

## **Chapter-4**

# **Health Awareness: Implications for Women's Reproductive Health**

The World Health Organization definition of health (1946) helped to broaden the view of health care beyond a narrow institution based, authoritarian model of care led by health professionals. Increasingly, the patient has moved from being a passive recipient of care to a client or consumer of care who weighs alternatives, seeks second opinions, and assumes responsibility for prevention through diet, exercise, early treatment, and injury prevention measures.

Though health education has become increasingly available through schools, community groups, mass media, the Internet, and other sources, many clients still do not have access to the high quality, reproductive-health information needed throughout their lives. This information would enable them to have optimum health, relaxed enjoyment of their sexuality, and understanding of how cultural values may help or hinder their reproductive and sexual health.

Reproductive Health Awareness applies to the life cycle from birth until death. It provides parents with the information they need to effectively interact with their own children on topics as diverse as newborn erections, giving factually correct information on anatomy and sexuality issues, and preparing boys and girls for puberty. It provides adolescents and adults with the information and skills to empower them to actively shape their own reproductive health destiny in a manner which brings self-esteem, satisfaction with timing and spacing of children if desired, self- and partner-protection from disease, joyous expression of one's own sexuality, and knowledge of normal body changes over time. Likewise, the aging adult can learn the difference between normal signs of aging and disease, recognize disease early, seek help for conditions without embarrassment, and creatively express sexuality until death.

Through Reproductive Health Awareness, people can learn to appreciate the regular functioning of their own bodies and reproductive systems, and use self-observation and an understanding of reproductive health to choose healthy behaviours, advocate for themselves, seek medical attention when needed, and communicate appropriately

with healthcare providers. Since people who are aware of their reproductive health also understand what is normal for both men and women at different ages, they can actively participate in maintaining the health of their partners and children.

### **Purification of drinking water**

According to a 2007 world Health Organisation report, 1.1 billion people lack access to an improved drinking water supply, 88 percent of the 4 billion annual cases of diarrheal disease are attributed to unsafe water and inadequate sanitation and hygiene, and 1.8 million people die from diarrheal diseases each year. The WHO estimates that 94 percent of these diarrheal cases are preventable through modifications to the environment, including access to safe water. Simple techniques for treating water at home, such as chlorination, filters, and solar disinfection, and storing it in safe containers could save a huge number of lives each year. Reducing deaths from waterborne diseases is a major public health goal in developing countries.

On the basis of consumption of purified drinking water, respondents are categorized into two categories: 1) No, 2) Yes. The distribution of the respondents into these categories is shown in table no Table-4.1

**Table-4.1: Purification of drinking water by the respondents**

<b>Purified</b>	<b>Rural (Heinoubok)</b>		<b>Urban (Nagamapal)</b>		<b>Total</b>	
	<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>
<b>No</b>	118	78.7	6	4.0	124	41.3
<b>Yes</b>	32	21.3	144	96	176	58.7
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

The data reveals that as many as 41.3 percent of the respondents use drinking water without purifying it.

A visible difference can be observed from the data among the rural respondents (21.3 percent) and the urban respondents (96 percent) in the preference for purification of drinking water. It informs the awareness level of the respondents in rural area about the importance of purification of drinking water.

## Method used for purification of drinking water

Water is life for all living beings. But, water from all sources of water is not safe for consumption. The respondents are reported of using two method of purification of drinking water in their house 1) by filter and 2) by boiling the water. The distribution of the respondents into these categories is shown in table no Table-4.2

**Table-4.2: Method used for purification of drinking water by the respondents**

Method	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>Filter</b>	30	93.8	132	91.7	162	92
<b>Boil</b>	2	6.2	12	8.3	14	8
<b>Total</b>	<b>32</b>	<b>100</b>	<b>144</b>	<b>100</b>	<b>176</b>	<b>100</b>

Source: Field Data

The data shows that among the respondents who drink purified water majority (92 percent) of the respondents are using filter with candles for the purification of drinking water and only 8 percent of the respondents are purifying the drinking water by boiling the water. There is no visible difference between rural and urban in opt the method of purifying drinking water.

## Sanitary Toilet

The availability of safe sanitation system is one of the important factors to determine socio-economic and cultural development of any state. Safe disposal of human waste has been a matter of concern since early civilization in different parts of the world. In Vedas it has been made very clear that driving away diseases and building human strength is definitely not possible without proper sanitation and adoption of hygienic rules.

