



ISSN (E): 2277- 7695
ISSN (P): 2349-8242
NAAS Rating: 5.03
TPI 2020; 9(6): 381-387
© 2020 TPI
www.thepharmajournal.com
Received: 16-04-2020
Accepted: 19-05-2020

Vinod Kumari
Department of Sociology,
CCS Haryana Agricultural
University, Hisar, Haryana,
India

Jatesh Kathpalia
Department of Sociology,
CCS Haryana Agricultural
University, Hisar, Haryana,
India

Subhash Chander
Department of Sociology,
CCS Haryana Agricultural
University, Hisar, Haryana,
India

Sangeeta Chahal
Department of Foods and
Nutrition, CCS Haryana
Agricultural University,
Hisar, Haryana, India

Corresponding Author:
Vinod Kumari
Department of Sociology,
CCS Haryana Agricultural
University, Hisar, Haryana,
India

Socio-economic appraisal of knowledge of rural women about food and health aspects

Vinod Kumari, Jatesh Kathpalia, Subhash Chander and Sangeeta Chahal

Abstract

Women are equal partner in the progress of any country and play an important role in the development of human society. Health status of women make an impact on their fertility and their role in the development of society, however, some women have poor health status because of a variety of factors like lack of knowledge and unavailability of medical services. This present study was conducted on 120 rural women of two blocks of Kaithal district of Haryana state in India to assess their knowledge about food and health aspects and effect of various socio-economic factors on their knowledge and health status. It was found that more than 50% of the respondents had high general knowledge of food and health aspects whereas their specific knowledge was low (65.00%). General knowledge of rural women about food and health aspects was significantly associated with age, caste, education, land holding, subsidiary occupation, mass media exposure and their socio-economic status. In general, more percentage of respondents having high specific knowledge were from young age group, educated up to graduation, having medium land holding, service as subsidiary occupation, having high mass media exposure and socio-economic status and belonging to high income group. The main health problems of rural women were common diseases (33.33%), infectious diseases (22.50%), ENT/hair/mouth problem (20.00%) and pregnancy related problem (10.83%). It was suggested that specific knowledge about health and nutritional aspects must be imparted to rural women for better health of family and society.

Keywords: rural women, knowledge, food, health, diseases, Soci-economic

Introduction

Health is a main determinant of human development as it has social and economic relationship with the quality of life. The right of health is the most basic of all human rights. Every human being wants to live in an environment with minimum health risk and access to health facilities throughout the life. Women are the pillars of Indian society and always have unique position in family as they are very personification of moral force that binds the family together. Women are the key providers of the child care, hygiene, nutrition and even primary health care. A multiplicity of factors affects individual's nutrition status such as food access and availability, health, water, sanitation and hygiene practices and the care given at the home. Women empowerment plays a major role their agency and ability to take the best decisions in terms of nutrition for the family, women responsibilities include cooking, cleaning and taking cares children. The better performance of these factors and better is the overall status of a woman.

Women are equal partner in the progress of any country and play an important role in the development of human society. Women constitute a significant part of the work force in India. They constitute half of the world's population. Out of total 121 crore Indian human population (Census 2011) 83.3 crore (68.84%). Women are key providers of health services to the family and society. Health status of women make an impact on their fertility and their role in the development of society, however, some women have poor health status because of a variety of factors like lack of knowledge and unavailability of medical services. Indian women have poor health status because of a number of factors; female gender has been given a secondary place in the Indian society and there are also major disparities in health care of different women population groups like urban and rural, elite and poor, tribal and non-tribal. Social behaviours are unfavourable towards the female sex in all spheres, like nutrition, food, health care, education, etc. Traditional cultural practices, health practices, food and nutrition, education, awareness about laws, mobility of girls, attitude toward female, son preference, etc. affect sex ratio and causes health deprivation of girl child (Kumari and Kaur, 2012) [6, 7]. Indian government has taken various steps to develop the health status and made several programmes for betterment of health of women, however, there are still many problems.

