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Sources of Maternal Health Information among Rural Women: A Study of Karimganj District, Assam

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ABSTRACT : *Communication has become widely accepted all over the developing world as a potent tool for rural development. Pregnancy and childbirth have a huge impact on the physical, mental, emotional, and socioeconomic health of women and their families. Pregnancy related health outcomes are influenced by a woman's health and other factors like race, ethnicity, age, education and income. The application of communication to influence fertility is natural extension of the basic idea that the media can both inform and motivate people. Communication efforts have become increasingly widespread in the developing world as part of international technical assistance and government programs designed to reduce fertility. This paper is based on a study carried out to find out the existing knowledge and awareness related to maternal health and what communication media are used by rural women in Karimganj district as sources of information.*

KEY WORDS: *Development, rural development, women and maternal health.*

I. DEVELOPMENT

The term development connotes overall development that involves change in social structures, attitudes, institutions, economic growth, reduction of inequality and the eradication of poverty. Development encompasses continuous change in a variety of aspects of human society. The dimensions of development are extremely diverse, including economic, social, political, legal and institutional structures, technology in various forms, the environment, religion, the arts and culture (Corbridge, 1995). It is a comprehensive and multidimensional concept that involves the development of agriculture and allied activities, village and cottage industries and crafts, socio-economic infrastructure, community services and facilities and, above all, human resources in rural areas. A country can grow rapidly, but still do badly in terms of literacy, health, life expectancy and nutrition. Development is an integrated process of expansion of substantive freedom from famine and malnutrition, freedom from poverty, access to health care, and freedom from premature mortality (Amartya Sen 1999). The prime goal of development is to improve the quality of life of the people by alleviating poverty through the instrument of self-employment and wage employment programmes, and by providing community infrastructure facilities such as drinking water, electricity, road connectivity, health facilities and education and promoting decentralization of powers to strengthen the *Panchayat raj* institutions.

II. RURAL DEVELOPMENT

Rural development has been an integral part of nation's socio-economic and political development (Santha Govind, G. Tamilselvi & j. Meenambigai, 2010). Srivastava (1961) opined that, *".Rural is an area, where the people are engaged in primary industry in the sense that they produce things directly for the first time in cooperation with nature".* Rural development is a strategy designed to improve the economic and social life of rural poor (Agarwal 1989). India is a country of villages where about 50% of the villages have very poor socio-economic status. Rural development is an integrated concept of growth and poverty elimination has been of paramount concern in all the consequent five year plans. Rural Development programmes comprises of *1) Provision of basic infrastructure facilities e.g. schools, health facilities, roads, drinking water, electrification etc, 2) Improving agricultural productivity, 3) Provision of social services like health and education for socio-economic development, 4) Implementation of schemes for the promotion of rural industry, providing rural employment etc, 5) Assistance to individual families and Self Help Groups (SHG) living below poverty line by providing productive resources through credit and subsidy.*

III. WOMEN AND MATERNAL HEALTH

ISSUES REGARDING HEALTH

The magnitude of women's reproductive health problems in India is a serious matter of concern. Among the reproductive health parameters ***'antenatal care (ANC) and safe delivery'*** have important positions as these are directly related with maternal morbidity and mortality,

etc. Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. In 1996, safe motherhood and child health services were incorporated into the ***Reproductive and Child Health Programme (RCH)***. ***The Safe Motherhood Initiative*** is a global effort that aims to reduce deaths and illnesses among women and infants, especially in developing countries. Regional disparities in maternal and neonatal mortality are wide. The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. The morbidity rate of women is higher than the men in India. Due ignorance and lack of knowledge women do not know to ask whom and where to go for privacy matters of their health. It might be for sexual affairs, using contraceptives, STD related diseases and even for HIV test also. Realizing the adverse effects of an expansion of the human population, organizations such as the **International Planned Parenthood Federation and the population Council were created in 1952**. India became the first country to adopt an official policy to reduce population growth by promoting family planning (John Bongarts, 1994). India's concern for controlling its population is reflected in its first five year plans. In this plan, importance was given to changing the attitudes of people in favour of using the contraceptives, spacing between child to child and to adopt family planning. **During the Fourth Five Year Plan (1969-74), an integrated approach, i.e. integrating family planning with health, maternity, child health care and nutrition** services at all levels was adopted. **In 1976, a New Population Policy** was announced which aimed at direct assault on the problem, i.e. pressurizing the people to adopt family planning. As a part of this policy, minimum marriageable age for girls was raised from 15 to 18 years and for boys from 18 to 21. A higher incidence of mortality and morbidity is found to occur among woman and girls who are poor or low-income, less educated and belong to socially disadvantaged castes and tribes. Despite impressive economic growth, majority of the female health indicators have not yet changed noticeably and still remain amongst the most vulnerable members of society.

