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Abstract

In order to identify the existing health information sources and channels of rural women, 213 married women of child bearing age from four villages of Kangpokpi District in Manipur, India were randomly selected. A questionnaire method was adopted for the data collection and Descriptive Statistics was used for analyzing the data collected from the women. The study identified a number of health information sources such as Family members, Friends, among others and Information channels like Word of Mouth ASHA, Pamphlet in Mother tongue, Mobile phone Short Message System (SMS) for communicating their health information needs.

Keywords: Women Health Information, Rural Women, Health Information Sources, Health Information Channels, India

Introduction

Webster dictionary defines health as the state of being hale, sound, or whole, in body, mind, or soul; especially, the state of being free from physical disease or pain ("Health", 1913). Information can be defined as any fact, or set of facts, knowledge, news, or advice, whether communicated by others or obtained by personal study and investigation; any datum that reduces the uncertainty about the state of any part of the world; intelligence; knowledge derived from reading, observation, or instruction (Webster, 1913). Health information sources

may be defined as place/s, person/s, and/or document/s from which information on health is obtained or originated. And the medium which acts in communicating the health information from the source to destination is called Health Information Channel. Sometimes some of the health information sources also act as health information communication channels by acting as medium in communicating the health information to people. Information is a vital resource in every aspects of human life. Access to right kind of information or possession of correct and relevant information and proper utilisation of information is crucial for the survival of modern society (Yusop, Ibrahim, Yusof, Aji, Dahalin, Ghazali, Saad, & Abu, 2013).

Women's health refers to the health issues relating to, or specific to human female anatomy such as menstruation, contraception, child birth, menopause, and breast cancer. It also includes proper nutrition, especially during pregnancy, child birth and during child nursing. Due to the low socio economic profile, rural women are suffering from many health related problems, particularly reproductive health problems. But most of these problems are often poorly addressed (Ogi, 2016).

Literature Review

Olaleye and Bankole (1994) conducted a study on influence of media messages about family planning, and attitudes toward media promotion of family planning, on contraceptive behavior of married women in Ghana among 4,488 female respondents. The study found that women who had heard or seen advertisements on contraceptive brands, and women who favour broadcast of family planning messages in the media, are found to be significantly more likely to adopt birth control behavior than women who had not heard or seen, and women who do not favor broadcast of such media messages.

The rural Ngwa women in Africa placed emphasis on witchcraft, curses and oaths as the primary causes of maternal reproductive health disorders. The women also held high value to herbal remedies for the treatment of reproductive health ailments. The study indicates an important challenge for a need to incorporate indigenous and faith healers into rural primary health care delivery schemes. This is very important since the solution to some of the maternal reproductive health problems can best be found within a framework that recognises local cultures and knowledge systems. The findings brought to focus the need to intensely encourage the education of women and incorporate various health providers into primary health care delivery schemes (Izugbara, 2000).

The women of the peri-urban community of Bairro da Luz, Brazilhighly trusted the medicinal plants for their health treatments. Only two of the 153 women did not use medicinal plants or phytotherapy because they did not believe it was an effective form of treatment. The

women prefer their own home remedies of the medicinal plants over the hospitals. The study suggested that Health care providers and policy makers could work with women to develop an inventory of locally available species of medicinal plants (Waylan, 2001).

McNay, Arokiasamy, and Cassen (2003) conducted a study on the use of contraception by uneducated Indian women. The Authors highlight the positive role of educated others and media exposure at the household and individual levels, indicating that the communication and diffusion of ideas about, and attitudes towards, fertility behavior through these channels such as the educated persons and media are playing an important part.

Rani and Bonu (2003) conducted a study on rural Indian women's care-seeking behavior and choice of provider for gynecological symptoms. The women seek their health information needs from Private and Public Providers. Public providers included government doctors, public health nurses, ANM (auxiliary nurse/midwives), lady health visitors, male multi- purpose workers, male supervisors, Anganwadi workers, village health guides, or other public-sector health workers. Private providers included private doctors, private nurses, compounder/pharmacists, vaid/hakim/homeopaths, traditional birth attendants and NGO workers.

Rural women in Koppal, Karnataka were found to repeatedly accessed informally as well as formally qualified health providers, located in government and private services, both in and outside the district, but they still failed to get effective obstetric care. Observations made in the study found the following service delivery failings such as weak information systems, discontinuity of care, unsupported health workers, haphazard referral systems and distorted account ability mechanisms (George, 2007).

