CHAPTER - 7

SUMMARY, CONCLUSIONS AND SUGGESTIONS

The present study aims to assess the health status and demand for health care facilities of rural Muslim married women in Cachar district. The study focuses mainly on three themes viz; health status of the women, accessibility and availability of rural health infrastructure in Cachar district and demand for health care facilities of the women. Based on the findings of the study mentioned in earlier chapters the conclusion and policy suggestions are framed in this chapter. This chapter is divided into four sections viz; summary of the study in section 7.1, conclusion of the study in section 7.2, policy suggestions in section 7.3 and finally limitation of the study and scope for further research in section 7.4.

7.1 Summary

Good health is a crucial component of well-being. However, improvements in health status may be justified on purely economic grounds. It seems to be a logical assumption that good health raises human capital levels and therefore the economic productivity of individuals and a country`s economic growth rate. Status of health shows the development of the society. This health status is influenced by different indicators like employment, income, educational attainment, social groups, level of awareness, accessibility to health care and availability of health services. Poor health leads to deficiency in human capabilities and it shows the level of deprivation among the people too. There is a close linkage between health and poverty and health and development but

the relationship is very complex. Hence, poor health is considered to be a major constraint of development. Health being the basic rights of all individuals, they are entitled to have quality health care service, safe drinking water, sanitation and so on. It becomes the obligation of the government to care for the health condition of the people.

Health is not only an important element of well being, it is also an important component of human capital, and is of major importance for economic growth and development. In poor countries, where physical jobs tend to be in abundance, health is more important than education in determining labor productivity. Most of the developing countries of the world face problem of malnutrition. These countries bear huge economic burden of poverty and malnutrition. Undernourishment prevents not only physical and mental growth of an individual but it also prevents an individual's economic progress. This results in poor productivity at their workplace. Developing countries with serious problem of malnutrition lack capacity to design effective programmes to tackle the problem of malnutrition and consequently health problems, affecting the quality of their workforce and overall economic growth. Studies have shown that most of the underdeveloped and developing economies invest less than their financial capacity in the health improvement programmes. Though developing countries have a number of nutritional programmes, actual spending on nutrition programmes is much lower than allocated amount in the budget.

Investment on health sector improves the productivity of a nation. Some of the empirical evidences suggest strong correlation between improvement in health programmes and consequent increase in rate of economic growth and development.

Though health and illness are universal phenomenon, perceptions about health varies from society to society. Therefore, an understanding of health is crucial in order to understand the health seeking behavior. Women have played an important role in the process of development of nation and unless the women folk are cared for they cannot contribute meaningfully. Women's health and their health seeking behavior affect their role performance in society as rightly pointed out by Chatterjee (1988). According to her, there are four arenas, which determine women's access to and utilization of health services. These are need, permission, ability and availability. Often health concerns are also regulated by religion and social codes of conduct as found among the Muslims. Islamic traditions are based on Quranic instruction, Hadith and Sunnah. The tradition of Prophet (Peace be Upon Him) and Quranic instruction both contain elements of health and healing. Several studies have revealed that modesty may be a barrier to health care (Scheinberg, 2006). In the sampled respondents, women have expressed that visiting a lady doctor is preferred. As they want to follow the modesty rule, by visiting a male health service provider it may not be socially appropriate. They also fear to expose sensitive body parts to a male health service provider and hesitate to even discuss any gynecological problem with a male doctor or other such health service provider.

The study attempts to analyze the health status based on both BMI and disease according to different age group of rural Muslim married women. The study also depicts the scenario of health infrastructure in rural area of Cachar district and the accessibility of health care facilities for women. Further, the study analyses the traditional preventive measures that they uses for different diseases and also attempts to examine their demand for health care facilities and its determinants.

To fulfill the above-mentioned objectives the study comprises with seven chapters which are briefly mentioned in the following.

Chapter 1 presents the concept of health, statement of the problem, area of the study, objectives, hypothesis, and data source of the study.

Chapter 2 deals with review of literatures related to the objective of the study.

