :** 3:30 pm to 4:00 pm
- **India News up (Arogya Mantra) :** 3:30 pm to 4:00 pm
- **IBN 7 (Arogya Mantra) :** 4:30 pm to 5:00 pm
- **Mahuua :** 5:00 pm to 5:30 pm
- **Mahuua Plus :** 5:30 pm to 6:00 pm
- **Sahara Samay :** 6:30 pm to 7:00 pm (Monday to Friday)
- **Care World (Eternal Health) :** 7:20 pm to 8:05 pm
Table: 5.1 Some Details of Programme telecasted on Care World with day and time can be studied as follows:

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Source: http://www.careworldtv.com/care_program/weekly_schedule
Swastha Bharat: DD LUCKNOW

Every Monday and Thursday, 6:00 pm to 6:30 pm

Programmes on TB (DOTS), AIDS, Malaria, Mother and Child Health, Hygiene Related, Leprosy Eradication, Diabetes, Eye Donation, and Seasonal Diseases such as Malaria, Diarrhoea etc.

Participatory Programme through Telephonic Conversation:

DD-VARANASI

Every Tuesday, 4:30 pm to 5:00 pm

- Special Show on Special Disease Related Day
  Eg. World Health Day, 07 April;
  World Leprosy Day, Last Sunday of January;
  Diabetic Day, 14 November
- Some details of programme (Sehat Live Expert) telecasted through DD – Varanasi

TABLE: 5.2 Details of Programme Telecasted on Doordarshan

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*Yoga for You: ZEE VARIASI*

Daily, 4:30 am – 5:00 am

*Swasthya Sanjivani: ISHWAR*

Daily, 9:30 am – 10:00 am

11:00 am – 11:30 am

*Health Mantra: A2Z NEWS*

Every Sunday, 3:30 pm – 4:00 pm

*Sanyansi Ayurveda: DIVYA*

Daily, 10:10 am – 10:40 am

4:10 pm – 4:40 pm

*Swasthya Sanjeevni: DIVYA*

Daily (Except Sunday), 10:10 am – 10:40 am

3:00 pm – 3:30 pm

*Yoga Yatra: SONY*

Every Sunday, 9:00 am – 10:30 am
Chapter - VI

DATA ANALYSIS

The functionalist perspective of mass media plays an efficient role in society. The eradication of social evils like gender disparity, declining sex-ratio, female foeticide may be directly correlated to the positive impact of social media mainly television which is easily accessible among all age groups and communities. Both mass media and gender health may be attributed as umbilical cord relationship (Odesanya, Hassan and Olauewoye, 2015). The roots of social media have strengthened from the central level to the district level up till the grass root level where it has shown its positive impact in the threshold of every household. Lasswell (1960) has mainly focused on three functions of mass media viz. surveillance, correlation and transmission of cultural heritage from one generation to the next. In addition to Lasswell’s three functions, Wright (1960) cited in Hanson (2005) and added the fourth function of the mass media viz. entertainment.

6.1 Objectives of the Study

1- To find out the health related Problems in Varanasi district.
2- To study television’s accessibility and acceptability on the health care of women and children.
3- To analyze the effectiveness of television programmes on healthcare of women & children.
4- To observe how the health care programme presented on television motivate viewers (women & children) regarding their health care.
5- To calculate the Impact of Television on health care on different classes in the study area.

6.2 Hypotheses of the Study

H$_1$– Impact of Television on healthcare of women and children is not effective.

H$_2$– The accessibility& acceptability of television on Health care is not uniform for study area.
The motivational behaviour of the television viewers through health care programme is negligible.

6.3 Methodology

In context to the above stated global issues, study was conducted on 401 women (reproductive and adolescent girls) to assess the impact of mass media especially television on the gender health by using *Multiple Regression Model*. (Reproductive was below 45 years of age and adolescent girls were above 18 years).

6.4 Research Design

**Data Collection:** In this research, data collection is basically based on primary data which is collected through structured schedule method. However secondary data has been taken in account through various resources (book, internet and govt. schedules) such as Indian Journal of Public health, Publmed.gov, Annual Health Serve Bulletin 2015-16, Uttar Pradesh stat, Annual Report to the people Health (Government of India 2014-15).

**Sampling:** Random Sampling has been used for collecting sample from four Blocks in Varanasi District consisting of total of eight blocks (Arajiline, Baragaon, Chiraigaon, Cholapur, Harhua, Kashi Vidyapeeth, Pindara, and Sewapuri). Among these blocks, four randomly selected blocks for study are Baragaon, Chiraigaon, Kashi Vidyapeeth and Sewapuri.

6.4.1 Survey Method

Seeing the astonishing popularity of Television for Health care among Rural/Urban women a questionnaire based survey were done in two blocks from Rural and two wards from Urban of Varanasi district to study the role of Television in spreading awareness regarding the Health care of Women and Children. Random sampling was done for selection of blocks in Varanasi district in which two stage cluster sampling was done in two blocks whereas one stage clustering was done in two wards for analysis of health related topics through television.
Descriptive survey was done for the study. A sample of four hundred and one (401) was taken from the whole women population taken as Universe from the two blocks and two wards in Varanasi district. The data has been analysed by using descriptive statistics to know the facts related to above Healthcares.

6.4.2 Analyzing Tools

A multivariate logistic regression analysis was done to examine the relationship between each of the predictor variables and the response variables because the response variables are categorical variables and not normally distributed.

In a logistic regression analysis, the relationship between the predictor variables and the response variables was better understood as the influence of other variables is controlled.

The main purpose of the content analysis was to understand systematically health related messages by the Television.

6.5 Reliability Analyses

We are using the Cronbach’s alpha reliability coefficient which has the ranges between 0 and 1. But however, this do have lower limit to the coefficient. The closer value of Cronbach’s alpha coefficient is 1.0, the greater the internal consistency of the items in the scale for all variables. On using the formula \( \alpha = \frac{rk}{1+(k-1)r} \), where k is the number of items we are using in the model considered and r is the mean of the inter-item correlations and the size of alpha is determined by both the number and the mean inter-item correlations. The total number of the respondents is 401 and there is none any excluded variables.

6.6 Analysis of the First Objective

The first objective of my study is to find out the health related problems in Varanasi District.
Table 6.1: The Disease most common\(^a\) in women at Varanasi District

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>36</td>
<td>09.01%</td>
</tr>
<tr>
<td>Asthma</td>
<td>13</td>
<td>03.25%</td>
</tr>
<tr>
<td>Depression</td>
<td>28</td>
<td>07.02%</td>
</tr>
<tr>
<td>Viral Hepatitis A</td>
<td>07</td>
<td>01.75 %</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45</td>
<td>11.12 %</td>
</tr>
<tr>
<td>Cancer</td>
<td>13</td>
<td>03.21%</td>
</tr>
<tr>
<td>Malaria</td>
<td>84</td>
<td>20.87 %</td>
</tr>
<tr>
<td>Typhoid</td>
<td>58</td>
<td>14.50%</td>
</tr>
<tr>
<td>Tumor</td>
<td>25</td>
<td>06.15 %</td>
</tr>
<tr>
<td>Fever of Unknown Origin (FUO)</td>
<td>120</td>
<td>30.00 %</td>
</tr>
<tr>
<td>Tuberculosis (T.B.)</td>
<td>26</td>
<td>06.50 %</td>
</tr>
</tbody>
</table>

*the diseases which is less than 1 % not including in the table*

Among the eight blocks of rural region of Varanasi district, most of the populations are suffering from the problem of Malaria, FUO, Typhoid etc. From the table 6.1, we can observe that 30.00 % of the women are suffering from Fever of Unknown Origin, and 20.87 % have Malaria. There can be a number of reasons responsible for the existing conditions such as illiteracy, having less or no awareness about the diseases, and weak social responsibility.

Table 6.2: The Disease most common\(^b\) in Children at Varanasi District

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea</td>
<td>123</td>
<td>30.75 %</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>18</td>
<td>04.50 %</td>
</tr>
<tr>
<td>Acute Respiratory Infection</td>
<td>129</td>
<td>32.25 %</td>
</tr>
<tr>
<td>Dengue</td>
<td>11</td>
<td>02.75 %</td>
</tr>
<tr>
<td>Influenza</td>
<td>20</td>
<td>05.00 %</td>
</tr>
<tr>
<td>Typhoid</td>
<td>72</td>
<td>18.00%</td>
</tr>
<tr>
<td>Fever of Unknown Origin</td>
<td>7</td>
<td>01.75 %</td>
</tr>
</tbody>
</table>

*the diseases which is less than 1 % not including in the table*
Most common diseases suffered by the children in the study areas are diarrhea and Upper Respiratory Tract with 30.75% and 32.25% respectively. Along with these, malnutrition is the major cause of many problems leading to diseases.

6.7 Analysis of the Second Objective

The second objective relates to study television’s accessibility and acceptability on the health care of women and children.

Chi-Square Test

Chi-square is a statistical test commonly used to compare observed data with data we would expect to obtain according to a specific hypothesis. For example, if, according to Mendel's laws, you expected 10 of 20 offspring from a cross to be male and the actual observed number was 8 males, then you might want to know about the "goodness to fit" between the observed and expected. Were the deviations (differences between observed and expected) the result of chance, or were they due to other factors. How much deviation can occur before you, the investigator, must conclude that something other than chance is at work, causing the observed to differ from the expected. The chi-square test is always testing what scientists call the null hypothesis, which states that there is no significant difference between the expected and observed result.

Table 6.3: (Accessibility) Health Care Programme on Television watching regularly * (Acceptability) Health Care Advise Provided by Television is Trustable and Adoptable Cross tabulation

<table>
<thead>
<tr>
<th>Health Care Programme on Television watching regularly</th>
<th>Heath Care Advise Provided by Television is Trustable and Adoptable</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>92</td>
<td>5</td>
<td>97</td>
</tr>
<tr>
<td>% within Health Care Programme on Television watching regularly</td>
<td>94.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Count</td>
<td>41</td>
<td>263</td>
</tr>
<tr>
<td>% within Health Care Programme on Television watching regularly</td>
<td>13.5%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Count</td>
<td>133</td>
<td>268</td>
</tr>
<tr>
<td>% within Health Care Programme on Television watching regularly</td>
<td>33.2%</td>
<td>66.8%</td>
</tr>
</tbody>
</table>
The above Table 6.3 shows the results obtained from 400 television female viewers in the serve with respect to the accessibility and acceptability of television programmes on health care about women and children in Varanasi district. 92 (94.8 \%) women do not watch T.V. regularly, but 5 (5.2 \%) of them accepted that television programmes on health care is acceptable and trustable. 41 (13.5 \%) female viewers watch health programmes regularly but have no trust about it. 268 (66.8\%) female viewers watch television regularly and have trust about it.

The result suggests that most of the female T.V. viewers tend to response positively about accessibility and acceptability role of T.V. on health care programmes. From the above result it can be inferred that female viewers have positive attitude towards role of TV on health care programmes.

