WOMEN HEALTH INFORMATION COMMUNICATION CHANNELS IN RURAL AREAS: A STUDY OF KANGPOKPI SUB-DIVISION, MANIPUR

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CHAPTER VI: FINDINGS, SUGGESTIONS, AND CONCULSION

This chapter will provide the findings of the present study and also the suggestions based on those findings. The study on Women Health Information Communication Channels of rural women carried out in the four villages under Kangpokpi Sub-Division, identified for the purpose of the study as: the Untreated Village, Mobile SMS, Word-of-Mouth Village, and, Pamphlet Village under Senapati district (now Kangpokpi District) of Manipur have provided the following findings and suggestions.

6.1 Findings of the present study

The study on Women Health Information Communication Channels of rural women carried out in the four villages under Kangpokpi Sub-Division, identified for the purpose of the study as: The Untreated Village, Mobile Phone SMS, Word-of-Mouth Village, and, Pamphlet in Mother Tongue Village under Senapati district (now Kangpokpi District) of Manipur have provided the following findings and suggestions.

The major findings based on the objectives are presented as follows:

The women identified about 27 different health information sources. Among these 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; Moursund, & Kravdal, 2003; Johnston, Ved, Lyall, & Agarwal, 2003; Rani, & Bonu, 2003; McNay, Arokiasamy, & Cassen, 2003; George, 2007; Chen, Liu, & Xie, 2010; Parveen, 2013). In the present study however, the door to door medicine is neither preferred and nor trusted source in contrast to the findings of the literatures. A mention may be made of a study conducted by Ramachandran, Jaggarajamma, Muniyandi, and Balasubramanian (2004) in rural areas of Tamil Nadu, India, where the authors found that the main communication channels, commonly used to disseminate information on health programmes were TV and wall posters, publicity through Panchayat office meetings and Dandora or beat of drums. This shows the diverse setting of the country.

In the present study, the women identified six types of health information channels, among which Word-of-Mouth is ranked the highest and Accredited Social Health Activists (ASHA), and Pamphlets-in-Mother tongue were second highest.

In terms of trust and preference of health information sources, the study found that women preferred most of the sources they trusted. Mention may be made of CHC (Community Health Centre) and Pharmacy where the scores on level of trust and level of preference are exactly the same. The health information sources having the same level of trust and preference are displayed in the table below:

Table - 6.1: Health information sources having same level of trust and preference

Mode			
Sl. No.	Source	Trusted	Preferred
1.	CHC	5	5
2.	Pharmacy	4	4
3.	Nurses	4	4
4.	Health Workers	4	4
5.	Friends	4	4
6.	Family Members	4	4
7.	Traditional Midwives	4	4
8.	Private Doctors	3	3
9.	Anganwadi Workers	3	3
10.	Herbal Practitioners	3	3
11.	Church Elders	3	3
12.	Village Elders	3	3
13.	Chief	3	3

Scale 1: Not Trusted/Not Preferred, 2: Somehow Trusted/Somehow Preferred, 3: Trusted/Preferred 4: Trusted More/Preferred More 5: Trusted Most/Preferred Most

There are also some sources which the women trusted but did not even include them in the list of their preferred health information sources, e.g. Church, Neighbours, etc. It is known that Church, and Neighbours are unconventional information sources. Therefore, they may never have served as sources for health information. Those sources which are highly different in their levels of trust and preferences are in the table below:

Table - 6.2: Health information sources having highly different level of trust and preference

Mode			
Sl. No.	Source	Trusted	Preferred
1.	Church	4	0
2.	Neighbours	4	0
3.	Television	4	1
4.	Primary Health Centre	3	1
5.	Rural Health Centre/Dispensary/ Sub Centre	3	0
6.	Priests	3	1
7.	Masseurs/Masseuse	3	1
8.	Radio	3	1
9.	Newspaper/Magazine	3	1
10.	Mobile Phone	2	0
11.	an Educated Person	2	1
12.	Posters	2	1

Scale 1: Not Trusted/Not Preferred, 2: Somehow Trusted/Somehow Preferred, 3: Trusted/Preferred 4: Trusted More/Preferred More 5: Trusted Most/Preferred Most.

Another interesting finding is that even though Famed Specialist Doctors (average score is 4) is a highly trusted health information source, the level of preference is not as high. This is likely because of the economic factors. Since Famed Specialist Doctors are private run health care providers, their charges, and fees are usually expensive so they are mostly not affordable to the rural women with no/ meager income. Therefore, even though the women trust this health care provider, they do not quite prefer because of the high cost.

It was found that education, age, and income have a positive impact on women's independence in Health Decision making and also on the level of independence in the Health Information Seeking among the women Therefore, the higher education qualification they have, the women are more independent in seeking

health information and also more independent in taking health decisions. Similarly, the older women are also more independent in seeking health information and health decision making, the same way as women with higher income are more independent in seeking health information and health decision making than women with lower income. The women find the scientifically approved methods of health care to be more reliable than the traditional forms of health care even though there are a number of barriers in accessing them. When it comes to matters on Child bearing and Sterilization, the women chose the opinions of themselves, their husbands', father- in-law, and mother-in-law's than the medical doctors.