Chapter 3 shows the theoretical and conceptual frameworks and methodology of the study. The study is mainly based on primary data. Primary data is collected from the field by preparing scheduled questionnaires. Three-stage stratified random sampling techniques are used for collecting the primary data. In Cachar district, there are 15 blocks. Out of these 15 blocks, 50 per cent (approximately) blocks are selected in the first stage. In the second stage, from each selected block, 10 per cent (approximately) villages are selected. The selection of blocks and villages are based on large demographic size of women population. In the final stage, eight households from each selected village are selected randomly from Muslim community. Therefore, approximately 450 households consisting of 586 respondents from 56 villages are considered for the study. In this study women are categorized into three groups viz; reproductive age group (15-35 years), pre-menopause age group (36-45 years), and menopause age group (46 year and above). In this study dimensional index and Body Mass Index is used to find the health status of women in different blocks of Cachar district. To identify the socio-economic determinants of health status or BMI, a multiple regression is used with containing both qualitative and quantitative variables are considered. These quantitative explanatory variables are age of the respondent, educational level of the respondent, household size,

food expenditure of the family, medical expenditure of the family, marital age of the respondent and area of the house. The qualitative explanatory variables taken as a dummy include housing condition, purification of water and sanitation facilities. To analyze the scenario of rural health infrastructure in Cachar district, secondary information is used. To examine the determinants of the demand for health care facilities of the women binomial logit model is used through contingent valuation technique. The primary use of contingent valuation method is to elicit the women's willingness to pay for getting health care facilities. This approach is used to check whether they are interested to pay or not. The response option will be binary type i.e.; 1 for yes and 0 for no. For the logit model both qualitative and quantitative variables are considered. These quantitative explanatory variables are age of the respondent, educational level of the respondent and her husband, BMI of the respondents, household size, per-capita income, per capita medical expenditure, distances of the health centre from home and area of the house. The qualitative explanatory variables taken as a dummy include housing condition, purification of water and sanitation facilities.

Chapter 4 examines the health status of Muslim married women both with the help of morbidity and BMI analysis. This chapter also deals with the comparative analysis of crucial diseases in different blocks of Cachar district. Further, it consists with the socio-economic determinants of health status of the women.

Chapter 5 depicts the health infrastructure and health care facilities in Cachar district. This chapter is based on both primary and secondary data. The secondary data explains the availability of health centres and health care facilities in rural health institutions. This chapter also depicts the accessibility of the health services based on

primary data collected from respondents view. There is a huge shortage of health centres and health care facilities in Cachar district. There is a huge shortage of both physical and human health infrastructures in Cachar district. The condition of Block Primary Health Centre (BPHCs) is relatively better in comparison to Sub Centre (SCs) and Community Health Centre (CHCs). However, the situation of Mini Primary Health Centre (MPHCs), State Dispensary (SDs) and Subsidiary Health Centre (SHCs) is very miserable. Non-setting up of the required health centre as per population norms resulted in non-achievement of the primary objective of improving accessibility to health facilities in rural areas. Most of the MPHCs are running by a nurse or pharmacists and as a result, patients are not getting proper treatment. Though some doctors are present in these PHCs, but specialist doctors are still not present in the health centers. For the treatment of women related diseases viz; menstrual problem, white discharge, sexual problem, gynecological problem etc. Female doctors are not available in these health centres which affect the rural women especially Muslim women because they are shy to discuss these problems with male doctor. The doctors do not want to continue their service in rural areas due to poor infrastructural facilities. Thus in these areas there is a huge demand of doctors and other staffs. Taking care of too many people by limited doctor may sometimes hamper the patients' health. Though govt. has introduced many schemes especially for reproductive women, but no special attention has given for the improvement of old aged women. Moreover, due to the illiteracy, ignorance and awareness problem, negligence behavior of the health providers the services are not properly being utilized by the women.

Chapter 6 shows the traditional preventive measures, which most of the women are taking for different diseases. This chapter also shows that there is a high demand for health care facilities because of huge shortage of both physical and human health infrastructure in rural are of Cachar district. The survey result shows that 72 per cent Muslim women are willing to pay for getting better health care facilities or for sharing cost of maintenance if any voluntary organization comes forward or public health sector establishes in their locality. The responsible factors of this demand are age of the respondent, educational level of the respondent and her husband, BMI of the respondent, household size, per-capita income, per-capita medical expenditure, distance of the health centre from home, area of the house and semi pucca house.

7.2 Conclusion

The conclusions are based on the findings mentioned in the earlier chapters. This is briefly explained in the following according to the hypotheses mentioned in section 1.5 in Chapter 1.

