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Annexure
# GLOSSARY

<table>
<thead>
<tr>
<th>Letters</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>ARSH</td>
<td>Adolescent Reproductive Sexual Health</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>AWC</td>
<td>Anganwadi Centre</td>
</tr>
<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
</tr>
<tr>
<td>B</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacillus of Calmette and Guerin</td>
</tr>
<tr>
<td>BPHC</td>
<td>Block primary Health Centre</td>
</tr>
<tr>
<td>BTN</td>
<td>Barak Television Network</td>
</tr>
<tr>
<td>C</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CBR</td>
<td>Crude Birth Rate</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
</tr>
<tr>
<td>CHV</td>
<td>Community Health Volunteer</td>
</tr>
<tr>
<td>CM</td>
<td>Community Mobilization</td>
</tr>
<tr>
<td>CP</td>
<td>Community Participation</td>
</tr>
<tr>
<td>CSSM</td>
<td>Child Survival and Safe Motherhood</td>
</tr>
<tr>
<td>D</td>
<td>District Accounts Manager</td>
</tr>
<tr>
<td>DCM</td>
<td>District Community Mobilizer</td>
</tr>
<tr>
<td>DH</td>
<td>District Hospital</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>DHAP</td>
<td>District Health Action Plan</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Shortcourse</td>
</tr>
<tr>
<td>DPM</td>
<td>District Programme Manager</td>
</tr>
<tr>
<td>DPT</td>
<td>Diptheria Pertusis Tetanus</td>
</tr>
<tr>
<td>EC</td>
<td>Eligible Couples</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected Date of Delivery</td>
</tr>
<tr>
<td>F</td>
<td>Full Immunization</td>
</tr>
<tr>
<td>FI</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FP</td>
<td>Face to Face</td>
</tr>
<tr>
<td>G</td>
<td>General Nurse Midwife</td>
</tr>
<tr>
<td>GOL</td>
<td>Government of India</td>
</tr>
<tr>
<td>H</td>
<td>Health and Family Welfare</td>
</tr>
<tr>
<td>H&amp;FW</td>
<td>Home Based Newborn Care</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno Deficiency Virus</td>
</tr>
<tr>
<td>HMS</td>
<td>Hospital Management Society</td>
</tr>
<tr>
<td>ICDS</td>
<td>Integrated Child Development Services</td>
</tr>
<tr>
<td>ID</td>
<td>Institutional Delivery</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>IFA</td>
<td>Iron Folic Acid</td>
</tr>
<tr>
<td>IIMC</td>
<td>Indian Institute of Mass Communication</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IPC</td>
<td>Interpersonal communication</td>
</tr>
<tr>
<td>IPD</td>
<td>Indoor Patient Department</td>
</tr>
<tr>
<td>J</td>
<td>Janani Sishu Suraksha Karyakram</td>
</tr>
<tr>
<td>JSY</td>
<td>Janani Suraksha Jojana</td>
</tr>
<tr>
<td>K</td>
<td>Knowledge Attitude &amp; Practice</td>
</tr>
<tr>
<td>L</td>
<td>Lady Health Visitor</td>
</tr>
<tr>
<td>M</td>
<td>Mother &amp; Child Health</td>
</tr>
<tr>
<td>MG</td>
<td>Mothers’ Group</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MNGO</td>
<td>Mother Non Government Organization</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MOHFW</td>
<td>Ministry of Health &amp; Family Welfare</td>
</tr>
<tr>
<td>MPHC</td>
<td>Mini Primary Health Centre</td>
</tr>
<tr>
<td>MSS</td>
<td>Mahila Swasthya Sangh</td>
</tr>
<tr>
<td>N</td>
<td>National AIDS Control Organization</td>
</tr>
<tr>
<td>NAMP</td>
<td>National Anti Malaria Program</td>
</tr>
<tr>
<td>NFHS</td>
<td>National Family Health Survey</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organization</td>
</tr>
<tr>
<td>NHP</td>
<td>National Health Policy</td>
</tr>
<tr>
<td>NIRD</td>
<td>National Institute of Rural Development</td>
</tr>
<tr>
<td>NPP</td>
<td>National Population Policy</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
</tr>
<tr>
<td>NSV</td>
<td>No Scalpel Vasectomy</td>
</tr>
<tr>
<td>NVBDCP</td>
<td>National Vector Borne Disease Control Program</td>
</tr>
<tr>
<td>O</td>
<td>Oral Contraceptive Pill</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>OPV</td>
<td>Oral Polio Vaccine</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Rehydration Salt</td>
</tr>
<tr>
<td>P</td>
<td></td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>PC</td>
<td>Percentage</td>
</tr>
<tr>
<td>PH</td>
<td>Public Health</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health Engineering</td>
</tr>
<tr>
<td>PNC</td>
<td>Post Natal Check-up</td>
</tr>
<tr>
<td>PPI</td>
<td>Pulse Polio Immunization Program</td>
</tr>
<tr>
<td>PRI</td>
<td>Panchayati Raj Institution</td>
</tr>
<tr>
<td>Q</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td></td>
</tr>
<tr>
<td>RBSK</td>
<td>Rastriya Bal Swasthya Karyakram</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RKS</td>
<td>Rogi Katyan Samiti</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Program</td>
</tr>
<tr>
<td>RSBY</td>
<td>Rastriya Swasthya Bima Yojana</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>S</td>
<td></td>
</tr>
<tr>
<td>SC</td>
<td>Sub Centre</td>
</tr>
<tr>
<td>SD</td>
<td>State Dispensary</td>
</tr>
<tr>
<td>SHG</td>
<td>Self Help Group</td>
</tr>
<tr>
<td>SITE</td>
<td>Satellite Instructional Television Experiment</td>
</tr>
<tr>
<td>SPM</td>
<td>State Programme Manager</td>
</tr>
<tr>
<td>SR</td>
<td>Sex Ratio</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>T</td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>TSC</td>
<td>Total Sanitation Campaign</td>
</tr>
<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>TV</td>
<td>Television</td>
</tr>
<tr>
<td>U</td>
<td></td>
</tr>
<tr>
<td>UIP</td>
<td>Universal Immunization Program</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
</tr>
<tr>
<td>V</td>
<td></td>
</tr>
<tr>
<td>VHAP</td>
<td>Village Health Action Plan</td>
</tr>
<tr>
<td>VHND</td>
<td>Village Health Nutrition Day</td>
</tr>
<tr>
<td>VHSNC</td>
<td>Village Health Sanitation &amp; Nutrition Committee</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Mass Media Strategies for Community Mobilization:  
A study of Health Sector in Cachar District of Assam

(Encircle wherever applicable)

A. Demographic Profile:

1. Name of the Respondent: .................................................................
   a. Name of the village: .................................................................
   b. Name of the para/lane: ..............................................................
   c. Telephone / Mobile No: ............................................................

2. Age: ..............................................................................................

3. Sex:  (i) Male    (ii) Female

4. Caste:  (i) General    (ii) SC    (iii) ST    (iv) OBC/MOBC    (v) Others

5. Marital Status:  (i) Married    (ii) Unmarried    (iii) Divorced    (iv) Widow

6. Religion:  (i) Hindu    (ii) Muslim    (iii) Christian    (iv) Any Other

7. Mother Tongue:  (i) Bengali    (ii) Assamese    (iii) Hindi    (iv) Any Other

8. Educational Qualification:  (i) Illiterate    (ii) Up to Primary    (iii) Below Matric    
   (iv) Matriculate    (v) Below Graduate    (vi) Graduate    (vii) Post Graduate    
   (viii) Professional / Other

9. Occupation:  (i) Govt. Service    (ii) Private Service    (iii) Professional    
   (iv) Business    (v) Daily Labourer    (vi) Farmer    (vii) Housewife    (viii) Any Other..........