A study on Health and Health Seeking Behaviour of Married Muslim Women in Katigorah Block of Cachar District, Assam was conducted by Parveen (2013). The researcher found that there is a prevalence of medical pluralism among both the lower and upper caste groups of the women in the study area. Drug sellers were identified as the first choice in the provision of healthcare in the area. PHC (Primary Health Centre), private MBBS doctors, and other qualified health service providers were found to be utilized only in case of pregnancy and delivery, or when illnesses turned serious, but less for general health problems.

While evaluating the healthcare services under National Rural Health Mission (NRHM) in Salem District, Tamil Nadu, Vadivelu (2015) found that Primary Health Centres (PHCs) contributed to increase the utilisation of health centers in the study area. The Primary health care centers (PHCs) are also better able to address poor coverage of basic health care and lack of equipment by communities in health systems.

A total of 278 women who belonged to the age group of 18-60 years were chosen to conduct a study on Women Beneficiaries of National Rural Health Mission in Barwani District of Madhya Pradesh. The study found that women access their health care needs from health care sources like the Sub Centre, Primary Health Centre (PHC), Community Health Centre (CHC), Auxiliary nurse midwife (ANM), Accredited Social Health Activist (ASHA) (Mathew, 2016).

General Inferences

From the above literatures it is seen that a number of studies on women's health information sources and channels have been conducted in different parts of the country and also in different parts of the world. The women seek health information needs from health information sources from both the public and private sectors. Public sectors include government doctors, public health nurses, ANM (auxiliary nurse/midwives), lady health visitors, male supervisors, Anganwadi workers, village health guides, or other public-sector health workers, and private health sectors include private doctors, private nurses, compounder/pharmacists, homeopaths, traditional birth attendants. The mentioned sources also sometimes serve as channels in communicating women health information. Literatures have also found that women preferred and trusted informal sources like family members, faith healers, herbal practitioners, other women in the community such as the close neighbours, other women in the village, or women in other parts of the country, educated persons as channels in communicating their health information needs (Waylan, 2001; Johnston, Ved, Lyall, & Agarwal, 2003; Rani, & Bonu, 2003; George, 2007; Parveen, 2013).

Statement of the problem

The awareness level of health care facilities is found to be very low especially among rural women in the developing poor countries. The health care provided to rural areas is highly disproportionate to the needs of the rural women and abnormally low as compared to urban areas. And also, the existing health services being provided through a network of government hospitals, dispensaries, and primary health centers in the rural areas do not reach or remain underutilized by women. One main reason for underutilization of such necessary schemes would be due to lack of awareness. Health information sources provide important information on health care and health information channels help in dissemination of health information to the target audience. Identification of the women health information sources and channels among the rural women of the study area will help in effective dissemination of health information.

Research Methodology

All married women of childbearing age, that is, 18 years to 45 years in the four villages formed the population. The whole population was covered in the study. Total population of married women of child bearing age about 213 (Two hundred thirteen). Since there is no official government census available, the total population, total number of households and the total number of women of child bearing age from each village is taken from the respective village chief from the four villages. Questionnaire method was adopted for the data collection and the data was analysed using Descriptive Statistics. The data collection was carried out from 2018-19.

Table – 1: Demographic profile of the respondents

Sl. No.	Village	Total Household	Total Population	Total population of married women of child bearing age
1.	Haijang	50	353	51
2.	South Changoubung	72	670	55
3.	Chaljang	130	875	61
4.	Wakotphai	124	700	46
5.	Total	376	2598	213

(Source: Study Area/Villages chiefs)

Table - 2: Education Qualification of the Respondents

Sl. No.	Level of Education	No. of Respondents	Percentage (%)
1.	None	67	31
2.	Primary	103	48
3.	Class X	31	15
4.	Class XII	11	05
5.	Graduate	01	00

Table-3: Annual Income of the Respondents

Sl. No.	Income (in INR)	No. of Respondents	Percentage (%)
1.	<10,000	204	96
2.	10,001-20,000	07	03
3.	20,001-30,000	02	01
4.	>30,000	00	00
5.	Total	213	100

Data Analysis and Interpretation

A list of a number of health information sources and channels were distributed among the women of the study area and they were made to rank the sources and channels in a five-point Likert scale. The responses were tabulated and analysed using Descriptive Statistics. Mode value was calculated for various information sources of all the villages and sorted and shown in the table. The average mean value of all the villages is also calculated.