The study also found that education and age have significant influence on Health Decision Making and also on Health Information Seeking. This means that older women and women having higher educational qualification have more independence in taking their health decisions as well as in seeking their health information needs. Another major finding of the study is that Word-of-Mouth is perceived as the most effective channel in communicating women health information. The reason behind this is that the Word-of-Mouth is simple and easy to understand. If there are any doubts, it can be clarified instantly on the spot. It is also reliable, instantly verifiable, and it also has a high trust value as there is a direct involvement of the information provider, so it was perceived to be the most effective health information communication channel by the rural women of the study area. The study found that the Pamphlets-in-Mother tongue was actually the most effective channel for communication women health information. Among all the four villages taken for the study, the Pamphlets village showed the highest level of awareness after being communicated with information on the women health schemes under NRHM through Pamphlets-in-Mother Tongue. The Word-of-Mouth was the second most effective

channel in communication women health information, and the Mobile Phone SMS to be the third. The ASHA was found to be the least effective among all the women health information communication channels among the women of the study area even though the perceived effectiveness of ASHA as women health information communication was quite high (average score:4 [(more effective)] in table 5.9 of the study.

On matters regarding child bearing and sterilization, the study found that almost 90% of the women chose the decisions of the family members than the medical doctors' advice.

6.2 Limitations of the present study

The study was carried out in four villages from Kangpokpi Sub-division under Senapati district (now Kangpokpi District) of Manipur. The selected villages for the present study are: - (1) Haijang (2) Chaljang (3) S. Changoubung and (4) Wakotphai. Therefore, the findings of the study are based on these four villages. More villages could not be taken due to limited resource and time.

Another limitation of the study is that the findings are indicative of Thadou-Kuki speaking community only.

6.3 Suggestions

The following suggestions are made based on the findings of the study:

i. Based on one of the findings of the study, the Community Health Centre (CHC) is one of the most preferred and trusted source of women health information seeking and health care treatment. The CHC being a State Government funded health care centre is bound to be inexpensive and even the health care providers are professionally trained staff. For this reason, the women from all the villages often go to the CHC for their health care needs

and also for the purpose of seeking their health information needs even though two of the villages were more than 30 kilometers from the CHC instead of the nearer Primary Health Centre, and Rural Health Centre/Sub Centre. Therefore, the Government should take steps and action for smooth functioning of the Primary Centres and Rural Health Centres so that the women could conveniently seek their health information needs and health care needs without having to go to the CHC. This will save on travel expenses and also time.

ii. The ASHA and Health Workers should conduct health camps and seminars on health care, especially on women and child health care more often, especially in the remote villages, to increase awareness.

iii. The researcher also met the ASHAs and interacted with them while visiting the field. The ASHAs shared their various grievances and one common thing was regarding the ASHA package of Rs. 600 for facilitating institutional delivery to the pregnant women. The ASHAs feel that the package is not sufficient considering the work load they were entrusted to carry out. And they also said that sometime they do not receive the amount in full. As we have already seen in the Chapter II, one ASHA has to cover a thousand populations. Moreover, the roles that the ASHA has to carry out and the responsibilities she has to fulfill and the list of tasks she has to fulfill are unending. For all these, the researcher feels it worth suggesting that the ASHA should be entitled to a regular salary on monthly basis instead of an honorarium, like the Anganwadi workers.

iv. According to one of the findings of the study, Church was considered to be one of the highly trusted health information sources among the women of the four villages. Therefore, emphasis should be made on making the Church

more involved in the role of disseminating health information through making announcements in church services, and organising health camps, and health awareness seminars and meetings in the church premises.

v. The findings of the study show the effectiveness of health information channels such as Pamphlets in mother tongue, Word-of-Mouth, Mobile phone SMS as these channels increase the level of awareness of women health schemes under NRHM. Therefore, the three mentioned channels are suggested in communicating important health information to reach more people. Since the study has found the Pamphlets-in-mother tongue to be the most effective channel in communicating women health information, it may be suggested that the State Government should go the extra mile in taking the initiative of making the information on women health schemes available in the local indigenous dialects.

6.3.1 Suggestions for future research

i. A study can be carried out on the awareness and impact of NRHM taking into account all the hill districts of Manipur. This will give the real picture of the benefits of NRHM to the villagers who are residing in remote areas.

ii. Comparative studies on the awareness and impact of NRHM in the urban districts and rural districts of Manipur can be carried out. Urban districts have better communication facilities and health facilities. This results of this study could bring out the high disparities of health information between the two.

iii. Comparative study on the awareness and impact of NHRM can be carried out on a larger scale considering all the eight north eastern states of India. This can study whether the north eastern states are comparable in health information system with the rest of the country.

6.4 Conclusion

Women's health matters not only to women themselves, but it is also crucial to the health of the children they bear. This suggests that paying due attention to the health of women today is an investment not just for the present but also for future generations (WHO, 2009). The government of India implemented a number of health care schemes to address the health needs of rural population, especially the vulnerable sections of society such as women and children through the implementation of a number of women and child care schemes such as the Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), Reproductive and Child Health Programme (RCH-II), Sterilization Compensation Scheme/Compensation for Acceptors of Sterilization, etc. under the National Rural Health Mission. The implementation of these schemes however, do not guarantee the successful utilisation of the facilities provided by the mentioned schemes in every corner of the country because in most rural areas, women are faced with numerous hardships and limitations in the form of economic, social and cultural barriers complicating their access to health facilities. Even though the Accredited Social Health Activists (ASHAs) are appointed as health facilitators to create awareness, enhance better utilisation of health services, and enable the rural women to claim health entitlements, the health care services provided under the NRHM still remained under utilised in the rural areas. Therefore, using the health information communication sources and channels identified in the rural areas to communicate the health schemes will contribute to the effective utilisation of health schemes particularly among women in Manipur, a state that is considered to be one of the poor performing states in the country in terms of health indicators in particular, and also all women in the rural

areas who are faced with various limitations and hardships in the form of economic, social and cultural barriers complicating their access to health facilities in general.