IV. OBJECTIVES

The following objectives were formulated to guide the study:

- To assess the "existing" knowledge and awareness related to maternal health among rural women in Karimganj district.
- To identify the major sources of information among the rural women in Karimganj district.

V. MATERIAL AND METHODS

Study Setting

The study is located in the Karimganj district of Barak Valley, in the Southern part of Assam, a state in the north-eastern corner of India. Together with two other neighbouring districts Silchar and Hailakandi, it constitutes the Barak Valley zone. Total area of the district is 1809 Sq.kms. which comprises of varied geographical features like agricultural plains, shallow wetlands, hilly terrains and forests. As per 2011 census report the population of the valley is 3,612,581. The district is comprised of 7 blocks, because of the convenience and limited resources like time, money and energy among these seven blocks; one village from each block was covered for the project. Namely Masly (Badarpur block), Sadarashi (North Karimganj block), Alongjuri (South Karimganj block), Moina (Patherkandi block), Sibergool (Lowairpoa block), Dargarbond (R.K. Nagar block) Beratuk (Dullavchera block).

Study Sample

A list of rural married women age between 15-35 years was prepared from that area. By using systematic random sampling procedure a total of 350 respondents were selected for the study covering fifty respondents from each village on the basis of voter list.

Instrument for data collection

The assessment was conducted using a structured schedule. Face to face survey schedule were administered by the researcher because of the low literacy level amongst the women in the study population. The required information was obtained with the help of well structured and pr-tested schedule using personal interview method. The questions in the knowledge test consisted of their awareness for antenatal checkups, immunization, exclusive breast feeding, family planning etc. Schedule for the survey were prepared in English and took about 15-20 minutes to complete. Most of the respondents were housewives, agricultural labourers they were busy with farm and home activities. They were contacted individually at their residence as per convenience.

VI. DATA ANALYSIS AND FINDINGS

TABLE 1: Respondents awareness regarding child immunization

OPTION	FREQUENCY	PERCENTAGE
OPV	82	**23.42**
BCG	61	**17.42**
DPT	54	**15.42**
Measles	49	**14.0**
Total no. of fully immunized	246	
Not immunized	104	**29.71**
Total	**350**	

Mothers were asked about the immunization received by each of their eligible children, and where possible, this information was verified by crosschecking against the child's vaccination card. According to the survey, 82 (23.42%) of infants received OPV, 61 (17.42%) BCG, 54 (15.42%) DPT, a slightly lower proportion of children 49 (14.0%) received the measles vaccine and 104 (29.71%) were not immunized. In the case of female children, coverage was significantly higher among Hindus and in literate families. Knowledge about Hepatitis B was very less.

TABLE 2: Reasons for Not Immunizing Children

Unaware of the need	60	**57.69**
No faith in vaccination	18	**17.30**
Place/time of vaccination was not known	13	**12.5**
Family problem	8	**7.69**
Fear of side effects	5	**4.80**
Total	**104**	

Out of 104 those who were not immunized, 60 (57.69%) mothers of the children are unaware of the need for immunization, followed by 18 (17.30%) with no faith in vaccination, 13 (12.5%) the place or time of vaccination was not known, 8 (7.69%) family problem, and 5(4.80%) fear of side effects.

TABLE 3: Sources of information about the programme

OPTION	FREQUENCY	PERCENTAGE
Health workers	158	**64.22**
Radio	57	**23.17**
Newspaper	14	**5.69**
TV	10	**4.06**
Hoarding	7	**2.84**
Folk media	-	**-**
Total	**246**	

Out of 246 major sources of information about Vaccine Preventable Diseases was mainly from health workers 158 (64.22%), followed by 57 (23.17%) radio, 14 (5.69%) newspaper, 10 (4.06%) TV, 7 (2.84) hoarding. Most women reported that the ANM and ASHA are key facilitators for immunization and a trusted source of information and advice on health issues.

TABLE 4: Respondents awareness regarding spacing of birth

OPTION	FREQUENCY	PERCENTAGE
Not aware	241	**68.85**
Less than 24 months	50	**14.28**
3 years	35	**10.0**
4 years or more	24	**6.85**
Total awareness	109	
Total	**350**	

Out of 350 majority of the respondents 241(68.85%) left this matter to God and they were actually not in favour of birth-spacing, followed by 50 (14.28%) mentioned a 'too short' interval (less than 24 months) as ideal space between births, 35 (10.0%) preferred 3 years, 24 (6.85%) preferred 4 years or more. Male respondents, however, preferred to have the next birth within a comparatively shorter interval. Among the respondents who had high school or college education, preferred a longer interval.

