

**Research Report-2019**

**Community Radio in Family Health and  
Nutrition Awareness Building among the  
Listeners**

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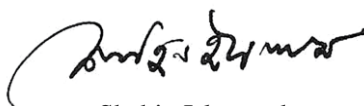
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# **Community Radio in Family Health, Nutrition and Awareness Building among Rural Listeners**

## **Preface**

Bangladesh has achieved impressive progress in the health and nutrition sector in the last few decades. It is one of the few countries to achieve most of its Millennium Development Goals (MDGs). The country has substantially reduced six preventable and diarrhoeal diseases. A sizeable drop took place in infant, under five, and maternal mortality. People's access to clean water and sanitation has increased. However, the country is still facing challenges in the areas of prenatal and post delivery care along with nutritional deficiencies and the dependency on non-skilled birth attendants. Low level of knowledge and lack of awareness are some of the major impediments to healthcare in Bangladesh. Mass media campaign on public health issues can be an effective tool to create awareness and improve health related behavior of the people. Among the mass media tools, community radio, due to its intimate community orientation, is considered valuable in facilitating and encouraging social change. In this context, the National Institute of Mass Communication (NIMC) has supported a research work to evaluate the effects of Community Radio on family health and nutritional awareness of the listeners. Three radio stations from three districts namely Rajshahi, Satkhira and Barguna districts were considered for the research from the period March to June, 2019. The research project revealed several crucial findings related to the objectives. Availability, access and ownership of Community Radio in the study area and listeners preferences of media were explored along with the challenges of improvement of quality health and nutrition programs. Important determinants of listening to community radio, health and nutrition programs were also examined. The findings of this study would be very helpful for developing effective strategies to influence people's health related behavior using Community Radio. I would like to express sincere appreciation for the researcher, Dr. Md. Mamun-ur-Rashid as well as all those who were concerned with this research.



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## Abstract

*Community radio has enormous potential in facilitating and encouraging social change and development through changing people's behavior, attitude, and awareness. This research was aimed at assessing the effect of community radio in family health and nutrition awareness building among the listeners in Bangladesh. The research was conducted on the audience of three selected radio stations, such as Radio Padma, Radio Nalta and Radio Lokobeter in three separate districts namely Rajshahi, Satkhira, and Barguna in the period March to April, 2019. To reach the objectives, this research adopted a mixed method approach and deployed Structured Interviews, Focus Group Discussions, and key Informant Interviews for collecting qualitative and quantitative data. The structured interview considered 605 randomly selected individuals proportionately from three study areas. The findings of the study show that 85% of the respondents listen CR programs, while 52% of the respondents listen at least one health and/or nutrition program at least once in last six months. Little more than three quarters (75.6%) of the respondents had very easy access to CR and 57% of the respondents enjoyed the availability of strong CR network. Most of the respondents (82%) own cell phone and a very small percentage (5.6%) own radio sets either by themselves or by family. The main purpose of using CR was entertainment followed by knowledge and information. Among different types of health and nutrition programs broadcast on CR, the most listened programs were Public Service Announcement (PSA) (WM = 1.70) followed by drama (WM= 1.49) and song (WM= 1.31). Multiple regression analysis shows that listening CR health and nutrition programs significantly influence respondent's family health and nutrition awareness, where listeners had 26.1% more probability of having awareness compared to non listeners. The majority of the respondents in qualitative data collection also agreed that CR health and nutrition programs had a profound effect on their family health and nutrition awareness. Present health and nutrition programs broadcast on CR had several shortcomings, such as short duration and limited number of programs, less promotion of program time and content, and inadequate planning for developing programs. Radio stations confronted several challenges, such as lack of resources and skilled workers, weak transmission system, the unavailability of physicians for providing expert opinion, etc., in broadcasting quality health and nutrition programs. Logistic regression analysis confirmed that availability of electricity, gender, health and nutrition training and use of other electronic media significantly influenced the person's probability of listening CR health and nutrition programs. As suggested by the respondents, the number of CR health and nutrition programs listener can be increased by giving wide publicity to the program time and content, developing and managing active listener clubs, making more participatory programs, and creating space for audience participation via quiz after programs, etc.*

**Key words:** Community Radio; Listeners; Awareness; Health; Nutrition; Bangladesh

# CHAPTER 1

## INTRODUCTION

### 1.1 Study Background

Bangladesh has experienced impressive progress in health sector in last three decades. The country has become one of the few countries to reach its Millennium Development Goals (MDG) as under five mortality and maternal mortality has dropped by 66 % and 75% respectively in last 25 years (USAID, 2018). From the year 2010 to 2016, infant mortality has plummeted from 37.4% to 30.5%, while access to clean water and sanitation has been increased from 54% to 98.9% and 34% to 70% respectively ( BBS and MOHFW in CRI, 2018). Bangladesh also meets MDG target in the reduction of underweight children, which shows 23% reduction in the period 2004 to 2014, dropped from 43% to 33% (MDG progress report, 2012; Bangladesh Demographic and Health Survey, 2014).

The nutrition sector of the country also represents a progressive scenario in last few decades. Between the years 1990 to 2014, the number of stunted children, underweight children, and wasted children has been dropped by 40%, 47% and 18% respectively (CRI, 2018). The percentage of undernourished women was also reduced from 52% to 24% between the period 1990 and 2011(Bangladesh Demographic and Health Survey, 2011). The proportion of the population failed to consume recommended level of dietary energy also declined from 28% to 17% in the same period (Bangladesh Health Bulletin, 2013).

### 1.2 Problem Statement

Despite remarkable progress made by the Bangladesh in health sector, improvements in the nutritional status of children and women have been less impressive (MDGIF, nd.). The levels of malnutrition in Bangladesh are amongst the highest in the world, and this is a major reason of death and disease in children and women (UNICEF, 2018).Malnutrition in children, adolescents and women is still a major concern. Of the 15 million under 5 children in Bangladesh, approximately 6.2 million (41%) are stunted (Bangladesh Demographic and Health Survey, 2011). These undernourished children have an elevated risk of mortality, illness and infections, delayed development, cognitive deficits, poorer school performance, and fewer years in school.

The prevalence of underweight among children aged less than five years is still high (41%). Nearly one-third of the women are undernourished having Body Mass Index  $<18.5 \text{ kg/m}^2$ . Maternal under nutrition peaks at 38% among women 15–19 years of age, who have had a birth in the past 3 years. The prevalence of anemia among young infants, adolescent

girls and pregnant women is still at undesirable levels (Ahmed et al., 2012). Anemia affects half of pregnant women (Chaparro et al., 2014). Not only the high maternal anemia, according to Bangladesh Demographic and Health Survey data in 2011, half of children under 5 are anemic and an alarming proportion of children 6–23 months of age are anemic (71%).

### **1.3 Justification of the Study**

At present Bangladesh is facing a number of challenges in health sector. Among these challenges one of the major challenge is improving healthcare seeking behavior such as education, awareness-raising and skill building (UNICEF, 2018). Low levels of knowledge and awareness is one of the major deterrents in health care use (Kalam, 2018). Public health mass media campaigns and social marketing campaigns is an effective tool and widely used to improve health behaviors, attitudes, and awareness of people (Milat et al., 2005; Randolph et al., 2012).

Community radio (CR) has been considered as a valuable tool in facilitating and encouraging social change and development by producing programs that are community focused and relevant, addressing community specific issues and concerns (James, 2007; Dagon, 2001). According to Bangladesh NGOs Network for Radio and Communication (BNNRC), there are 17 CR stations licensed by the Information Ministry covering a large number of audiences. They are playing a vital role in providing entertainment, news, education, weather forecasts, daily market prices, information on topics like agriculture, health, sanitation and climate change, as well as building awareness on important social issues, like child and women's rights (Debnath, 2018). Deplorably, present status and effect of CR programs remain largely unknown due to paucity of research, which is indispensable for further development and utilization of CR programs. Hence, it is essential to carry out a research on the effect of CR programs on health and nutrition awareness of the listeners for better use of CR health and nutrition programs in raising awareness.

### **1.4 Review of literature**

Community Radio is a broadcasting system established by the efforts of a specific community, operated by the community for the purpose of the community's welfare (Ministry of Information, 2008). Community radio is a third tier broadcasting along with public and private radio broadcasting which is managed, run, controlled, and owned by a community for the betterment of the community and cater the needs, interests and aspirations of a community (Nirmala, 2015). Many rural communities around the globe don't have access to the conventional mass media, hence can't share their needs, complains or successes with mass people. Community radio is a medium that gives a voice to the



voiceless and serves as a platform of the marginalized. Community radio is non-profit, non-commercial and assisted by its listeners and communities. Therefore, UNESCO defines CR as ‘a broadcast station that is operated in the community, for the community, about the community and by the community.

Community radio can facilitate the underprivileged and vulnerable groups by raising their voice, exploring their problems, sharing their innovative ideas and thinking for the development community as well as the whole nation. Community radio provides a means for individuals, groups and communities to become active creators of and contributors to the media (Al-hassan et al., 2011). Hence, it can play a significant role in the rural development of third world countries like Bangladesh focusing agriculture, education, health and sanitation, recreation and social problems of a target community (Khan et al., 2017).