On the basis of whether the respondents have sanitary latrine, the respondents are categorized into two categories: 1) No, 2) Yes. The distribution of the respondents into these categories is shown in Table-4.3

**Table-4.3: Use of sanitary toilet among the respondents**

Sanitary Toilet	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>No</b>	76	50.7	0	0	76	25.3
<b>Yes</b>	74	49.3	150	100	224	74.7
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

The data shows that majority (74.7 percent) of the respondents have sanitary toilets and rest little more the one –forth (25.3 percent) of the respondents don't have sanitary toilet facility in their house.

It can be observe that all the respondents who don't have sanitary toilets are from the rural area.

### Mass Media Exposure

Mass media provide the best means of imparting the latest scientific information to large groups of people. It has been the experience of health workers that the general public possesses a great deal of incorrect information about traditional health problems and at the same time lacks an understanding of the advances in numerous public health fields. The medium of mass media exposure of the respondents determined on the basis of exposure to newspaper, T.V. and radio. The distribution of the respondents into these categories is shown in table no Table-4.4

**Table-4.4: Mass media exposure of the respondents**

Mass Media		Rural (Heinoubok)		Urban (Nagamapal)		Total	
		f	%	f	%	f	%
<b>Television</b>	<b>Yes</b>	150	<b>100</b>	150	<b>100</b>	300	<b>100</b>
	<b>No</b>	0	<b>0</b>	0	<b>0</b>	0	<b>0</b>
<b>Radio</b>	<b>Yes</b>	136	<b>90.7</b>	90	<b>60</b>	226	<b>75.3</b>
	<b>No</b>	14	<b>9.3</b>	60	<b>40</b>	74	<b>24.7</b>
<b>Newspaper</b>	<b>Yes</b>	104	<b>69.3</b>	149	<b>99.3</b>	253	<b>84.3</b>
	<b>No</b>	46	<b>30.7</b>	1	<b>0.7</b>	47	<b>15.7</b>

Source: Field Data

The data reveals that cent of the respondents watch television, little more than three-fourth (75.3 percent) of the respondents listen radio and majority (84.3percent) of the respondents read newspaper,

There is no difference between rural and urban respondents regarding the watching Television, among the radio listeners' majority of the respondents are from the rural area and more newspaper readers are from the urban area.

### **Level of mass media exposure**

The level of mass media exposure of the respondents is determined by the frequency of exposure to newspaper, T.V. and radio. The frequency of exposure to these medium of communications are categorized into three levels viz. regularly, irregularly and never. The distribution of the respondents into these categories is shown in Table-4.5

**Table-4.5: Level of mass media exposure of the respondents**

<b>Mass Media</b>	<b>Frequency</b>	<b>Rural (Heinoubok)</b>		<b>Urban (Nagamapal)</b>		<b>Total</b>	
		<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>
<b>Newspaper</b>	<b>Everyday</b>	39	26	114	76	153	51
	<b>Sometimes</b>	65	43.3	35	23.3	100	33.3
	<b>Never</b>	46	30.7	1	0.7	47	15.7
<b>Television</b>	<b>Everyday</b>	37	24.7	125	83.3	162	54
	<b>Sometimes</b>	113	75.3	25	16.7	138	46
<b>Radio</b>	<b>Everyday</b>	69	46	31	20.7	100	33.3
	<b>Sometimes</b>	67	44.7	59	39.3	126	42
	<b>Never</b>	14	9.3	60	40	74	24.7

Source: Field Data

The data shows that little more than half (51 percent) of the respondents have the habit of reading newspaper daily, 33.3 percent of the respondent read newspaper occasionally and 15.7 percent of the respondents never read newspaper. Therefore though little more than half of the respondents read newspaper regularly, but a significant share of them read it either occasionally or don't read at all.

But there is a noticeable inconsistency in the frequency of reading newspapers by the respondents in rural and urban settings. Majority of the respondents (76 percent) are

regular readers of newspapers in urban setting, whereas, majority of the respondents are either irregular readers (43.3 percent) of newspapers or don't read it at all (30.7 percent).

The data reveals that more than half (54 percent) of the respondents watch television daily and the rest 46 percent of the respondents don't watch it regularly.

Among the regular viewers of T.V. most of them are from urban background (83.3 percent) and majority of the rural respondents watch T.V. only occasionally. It is worth mentioning here that the role of poor electricity supply in the rural areas of Manipur, particularly in Heinoubok is a major reason behind the asymmetrical statistics.

Though, radio as medium of communication is losing its popularity in most part of the country, but it can observe here that a significant proportion (75.3 percent) of the respondents listen to radio regularly and most of them are from rural background.