Health Information Sources

The table 4 displays the different sources identified by the women from the four villages in seeking their health information. The data was collected from four villages. The total respondents from these four villages are 213 women. Mode value was calculated for various information sources of all the villages and sorted and shown in the table. The average mean value of all the villages is also calculated. The findings are shown below: -

Table – 4: Health Information sources identified by respondents

(N=51+55+61+46=213)

Sl. No.	Source	Average Frequency					
		All Villages (Mean)	Untreated Village	Mobile SMS Village	Word-of-Mouth Village	Pamphlet-in-Mother Tongue Village	All Villages (Mode)
1.	Family Members	3.8	4	4	4	4	4
2.	Friends	3.7	3	4	4	4	4
3.	Traditional Midwives	3.5	4	4	4	4	4
4.	Pharmacy	3.5	3	4	3	3	4
5.	Neighbors	3.5	4	4	3	3	4
6.	Health Workers	3.2	4	4	3	4	4

7.	Community Health Centre	2.7	4	2	2	2	3
8.	Nurses	2.7	4	3	2	2	3
9.	Church	2.6	3	4	1	2	3
10.	Anganwadi Workers	2.5	3	3	1	2	3
11.	Village Chief	2.2	2	3	1	2	2
12.	Church Elders	2.1	2	3	2	2	2
13.	Herbal Practitioners	2.1	1	3	2	2	2
14.	Village Elders	2.1	2	3	2	2	2
15.	Rural Health Centre/Dispensary/Sub-Centre	1.9	1	2	3	2	2
16.	Masseurs/Masseuse	1.8	2	1	1	2	2
17.	Private Clinics	1.7	1	2	2	1	2
18.	Private Doctors	1.7	2	1	2	1	2
19.	Quacks	1.6	1	2	1	2	2
20.	Primary Health Centre	1.6	1	1	2	2	2
21.	Specialist Doctors	1.6	2	2	1	1	2
22.	Priests	1.5	2	1	1	2	2
23.	Traditional Healers	1.5	2	1	2	1	2
24.	Newspaper/Magazine	1.5	1	2	1	2	2

Scale1: Not Aware, 2: Somewhat Satisfactory, 3: Satisfactory, 4: Good, 5: Excellent

The study found that, among the different types of health information sources identified by the women, Family members, Friends, Traditional Midwives, Pharmacy, Neighbors and Health workers are the highest ranked sources for health information which has the average rank of 4 (Good) each, which is followed by Community Health Centre (CHC), Nurses, Church, and Anganwadi workers with average rank of 3 (Satisfactory) each; then from Village Chief, Village Elders, Church Elders, Herbal Practitioners, Rural Health Centre (RHC),Masseurs/Masseuse, Private Clinics, Private Doctors, Quacks, PHC, Specialist Doctors, Priests, Traditional Healers, Newspaper/Magazine with average rank of 2 (Somewhat Satisfactory) each.

It may be noted that the women had ranked the traditional forms of health information sources such as Family Members, Friends, and Neighbours higher than scientifically proven health information sources such as Primary health Centre, Rural Health Centre, Private Doctors, and Specialist Doctors. This may be because the women being barely literates with no formal education or just basic education (Table: 2) and residing in rural or remote areas with meager or no income of their own (Table: 3), do not have much choices in seeking health information needs from the scientifically proven sources which are mostly expensive and located in urban areas. Therefore, they rely mostly on the sources that are within their comfort zone such as family, friends, church, village chief, and herbal practitioners that are easily and readily available in the villages with no cost or at minimum cost. In more serious illness conditions, the women have reported to consult private doctors, Specialists doctors, and Private clinics. But other than that, the women rely on sources available in and around their respective villages, which are accessible and affordable.

Table - 5: Average frequencies of identified Health Information sources

Sl. No.	Source	Average Frequency					
		All Villages (Mean)	Untreated Village	Mobile SMS Village	Word-of-Mouth Village	Pamphlet-in-Mother Tongue Village	All Villages (Mode)
1.	Faith Healers	1.4	1	1	1	1	1

2.	Alternative medicine Sellers	1.3	1	2	1	1	1
3.	Door to Door Medicine Sellers	1.3	1	2	1	1	1
4.	An Educated Person	1.2	1	1	1	1	1
5.	Radio	1.0	1	1	1	1	1
6.	Mobile Phone	1.0	1	1	1	1	1
7.	Television	1.0	1	1	1	1	1
8.	Internet	1.0	1	1	1	1	1
9.	Posters	1.0	1	1	1	1	1

Scale1: Not Aware, 2: Somewhat Satisfactory, 3: Satisfactory, 4: Good, 5: Excellent

The table 5 shows the other health information sources which are listed in the questionnaires but have a mean value of less than 1.5 and mode score of less than 2. This means that these sources are hardly used by the respondents in seeking their health information needs.