Community radio can play a significant role in enhancing people’s livelihood. In a study of a community radio called Simli Radio in the Tolon-Kumbungu District of the Northern Region of Ghana on Livelihood improvement, Al-Hassan et al. (2011) found that the Radio has contributed to improve awareness and knowledge of solutions to community development problems ranging from culture, rural development, education, hygiene and sanitation, agriculture, local governance, etc. The same study also found that the radio promoted small and medium enterprise development by creating market opportunities for Small and Medium Enterprise (SME) operators and consequently improved sales and incomes. In another study in Ghana on Radio Gaakii, Aamadu & ALhassan (2018) claimed that the radio contributed in the areas of agriculture, health and sanitation, women and youth empowerment. Fombad and Jiyane (2016) in their study on the role of community radios in information dissemination to rural women in South Africa claimed that Community Radio is the only accessible and readily affordable medium within the rural community and can play a significant role in the development of rural women.

Community radio plays a decisive role in the improvement of health and nutrition awareness of rural people. In a study in Africa on the ‘Effectiveness of Community Radio in Promoting Health Policy Information Diffusion for Timely Achievement of SDG 3 in Africa by 2030’ Okaka (2016) claimed that Community Radio Stations (CRS) are crucial for rapid information diffusion of health policy innovation. Community radio is the best nexus of community media for healthcare policy communication based on gender mainstreaming. In their study on ‘Health promoting community radio in rural Bali: an impact evaluation’ Water’s et al. (2011) found that a Balinese community judged a local radio station to have made a significant change in community life.

### **1.5 Research Objectives**

The general objective of this research was to assess the effect of CR programs on the health and nutrition awareness of the listeners.

However, the specific objectives were:

- I. To reveal the status of present health and nutrition programs broadcast by community radio for creating awareness among the listeners
- II. To explore the effect of CR programs on the health and nutrition awareness of the listeners
- III. To identify the factors contributing to the listing of CR health and nutrition programs.
- IV. To explore communication strategies able to play more effective role in increasing health and nutrition awareness among the CR listeners.

### **1.6 Research Questions**

A good research question is one of the first critical steps in the research process. The research questions act as the guide in a research endeavor and assist in the construction logical argument. However, in the course of research process this research tried to find out the answer of the following questions:

- Q1. What is the present status of CR health and nutrition programs targeted to change people's awareness?
- Q2. What is the effect of CR health and nutrition programs in awareness building among the listeners?
- Q3. What factors are affecting the health and nutrition awareness building among the CR listeners?
- Q4. What CR based communication strategies can be more effective in building health and nutrition awareness among the listeners?

## **CHAPTER 2**

### **METHODOLOGY**

#### **2.1 Study Locale**

There are seventeen community radio stations in Bangladesh broadcasting various programs to the listeners. The intensity of health and nutrition programs differ based on radio stations. This research purposefully selected three radio stations from three different regions of the country. The selected stations were Radio Padma in Rajshahi district, Radio Nalta in Shatkhira district and Radio Lokobeter in Barguna District. Among these stations Radio Padma was the first community radio station in the country, Radio Nalta was established based on a local hospital for mainly broadcasting health information and Radio Lokobeter is situated at Barguna district lying close to the Bay of Bengal.

#### **2.2 Study Approach**

This research adopted mixed method approach. Mixed method research is a method becoming progressively articulated, attached to research practice, and appreciated as the third major research approach (Johnson et al., 2007). According to Creswell (2007)' mixed method research is a research design with philosophical assumptions as well as a method of inquiry. As a method, it focuses on collecting, analyzing, and mixing both qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of both methods in combination provides a better understanding of research problems than either approach alone.

#### **2.3 Population and Sampling**

All the adult people living in the three selected district constitute the population of the study. This study adopted multistage random sampling for determining the sample size. From each district one upazila was randomly selected from that selected upazila two unions were randomly selected and from each union two villages were randomly selected. Hence, the total numbers of villages considered in this study were twelve. It is important to note that in case of Rajshahi we have considered two upazila because of the weak coverage of network of community radio. According to population census, 2011 the total population residing in the three selected districts was 5473937. At 95% confidence level 4% margin of error the required sample size was 601. However, this research considered a sample size equivalent to 605. A detail of sampling frame of the study is presented in Table 2.1.

**Table 2.1 sampling Frame of the Study**

| District & Radio Station  | District wise population | Required sample | Upazila        | Unions     | Villages       | Samples selected |
|---------------------------|--------------------------|-----------------|----------------|------------|----------------|------------------|
| Barguna (Radio Lokobeter) | 8,92,781                 | 98              | Bargna Sadar   | Badarkhali | Patakata       | 20               |
|                           |                          |                 |                |            | Tetulbaria     | 25               |
|                           |                          |                 |                | Burirchar  | Burirchar      | 28               |
|                           |                          |                 |                |            | Manikkhail     | 26               |
| Rajshahi (Radio Padma)    | 25,95,197                | 284             | Charghat       | Yosufpur   | Chalk Kapashia | 69               |
|                           |                          |                 |                |            | Tangon         | 80               |
|                           |                          |                 | Rajshahi Sadar | Motihar    | Buthpara       | 65               |
|                           |                          |                 |                |            | Dharampur      | 73               |
| Satkhira (Radio Nalta)    | 19,85,959                | 219             | Kaligonj       | Nalta      | Nalta          | 70               |
|                           |                          |                 |                |            | PurbaNalta     | 74               |
|                           |                          |                 |                | Champaphul | Podali         | 35               |
|                           |                          |                 |                |            | Nobinagar      | 40               |
| Total                     | 5473937                  | 601             |                |            |                | 605              |

#### 2.4 Data Collecting Instrument

This research adopted both qualitative and quantitative methods of data collection.

A structured interview schedule was developed to collect general information, as well as to find out the determinants of family health and nutrition awareness and listening CR health and nutrition programs. Family health and nutrition awareness was measured based on a five point Likert scale (Strongly agree= 5; Agree= 4; Neutral = 3; Disagree=2; Strongly disagree= 1 for positive statements and Strongly agree= 1; Agree= 2; Neutral = 3; Disagree = 4; Strongly disagree = 5 for negative statements) composed of 15 statements (3 positive and 12 negative statements). The statements were prepared consulting health and nutrition program contents of three selected CR stations, Training manual-1(Food based nutrition related training manual) published in 2015 by Bangladesh Applied Nutrition Research and Training Institute, and Research report, 2017 of National Institute of Mass Communication. Initial interview schedule was composed of 25 items 8 positive and 17 negative items. After pretest on 40 respondents in Barguna Sadar upazila the number of items was reduced to 15. The reliability of the awareness scale was checked based on Cronbach  $\alpha$ . The value was 0.80, which is well beyond the value 0.70 suggested by Nunally (1978). Listening community radio health and nutrition programs was measured by a dichotomous response (yes/no). However, the detail measurement procedure of the other variables of the study is presented in Appendix-I and a copy of interview schedule is placed in Appendix-II. Alongside quantitative methods this research also used qualitative methods such as

8 Focus Group Discussions (FGD), 22 Key Informant Interviews (KII). The respondents included in qualitative methods were radio listeners, radio listening club members, community radio station managers, health and nutrition program anchors, doctors participated in CR health programs, etc. A list of questions used in qualitative data collection methods is placed in Appendix-III.

## 2.5 Statistical analysis

Data collected in this research are described by deploying descriptive statistics such as mean, median, mode, standard deviation, range, frequency, percentage, weighted mean, etc. As inferential analyses, this study used multiple regression and logistic regression analysis. Content and narrative analyses were followed in interpreting qualitative data. All quantitative statistical analyses were performed using SPSS 23.0 software package.

### 2.5.1 Multiple Regression Model

Regression analysis deals with the study of the dependence of one variable, the dependent variable, on one or more other variables, the explanatory variables, with a view to estimating and/or predicting the (population) mean or average value of the former in terms of the known or fixed (in repeated sampling) values of the later (Gujarati et al., 2015, p.15). Multiple regression analysis allows many observed factors to affect Y. The general multiple linear regression model (also called the multiple regression model) can be written in the population as

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \dots + \beta_k X_k + u$$

Where

$\beta_0$  is the intercept

$\beta_1$  is the parameter associated with  $x_1$

$\beta_2$  is the parameter associated with  $x_2$  and so on. (Wooldridge, 2013)

Based on the above equation the regression model of the research can be expressed as

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5$$

Where,

$Y = \text{Family health and nutrition awareness}$

$\beta_0 = \text{Constant term}$

$X_1 = \text{Gender}$

$X_2 = \text{Education}$

$X_3 = \text{Annual income}$

$X_4 = \text{Strong CR network}$

$X_5 = \text{Weak CR network}$

$\beta_1 \dots \beta_{14} = \text{Co-efficient of respective variable}$

## 2.5.2 Multiple Logistic Regression Model

Logistic regression analysis is a popular and widely used analysis that is similar to linear regression analysis except that the outcome is dichotomous (e.g., success/failure or yes/no or died/lived). Multiple logistic regression analysis applies, when there is a single dichotomous outcome and more than one independent variable. To find out the determinants of listening community radio health and nutrition programs (Yes/No) this research also used multiple logistic regression analysis. The outcome in logistic regression analysis is often coded as 0 or 1, where 1 indicates that the outcome of interest is present, and 0 indicates that the outcome of interest is absent. If we define  $p$  as the probability that the outcome is 1, the multiple logistic regression model can be written as follows:

$$\hat{p} = \frac{\exp(b_0 + b_1X_1 + b_2X_2 + \dots + b_pX_p)}{1 + \exp(b_0 + b_1X_1 + b_2X_2 + \dots + b_pX_p)}$$

$\hat{p}$  is the expected probability that the outcome is present;  $X_1$  through  $X_p$  are distinct independent variables; and  $b_0$  through  $b_p$  are the regression coefficients. The multiple logistic regression model is sometimes written differently. In the following form, the outcome is the expected log of the odds that the outcome is present,

$$\ln\left(\frac{\hat{p}}{(1-\hat{p})}\right);$$

$$\ln\left(\frac{\hat{p}}{(1-\hat{p})}\right) = b_0 + b_1X_1 + b_2X_2 + \dots + b_pX_p$$

Here,  $\hat{p}$  = The expected probability that the respondent will listen CR health and nutrition programs

X1 = Availability of electricity

X2 = Have health and nutrition education or training

X3 = Gender of the respondent

X4 = Use of other electronic media for family health and nutrition information

X5 = Family health and nutrition information need

$b_0 \dots b_p$  = Regression coefficient of the respective independent variable.