### **Health Awareness Program**

Attendance in health awareness program increases the awareness level of the people regarding the problems and cure from the most widely affected health problems in the area. Attendance of the respondents in the health awareness programs are categorized in two categories 1) Yes and 2) No. The distribution of respondents into these categories is shown in Table-4.6

**Table-4.6: Health awareness program attended by the respondents**

<b>Attend HAP</b>	<b>Rural (Heinoubok)</b>		<b>Urban (Nagamapal)</b>		<b>Total</b>	
	<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>
<b>No</b>	74	49.3	122	81.3	196	65.3
<b>Yes</b>	76	50.7	28	18.7	104	34.7
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

The data shows that majority (65.3 percent) of the respondents have not attended any health awareness program. But when the data is segregated into rural and urban setting, more than half of the respondents in the rural setting have attended health awareness programs whereas a huge majority (81.3 percent) of the respondents in the urban setting reported not to have attended any health awareness program.

## Organizer of the health awareness program

After knowing the status of attendance of health awareness programs, the next question that is to be asked is who is organizing those programs. This will help to identify whether government agencies or civil societies are more effective in the area as far as dissemination of health related information is concerned. Organizers' of the programs are categorized into three categories. The distribution of the respondents into these categories is shown in Table-4.7

**Table-4.7: Organizers' of the health awareness program**

Organized by	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>N.G.O</b>	2	2.6	10	35.7	12	11.5
<b>Health workers from health dept.</b>	21	27.6	15	53.6	36	34.6
<b>Both</b>	53	69.8	3	10.7	56	53.9
<b>Total</b>	<b>76</b>	<b>100</b>	<b>28</b>	<b>100</b>	<b>104</b>	<b>100</b>

Source: Field Data

The data shows that out of the 34.7 percent of the respondents more than half (53.9 percent) of the respondents have attended health awareness programs organized by both the NGOs and the health workers from the health department, followed by 34.6 percent of the respondents who attended health awareness programs organized by only the health workers from the health department, the rest 11.5 percent of the respondents have attended health awareness programs organized only by the NGOs.

But when it looks at the rural urban difference it can see that most of the rural respondents (69.73 percent) have given the credit of organizing health awareness programs in their locality to both the NGOs and the health workers from the health department, but in the urban setting more than half of the respondents (53.6 percent) have reported that the health workers from the health department are organizing health programs followed by the NGOs (35.7 percent).

## Medicine preferred

To get more specific information about the treatment preferred by the respondents, the respondents are categorized into four categories of medicines that they prefer viz, Homeopathic Ayurvedic treatment, Allopathic, Allopathic + folk medicine. The distribution of the respondents into these categories is shown in Table-4.8

**Table-4.8: Medicine preferred by the respondents**

Medicine	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Homeopathic	2	1.3	2	1.3	4	1.3
Ayurvedic treatment	0	0	6	4	6	2
Allopathic	1	0.7	134	89.3	135	45
Allopathic + folk medicine	147	98	8	5.3	155	51.7
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

Little more than half (51.7 percent) of the respondents prefer allopathic together with folk medicine, whereas almost half (45 percent) of the respondents prefer only allopathic medicine for treating these health problems.

Hence the data shows that the respondents from the rural setting are clearly preferring (98 percent) allopathic together with folk medicine, whereas in the urban setting only allopathic medicine is more (89.3 percent) preferred

## First health problem consult

The reported preferences for the place of consulting first health problem by the respondents are categorized into four categories: 1) Nearest pharmacy 2) Private Doctor 3) Nearest RMP 4) Nearest PHC/Sub centre. The distribution of the respondents into these categories is shown in Table no-4.9



**Table-4.9: Place for consulting first health problems by the respondents**

Place	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>Nearest pharmacy</b>	143	95.3	28	18.7	171	57
<b>Private doctor</b>	2	1.3	113	75.3	115	38.3
<b>Nearest RMP</b>	0	0	9	6	9	3.0
<b>Nearest PHC/sub centre</b>	5	3.3	0	0	5	1.7
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

The data shows that more than half (57 percent) of the respondents consulted the nearest pharmacy for the first health problem they had, followed by 38.3 percent of the respondents who consulted private doctors for the purpose.

But the segregation of the data into rural and urban setting reveals difference of preference as the respondents from the rural setting clearly prefer (95.3 percent) the nearest pharmacy for treating the first health problem they had and the respondents from the urban setting visibly prefer (75.3 percent) the private doctors for the purpose. The economic condition of the households together with lack of facilities can be looked as the reason behind the preference in both the setting.