10. Total no. of family members:

11. Family Income (Per month in Rupees):  (i) Up to Rs. 5000    (ii) 5000 – 10000    
    (iii) 10000 – 15000    (iv) 15000 – 20000    (v) More than 20000

12. How much money do you spend on health expenditure/month (Avg) Rs. ............

13. Housing:  (i) Own House    (ii) Rented House    (iii) Others (pl. Specify) ...............

14. Do you have electricity at your home:  (i) Yes    (ii) No

15. Source of drinking water:  (i) Supply water    (ii) Tube well    (iii) Well    (iv) pond    
   (v) River    (vi) Others (pl. Specify) ............................................

16. What sanitation facility do you use:  (i) Sanitary Latrine    (ii) Kaccha Latrine    
   (iii) Open Defecation    (vi) Others (pl. Specify) ..............................
B. Media Seeking Habits:

17. How often do you read newspaper:  
(i) Daily (ii) Occasionally (iii) Do not read  
(if option iii, go to Q. No 20)

18. Which of the following newspaper do you read:  
(Kindly give 1st three order of preference – 1 for most preferred item, 2 for next and so on)

<table>
<thead>
<tr>
<th>Newspaper 1</th>
<th>Newspaper 2</th>
<th>Newspaper 3</th>
<th>Newspaper 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dainik Jugasankha</td>
<td>Dainik Sakalbela</td>
<td>Asomiya Pratidin</td>
<td>The Statesman</td>
</tr>
<tr>
<td>Samayik Prosongo</td>
<td>Dainik Prantojyoti</td>
<td>Assam Tribune</td>
<td>Times of India</td>
</tr>
<tr>
<td>Dainik Janakantha</td>
<td>The Sentinel</td>
<td>The Telegraph</td>
<td>Others (pl Specify)</td>
</tr>
</tbody>
</table>

19. Which section of the newspaper attracts your attention the most:  
(i) Front Page (ii) Advertisement (iii) Back Page (iv) Editorial column  
(v) Health related article (vi) Any other.................................

20. Do you read any Magazine: (i) Yes (ii) No (If No, Skip to Q. No. 22)  
a. If yes, which language do you prefer (i) Bengali (ii) English (iii) Other.........

21. Which magazine do you generally read: (i) .....................................(ii).............................

22. Do you listen to the Radio? (i) Yes (ii) No (If No, Skip to Q. No. 25)  
a. If yes, when do you listen to the radio and for how much time?  
(In case you do not listen to the Radio in specific session, fill "0" in the corresponding boxes)

<table>
<thead>
<tr>
<th>Session</th>
<th>Time (in minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Morning (6 am – 9 am)</td>
<td></td>
</tr>
<tr>
<td>Morning (9 am – 12 noon)</td>
<td></td>
</tr>
<tr>
<td>Afternoon (12 noon – 5 pm)</td>
<td></td>
</tr>
<tr>
<td>Evening (5 pm – 8 pm)</td>
<td></td>
</tr>
<tr>
<td>Night (8 pm – 12 mid night)</td>
<td></td>
</tr>
<tr>
<td>Anytime, when I get time</td>
<td></td>
</tr>
<tr>
<td>Total minutes of Radio Listening</td>
<td></td>
</tr>
</tbody>
</table>

23. Which program do you listen on the Radio?  
(Kindly give 1st three order of preference – 1 for most preferred item, 2 for next and so on)

<table>
<thead>
<tr>
<th>Program</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bengali Music</td>
<td>Youth Program</td>
</tr>
<tr>
<td>Hindi Film Music</td>
<td>News</td>
</tr>
<tr>
<td>Radio Serials</td>
<td>Agriculture Based Program</td>
</tr>
<tr>
<td>Health Talks</td>
<td>Others (Pl Specify)</td>
</tr>
</tbody>
</table>
24. Which channel do you prefer?

(Kindly give 1st three order of preference – 1 for most preferred item, 2 for next and so on)

<table>
<thead>
<tr>
<th>Akashbani/All India Radio (AIR) – local channel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vividh Bharati</td>
</tr>
<tr>
<td>Any Other (Pl Specify)</td>
</tr>
</tbody>
</table>

25. Do you watch Television: (i) Yes (ii) No (if No, Skip to Q. No. 30)

a. If yes, when do you watch TV and for how much time in average / day?

(In case, you do not view TV in specific session, fill “0” in the corresponding boxes)

<table>
<thead>
<tr>
<th>Session</th>
<th>Time (in minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Morning (6 am – 9 am)</td>
<td></td>
</tr>
<tr>
<td>Morning (9 am – 12 noon)</td>
<td></td>
</tr>
<tr>
<td>Afternoon (12 noon – 5 pm)</td>
<td></td>
</tr>
<tr>
<td>Evening (5 pm – 8 pm)</td>
<td></td>
</tr>
<tr>
<td>Night (8 pm – 12 mid night)</td>
<td></td>
</tr>
<tr>
<td>Anytime, when I get time</td>
<td></td>
</tr>
<tr>
<td>Total minutes of TV viewing</td>
<td></td>
</tr>
</tbody>
</table>

26. Which Program do you watch on Television?

(Kindly give 1st three order of preference – 1 for most preferred item, 2 for next and so on)

<table>
<thead>
<tr>
<th>News</th>
<th>Film Song</th>
<th>Sports</th>
<th>Reality Show</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serials</td>
<td>Movies</td>
<td>Talk Show</td>
<td>Others (Pl Specify)</td>
</tr>
</tbody>
</table>

27. Which Channel do you prefer?

(Kindly give 1st three order of preference – 1 for most preferred item, 2 for next and so on)

<table>
<thead>
<tr>
<th>Doordarshan</th>
<th>ABP News</th>
<th>Astha</th>
<th>News Live</th>
</tr>
</thead>
<tbody>
<tr>
<td>ND TV 24X7</td>
<td>Zee TV</td>
<td>E TV Bangla</td>
<td>DY 365</td>
</tr>
<tr>
<td>Star Plus</td>
<td>Sony</td>
<td>Zee News</td>
<td>Frontier TV</td>
</tr>
<tr>
<td>Star Ananda</td>
<td>Aaj Tak</td>
<td>Star Jalsha</td>
<td>NE TV</td>
</tr>
<tr>
<td>Discovery Channel</td>
<td>Times Now</td>
<td>Others (Pl Specify)</td>
<td>News Time</td>
</tr>
</tbody>
</table>

28. Do you watch any health related program on TV? (i) Yes (ii) No (if No, Skip to Q. 30)

29. If yes, which health related program do you watch?

a. Talk show with Doctor    b. Kalyani    c. Any Other..........................

30. Do you access internet:  (i) Yes   (ii) No (if No, Skip to Q. No 33)

31. How often do you access internet?
(i) Once in a week    (ii) Twice in week    (iii) Thrice in a week    (iv) Daily
(v) Once in 2 week    (vi) Four times a week    (vii) Any Other (Pl Specify) .......... 

32. Do you browse any health related site? (i) Yes    (ii) No

33. Which of these traditional media are known to you? (encircle all applicable option)
   (i) Folk Song   (ii) Puppet show   (iii) Yatra   (iv) Drum Beating   (v) Miking
   (vi) Kirtan    (vii) Dhamail    (viii) Others.........................................................

34. For what activity you saw the particular media?
   (i) Awareness program about a govt. scheme   (ii) Religious program
   (iii) Cultural event   (iv) Any other...............................................

C. Health Seeking Behavior:

35. Which of the following is the nearest health facility from your home:
   (i) SC    (ii) PHC    (iii) CHC    (iv) DH    (v) Other Govt. facility    (vi) Private Facility

36. Distance from home to the nearest facility: ........................................... (in Km):

37. Do you know what type of services are provided by the nearest facility
   (i) General Medicine   (ii) Delivery Services   (iii) Laboratory Services
   (iv) Immunization   (v) Providing TB Drugs   (vi) Providing Malaria Drugs   (vii) Other.........