It can be noticed that the right hand side of the equation above looks like the multiple linear regression equation. However, the technique for estimating the regression coefficients in a logistic regression model is different from that used to estimate the regression coefficients in a multiple linear regression model. In logistic regression the coefficients derived from the model (e.g.,  $b_1$ ) indicate the change in the expected log odds relative to a one unit change in  $X_1$ , holding all other predictors constant. Therefore, the antilog of an estimated regression coefficient,  $\exp(b_1)$ , produces an odds ratio

## CHAPTER 3

### RESULT AND DISCUSSION

#### 3.1 General Characteristics of the Respondents

Data presented in Table 3.1 shows that the majority (62.2%) of the respondents were young and little more than two third (69.3%) of respondents were male. The majorities (67.7%) of the respondents were unmarried and had average education up to class nine and average family size 4.7. In case of occupation, most of the respondents were students (25.6%), followed by housewife (22.1%) and business (17.2%). The respondents were predominantly (74.9%) from lower middle income group and most of them (82.3%) were under the coverage of electricity. However, a detail of the other variables can be observed from Table 3.1.

Table 3.1 Descriptive characteristics of the respondents (n=605)

| Variable                 | Mean  | Median | std. | OR   | PR      |
|--------------------------|---|--------|------|------|---------|
| Age                      | Young = 377 (62.2%); Middle aged = 179 (29.5%); Old = 48 (7.9%); Missing = 3(0.5%)  |        |      |      |         |
| Gender                   | Male = 420 (69.3%); Female= 183 (30.3%); Missing = 3(0.5%)  |        |      |      |         |
| Marital status           | Unmarried = 183 (30.2%); Married = 410 (67.7%); Missing= 13 (2.1%)  |        |      |      |         |
| Education                | 8.89  | 10     | 4.48 | 0-18 | 0-18    |
| Family members           | 4.7   | 4.0    | 1.70 | 1-14 | unknown |
| Occupation               | Service = 37 (6.1%); Day laborer = 57(9.4%); Business = 104(17.2%); Housewife = 134 (22.1%); Farming = 44 (7.3%); Student = 155 (25.6%); Others = 70 (11.6%); Missing = 5 (0.80%) |        |      |      |         |
| Monthly income           | Low income = 58 (9.6%); Lower middle = 460 (74.9%); Upper middle = 80(13.2%); High income = 3 (0.5%); Missing = 5(0.8%)   |        |      |      |         |
| Electricity availability | Available = 499 (82.3%); Unavailable = 107 (17.7%)  |        |      |      |         |
| H&N training             | Yes = 118 (19.5%); No = 485 (80%)   |        |      |      |         |
| H&N information need     | 13.66   | 10     | 5.3  | 0-30 | 0-30    |
| Use of other NEM         | 10.29   | 9      | 6.09 | 1-35 | 0-40    |
| Use of other EM          | 3.22  | 2      | 3.20 | 0-21 | 0-28    |

**Note:** H&N= Health and nutrition; EM = Electronic Media; NEM = Non Electronic Media; OR= Observed range; PR=Possible range



### 3.2 Status of Listening Community Radio

Data presented in Figure 1 mirrors that 85.3% of the respondents listen community radio programs. However, their frequency of listening community radio programs differ significantly where little less than one-third (31.5%) respondents are moderate to very irregular in listening community radio programs (Figure 2). More than half of the respondents (53.8%) are very regular to regular in listening community radio programs. The respondents particularly the young people listen CR mainly for entertainment programs such as songs, drama, etc. The young listeners in FGDs in Chowmohani Bazar, Rajshai and Nalta Barar in Shatkhira approved that they listen CR predominantly for entertainment purposes, specially the programs broadcast at mid night such as ‘Rat Jaga Pakhi’ in Radio Nalta, ‘Hello Rajshai’ in Radio Padma. Deplorably, majority of the youngsters had meager interest on informative programs.

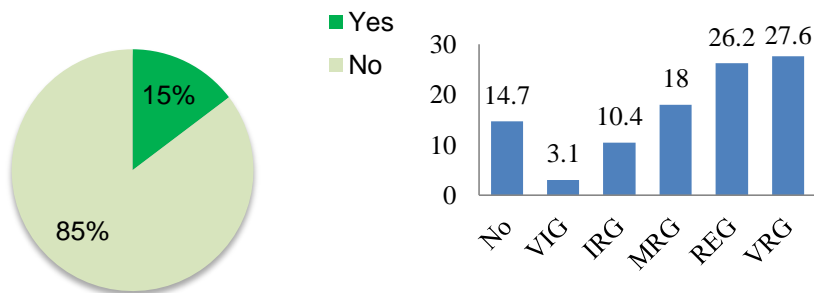


Figure 3.1 Graph showing percentage of respondents listen CR programs

Figure 3.2 Bar graph showing percentage distribution of the respondents based on frequency of listening CR programs (No= Don't listen; VIG= Very irregular; IRG = Irregular; MRG = Moderately regular; REG = Regular; VRG = Very regular)

### 3.3 Access to Community Radio & Network Availability

Figure 3.3 represents that more than three quarters (75.6%) of the respondents had very easy access to CR. Only a negligible percentage of people had (1.8%) difficult access to CR. Community radio has various advantages over conventional radio broadcasting. Along with using Radio sets people can also access CR via cell phone and internet. As almost all the people have access to cell phone, so people had very easy access to CR. The network availability of CR presented in Figure 3.4 shows a conspicuous difference. CR stations are localized, hence suppose to offer a strong network to the listeners. But, due to several regions CR stations failed to provide a strong network. One of the reasons of such difference was linked with the use of low cost equipment's for broadcasting. Interference with other networks, such as mobile telecommunication network also creates obstacles in listening CR, although the area is not very far from the radio stations.

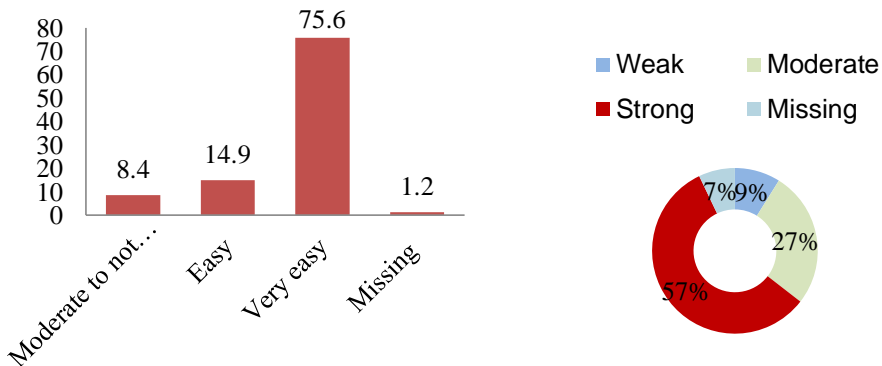


Figure 3.3 Bar graph showing percentage of respondents in terms of access to CR

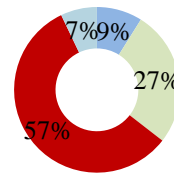


Figure 3.4 Graph showing distribution of respondents in terms of availability of CR network

### 3.4 Ownership of CR Access Device

Data presented in Table 3.2 shows that 82% of the respondents have cell phone mostly by themselves or by family. Contrasting ownership of cell phone, a puny section (5.6%) of the respondents own radio sets. According to the participants of several FGD and Key Informant Interviews, widespread existence of Smartphone and television make radio sets almost non-existent. Smartphone and television provide opportunity of enjoying both audio and video entertainment. Nonetheless, carrying and charging cell phone is very convenient compared to radio sets. In case of internet, except from a single person none of the respondents own internet for accessing CR programs.

Table 3.2 Ownership of CR access device by the respondents (n=605)

| Device     | Ownership  | Percentage | Frequency |
|------------|------------|------------|-----------|
| Cell phone | Didn't won | 100        | 16.5      |
|            | Family     | 65         | 10.7      |
|            | Self       | 432        | 71.3      |
|            | Missing    | 9          | 1.5       |
| Total      |            | 606        | 100       |
| Radio      | Didn't won | 572        | 94.4      |
|            | Family     | 14         | 2.3       |
|            | Self       | 20         | 3.3       |
| Total      |            | 605        | 100       |
| Internet   | Didn't won | 604        | 99.8      |
|            | Self       | 1          | 0.2       |
| Total      |            | 605        | 100       |

In case of objective of using CR, the respondents mainly use community radio for entertainment followed by gaining knowledge and information (Table 1). Supporting this fact an anchor of Radio Padma in a KII claimed that '*We receive more response in Entertainment programs compared to informative programs*'. Some of them also use CR for relieving stress and very few of them use CR to show elevated social status.