TABLE 5: Sources of information

OPTION	FREQUENCY	PERCENTAGE
Health workers	64	**58.71**
Radio	40	**36.79**
TV	5	**4.58**
Newspaper	-	-
Hoarding	-	-
Folk media	-	-
Total	**109**	

Out of 109 those who are aware, health workers were the most cited source of information 64 (58.71%) followed by 40 (36.79%) radio, 5 (4.58%) TV.

TABLE 6: Respondents awareness about TT immunization during pregnancy

OPTION	FREQUENCY	PERCENTAGE
Aware	101	**28.85**
Not aware	249	**71.14**
Total	**350**	

Most of the respondents had little knowledge on immunization and received two or more tetanus injections while pregnant 101 (28.85%), followed by 249 (71.14%) had no knowledge at all. There were still misconceptions among rural women in Karimganj district like sterility and many respondents considered it as ineffective.

TABLE 7: Sources of information

OPTION	FREQUENCY	PERCENTAGE
Health workers	59	**58.41**
Radio	36	**35.64**
Newspaper	6	**5.94**
TV	-	-
Hoarding	-	-
Folk media	-	-
Total	**101**	

Out of 101 majority of the respondents 59 (58.41%) who had more visits from health workers showed a significantly higher immunization rate, followed by 36 (35.64%) radio, newspaper 6 (5.94%). This was due to better awareness associated with visits from health workers.

TABLE 8: Awareness about various provisions given in JSY scheme

OPTION	FREQUENCY	PERCENTAGE
Monetary benefit	209	**59.71**
Accompanying person	87	**24.85**
Accompanying person to escort pregnant woman	54	**15.42**
Total	**350**	

Majority 209 (59.71%) were aware of monetary benefits and exact amount of money given to beneficiaries, followed by 87 (24.85%) were aware about the payment to accompanying person under scheme, 54 (15.42%)

respondents reported there is a provision of accompanying person to escort pregnant woman to health care facility.

TABLE 9: Sources of information

OPTION	FREQUENCY	PERCENTAGE
Health workers	277	**79.14**
Radio	58	**16.57**
Newspaper	-	**-**
TV	5	**1.42**
Hoarding	10	**2.85**
Folk media	-	**-**
Total	**350**	

Source of knowledge about these initiatives are predominantly ASHA/ANM 277 (79.14%), followed by 58 (16.57%) radio, 5 (1.42%) TV, hoarding 10 (2.85%). As far as source of the awareness of the scheme is concerned, most of the mothers knew about the scheme from ASHAs. They also reported having heard about the scheme from their relatives and friends.

TABLE 10: Respondents awareness regarding family planning

OPTION	FREQUENCY	PERCENTAGE
Aware	297	**84.85**
Not aware	53	**15.14**
Total	**350**	

Majority respondents 297 (84.85%) said that they considered family planning for the health of the mother and their children. Lack of knowledge of family planning was cited by 53 (15.14%) of women who do not intend to use a method in the future.

TABLE 12: Adoption of family planning methods among the respondents

OPTION	FREQUENCY	PERCENTAGE
Sterilization	51	**53.68**
Copper-t	25	**26.31**
Oral pills	11	**11.57**
Others	8	**8.42**
Total no. of adoption	95	
Not adopted	202	**68.01**
Total	**297**	

Out of 297 respondents, those who know and have children, only 95 (31.98%) respondents have adopted permanent family planning and 202 (68.01%) respondents who disapproved of contraceptive use. Out of 95, 51 (53.68%) respondents adopted sterilization followed by 25 (26.31%) copper-t, 11 (11.57%) oral pills and 8 (8.42%) others.

TABLE 13: Sources of information

OPTION	FREQUENCY	PERCENTAGE
Health workers	47	**49.47**
Radio	31	**32.63**
TV	8	**8.42**
Hoarding	7	**7.36**
Newspaper	2	**2.10**
Folk media	-	**-**
Total	**95**	

Out of 95, the main source of knowledge was health workers as reported by 47 (49.47%), followed by 31 (32.63%) radio, 8 (8.42%) TV, 7 (7.36%) hoarding, 2 (2.10%) newspaper. women with more education, and women in the higher wealth quintiles are more likely to have been exposed to family planning messages in the media.

TABLE 14: Respondents awareness regarding institutional delivery

OPTION	FREQUENCY	PERCENTAGE
Home	218	**62.28**
Government facility	102	**29.14**
Private facility	30	**8.57**
Total no. of institutional delivery	132	
Total	**350**	

Of the total respondents, majority of them 218 (62.28%) delivered at home claiming that home was best place for giving birth and were assisted by family members, followed by only 102 (29.14%) of them gave birth at health facilities, 30 (8.57%) in a private facility. Key reasons for not delivering in a health facility, as reported by women, were the perception that the delivery was normal and hence it was not necessary to go to a facility, elders' decision, poverty leading to non-availability of ready cash to meet immediate expenses as institutional delivery costs too much etc.