### **Sources of information about health facilities**

The knowledge of the source of information about health facilities will help to identify the source of information which is doing well and the source which needs more attention. Hence, the respondents are categorized into following seven categories which is shown in Table- 4.10

**Table-4.10: Sources of information about health facilities**

Sources	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>T.V</b>	0	0	1	.7	1	.3
<b>Health workers from health dept.</b>	0	0	3	2	3	1
<b>Neighboring people</b>	0	0	4	2.7	4	1.3
<b>Radio</b>	3	2	2	1.3	5	1.7
<b>NGO</b>	0	0	77	51.3	77	25.7
<b>Health workers from health dept.+ neighboring people</b>	57	38	12	8	69	23
<b>T.V+newspaper+health workers+neighboring people</b>	90	60	51	34	141	47
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

The data shows that nearly half (47 percent) of the respondents got information about health facilities from all the sources as the T.V, newspaper, health workers, neighboring people. Little more than one-fourth (25.7 percent) of the respondents got these information from the NGOs and health workers together with neighboring people are the sources of information regarding health facilities available for as many as 23 percent of the respondents.

Here it can be observed that in the rural setting more than half (60 percent) of the respondents are getting information from all the sources (T.V, newspaper, health workers, neighboring people) and health workers together with neighboring people are the sources of information regarding health facilities available for as many as 38 percent of the rural respondents. But in the urban setting it is the NGOs which is providing these information to more than half (51.3 percent) of the respondents followed by all the sources (34 percent) as T.V, newspaper, health workers, neighboring people.

## Reproductive health beliefs

Respondents beliefs regarding the menstruation, pregnancy and after delivery are analyzed below-

### Soaking material

Soaking material used for menstruation blood by the respondents are categorized into six categories: 1) sanitary napkin, 2) piece of cloth, 3) phanek, 4) sanitary napkin + piece of cloth, 5) piece of cloth + phanek, and 6) sanitary napkin + piece of cloth + phanek. The distribution of the respondents into these categories is shown in Table no-4.11

**Table-4.11: Menstruation blood soaking material of the respondents**

Material	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Sanitary napkin	14	9.3	65	43.3	79	26.3
Piece of cloth	24	16	28	18.7	52	17.3
Phanek	0	0	1	0.7	1	0.3
Sanitary napkin+torn cloth	39	26	50	33.3	89	29.7
Torn cloth +Phanek	68	45.3	5	3.3	73	24.3
Sanitary napkin+torn Cloth+Phanek	5	3.3	1	0.7	6	2
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

*\*Phanek- A wrap round common dress of Manipuri women*

The data shows that 29.7 percent of the respondents are using sanitary napkin + torn cloth to soak the menstrual blood, little more than one-fourth (26.3 percent) of the respondents are using only sanitary napkin to soak the menstrual blood, about one-fourth (24.3 percent) are using torn cloth + phanek to soak menstrual blood material, 17.3 percent of the respondents are using only torn cloth to soak menstrual blood material.

Hence it can be note that apart from the 26.3 percent of the respondents who are using only sanitary napkins for the purpose almost all the respondents are not regularly

using the proper hygienic and safe means for soaking menstrual blood. Those who are either using both sanitary napkins and phanek or cloth are using napkins only occasionally only during outdoor visits.

Hence the data indicates that the sanitary napkins are clearly preferred more (43.3 percent) by the urban respondents than the rural ones (9.3 percent). Moreover, among the occasional users of sanitary napkins, the urban respondents are using it more often as they are more engaged in outdoor activities which demand them to look neat and tidy than their rural counterparts.

### **Regular bath during menses**

Menstruation is a normal physiological process which has many associated myths and misconceptions. Health behaviours and practices vary from culture to culture, and ignorance of culturally divergent beliefs and practices may lead to failure in health care delivery, thereby complicating various reproductive health problems. In Meitei society during menstruation, women are generally not prescribed to take bath as they believe that the menstrual blood will pollute the surroundings and taking bath during menarche will hamper the menstruation cycle. And during the period the women's reproductive system is a bit more prone to infections, which is why personal hygiene is absolutely essential.

To know the awareness level about the personal hygiene during period, the respondents are categorized into two categories: 1) No, and 2) Yes. The distribution of the respondents into these categories is shown in Table no-4.12

**Table-4.12: Frequency of bath during menstruation by the respondents**

Everyday	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>No</b>	134	89.3	85	56.7	219	73
<b>Yes</b>	16	10.7	65	43.3	81	27
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

The data reveals that majority (73 percent) of the respondents don't take daily bath during menstruation and little more than one-fourth (27 percent) of the respondents take bath daily during menstruation.

Therefore the number of respondents who follow the traditional belief of not taking bath during menstruation is more (89.3 percent) in the rural setting than the urban setting (56.7 percent), moreover the engagement of the majority of the respondents of the urban setting in the outdoor activities as business and private jobs also necessitates them to take regular bath.