Table 3.3 Objectives of the respondents in using CR (n=605)

| Objective                       | First |     | Second |     | Third |     | Fourth |     | Missin<br>g |
|---------------------------------|-------|-----|--------|-----|-------|-----|--------|-----|-------------|
|                                 | f     | %   | f      | %   | f     | %   | f      | %   |             |
| Knowledge<br>and<br>information | 25    | 41. | 16     | 26. | 96    | 15. | 7      | 1.2 | 1           |
|                                 | 0     | 3   | 2      | 7   |       | 8   |        |     |             |
| Social status                   | 1     | 0.2 | 52     | 8.6 | 12    | 20  | 33     | 55. | 1           |
|                                 |       | 0   |        |     | 1     |     | 9      | 9   |             |
| Relieve<br>stress               | 7     | 1.2 | 14     | 24. | 21    | 36. | 14     | 23. | 0           |
|                                 |       |     | 6      | 1   | 9     | 1   | 2      | 4   |             |
| Entertainme<br>nt               | 26    | 43. | 15     | 25. | 76    | 12. | 24     | 4   | 0           |
|                                 | 1     | 1   | 4      | 4   |       | 5   |        |     |             |

### 3.5 Listening of CR Health and Nutrition Programs

Although a mammoth percentage of the respondents listen CR but little less than half (48.2%) of the respondents listen CR health and nutrition programs (Figure 3.5). Most of the respondents in qualitative data collection methods were in agreement that community radio stations are broadcasting valuable programs related to family health and nutrition of the listeners, lamentably very few people regularly enjoyed those

programs. Many respondents in FGD and KII claimed that they listen CR health and nutrition programs, but very few of them can mention the name programs they enjoy on CR.

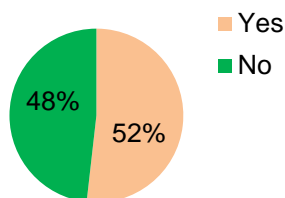


Figure 3.5 Percentage distribution of respondents listen CR health and nutrition programs

Data displayed in Table 3.4 mirrors that according to weighted mean (WM) the top listened health and nutrition program is Public Service Announce (PSA) followed by drama, song, phone in programs and issue based discussion. PSA is a kind of advertisement broadcast repeatedly as like as commercials. So, the people who often hear PSA even did not regularly listen CR health and nutrition programs. Drama is the second most listened program as people can get both information and entertainment from a single program. Most of the respondents in FGDs and KIIs conducted in the study area expressed that they like drama and song as these programs offer both entertainment and information. People also like phone in programs as they can directly contact doctors and seek solutions of general health problems. In a FGD in Chwmohoni Bazar, Charghat, Rajshahi the participants were in agreement that they mostly prefer phone in programs as they have chances to talk with the doctor or they can learn many health issues from the question of other listeners .

Table 3.4 Frequency of listening CR health and nutrition programs by the respondents (n=605)

| Type of program        | listening frequency |     |     |     |     |     | WM    | Rank |
|------------------------|---------------------|-----|-----|-----|-----|-----|-------|------|
|                        | DLN                 | VIR | IRG | MOD | REG | VRE |       |      |
| Drama                  | 317                 | 46  | 63  | 50  | 61  | 68  | 1.495 | 2    |
| Song                   | 317                 | 64  | 67  | 68  | 59  | 31  | 1.309 | 3    |
| Phone in programs      | 316                 | 74  | 63  | 72  | 59  | 22  | 1.257 | 4    |
| PSA                    | 314                 | 21  | 44  | 71  | 72  | 84  | 1.700 | 1    |
| Issue based discussion | 317                 | 73  | 72  | 79  | 46  | 19  | 1.210 | 5    |

**Note :** DLN= don't listen; VIR= Very irregular; IRG= Irregular; MOD= Moderate; REG= Regular; VRE= Very regular; PSA = Public Service Announcement.

### 3.6 Effect of CR listening on Family Health and Nutrition

#### Awareness

Effect of CR listening on family health and nutrition awareness was measured by regression analysis. The predictor variables entered in the model were listen CR health and nutrition programs, access to the CR and the availability of the community radio network. Availability of network was entered in the model by creating dummy variables where moderate network was kept as the reference category. Suitability of the data for regression analysis was checked (Please see the bottom row of Table 3.5). Regression analysis results presented in Table 3.5 shows that all the predictor together can describe 5.8 % change in the family health and nutrition awareness and produced an significant model ( $F_{4, 554} = 9.53$   $p < 0.000$ ). The results presented in the same Table further display that listening CR is the strongest ( $\beta = 0.171$ ,  $p < 0.01$ ) predictor of respondents family health and nutrition awareness, which means that the respondent who listen community radio health and nutrition programs have 26.1% more probability of having family and health awareness compared to people who didn't listen CR health and nutrition programs. Access to CR also have significant ( $\beta = 0.087$ ;  $p < 0.05$ ) relationship with respondent's family and health and nutrition awareness. The other variable in the model didn't have any significant relationship with health and nutrition awareness of the respondents.

Table 3.5 Determinants of family health and nutrition awareness of the respondents.

| Variable                                | B      | SE    | $\beta$ | t      | p     | VIF   |
|---|--------|-------|---------|--------|-------|-------|
| Constant                                | 51.236 | 2.195 |         | 23.337 | 000   |       |
| Listen CR Health and Nutrition programs | 2.61   | 0.645 | 0.171   | 4.048  | 000   | 1.053 |
| Access to CR                            | 0.959  | 0.460 | 0.087   | 2.083  | 0.038 | 1.037 |
| Have strong CR network                  | 1.287  | 0.712 | 0.082   | 1.806  | 0.071 | 1.217 |
| Have weak CR network                    | -1.616 | 1.171 | -0.062  | -1.380 | 0.168 | 1.212 |

Dependent variable: Family health and nutrition awareness;  $R = 0.254$ ;  $R^2 = 0.064$ ;  $Adj-R^2 = 0.058$ ; Durbin-Watson = 1.45; Cook's distance = 00-0.0407; Kolmogorov-Smirnov = 0.030  $P = 0.200$

Listening community radio enhanced widespread health and nutrition awareness among the listeners. A 25 years old women called Ruma in a KII in Buthpara, Rajshahi said 'I have become aware of many health and nutrition related issues, such as awareness in taking medicine while pregnant, avoiding raw salt during meals, watering head during fever, avoiding powder milk or other packaged feed for infants, etc., by listening

*CR health and nutrition programs*'. Respondents also claimed that they learn many life saving hacks, such as things to do while someone drawn in water, how to take care diarrhea patients, symptoms of pneumonia in children, danger signs of pregnant women, immunization of children, etc. Mohammad Ramjan Ali a former business man in Nalta, Kaligonj, Satkhira claimed that *'I love radio more than television. I have two grandsons. I have learned many things related to pregnancy and child rearing from radio and suggested these things to my daughter.'* Aged people also claimed that they have learnt many important things by listening CR health and nutrition programs. The detail of a FGD performed in Nurnagar Bazar, Shyamnagar, Satkhira with elderly listeners is presented in Box 1.

**Box 1.** Health and nutrition learning of elderly listeners from CR programs

1. Start taking more vegetables and small fish
2. Stop taking date juice
3. Heart patient should avoid gas creating foods and have more physical exercise such as walking
4. Washing vegetables before cutting to avoid nutrition loss
5. Washing fruits before consuming

### **3.7 Advantages of CR over Other Conventional Media**

In Bangladesh a bunch of different audio and audio-visual media are catering various health and nutrition related information to its audiences. However, CRs have certain privileges over the other media. One of the major benefits of CR is it broadcast programs on local dialects, which is easily understandable for audiences. As community radios broadcast their programs in a confined territory, so people have comparatively easy access in phone in programs. Nonetheless, audiences can easily provide their opinion through cell phone calls or Facebook post on the Facebook page of the particular radio. The health or nutrition related songs or drama broadcast on the community radio stations are based on the local familiar facts which always portrays a deeper impression. Community radios disseminate various health and nutrition related information closely related to that particular community, for example Radio Nalta conduct programs on management of skin problems happen due to high salinity, which is a very common problem for the people residing in adjacent areas of the radio stations. Radio Padma on the other hand have programs on how to remain well in hot weather, which is very common in Rajshahi district. The interest of the audience significantly perpetuated, when they heard their names during the programs. Their interests have also soared, when they heard the names of the people from

their own territory. As community radios are based on the comparatively small territory, so people have more access to the programs compared to national radios and television channels.