38. Distance from home to the District Hospital: ........................................... (in Km):

39. For any treatment of you and your family, which facility do you prefer:
   (i) SC    (ii) PHC    (iii) CHC    (iv) DH    (v) Other Govt. facility    (vi) Private facility

40. The main reason for selecting the facility:
   (i) It is nearby facility    (ii) Health staffs are very good    (iii) Cannot afford private facility
   (iii) Need not pay any fees    (iv) Free medicines are available    (v) Others....

41. Where do you go for treatment, if you do not go to the health facility during illness:
   (i) Manage at Home    (ii) Local Healer/quacks    (iii) Medical store   (iv) Others ........

42. If you are not going to the Govt. facility, what are the reasons:
   (i) Not easily accessible    (ii) No quality services    (iii) MO/ANM is not available on time
   (iv) Poor behavior of the health staffs    (v) No waiting facility    (vi) Charges money for treatment / lab tests
   (vii) No faith in Govt. facility    (viii) Others .........................

43. Did you visit nearest health facility in last six months? (i) Yes (ii) No (if No, Skip to 48)

44. If yes, why did you go to the health facility?
   (i) Self illness    (ii) Family member’s illness    (iii) To visit patient   (iv) To get information
   (v) To collect due incentive    (vi) To register a complaint    (vii) Any Other.................................
45. Who motivated you to go to hospital?
   (i) ASHA   (ii) ANM   (iii) AWW   (iv) My relative   (v) Any media   (vi) Improved health service of the health centre   (vii) Any other

46. Did you find any change in hospital with compare to your visit six month before or more?   (i) Yes   (ii) No   (iii) I did not visit before 6 months   (iv) cannot say

47. If yes, what changes did you see in your last visit?
   (i) Hospital was looking clean   (ii) More OPD load   (iii) More indoor patient
   (iv) Improved staff behaviour   (v) Given immediate response   (vi) Other

48. What was the place of birth of your last son/daughter: (i) Home (ii) Health Institution

49. Where do you prefer delivery: (i) Home (ii) Health Institution   (iii) Cannot say

50. If hospital delivery, who motivated your wife / you to go to hospital?
   (i) ASHA   (ii) AWW   (iii) Self   (iv) Media   (v) Relative   (vi) Any Other

51. If home delivery (HD), why you do not prefer Institutional delivery (ID)?
   (i) Hospital is very far   (ii) They charge bribe   (iii) Family tradition   (iv) Do not feel necessity of ID
   (v) Male doctor does delivery   (vi) Any other

52. Did you go for Antenatal Check up during pregnancy (i) Yes (ii) No (if No, Skip to 54)

53. If yes, who motivated your wife / you to go to hospital?
   (i) ASHA   (ii) AWW   (iii) Self   (iv) Media   (v) Relative   (vi) Any Other

54. Did you go for Postnatal Check (PNC) up after 2 days and within 14 days of delivery?
   (i) Yes   (ii) No (if No, Skip to Q. No 56)

55. If yes, who motivated your wife / you to go for PNC to hospital?
   (i) ASHA   (ii) AWW   (iii) Self   (iv) Media   (v) Relative   (vi) Any Other

56. Did you immunize your child?   (i) Yes   (ii) No (if No, Skip to Q. No 59)

57. If yes, who motivated you to go to hospital?
   (i) ASHA   (ii) AWW   (iii) Self   (iv) Electronic Media   (v) Print Media
   (vi) Relative   (vii) Family member   (viii) Any Other

58. Do you have child immunization card?   (i) Yes   (ii) No

D. Role of Interpersonal Communication (IPC) in Health Sector:

59. Have you ever had any interaction with the following persons in the village?
   (i) ASHA   (ii) ANM   (iii) NGO Health Worker   (iv) AWW   (v) Others

60. What kind of interaction you had?
   (i) Counseling   (ii) Group Discussion   (iii) Small Group meeting   (iv) Others

61. Where did it happen?
   (i) At your home    (ii) At AWC    (iii) At SC    (iv) Other health facility .................
62. Have you ever been attended by ASHA? (i) Yes    (ii) No (If No, Skip to Q. No.66)
63. If yes, what was the event?
   (i) Home visit    (ii) You visited the health facility    (iii) Group meeting    (iv) Others...
64. What she did during the meeting?
   (i) Awareness meeting    (ii) Discussion about various schemes
   (iii) Clarifying doubts    (iv) Imparting skills to save newborn    (v) Others ........
65. What material did she use while discussing with you?  
   (i) Flip chart    (ii) Others
66. Have you been counseled in hospital when you visited? (i) Yes    (ii) No
   (If No, Skip to Q. 70)
67. If yes, on what topic you were counseled? .................................................................
68. Was the interactive session / IPC / Counseling session useful?  
   (i) Yes    (ii) No
69. If yes, in what way it was useful: (response may be more than one)
   (i) Awareness level has increased    (ii) Improvement in health seeking behavior
   (iii) I could pass on the information to others    (iv) Others ................................................

E. Community Mobilization initiative under NRHM
70. Do you have an ASHA in the village?  
   (i) Yes    (ii) No (If No, Skip to Q. No 76)
71. If yes, do you know the name of ASHA?  
   (i) Yes    (ii) No
72. If yes, Name of ASHA.................................................................
73. Are you aware what kind of activities she does?
   (i) Awareness generation    (ii) Motivating beneficiaries    (iii) Health Service Provider
   (iv) Accompanying Pregnant Woman    (v) Immunization for children(vi) Home visits
   (vii) Holding community level meetings    (viii) Any Others.................................
74. Has she ever visited you during last 3 months?  
   (i) Yes    (ii) No
75. If yes, what did she do during her visit?  .................................................................
76. Is there VHSNC (Village Health Sanitation & Nutrition Committee) in your village? 
   (i) Yes    (ii) No    (iii) Not Aware (If No / Not Aware, Skip to Q. No 85)
77. Are you a member of the VHSNC?  
   (i) Yes    (ii) No (If No, Skip to Q. No 82)
78. Did you ever attend VHSNC meeting in the village? 
   (i) Yes    (ii) No
79. If yes, what was discussed in the VHSNC meeting?
   (i) Utilization of untied fund   (ii) Preparing Village Health Plan   (iii) Awareness meeting
   (iv) Conducting health camp(v) Others ........................................
80. What was your role in the program (VHSNC meeting)?
   (i) As volunteer   (ii) As Resource Person
   (iii) As Audience   (iv) As VHSNC Member   (v) Others .............
81. At what frequency, VHSNC sits for meeting or how many meetings were held in last six months:
   (i) Monthly,   (ii) Bi-monthly   (iii) Quarterly   (iv) Six monthly   (v) Yearly
   (vi) As and when needed   (vii) Do not know   (viii) Others.................................
82. Who is the Member Secretary of the VHSNC?   (i) ASHA   (ii) AWW   (iii) Others....
83. Do you think, villagers have been benefitted by VHSNC? (i) Yes   (ii) No
84. If yes, in what way villagers have been benefitted by VHSNC?
   (i) Provides referral transport in emergency   (ii) Gives money for buying medicine
   (iii) Constructs Public toilet for village   (iv) Disposable site for throwing waste
   (v) Takes up village cleanliness drive   (vi) Any other......................
85. Does your VHSNC organize VHND (Village Health & Nutrition Day) in the village?
   (i) Yes   (ii) No (If No, Skip to Q. No 89)
86. If yes, what are the activities done in VHND?
   (i) Awareness Generation   (ii) Immunization   (iii) Providing Ante Natal Check up
   (iv) Providing PNC   (v) Nutritional Support   (vi) Providing medicines to sick children
   (vii) Others .................................................................
87. Who attends the VHND? (response may be more than one)
   (i) ASHA   (ii) AWW   (iii) Villagers   (iv) ANM   (v) Medical officer   (vi) Others............
88. At what frequency, VHND is organized or how many meetings held in last 6 months?
   (i) At every week in a fixed day   (ii) at every 15 days   (iii) monthly   (iv) Bi-monthly
   (v) As per the wish of the ANM   (vi) Others (PI specify) .........................................
89. Were you ever been involved in preparing Village Health Action Plan (VHAP)?
   (i) Yes   (ii) No (If No, Skip to Q. No 91)
90. If yes, who took the initiative of preparing VHAP?
   (i) ASHA   (ii) ANM   (iii) AWW   (iv) ASHA Supervisor   (v) Medical Officer of the PHC
91. Do you know that VHSNC gets Rs. **10000/-** per year for taking up health care initiative in village?
   (i) Yes   (ii) No (If No, Skip to Q. No 93)
92. If yes, what is generally done with Rs. 10000/- VHSNC amount?
   (i) Helping poor patient   (ii) Giving referral amount to needy (iii) Organizing VHND
   (iv) Carrying out village cleanliness drive   (v) Any others (Pl specify) ....................