Moreover, evaluation of women health services must be seen beyond their availability as it relies on social status, cultural setting and the attitude of a society. In developing countries, women and children are neglected groups in all spheres of life. Women in almost all parts of the world have complex and diverse roles. Social, cultural, economic and environment factors influence their health status. There are various factors that affect the women health *viz.*, gender and age; economic factors such as income of family, expenses on family health, high cost of treatment and health status. Rural women generally visit doctors only when they fall sick and the symptoms begin to interfere with their daily functioning. The awareness and knowledge about various health aspects and diseases are the important factors which can reduce disease prevalence in the society in general and in the women of rural society in particular. Promotion of health education is the foundation of health knowledge and awareness of people. Improving the health knowledge of society will be helpful in promoting self-health care and the optimal use of existing medical and health resources. This present study was planned to assess the knowledge of rural women about food and health aspects and effect of various socio-economic factors on their knowledge and health status.

Material and Methods

The study was conducted in Kaithal district of Haryana state. Two blocks namely Kaithal and Guhla form this district were selected randomly for the purpose of the study. Mundhari, Bhatian, Umedpur and Seewan villages were selected randomly for the purpose of the study. On the whole, a total

of 120 women respondents were surveyed with the help of well structures Interview schedule as per objectives.

Participants

The participant of the study were 120 farm women of various age groups and majority of them were up to 35 years of age (Table 1). The contextual matrix of the respondents as presented in table 1 indicate that majority of the respondents were married, belonged to joint families having 5-8 members in the family. About half of the respondents had annual family income between 1.5 to 4.0 lakhs and were having small landholdings with no subsidiary occupation of the family. They were having medium level of mass media exposure and were having medium socio-economic status in the society.

Instrument

Interview Schedule was prepared to collect the data from 120 rural women respondents from Kaithal district of Haryana state. The questions were framed which clearly indicate their meaning to the respondents and covered relevant aspects of the problem according to objectives of the study.

Statistical analysis

The collected data were coded, tabulated, analyzed using SPSS Programme and interpreted keeping in view the objectives of the present study with the help of appropriate statistical techniques. The descriptive statistical tools such as frequency, percentage and chi-square have been applied to draw the inferences.

Table 1: Contextual matrix of the respondents (n=120)

S. No.	Variables	Frequency	%age
1.	Age		
	Up to 35 years age group	62	57.70
	36-50 years age group	31	25.80
	Above 50 years age group	27	22.50
2.	Caste		
	General caste	49	40.83
	Backward caste	44	36.67
	Scheduled Caste	27	22.50
3.	Education		
	Upto Primary	32	26.67
	High School	42	35.00
	Sr. Secondary and Graduate	46	38.33
4.	Marital Status		
	Unmarried	02	1.70
	Married	114	95.00
	Widow	04	3.40
5.	Type of family		
	Nuclear	49	40.83
	Joint	71	59.17
6.	Size of family		
	Up to 4 members	48	40.00
	5-8 members	60	50.00
	Above 8 members	12	10.00
7.	Size of land holding		
	Landless	09	7.50
	Marginal (up to 1 ha)	37	30.83
	Small (1-2 ha)	53	44.17
	Semi-medium (2-4 ha)	12	10.00
	Medium (4-10 ha)	09	7.50
8.	Subsidiary occupation of the family		
	Nil	56	46.67
	Labour	25	20.83
	Business (small scale enterprise)	11	9.17

	Service	28	23.33
	Annual family income		
9.	Rs. 75,000-1,50,000	35	29.17
	Rs. 1,50,001 – 4,00,000	41	34.17
	Above Rs. 4,00,000	44	36.66
	Mass Media Exposure		
10.	Low (up to 9)	23	19.16
	Medium (10-17)	59	49.17
	High (above 17)	38	31.67
	Socio-economic status		
11.	Low (12-18)	26	21.67
	Medium (19-24)	59	49.17
	High (25-31)	35	29.16

Results and Discussion

As the objective of the present study was to assess the knowledge of rural women about food and health aspects and to study the effect of various socio-economic factors on their knowledge and health status, the results are discussed under following headings.

Food habits of rural women

Food habits and diet of particular area is greatly influenced by local conditions, soil type, urban context, religious traditions & customs and interactions etc.

Food habits have great impact on the health of human beings. Efforts were made to know the consumption pattern of different food items and results are presented in Table 2. An overwhelming majority of respondents were consuming wheat, milk, vegetables, ghee, sugar and jaggery daily whereas 67.50% respondents were consuming green leafy vegetables seasonally and 32.50% weekly in any form either fresh or preserved. Fruits were eaten by 28.3% women daily and by 47.5% on weekly basis. The consumption pattern of pear millet and maize was seasonal as majority of the respondents consumed these in winter season. Majority of respondents were not consuming egg and meat and only 4.16% consumed egg and meat in winter season. Kumari (2013) ^[4] also reported similar findings regarding food consumption pattern of rural women.