**Table 6.4: Chi-Square Tests**

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>2.1962(^a)</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction(^b)</td>
<td>215.933</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>229.678</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td>.000</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear</td>
<td>219.041</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases(^b)</td>
<td>401</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) 0 cells (.0\%) have expected count less than 5. The minimum expected count is 32.17.
\(^b\) Computed only for a 2\times2 table

Finally, the above table 6.4 provides the Summary static info. The observed chi-square statistic is 2.196, which is associated with a 05 % risk of being wrong in rejecting the null hypothesis. This is too small risk for acceptance of acceptability and accessibility of health care programmes on TV. So we are able to accept the null. We therefore find support for the research hypothesis, and can conclude the TV playing better role for accessibility and acceptability of Health care programmes on TV.
6.8 Analysis of the Third Objective

The third objective is to analyse the effectiveness of television programmes on healthcare of women and children.

Effectiveness of Television in Mass Media Tools for Providing the Health care Awareness for Women and Children.

For estimating the Effectiveness of Television on Health care of Women and Children we generate a multiple regression model.

Multiple Regression Model

Table 6.5 Case Processing Summary

<table>
<thead>
<tr>
<th>Cases</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>401</td>
<td>100.0</td>
</tr>
<tr>
<td>Excluded(^a)</td>
<td>0</td>
<td>.0</td>
</tr>
<tr>
<td>Total</td>
<td>401</td>
<td>100.0</td>
</tr>
</tbody>
</table>

\(^a\) Listwise deletion based on all variables in the procedure.

For the case processing summary we have utilized 401 samples taken for the study which shows that it is valid having 100 percent response.

Table 6.6 Reliability Statistics

<table>
<thead>
<tr>
<th>Cronbach’s Alpha</th>
<th>N of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>.837</td>
<td>16</td>
</tr>
</tbody>
</table>

The above table 6.6 represents the reliability of all the variables which is 0.837; in which total numbers of items are sixteen. This value comes under the Excellence range i.e. greater than 0.8.
<table>
<thead>
<tr>
<th>Description</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of the Respondent</td>
<td>2.8055</td>
<td>1.13229</td>
<td>401</td>
</tr>
<tr>
<td>Sex</td>
<td>2.0000</td>
<td>.00000</td>
<td>401</td>
</tr>
<tr>
<td>Educational Qualification of the Respondent</td>
<td>2.0748</td>
<td>1.22450</td>
<td>401</td>
</tr>
<tr>
<td>Occupation</td>
<td>.8878</td>
<td>.74490</td>
<td>401</td>
</tr>
<tr>
<td>Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children.</td>
<td>3.5636</td>
<td>1.23554</td>
<td>401</td>
</tr>
<tr>
<td>Health care advise provided through Television is Trustable</td>
<td>3.2918</td>
<td>1.58340</td>
<td>401</td>
</tr>
<tr>
<td>Health care advise provided through Television should be Local Health Problem-Oriented</td>
<td>3.3840</td>
<td>1.33684</td>
<td>401</td>
</tr>
<tr>
<td>Health care advice reports too fast in comparison to another medium of reporting</td>
<td>3.4938</td>
<td>1.36952</td>
<td>401</td>
</tr>
<tr>
<td>Mostly Television channels broadcasting health care advises only general problems</td>
<td>3.2519</td>
<td>1.43663</td>
<td>401</td>
</tr>
<tr>
<td>T.V. Health care awareness programme is more effective in urban area in comparison to rural area</td>
<td>4.1771</td>
<td>6.20049</td>
<td>401</td>
</tr>
<tr>
<td>Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness</td>
<td>3.4663</td>
<td>1.38365</td>
<td>401</td>
</tr>
<tr>
<td>Acceptability of Health care advises of T.V.is more in Women in comparison to men</td>
<td>3.4663</td>
<td>1.23874</td>
<td>401</td>
</tr>
<tr>
<td>T.V. is playing a significant role in providing more awareness of vaccinisation in comparison to other mass media tools.</td>
<td>3.6808</td>
<td>1.29339</td>
<td>401</td>
</tr>
<tr>
<td>Awareness programme related to children and women is in T.V. more effective in compare to other age group</td>
<td>3.5461</td>
<td>1.24237</td>
<td>401</td>
</tr>
<tr>
<td>T.V. channels should include some serials and tele-films related to health care awareness</td>
<td>3.4389</td>
<td>1.21115</td>
<td>401</td>
</tr>
<tr>
<td>Health care awareness programme should be telecasted in peak hours and peak days</td>
<td>3.2195</td>
<td>1.38806</td>
<td>401</td>
</tr>
</tbody>
</table>
The values in the column labelled *Alpha if Item is Deleted* are the values of the overall alpha if that item isn’t included in the calculation. As such, they reflect the change in Cronbach’s alpha that would be seen if a particular item were deleted. The overall alpha is 0.837, and so all values in this column should be around that same value. We’re looking for values of alpha greater than the overall alpha because if the deletion of an item increases Cronbach’s alpha then this means that the deletion of that item improves reliability. None of the items here would substantially affect reliability if they were deleted.

**Table 6.8 Item-Total Statistics**

<table>
<thead>
<tr>
<th></th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach’s Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of the Respondent</td>
<td>46.9426</td>
<td>295.694</td>
<td>.288</td>
<td>.853</td>
</tr>
<tr>
<td>Sex</td>
<td>47.7481</td>
<td>285.744</td>
<td>.000</td>
<td>.840</td>
</tr>
<tr>
<td>Educational Qualification of the Respondent</td>
<td>47.6733</td>
<td>259.836</td>
<td>.618</td>
<td>.824</td>
</tr>
<tr>
<td>Occupation</td>
<td>48.8603</td>
<td>271.010</td>
<td>.578</td>
<td>.830</td>
</tr>
<tr>
<td>Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children.</td>
<td>46.1845</td>
<td>252.926</td>
<td>.796</td>
<td>.817</td>
</tr>
<tr>
<td>Health care Advise Provided through Television is Trustable</td>
<td>46.4564</td>
<td>247.359</td>
<td>.720</td>
<td>.815</td>
</tr>
<tr>
<td>Health care Advise Provided through Television should be Local Health Problem-Oriented</td>
<td>46.3641</td>
<td>248.177</td>
<td>.849</td>
<td>.813</td>
</tr>
<tr>
<td>Health care advice reports too fast within some time in comparison to another medium of reporting</td>
<td>46.2544</td>
<td>249.440</td>
<td>.796</td>
<td>.815</td>
</tr>
<tr>
<td>Mostlly Television channels broadcasting health care advises only general problems</td>
<td>46.4963</td>
<td>248.951</td>
<td>.766</td>
<td>.815</td>
</tr>
<tr>
<td>T.V. Health care awareness programme is more effective in urban area in comparison to rural area</td>
<td>45.5711</td>
<td>188.701</td>
<td>.344</td>
<td>.940</td>
</tr>
<tr>
<td>Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness</td>
<td>46.2818</td>
<td>249.978</td>
<td>.774</td>
<td>.816</td>
</tr>
<tr>
<td>Acceptability of Health care advises of T.V. is more in women in the comparison to men</td>
<td>46.2818</td>
<td>257.063</td>
<td>.683</td>
<td>.821</td>
</tr>
<tr>
<td>T.V. is playing a significant role in providing more awareness of vaccinisation in comparison to other mass media tools</td>
<td>46.0673</td>
<td>254.693</td>
<td>.712</td>
<td>.819</td>
</tr>
<tr>
<td>Awareness programme related to children and women is in T.V. more effective in compare to other age group</td>
<td>46.2020</td>
<td>251.937</td>
<td>.818</td>
<td>.816</td>
</tr>
<tr>
<td>T.V. channels should include some serials and tele-films related to health care awareness</td>
<td>46.3092</td>
<td>253.769</td>
<td>.791</td>
<td>.818</td>
</tr>
<tr>
<td>Health care awareness programme should be telecasted in peak hours and peak days</td>
<td>46.5287</td>
<td>246.740</td>
<td>.850</td>
<td>.812</td>
</tr>
</tbody>
</table>
Table 6.9 Descriptive Statistics

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television is the most effective Mass Media Tools in Providing the Health care Awareness for Women and Children</td>
<td>3.5636</td>
<td>1.23554</td>
<td>401</td>
</tr>
<tr>
<td>Age of the Respondent</td>
<td>2.8055</td>
<td>1.13229</td>
<td>401</td>
</tr>
<tr>
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<td>2.0748</td>
<td>1.22450</td>
<td>401</td>
</tr>
<tr>
<td>Occupation</td>
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<td>.74490</td>
<td>401</td>
</tr>
<tr>
<td>Health care Advise Provided through Television is Trustable</td>
<td>3.2918</td>
<td>1.58340</td>
<td>401</td>
</tr>
<tr>
<td>Health care Advise Provided through Television should be Local Health Problem-Oriented</td>
<td>3.3840</td>
<td>1.33684</td>
<td>401</td>
</tr>
<tr>
<td>Health care advice reports too fast in comparison to another medium of reporting</td>
<td>3.4938</td>
<td>1.36952</td>
<td>401</td>
</tr>
<tr>
<td>Mostly Television channels broadcasting health care advises only general problems</td>
<td>3.2519</td>
<td>1.43663</td>
<td>401</td>
</tr>
<tr>
<td>T.V. Health care awareness programme is more effective in urban area in comparison to rural area</td>
<td>4.1771</td>
<td>6.20049</td>
<td>401</td>
</tr>
<tr>
<td>Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness</td>
<td>3.4663</td>
<td>1.38365</td>
<td>401</td>
</tr>
<tr>
<td>Acceptability of Health care advises of T.V. is more in women in the comparison to men</td>
<td>3.4663</td>
<td>1.23874</td>
<td>401</td>
</tr>
<tr>
<td>T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools</td>
<td>3.6808</td>
<td>1.29339</td>
<td>401</td>
</tr>
<tr>
<td>Awareness programme related to children and women is in T.V. more effective in compare to other age group</td>
<td>3.5461</td>
<td>1.24237</td>
<td>401</td>
</tr>
<tr>
<td>T.V. channels should include some serials and tele-films related to health care awareness</td>
<td>3.4389</td>
<td>1.21115</td>
<td>401</td>
</tr>
<tr>
<td>Health care awareness programme should be telecasted in peak hours and peak days</td>
<td>3.2195</td>
<td>1.38806</td>
<td>401</td>
</tr>
</tbody>
</table>
Effectiveness of Television in Mass Media Tools for Providing the Health care Awareness for Women and Children

For estimating the Effectiveness of Television on Health care of Women and Children we generate a multiple regression model:

\[ Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \beta_6 X_6 + \beta_7 X_7 + \beta_8 X_8 + \beta_9 X_9 + \beta_{10} X_{10} + \beta_{11} X_{11} + \beta_{12} X_{12} + \beta_{13} X_{13} + \epsilon \]

