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IDENTIFYING THE TRUSTED AND PREFERRED HEALTH INFORMATION SOURCES OF RURAL WOMEN OF KANGPOKPI AREA, MANIPUR

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Abstract

To identify the trusted and preferred sources of health information among rural women, all women of four rural/remote villages around Kangpokpi town, namely, Haijang, South Changoubung, Chaljang, and Wakotphai are studied. The study has found that the most trusted and preferred source of health information of the rural women is found to be Community Health Centre (CHC). There is also a high preference and high level of trust in the Informal sources such as family members, Traditional Mid-wives, and friends.

Keywords: Health Information Sources, Women Health, Rural Women

Introduction

Health is defined 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 (*http://www.webster-dictionary.org/definition/health*). Information is defined as "data that is accurate and timely, specific and organized for a purpose, presented within a context that gives it meaning and relevance, and can lead to an increase in understanding and decrease in uncertainty (http://www.businessdictionary.com/definition/information.html#ixzz4HNqcaQb6). Health Information can be defined as "a health service provided, or to be provided, to an individual" (Australian Law Reform Commission, n.d.). Health information source is where information on health care is obtained. Health information sources can be persons such as Doctors, Nurses, other health professionals, or offices and hospitals. Some of the health information sources also act as health information channels. A variety of factors combine to make rural life unfavourable for

women. When compared to urban residents, women in rural areas are older, poorer, less educated, have greater financial hardship, and encounter more geographical barriers (HRSA 2005 in Gerrior, S.A., Crocoll, C., Hayhoe, C. &Wysocki, J., n.d.).

Literature Review

The qualitative data from the study in four villages in rural Uttar Pradesh demonstrate that women who experienced abortion complications generally first sought care from un-trained or inadequately trained providers in their village. When their medical condition worsened, some women sought the services of providers who were more qualified but less affordable or less conveniently located (Johnston, Ved, Lyall&Agarwal, 2003). In the words ofRani Bonu, (2003), less than one-third of women surveyed in rural India who had gynecological symptoms sought formal medical treatment. Of those who sought care, only 23 percent consulted a public provider such as government doctors, public health nurses, auxiliary nurse/midwives, lady health visitors, male multi-purpose workers, male supervisors, Anganwadi workers, village health guides, or other public-sector health workers, 71 percent consulted a private provider private doctors, private nurses, compounder/pharmacists, vaid/hakim/homeopaths, traditional birth attendants and NGO workers, and 6 percent consulted both a public and a private provider. The proportions seeking care varied significantly according to location and by socioeconomic and demographic group. It is also found that only 8 percent of all consultations with providers took place with frontline paramedical workers, and the majority of symptomatic women, including women from disadvantaged groups, consulted private providers, except in a few northeastern states. Women who had heard or seen advert on contraceptive brands, and women who favor broadcast of family planning messages in the media, are 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, respectively. A study carried out on influence of media messages about family planningand attitudes toward media promotion of family planning, on contraceptive behavior of married women in Ghana by Olaleye&Bankole (1994) The study shows that women who had heard or seen advert on contraceptive brands, and women who favor broadcast of family planning messages in the media, are 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, respectively.

Statement of the Problem

According to Census of India (2011) out of the total of 1210.2 million populations in India, the size of rural population is 833.1 million (or 68.84% of the total population) and urban population is 377.1 million (or 31.16%). However, about 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas, where about 31.2% of the population resided. Women living in rural locations are more likely to report poorer health status and more physical limitations than urban women (ERS, 2006 in Gerrior, S.A., Crocoll, C., Hayhoe, C. &Wysocki, J.,n.d.) Therefore, emphasis should be made to strengthen links between rural, village-based providers and the formal health care system, to help women avoid unsafe abortion and to ensure that health care services reflect and meet the priorities and needs of women and those who seek care on their behalf (Johnston, Ved, Lyall&Agarwal, 2003).