Knowledge of rural women about food and health aspects

The results in table 3 depict rural women's knowledge on various food and health aspects. Two types of knowledge were judged i.e. general and specific knowledge. For general knowledge 15 questions were asked like observance of

personal hygiene, use of baking soda, sieving of flour before kneading, use of sprouted pulses, limca/coca cola provide good nutrition, etc. The options of reply were 'yes' and 'no' and score were awarded by giving two points for right answer and one point for wrong answer. In such a way total score for each respondent was calculated by summing up total points and general knowledge was categorized as low (15-19 points), moderate (20-24 points) and high (>25 points). In the same way specific knowledge was calculated. Here 17 questions were asked about specific knowledge like peanut/til/flex seeds are nutritious, fruits and vegetable provide energy, sprouted pulses are more nutritious, amwla and citrus are rich source of vit-C, one should use seasonal fruits for better health, thin skin should be removed while peeling vegetables, sources of vitamins and minerals, etc. These statements were having true/false or fill in the blank answers. Specific knowledge was categorised as low (17-23 points), moderate (24-30) and high (>30 points) based on number of right statements of the respondents. The results regarding knowledge of rural women about food and health aspects are presented in table 3. It was found that more than 50% of the respondents had high general knowledge of food and health aspects whereas their specific knowledge was low (65.00%). Time devoted by rural women for various activities was also analysed. It was observed that 65.83% respondents devoted 5-6 hours per day on house hold work whereas 30.83 per cent devoted 3-4 hours. Majority of respondents (66.67%) devoted 1-2 hours on animal care. In agriculture activity only 25.00% respondents devoted time 7-8 hours seasonally. An overwhelming majority (94.16%) also got leisure time of 1-2 hours daily and 3-4 hours by 5.84% respondents.

Table 2: Food habits of rural women (n=120)

Food items	Daily	Weekly	Seasonally	Rarely	Never
Cereals					
Wheat	120(100)	-	-	-	-
Rice	62(51.66)	58(48.34)	-	-	-
Pearl millet	-	-	97(80.80)	23(19.20)	-
Maize	-	-	92(76.60)	28(23.40)	-
Pulses	81(67.50)	39(32.50)	-	-	-
Milk and milk products	118(98.30)	-	-	2(1.70)	-
Root and tubers	53(44.20)	45(37.50)	22(18.30)	-	-
Green leafy veg.	-	39(32.50)	81(67.50)	-	-
Other veg.	91(75.80)	29(24.20)	-	-	-
Fruits	34(28.34)	57(47.50)	29(24.16)	-	-
Fat and Oils	118(98.30)	-	-	-	2(1.70)
Sugar and jaggary	118(98.30)	-	-	2(1.70)	-
Egg and meat	-	-	5(4.16)	11(9.17)	104(86.67)

Figures in parenthesis denote percentage

Table 3: Knowledge of rural women about food and health aspects (n=120)

Type of knowledge	Level of knowledge			Total
	Low	Moderate	High	
General knowledge	26(21.67)	32(26.67)	62(51.66)	120(100)
Specific knowledge	78(65.0)	29(24.17)	13(10.83)	120(100)

Figures in parenthesis denote percentage

Association of socio-economic variables with general knowledge about food and health aspects

The association of general knowledge on food and health knowledge of respondents with their socio-economic profile was analysed and the results are cited in table 4. It was noticed that general knowledge was significantly associated with age, caste, education, land holding, subsidiary occupation, mass media exposure and SES. More percentage of respondents having high general knowledge were from young age group, general caste, nuclear family, educated up

to graduation, small land holding, medium and high mass media exposure and high SES. Masuku and Lan (214 found that rural women had knowledge about general aspects like vegetables and fruits should be washed before cutting (49.0%) but were not aware that these should be cut just before cooking (93.12%). Singh and Verma (2015) [14] reported that overall knowledge, attitude and practices regarding utilization of green leafy vegetables was less in selected areas of Allahabad. Suchitra and Kumar (2018) [17] reported that rural women had low knowledge about food and nutrition. They know only general aspects like hands should be washed before taking meals. Bathla *et al.* (2018) [1] also reported that only 42.5% of the respondents in their study high knowledge about general aspects of foods. It was observed that young educated women of general caste from families having small landholding were having higher general knowledge about food and health aspects as compared to others.