### **3.8 Present Status of Health and Nutrition Programs on CR**

According to the general opinion of the respondents the overall quality of the community radio health and nutrition program is satisfactory. However, it does not mean that all the programs broadcast on community radios, were of good quality. It was claimed in group discussions that some of the doctors participated in the phone in programs were not well qualified. A proportion of the physicians seemed to be not sufficiently prepared on the issues they are talking about. However, this is not all alone the physician's fault, because in many cases, they are not informed well ahead of the programs about the content, which impede early preparation. A significant proportion of the respondents also feel that the number and duration of the health and nutrition programs were also limited. For instance, Radio Nalta broadcast programs for 63 hours each week, of which only 3 hours allotted for health and nutrition programs. The duration of the programs was also short. For example, the phone in programs lasts only 30 minutes in a radio station, which is not long enough for a physician to have a good discussion and answer the queries of the listeners. The broadcasting time of many programs were also not suitable for majority of the audience. Most of the audience claimed that they enjoy radio from evening to early night i.e. from 6 pm to 10 pm, so it is difficult for them to listen programs broadcast out of this time range. Most of the respondents were in agreement that rebroadcasting of a program in other convenient time is helpful for them. However, some radio stations exercise excessive repetition of the same program, which create boredom among the listeners. The audiences had to spend a handsome toll for calling or sending SMS to a doctor in a phone in program, which refrain many audiences in participating in phone in programs via call or SMS. A good radio program necessitates sufficient advance preparation, which in most cases was absent for health and nutrition programs. The publicity and prior advertisement of time and content of health programs were almost non-existent in the case of health and nutrition programs. The audience didn't exactly know the time and the content of the programs. They didn't know which topic the CR is going to discuss in the upcoming programs. This creates obstacles for much audience, who badly needed such information. Few audiences also complained against the individuals work as anchor of the programs. Their accent and choice of words is not appropriate for a standard health program. Most of the audience listen CR for entertainment purpose. Realizing this fact community radios emphasizes more on entertainment programs ignoring informative programs. They concentrate more on popularity rather than developing awareness and knowledge.

### **3.9 Challenges Faced by the CR Stations in Developing Quality Programs**

Developing a quality health and nutrition programs needs sufficient resources and skill. All the radio stations lack sufficient resources and skill for preparing quality health and nutrition programs. Due to acute shortage of fund the radio stations can't provide sufficient allowance for a physician. This research revealed that the highest allowance provided to a physician for an hour long programs was 500 Taka. Finding expert physician is also challenging. Many physicians due to their professional busyness were not interested in CR health and nutrition programs. Development of a quality program needs to follow several steps, such a topic selection, script writing, content development, rehearsal, broadcasting, feedback collection, etc. For performing each of these steps skilled human resources are essential. Workers working in the radio stations irrespective of location were sternly underpaid. For instance, an anchor for working in an hour long program received Taka 200. Due to very low salary payment the employees always sought for other better salaried jobs. So, employees who are expert in making and presenting programs leave jobs in radio stations every now and then, which create a perpetual shortage of skilled manpower in producing quality health and nutrition programs.

Most of the health and nutrition programs are project supported, hence ends up with the termination of the project. A station manager in a KII regretted '*We had to quit many popular programs with the end of projects*'. Community radio is an audio based and predominantly one way communication method. In such communication, expertise is essential from the part of the communicator. Hence, the doctors participated in CR programs need training for efficient handling of audience response. Entertaining programs such drama, song, etc., needs musical instruments. But the radio stations didn't have musical instruments. They were also not economically capable of renting such instruments, which is an obstacle in developing quality programs. One of the regular singers of Radio Nalta, who is also an enlisted singer of Khulna Bater claimed '*My songs would have been much popular, if musical instruments were used in Community Radio*'.

A strong network is necessary for clear listening of radio programs. Lamentably, there are areas in the coverage of CR network, where the network is feeble creating obstacles in listening. At present many service providers such as cell phone industries, public and private TV channels, radio stations other than CR use radio networks for broadcasting programs which creates an antagonistic effect among the networks. The broadcasting equipments used by the radio stations were not of high quality, hence failed to compete with other networks and face obstacles to reach its audience smoothly.



At present in Bangladesh there are a large number of public and private television and radio channels broadcasting programs for its audience. People predominantly like audio-visual channels as they can hear and see the programs together. In case of radio channels other than the CR, they are more capable in terms of skill and resources in developing quality programs. The community radios in the adjacent areas of Indian border also have to fight foreign channels to retain its audiences. The high competition among the communication channels made things difficult for CRs as they are resource poor and economically nonviable in producing high quality programs.

### **3.10 Ways of Involving more Listeners with CR Radio Health and Nutrition Programs**

Many audiences during data collection complained that they missed CR health and nutrition programs due to not knowing the schedule and the content of the programs earlier. In fact, linking audiences necessitate wide publicity of the program time and content before broadcasting the program. Except one radio station other two stations didn't have promotions even in their own radio regarding health and nutrition programs, although they had promotions for other entertainment programs. Program anchors, station managers and audiences were in agreement that 'It is obligatory to provide wide publicity of health and nutrition programs content and time for attracting more potential audiences'. The publicity of these programs can be performed by hanging posters, banners, and billboards in public places, such as markets, hospitals, school, colleges, etc. In addition, the radios can also use mobile SMS and public announcement via miking for informing its audiences.

Establishment of active listener club may also be fruitful for increasing the number of potential listeners. At present all the radio stations have radio listening clubs. However, except very few, most of these radio listening clubs were non-functional, where many members never or rarely listen radio programs. Regular contact and management of these clubs from the part of the radio is almost non-existent. This research found few radio listening clubs, where the members were very active and enthusiastic, who regularly participated in radio programs and share their experiences with the group members and people outside the group, particularly with their family members.

The radio needs to create space for the active participation of the audiences. After the programs, radio can launch quizzes for the listeners. The winners can be rewarded with gifts such as radio sets, books, etc. Repeated announcement of the names of winner might also inspire the participants. In a KII a respondent called Mustakin in Rajshahi said 'I really feel thrilled when I heard my name on the Radio'. The periodic

Congress of the audiences can also trigger peoples' enthusiasm in listening and participating health and nutrition programs.

The community radios were established based on the philosophy of enhanced participation of the community people. Lamentably, people's participation in health and nutrition programs was not satisfactory. Hence, beside programs arranged in studio, doctors and nutrition experts can move to the audience and have open discussion with potential listeners. Issues related to health can be discussed with a group of patients and broadcast on radio. Similarly, nutrition programs can be arranged in schools, colleges, with elderly people, pregnant mothers, lactating mothers, etc. Arranging such kind of programs can answer many crucial questions, as well as inspire audience in active participation. In an FGD in Nalta, Sharkhira a primary school headmaster suggested '*If CR arranges programs on health and nutrition issues in primary schools, it will certainly play an enormous impact in inspiring children as well as their guardians*'. Nonetheless, the radio stations might be able to collect effective feedback from the listeners to improve the present status of health and nutrition programs and design future programs.

Feedback is considered as the backbone of communication. It is an indispensable factor for enhancing effectiveness of communication. Apart from collecting few feedbacks from interested audiences during programs, none of the radio station had a permanent mechanism of collecting feedbacks from mass audience regarding health and nutrition programs. As a result, the radios prepare and broadcast programs considering the supply side perspective rather than demand side perspectives. This problem hinders developing community centered programs, which might have a profound impact on the life of the listeners. Hence, a permanent mechanism collecting periodic feedback of the mass audience is essential for tagging more people with community radio health and nutrition programs.

### **3.11 Determinants of CR Health and Nutrition Program Listening**

CR health and nutrition program listening was a dichotomous variable having binary response yes or no. Hence, the determinants of community radio health and nutrition program listening were identified by logistic regression. The predictor variables were availability of electricity in residence, receive health or nutrition education or training, gender of the respondent, use of other electronic media other than CR, and information need in family health. A test of the full model versus a model with intercept only was statistically significant  $\chi^2(5, N=600) = 37.371, p < 0.001$ . The model was able correctly to classify 69% of those who didn't listen CR health and nutrition programs and 51% of those

who listen CR health and nutrition programs, for an overall success rate of 60%.

Table 3.6 shows the logistic regression coefficient, Wald test, and odds ratio for each of the predictors. Employing a 0.05 criterion of statistical significance availability of electricity, health and nutrition education and/or training, gender, use of other electronic media had significant partial effects. Inverting the odds ratio of availability of electricity indicates that when holding all the other variables constant individual who didn't have electricity in residence have 2.5 times more likely to listen CR health and nutrition programs than people who had electricity in their residence. Similarly, women are 1.5 times more likely to hear CR health and nutrition programs compared to men. The individuals who received health and nutrition education and/or training have 1.5 times more likely to listen CR health and nutrition programs compared to the persons who didn't have any education and/or training in family health and nutrition. In case of use of other electronic media it can be observed from Table 3.6 that one point increase in the use of other electronic media scores being associated with odds of listening community radio health and nutrition programs by a multiplicative factor of 1.077.