F. Mass Media Strategies:

93. Can you name some of the government health programs / schemes?
   (i) ............................................................................................................................
   (ii) ............................................................................................................................
   (iii) ............................................................................................................................

94. How did you come to know about these health schemes / programs?
   (i) News paper   (ii) Radio   (iii) TV   (iv) Flex/Banner/Poster   (v) Booklet
   (vi) Interaction with health staffs   (vii) Folk media   (viii) Any others ......................

95. Can you recall any health advertisement in newspaper? (i) Yes   (ii) No
   (if No, skip to 100)

96. If yes, what was the subject? ..................................................................................

97. What makes you able to recall the advertisement?
   (i) Content was colorful   (ii) Content was satisfying my need / desire   (iii) Presentation
   was catchy / appealing   (iv) Knew about benefits   (v) Any Others............

98. Did you try to take advantage of the advertisement? (i) Yes   (ii) No

99. If yes, what advantage you got?
   (i) Self awareness increased   (ii) Received incentive   (iii) Advised others about
   the scheme   (iv) Received service   (v) Others ..................................................

100. Can you recall any health advertisement in the Radio? (i) Yes   (ii) No
     (if No, skip to Q. 105)

101. If yes, what was the subject? ..................................................................................

102. What makes you able to recall the advertisement?
     (i) Content was brief and clear   (ii) Content was satisfying my need / desire
     (iii) Presentation was nice & appealing   (iv) Knew about benefits   (v) Others............

103. Did you try to take advantage of the advertisement? (i) Yes   (ii) No

104. If yes, what advantage you got?
     (i) Self awareness increased   (ii) Received incentive   (iii) Advised others about
     the scheme   (iv) Received better service   (v) Others ..................................................
105. Can you recall any health advertisement in the TV? (i) Yes (ii) No

(If No, skip to Q.110)

106. If yes, what was the subject? .................................................................

107. What makes you able to recall the advertisement?

(i) Content was brief and clear (ii) Content was satisfying my need / desire
(iii) Presentation was attractive & appealing (iv) Knew about benefits (v) Others...

108. Did you try to take advantage of the advertisement? (i) Yes (ii) No

(If No, skip to Q.112)

109. If yes, what advantage you got?

(i) Self awareness increased (ii) Received incentive (iii) Advised others about
the scheme (iv) Received better service (v) Others .................................

110. Did you attend any group / awareness meeting in your village on health issue?

(i) Yes (ii) No (If No, Skip to Q.113)

111. If yes, what was the subject? .................................................................

112. Did you find meeting useful? (i) Yes (ii) No (response may be more than one)

(i) Health awareness level has increased (ii) Improvement in health seeking behavior
(iii) Could pass on the information to others (iv) Any Others ......................

113. What more should be added in future to make the advertisement / health message
more attractive in newspaper?

........................................................................................................................

........................................................................................................................

........................................................................................................................

114. What more should be added in future to make the advertisement / health message
more attractive in Radio?

........................................................................................................................

........................................................................................................................

........................................................................................................................

115. What more should be added in future to make the advertisement / health message
more attractive in Television?

........................................................................................................................

........................................................................................................................
116. Did you ever attend any traditional folk show program like street play, folk song, puppet show, dhamail on health issue in your village?  (i) Yes  (ii) No  
(if No, Skip to Q. No 118)

117. If yes, what was the event? .................................................................
   a. What was the topic/theme? ..............................................................

118. What do you suggest for better community mobilization using mass media strategies?
   (i) More need analysis of the community and then designing the program  (ii) Program contents to be shared in local dialect  (iii) Repeated broadcast/presentation of the program  (iv) Any Other (Pl. specify)

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Thanks for your Support & Cooperation
Appendix
Introduction

The State of Assam is the most populous, important and the biggest State in the North-Eastern region of India with a population of 31.16 million \textit{(Census 2011)}. The State is almost isolated from the rest of the country except from a narrow corridor known as chicken’s neck running through the foothills of Himalayas. It is bordered in the North and East by the Kingdom of Bhutan and Arunachal Pradesh; along the south, it has Nagaland, Manipur and Mizoram. Meghalaya, West Bengal and Bangladesh are her Western neighbours. Its geographical area is 78,438 sq km with a population density of 397 per sq km \textit{(as per Census 2011)}. 87 per cent of the State’s population resides in the rural areas and remaining 13 per cent in urban areas. The State exhibits diverse geographical contours and largely dependent on an agrarian economy (Table 14.1).

It is also the State which has been identified by the Government of India as one of the 18 High Focus States (HFS). This categorization is based on the weak public health indicators and infrastructure. For example, maternal mortality ratio is 381 \textit{(Annual Health Survey 2010-11)} per 100,000 live births, which is the highest in the country.
Table 14.1: Demographic Trends of Assam as compared to India

<table>
<thead>
<tr>
<th></th>
<th>Assam</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (in millions)(^{a})</td>
<td>31.16</td>
<td>1210.19</td>
</tr>
<tr>
<td>Sex ratio (females/1000 males)(^{a})</td>
<td>954.00</td>
<td>940.00</td>
</tr>
<tr>
<td>Crude Birth Rate (per 1000 population)(^{b})</td>
<td>23.20</td>
<td>22.10</td>
</tr>
<tr>
<td>Crude Death Rate (per 1000 population)(^{b})</td>
<td>8.20</td>
<td>7.20</td>
</tr>
</tbody>
</table>

Source: *Census 2011; \(^{b}\)SRS December 2011.

Although the public health infrastructure of the State is weak, the public health facilities happen to be the primary providers of health care services in the State. The health care delivery system of the State follows Indian Public Health Delivery System of three-tier model. At the lowest level, Sub Centres (SC) provides public health services. The next tier is Primary Health Centres (PHCs) where basic medical care, disease prevention and health education are provided. At the top tier, Community Health Centres (CHCs) and District Hospitals (DHS) offer specialist services. The State also has medical colleges and nursing colleges. The private sector hospitals of the State are unevenly distributed and are clustered mostly in Guwahati; and the State capital like many other underdeveloped States of India. As per the State Programme Implementation Plan (2010-11), Assam has got 131 private sector hospitals spread over 13 districts. The public health infrastructure of the State can be summarized as follows:

Table 14.2: Public Health Infrastructure

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Colleges</td>
<td>4</td>
</tr>
<tr>
<td>State Level Hospital</td>
<td>1</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>24</td>
</tr>
<tr>
<td>Sub-Divisional Hospitals</td>
<td>13</td>
</tr>
<tr>
<td>CHC</td>
<td>108</td>
</tr>
<tr>
<td>PHC</td>
<td>844</td>
</tr>
<tr>
<td>SC</td>
<td>4682</td>
</tr>
<tr>
<td>B.Sc Nursing College</td>
<td>1</td>
</tr>
<tr>
<td>General Nurse Midwife (GNM) Training Centres</td>
<td>15</td>
</tr>
<tr>
<td>Auxiliary Nurse Midwife (ANM) Training Centres</td>
<td>18</td>
</tr>
</tbody>
</table>

Source: SPIP 2010-11.