\( Y \) = Television is effective Mass Media Tools in Providing the Health care Awareness for Women and Children (Dependent Variable)
\( X_1 \) = Age of the Respondent (Independent variable)
\( \beta_1 \) = Parameters attached to the variable \( X_1 \)
\( X_2 \) = Educational Qualification of the Respondent
\( \beta_2 \) = Parameters attached to the variable \( X_2 \)
\( X_3 \) = Occupation
\( \beta_3 \) = Parameters attached to the variable \( X_3 \)
\( X_4 \) = Health care Advise Provided through Television is Trustable
\( \beta_4 \) = Parameters attached to the variable \( X_4 \)
\( X_5 \) = Health care Advise Provided through Television should be Local Health Problem-Oriented
\( \beta_5 \) = Parameters attached to the variable \( X_5 \)
\( X_6 \) = Health care advice reports too fast in comparison to another medium of reporting
\( \beta_6 \) = Parameters attached to the variable \( X_6 \)
\( X_7 \) = Mostly Television channels broadcasting health care advises only general problems
\( \beta_7 \) = Parameters attached to the variable \( X_7 \)
\( X_8 \) = Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness
\( \beta_8 \) = Parameters attached to the variable \( X_8 \)
\( X_9 \) = Acceptability of Health care advises of T.V.is more in women in comparison to men
\( \beta_9 \) = Parameters attached to the variable \( X_9 \)
\( X_{10} \) = T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools
\( \beta_{10} \) = Parameters attached to the variable \( X_{10} \)
$X_{11} = \text{Awareness programme related to children and women is in T.V. more effective in compare to other age group}$

$\beta_{11} = \text{Parameters attached to the variable } X_{11}$

$X_{12} = \text{T.V. channels should include some serials and tele-films related to health care awareness}$

$\beta_{12} = \text{Parameters attached to the variable } X_{12}$

$X_{13} = \text{Health care awareness programme should be telecasted in peak hours and peak days}$

$\beta_{13} = \text{Parameters attached to the variable } X_{13}$

**Table 6.10 Variables Entered/Removed}$^b$

<table>
<thead>
<tr>
<th>Model</th>
<th>Variables Entered</th>
<th>Variables Removed</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Occupation, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V. playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V. is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness$^a$</td>
<td></td>
<td>Enter</td>
</tr>
</tbody>
</table>

$^a$ All requested variables entered

$^b$ Dependent Variable: Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children
Table 6.11 Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of the Estimate</th>
<th>Change Statistics</th>
<th>R Square Change</th>
<th>F Change</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.958^a</td>
<td>.918</td>
<td>.915</td>
<td>.36093</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Occupation, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V. is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.

b. Dependent Variable: Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children.

The coefficient of multiple determinations is 0.958; therefore, about 95.80% of the variation in the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children is explained through Health care awareness programme that should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Occupation, Literacy is plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V. is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.
awareness. The regression equation appears to be very useful for making predictions since the value of $R^2$ is close to 1.

Table 6.12: ANOVA

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>560.343</td>
<td>14</td>
<td>40.025</td>
<td>307.237</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>50.285</td>
<td>386</td>
<td>.130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>610.628</td>
<td>400</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a. Predictors:* (Constant), Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Occupation, Literacy plays a significant role for increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tool., Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V.is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V. more effective in comparison to other age group, T.V.channels should include some serials and tele-films related to health care awareness.

*b. Dependent Variable:* Television is effective Mass Media Tools for Providing the better Health care Awareness for Women and Children.

**Hypotheses**

$H_0$: $\beta_1 = \beta_2 = 0$

$H_a$: at least one $\beta_i \neq 0$

- **Significance Level**
  $\alpha = 0.05$

- **Rejection Region**
  Reject the null hypothesis if $p$-value $\leq 0.05$

- **ANOVA Table (Test Statistic and $p$-value)**
  *(See above)* $F = 307.237$, $p$-value $< 0.000$

- **Conclusion**
  Since $p$-value $< 0.000 \leq 0.05$, we shall reject the null hypothesis.

- **State conclusion in words**
  At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that at least one of the predictors is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District; therefore the model is useful.
Table 6.13: Coefficients

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>95% Confidence Interval for B</th>
<th>Collinearity Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td>T</td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>1.407</td>
<td>.103</td>
<td>.13641</td>
</tr>
<tr>
<td></td>
<td>Age of the Respondent</td>
<td>-.232</td>
<td>.023</td>
<td>-.213</td>
</tr>
<tr>
<td></td>
<td>Educational Qualification of the Respondent</td>
<td>.044</td>
<td>.032</td>
<td>.044</td>
</tr>
<tr>
<td></td>
<td>Occupation</td>
<td>.427</td>
<td>.046</td>
<td>.258</td>
</tr>
<tr>
<td></td>
<td>Health care Advise Provided through Television is Trustable</td>
<td>.072</td>
<td>.025</td>
<td>.092</td>
</tr>
<tr>
<td></td>
<td>Health care Advise Provided through Television should be Local Health Problem Oriented</td>
<td>.150</td>
<td>.035</td>
<td>.162</td>
</tr>
<tr>
<td></td>
<td>Health care advice reports too fast in comparison to another medium of reporting</td>
<td>.146</td>
<td>.030</td>
<td>.162</td>
</tr>
<tr>
<td></td>
<td>Mostly Television channels broadcasting health care advises only general problems</td>
<td>-.009</td>
<td>.027</td>
<td>-.011</td>
</tr>
<tr>
<td>T.V. Health care awareness programme is more effective in urban area in comparison to rural area</td>
<td>-0.022</td>
<td>0.005</td>
<td>-0.109</td>
<td>4.806</td>
</tr>
<tr>
<td>Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness</td>
<td>0.113</td>
<td>0.034</td>
<td>0.127</td>
<td>3.350</td>
</tr>
<tr>
<td>Acceptability of Health care advises of T.V. is more in women in comparison to men</td>
<td>0.099</td>
<td>0.041</td>
<td>0.099</td>
<td>2.410</td>
</tr>
<tr>
<td>T.V. is playing a significant role for providing the awareness of vaccinisation in comparison to other mass media tools</td>
<td>-0.240</td>
<td>0.034</td>
<td>-0.251</td>
<td>-7.038</td>
</tr>
<tr>
<td>Awareness programme related to children and women is in T.V. more effective in compare to other age group</td>
<td>0.114</td>
<td>0.042</td>
<td>0.114</td>
<td>2.731</td>
</tr>
<tr>
<td>T.V. channels should include some serials and tele-films related to health care awareness</td>
<td>0.219</td>
<td>0.067</td>
<td>0.214</td>
<td>3.269</td>
</tr>
<tr>
<td>Health care awareness programme should be telecasted in peak hours and peak days</td>
<td>0.061</td>
<td>0.040</td>
<td>0.069</td>
<td>1.526</td>
</tr>
</tbody>
</table>

**a. Dependent Variable:** Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children.
Hypotheses

\( H_0: \beta_1 = 0 \) (Age of the Respondent is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

\( H_a: \beta_1 \neq 0 \) (Age of the Respondent is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  \( \alpha = 0.05 \)

- **Rejection Region**
  Reject the null hypothesis if \( p \)-value \( \leq 0.05 \)

- **Test Statistic and \( p \)-value**
  \( (\text{see above}) \ T = 10.09, \ p \)-value = 0.000

- **Conclusion**
  Since \( p \)-value = 0.000 \( \leq 0.05 \), we shall reject the null hypothesis.

- **State conclusion in words**
  At the \( \alpha = 0.05 \) level of significance, there exists enough evidence to conclude that the slope of the Age of the respondent is not zero and, hence, that the Age of the respondent is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Occupation, Literacy plays a significant role for increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through by Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccination in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V. is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V.channels should include some serials and tele-films related to health care awareness.
Hypotheses

$H_0: \beta_2 = 0$ (Educational Qualification of the Respondent is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

$H_a: \beta_2 \neq 0$ (Educational Qualification of the Respondent is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  $\alpha = 0.05$

- **Rejection Region**
  Reject the null hypothesis if $p$-value $\leq 0.05$

- **Test Statistic and $p$-value**
  
  $(see\ above) \ T = 1.376, p$-value $= 0.001$

- **Conclusion**
  Since $p$-value $= 0.001 \leq 0.05$, we shall reject the null hypothesis.

- **State conclusion in words**
  At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that the slope of the Educational Qualification of the Respondent is not zero, and hence, that the Educational Qualification of the Respondent is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Occupation, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V.is playing a significant role for providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V.is more in women in comparison to men, Health care Advise Providing by Television should be Local Health Problem Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group,
T.V.channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

$H_0$: $\beta_3 = 0$ (Occupation of the Respondent is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

$H_a$: $\beta_3 \neq 0$ (Occupation of the Respondent is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  $\alpha = 0.05$

- **Rejection Region**
  Reject the null hypothesis if $p$-value $\leq 0.05$

- **Test Statistic and $p$-value**
  
  (see above) $T = 9.228$, $p$-value = 0.000

- **Conclusion**
  Since $p$-value = 0.000 $\leq 0.05$, we shall reject the null hypothesis.

- **State conclusion in words**
  At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that the slope of the Occupation of the Respondent is not zero and, hence, that the Occupation of the Respondent is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Literacy plays a significant role for increasing the effectiveness of T.V. for health care awareness, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V.is more in women in the comparison to men, Health care Advise Provided through by Television should be Local Health Problem-Oriented, Awareness programme related to children
and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

\( H_0: \beta_4 = 0 \) (Health care Advise Provided through Television is Trustable is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

\( H_a: \beta_4 \neq 0 \) (Health care Advise Provided through Television is Trustable is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  \( \alpha = 0.05 \)

- **Rejection Region**
  Reject the null hypothesis if \( p\)-value \( \leq 0.05 \)

- **Test Statistic and \( p\)-value**
  \( (\text{see above}) \ T = 2.839, \ p\)-value = 0.005

- **Conclusion**
  Since \( p\)-value = 0.005 \( \leq 0.05 \), we shall reject the null hypothesis.

- **State conclusion in words**
  At the \( \alpha = 0.05 \) level of significance, there exists enough evidence to conclude that the slope of the Health care Advise Provided through Television is Trustable is not zero and, hence, that the Health care Advise Provided through Television is Trustable is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, the Occupation of the Respondent, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care
advices of T.V.is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V.more effective in compare to other age group, T.V.channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

**H₀**: β₅= 0 (Health care Advise Provided through Television should be Local Health Problem-Oriented is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

**Hₐ**: β₅≠ 0 (Health care Advise Provided through Television should be Local Health Problem Oriented is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  \[ \alpha= 0.05 \]

- **Rejection Region**
  Reject the null hypothesis if \( p \)-value ≤ 0.00

- **Test Statistic and p-value**
  \( (see \ above) \ T = 4.325, p\)-value = 0.000

- **Conclusion**
  Since \( p \)-value = 0.005 ≤ 0.05, we shall reject the null hypothesis.