Methodology

Four villages were selected from the rural villages around Kangpokpi of Manipur for the study. The sites were selected on the basis of the researcher's familiarity with the people, place, mother tongue of the population and accessibility.The questionnaires are constructed using a point 5 scale ranking system, where 1 is the least (never) and 5 the most (most frequently). The questionnaires are distributed among all the women for response.

Population: All married women of childbearing age in the four villages will form the population. The whole population will be covered in the study. The total population of the women in all four villages is 213.

Age group	No. of persons	Education	No. of persons
< 17	0	None	67
18-25	90	Class-VI	104
26-32	95	Class-X	30
33-40	24	Class-XII	11
>40	4	Graduate	1
Total	213	Total	213

N=213

Table: Age group and Educational qualification of the women

Analysis and Interpretation

The data collected were tabulated and analysed using Descriptive Statistical method as follows:

Preferred sources

1=Not preferred, 2= Rarely Preferred, 3= Preferred, 4= Preferred More, 5= Preferred Most

Sl.no.	Preferred source	Average Frequency					
		All villages mean	Village 1	Village 2	Village 3	Village 4	All Villages
1	Community Health Centre (CHC)	4.1	5	4	5	4	5
2	Family Members	3.9	4	4	4	4	4
3	Traditional Midwives	3.9	4	4	4	4	4
4	Nurses	3.7	4	4	4	4	4
5	Pharmacy	3.7	4	4	4	4	4
6	Friends	3.6	3	4	4	4	4
7	Health Workers	3.5	4	3	4	4	4
8	Private Clinics	2.8	3	3	3	3	3
9	Anganwadi Workers	2.8	2	3	3	3	3
10	Specialist Doctors	2.8	3	1	4	3	3
11	Church Elders	2.6	3	3	3	3	3
12	Chief	2.6	3	3	2	3	3
13	Herbal Practitioners	2.6	1	4	3	3	3
14	Private Doctors	2.5	3	1	3	3	3
15	Village Elders	2.5	3	3	2	3	3
16	Rural Health Centre (RHC)/Sub Centre/Dispensary	2.3	1	2	4	3	2
17	Priests	2.3	1	1	3	1	2

18	Primary Health Centre (PHC)	2.2	1	1	4	3	2
19	Newspaper	2.2	1	3	3	1	2
20	Masseur/Masseuse	2	1	1	3	1	2
21	Traditional Healers	1.9	1	1	3	1	2
22	Faith Healers	1.9	1	1	2	1	2
23	Quacks	1.8	1	1	1	1	2
24	Television	1.6	1	1	3	1	2
25	Alternative medicine Sellers	1.6	1	3	1	1	2
26	an Educated Person	1.5	1	1	3	1	2
27	Door to Door Medicine Sellers	1.4	1	2	1	1	1
28	Radio	1.3	1	1	1	1	1
29	Posters	1.2	1	1	2	1	1

N=213, Village 1: Haijang, Village 2: S.Changoubung. Village 3: Chaljang, Village 4: Wakotphai

Table: Average Frequency of Preferred Health Information sources in descending order.

Trusted Sources

1=Not Trusted, 2= Rarely Trusted, 3= Trusted, 4= Trusted More, 5= Trusted Most

Sl.No.	Source	Average Mean	Average Frequency				
			Village 1	Village 2	Village 3	Village 4	All Villages
1	CHC	4.67	5	4	5	4	5
2	Family Members	4.18	4	4	4	4	4
3	Nurses	4.14	4	4	4	4	4
4	Traditional Midwives	4.14	4	4	4	4	4