Approximately 81 per cent of the women out of total women are suffering from different types of health diseases. Out of the total women, the women of menopause group are mostly affected followed by pre-menopause and reproductive group of women. Percentage of affected women or the number of average disease increases according to the higher age bracket. An ill woman is facing on an average more than three (3.84) types of diseases. Affected reproductive women suffer on an average approximately three types of diseases. On the other hand, an affected pre-menopause woman and menopause woman suffer on average more than four and five types of diseases respectively.

Most of the women belonging to reproductive age group are facing the diseases such as anemia, menstrual, calcium shortage, white discharge, sexual problem, gynecological problem, hair falling, skin problem, stress, headache etc. Most of the women belonging to pre-menopause age group are facing the diseases such as gas, anemia, menstrual, calcium shortage, arthritis, headache, gynecological problem, hair falling, skin problem, stress, eye, dental etc. Women of menopause age group are facing multiple crucial problems such as gas, arthritis, rheumatism, dental problem, eye problem, calcium shortage, menopause, anemia, giddiness, mental problem, skin disease, headache, blood presser problem, forgetfulness, respiratory problem, piles etc.

Among the crucial diseases faced by the reproductive women in different blocks of Cachar district it is seen that anemia problem is highest in Kalain block followed by Sonai block and Borkhola block and this problem is lowest in Borjalenga block. Calcium shortage related diseases is highest in Borkhola block and lowest in Katigorah block. Gastroenterlogical problem faces the respondent is almost similar in all the blocks except Udharbond block, Borkhola block and Katigorah block. Gynecological problem is not significantly observed in all the blocks. Among all the blocks, hair falling problem is highest in Sonai block and lowest in Borjalenga block. Both menstrual and white discharge problem is highest in Kalain block and lowest in Borjalenga block. Sexual problem is highest in Kalian block and lowest in Katigorah block. Finally, skin diseases are highest in Sonai block and lowest in Borjalenga block.

For pre-menopause women it is seen that anemia, arthritis and calcium shortage is relatively higher in Barjalenga, Borkhola and Narshingpur block whereas these problems are relatively lower in Udharbond block. Further, it is observed that eye and mental

problems are more prevalent in Borkhola block. However, these problems are relatively lower in Katigorah and Sonai block. Dental and hair falling problem is reported more by the women of Udharbond block whereas dental problem is found to be lower in Katigorah and Sonai block and hair falling is reported less by the women of Kalian block. Gastroenterological problem, which is found to be significant in all the blocks, is relatively higher in Borjalenga block and lower in Katigorah block. Giddiness, gynecological and rheumatism problem is more prevalent in Borkhola block. Menstrual problem, which is common for the pre menopause group of women, is found to be higher in Kalain block and lower in Narshingpur block. Hearing problem is not very significant in all the blocks of Cachar district, though this problem is relatively higher in Borjalenga block and relatively lowers in Katigorah, Narshingpur and Sonai block. Finally, skin problem is reported more by the pre menopause women of Narshingpur block and no women from Borkhola and Katigorah block reported this problem.

For menopause women it is seen that gastroenterological problem is more prevalent in all the blocks of Cachar district and this percentage is highest in Borkhola block and lowest in Borjalenga block. The problem of calcium shortage, giddiness and skin related diseases are found to be relatively more in Borjalenga block and relatively low in Udharbond block than the other blocks of Cachar district. Further, it is observed that anemia problem is relatively higher in Barjalenga block followed by Udharbond block and lowest in Kalain block. The problem of arthritis is also very high in all the blocks and this percentage is highest in Sonai block and lowest in Udharbond block. The problem of rheumatism and menopause is more prevalent in Borkhola block. However, these problems are relatively lower in Udharbond block. Heart and high blood pressure

problems are reported more by the women of Sonai block whereas no menopausal women in both Borjalenga and Udharbond block are found to be sufferer from these two problems. Though sugar problem is not significantly observed among the women of all the blocks, still this problem is found to be relatively higher in Sonai block and lower in Katigorah block. Similarly, piles problem is also not significantly observed in all these blocks and among these blocks this problem is found to be highest in Kalain block and lowest in Sonai block. Dental problem is seen to be more or less same in all the blocks and this percent is highest in Sonai block and lowest in Udaharbond block. Finally, eye problem is reported less by the women of Udharbond block and affected more by the women of Kalain block.

Therefore, it is concluded that health situation of Muslim married women in different blocks of Cachar district is not satisfactory and among these blocks, the health status of reproductive women in Borjalenga block is relatively better than other blocks of Cachar district. Similarly, the health status of pre-menopause women in Katigorah block is reatively and health scenario of women in Udharbond block is relatively better than other blocks of Cachar district.