Health Information Channels

The table 6 displays the health information channels which are identified by the women as the most important for health information. The mode values of each village and average mean of all villages of health information channels is shown in the table below. The health information channels identified in the study area are Word of Mouth, ASHA, Pamphlet in Mother tongue, Mobile phone SMS.

Table - 6: Health Information channels identified by women

Sl. No.	Channels	Average Frequency					
		All Villages (Mean)	Untreated Village	Mobile SMS Village	Word-of-Mouth Village	Pamphlet-in-Mother Tongue Village	All Villages (Mode)
1.	Word of Mouth	4.7	5	5	5	5	5

2.	ASHA	3.8	4	4	3	4	4
3.	Pamphlet in Mother tongue	3.7	4	4	3	5	4
4.	Mobile phone SMS	2.1	1	3	1	1	2

Scale1: Not preferred, 2: Preferred Moderately, 3: Preferred, 4: Preferred More,

5: Preferred Most

Among the different heath information channels, the Word of Mouth is found to be ranked highest health information channel identified in these four villages. It may be because Word of Mouth is effortless for them where information is given to them verbally or through word of mouth. Next to word of mouth, the ASHA is the second highest ranking channel for communicating health information channels. The ASHAs are women from the village itself, speaking the local dialect and are appointed by the Government mainly for communicating the women health information needs directly to the women by paying the women regular home visits. The third highest ranking choice of channel is the Pamphlet in mother tongue. Next is the Mobile Phone SMS. Mobile phones may not still reach many remote villages but in the areas where mobile phones are used, the women identified it as one source of health information channel.

Findings

The women identified about 27 different health information sources and 4 health information communication channels such as Word of Mouth, ASHA, Pamphlet in Mother tongue, Mobile phone SMS. Word of Mouth is found to be ranked the highest health information channel identified by the women. Among those 27 identified sources, the top ten highest ranked health information sources are Family Members, Friends, Traditional Midwives, Pharmacy, Neighbors, Health Workers, Community Health Centre, Nurses, Church, and Anganwadi Workers. This shows that informal sources of health information are more popular than the formal health information sources among the rural women of the study area. This finding is similar to the findings of the literatures on women health information sources and channels where women were found to trust the informal sources such as Family members, Priests, herbal practitioners, neighbors, educated person, and Traditional healers. The women were also found to seek their health information needs from the public health sources such as Govt. Doctors, public health nurses, Auxiliary Nurse/Midwives (ANM), and also from private

sectors like private doctors, private nurses, pharmacists, etc. (Waylan, 2001; Johnston, Ved, Lyall, & Agarwal, 2003; Rani, & Bonu, 2003; George, 2007; Parveen, 2013).

Conclusion

In India, there is an adverse declining sex ratio and the life expectancy of women is lower than that of men's. Women in rural areas are older, poorer, less educated, have greater financial hardship, and encounter more geographical barriers (Gerrior, Crocoll, Hayhoe, & Wysocki, n.d.). Due to the low socio economic profile, rural women are suffering from many health related problems, particularly reproductive health problems. Infant and maternal mortality are also higher in rural areas. To provide better health and awareness level, and to lower the growing rates of mortality due to lack of adequate health facilities, special attention needs to be given to the health care system in rural areas. In order to address the various health problems faced by the women in general, and the rural women in particular, the government should take steps in identifying the women health information sources and channels among the rural women as this will mean bringing better awareness to the rural women about their health information needs by communicating the health information through the sources and channels identified, chosen, and preferred by them.

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Appendix: Questionnaire

BACKGROUND INFORMATION

1. Age (as on 31/03/2018): ……

2. Marital Status: ……

3. Religion: …….

4. Occupation: (Please tick)

Trading		Farming		Housewife		Handicraft	
Government		Others (Specify):		……		……	

5. Village: .....

6. Household size: (Actual number)

   No of female members […….]

   No of male members […….]