Table 4: Association of socio-economic variables with general knowledge about food and health aspects. (n=120)

Socio-economic variables	General food & health knowledge level			Total	χ^2 value
	Low	Moderate	High		
Age					
Upto 35 years	5(8.06)	18(29.03)	39(62.90)	62(51.67)	25.04*
36-50 years	7(22.58)	6(19.35)	18(58.06)	31(26.67)	
Above 50	14(51.85)	8(29.63)	5(18.52)	27(22.50)	
Caste					
General	4(8.16)	7(14.28)	38(77.56)	49(40.83)	22.78*
Backward	13(29.55)	15(34.09)	16(36.36)	44(36.67)	
Scheduled caste	9(33.33)	10(37.04)	8(29.63)	27(22.50)	
Family type					
Nuclear	5(10.20)	17(34.69)	27(55.11)	49(40.84)	7.21
Joint	21(29.58)	15(21.13)	35(49.29)	71(59.16)	
Education of Respondent					
Upto primary	20(62.50)	8(25.00)	4(12.50)	32(26.67)	59.37*
High school	4(9.52)	18(42.86)	20(47.62)	42(35.00)	
Sr. Secondary & Graduate	2(4.35)	6(13.04)	38(82.61)	46(38.33)	
Subsidiary occupation					
Nil	12(21.43)	21(37.50)	23(41.07)	56(46.67)	27.22*
Labour	11(44.00)	7(28.0)	7(28.00)	25(20.83)	
Business (small enterprise)	1(9.09)	2(18.18)	8(72.73)	11(9.17)	
Service	2(7.14)	2(7.14)	24(85.71)	28(23.33)	
Land holding					
Landless	6(66.77)	3(33.33)	0(0.00)	9(7.50)	45.47*
Marginal	16(43.24)	12(32.43)	9(24.32)	37(30.83)	
Small	3(5.66)	10(18.86)	40(75.47)	53(44.17)	
Semi-medium	1(8.33)	5(41.67)	6(50.00)	12(10.00)	
Medium	0(0.0)	2(22.22)	7(77.88)	9(7.50)	
Socio-economic status					
Low	15(57.69)	8(30.77)	3(11.54)	26(21.67)	31.44*
Medium	7(11.86)	17(28.81)	35(59.33)	59(49.17)	
High	4(11.43)	7(20.00)	24(68.67)	35(29.16)	
Mass-media exposure					
Low	18(78.26)	3(13.04)	2(8.70)	23(19.17)	61.80**
Medium	5(8.47)	23(38.98)	31(52.55)	59(49.17)	
High	3(7.89)	6(15.79)	29(76.32)	38(31.67)	

Figures in parenthesis denote percentage

Association of socio-economic variables with specific Knowledge about food and health aspects

The association of specific knowledge of respondents with their socio-economic profile was analysed and the results are presented in table 5. The results indicated that specific knowledge about food and health aspects was significantly affected by education, subsidiary occupation, income, socio-economic status and mass media exposure of the respondents.

In general, more percentage of respondents having high specific knowledge were from young age group, educated up to graduation, having medium land holding, service as subsidiary occupation, having high mass media exposure and socio-economic status and belonging to high income group. Nutritional deficiency knowledge was moderate to poor among rural women (Rani *et al.*, 2015) [12]. Bathla *et al.* (2018) [1] reported that the specific knowledge of women

regarding foods and nutritional deficiencies was moderate to low. Nivedita and Shanthini (2016) [10] also found that awareness about rich food was poor in countryside and about 63.87% were anaemic.