The Governments at the national and State level appear to be well informed of the public health status and issues of the State and
have been forced to take note of the abysmal scenario existing at the grass roots level. Since 2005, under National Rural Health Mission (NRHM) a flagship programme of Government of India, efforts have been made by the State agency of this social sector initiative to improve the health of its region including Assam.

**Mass Media Intervention**

Mass Media are considered to be the tools for the transfer of information, concepts, and ideas to both heterogeneous and specific audiences for decades especially in the last fifty years of independent India. While in keeping with the dominant tradition of the West to use mass media as a magic multiplier of social messages, the use of mass media in the context of development especially in societies with deep rooted tradition has been a little intriguing because of the mixed results. Communicating about health through mass media has been found to be a little more complex as had already happened with family planning programme in India. Liana Winett and Lawrence Wallack (1996) argued that “using the mass media to improve public health can be like navigating a vast network of roads without any street signs—if you are not sure where you are going and why, chances are you will not reach your destination” (p. 173).

Using mass media can be counterproductive if the channels used are not audience-appropriate, or if the message being delivered is too emotional, fear arousing, or controversial. Undesirable side effects usually can be avoided through proper formative research, knowledge of the audience, experience in linking media channels to audiences, and message testing.

Sophisticated societies are dependent on mass media to deliver health information and especially electronic media have been described as “extensions of man.” G.L. Kreps and B.C. Thornton (1992) believe media extend “people’s ability to communicate, to speak to others far away, to hear messages, and to see images that would be unavailable without media” (p. 144). The value of health news is related to what gets reported and how it gets reported. According to Ray Moynihan and colleagues (1999).

The news media are an important source of information about health and medical therapies, and there is widespread interest in the quality of reporting. Previous studies have identified inaccurate coverage of published scientific papers, overstatement of adverse
effects or risks, and evidence of sensationalism. The media can also
have a positive public health role, as they did in communicating simple
warnings about the connection between Reye’s syndrome and the
use of aspirin in children (p. 1645).

Despite the potential of news media to perform valuable health
education functions, Moynihan et al., (ibid.) conclude that media
stories about medications continue to be incomplete in their coverage
of benefits, risks, and costs of drugs as well as in reporting financial
ties between clinical trial investigators and pharmaceutical
manufacturers.

The mass media are capable of facilitating short-term,
intermediate-term, and long-term effects on audiences. Short-term
objectives include exposing audiences to health concepts; creating
awareness and knowledge; altering outdated or incorrect knowledge;
and enhancing audience recall of particular advertisements or public
service announcements (PSAs), promotions, or programme names.
Intermediate-term objectives include all the earlier said objectives as
well as changes in attitudes, behaviours, and perceptions of social
norms. Finally, long-term objectives incorporate all of the
aforementioned tasks, in addition to focused restructuring of perceived
social norms, and maintenance of behaviour change. Evidence of
achieving these three tiers of objectives is useful in evaluating the
effectiveness of mass media intervention.

Mass media, in the realm of social campaign domain are expected
to perform three key functions: educating, shaping public relations,
and advocating for a particular policy or point of view. As education
tools, media not only impart knowledge, but can be part of larger
efforts (e.g., social marketing) to promote actions having social utility.
As public relations tools, media assist organizations in achieving
credibility and respect among public health opinion leaders,
stakeholders, and other gatekeepers. Finally, as advocacy tools, mass
media assist leaders in setting a policy agenda, shaping debates about
controversial issues, and gaining support for particular viewpoints.

Public Health Campaigns through Mass Media – The Conundrum

The inherent properties of various mass media have always forced
the health-message designers to consider a series of questions relative
to choice of channels:
Mass Media Intervention and Health Sector

- Which channels could be the most appropriate for the health problem and message,
- Are these channels the most likely to be considered as credible and accessible by audience,
- What are those channels which fit in with the objective of the programme (inform, influence attitudes, change behaviour), and
- What could be the most feasible channels considering advertisers' time and budget?

Maternal Health and Child Health: The Unresolved Quagmire

Reduction of maternal mortality, infant mortality and improvement in maternal and child health are the major goals in Millennium Development, to which India is a signatory. This goal can be achieved only if the maternal and child health improves in the states like Assam where the maternal and infant mortality is very high, which needs to be reduced.

Worldwide it has been recognized that the women in the reproductive age group (15-49 years) are the vulnerable fraction of the population due to risk connected with child bearing (WHO, 2004). Each year in Assam, approximately 680,000 women experience pregnancy and 612,000 have a live birth. Of these, an estimated maternal 2,998 deaths occur each year (PIP, 2010). The causes of maternal mortality in India are anaemia (24%), hemorrhage (23%), abortion (12%), toxemia (10%), puerperal sepsis (10%), malpositions (7%) and others (14%). This causes can be held true for Assam as well (WHO, 2004). The socio-cultural determinants also have a cumulative effect on maternal health. A correlation exists between gender/social inequity and maternal health. For example – the female literacy rate is 67.27 per cent, sex ratio is 954 females per 1000 males which exhibit a son preference and 36.1 per cent of the population still lives below poverty line.

Similar to national average, in Assam motherhood comes early in most of the women’s lives. About 38.6 per cent of the women are married by 18 years. Median age at first birth is 20.7 per cent; however 16 per cent of the women experience motherhood before the age of 19. Women in the rural areas (17%) are more vulnerable to begin child bearing at an early age than the urban areas (13%). This shows that motherhood comes before physical maturity of the women and
hence can have adverse consequences that could be related to pregnancy complications and maternal mortality.

Around the world, it has been recognized that pregnancy related care plays a vital role in pregnancy outcome. Antenatal checkup (ANC) helps in detecting and preventing pregnancy related complications. In Assam over 66 per cent of the women receive some sort of antenatal care from the health professionals but only 36 per cent receive at least three ANC. Only 38 per cent of women seek ANC during first trimester. Again, urban women are twice more likely to have three or more visits than women in rural areas.

The quality of care during ANC is poor. The common service received by the pregnant women during ANC is examination of abdomen (61%) and blood pressure (53%). The services of weight check (around 50%), blood and urine test (37 to 39%) is poor. Consumption of iron and folic acid (IFA) supplements is also poor; from 62 per cent of mothers only 16 per cent had consumed IFA for the recommended 90 days or more, only 2 per cent took de-worming during pregnancy.

During pregnancy along with ANC, there is also a need of skilled birth attendant (SBA) during and around delivery. In the State, out of all births 31 per cent takes place with the assistance from health professional and the remaining 69 per cent is delivered by trained birth attendant (TBA), relatives or untrained persons. The poor access to skilled professionals during delivery is justified by high home delivery. Around 78 per cent of the births take place at home and only 22 per cent in a health facility. Postpartum care is also a concern in Assam, only 16 per cent had postpartum check-up and 14 per cent received within two days of birth.

The situation of infant care is also grim in the State. Out of the home deliveries, many neonates develop complications just after the birth but due to not having adequate set-up at most of the health facilities (CHC, PHC), most of the neonates die at an early age. It is estimated that neonatal death contributes 65 per cent of the Infant deaths (as per study conducted by SEARCH, Gadchirol), the same must be true for Assam too. However, the scenario of infant deaths have improved in Assam as under NRHM, a good number of initiatives have been initiated by the Government for popularizing full ANC of pregnant mothers, institutional delivery, 48 hours stay of mother at the hospital with the new born. Even to improve the sex ratio in the State, Government of Assam has initiated scheme, where
the newborn girl child is gifted with Rs. 5000 (Five thousand only), which she can encash after 18 years.