5	Famed Specialist Doctors	4.1	4	5	4	4	4
6	Church	4.04	4	5	4	4	4
7	Pharmacy	3.8	4	4	3	4	4
8	Neighbors	3.8	4	4	4	4	4
9	Friends	3.8	4	4	4	4	4
10	Health Workers	3.71	4	3	4	4	4
11	Television	3.63	4	4	4	4	4
12	Private Clinics	3.51	4	4	3	3	4
13	Private Doctors	3.41	3	4	3	3	3
14	Newspaper/Magazine	3.2	3	4	3	4	3
15	Chief	2.98	3	3	3	3	3
16	Church Elders	2.92	3	3	3	3	3
17	Village Elders	2.88	3	3	3	3	3
18	RHC	2.84	3	2	4	3	3
19	PHC	2.78	3	2	4	3	3
20	Radio	2.78	3	3	2	3	3
21	Anganwadi Workers	2.69	3	3	2	3	3
22	Priests	2.63	3	3	3	3	3
23	Traditional Healers	2.47	2	2	2	2	2
24	Faith Healers	2.39	2	3	3	2	2
25	Herbal Practitioners	2.33	3	4	3	3	3
26	Masseurs/Masseuse	2.22	2	3	3	3	3
27	an Educated Person	2.1	2	2	3	2	2
28	Mobile Phone	2.08	2	3	2	2	2
29	Posters	2.06	2	2	2	2	2
30	Quacks	1.82	1	1	1	1	1
31	Door to Door Medicine Sellers	1.53	1	2	1	1	1
32	Alternative Medicine	1.53	1	3	1	1	1

	Sellers						
33	Internet	1.29	1	1	1	1	1

N=213, Village 1: Haijang, Village 2: S.Changoubung. Village 3: Chaljang, Village 4: Wakotphai

Table: Average Frequency of Trusted Health Information sources in descending order