**Table 3.6 Determinants of CR health and nutrition program listening.**

| Predictor   | B      | Wald $\chi^2$ | $\rho$ | OR    |
|---|--------|---------------|--------|-------|
| Constant  | 0.448  | 2.211         | 0.137  | 1.565 |
| Availability of electricity                         | -0.958 | 16.515        | 0.000  | 0.383 |
| Receive health and nutrition education and training | 0.485  | 4.637         | 0.031  | 1.624 |
| Gender  | -0.378 | 4.083         | 0.043  | 0.685 |
| Use of other electronic media                       | 0.074  | 7.652         | 0.006  | 1.077 |
| Health information need                             | 0.018  | 1.079         | 0.299  | 1.018 |

## **CHAPTER 4**

### **CONCLUSION & RECOMMENDATIONS**

#### **4.1 Conclusion**

This research evaluates the effect of CR health and nutrition programs on the family health and nutrition awareness of the listeners. It is clear from the findings that CRs were playing a crucial role in enhancing listener's family health and nutrition awareness. The respondents prefer community radio over other conventional media as it is premised on community culture, needs and interests. It was observed that at present the number and duration of health and nutrition programs in CRs are very limited. Well planned health and nutrition programs were also scarce. The findings also reveal that CRs lack resources and skilled manpower in furnishing quality health and nutrition programs. In order for the radios to increase the number of health and nutrition program listeners, wide publicity of the time and the content of the program along with the development on-field participatory programs are necessary. The radio should emphasize more on the demand side perspectives in deciding the content and style of health and nutrition programs.

#### **4.2 Recommendations**

In the light of information derived and analyzed in this report, this research suggests the following recommendations:

- 4.2.1 Family health and nutrition awareness significantly depend upon the listening of CR health and nutrition programs along with the access to CR. Hence, more CR radio stations with increased number of health and nutrition programs need to be established targeting specific community needs and interests.
- 4.2.2 Men were less interested in listening CR health and nutrition programs compared to women, although they are the central decision maker in most of the families regarding health issues, particularly treatment. So, community radio stations should adopt special strategies to involve more male listeners in CR health and nutrition programs.
- 4.2.3 Training of CR workers along with participating physicians in handling telemedicine is necessary for the development of quality programs and efficient handling of the information seekers.
- 4.2.4 Allocation of adequate resources and development strong network for the community radio stations are mandatory for ensuring quality health and nutrition programs and the satisfaction of the listeners.

- 4.2.5 An extensive promotional activity regarding the timing and content of the forthcoming health and nutrition programs is obligatory for all the radio stations.
- 4.2.6 Prior education and training on health and nutrition was significantly connected with the individual's probability of listening CR health and nutrition programs. Hence, widespread health and nutrition education and training might be helpful for the increase of the number of CR health and nutrition program listeners.

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## Appendix-I

### Measurement technique of different variables of the study

| Sl no. | Variable   | Variable Type | Unit of measurement   | Definition of the variable   |
|--------|--|---------------|---|--|
| 1.     | Age  | Continuous    | Year  | Age of the respondent  |
| 2.     | Sex  | Dummy         | Male /Female/others   | Sex of the respondents   |
| 3.     | Marital status   | Categorical   | Married/Unmarried/Others  | Marital status of respondents  |
| 4.     | Education  | Continuous    | Year of schooling   | Education level of the member  |
| 5.     | Family size  | Continuous    | Number of members   | Number of family member seat together  |
| 6.     | Occupation   | Categorical   | Service/day laborer/business/housewife/farmers/student/others   | Occupation of the respondents  |
| 7.     | Family income  | Categorical   | low/lower middle/upper middle/high  | The amount of total yearly income earned by all the family members in Taka   |
| 8.     | Availability of electricity                                  | Dummy         | Yes/No  | Availability of any kind of electricity in the residence   |
| 9.     | Receive training or education in family health and nutrition | Dummy         | Yes/No  | Participate in training or receive education on family health and nutrition related issues   |
| 10.    | Health and nutrition information need                        | Continuous    | Rating scale ( Very high=5; High = 4; Moderate = 3; Low =2; Very low = 1) against 6 selected area of information need | Health and nutrition information requirement related to different aspects, such as mother and child, personal cleanliness, adolescent health, etc. |
| 11.    | Listen CR  | Dummy         | Yes/No  | Listen community radio for any program(s).   |
| 12.    | Frequency of listening community radio                       | Categorical   | Very regular = 5; Regular = 4; Moderately regular = 3; Irregular = 2; Very irregular = 1                              | Regularity of listening CR   |
| 13.    | Access to CR   | Categorical   | Very easy=4; Easy=3; Moderate=2; Less easy=1; Not easy=0  | Access of the respondents to CR  |

|     |  |             |  |   |
|-----|--|-------------|--|---|
| 14. | Availability of CR network                                 | Categorical | Strong = 3; Moderate = 2; Weak = 1   | Availability of CR network in the residence of the respondents  |
| 15. | Ownership of CR listening device                           | Continuous  | Rating scale ( Personal ownership=2; Family ownership=1; Don't own=0) against three CR listening device such as cell phone, radio set and internet                             | Community radio listening device owned either by the respondent or family   |
| 16. | Objectives of listening CR                                 | Nominal     | Rating of four objective (entertainment, acquiring knowledge, enhancing social status, relieve stress) selected based on use and gratification theory of Commutation media use | The purposes of listening CR programs   |
| 17. | Listen health and nutrition program on CR                  | Dummy       | Yes/No   | Listen community radio for health and nutrition programs  |
| 18. | Frequency of listening health and nutrition programs on CR | Continuous  | Very regular = 5; Regular = 4; Moderately regular = 3; Irregular = 2; Very irregular = 1 against five types of programs  | Regularity in listening CR health and nutrition programs such as drama, song, participatory programs, PSA, issue based discussion |
| 19. | Use of other non-electronic media                          | Continuous  | Rating scale ( Always=4; Frequently=3; Occasionally=2; Rarely=1; Never=0) against 10 different media   | Use of non-electronic media for family health and nutrition related information   |
| 20. | Use of electronic media other than CR                      | Continuous  | Rating scale ( Always=4; Frequently=3; Occasionally=2; Rarely=1; Never=0) against nine different media   | Use of other electronic media for receiving family health and nutrition related information                                       |

## Appendix-II

### Structured Interview Schedule



#### জাতীয়গণমাধ্যমইনস্টিটিউট

তথ্য মন্ত্রণালয়, গণপ্রজাতন্ত্রীবাংলাদেশ সরকার

১২৫/এ, দারুসসালাম, এ.ডব্লিউ চৌধুরী রোড, ঢাকা-১২১৬

পিএবিএক্স-৫৫০৭৯৪৩৮-৪২, ফ্যাক্স- ৫৫০৭৯৪৪৩

e-mail-dgnimco@gmail. পডস, Website-www.nimc.gov.bd

#### সাক্ষাৎকার অনুসূচী

বিষয়: গ্রামীণ শ্রোতাদের স্বাস্থ্য ও পুষ্টি সচেতনতায় কমিউনিটি রেডিও

সহযোগিতার জন্য আপনাকে অগ্রিম ধন্যবাদ। উল্লিখিত গবেষণাটি জাতীয় গণমাধ্যম ইনস্টিটিউট কর্তৃক পরিচালিত। এ বিষয়ে তথ্য প্রদানে আপনি সম্পূর্ণ স্বাধীন। আপনার প্রদানকৃত তথ্য শুধুমাত্র গবেষণা কাজ ব্যতীত অন্য কোন কাজে ব্যবহার করা হবেনা। প্রদানকৃত তথ্যেও বিষয়ে বিব্রতবা স্বাচ্ছন্দ্যবোধ না করলে বা আপনার প্রদানকৃত সাক্ষাৎকার প্রত্যাহার করতে চাইলে নিম্নলিখিত ঠিকানায় মুখ্য গবেষকের সাথে অনুগ্রহপূর্বক যোগাযোগ করুন।

ড. মো: মামুন-উর-রশিদ, অধ্যাপক, কৃষিসম্প্রসারণ ও গ্রামীণ উন্নয়ন বিভাগ, পটুয়াখালী বিজ্ঞান ও প্রযুক্তি বিশ্ববিদ্যালয়

মোবা: ০১৭১২১৪৩২৩৬, ই-মেইল: [murashidpstu@gmail.com](mailto:murashidpstu@gmail.com)

আইডি নং:

গ্রাম :

ইউনিয়ন :

উপজেলা কোড : BRG/KLI/PUT

মোবাইল : নং (যদি থাকে) :

(দয়া করে নিম্ন লিখিত প্রশ্নগুলোর উত্তর দিন)

যুবক (১৮-৩২)

মধ্য বয়সী (৩৩-৫০)

বয়স্ক (৫১-৬০)

১. আপনার বয়স।

২. জেন্ডার :

ক. পুরুষ

খ. মহিলা

গ. অন্যান্য

৩. বৈবাহিক অবস্থা

ক. বিবাহিত

খ. অবিবাহিত

গ. অন্যান্য

৪. আপনি কোন শ্রেণি পর্যন্ত লেখাপড়াকরেছেন। (বৃত্ত দ্বারা চিহ্নিত করুন)।

১ ২ ৩ ৪ ৫ ৬ ৭ ৮ ৯ ১০ ১১ ১২ ১৩ ১৪ ১৫ ১৬

১৭ ১৮ +

৫. পরিবারের সদস্য সংখ্যা: (পরিবার মানে এক ঘরে একসাথে থাকেন ও একসাথে খাওয়া-  
দাওয়া করেন)

প্রাপ্তবয়স্ক ১৮-৬০ ( ) জন + শিশু < ১৮ ( ) জন + বয়স্ক সদস্য >  
৬০ ( ) = মোট ( ) জন

৬. আপনার পেশা:

ক. চাকুরী  খ. দিনমজুর  গ. ব্যবসা  ঘ. গৃহিনী  ঙ. কৃষিকাজ

চ. ছাত্র/ছাত্রী  ছ. অন্যান্য

৭. ছাত্র/ছাত্রী  ছ. অন্যান্য

৭. পারিবারিক মাসিক আয়: (টিক চিহ্ন দিন যে কোন একটি ঘরে)

নিম্ন আয় (<৭০০০)  নিম্ন মধ্যবিত্ত (৭০০০ - ২৭,০০০/-)  উচ্চ মধ্যবিত্ত (২৭,০০১- ৮৩,০০০/-)  উচ্চ আয় (> ৮৩,০০০/-)

৮. বাড়িতে বিদ্যুতের ব্যবস্থা: (টিক চিহ্ন দিন যে কোন একটি ঘরে) ক. আছে

খ. নেই

৯. পরিবারিক স্বাস্থ্য ও পুষ্টি বিষয়ে কোন লেখাপড়া বা প্রশিক্ষণ নিয়েছেন কি? ক. হ্যাঁ

খ. না

১০. স্বাস্থ্য ও পুষ্টি বিষয়ক তথ্যের প্রয়োজনীয়তা। (প্রতিটি বিষয়ের জন্য প্রয়োজনীয়তার মাথা

| ক্র: | তথ্যের বিষয়  | প্রয়োজনীয়তার মাথা |      |          |    |        |
|------|---|---------------------|------|----------|----|--------|
|      |   | খুব বেশী            | বেশী | মোটামুটি | কম | খুব কম |
| ১    | মা ও শিশুর স্বাস্থ্য ও পুষ্টি   |                     |      |          |    |        |
| ২    | ব্যক্তিগত পরিষ্কার-পরিচ্ছন্নতা এবং যত্ন                                       |                     |      |          |    |        |
| ৩    | কিশোর কিশোরীর স্বাস্থ্য ও পুষ্টি  |                     |      |          |    |        |
| ৪    | দৈনন্দিন স্বাস্থ্য সমস্যা যেমন: জর, সর্দি, কশি, পেটের অসুখ, দুর্বলতা, ইত্যাদি |                     |      |          |    |        |
| ৫    | নন কমিউনিকেশন রোগ যেমন: উচ্চ রক্তচাপ, ডায়াবেটিসহাটের অসুখ, ইত্যাদি           |                     |      |          |    |        |
| ৬    | অন্যান্য (যদি থাকে) -----   |                     |      |          |    |        |

অনুযায়ী সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

নোট: খুব বেশী = প্রতি মাসে; বেশী = প্রতি দেড় মাসে; মোটামুটি = প্রতি তিন মাসে; কম = প্রতি ৬ মাসে; খুব কম = প্রতি বৎসর

১১. আপনি কি গত ছয় মাসে কমিউনিটি রেডিও শুনেছেন? ক. হ্যাঁ  খ. না

উত্তর হ্যাঁ হলে

ক. কমিউনিটি রেডিও শোনার মাএা: (উপরের সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

|                                   |  |
|-----------------------------------|--|
| খুবই নিয়মিত (অন্তত ১ বার/ ৩ দিন) | অনিয়মিত (অন্তত ১ বার/ প্রতি ৩ মাস)      |
| নিয়মিত (অন্তত ১ বার/ সপ্তাহ)     | খুবই অনিয়মিত (অন্তত ১ বার/ প্রতি ৬ মাস) |
| মোটমুটি নিয়মিত (অন্তত ১ বার/মাস) |  |

খ. কমিউনিটি রেডিওতে প্রবেশগম্যতা: (উপরের সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

|   |                               |
|---|-------------------------------|
| খুবই সহজ (চাইলেই শুনতে পারি)                | কম সহজ (সহজে শোনা যায় না)    |
| সহজ (চাইলেই নিদ্রুত সময়ে শুনতে পারি)       | সহজ নয় (ব্যবহারের সুযোগ নেই) |
| মোটমুটি সহজ (চাইলেই কিছুদিন পরপর শোনা যায়) |                               |

গ. কমিউনিটি রেডিও নেটওয়ার্কের সহজলভ্যতা: (উপরের সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

|           |                    |        |
|-----------|--------------------|--------|
| শক্তিশালী | মোটামুটি শক্তিশালী | দুর্বল |
|-----------|--------------------|--------|

ঘ. কমিউনিটি রেডিও ব্যবহারের মুখ্য উদ্দেশ্য। (সংশ্লিষ্ট ঘরে গুরুত্বের ক্রম অনুযায়ী টিক চিহ্ন দিন)

| ক্র: | উদ্দেশ্য  | গুরুত্বের ক্রম |   |   |   |
|------|---|----------------|---|---|---|
| ১    | জ্ঞানঅর্জন ও তথ্য সংগ্রহেরজন্য                        | ১              | ২ | ৩ | ৪ |
| ২    | সামাজিকঅবস্থানবৃদ্ধির জন্য যেমন: অন্যর থেকে বেশী জানা | ১              | ২ | ৩ | ৪ |
| ৩    | দুশ্চিন্তা থেকে মুক্তিরজন্য                           | ১              | ২ | ৩ | ৪ |
| ৪    | আনন্দ-বিনোদনেরজন্য                                    | ১              | ২ | ৩ | ৪ |

ঙ. কমিউনিটি রেডিওতে স্বাস্থ্য ও পুষ্টি বিষয়ক অনুষ্ঠান শোনে ন? ক. হ্যাঁ

খ. না

চ. উত্তর হ্যাঁ হলে শোনার মাএা উল্লেখ করুন (প্রতিটি বিষয়ের জন্য সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

| ক্র: | স্বাস্থ্য ও পুষ্টি বিষয়ক               | শোনার মাএা |        |        |       |         |
|------|---|------------|--------|--------|-------|---------|
|      |   | খুবনি      | নিয়মি | মোনিয় | অনিয় | খুঅনিয় |
| ১    | নাটক                                    |            |        |        |       |         |
| ২    | গান                                     |            |        |        |       |         |
| ৩    | অংশগ্রহণমূলক প্রোগ্রাম                  |            |        |        |       |         |
| ৪    | স্বাস্থ্য ও পুষ্টি বিষয়ক ক্ষুদে বার্তা |            |        |        |       |         |
| ৫    | বিষয় ভিত্তিক আলোচনা                    |            |        |        |       |         |

নোট: খুবনি = খুবই নিয়মিত (প্রতি ৭ দিনে অন্তত ১ বার); নিয়মি=নিয়মিত (প্রতি ১৫ দিনে আন্তত একবার); মোনিয়মি=মোটমুটি নিয়মিত(অন্তত ১ বার ১ মাস); অনিয়ম= অনিয়মিত (অন্তত ১ বার/ ৩ মাস); খুব অনিয়ম=খুবই অনিয়মিত (অন্তত ১ বার/ ৬ মাস)

১২. স্বাস্থ্য ও পুষ্টি বিষয়ক তথ্য প্রাপ্তিরজন্য কমিউনিটি রেডিও ব্যতীত অন্যান্য

কমিউনিটি রেডিও শোনার জন্য ব্যবহৃত ডিভাইসের মালিকানা

| মোবাইল ফোন |           |     | রেডিও |           |     | ইন্টারনেট |           |     |
|------------|-----------|-----|-------|-----------|-----|-----------|-----------|-----|
| নিজ        | পারিবারিক | নেই | নিজ   | পারিবারিক | নেই | নিজ       | পারিবারিক | নেই |

১৩. অন্যান্য যোগাযোগ মাধ্যমের ব্যবহার।

(প্রতিটি প্রশ্নের জন্য সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

| ক্রঃ | যোগাযোগ মাধ্যমের নাম                                | ব্যবহারের ৪ মাত্রা |           |          |        |       |
|------|---|--------------------|-----------|----------|--------|-------|
|      |   | সবসময়*            | প্রায়শ:ই | মাঝেমাঝে | কদাচিৎ | করিণা |
| ১    | সরকারি হাসপাতাল এবং স্বাস্থ্য কেন্দ্র               |                    |           |          |        |       |
| ২    | এম বি বি এস ডাক্তার                                 |                    |           |          |        |       |
| ৩    | এলএমএএফ ডাক্তার (RMP) / প্যারামেডিকেল ডাক্তার (DMF) |                    |           |          |        |       |
| ৪    | মাঠ স্বাস্থ্য কর্মী (সরকারি)                        |                    |           |          |        |       |
| ৫    | মাঠ স্বাস্থ্যকর্মী (বেসরকারি)                       |                    |           |          |        |       |
| ৬    | ঔষধ বিক্রেতা  |                    |           |          |        |       |
| ৭    | খবরের কাগজ, ম্যাগাজিন, ইত্যাদি                      |                    |           |          |        |       |
| ৮    | বিলবোর্ড, পোস্টার, লিফলেট, ইত্যাদি                  |                    |           |          |        |       |
| ৯    | স্কুল-কলেজগামী ছেলে-মেয়ে                           |                    |           |          |        |       |
| ১০   | বন্ধুবান্ধব, আত্মীয় স্বজন, প্রতিবেশী               |                    |           |          |        |       |

১৪. স্বাস্থ্য ও পুষ্টি বিষয়ক তথ্য সংগ্রহেরজন্য কমিউনিটি রেডিও ব্যতীত অন্যান্য ইলেকট্রনিক যোগাযোগ মাধ্যমেরব্যবহার।