- **State conclusion in words**
  At the \( \alpha = 0.05 \) level of significance, there exists enough evidence to conclude that the slope of the Health care Advise Provided through Television should be Local Health Problem-Oriented is Trustable is not zero, and hence, that the Health care Advise Provided through Television should be Local Health Problem Oriented is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V.Health care awareness programme is more effective in
urban area in comparison to rural area. Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, the Occupation of the Respondent, Mostly Television channels broadcasting health care advises only general problems, T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V.is more in women in comparison to men, Health care Advise Provided through Television is Trustable, Awareness programme related to children and women is in T.V.more effective in compare to other age group, T.V.channels should include some serials and tele-films related to health care awareness.

Hypotheses

$H_0$: $\beta_6 = 0$ (Health care advice reports too fast in comparison to another medium of reporting is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

$H_a$: $\beta_6 \neq 0$ (Health care advice reports too fast in comparison to another medium of reporting is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  $\alpha = 0.05$

- **Rejection Region**
  Reject the null hypothesis if $p$-value $\leq 0.00$

- **Test Statistic and $p$-value**
  ($see\ above$) $T = 4.814$, $p$-value $= 0.000$

- **Conclusion**
  Since $p$-value $= 0.000 \leq 0.05$, we shall reject the null hypothesis.

- **State conclusion in words**
  At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that the slope of the Health care advice reports too fast in comparison to another medium of reporting is Trustable is not zero, and hence, that the Health care advice reports too fast in comparison to another medium of reporting is useful as a predictor
of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent , T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, the Occupation of the Respondent, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, the Health care Advise Provided through Television should be Local Health Problem-Oriented, Acceptability of Health care advises of T.V. is more in women in comparison to men, the Health care Advise Provided through Television is Trustable, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.

Hypotheses

\( H_0: \beta_7 = 0 \) (Mostly Television channels broadcasting health care advises only general problems is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

\( H_a: \beta_7 \neq 0 \) (Mostly Television channels broadcasting health care advises only general problems is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  \[ \alpha = 0.05 \]

- **Rejection Region**
  Reject the null hypothesis if \( p\)-value \( \leq 0.00 \)

- **Test Statistic and \( p\)-value**
  \( (see\ above) \ T = -0.333, \ p\)-value = 0.739

- **Conclusion**
  Since \( p\)-value = 0.739 \( \geq 0.05 \), we shall accepted the null hypothesis.

- **State conclusion in words**
At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that the slope of the Mostly Television channels broadcasting health care advises only general problems is zero, and hence, that Mostly Television channels broadcasting health care advises only general problems is not useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, T.V. Health care awareness programme is more effective in urban area in comparison to rural area, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, the Occupation of the Respondent, Health care advice reports too fast in comparison to another medium of reporting, T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care Advise Provided through Television should be Local Health Problem-Oriented, Acceptability of Health care advises of T.V.is more in women in comparison to men, the Health care Advise Provided through Television is Trustable, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V.channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

$H_0$: $\beta_8 = 0$ (Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness is not useful for predicting the effectiveness of television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

$H_a$: $\beta_8 \neq 0$ (Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  
  $\alpha = 0.05$

- **Rejection Region**
  
  Reject the null hypothesis if $p$-value $\leq 0.00$
- **Test Statistic and p-value**
  
  *(see above)* \( T = 4.806, p\text{-value} = 0.000 *

- **Conclusion**
  
  Since \( p\text{-value} = 0.000 \leq 0.05 \), we shall reject the null hypothesis.

- **State conclusion in words**
  
  At the \( \alpha = 0.05 \) level of significance, there exists enough evidence to conclude that the slope of the Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness is not zero, and hence, that Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days. Age of the Respondent, Occupation, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V. is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

\[ H_0: \beta_9=0 \] (T.V. Health care awareness programme is more effective in urban area in comparison to rural area is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

\[ H_a: \beta_9\neq0 \] (T.V. Health care awareness programme is more effective in urban area in comparison to rural area is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)
• **Significance Level**
  \[ \alpha = 0.05 \]

• **Rejection Region**
  Reject the null hypothesis if \( p \)-value \( \leq 0.00 \)

• **Test Statistic and \( p \)-value**
  \( (see \ above) \ T = 3.350, \ p \)-value = 0.001

• **Conclusion**
  Since \( p \)-value = 0.001 \( \leq 0.05 \), we shall reject the null hypothesis.

• **State conclusion in words**
  At the \( \alpha = 0.05 \) level of significance, there exists enough evidence to conclude that the slope of T.V. Health care awareness programme is more effective in urban area in comparison to rural area is not zero, and hence, that T.V. Health care awareness programme is more effective in urban area in comparison to rural area is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, Occupation of the respondents, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Acceptability of Health care advises of T.V. is more in women in comparison to men, Health care Advise Provided through Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

\( H_0: \beta_{10} = 0 \) (Acceptability of Health care advises of T.V. is more in women in comparison to men is not useful for predicting the effectiveness of Television in
Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District

$H_0$: $\beta_{10} \neq 0$ (Acceptability of Health care advises of T.V. is more in women in comparison to men is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  $\alpha = 0.05$

- **Rejection Region**
  Reject the null hypothesis if $p$-value $\leq 0.00$

- **Test Statistic and $p$-value**
  $T = 2.410$, $p$-value $= 0.016$

- **Conclusion**
  Since $p$-value $= 0.016 \leq 0.05$, we shall reject the null hypothesis.

- **State conclusion in words**
  At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that the slope of Acceptability of Health care advises of T.V. is more in women in comparison to men is not zero, and, hence that Acceptability of Health care advises of T.V. is more in women in comparison to men is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, Occupation of the respondents, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Health care advice reports too fast in comparison to another medium of reporting, Health care Advise Provided through Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.
Hypotheses

$H_0$: $\beta_{11} = 0$ (T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

$H_a$: $\beta_{11} \neq 0$ (T.V. is playing a significant role for providing the awareness of vaccinisation in comparison to other mass media tools is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  
  $\alpha = 0.05$

- **Rejection Region**
  
  Reject the null hypothesis if $p$-value $\leq 0.00$

- **Test Statistic and $p$-value**
  
  $(see \ above)$ $T = 2.410$, $p$-value $= 0.016$

- **Conclusion**
  
  Since $p$-value $= .016 \leq 0.05$, we shall reject the null hypothesis.

- **State conclusion in words**
  
  At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that the slope of T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools is not zero, and hence, that T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, Occupation of the respondents, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, Acceptability of Health care advises of T.V. is more in women in comparison to men, Health care advice reports too fast in comparison to another medium of reporting, Health care Advise through
Television should be Local Health Problem-Oriented, Awareness programme related to children and women is in T.V. more effective in compare to other age group, T.V. channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

\[ H_0: \beta_{12} = 0 \] (Awareness programme related to children and women is in T.V. more effective in compare to other age group is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

\[ H_a: \beta_{12} \neq 0 \] (Awareness programme related to children and women is in T.V. more effective in compare to other age group is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  \[ \alpha = 0.05 \]

- **Rejection Region**
  Reject the null hypothesis if \( p \)-value \( \leq 0.00 \)

- **Test Statistic and \( p \)-value**
  \( (see \ above) \ T = 2.410, \ p \)-value \( = 0.016 \)

- **Conclusion**
  Since \( p \)-value \( = 0.016 \leq 0.05 \), we shall reject the null hypothesis.

- **State conclusion in words**
  At the \( \alpha = 0.05 \) level of significance, there exists enough evidence to conclude that the slope of Awareness programme related to children and women is in T.V. more effective in compare to other age group is Trustable is not zero and, hence, that Awareness programme related to children and women is in T.V. more effective in compare to other age group is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, Occupation of the respondents, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care
Advise Provided through Television is Trustable. Mostly Television channels broadcasting health care advises only general problems, Acceptability of Health care advises of T.V.is more in women in comparison to men, Health care advice reports too fast in comparison to another medium of reporting, Health care Advise Provided through Television should be Local Health Problem-Oriented, T.V. is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, T.V.channels should include some serials and tele-films related to health care awareness.

**Hypotheses**

*H₀: β₁₂= 0* (T.V.channels should include some serials and tele-films related to health care awareness is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

*Hₐ: β₁₂≠ 0* (T.V.channels should include some serials and tele-films related to health care awareness is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  \[ α= 0.05 \]

- **Rejection Region**
  Reject the null hypothesis if \( p \)-value \( ≤ 0.00 \).

- **Test Statistic and \( p \)-value**
  \[(see \ above) \ T = 3.269, \ p \text{-}value = 0.001\]

- **Conclusion**
  Since \( p \)-value = 0.001 \( ≤ 0.05 \), we shall reject the null hypothesis.

- **State conclusion in words**
  At the \( α = 0.05 \) level of significance, there exists enough evidence to conclude that the slope of T.V.channels should include some serials and tele-films related to health care awareness is not zero, and hence, that T.V.channels should include some serials and tele-films related to health care awareness is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care
Awareness for Women and Children in Varanasi District for Health care awareness programme should be telecasted in peak hours and peak days, Age of the Respondent, Occupation of the respondents, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, Acceptability of Health care advises of T.V.is more in women in comparison to men, Health care advice reports too fast in comparison to another medium of reporting, Health care Advise Provided through Television should be Local Health Problem-Oriented, T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Awareness programme related to children and women is in T.V.more effective in compare to other age group.

$H_0$: $\beta_1 = 0$ (Health care awareness programme should be telecasted in peak hours and peak days is not useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

$H_a$: $\beta_1 \neq 0$ (Health care awareness programme should be telecasted in peak hours and peak days is useful for predicting the effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District)

- **Significance Level**
  $\alpha = 0.05$

- **Rejection Region**
  Reject the null hypothesis if $p$-value $\leq 0.00$.

- **Test Statistic and $p$-value**
  $(see\ above)\ T = 1.526,\ p$-value $= 0.000$

- **Conclusion**
  Since $p$-value $= 0.000 \leq 0.05$, we shall reject the null hypothesis.

- **State conclusion in words**
  At the $\alpha = 0.05$ level of significance, there exists enough evidence to conclude that the slope of Health care awareness programme should be telecasted in peak hours and peak days is not zero, and hence, that Health care awareness programme should
be telecasted in peak hours and peak days is useful as a predictor of effectiveness of Television in Mass Media Tools for Providing the better Health care Awareness for Women and Children in Varanasi District for T.V.channels should include some serials and tele-films related to health care awareness, Age of the Respondent, Occupation of the respondents, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, Acceptability of Health care advises of T.V.is more in women in comparison to men, Health care advice reports too fast in comparison to another medium of reporting, Health care Advise Provided through Television should be Local Health Problem Oriented, T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Awareness programme related to children and women is in T.V.more effective in compare to other age group.