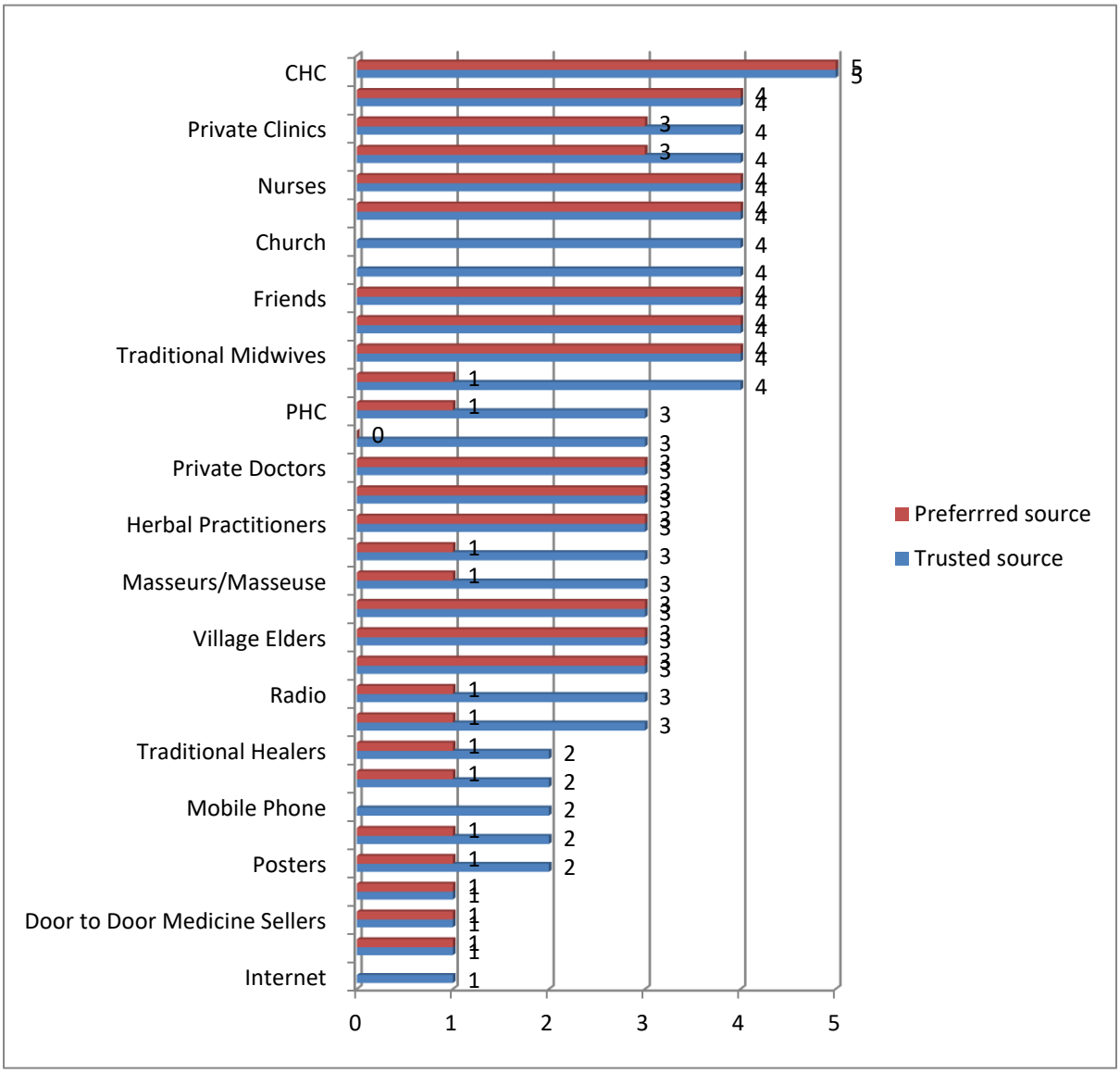

Fig.1: Bar graph showing the average frequency of trusted sources and preferred sources of all villages

The most trusted and preferred source of health information of the rural women is found to be Community Health Centre. Sources such as Pharmacy, Nurses, Health Workers, Friends, Family, Traditional midwives are both highly trusted as well as highly preferred by the women. The women also equally trusted and preferred sources such as Private Doctors, Anganwadi Workers, Herbal Practitioners, Church Elders, Village Elders, and Village Chief. The findings have shown that the women mostly trust the sources they preferred. The high level of preference and trust of Informal sources such as family members, Traditional Mid-wives, and friends by the women as sources of health information may be because majority of the respondents are illiterates or barely literates so they are likely to have low literacy level, and low awareness of the formal information sources. Another reason could be cost of health care. Since almost all of the women are cultivators and housewives, and their husband cultivators too, they do not have sufficient income to seek for better and more expensive scientifically approved, formal forms of health care. Being someone they can trust, seeking information from family and friends may also give emotional support to the women in addition to the health information they needed. The level of preferred and trusted sources of health information sources is quite similar among the women with the exception of Famed Specialist Doctors, Private Clinics, Television, Priests, Masseuse/Masseurs, Radio, Newspaper/ Magazines, Church, Neighbors, and Rural Health Centres (RHC) where these sources are trusted but not preferred. This could be due to a number of reasons such as high cost, unavailability, and ignorance. Sources like Famed Specialist Doctors, Private Clinics are private health care set-ups so they are not affordable to many of the women so they consult these sources mostly in case of emergencies and more serious illnesses. Therefore, the women didn’t choose them as their preferred sources even though they trust the sources. This shows that these sources, if made freely available to them, they can be used in effective communication of women health information.

Findings

The findings show that most trusted and preferred source of health information of the rural women is found to be Community Health Centre (CHC). Next to the CHC, the women highly prefer and trust the Informal sources such as family members, Traditional Mid-wives, and friends. The women also quite prefer professional healthcare providers like the Nurses, Pharmacy, Health Workers, Private Clinics, Famed Specialist Doctors. This may be because they

found healthcare workers to be authoritative sources of information because of their medical trainings and expertise. Sources like nurses, pharmacy, health workers are more or less available in all the villages due to government interventions. Private clinics, famed specialist doctors, private doctors are moderately preferred by the women because these are private health care set-ups so they are not affordable to many of the women so they consult these sources mostly in case of emergencies and more serious illnesses. Sources such as Posters, Quacks, Door to Door Medicine Sellers, Alternative Medicine Sellers, Internet are not preferred as well as not trusted by the women. This may be because the women are not familiar with these sources.