7. Highest level of education:

   None [……] Primary School [……] Class X pass [……] Class 12 pass [……]

   Graduate [……] Post-Graduate [……] Others (Specify): ……

8. Knowledge of **Mother Tongue**: (*Please tick the appropriate box*)

   Read & Write [……], Read & Speak [……], Speak only [……]

9. Knowledge of **Other languages**: (*Please name the language known to you and indicate the level of knowledge by ticking the appropriate box*)

   (a) ……..…… : Read [……] Write [……] Speak [……]

   (b) ……. : Read [……] Write [……] Speak [……]

   (c) ……. : Read [……] Write [……] Speak [……]

10. Approximate annual income of your family from all sources (in Rupee):

    ……

11. Your approximate annual income from all sources (in Rupee):

……

12. Who is/are the main bread winner(s) in the family?

……

ON DECISION MAKING

13. Using the scale provided please rank the following according to your opinion:

1 – Strongly Disagree, 2 – Disagree, 3 – Undecided, 4 – Agree, 5 – Strongly Agree

You should take your own health related decisions	1	2	3	4	5
Husband should take your health related decisions	1	2	3	4	5
In-laws should take your health related decisions	1	2	3	4	5
Your parents should take your health related decisions	1	2	3	4	5
Relatives have the right to share their opinion on your health related decisions	1	2	3	4	5
Your community has the right to have a say on your health	1	2	3	4	5
Your doctor should take your health decisions	1	2	3	4	5
Anyone you trust could treat your treatments best should take your health decisions	1	2	3	4	5

Please specify others whose opinion matters:

	1	2	3	4	5
	1	2	3	4	5

14. Who take the final decision on issues related to your health? Please rank the options using the scale: **1 – Never**, **2 – Sometimes**, **3 – Occasionally**, **4 – Often**, **5 – Always**

Self	1	2	3	4	5
Husband	1	2	3	4	5
Father-in-law	1	2	3	4	5
Mother-in-law	1	2	3	4	5

Your Parents	1	2	3	4	5
Doctor	1	2	3	4	5
Others (Specify): ……	1	2	3	4	5

15. Whose opinion matters on your child bearing related decisions? Please rank the options using the scale: **1 – Never**, **2 – Sometimes**, **3 – Occasionally**, **4 – Often**, **5 – Always**

Self	1	2	3	4	5
Husband	1	2	3	4	5
Father-in-law	1	2	3	4	5
Mother-in-law	1	2	3	4	5

Your Parents	1	2	3	4	5
Doctor	1	2	3	4	5
Others (Specify): ……	1	2	3	4	5

16. Please choose the option closest to your level of **independence in seeking health information**.

1	Not independent at all
2	Rarely independent
3	Independent
4	More independent
5	Most independent

HEALTH INFORMATION SEEKING

17. How often do you seek health information?

1 Never	**2** Rarely	**3** Occasionally	**4** Frequently	**5** Quite Frequently

18. Which sources of health information are most helpful in taking health related decision? Please rank the options on the basis of the frequency of information sought using the scale: **Not Aware, 2: Somewhat Satisfactory, 3: Satisfactory, 4: Good, 5: Excellent**

Community Health Centre	1	2	3	4	5
Primary Health Centre	1	2	3	4	5
Rural Health Centre Dispensary/Sub Centre	1	2	3	4	5
Chemist (Pharmacy)	1	2	3	4	5

Faith healers	1	2	3	4	5
Priests	1	2	3	4	5
Friends	1	2	3	4	5
Family members	1	2	3	4	5

Private Clinics/Nursing home	1	2	3	4	5	Traditional midwives	1	2	3	4	5
Private Doctors	1	2	3	4	5	Church elders	1	2	3	4	5
Famed Specialist Doctors	1	2	3	4	5	Village elders	1	2	3	4	5
Nurses	1	2	3	4	5	Chief	1	2	3	4	5
Health Workers	1	2	3	4	5	An educated persons	1	2	3	4	5
Anganwadi Workers	1	2	3	4	5	Radio	1	2	3	4	5
Traditional Healers	1	2	3	4	5	Television	1	2	3	4	5
Herbal Practitioners	1	2	3	4	5	Newspaper/Magazine	1	2	3	4	5
Self- Practitioners (Quacks)	1	2	3	4	5	Posters	1	2	3	4	5
Door to door medicine sellers	1	2	3	4	5	Others (Specify):					
Masseur / Masseuse	1	2	3	4	5		1	2	3	4	5
Alternative medicine Sellers	1	2	3	4	5		1	2	3	4	5