- **Multicollinearity Problems**
  
  Since neither of the predictor variables has a *Variance Inflation Factor* (VIF) greater than ten (both VIFs are less than 8.213), there are no apparent multicollinearity problems; in other words, there is no variable in the model that is measuring the same relationship/quantity as is measured by another variable or group of variables.

  Obtain and interpret 95% confidence intervals for the slopes, \( \beta_i \), of the population regression line that relates net effectiveness of the television on health care of women and children in Varanasi district to maximize their health related information. Obtain and interpret 95% confidence intervals for the slopes, \( \beta_i \), of the population regression line that relates T.V.channels should include some serials and tele-films related to health care awareness, Age of the Respondent, Occupation of the respondents, Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, Educational Qualification of the Respondent, Health care Advise Provided through Television is Trustable, Mostly Television channels broadcasting health care advises only general problems, Acceptability of Health care advises of T.V.is more in women in comparison to men, Health care advice reports too fast in comparison to another medium of reporting, Health care Advise Provided
through Television should be Local Health Problem Oriented, T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, Awareness programme related to children and women is in T.V. more effective in compare to other age group, Effective tools for providing the awareness about health care related to the Women and Children in the Varanasi District in Uttar Pradesh.

- We are 95% confident that the slope for Age of the Respondent is somewhere between –0.217 and –0.187. In other words, we are 95% confident that for every single-unit increase in Age of the Respondent, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between –0.217 and –0.187.

- We are 95% confident that the slope for Educational Qualification of the Respondent is somewhere between -0.019 and 0.107. In other words, we are 95% confident that for every single-unit increase in Educational Qualification of the Respondent; the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between -0.019 and 0.107.

- We are 95% confident that the slope for Occupation of the Respondent is somewhere between 0.336 and 0.518. In other words, we are 95% confident that for every single-unit increase in Occupation of the Respondent, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.336 and 0.518.

- We are 95% confident that the slope for Health care Advise Providing's somewhere between 0.022 and 0.122. In other words, we are 95% confident that for every single-unit increase in Health care Advise Provided through Television is Trustable, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.022 and 0.122.

- We are 95% confident that the slope for Health care Advise Provided through Television should be Local Health Problem-Oriented somewhere between 0.082 and 0.218. In other words, we are 95% confident that for every single-unit increase in Health care Advise Provided through Television should be Local Health Problem-Oriented is Trustable, the average changing the
effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.022 and 0.122.

- We are 95% confident that the slope for Health care advice reports too fast in comparison to another medium of reporting is somewhere between 0.087 and 0.206. In other words, we are 95% confident that for every single-unit increase in Health care Advise Provided through Television is Trustable, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.087 and 0.206.

- We are 95% confident that the slope for Mostly Television channels broadcasting health care advises only general problems is somewhere between -0.063 and – 0.045. In other words, we are 95% confident that for every single-unit increase in Mostly Television channels broadcasting health care advises only general problems, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between -0.063 and – 0.045.

- We are 95% confident that the slope for T.V. Health care awareness programme is more effective in urban area in comparison to rural area is somewhere between -0.031 and – 0.0013. In other words, we are 95% confident that for every single-unit increase in T.V. Health care awareness programme is more effective in urban area in comparison to rural area, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between -0.031 and – 0.0013.

- We are 95% confident that the slope for Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness is somewhere between 0.047 and 0.180. In other words, we are 95% confident that for every single-unit increase in Literacy plays a significant role in increasing the effectiveness of T.V. for health care awareness, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.047 and 0.180.

- We are 95% confident that the slope for Acceptability of Health care advises of T.V. is more in women in the comparison to men is somewhere between 0.018 and 0.180. In other words, we are 95% confident that for every single-unit increase in Acceptability of Health care advises of T.V. is more in women
in the comparison to men, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.018 and 0.180.

- We are 95% confident that the slope for T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools is somewhere between - 0.307 and 0.173. In other words, we are 95% confident that for every single-unit increase in T.V.is playing a significant role in providing the awareness of vaccinisation in comparison to other mass media tools, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between - 0.307 and 0.173.

- We are 95% confident that the slope for Awareness programme related to children and women is in T.V.more effective in compare to other age group is somewhere between 0.032 and 0.196. In other words, we are 95% confident that for every single-unit increase in Awareness programme related to children and women is in T.V.more effective in compare to other age group, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.032 and 0.196.

- We are 95% confident that the slope for T.V.channels should include some serials and tele-films related to health care awareness is somewhere between 0.087 and 0.350. In other words, we are 95% confident that for every single-unit increase in T.V.channels should include some serials and tele-films related to health care awareness, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.087 and 0.350.

- We are 95% confident that the slope for Health care awareness programme should be telecasted in peak hours and peak days is somewhere between 0.018 and 0.140. In other words, we are 95% confident that for every single-unit increase in Health care awareness programme should be telecasted in peak hours and peak days, the average changing the effectiveness of Television on Health care Awareness for Women and Children in Varanasi District is between 0.018 and 0.140.
### Table 6.14: Residuals Statistics\(^a\)

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predicted Value</td>
<td>.9241</td>
<td>4.9737</td>
<td>3.5636</td>
<td>1.18358</td>
<td>401</td>
</tr>
<tr>
<td>Std. Predicted Value</td>
<td>-2.230</td>
<td>1.191</td>
<td>.000</td>
<td>1.000</td>
<td>401</td>
</tr>
<tr>
<td>Standard Error of</td>
<td>.049</td>
<td>.170</td>
<td>.068</td>
<td>.017</td>
<td>401</td>
</tr>
<tr>
<td>Predicted Value</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted Predicted Value</td>
<td>.8710</td>
<td>4.9726</td>
<td>3.5641</td>
<td>1.18300</td>
<td>401</td>
</tr>
<tr>
<td>Residual</td>
<td>-2.11873</td>
<td>1.80958</td>
<td>.00000</td>
<td>.35456</td>
<td>401</td>
</tr>
<tr>
<td>Std. Residual</td>
<td>-2.343</td>
<td>2.673</td>
<td>.000</td>
<td>.982</td>
<td>401</td>
</tr>
<tr>
<td>Stud. Residual</td>
<td>-6.103</td>
<td>5.180</td>
<td>.000</td>
<td>1.005</td>
<td>401</td>
</tr>
<tr>
<td>Deleted Residual</td>
<td>-2.29036</td>
<td>1.93143</td>
<td>-.00048</td>
<td>.37105</td>
<td>401</td>
</tr>
<tr>
<td>Stud. Deleted Residual</td>
<td>-6.413</td>
<td>5.363</td>
<td>-.001</td>
<td>1.014</td>
<td>401</td>
</tr>
<tr>
<td>Mahal. Distance</td>
<td>6.294</td>
<td>87.962</td>
<td>13.965</td>
<td>9.074</td>
<td>401</td>
</tr>
<tr>
<td>Cook's Distance</td>
<td>.000</td>
<td>.201</td>
<td>.003</td>
<td>.013</td>
<td>401</td>
</tr>
<tr>
<td>Centered Leverage Value</td>
<td>.016</td>
<td>.220</td>
<td>.035</td>
<td>.023</td>
<td>401</td>
</tr>
</tbody>
</table>

\(a\). **Dependent Variable**: Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children.

In the residual statistics we can see that the minimum and the maximum of standardized residual is −2.343 and 2.673 respectively, both are lower than 3. So, that there is no exceptional value in the residual table.
Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children appears to be linearly related to each of the predictor variables with no visible potential outliers or influential observations (no points away from the main cluster of points); thus, Assumption 1 appears to be satisfied.

The normal plot of the residuals shows the points close to a diagonal line; thus, Assumption 2 is satisfied. The studentized residual plot shows a random scatter of points with constant variability and no definite outliers (although, there is one very slight potential outlier); thus, Assumption 3 is met.
The normal plot of the residuals shows the points close to a diagonal line; thus, Assumption 2 is satisfied. Each of the studentized residual plots shows a random scatter of points with constant variability; thus, Assumption 3 is met.

Also, at first glance one might think that the variability is less for the right half of the plots when compared to the left half. This is likely not the case, and any apparent decrease in variability is probably due to the fact that there are far fewer observations in the right half (having fewer values leaves less room for variability).

**Fig. 6.2**

**Normal P-P Plot of Regression Standardized Residual**

Dependent Variable: Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children.
Fig. 6.3

Scatterplot

Dependent Variable: Television is effective Mass Media Tools for Providing the Health care Awareness for Women and Children.

Table 6.15: Model Description

<table>
<thead>
<tr>
<th>Model Name</th>
<th>MOD_1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Variable</td>
<td>1</td>
</tr>
<tr>
<td>Equation</td>
<td>1</td>
</tr>
<tr>
<td>Independent Variable</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>Included</td>
</tr>
<tr>
<td>Variable Whose Values Label Observations in Plots</td>
<td>Unspecified</td>
</tr>
</tbody>
</table>
Table 6.16: Case Processing Summary

<table>
<thead>
<tr>
<th></th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases</td>
<td>401</td>
</tr>
<tr>
<td>Excluded Casesa</td>
<td>0</td>
</tr>
<tr>
<td>Forecasted Cases</td>
<td>0</td>
</tr>
<tr>
<td>Newly Created Cases</td>
<td>0</td>
</tr>
</tbody>
</table>

a. Cases with a missing value in any variable are excluded from the analysis.

Table 6.17: Variable Processing Summary

<table>
<thead>
<tr>
<th>Variables</th>
<th>Dependent</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unstandardized Residual</td>
<td>Studentized Residual</td>
</tr>
<tr>
<td>Number of Positive Values</td>
<td>225</td>
<td>225</td>
</tr>
<tr>
<td>Number of Zeros</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of Negative Values</td>
<td>176</td>
<td>176</td>
</tr>
<tr>
<td>Number of Missing Values</td>
<td></td>
<td></td>
</tr>
<tr>
<td>User-Missing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>System-Missing</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 6.18: Model Summary and Parameter Estimates

<table>
<thead>
<tr>
<th>Equation</th>
<th>Dependent Variable: Unstandardized Residual</th>
<th>Model Summary</th>
<th>Parameter Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R Square</td>
<td>F</td>
</tr>
<tr>
<td>Linear</td>
<td></td>
<td>1.000</td>
<td>1.856E6</td>
</tr>
</tbody>
</table>

The independent variable is Studentized Residual.
According to World Health Organization, Health is a state of complete physical, mental and social well being not merely the absence of diseases. The WHO has stated three levels of Health Care. Primary Healthcare is easily accessible and affordable to all people and serves as first point of consultation. The specialized services provided by medical professionals that is included under secondary Health Care, and the tertiary Health Care involves higher level of speciality care which requires highly specialized equipment and support (Torrey, 2014). The Mass Media especially Television plays a proactive role as messages imparted or shown by means of media are rapidly absorbed & diffused in the society. The youth, upcoming future of India are strongly motivated by T.V actors who act as their mentor and guide. It has been observed that topics like gender equality, decaling sex ratio, female infanticide covered by the mass media are influencing the common mass who has shown revolutionary change in their behaviour towards burning global issues.
The health status of women and adolescent girls have direct correlation with happiness which in a by-product function of mass media with increase in entertainment and joyful time, women feel free of tension after their tedious household and agriculture work which in turn acts as a booster for their health.