Association of socio-economic variables with health problems of rural women

The respondents were asked to mention the most prominent problem/disease from which they were suffering. It was found that the main health problems of rural women were common diseases (33.33%), infectious diseases (22.50%), ENT/hair/mouth problem (20.00%) and pregnancy related problem (10.83%). Rest of the respondents were suffering from gynaecological, psychological, deficiency and heart problems. The data were analysed to find out the association of different socio-economic factors with occurrence of disease/problems and the results are presented in table 6. Chi-square values indicated that only age was found to be associated significantly with the occurrence of diseases. Kamari (2012a) found significant effect of occupation and family size on health attributes of rural women. She observed that women from nuclear family were having more common diseases (34.2%) followed by chronic (15.8%) and sex related problems (13.2%). Singh and Dak (1993) [16] and Bimla (1995) [2] also reported significant association of family type

and health of rural women. Kumari (2012) [6, 7], Garbarshi and Witt (2013) [3] and Lowe *et al.* (2016) [8] also reported that socio-economic factors affected maternal health. Yarney (2019) [18] reported that socio-economic factors like age at marriage, high fertility, poor food habits and socio-cultural factors affect the maternal health. Singh *et al.* (2019) [15] also reported that women health in rural areas was affected by economic status, gender and social discrimination. In the present study young age respondents were suffering mainly from common diseases (37.10%) followed by pregnancy problems (21.00%), ENT/hair/mouth problems (17.70%). Whereas women in older age were more suffering from ENT (26.90%) followed by common diseases (23.10%) and infectious diseases (15.40%). Patil *et al.* (2013) [11] observed that 85.7% women never consulted doctor for oral cavity and routine check-up. Lack of knowledge and time, limited access to oral health were reported as barriers for poor oral health of women. Sidhaya and Patel (2010) reported that socio-economic, cultural and gender inequality were significantly associated with common diseases in females. Singh *et al.* (2019) [15] also observed that economic factors had combing effect on health status like heavily physical activities, poor food and nutrition, avoiding medical check-ups which in turn leads to high risk of chronic illness.

Table 5: Association of socio-economic variables with specific knowledge about food and health aspects. (n=120)

Socio-economic variables	Specific food & health knowledge			Total	χ ² value
	Low	Moderate	High		
Age					
Upto 35 years	34(54.84)	19(30.64)	9(14.52)	62(51.67)	5.94*
36-50 years	24(77.42)	5(16.13)	2(6.45)	31(25.83)	
Above 50	20(74.07)	5(18.52)	2(7.41)	27(22.50)	
Total	78(65.00)	29(24.17)	13(10.83)	120(100.0)	
Caste					
General	34(69.39)	11(22.45)	4(8.16)	49(40.83)	1.68
Backward	29(65.91)	10(22.73)	5(11.36)	44(36.66)	
Scheduled caste	15(55.56)	8(29.63)	4(14.81)	27(22.50)	
Family type					
Nuclear	34(69.39)	9(18.37)	6(12.24)	49(40.83)	1.55
Joint	42(59.15)	20(28.17)	7(9.86)	71(59.17)	
Family size					
Upto 4	38(79.17)	7(14.58)	3(6.25)	48(40.00)	8.58
5-8	32(53.33)	20(33.33)	8(13.34)	60(50.00)	
Above 8	8(66.67)	2(16.67)	2(16.67)	12(10.00)	
Education					
Upto primary	29(90.62)	2(6.25)	1(3.12)	32(26.67)	20.0*
High school	28(66.67)	12(28.57)	2(4.76)	42(35.00)	
Graduate	21(45.65)	15(32.61)	10(21.74)	46(38.33)	
Land holding					
Landless	6(66.67)	2(22.22)	1(11.11)	9(7.50)	16.51*
Marginal	26(70.27)	9(24.32)	2(5.41)	37(30.83)	
Small	41(77.435)	10(18.87)	2(3.77)	53(44.17)	
Semi-medium	5(41.67)	4(33.33)	3(25.00)	12(10.00)	
Medium	0(00)	4(44.44)	5(55.55)	9(7.50)	
Subsidiary occupation					
Nil	51(91.07)	3(5.36)	2(3.57)	56(46.67)	42.35**
Labour	16(64.00)	7(28.00)	2(8.00)	25(20.83)	
Business (small enterprise)	2(18.18)	7(63.63)	2(18.18)	11(9.17)	
Service	9(32.14)	12(42.86)	7(25.00)	28(23.33)	
Socio-economic status					
Low	21(80.77)	3(11.54)	2(7.69)	26(21.67)	10.98*
Medium	39(66.10)	17(28.81)	3(5.08)	39(49.17)	
High	18(51.43)	9(25.71)	8(22.86)	35(29.16)	
Mass-media exposure					
Low	18(78.26)	3(13.04)	2(8.70)	23(19.17)	27.53**

Medium	48(81.35)	8(13.56)	3(5.09)	59(49.17)	
High	12(31.58)	18(47.37)	8(21.05)	38(31.67)	
Income					
Low	28(80.00)	5(14.29)	2(5.71)	35(29.17)	9.59*
Medium	23(56.10)	15(36.59)	3(7.32)	41(34.17)	
High	27(61.36)	9(20.45)	8(18.18)	44(36.66)	

Figures in parenthesis denote percentage * & ** Significant at 5% & 1% level of significance, respectively.