A few of the schemes, which has largely contributed in improving the maternal and child health scenario in the State is discussed below.

1. Janani Suraksha Yojana (JSY)—A Conditional Cash Transfer to Promote Institutional Delivery

In 2005, Government of India launched Janani Suraksha Yojana (JSY) to incentivize women to give birth in a health facility (Lancet, 2010). The State of Assam has also implemented this programme to increase births in health facilities and is not limited only to the public health facilities. According to the JSY guideline, the State has also included empanelled/accredited private hospitals under PPP; the women giving birth in these health facilities are entitled for the incentive. All women in the State irrespective of socio-economic status and parity are eligible for the cash benefit (MOHFW, 2006), as the State belongs to Low Performing State (LPS). The women in rural areas receive incentive of Rs. 1,400 and Rs. 1,000 in rural areas (MOHFW, 2006). This lone initiative has helped State in multiplying institutional deliveries to a large extent. The institutional deliveries, which were just 1,49,003 in the year 2005-06 went to more than 4,53,356 in the year 2011-12 and this quantum of jump in the institutional delivery has saved lives of many mothers and infants.

1. Majoni—A Special State Assistance Scheme for New-born Girl Children

<table>
<thead>
<tr>
<th>Title</th>
<th>MAJONI—Special care for the girl child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic area of Coverage</td>
<td>In entire Assam</td>
</tr>
<tr>
<td>Target Population</td>
<td>Girl Child</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>Up to two child norms</td>
</tr>
<tr>
<td>Project Life</td>
<td>Launched on 17 February, 2009</td>
</tr>
<tr>
<td>Budget</td>
<td>Rs 100 crore per Year</td>
</tr>
<tr>
<td>Implementing Partners</td>
<td>Assam Bikashi Yojana (ABY)</td>
</tr>
</tbody>
</table>

Objectives: The key objective is to provide special attention to girl child. In Assamese, beloved girl child is named as “Majoni”.
Many a time, because of poverty, girl child is considered as burden and parent want to marry her as soon as they can. Majoni also aims to usher in radical changes in caring the girl child in the State through eliminating all kinds of gender bias and help the girl child grow with dignity.

**Strategies:** The scheme covers only the girl child born at a government hospital. On having institutional delivery, the girl (up to two child norms) gets a fixed deposit of Rs. 5000 (five thousand) in her name, which can only be encashed once the child completes 18 years of age. The photograph of both parents will have to be submitted at the time of issue of the fixed deposit and thumb impression of the child. A certificate is issued by the bank while renewing the Fixed Deposit in the name of the Girl Child wherein her photograph at 10 years, i.e., time of renewal of Fixed Deposit (photograph attested by any executive Magistrate or Revenue Officer) and a ‘life certificate’ will be stamped by the bank. Photograph at the time of maturity to be attested by the local Revenue Circle Officer/Executive Magistrate. In keeping with the policy of the government, the child beneficiary should not be married before the age of 18. However a girl child born to a mother staying in a paying cabin or a private hospital is not eligible for the assistance. The scheme has come into effect in Assam from 1st February, 2009. The beneficiaries/nominee can encash the matured policy at any branch of the scheduled bank on identification by Executive Magistrate or local revenue officer. In the event there is no claim after 18 years the maturity value against the Fixed Deposit will revert back to the Assam Bikash Yojana (ABY) account of the issuing bank.

2. **Mamoni—Nutritional Food to Pregnant Women**

<table>
<thead>
<tr>
<th>Title</th>
<th>Mamoni—Nutritional Food to Pregnant Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical area of coverage</td>
<td>In entire Assam</td>
</tr>
<tr>
<td>Target Population</td>
<td>Pregnant Women</td>
</tr>
<tr>
<td>Project Life</td>
<td>Started on 1st March, 2009</td>
</tr>
<tr>
<td>Budget</td>
<td>Rs. 80 crore per Year</td>
</tr>
<tr>
<td>Implementing Partners</td>
<td>Assam Bikash Yojana (ABY)</td>
</tr>
</tbody>
</table>

**Objectives:** Recognizing the fact that "a healthy mother begets..."
*a healthy child*, Government of Assam under Assam Bikash Yojana (ABY) launched the innovative scheme namely Ma-moni, which allows every expectant mother to get Rs. 1,000 for supplementary nutrition during pregnancy. To ensure healthy pregnancy, the importance of balanced diet along with regular antenatal check-up is important, especially calcium and iron rich diet is essential for the growth of a baby in the mother’s womb.

**Strategies:** The scheme can be availed by the mother up to two children. The expectant mother will receive a copy of the “Ma-moni” booklet at the first antenatal check-up, immediately after registration. During her second ANC, the expectant mother will also receive an A/C payee cheque of Rs. 500 and a voucher for free transfer to the hospital. The expectant mother will receive Rs. 500 at the time of the third antenatal check-up. For second and third ANC, mother will have to carry MCH card. The cash assistance can be availed of during second and third ANC in the government health institutions, which can be Sub-Centre including village health and nutrition day (VH & ND), PHC, CHC, District Hospital. The staffs of the health institutions wherever mother has registered herself will be responsible to provide information about the scheme and its importance. The pregnant woman will be entitled to receive the cash assistance only if she belongs to that village, i.e., her husband’s village. Simultaneously, she will receive the remaining amount only if she completes her third ANC in the same health institution where she did her first and second ANC. In cases, where a pregnant woman is planning her delivery in the health institution other than the health institution in her husband’s village/block/district (e.g., her maternal village) and accordingly has planned her third trimester ANC in other village/block/district. In those circumstances, it is prerequisite that she has registered herself in the SC/health institution of her husband’s village and has received Rs. 500 along with ANC materials. The ANM/doctor of the SC/health institution will certify that she can avail the assistance amount for third trimester from other health institution but the name of the block/district should be specified. The SC/health institution will disburse the cheque of remaining Rs. 500, if the pregnant woman carry the certificate and the MCH Card along with her. The ANM will prepare a village-wise list of pregnant women registered and hand it over to the ASHA of the respective village for follow-up. ASHA in the village will be responsible for follow-up of the pregnant women and will ensure through counselling that the amount is utilized for the given purpose.
Service Utilization–Institutional Delivery

Assam has shown considerable progress between 2005 and 2012, institutional deliveries have been gradually increasing from 23 per cent (NFHS 3) to 64.4 per cent (CES). This positive trend depicts that the State has been able to improve access of pregnant women to health care.

Fig. 14.1: Trend of Institutional Delivery in Assam

Fig. 14.2: Trends in Institutional Delivery, 2005-2009
However, the increase in the institutional delivery still maintains the urban and rural disparity in service utilization. The figure shows that gap between urban and rural have been reduced since 2005, still a gap of 20 per cent remains between the two areas. This describes that a focused intervention concentrating on rural areas is the need of the hour.

Moreover, while the delivered women are discharged in less than 48 hours without admitting them for post-delivery (JRM 6, 2009), 28 per cent of the women are discharged in less than 24 hours and 26 per cent within 1 day (CES, 2009). This highlights that although the institutional delivery has increased but this increase in service utilization is not complemented by post-natal care. There is no provision or initiative on post-natal practices at the facilities (JRM 6, 2009).

All these programmes/initiatives would not have yielded any result if mass media would not have generated awareness among community to avail of all these benefits. The advertisement on these new programmes come to different newspapers through which people came to know about these programmes and started availing these benefits. The role of ASHA (Accredited Social Health Activist) in generating awareness also needs to be specially mentioned. These ASHAs are also taken into confidence for propagating any new messages among the masses. The ASHAs through interpersonal/group
communication take the messages to the target group and make them convinced to take the benefits of the programmes. This mass media intervention has shown result not only in Assam but also in entire North-Eastern States, which is seen from Table 14.3 given below in the context of IMR.