It is a well documented fact from the previous researches that at regional level still burning issues like male preference, lack in girl education requires immediate concern. However, these issues are somewhat controlled by the propagation of local leaders through mass media. The eradication of polio may be considered as a fruitful result of Television acting as a tool of social media. The important dates of vaccination, the special care during pregnancy, importance of girl education are regularly propagated following the cultivation theories which have definitely shown positive impact in improving health status especially of rural women.

6.9 Analysis of the Fourth Objective

The fourth objective is to observe how the health care programme presented on television motivate viewers (women & children) regarding their health care.

The logit model - Analytical model and Model specifications

The study focuses on Motivational behaviour of respondent regarding to health care on TV. Motivation of the respondent is determined by many variables, it further quantifies the probability of the factors that may significantly constraint or influence.

The logistic model is the standard method of analysis when the outcome variable is dichotomous² (Hosmer and Lemeshow), and the dependent variable was dichotomized with the value of 1 and 0,

\[ P_i = \frac{\exp^{Z_i}}{1 + \exp^{Z_i}} \]  \hspace{1cm} (1)

Where \( P_i \) = a random variable that predicts the probability of the \( i^{th} \) respondent motivates positively More specifically, the relationship between these variables and \( Z_i \) may be specified as follow:

\[ Z_i = \beta_0 + \beta_1 x_{1i} + \beta_2 x_{2i} + \beta_3 x_{3i} + \ldots + \beta_n x_{ni} \]  \hspace{1cm} (2)

The model is specification for the study can therefore be summarized in equation:

### Table 6.19: Classification Table\textsuperscript{a,b}

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted</th>
<th>Health Care Programme of Television Motivate for curving of their Health Related Problem</th>
<th>Percentage Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 0</strong></td>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Health Care Programme</td>
<td>No</td>
<td>0</td>
<td>137</td>
</tr>
<tr>
<td>of Television Motivate</td>
<td>Yes</td>
<td>0</td>
<td>264</td>
</tr>
<tr>
<td>for curving of their</td>
<td></td>
<td></td>
<td>100.0</td>
</tr>
<tr>
<td>Health Related Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Percentage</td>
<td></td>
<td></td>
<td>65.8</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Constant is included in the model.

\textsuperscript{b} The cut value is .500

### Table 6.20: Variables in the Equation

<table>
<thead>
<tr>
<th>Step 0</th>
<th>Constant</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>.656</td>
<td>.105</td>
<td>38.810</td>
<td></td>
<td>.000</td>
<td>1.927</td>
</tr>
</tbody>
</table>

### Table 6.21: Omnibus Tests of Model Coefficients

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step</th>
<th>Chi-square</th>
<th>Df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Block</td>
<td>316.140</td>
<td>1</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Model</td>
<td>316.140</td>
<td>1</td>
<td>.000</td>
</tr>
</tbody>
</table>

### Table 6.22: Model Summary

<table>
<thead>
<tr>
<th>Step</th>
<th>-2 Log likelihood</th>
<th>Cox &amp; Snell R Square</th>
<th>Nagelkerke R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>198.841\textsuperscript{a}</td>
<td>.545</td>
<td>.754</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Estimation terminated at iteration number 6 because parameter estimates changed by less than .001.
Table 6.23: Classification Table

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted</th>
<th>Percentage Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Programme of Television Motivate for curving of their Health Related Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>128</td>
<td>9</td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>243</td>
</tr>
<tr>
<td>Overall Percentage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. The cut value is .500

The validity of the model

The coefficients of the binary logistic regression model were estimated by maximum likelihood methods. The Hosmer and Lemeshow statistic is one of the most reliable tests of model fit for binary regression (Sidibe’, 2005). The results of the model are given in the above tables. The overall percentage of correct predictions is 92.5%. Hosmer and Lemeshow Goodness-of-Fit Test, which is computed from the Chi-square distribution with 1 d.f. We fail to reject the null hypothesis that there is no difference between the observed and predicted values of the dependent, implying that the model’s estimates very well fit the data at an acceptable level. Sidibe’ (2005) also mentioned that a p-value less than 0.05 indicate a poor fit for a binary logistic regression model.

The column, exp (B), in Table 6.20 gives the exponential of expected value of B raised to the value of the logistic regression coefficient, which is the predicted change in odds for a unit increase in the corresponding explanatory variable. The
Table showed that 23 explanatory variables in the model were significant in explaining that motivational behavior of the respondent.

Motivational behaviour of the respondent is determined by many explanatory variables such as immunization awareness, discussing about the journal topic, health related camping benefited them etc. We are assuming in the hypothesis that only economic structure determine the motivational behaviour, and our hypothesis is rejected and alternative hypothesis is proved.

6.10 Analysis of the Fifth Objective

To calculate the Impact of Television on health care on different classes in the study area.

**Table 6.24: Different Economic Class of the Society * Health Care Programme of Television improving the health of the family Crosstabulation**

<table>
<thead>
<tr>
<th>Different Economic Class of the Society</th>
<th>BPL</th>
<th>APL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>128</td>
<td>9</td>
<td>149</td>
</tr>
<tr>
<td>% within Different Economic Class of the Society</td>
<td>85.9%</td>
<td>14.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Count</td>
<td>9</td>
<td>243</td>
<td>252</td>
</tr>
<tr>
<td>% within Different Economic Class of the Society</td>
<td>3.6%</td>
<td>96.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Count</td>
<td>137</td>
<td>264</td>
<td>401</td>
</tr>
<tr>
<td>% within Different Economic Class of the Society</td>
<td>34.2%</td>
<td>65.8%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The above Table 6.24 shows the results obtained from 401 female TV viewers. Whether they are APL or BPL, their decision about Health Care Programme of Television shows improvement in the health of their family. The BPL family’s female
decision is about Health Care Programme of Television are helpful in improving the health of the family 21 (14.1 %).

The results suggest that most APL families tend to respond positively and have a strong attitude about Health Programmes on Television in comparison to BPL family. Thus we can say that in Varanasi district most of the APL and BPL families have positive attitude regarding Health care programmes telecasted on Television but APL class have much more.

Table 6.25: Chi-Square Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>2.822</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction</td>
<td>278.561</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>316.140</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td>316.140</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>281.506</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>401</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 50.91.
b. Computed only for a 2x2 table

Finally, the above Table 6.25 provides the Summary static info. The observed chi-square statistic is 2.822, which is associated with a 05 % risk of being wrong in rejecting the null hypothesis. This is too small risk to Different Economic Class of the Society about health care programme on TV. So we are able to accept the null hypothesis. As such one can find support for further researchhypothesis to conclude the Different Economic class having different attitude regarding to health programme on television.
Chapter - VII

CONCLUSION AND RECOMMENDATIONS

Over the last two decades the growth of television in the developing world has been extraordinary. Estimation has been done which inform that the number of television sets in Asia has increased more than six-fold, i.e. from 100 million to 650 million, since the 1980s. In country like China, television exposure stares up from 18 million people in 1977 to 1 billion by 1995 (Thomas, 2003). In the present scenario, satellite and cable television availability has increased drastically. Considering the example of China, once again the number of people with satellite access increased from just 270,000 in 1991 to 14 million by 2005. Further, these numbers are likely to understake the change in the number of people as a single television is often watched by many.

Since 1959 when television was first introduced to India, for the first three decades almost all broadcasting was in the hands of the state, and the content was primarily focused towards news or information about economic development. But the most significant and crucial change which took place with the innovation in terms of both content and viewership was the introduction of satellite television in the early 1990s. According to the National Readership Studies Council 2006, about 30 million households, representing approximately 150 million individuals, added cable service between 2001 to 2006 and since television is often watched with family and friends by those without a television or cable, the growth in actual access or exposure to cable is likely to have been even more dramatic. The program telecasted through cable television are quite different in comparison to government programming. The most popular shows tend to be reality shows, game shows, live concerts and soap operas. For example, among the most popular shows in both 2000 and 2007 (based on Indian Nielsen ratings) is “Kyunki Saas Bhi Kabhi Bahu Thi,” (Because a Mother-in-Law was Once a Daughter-in-Law, too) a show based around the life of a wealthy industrial family in the large city of Mumbai. As as the very title represents, the main themes and plots of the show revolve around issues of old and new generation.
thinking for the family and gender. The introduction of television appears in general to have had large effects on Indian society regarding gender in particular, since this is an area where the lives of rural along with urban viewer’s differ greatly than in any other programmes or shows telecasted on private or public channels. By virtue of the fact that almost all the popular Indian soaps and serials take place in urban settings, women depicted on these shows are typically much more emancipated than rural women. Also in some of the cases there is access to Western television, where these behaviours differ even more markedly from rural India. The anthropological studies report that this seems to have affected attitudes within India. In the very study itself numbers of the respondents have demonstrated that the information and exposure provided by television influences a wide range of attitudes and behaviour among the women. The report also delineates that television viewership in the Muslim world affects attitudes towards the West that can be visualised through the effects of the Fox News channel on voting patterns in the United States. The striking result of these shows on television having been the decreasing participation in social organizations along with exposure to soap operas reduces fertility both in the developed and developing countries. This clearly indicates that India has not been left out of the cable and satellite revolution. Once again a study made by National Readership Studies Council in 2006 flashes that 112 million households in India own at least one television, along with 61 percent of the owners having cable or satellite services. This figure represents a doubled in cable access in just five years from a previous survey. The survey finds that in some states, the change has been even more dramatic; in the span of just 10-15 years since it first became available, cable or satellite penetration has reached an astonishing 60 percent in states such as Tamil Nadu, even though the average income is below the World Bank poverty line of two dollars per person per day. Television vastly plays a major role in increasing both the availability of information about the outside world and exposure to other ways of life along with various entertainment programmes. The ethnographic and anthropological studies clearly review that this is especially true for remote, rural villages, where television is the primary channel through which households get information about life outside their village. Most popular cable programming features urban settings where lifestyles differ in prominent and salient ways from those in rural areas. This can be represented through many characters on popular soap operas images to have more education,
want to have late marriage and have smaller families along with those female characters working outside their home, as professionals business-woman or in other positions of authority that are rarely found in rural areas. The above study also accounts that the growth of TV in rural areas has had large effects on a wide range of day-to-day lifestyle behaviours, including toilet building and fan usage. Few rigorous empirical studies has been done to explore the effect of the introduction of cable television in rural areas of India on a particular set of values and behaviours, namely attitudes towards and discrimination against women. Although issues of gender equality are important throughout the world, they are particularly salient in India. The population bias towards male sex has its worse effects in the last two decades, as sex selective abortion has become more widely used to avoid female births. It was also argued that there were millions of ‘missing women’ in India—women and girls who died prematurely due to miss treatment. They are discriminated against in nutrition vaccination, medical care and education, resulting in a drastically male oriented population along with gender inequality which is worse in rural areas in comparison to urban. By exposing rural households to urban attitudes and values, cable and satellite television may lead to improvements in status for rural women.