(প্রতিটি মাধ্যমের জন্য সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

| ক্রঃ | যোগাযোগ মাধ্যমের নাম                                       | ব্যবহারের মাত্রা |           |           |         |       |
|------|--|------------------|-----------|-----------|---------|-------|
|      |  | সবসময়*          | প্রায়শ:ই | মাঝে মাঝে | কদা চিৎ | করিণা |
| ১    | টেলিভিশন   |                  |           |           |         |       |
| ২    | রেডিও (কমিউনিটি রেডিও ব্যতীত)                              |                  |           |           |         |       |
| ৩    | মোবাইল ফোন হেল্পলাইন (কল/মেসেজ)                            |                  |           |           |         |       |
| ৪    | ইন্টারনেট ওবেসাইট, ওয়েব ভিত্তিক কল                        |                  |           |           |         |       |
| ৫    | সরকারীপ্রামাণ্য চিএ  |                  |           |           |         |       |
| ৬    | মোবাইল বা কম্পিউটার ভিত্তিক ভিডিও ক্লিপ, সিনেমা, নাটক, গান |                  |           |           |         |       |
| ৭    | মোবাইল বা কম্পিউটার ভিত্তিক আপস                            |                  |           |           |         |       |

\*সবসময়= ১বার/১৫ দিন, প্রয়শ:ই= ১বার/মাস, মাঝেমাঝে= ১ বার/৩ মাস, কদাচিৎ= ১ বার/৬ মাস, করিনা = গত ছয় মাসে করি নাই

১৫. পরিবারিক স্বাস্থ্য ও পুষ্টি বিষয়ে সচেতনতা। (প্রতিটি প্রশ্নের জন্য সংশ্লিষ্ট ঘরে টিক চিহ্ন দিন)

| ক্র:    | বিষয়   | সচেতনতার মাত্রা |   |   |   |   |
|---------|---|-----------------|---|---|---|---|
|         |   | ক               | খ | গ | ঘ | ঙ |
| ১.(-)   | বংশে ডায়বেটিস, উচ্চ রক্তচাপ, হার্টের অসুখের ইতিহাস থাকলে জীবনযাত্রা এবং খাদ্যাভাস পরিবর্তনের মাধ্যমে প্রতিরোধ সম্ভব নয়      |                 |   |   |   |   |
| ২. (+)  | ডায়বেটিসের চিকিৎসা তেমন ব্যয়বহুল নয় বরং চিকিৎসা না করা বেশী ব্যয়বহুল  |                 |   |   |   |   |
| ৩. (-)  | শিশুর স্বাস্থ্য ভাল থাকলে নিয়মিত উচ্চতা এবং ওজন মাপার প্রয়োজন নেই   |                 |   |   |   |   |
| ৪. (-)  | স্বাস্থ্য ও পুষ্টি বিষয়ক অনেক গুরুত্বপূর্ণ তথ্য ঔষধের দোকান থেকেই পাওয়া সম্ভব   |                 |   |   |   |   |
| ৫. (-)  | উচ্চরক্তচাপে আক্রান্ত রোগীর নিয়মিত ঔষধ খেলে খাবারপাতে আলগা লবণ খেতে পারবেন   |                 |   |   |   |   |
| ৬. (-)  | ডায়রিয়া বা পাতলা পায়খানা হলে শুধুমাত্র খাবার স্যালাইন খাওয়া যথেষ্ট  |                 |   |   |   |   |
| ৭. (-)  | ছোট শিশুদের মল বা পায়খানা বাড়ির পাশ্ববর্তী যেকোন স্থানে ফেললে রোগ-ব্যাধি ছড়ানোর কোন সম্ভাবনা থাকে না                       |                 |   |   |   |   |
| ৮. (-)  | মাছ-মাংস, ডিম, ইত্যাদি রোগ প্রতিরোধক খাবার  |                 |   |   |   |   |
| ৯. (+)  | বয়:সন্ধিকালে কিশোর-কিশোরীদের মানসিক সাহায্যের প্রয়োজন হয়   |                 |   |   |   |   |
| ১০. (-) | শিশুর বয়স ৬ মাস হলে মায়ের দুধের পাশাপাশি পরিমাণমত প্যাকেটজাত খাবার (যেমন: সেরিল্যাক, গুড়া দুধ, জুস, ইত্যাদি) খাওয়ানো উচিত |                 |   |   |   |   |
| ১১. (-) | জন্মের পর শিশুর মুখে মধু, চিনির পানি, মিসরির পানি বা অন্য কোন তরল জিনিস দেয়া যেতে পারে                                       |                 |   |   |   |   |
| ১২. (-) | উপযুক্ত পরিবেশ থাকলে বাড়িই সন্তান প্রসবের উপযুক্ত স্থান  |                 |   |   |   |   |
| ১৩. (+) | নিউমোনিয়া শিশুদের শ্বাসতন্ত্র সংক্রান্ত একটি মারাত্মক রোগ  |                 |   |   |   |   |
| ১৪. (-) | খাবার পরে ভালভাবে সাবান দিয়ে হাত ধোয়া উচিত পূর্বে নয়   |                 |   |   |   |   |
| ১৫. (-) | শিশু জন্মের পর পর তাকে হালকা গরম পানি দিয়ে গোসল করানো উচিত   |                 |   |   |   |   |

নোট: ক= সম্পূর্ণ একমত, খ= একমত, গ= একমতওনইদ্বিমতওনই, ঘ= দ্বিমত, ঙ= সম্পূর্ণ দ্বিমত; সিআর= কমিউনিটি রেডিও; অন্যান্য= কমিউনিটি রেডিও ব্যতিত অন্য যেকোন মাধ্যম

সাক্ষাৎকার প্রাদানের জন্য আপনাকে ধন্যবাদ

সাক্ষাৎকার গ্রহনকারীর স্বাক্ষর ও তারিখ

## Appendix-III

### Check list of Questions for Qualitative Data Collection Methods

১. কমিউনিটি রেডিওতে প্রচারিত স্বাস্থ্য বিষয়ক কয়েকটি অনুষ্ঠানের নাম বলুন।
২. কমিউনিটি রেডিওতে প্রচারিত স্বাস্থ্য বিষয়ক অনুষ্ঠানের মধ্যে কোন ধরনের অনুষ্ঠান (যেমন: বিষয়ভিত্তিক আলোচনা, নাটক, গান, অংশগ্রহণমূলক আলোচনা, ক্ষুদে বার্তা, ইত্যাদি) আপনার বেশী ভাল লাগে এবং কেন?
৩. কমিউনিটি রেডিওতে প্রচারিত স্বাস্থ্য বিষয়ক অনুষ্ঠানের আলাদা কোন বিশেষত্ব আছে কি? থাকলে বিস্তারিত বলুন।
৪. কমিউনিটি রেডিওতে প্রচারিত স্বাস্থ্য ও পুষ্টি বিষয়ক থেকে আপনি কিভাবে লাভবান হছেন তা বিস্তারিত বলুন? এমন কোন ঘটনা থাকলে তা উল্লেখ করুন।
৫. কমিউনিটি রেডিওতে স্বাস্থ্য ও পুষ্টি বিষয়ক তথ্য পেতে আপনি কি কি সমস্যার সম্মুখীন হন?
৬. কমিউনিটি রেডিওতে স্বাস্থ্য ও পুষ্টি বিষয়ক তথ্য সহজলভ্য করতে কি কি পদক্ষেপ নেয়া উচিত বলে আপনি মনে করেন ?
৭. দিন বা রাতের কোন সময়ে আপনি স্বাস্থ্য ও পুষ্টি বিষয়ক তথ্য পেতে চান এবং কেন?
৮. স্বাস্থ্য ও পুষ্টি বিষয়ক বিভিন্ন তথ্য প্রচারে কমিউনিটি রেডিওর সম্ভাবনা কেমন বলে আপনি মনে করেন? বিস্তারিত বলুন।
৯. অন্যান্য প্রচলিত মাধ্যম থেকে এ মাধ্যমের বাড়তি কোন সুবিধা আছে কি? থাকলে বিস্তারিত বলুন।
১০. কমিউনিটি রেডিওতে স্বাস্থ্য বিষয়ক অনুষ্ঠান পরিচালনা করতে গিয়ে আপনি কি ধরনের সমস্যার সম্মুখীন হন?
১১. কোন ধরনের (যেমন: বিষয়ভিত্তিক আলোচনা, নাটক, গান, অংশগ্রহণমূলক আলোচনা, ক্ষুদে বার্তা, ইত্যাদি) স্বাস্থ্য বিষয়ক অনুষ্ঠান শ্রোতারা বেশী পছন্দ করেন এবং কেন?
১২. কোন সময়ে প্রচারিত স্বাস্থ্য ও পুষ্টি বিষয়ক অনুষ্ঠানে শ্রোতারা সবচেয়ে বেশী অংশগ্রহণ করে এবং কেন?
১৩. কমিউনিটি রেডিওতে প্রচারিত স্বাস্থ্য ও পুষ্টি বিষয়ক অনুষ্ঠানের মান কিভাবে আরও বৃদ্ধি করা যায়?
১৪. কিভাবে কমিউনিটি রেডিওতে প্রচারিত স্বাস্থ্য ও পুষ্টি বিষয়ক অনুষ্ঠানের শ্রোতা আরও বৃদ্ধি করা যেতে পারে?