The illness index value is very high in all the blocks, which show a poor health status of the Muslim married women. Total numbers of illed married women are highest in Borkhola block and lowest in Barjalenga block.

The problem of malnutrition is also very high in all these three groups as 26.11 per cent respondents are faces this problem. The problem of malnutrition is highest in reproductive group and lowest in pre-menopause group. The problem of overweight is

highest in menopause group followed by pre-menopause group. However, obesity cases are rare in all the groups. The condition of health is better among reproductive group. All together 32.76 per cent respondents are enjoying a relatively better healthy condition. Among these respondents most of the women are from reproductive age group followed by menopause and pre-menopause group.

Therefore, it is concluded that the first hypothesis i.e. health status of the Muslim married women in rural area of Cachar district is not satisfactory or in other words we can say that null hypothesis is accepted.

To identify the socio-economic determinants of health status multiple regression is used. BMI of the women is taken as a proxy for health status. There are several significant responsible factors of health status which are both quantitative and qualitative factors viz; age of the respondent, educational level of the respondent, household size, monthly food expenditure of the family, monthly medical expenditure of the family, marital age of the respondent and area of the house and semi pucca and pucca housing condition. Therefore, it is concluded that the second hypothesis i.e. there are various factors that affect BMI or health status of the Muslim married women in rural area of Cachar district is accepted.

Health infrastructure of Cachar district is not satisfactory. There is a huge shortage of both physical and human health infrastructures in Cachar district. The condition of Block Primary Health Centre (BPHCs) is relatively better in comparison to Sub Centre (SCs) and Community Health Centre (CHCs). However, the situation of Mini Primary Health Centre (MPHCs), State Dispensary (SDs) and Subsidiary Health Centre

(SHCs) is very miserable. Most of the MPHCs are running by a nurse or pharmacists and as a result, patients are not getting proper treatment. Though some doctors are present in these PHCs, but specialist doctors are still not present in the health centers. For the treatment of women related diseases female doctor are not available in these health centres, which affect the rural women, especially Muslim women because they are shy to discuss these problems with male doctor. Non-setting up of the required health centre as per population norms resulted in non-achievement of the primary objective of improving accessibility to health facilities in rural areas.

Though the situation of Cachar district for some health indicators like infant mortality rate, mortality rate under the age five and maternal mortality rate (IMR, UMR-5, and MMR) are better than the state average but still the health status of Cachar district is not satisfactory. It is thus, clear that the health status of the rural areas is poorer than the urban areas. The reproductive health care services of the district are also not satisfactory and a visible inequality between rural and urban areas is observed with an inclination towards the private sector. Govt. has introduced many schemes especially for reproductive women, but no special attention has given for the improvement of old aged women.

Though govt. has introduced various health schemes but due to their illiteracy, ignorance and awareness problem, negligence behavior of the health providers the services are not properly utilized. Only 65.52 and 45 per cent respondents respond that they are satisfied with the services provided by the SCs, PHCs and CHC respectively. A significant percentage of the respondents argue that they are not getting proper service in time. Though govt. has introduced many health schemes especially for reproductive

women but still only 42 per cent respondent argued that they are benefitted from these schemes. A remarkable number of respondent respond that they are satisfied with the service provided by Accredited Social Health Activist (ASHA). Therefore, it is concluded that availability and accessibility of rural health infrastructure especially for women in Cachar district is not satisfactory ie; the third hypothesis is accepted.

Due to shortage of poor health infrastructure and low economic status a significant number of Muslim married women are either using traditional preventive measures to get relief from the diseases or neglecting such problems. Only a few numbers of women are using modern medical treatment either from private or government health institution. In the study area, it is observed that approximately 54.68 per cent respondents are involved in superstitious belief while 45.32 per cent respondents are not involved in these activities. It is observed that out of the total reported diseased women (2248), majority of the respondents (53.91 per cent) are neglecting their health problems and only a few number of women are going for either traditional preventive measures (30.16 per cent) or modern measures (25.88 per cent). Most of the married women neglect the problems such as mental, white discharge, low blood pressure, anemia, mouth ulcer, diabetic, eye etc. without taking any measures. Married women are following the traditional measures for the problems such as dental, calcium shortage, skin related problem, hearing problem, headache, rheumatism, menstrual, hair etc; only in case of heart, mental and thyroid related problem, no traditional measures are taken. For gynecological and heart related problem the married women are not following traditional measures whereas they keep faith on modern measures. Therefore, it is concluded that

fourth hypothesis i.e. Muslim married women mainly depends on traditional preventive measures is rejected.