With the help of the primary data collected through the primary survey in Varanasi district of Uttar Pradesh, it can be concluded that the introduction of television along with cable satellites has large effects on women’s and children’s health status. As soon as the connection was made to various villages, there have been significant changes in gender attitudes regarding the health status and health awareness. Presently, the women are less likely to report that it is acceptable for them to be positively influenced by health related programmes on TV, and are less likely to express a preference for sons. On the same platform women’s status has also changed; as women report increased autonomy (for example, the ability to go out without permission and to participate in household decision-making regarding their health care and sanitation), and also lower fertility. In terms of magnitude, the effects of cable networks are quite large— that can be reflected through the differences in attitudes and behaviours between urban and rural areas by 45 to 70 percent. The impact of television has been consistent with existing work on the effects of media exposure, which typically find rapid changes (within a few months, in many cases) in
behaviours like the use of contraceptives, pregnancy, toilet building and perception of own-village. A central empirical concern is the possibility that trends in other variables (for example, “income” or “modernity”) affect both cable access and women’s status. One can argue that this does not appear to be the case, first showing visually that there are no pre-existing differential trends in women’s status for villages that do and do not add cable, and that the timing of changes in outcomes is closely aligned with the introduction of cable, and second, that the outcomes are not correlated with future cable access.

The report of World Bank 2006 shows that the policy-makers and academicians often argue that a significant benefit of improved status for women is increment in investments on children. Although our ability to look at children’s outcomes is limited, we are able to look at the effects of television and cable access on school enrollment. Using both our household panel data and administrative data for roughly 401 respondents in the state of Varanasi District, we provide evidence that the introduction of television cable increases school enrolment along with good health among younger children. Although the enrolment data have some limitations relative to the data on women’s status, we see large effects of cable that also appears to increase over time. Again, one can argue that these results are not driven by pre-existing trends in the outcome variables. The results are potentially quite important for policy. As noted, a large literature in economics, sociology and anthropology has explored the underlying causes of discrimination against women in India, highlighting the dowry system, low levels of female education, bad health status, and other socioeconomic factors as central factors.

One of the primary objectives of this program is to enable women, particularly in rural areas, to “acquire knowledge for health care of women & children and social development”. Therefore, the results also provide insight into the potential impact of this unique and non-traditional strategy that can have on critical policy priorities. From a policy perspective, however, there are potential concerns about whether the changes in reported attitudes, such as towards health care, domestic violence or son preference, represent changes in behaviours, or it is just in reporting. For example, we may be concerned that exposure to television only changes what the respondent thinks the interviewer wants to hear about the acceptability of health care programme in their
regular life. This is less of a concern in the case of autonomy and fertility, where women are asked about their actual behaviour (and for fertility, there is less scope for misreporting since both pregnancies and recent births are likely to be observable by the interviewer). In addition, the fact that we find effects on education in administrative data provides support for an effect of cable on behaviour. Without directly observing people in their homes, however, it is difficult to conclusively separate changes in reporting from changes in behavior. However, even if cable only changes what is reported, it still may represent progress: changing the television in India and discusses existing anthropological and ethnographic evidence on the impact of television on health care of Indian society, as well as the determinants of cable placement.

In today’s world, when India is advancing towards developed nation, men and women are able to ‘open up a lot more’ because of television. It was also found that there were number of respondents describing changes in gender roles as a result of television that might lead women to question their social position and might help the cause of female advancement one of the respondent have noted, “Since television has come to our village, women are doing less work than before. They only want to watch TV. So we (men) have to do more work. Many times I help my wife clean the house”. Many of the studies reflect the consequences of television through variety of outcomes, eg. eating disorders, sex role stereotypes, and perceptions of women’s right. One can argue that exposure to telenovelas (as can be delineated through the example and effects happened in Brazil also) provides women in particular with alternative models of what role they might play in society. The effect of television along with cable network introduction in this country have changed the framework of social interactions, increase gender world knowledge and also changed people’s perceptions about the status of their village in the wider world. The effects can also be reframed from isolated area, where views on gender and the role of women in both the workplace and in relationships have become more liberal and diversified. The aftermath can also be seen in fertility in response to access to telenovelas, and also found changes in naming patterns of their children with names of main characters featured on these programmes increasing in popularity.
7.1 Accessibility of Cable Programmes

To proceed through more quantitative analysis of the impacts of television along with cable networks, we have to recognize that variation in access is certainly non-random. Therefore, in order to understand the determinants of the timing and placement of cable, it is important for our ability to attribute changes in women’s status to the introduction of cable itself. For having a precise study on it, the cable operators were also interviewed to some extent in the very district. In these interviews, the operators emphasized two primary considerations: (i) access to electricity and (ii) distance to the nearest town or city. Electricity is, of course, a fundamental requirement for television but distance is important because most operators who provide service to rural villages reside in towns or cities. As the distance increases (i.e. more remote villages), it increases the operator’s costs, since they often must personally travel to the village to monitor the cable set-up (in order to ensure whether it is working properly or not and also no unauthorized users are connecting to it), to collect payments, make repairs or update equipment, or add new subscribers. For the most remote villages, a single trip could require an entire day. As a result, villages closest to larger towns are served first, with more distant villages only being covered after the more profitable villages are taken. Income was less often mentioned by operators as a constraint, since charges for cable access are small (about Rs. 100-150 per month); but the companies marketing televisions, this was more of a concern. Overall, most of the cable operators reported that variation in access was not demand-driven but was largely controlled by costs.

Here it is worth to briefly explore the effect of cable access on TV watching, since all the blocks taken for study have long had access to broadcast television. It is ex ante unclear whether the introduction of cable will change the amount of television watched, which is potentially important as a “first stage” (although cable is likely to change the content of TV watched, even if it does not change the amount, which could also have an effect). Once it is clear that cable increases TV watching, we turn to the effects on women’s health status representing the effects of cable access on attitudes towards their health care awareness, son preference, autonomy and fertility. Changing behaviours (autonomy, for example) may require coordination with other family members and larger scale changes in
lifestyle. As such changing attitudes, which may or may not be accompanied by changes in behaviour, is the first and most obvious place to look for effects of exposure to other lifestyles and values.

**The other effects can be delineated through the following points:**

- Women in the early stages of pregnancy might happen that they may not know or may not report about their pregnancy, leading to lower apparent pregnancy rates when measured by directly asking about current pregnancies. On the other hand, since many pregnancies result in spontaneous or induced abortions rather than births, which ultimately results in estimating pre-survey pregnancies by counting backwards from pre-survey births that leads to an undercount. While these measurement difficulties make our estimated effects of television shows on pregnancies less precise, they should not be systematically correlated with whether the village has television or cable connection or not.

- To raise public awareness on public issues, mass media can be a powerful tool. Television has been found to be effective in situations where radio is limited and also as a tool for development because of its combination both sight and sound.

- The basic philosophical foundation of the initial stage of television for development in Varanasi was for education. It has been however, observed that it is being used today for national development and mobilization of the citizens for developmental efforts on family planning along with primary healthcare and many more plans. Health education which are crucial to the attainment of the millennium development goals one of which is to improve maternal health.

- The mass media through television programmes not only helps to increase capacity and provide people with information but also assists to learn about reproductive health and where to seek services. Media can also be used to overcome stigma, shame, discrimination as well as raise awareness and public and financial commitment to the issue.
• In order to attract or gain attention of the women weavers on health shows telecasted on television, health communicators should always include elements of information, education and entertainment in their health and other development messages targeted at women. The study reveals that in Varanasi District, women experience a serious improvement in knowledge and acquired a positive change in their health behaviour as a result of their watching and listening to various health programmes on Entertainment-Education channels.

• Due to socio-cultural and economic factors, particularly low educational levels, religious beliefs, misinformation, poverty, and poor spousal communication, the study also found that there is also a marked level of resistance to family planning.

• It also appears that excessive television viewing among adolescents may lead to poor dietary patterns in later years. They are associated with a raised likelihood of overweight and results to a combination of unhealthy dietary habits along with unawareness of health, sedentary behaviour and exposure to TV advertising. The same is the condition with women too.

• Children and young guys appear to be more likely to engage in unhealthy dietary habits such as consuming more snacks and soft drinks, and less fruit and vegetables while watching television. Experimental studies show that watching television acts as a distraction resulting in a lack of awareness of actual and right amount of food consumption, leading to over consumption and increased energy intake.

• Some evidences represent that TV viewing is normally a sedentary behaviour and it leads to high levels of obesity, independently of physical activity levels. It is important to distinguish this from the level of physical activity, as children can have high levels of both physical activity and TV screen time.

• The report clearly identifies that children’s food preferences and consumption are influenced by television advertising. The result can be viewed through overweight and obese children along with those who watch high levels of TV. They are also susceptible to food promotion on TV, and boys are more susceptible than girls.
• A result of the replacement of fruit and vegetables by other foods advertised more frequently indicates the association between watching TV and reduced likelihood of regularly consuming fruit and vegetables.

• As the regulatory environment becomes more defined and innovative organizations may demonstrate the importance of T.V. from day to day life, increasing the numbers of health care stakeholders who are expected to recognize – and leverage – this transformational technology’s role in information acquisition and access. Indeed, thus the T.V. is a trend that could change the face of health care information sharing and providing new power for providers and patients alike.

• The study delineates that televisions are likely to have a significant impact on the future of people’s health care. Though, these networks are enabling patients to better communicate with each other along with satisfactory treatment and physicians to communicate for a better medical practice. The corporators envision a future where social networks are an integral part of the health care landscape.

• The television and women in India has not made adequate efforts to discuss serious issues concerning women and prepare then to play their rightful and equal role in society.

• In order to know and use pre natal care services mothers who are regularly exposed to electronic mass media especially television are much more active for their reproductive health in comparison to other mothers, and also for successful outcome of pregnancy.

• The effect on awareness and use of prenatal care services is stronger in Rural Blocks of Varanasi District than in Urban Blocks, probably because urban area mothers had already been more exposed to the benefits, through better education level, and comparatively higher status. They have access to a wider variety of services and sources of information than Rural Blocks in Varanasi District.

• It is important to note that electronic mass media (television) need not only to reach low privileged mothers living in rural areas, and are illiterate, and but
also to those who belong to disadvantaged SC/ST groups, and are from households with a low standard of living.

- The study illustrates that various issues related with some subjects are given more importance and space while telecast of various programmes on TV, and are frequently discussed while others are totally absent. This can be illustrated through the example of advertisements related to beauty and health products which are generally telecasted more on television especially at the prime time when the viewership is high. The health messages on the other side are generally broadcasted more on radio and in newspapers than telecasted on television. The reason behind this may be of financial investment which is more in the case of television than radio.