### **Perception for treating shunned during menses**

The perceptions of the respondents for treating as shunned during menses are categorized into two categories: 1) Natural, and 2) Bad. The distribution of the respondents into these categories is shown in Table no-4.13

**Table-4.13: Respondents perception of treating shunned during menses**

Perception	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>Natural</b>	74	49.3	68	45.3	142	47.3
<b>Bad</b>	76	50.7	82	54.7	158	52.7
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

Cent percent of the respondents are treated as shunned during their menstruation period. More than half 53.3 percent of the respondents feel bad about this system and 46.7 percent of the respondents consider as normal.

There is hardly any evident rural urban difference that can be observed in this category.

### **Food restriction during menses**

The menstrual cycle in a woman is a delicate interaction of hormones and physiological responses. The menstruation cycle is the body's way of preparing itself every month for a possible pregnancy. As women of childbearing age go through menstruation, overall nutrition is an important issue.

The respondents are categorized into two categories to know the status of knowledge of consuming nutritious food during period. The distribution of the respondents into these categories is shown in Table no-4.14

**Table-4.14: Food restriction of the respondents during menses**

Restriction	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	Freq	%	Freq	%	Freq	%
<b>No</b>	5	3.3	12	8	17	5.7
<b>Yes</b>	145	96.7	138	92	283	94.3
<b>Total</b>	<b>150</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>300</b>	<b>100</b>

Source: Field Data

The data indicates that majority (94.3 percent) of the respondents are restricted in consuming some particular food during menarche (fruits like banana, amla, lemon, guava etc and milk, vegetables like brinjal, coriander, bamboo shoot, banana flower, *yongchak* (tree bean) , and traditional curry like *oohti* (dish made of pea, rice and baking soda). As they believe that consuming these foods during the menstruation period will make the menstrual blood soaking cloth stain and it will impede the blood circulation and 5.7 percent of the respondents are not following any restriction in consuming foods during menstruation.

### **Nutritional food during pregnancy**

Nutritional food is a very important particularly during pregnancy for the health of the mother and the unborn child. Hence the consumption of nutritional food will reflect the awareness level of the respondents and their family about the importance of nutritional food in this period. The distribution of the respondents into whether they consume nutritious food or not is shown in the Table no-4.15

**Table-4.15: Intake of nutritional food during pregnancy by the respondents**

Nutritional food	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>No</b>	48	71	20	27	68	48
<b>Yes</b>	20	29	54	73	74	52
<b>Total</b>	<b>68</b>	<b>100</b>	<b>74</b>	<b>100</b>	<b>142</b>	<b>100</b>

Source: Field Data

The data shows that little more than half (52 percent) of the respondents reported to have consumed nutritional food during their pregnancy.

But when the sample size is split into rural urban setting, it can clearly detect the disparity as 73 percent of the respondents from the urban setting have reported to have consumed nutritional food during their pregnancy whereas only 29 percent of their rural counterparts believe that they consumed nutritional food during their pregnancy.

Hence it can draw dearth of awareness particularly in the rural area regarding the importance of nutritional food during pregnancy; moreover the poor economic condition is also responsible for this.

### **Enough rest during pregnancy**

Both physical and mental rest is a prerequisite for any pregnant lady to give birth to a healthy child. Hence the preference given to physical rest is an indicator of their awareness about its importance and it is generally found in different studies that even all people give importance to good food and rest during pregnancy, though the definition of food and duration of rest may differ from culture to culture. The distribution of the respondents into whether they have taken enough rest during pregnancy is shown in Table-4.16

**Table-4.16: Enough rest during pregnancy**

<b>Enough rest</b>	<b>Rural (Heinoubok)</b>		<b>Urban (Nagamapal)</b>		<b>Total</b>	
	<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>	<b>f</b>	<b>%</b>
<b>No</b>	34	50	15	20	49	35
<b>Yes</b>	34	50	59	80	93	65
<b>Total</b>	<b>68</b>	<b>100</b>	<b>74</b>	<b>100</b>	<b>142</b>	<b>100</b>

Source: Field Data

The data shows the 65 percent of the respondents have reported to have got enough rest during their pregnancy whereas as many as 35 percent of the respondents are not happy with the duration of rest that they are allowed to have during their pregnancy.

In the rural setting as many as 50 percent of the respondents are not happy with the duration of rest that they are allowed to have during their pregnancy whereas in the urban setting their number is only 20 percent. Therefore in the rural area there is also dearth of awareness about the importance of rest during pregnancy, moreover the poor economic condition is also responsible for this as women in rural areas play an important role in their household economy.