Conclusion

The nature of preferences and choice of sources of health information among the rural women is also seen to depend largely on the availability or accessibility of the sources with the exception of Community Health Centre (CHC). The CHC is situated at Kangpokpi town, which is about 1 to 3 kilometers from the first two villages, namely, Haijang, and Changoubung village which explains the high preferences of the CHC as source of health information among the women in the two mentioned villages. But the distance of CHC from the other two villages, namely, Chaljang, and Wakotphai is over 30 kilometers away with poor transportation system. Despite this, the level of preference and trust is very high among the women of these two villages. The reason could be because, the CHC being a Government/State run health-care institution, is more well equipped than the smaller government health institutions such as Primary Health Centre (PHC), Rural Health Centre (RHC), Sub Centre, Dispensary, is not expensive and it provides a number of health care treatment, and health care services in no/low cost by scientifically trained medical professionals. The study shows that the most trusted and most preferred sources of rural women health information are Community Health Centre (CHC), Pharmacy, Nurses, Health Workers, Friends, Family Members, Traditional Midwives.

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References:

1. Australian Law Reform Commission. (n.d). Australian Privacy Law and Practice (ALRC): The Privacy Act and Health Information (Report no. 108). Retrieved from

https://www.alrc.gov.au/publications/62.%20The%20Privacy%20Act%20and%20Health%20Information/definition-%E2%80%98health-information%E2%80%99

2. Bamezai, G. (n.d.). Negotiating and Strengthening Women's Access To Health Information: Community- based Communication channels. Retrieved from http://www.portalcomunicacion.com/bcn2002/n_eng/programme/prog_ind/papers/b/pdf/b004_bamez.pdf
3. Census of India (2011). Retrieved from http://censusindia.gov.in/2011-prov-results/paper2/data_files/india/Rural_Urban_2011.pdf
4. Chandramouli, C. (2011). Census of India 2011: Rural urban distribution of population. Retrieved from http://censusindia.gov.in/2011-prov-results/paper2/data_files/india/Rural_Urban_2011.pdf
5. Chen, J., Liu, H.&Xie, Z. (2010). Effects of Rural—Urban Return Migration on Women's Family Planning and Reproductive Health Attitudes and Behavior in Rural China. *Studies in Family Planning*, 41, (1), 31-44. doi:http://www.jstor.org/stable/25681338
6. Gerrior, S.A., Crocoll, C., Hayhoe, C.&Wysocki, J. (n.d.).Challenges and Opportunities Impacting the Mental Health of Rural Women. *Journal of Rural Community Psychology*, E11, (1). Retrieved fromhttp://muwww-new.marshall.edu/jrcp/V11%20N1/Gerrior.pdf
7. Johnston, H. B., Ved, R., Lyall, N.&Agarwal, K. (2003). Where Do Rural Women Obtain Postabortion Care? The Case of Uttar Pradesh, India. *International Family Planning Perspectives*, 29, (4), 182-187
8. Olaleye, D.O.&Bankole, A. (1994). The Impact of Mass Media Family Planning Promotion on Contraceptive Behavior of Womenin Ghana. *Population Research and Policy Review*, 13, (2), 161-177. doi:http://www.jstor.org/stable/40229755
9. Rani, M.&Bonu, S. (2003). Rural Indian Women's Care-Seeking Behavior and Choice of Provider for Gynecological Symptoms. *Studies in Family Planning*, Vol. 34, No. 3 (Sep., 2003), 173-185. doi:http://www.jstor.org/stable/3181104