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Source: SRS, Dec - 2011

Epilogue

Analyzing all the important footsteps made in improving the maternal and child health status, it can fairly be argued that the mass media appeared to have played an important role in making all these schemes popular and generated an awareness among masses to encourage them to avail the benefits of all these schemes and thus improving the maternal and child health status in the State. The situation demanded a proper choice of mass media and also a proactive role of mass media, and the combined effort of these two helped messages related to all these schemes reach the remote villages generating demand of the community to have the benefits of all these schemes. The concerned agencies, virtually forced by the situation had no other choice but to respond to the community demand and to extend the services highlighted under the scheme to the beneficiaries. The reduction in the maternal and infant death in the State to a large extent is the classic example of mass media intervention in this regard. The MMR, which was 490 as per SRS 2004-06 has come down to 381 as per Annual Health Survey, 2010-11. An independent evaluation, conducted by Regional Resource Centre for North-Eastern States (RRC-NF) in 2010-11 found out that the State’s MMR is 333. Although, it has come down, but it has to be further brought down to achieve the NRHM goal. The Infant mortality rate has also reduced.
from 66 (SRS, April '06) to 58 (SRS, Dec '11), which is seen as a big achievement. The situation of infant mortality in other North-Eastern States have also changed, which is shown in the above table. The role of mass media in tackling the challenges posed by underdeveloped health sector in the State has been a laudable one.

However, thereby hangs a tale, which needs to be told before one becomes too optimistic about the use of mass media and it is so called guaranteed success in health sector. When one gets engaged in the process of evaluating the capability of mass media intervention in the health sector, one must also understand the grey areas which demand a certain amount of clinical inspection. Mass media, although, tom toed as a magic multiplier has been rejected in many cases as it failed to caste a spell on the audience for their sheer inability to access or afford it due to both financial and literacy constraint. The idea of information rich and information poor are the ideas that germinated in mass media. While we have reached the era of new media, the burdens of poverty and illiteracy are as yet strenuous enough to stop the dispersal of any message. There have been efforts all over the world, especially the third world countries to use a right mix of mass and alternative channels of communication. Problems with mass media essentially are twofold; it treats a heterogeneous audience as a homogeneous one as in the case of advertising and including social campaigns converting the social initiatives into a case of social marketing, a major factor responsible for rejection of mass media as dominant wheels of development. Secondly, it uses a uniform code for the dissemination of messages which fails to transcend the barriers imposed by the cultural ethos of a tradition bound society. The development planners in the health sector in India on the whole and in particular in the North-East must be able to put too many eggs into the basket of mass media. It should not be treated as a panacea or the golden boy of social campaign. The campaign strategy in the health sector must be homogenized and Indianized. It has to be even so in the North-East, a place full of multicultural ethos. Multiculturalism by its very propensity rejects any effort of homogenization and the dismal scenario of any social campaign with a blanket strategy is bound to fail in this region.

While designing a message for local populace, the health development planners have to seek the help of health service seekers. It might be a little too much to expect from the development planners to reverse the well defined top down approach, but it has to be
accepted in a region which has a tradition to live in terms of cloistered societies. The messages, without a shade of doubt, has to be culture specific especially in a region where too many cultures are vying for attention and in fact is dominated by the politics of identity.

To put it more succinctly, unless and until, alternative communication channels like community radio or folk formalized messages are used hugely; it is difficult to reach the hitherto unreachable. Even though, the success of mass media in disseminating developmental messages in the health sector of Assam is remarkable compared to the abundant stories of failures in different sectors and different parts of the country of the same communication tool, the fact remains that conventional media is being increasingly treated as a dead horse in the domain of social communication without fail and without exception across the world when communication in the age of Dispersed Media is becoming increasingly culture specific.

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Women in North East India

Status, Empowerment and Development Perspectives

Harendra Sinha
Sanjay Sinha

This book, containing sixteen papers, attempts to examine the status, empowerment and development of women in North East India. Authors have discussed in detail the changing status of women in health and education, as well as socio-economic and political empowerment. Development participation in S&G schemes, roles of mass media on titled women and their linkages with environment.

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Accredited Social Health Activist (ASHA) towards Socio-economic Empowerment: A Case Study in Assam

Biraj Kanti Shome

INTRODUCTION

The Government of India launched National Rural Health Mission (NRHM) to address the health needs of rural population, especially the vulnerable sections of society in April 2005. The goal of the Mission is to improve the availability and access to quality primary health care for the people, especially for the vulnerable groups focusing the women and children. To serve the rural community, the Sub-centre is the most peripheral level of contact with the community under the public health service delivery system. This caters to a population of around 5000, but is effectively serving much larger population in most of the states. With less than 50 percent MPW (M) being available in the State, the ANM is heavily overworked, which compromise the quality of services and community aspects of services. The very nature of her job responsibilities makes
it difficult for her to take up the responsibility of a ‘Change Agent’ on health in a village. Thus a new band of community based activists, named as Accredited Social Health Activist (ASHA) has been positioned to fill this void of community processes.

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. ASHA is a health activist in the community to create awareness on health and its social determinants, mobilize the community towards local health planning and increased utilization of existing health services. She is a promoter of good health practices and also provides a minimum package of curative care as appropriate and feasible at her level and ensures timely referrals for cases requiring higher level of care/intervention.

ROLE OF ASHA

The buzzword in functioning of ASHA, as activist, is “Voluntarism”. However, the important roles of ASHA can be seen as under:

1. Plays a pivotal role in mobilizing/empowering the community in local health planning and facilitate the accountability of the existing healthcare services;

2. To create awareness in areas like nutrition, sanitation and hygiene, existing health services and their utilization;

3. Mobilize the community and assist them in accessing the services, already available at Anganwadi Centres, Sub-Centres, PHCs, CHCs, etc;

4. To work with Village Health and Sanitation Committees;

5. Counseling women on birth preparedness, immunization, contraceptive, RTI/STI, Care during illness; and
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6. Act as depot holder for ORS, IFA, chloroquine tablets, delivery kits, oral pills, condoms etc., promote construction of toilets under TSC.

ASHA is not a paid employee, but she is epitome of voluntarism, being offered token incentives. ASHAs are accountable to the community through the Gram Panchayat.

It has already been proved that high level of motivation of ASHAs have been contributing to a large extent in ensuring better reach out to people and extending them better health services. The zeal of taking more responsibilities and rendering better services by ASHAs has been multiplied because of incentivizing the performances of ASHAs. It is a known fact that the incentive always enhances the performance of human being, which in turn may enhance the quality of the health services practices by the community. This urge to earn more incentive may lead to increasing the inner drive for better performance by ASHA, which once again results into improved utilization of health services by community. Moreover, ASHA gets better social status because of her very deep social attachment, which itself gives her high esteem and satisfaction and that also motivates her to take up more responsibilities. Once, one ASHA from Azara Block PHC, Kamrup District, Assam opined “the social recognition, which I have been getting, is the driving force for me to continue as ASHA”. The exemplary performances of ASHAs has helped in registering improved performances of the state in terms of institutional deliveries, full immunization, holding Village Health & Nutrition Days (VHND) has also increased. The institutional delivery, which was 23.2 (DLHSII, 2002-04) went to 73.1 (RRC-NE, 2011), Full immunization increased from 16 (DLHSII, 2002-04) to 78 (RRC-NE, 2011). Even other agency like UNICEF has also confirmed this increase in institutional delivery and in full immunization. ASHA, who is little literate and was not doing anything (most of them were housewives) has got confidence through regular training, supportive supervision.
and now they are instrumental not only in bringing change in health care scenario in the village but also at household level.