## Food restriction during and after delivery

The study reveals that majority (98.7 percent) of the respondents are restricted in consuming some foods during pregnancy and 1.3 percent of the respondents are not restrict in consuming any foods during pregnancy and all the mother respondents are restricted in consuming some foods after giving birth of a child

## Duration of food restriction after delivery

Duration of food restriction by the mother respondents are categorized into three categories. They are: 1) forty days 2) three months 3) more than three months. The distribution of the respondents into these categories is shown in Table-4.17

**Table-4.17: Duration of food restriction of the respondents after delivery of a child**

Duration	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
<b>40 days</b>	21	30.9	15	20.2	36	25.3
<b>3 months</b>	40	58.9	57	77	97	68.3
<b>More than 3 months</b>	7	10.2	2	2.8	9	6.3
<b>Total</b>	<b>68</b>	<b>100</b>	<b>74</b>	<b>100</b>	<b>142</b>	<b>100</b>

Source: Field data

The data shows that majority (68.3 percent) of the respondents are restricted in consuming some foods after giving birth up to three months, about one-fourth (25.3 percent) of the respondents are restricted up to forty days and 6.3 percent of the respondents are restricted more than three months.

## Duration of rest after delivery

Mere knowledge of whether the pregnant lady is given enough rest is at times not enough as the definition of rest may differ from area to area and culture to culture, which necessitates the requirement of knowing the duration of the rest after delivery. Hence the distribution of the respondents into four categories of duration of rest is shown in Table-4.18



**Table-4.18: Duration of rest of the mother respondents after delivery of a child**

Duration	Rural (Heinoubok)		Urban(Nagamapal)		Total	
	f	%	f	%	f	%
Less than 40 days	0	0	5	7	5	4
40 days	55	81	7	9	62	44
3 months	13	19	53	72	66	46
More than 3 months	0	0	9	12	9	6
<b>Total</b>	<b>68</b>	<b>100</b>	<b>74</b>	<b>100</b>	<b>142</b>	<b>100</b>

Source: Field Data

The data shows nearly half (46 percent) of the married respondents are given three months of rest after delivery, 40 percent of the respondents got forty days of rest after delivery, 6 percent are got more than three months of rest and 4 percent of the married respondents got less than forty days of rest after giving a birth.

But only after the sample size is divide into rural and urban setting it can be observe the real disparity which says that majority of the urban respondents (72 percent) are given three months of rest after their delivery whereas most of the rural respondents (81 percent) got only 40 days of rest after their delivery. The poor economic conditions of the rural respondents hardly allow them to take rest more the 40 days before which traditionally they are not allowed in the kitchen

### **Decision taken regarding size of the family**

Role in the decision regarding the size of the family tells the position of women in her family. On the basis of the decision making, the distribution of two categories of decision makers are shown in Table-4.20

**Table-4.20: Decision taken regarding size of the family**

Decision taken by	Rural (Heinoubok)		Urban (Nagamapal)		Total	
	f	%	f	%	f	%
Husband	4	5.3	1	1.3	5	3.3
Both	71	94.7	74	98.7	145	96.7
<b>Total</b>	<b>75</b>	<b>100</b>	<b>75</b>	<b>100</b>	<b>150</b>	<b>100</b>

Source: Field Data

The data shows that majority (96.7 percent) of the respondents' families decision regarding size of the family is taken by both husband and wife, and in a mere 4 percent of the household the decision regarding size of the family is taken by the respondent spouse. The same picture can be observed in both the settings (rural- 94.7 percent, urban- 98.7 percent) too.

In case of using contraceptives the data shows that both husband and wife in all the respondent families take the decision.

### **Sex without consent during pregnancy and after delivery**

Many feminist argue that the real picture of exploitation of women and the display of patriarchal domination can be seen in the guise of sex without consent of the women by their husband. Hence the following table attempts to see the share of women who are suffering from this problem. The distribution of the respondents into these categories is shown in Table-4.21

**Table-4.21: Experience of sex without the respondents consent during pregnancy and after delivery**

Sex without consent		Rural(Heinoubok)		Urban(Nagamapal)		Total	
		f	%	f	%	f	%
During pregnancy	No	20	26.7	41	54.7	61	40.7
	Yes	55	73.3	34	45.3	89	59.3
	<b>Total</b>	<b>75</b>	<b>100</b>	<b>75</b>	<b>100</b>	<b>150</b>	<b>100</b>
After delivery	No	46	61.3	70	93.3	116	77.3
	Yes	29	38.7	5	6.7	34	22.7
	<b>Total</b>	<b>75</b>	<b>100</b>	<b>75</b>	<b>100</b>	<b>150</b>	<b>100</b>

Source: Field Data

The data reveals that about three-fifth (59.3 percent) of the respondents had experienced sex without consent during their pregnancy and more than three-fourth (77.3 percent) of the respondents had experiences of sex without consent after delivery.