Table 6: Association of socio-economic variables with health problems of rural women (n=120)

Socio-economic variables	Diseases									χ ² value
	Common disease	Infectious	Psycho-logical /anxiety	Gynaecology	Deficiency	Pregnancy	ENT/ hair etc	Chronic	Total	
Age (years)										
Upto 35	23(37.00)	11(17.74)	2(3.22)	7(1.29)	1(1.61)	13(20.97)	11(17.714)	0(00)	62(51.67)	24.43*
36-50	11(36.4.37)	12(37.50)	1(3.12)	2(6.25)	0(00)	00(00)	6(18.75)	0(00)	32(26.66)	
Above 50	6(23.08)	4(15.38)	2(7.69)	3(11.54)	2(7.69)	00(00)	7(26.92)	2(7.69)	26(21.67)	
Total	40(33.33)	27(22.50)	05(4.17)	06(5.00)	03(2.50)	13(10.83)	24(20.00)	02(1.67)		
Caste										
General	19(38.77)	9(18.37)	2(4.08)	2(4.08)	1(2.04)	7(14.28)	8(16.32)	1(2.04)	49(40.83)	14.71
Backward	18(40.91)	7(15.91)	1(2.27)	3(6.82)	2(4.54)	3(6.82)	9(20.45)	1(2.27)	44(36.67)	
Scheduled caste	3(11.11)	11(40.74)	2(7.41)	1(3.70)	0(00)	3(11.11)	7(25.92)	00(00)	27(22.50)	
Education										
Upto primary	7(21.87)	6(18.75)	2(6.25)	3(9.37)	2(6.25)	6(18.75)	4(12.50)	2(6.25)	32(26.67)	11.34
High school	16(38.10)	10(23.81)	2(4.76)	2(4.76)	1(2.38)	4(9.52)	7(16.67)	0(00)	42(35.00)	
Upto Graduation	17(37.00)	11(23.9)1	1(2.17)	1(2.17)	0(00)	3(6.52)	13(28.26)	0(00)	46(38.33)	
Family Size										
Upto 4	17(35.42)	11(22.92)	1(2.08)	0(00)	0(00)	9(18.75)	9(18.75)	2(4.16)	48(40.00)	13.84
5-8	19(31.67)	14(23.33)	3(5.00)	4(6.67)	2(3.33)	3(5.0)	15(25.00)	0(000)	60(50.00)	
Above 8	4(33.33)	3(25.00)	1(8.35)	2(16.57)	1(8.33)	1(8.33)	0(00)	0(00)	12(10.00)	
Socio-economic status										
Low	7(26.92)	4(15.38)	1(3.85)	2(7.69)	2(7.69)	3(11.45)	6(23.08)	1(3.85)	26(21.67)	6.47
Medium	20(33.90)	15(25.42)	2(3.39)	2(3.39)	1(1.69)	4(6.78)	14(23.72)	1(1.69)	59(49.2)	
High	13(37.14)	8(22.80)	2(5.71)	2(5.71)	0(00)	6(11.43)	4(11.43)	0(00)	35(29.17)	
Income level										
Low	10(28.57)	7(20.00)	2(5.71)	2(5.71)	1(2.86)	4(11.43)	6(17.14)	1(2.86)	35(29.17)	11.02
Medium	12(29.26)	9(21.95)	2(4.88)	1(2.44)	2(4.88)	5(12.19)	14(34.15)	1(2.44)	41(34.17)	
High	18(40.91)	11(25.00)	1(2.27)	3(6.80)	0(00)	4(9.09)	4(9.09)	0(00)	44(36.66)	
Mass-media exposure										
Low	10(43.48)	5(21.74)	1(4.35)	0(00)	0(00)	0(00)	6(26.09)	1(4.35)	23(19.17)	12.84
Medium	14(23.72)	14(23.72)	3(5.08)	4(6.78)	2(3.39)	7(11.86)	15(25.42)	0(00)	59(49.16)	
High	16(42.11)	8(21.05)	1(2.63)	2(5.26)	1(2.63)	6(15.79)	3(7.89)	1(2.63)	38(31.67)	