The empowerment of ASHAs is not restricted to only health sector. Many of the ASHAs contested in last panchayat election held in Assam, where in many of them got selected as member of the panchayat. This is undoubtedly can be seen as a process of empowerment for the ASHA because, a housewife, who was not known in the village got elected as panchayat member because of her good work as ASHA. As because ASHA is a known name in the community, so in various village level affairs ASHA is now consulted in different village level affairs, where she shares her views in the process of taking decision. Based on the good work being performed by ASHA in reaching the rural community at large, many other departments like Panchayat and Rural development (P & RD), Social Welfare, Total Sanitation Campaign under Public Health Engineering Department are also citing on ASHA to use her as vehicle in reaching the rural community for achieving the objectives of the respective department.

There are 29693 ASHAs working in Assam, who have been trained in ASHA Module 1-5 for 23 days (7+4+4+4+4) and now module 6 and 7 training is going on. Under module 6 and 7, ASHA will be trained for 20 days (5 days each for 4 rounds). Under module 1-4, ASHAs were trained in health thematic areas, like maternal health, child health, immunization, tuberculosis, malaria, HIV/AIDS etc and in module 5, ASHAs were trained on soft skills, like how to communicate, negotiate, leadership skills etc. The module 5 was very much important because in absence of these soft skills, ASHAs will not be able to take the inputs gathered in module 1-4 to the masses. Under module 6 & 7, ASHAs are given special training on how to take care of the newborn (with 0-28 days) and thus to bring down the rate of infant mortality rate. Taking care of new born is so much important because it is estimated that neonatal
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mortality contributes almost 65 percent of the infant mortality rate. So, to bring down the infant mortality, the utmost thrust has to be given on neonatal survival. With this aim, the ASHAs are trained on module 6 and 7.

In family life too her contribution has increased over the years. Because of her earning, she is now better consulted in family decision-making and she gets due recognition for what she does. She is now more independent in running her life as she can decide what she wants to do for the welfare of the family. Most importantly, the bargaining power is now in her hands. With her earning, she can support her husband / family to maintain the family expenditure and that results better understanding in family. In village life too, she is getting high degree of respect from the villagers as she is the one who is available at the villager’s call and has been responding to their need. She is even seen as a person next to doctor in the village as the person, who responds immediately in case of any medical need.

Recently, during field visit, it was tried to look at the ASHAs monthly income on an average in Assam in two districts (Sibsagar and Nalbari District). It was seen that the average ASHAs can earn Rs. 1,200 to Rs. 1,500 per month and few of them can even earn more than Rs. 3,000 per month. Very few ASHAs have been found earning in between Rs. 700 to Rs. 1,000 per month. Even if we take Rs. 1,200 as average earning per month then also it can be said that ASHAs are in the path of economic empowerment. This Rs. 1,200 per month has given her a voice in the family and also in the community, which is an encouraging trend.

ASHA AND SOCIO-ECONOMIC EMPOWERMENT: A CASE STUDY

To cite a classic example of socio-economic empowerment through ASHA, a case study was conducted in a remote village of Assam.
Sairun Nessa (40) is a resident of Khilorbond, village Burungga Gaon Panchayat under Patharkandi block PHC of Karimganj district of Assam. This BPHC covers population 335753 (as per ANMs report April 2010). Khilorbond village falls under Khilorbond Sub Centre, which has 2 ANMs, namely Mrs. Namita Deb Roy & Ms. Binita Sinha. Mr. Mainul Haque, husband of Mrs. Sairun Nessa, is a farmer. She has three sons and two daughters. Both daughters are married and all three sons are reading in class X, VIII and V respectively. Since her early age, she is deeply involved into many social welfare activities like intensive pulse polio immunization campaign, forming self help group (SHG) etc. Because of her social involvement, her name is well known by the villagers. "Chaturango" - a renowned social organization of Patharkandi has been working in health, economic empowerment in and around Khilorbond area and Sairun Nessa takes active part as and when activities are taken up by the organization. Sairun Nessa says "Activities, what I perform as an ASHA have given new direction to my life".

While selecting ASHA in the village, villagers of Khilorbond unanimously decided to select her as ASHA. Thus, she has been covering two villages namely Khilorbond, and Madhurbond with population 960 and 660 respectively. She got induction training as ASHA during Feb. 2007 and followed by other training from module 2 to 6.

To begin with her activities as ASHA, she carried out survey and listed out potential target groups. After survey, she planned to popularize institutional delivery among the villagers as the institutional delivery figure was very poor. Accordingly, she started making regular home visits to convince mother as well as other family members for preferring ANC services followed by institutional delivery and finally availing post delivery follow up support from concerned ANM. Because of her own initiative and social acceptance, she could successfully mobilize expectant mothers and their family members to go for ANC services
and also for institutional delivery. Till Jan. 2011, she could bring 249 (2006-07 – 14, 2007-08 – 71, 2008-09 – 52, 2009-10 – 70, 2010 till Jan. 2011 – 42) cases since May 2006, which undoubtedly needs to be termed as huge success considering the fact that the population she has been catering belongs to Muslim minority. She is also involved in mobilizing community for increasing routine immunization coverage, organizing village health and nutrition day etc. She has also facilitated in getting 9 (nine) cataract operation done, 11 cases of non scalpel vasectomy (NSV) etc. She has also been working as DOTS provider for 13 cases, where from she gets incentive. She knows how to use Rapid Diagnostic Kits (RDK) to identify malaria. She has made the job of concerned ANM easier as she moves around the village and collects all necessary information for her and also extends support as per need. The ANM also opined that because of Mrs. Nessa’s involvement in the community she (ANM) can ensure better ANC, immunization coverage, successful holding of VH& ND.

The incentives, whatever she earns after performing different activities under NRHM, she has bought 5.5 bighas of agricultural land. Now, she gets enough rice from her agricultural land. While describing this achievement, she started crying because of extreme happiness. Her husband also supports her and takes her advice in running the family as she also now earns for the family. Her position in the family has improved as far as decision-making process in the family is concerned. She is also a member of SHG and also has been facilitating the functioning of 10 other SHGs, promoted by Chaturango, Patharkandi. As she facilitates other 10 groups, she also earns facilitation fee for those groups. All these groups are functioning well so these groups are awarded Rs. 25,000 (twenty-five thousand) as revolving fund by the Patharkandi Development Block and for successfully using the revolving fund money, her group is given credit of Rs. 2,25,000 (two lakh twenty-five thousand) in Dec. 2007 by the Patharkandi Development Block. The members of the
group have bought cows and centrally milk is collected and sold in a shop. This group is paid back the loan amount and got Rs. 5 lakh as loan. While highlighting the process of empowerment of the SHG members, she said that almost all the SHG members have at least learnt how to put signature. One of the group members namely, Labjan Bibi has constructed a house almost spending 2 lakh rupees using the profit, whatever she earned from business. All these active involvement has helped her in getting community’s confidence and carrying out job efficiently.

Mrs. Nessa further said that the president of the VH and SC also help her whenever she approaches with any good proposal. The VH and SC has received fund and have been making expenditure in a most innovative way. The VH and SC organizes health baby show, dharmail (Bengali folk) competition and gives away prizes. Other than programmatic incentive, sometime she gets gift from mothers, after delivery. She was so happy while sharing the fact that in her younger daughter’s marriage, she gave seven saris, which she got as gift.

Sairun Nessa is a classic example of empowered ASHA. ASHAs, who are struggling hard in achieving success, can follow her to learn her techniques of winning community’s heart and to become successful ASHA and thus realizing the goal of NRHM as well as ensuring personal growth.

CONCLUSION

In fine, it needs to be said that because of ASHAs high sense of voluntarism, which has led to their active involvement, the state of Assam has achieved a lot in improving the health care delivery system and it is hoped that ASHAs would maintain this spirit so as to emerge as a classic example of empowered women in the community.
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