The share of rural respondents (73.3 percent) is more than their urban (45.5 percent) counterparts regarding the experienced of sex without consent during their pregnancy and 38.7 percent of the rural married respondents and 6.7 percent of the married urban

respondents had the experienced of sex without her consent after delivery which also highlights the overall status of women particularly in rural area and it also points towards the potent existence of patriarchal values in the area. But the study didn't found any report of facing complication of having sex without their consent during pregnancy. Among the respondents who had experienced of having sex without their consent after delivery, half (50 percent) of them are reported of faced some problems like unwanted pregnancy, among these 94.1 percent are from the rural setting.

### **Perception about contraceptive**

The perception of women regarding the preferred user for contraceptive methods, also gives a glimpse of their empowerment status. Here the data indicates that most of the women (59.3 percent) believe that husbands should use contraceptives. Though majority of the respondents from both the setting believe that husbands should use contraceptives, but the share of urban respondents (68.7 percent) is more in this category than their rural counterparts (50 percent).

### **Ideal age of boy's marriage**

As far as the perception of the women regarding the ideal age of marriage is concerned, in case of boys most of the respondents believe that boys should get married between 21-25 years followed by those who believe that they should get married between 21-25 years. But most of the rural respondents believe that boys should get married between 21-25 years of age whereas in case of urban respondents they seem give boys a little more time as they prefer them to get married between 26-30 years of age. This may be because the urban respondents give more weight to their economic self-sufficiency before getting married.

In case of girls most of them believe that ideal age of marriage is between 18-25 years followed by those who believe that they should get married after 25 years. But again most of the rural respondents believe that girls should get married between 18-25 years of age whereas in case of urban respondents they seem give girls a little more time as they prefer them to get married between 26-30 years of age. This may be because the urban respondents give more weight mainly to their education together with their economic independence before getting married.

## **Food Habits**

Food habits are important aspect of a good health. Meals taken in a day, water consumption, addiction of the respondents are analyzed below:

### **Meals**

In order to assess the overall status of health of women, one of the prime indicators can be the number of time they take meal and amount of water consumed in a day. In the present study the data reveals that about half (50.7 percent) of the respondents take meal twice in a day and 47.3 percent of the respondents take meal thrice a day. In the rural setting where women are engaged in farming and outdoor activities, no wonder more than half of them (55.3 percent) take only two times meal a day whereas 46 percent of the urban women take meal twice a day.

### **Water**

In case of consumption of water most of the respondents (64.7 percent) consume 1-2 liters of water in a day, followed by 27.3 percent of the respondents who consume about 1 liter of water a day and almost same picture can be seen in both the setting. Hence it can see that the consumption of drinking water by the women in the study area is much below par.

### **Addiction**

The status of health of any individual is reflected from their both positive and negative food habits. Hence the study of addictions to practices that is injurious to health will naturally gives a picture of the overall status of health of women.

### **Alcoholic**

The status of women at their house is a reflection of their status in the society as a whole. The consumption of alcoholic drinks by the spouse or father is generally found as the reason for unwanted happenings in the house and mostly in such cases women or the child are the victims. In the present study it found that about four-fifth (79.3 percent) of the respondents either spouse or father consumes alcoholic drinks and the share is little more in the urban area (82.7 percent) than the rural setting (76 percent).

## **Violence after consumption of alcoholic drinks**

The study found that 35.7 percent of the respondents have reported that their spouse/father generally befall violent after consuming these alcoholic drinks. It can see a visible discrepancy in both the setting, almost half of (49.1 percent) of the respondents spouse/husband who consume alcohol of the rural setting have reported that their spouse/father generally befall violent after consuming these alcoholic drinks whereas 23.4 percent of the urban respondents have this grumble from their spouse/father.

In the present study the data reveals that more than half (53.7 percent) of the respondents reported to have some kinds of addiction like chewing pan, tobacco, smoking etc. The share of rural respondents (60.7 percent) in this category is more than their urban counterparts (46.7 percent).

Out of these addicts, the data shows that little more than two- fifth (42.3 percent) of the respondents have addiction of consuming jarda pan, 12 percent of the respondents are addicted to eating talab and 2 percent of the respondents are addicted to smoking.

In the rural setting more than half of the respondents reported to have addicted to jarda pan, whereas in the urban setting most of the respondents are addicted to jarda pan. Hence it can see here that the respondents in the urban setting are addicted to a food habit (jarda pan) that is more injurious to their health.