Figures in parenthesis denote percentage *Significant at 5% level of significance

Conclusion

It was concluded that majority of respondents were having high general knowledge about food and health aspects but their specific knowledge was low and there was a significantly association between some of the socio-economic factors and knowledge level. It was also suggested that Specific knowledge about health and nutrition aspects must be imparted to rural women. There is need to educate women on healthy life style while organizing awareness campaigns, trainings and workshops.

Acknowledgement

The authors are thankful to the CCS HAU, Hisar administration, for providing the necessary facilities for conducting the present research.

References

1. Bathla S, Sharma M, Bala R. Assessment of food habits and dietary intake of rural women. Journal of Krishi Vigyan, 2018; 7(1):25-29.
2. Bimla. How healthy are village women? Social welfare, 1995; 42(3):16-17.
3. Garbarshi D, Witt WP. Maternal material and socio-

economic factors and maternal health. Journal of family issues. 2013; 34(4):484-509.

4. Kumari V. Studies on food habits in rural women. Asian Journal of dairy and food research. 2013; 32(1):74-78.
5. Kumari, V, Kaur K. Socio-cultural Factors Affecting Sex Ratio and Health Deprivation of Girl Child in India: A Review. Indian Journal of Health and Well-being. 2014; 8(4):310-314.
6. Kumari V. Effect of family type on birth practices and health problems of rural women. Indian journal of health and wellbeing. 2012; 3(3):820-823.
7. Kumari V. Factors affecting health attributes of rural women. Eco research journal of bio sciences. 2012a; 10-11(1-2):70-78.
8. Lowe M, Chen DU, Huang SL. Social and cultural factors affecting maternal health in rural Gambia: an exploratory qualitative study. Journal pone. 2016; 11(9):1-16.
9. Masuku SK, Lan SJ. Nutritional knowledge, attitude and practices among pregnant and lactating women living with HIV in the Manzini region communities. Journal of health population and nutrition. 2014; 32(2):237-248.
10. Nivedita K, Shanthini N. Knowledge, attitudes and

- practices of pregnant women regarding anemia, iron rich diet and iron supplement. *International journal of reproduction contraception, obstetrics and gynecology*. 2016; 5(2). <http://www.ijrcog.org>.
11. Patil S, Thakur R, Madhu K, Paul ST, Gdicherla P. Oral health coalition: knowledge, attitudes and practices behaviors among gynecologist and dental practitioners. *International journal of oral health*. 2013; (5):8-13.
 12. Rani PR, Devi T, Sowandariya R, Pratheeba B. Knowledge, attitude and practices on pregnancy and post-partum care among rural and tribal women. *Indian journal of research in food science and nutrition*. 2015; 2(1):10-16.
 13. Shidhaye R, Patel V. Association of socio-economic, gender and health factors with CMDs in women: a population- based study of 5703 married rural in India. *International journal of epidemiology*. 2010; 39(6):1510-1521.
 14. Singh J, Verma NB. Knowledge attitude and practices of rural women regarding underutilized green leafy vegetables in Allahabad district. *International journal of applied and pure science and agriculture*. 2015; 1(9):25-30.
 15. Singh L, Goel R, Rai RK, Singh PK. Socio-economic inequality in functional deficiencies and chronic disease among older Indian adults: a sex- stratified cross-sectional decomposition analysis. *BMJ open*. 2019; (9):1-9.
 16. Singh S, Dak TM. Food beliefs in rural women in Haryana. *HAU journal of research*. 1993; 23:202-205.
 17. Suchita, Kumar R. Knowledge of rural women regarding nutrition practices in Bikaner District of Rajasthan, India. *International journal of current microbiology and applies sciences*, 2018; 7(2):3174-3184.
 18. Yarney L. Does knowledge on socio-cultural factors associated with maternal mortality affects maternal health decisions? A cross sectional study of the grater Accra region of Agahana. *BMC pregnancy and childbirth*. 2019; 19(47):2-12.