TABLE 15: Sources of information

OPTION	FREQUENCY	PERCENTAGE
Health workers	79	**59.84**
Radio	44	**33.3**
TV	6	**4.54**
Newspaper	3	**2.27**
Hoarding	-	**-**
Folk media	-	**-**
Total	**132**	

Out of 132 those who are aware about institutional delivery, the main source of knowledge was health workers as reported by 79 (59.84%), followed by 44 (33.3%) radio, 6 (4.54%) TV, 3 (2.27%) newspaper. JSY seeks to promote institutional delivery by providing a cash incentive to mothers who deliver their babies in a health facility.

TABLE 16: Respondents awareness regarding anti/post natal check up

OPTION	FREQUENCY	PERCENTAGE
Aware	82	**23.42**
Not aware	268	**76.57**
Total	**350**	

The prevalence of anti/post natal care coverage is still low among rural women in Karimganj district. The results show a discouraging picture of antenatal care utilization by respondents. Among those who did obtain care only about 82 (23.42%) received antenatal care before the sixth months of gestation from a medically trained provider (i.e. Doctor/ nurse/ midwife) while majority 268 (76.57%) did not obtain any care.

TABLE 17: Sources of information

OPTION	FREQUENCY	PERCENTAGE
Health workers	41	**50.00**
Radio	27	**32.92**
Newspaper	8	**9.75**
TV	6	**7.31**
Hoarding	-	**-**
Folk media	-	**-**
Total	**82**	

About anti/post natal care, out of 82 the majority of the respondents 41 (50.00%) reported hearing about these through health workers, followed by 27 (32.92%) radio, 8 (9.75%) newspaper, 6 (7.31%) TV.

TABLE 18: Respondents awareness regarding initiation of breast-feeding

OPTION	FREQUENCY	PERCENTAGE
After one hour	208	**59.42**
Six hours later	90	**25.71**
Twelve hours later or more	52	**14.85**
Total	**350**	

Women in rural areas of Karimganj district have a very positive attitude toward the initiation of breastfeeding. About 208 (59.42%) of the children below 3 years were breastfed after one hour of birth followed by 90 (25.71%) six hours later, 52 (14.85%) twelve hours later or more. Majority of the women had admitted that someone had helped them out in initiating breastfeeding. Many sources have been responsible for this initiation.

TABLE 19: Sources of information

OPTION	FREQUENCY	PERCENTAGE
Health workers	271	**77.42**
Radio	44	**12.57**
Newspaper	18	**5.14**
TV	10	**2.85**
Hoarding	7	**2.00**
Folk media	-	**-**
Total	**350**	

Majority 271 (77.42%) of the mothers were influenced not only by health workers but also elderly female family members like mother, mother-in law/ Grandma, regarding exclusive breast feeding 44 (12.57%) radio followed by, 18 (5.14%) newspaper, 10 (2.85%) TV, 7 (2.00%) hoarding.

VII. DISCUSSION

The above findings revealed a number of similar previous research findings about the realities of communication in the rural sector. Low literacy level among rural women in Karimganj district is one of the major barriers to exposure to the print media. The study has also showed the relative unimportance of the mass media, with the exception of radio, as sources of information and the importance of such interpersonal communication channels such as health workers (ASHA/ANM) and relatives. In context of rural women in karimganj district it is gratifying to note from the findings of this study that radio and health workers (ASHA) are major sources of information regarding maternal health issues among the rural women. Radio happens to be an exceptionally powerful mass medium for the rural people though television claims to have a wider influence on the imagination of the people.

The influence of mass media has been offset to an extent by the intervention of government/non-governmental workers at the door-to-door level. It was observed that rural women in villages are now becoming increasingly dependent on interpersonal communication and are more interested in meetings and group discussions in comparison to utilizing other modern tools of media. It is true that modern mass media are flourishing but these are not performing the expected role among the rural people due to several reasons like illiteracy, poverty, lack electricity and many others. Folk media are part and parcel of rural people, but their viewership/utilization is getting reduced. With regard to the awareness about the health issues, it is revealed that the role of folk media as source of information is insignificant.

Yet since a considerable number of respondents said that they are interested in folk media, the potentialities of folk media cannot be underestimated/ undermined. From the analysis, it is event that any strategy for effectively communicating development programmes to rural women in Karimganj district must combine both folk/mass media, particularly radio, with interpersonal interaction. Such a strategy will not only complements the power of the mass media to widely disseminate messages but also can create awareness among rural women of karimganj district for development.

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