## **Conclusion**

After studying the status of health awareness of the respondents with particular reference to reproductive health, it can be concluded that there is a visible difference in almost all the indicators studied between rural and urban respondents. Education, poor economic condition together with dismal infrastructure can be seen as the key rationale behind the disparity in the overall status of awareness in both the setting.

Indexes as purification of drinking water and use of sanitary toilets reveals that the respondents from the rural setting are performing inadequately in comparison to their urban counterparts.

The exposure to mass media also reveals the same story. Though in case of watching television there is no diversity between rural and urban respondents but most of the rural respondents watch television only occasionally. It is worth mentioning here that

the role of poor electricity supply in the rural areas of Manipur, particularly in Heinoubok is a major reason behind the asymmetrical statistics. Moreover in case of newspapers there is a noticeable inconsistency in both reading and the frequency of reading newspapers by the respondents in rural and urban settings. As most of the rural respondents believe that they don't need to spend money on newspapers as they can get the necessary information from other sources like radio, T.V. and peer groups. Surprisingly though radio as medium of communication is losing its popularity in most part of the country, but in the study area a significant proportion of the respondents listen to radio regularly and most of them are from rural background (90.7 %). Hence apart from listening radio the rural respondents' mass media awareness is indigent in comparison to urban respondents.

Though the attendance of the rural respondents is healthier in the health awareness programs than their urban counterparts which is a good sign, but it also signify that the respondents in the rural setting with lesser education and poor infrastructural facilities considers themselves more the need to attend these programs.

In case of medicine preferred by the respondents, the rural respondents are found to be still loyal to their folk medicine though they are also using allopathic medicines whereas majority of the urban respondents are favoring only allopathic medicines. Hence the rural respondents are still attached to their natural way of treating diseases. The venue for treating the first health problem also reveals the status of health awareness of the respondents, the respondents from the rural setting clearly prefer (95.3 percent) the nearest pharmacy for treating the first health problem they had and the respondents from the urban setting visibly prefer (75.3 percent) the private doctors for the purpose. The economic condition of the households together with lack of facilities can be looked as the reason behind the preference in both the setting.

Data related to the reproductive health beliefs also highlights the poor status of the rural respondents. In case of Sanitary napkins which are clearly preferred more (43.3 percent) by the urban respondents than the rural ones (9.3 percent). The rationale for these diverse stats is the dissimilar economic condition, and awareness level of the respondents. More than 70 percent of the respondents (both in rural and urban) were not taking bath during the menstrual period by complying the traditional myth. In rural area this rate is high (89.3percent) than urban area (56.7 percent), moreover the

engagement of the majority of the respondents of the urban setting in occupations as business, government and private jobs also necessitates them to take regular

The study clearly detect disparity in both the setting in both the consumption of nutritional food and practice of giving enough rest during pregnancy, which draw dearth of awareness particularly in the rural area regarding the importance of both nutritional food during pregnancy and rest during pregnancy; moreover the poor economic condition is also responsible for this.

Moreover the share of rural respondents is more than their urban counterparts who had experienced sex without consent during their pregnancy and after delivery which also highlights the status of women particularly in rural area and it also points towards the potent existence of patriarchal values in the area. The habit of taking alcohol drinks by the rural respondents' spouse can also be seen as one of the prime rationale behind the problem. The consumption of alcoholic drinks by the spouse or father is generally found as the reason for unwanted happenings in the house and mostly in such cases women or the child are the victims. In the present study it is found that most of the respondents' either spouse or father in both the setting consumes alcoholic drinks. But surprisingly most of the alcoholics in the urban setting, targets their wife whereas in the rural setting they generally do not target any particular family member. This because in urban setting people are more isolated so they have no one but their family to throw their frustrations, whereas in rural setting they are more connected with their peer groups which help them to share their distresses.

In order to assess the overall status of health of women, one of the prime indicators can be the number of time they take meal and amount of water consumed in a day. In the present study the data reveals that most of the respondents take meal twice a day and in case of consumption of water most of the respondents consumes much below par i.e. below 2 liters. In the present study the data reveals that more than half (53.7 percent) of the respondents reported to have some kinds of addiction like chewing pan, tobacco, smoking etc. The share of rural respondents (60.7 percent) in this category is more than their urban counterparts (46.7 percent). Hence the respondents in the urban setting are addicted to a food habit (jarda pan) that is more injurious to their health. Hence the overall food habit in terms of amount of drinking water, number of meal and addictions, it can be concluded that respondents from both the setting are following an unhealthy food habits.