- No one can interrupt to say that the electronic media are vital sources of information, because it can cover up both the urban and rural areas widely. Interestingly, these mass media tools reach the hearts of even illiterates. However, urban women and men have had better access to all media sources than their rural counterparts.

- To motivate the people towards better society the study also emphasized that one of the most important communications facility is television. It can have a greater influence on people’s thought and extend knowledge, effect public opinion, and introduce new ways of life. Regarding the health field, in urban areas and in rural communities, it has already served as a powerful advocate of healthy behaviour.

- The results may be attributed to the fact that through acculturation, rural people gradually diluted their mind in appreciating the core value of traditional media where they get exposed to all modern electronic and printed mass media for getting message related to their welfare. But still some people who are ordinarily traditional minded and attach themselves to their respective culture do value favourably the folk and traditional media.

- It could be seen that women's awareness on diet related diseases and infections, are least through social media or Internet but most through Television. On the other side of the coin as far as awareness of heart disease is concerned, radio and television both are having same percentage and the credit
goes to the commercial advertisements of different types of cooking oil which continuously talk about decreasing the risk of heart disease by using that particular type of cooking oil.

- In the study area it can be demonstrated that there is a positive correlation between accessibility and acceptability between health care awareness and television watching by women. Therefore, health communicators should always include some elements of information, education and entertainment in their health and other development messages targeted at women in order to get their attention. The study concluded that women residing in Varanasi District experienced a serious improvement in their knowledge and a positive change in their health behaviour by watching and listening to various health programmes on Entertainment Education channel telecasted on particular day and time.

- Digital India has been able to generate the habits for watching the television on regular basis so that maternal health messages could be incorporated through television dramas and soap operas as a form of Edutainment.

- The study revealed that the respondents are utilizing the electronic media more than the expectation. This media to a great extent is being used for getting not only the news and sports information but also health related information among respondents. Comparatively very few are unaware of the media health program.

- The study shows that television is being the most popular and reliable media for most of the problem solution but then too large number of respondents are unable to expose themselves to modern media. The increase in age increases the awareness towards health problems and its remedies for which most young women are influenced with both traditional media and modern media. Interestingly, most respondents prefer watching television for current affairs and not for health awareness.

- Most of the respondents of Varanasi District watch the Doordarshan and other private infotainment television channels (cable channels) for health related programmes. While interacting with respondents during data collection, some of them responded that “these health programmes are very helpful for
providing more information and remedies about certain common diseases such as viral fever, skin related problems, cough and cold”. Using remedies provided by the doctors, dietitian, nutrition and experts in health programmes keeps them away from doctors. Also because of biological difference compared to men, health of women always requires care and affection along with lot of attention forever for their healthcare.

- The study revealed that television news coverage on various public and private channels on medication-related healthcare that has the potential to dramatically increase the overall rate of adverse event, particularly in the early stages increases anxiety in viewers, leading to a general increase in symptoms that people experience.

**Recommendations**

There are several challenges posed before the government in making proper implementation of various plans and programmes in providing health services to the people. Improving the quality of and access to services is the main challenge because of the large number of vacancies in public health institutions, especially for medical officers, supervisors and technicians, in addition to over infrastructure, including lack of equipment and inadequate facilities. It has been proved many times that government system has failed in providing services at the grass root level. The Central and State governments have implemented many policies like National Rural Health Mission, Health for All, National Urban Health Mission and several policies targeting reproductive health and child health. They are working at the rural and urban areas with their limitations. There is a vast scope to improve the situation in health sector by spreading awareness and using practical knowledge.

Rural health services which form in the backbone of public health system, is lacking in basic infrastructure, staff and essential medicines. Presently, at the District level and below there is a hurry to achieve ‘targets’ which cannot be achieved in the absence of trained personal and improved infrastructure. There is an urgent need to strengthen the implementation of all the rural and urban Health Care Programmes and
improve infant and young child feeding practices among lactating women. However, most of the patients in Government Hospitals have to wait hour after hour for treatment. Still a good section of the society is visiting these hospitals as they are financially crippled.

Keeping this in view the study came out with the following recommendations and suggestions.

- All health facilities should be made functional according to IPHS i.e. adequate staff especially specialist should be appointed/hired to provide emergency and quality services.
- Inadequacy of logistics (equipments, medicine, and vaccine) and infrastructure should be met.
- There is a need for providing health services for 24 hours to improve the utilization of health services.
- The cleanliness and maintenance of infrastructure of the health centres is also very important factor to increase the utilisation of the government health services.
- Free and sufficient medicines should be made available.
- Cleanliness of the health centres and hospitals should be ensured.
- No amount should be deducted in JSY scheme.
- IEC activities must be strengthened to create awareness among the community about various health schemes.
- Availability of pathological services at rural centres.
- Health services providers should be given training to build their capacity to improve in their dealing with the patients.
- Availability of female doctor should be ensured at CHC.
- No one should be charged for the case paper and injection.
• The PNC services needed to be strengthened and encourage mothers for the utilisation of the services.

• Electricity should be made available at delivery places with a proper power backup.

• Sub-centre should be at secure place so ANM can stay there.

• Increase the OPD timings with proper arrangement for emergency at night.

• Pooling of human resources needs to be done (of experts/surgeons and anaesthetics with O.T. support services) at the block PHCs who can go to different APHCs on call to provide the services or alternatively patients be referred for specialised services at PHC phone calls so that experts to be ready before patients reach.

• All APHCs be made fully functional for inpatient services particularly for basic services like delivery services, incremental care and so on.

• All health services staff are provided related manuals/guidebooks about IPHS, NRHM in Hindi language also.

• Rogi Kalyan Samiti (RKS) needs to be more active in its monitoring responsibility.

• Participation of community through Panchayati Raj Institutions and Urban Local Self-Governments in health sector should be insured as government alone cannot be able to take the responsibility.

• Reducing the market rates for different diagnostic tests/procedures etc. for the poor and vulnerable sections of populations.

• The private sector, especially in the not- for-profit sector should take the initiative in attempting to ensure greater coordination of activities list of such an approach should result in greater coordination of geographical spread of activities. One of the major findings of the research is that there is seldom any logical correlation between need and activities. The aversion that not- for-profit organisations have to be correlated by government agencies, ensuring better condition amongst themselves should appeal to the not-for-profit sector.
However, it is believed that government, by contracting this sector for service delivery, can influence we are and what these organisations are involved in.

- The public sector should seriously look at the ability of the private sector to increase service delivery to the uninsured. The case study and the section on PPPs clearly demonstrable ability of this sector to absorb substantial amounts of money, in a responsible manner, and the ability of this sector to reach large numbers of the uninsured population. Drawing on these excellent ties could dramatically increase service delivery and go up long way in creating a truly unified health care system. The former Secretary General of the United Nations, Kofi Annan, summarised this potential perfectly when he said: “The UN once the only with Governments, but now we know that peace and prosperity cannot be achieved without partnerships involving government, international organisations, the business community, and civil society. In today’s world we depend on each other”.

- The public sector needs to look at creating a forum and the health district level to English private sector players to create an integrated healthcare system.

- The human resources issues highlighted need to be more looked at, as a matter of urgency. Defaults to attract and retain healthcare professionals in the public sector have to move away from purely attempts to improve salaries, or coerce young professionals into public service. It is believed, that paying attention to how management treats healthcare professionals could have dramatic positive effects. In the final analysis, we are living in a world where competition for scarce resources, such as skilled people, is years and currently we are losing this competition.

- The production of skilled healthcare professionals should be increased as set out in the Human Resource for Health Policy of 2006. However, it is time to explore how to engage the private higher education sector in these efforts. The fears expressed by some policymakers that if the private sector was allowed to establish, for example medical schools, that this will undermine the attempts of government to improve racial and gender representation in these professions, are valid given that the private sector cannot be instructed to
apply targets intakes of students. However, the inclusion of the private sector in the government higher education subsidy schemes would address these concerns, as those subsidies are limited to race and gender targets.

- In a country with a desperate shortage of skilled human resources, it is needed to tap into the enormous potential of volunteerism. Creating company volunteer programs is a positive beginning, but consideration should be given to establishing volunteer service organisation, that can act as brokers between those with skills and those in need of these skills.

Along with the above given recommendations we can also visualise on the functioning of mass media especially television. In this regard we can suggest that there should be special expert reporters for the coverage of different areas health problems, its remedies and its development. Such reporters should be specialists in their subject. Turning towards print media, due to preference of majority of readers, the health messages should be given either on first page which covers mainly political news or on sports page of the newspaper. On the other hand, due to large viewership, the health related information or messages should be telecasted more during the prime time on radio and television in comparison to other infotainment.

- The management of media houses operating in Varanasi District need to find ways to improve health and safety awareness programs such as sensitization, education, and seminar by the Dish cables, so that most of the viewers can be benefited and should come up with new occupational health and sanitation of Women’s and Children, practices to suit the dynamic and ever changing work environment.

- The government should look into ways of providing adequate resources for Electronic public media stations to ensure that they do not lag behind private media houses in terms of occupational health and sanitation.

The cultivation theory should also be emphasized. Emphasis should be given to the repetition of all global issues regularly for increasing their impact. Regional local leaders may be involved through regional channel for motivating regional people inspite of national figure. At the regional level and national level important health issues programmes should be broadcasted in English, Hindi as well as in regional language. The cultural heritages which are now fading away can be
revived by social media. The prime areas which are always remaining unheard should be given major importance. The involvements of women health experts may be a new hope for women to discuss their problem freely. Rural India is crucially trapped by various fads and fallacies which are against scientific principles and sometimes result fatal. Hence Mass Media would play a major role in eradicating such fads and fallacies.

The study explored a number of key concepts like maternal health, adolescent girls hygiene & health which is an issue of global concern and fifth of the Eight Millennium Development Goal launched in 2000 by UN and members states. The global level statistics have clearly alarmed the rising of maternal mortality indicators. Hence there is an urgent need for intensification of efforts by countries and each country should put major efforts from basic grass root level. The mass media has definitely been proactive as revolutionary behaviour change and has been observed by increased awareness of Mass Media.
BIBLIOGRAPHY


Bazruchka, (2005), "From Womb to Tomb : The Influence of Early Childhood on Adult Health", *Alternative Radio*, pp. 01-08.


Castro, Claudio de Moura, and Philip Musgrove, (2001), "Why Education and Health are more Different from Alike", World Bank, Washington, D.C.

Bibliography


Duggal, Ravi, "The State's Role in Financing Health Care : Health for the Millions", Vol. XVI, No. 03, pp. 05-08.


Dutt, P.R., (1962), "Rural Health Services in India: Primary Health Centres," *Central Health Education Bureau*, New Delhi.
Eoster, (2009), "The Power of TV: Cable Television and Women's Status in India", eoster @uchicago.edu.


National Health Policy, 2002.


Sunder, Ramanand, "Household Survey of Medical Care", Margin, Vol. 10, No. 02, pp. 169-175.