Shortage of rural health infrastructure especially for women creates a huge demand for health care facilities in their locality. The survey result shows that 72 per cent Muslim women are willing to pay for getting better health care facilities or for sharing cost of maintenance if any voluntary organization comes forward or public health sector establishes in their locality. Moreover, it is also observed that the demand for health care facilities is relatively higher in Kalain block followed by Borjalenga and Katigorah block whereas it is relatively lower in Narshingpur block. Further, it reveals that the responsible factors of this demand are age of the respondent, educational level of the respondent and her husband, BMI of the respondent, household size, per capita income, per capita medical expenditure, distance of the health centre from home, area of the house and semi pucca house. Therefore, the fifth hypothesis i.e. there is a huge demand for health care facilities is accepted and this demand is affected by various factors.

7.3 Suggestions

From the above analysis it is found that the health status of Muslim married women in rural area of Cachar district is not at all satisfactory and there is a huge shortage of both physical and human health infrastructure which leads a very high demand for health care facilities among them. Thus, on the basis of the above findings and conclusion of this study the following suggestions can be framed.

- Effective policies and programmes are required to reduce both forms of malnutrition. Hence, information and health education programs for women of the district are

needed to help them to understand the components of a healthy diet and to ensure adequate access to health services.

- Effective health awareness programs need to be introduced to change the perception of illness of Muslim households.
- Perspective to health status is highly influenced by socio-cultural beliefs and practices. Thus, socio-economic status and income saving opportunities of the Muslim married women needs to be developed by education and employment programmes of the govt.
- The laws should be strictly focused on preventing injustice against Muslim women.
- Integrated Child Development Schemes (ICDS), the package of services includes physical and obstetrical examination: monitoring weight, blood pressure, supplying iron and folic acid tablets, food supplements, identification and referral of high-risk mothers and health education on antenatal care, breast-feeding, child rearing and family planning should be highly implemented among Muslim women.
- Though govt. has initiated to improve the health infrastructure but still it is not sufficient compare to the need because of poor administrative monitoring. Therefore, it is suggested that the administrative monitoring should be increased for the improvement of the health care facilities.
- The study reveals that due to the absence of female doctor women are reluctant to go to the hospital for treatment of gynecological problem. Therefore, it is suggested that female doctor should be appointed in these health centres for the treatment of women patient.

- As there is huge demand for health care and people are ready to pay some amount of money for getting better health care facilities so some volunteer organizations, NGOs should come forward on the cost sharing basis. Even mobile medical unit for the interior area may be a possible solution where there is no health service.
- Since most of the health schemes are related for reproductive women. Therefore, govt. should take policies for the older women too.
- Muslim women are weaker sections of the society who have lagged behind in all fields. Hence, it is suggested that more importance should be given to improve the accessibility of getting available health care facilities by governmental and nongovernmental programmes with their close monitoring, early detection of problems in implementation and midcourse correction for the upliftment of Muslim women's' health status.
- Since in Cachar district especially in rural area the road infrastructure is very miserable and as a result, women mainly pregnant and old aged women are facing difficulty to reach the health centre. Therefore, the government should improve the rural infrastructure, transport facilities, or establish more health infrastructure in rural areas.

7.4 Limitations of the Study and Scope for Further Research

Though the study highlights many aspects but there are some limitations which are discussed in the following for pursuing further research in this field:

- Health status is measured by using BMI in this study. Nutritional calorie index is another important index for showing health status in terms of nutritional deficit or surplus though it is not done here due to time limitation.
- Since most of the women are house wives and their husbands are daily workers. Therefore, there is a problem of authentication related to income and expenditure information. Here, the information has been provided the respondent based on their memory.
- Estimation of cost structure of alternative health facilities is essential for which the people are ready to pay. After estimation of the cost structure an actual required contribution can be estimated and accordingly an open ended bidding could be asked to the respondent for getting the absolute value of willingness to pay.
- In present study a cross-sectional data are used. A time series data. It is difficult to include all the socio-economic and other aspects in a particular study due to time constraint. However, these limitations of the present study may open up for pursuing further researches.