CHAPTER - 1

INTRODUCTION

1.1 Background of the Study

Health is an important dimension of the country's development. Now-a-days the concept of health and illness are universal phenomenon. Both health and illness are an integral and essential part of life for an individual, family, community and society. Many definitions of health have been offered from time to time. However, the widely accepted definition of health is given by the World health organization (WHO). WHO defines health, as a state of complete, physical, mental and social well-being and not merely an absence of disease or infirmity.

An understanding of health is the basis of all health care. Health is not merely an issue of doctors, social services and hospitals; it is an issue of social justice and a common theme in most cultures. Various professional groups for example, the biomedical scientists, social scientists, health administrators, ecologists, etc. has given a number of concepts regarding health and the understanding of health.

Health has evolved over the centuries from an individual concern to worldwide social goal encompassing the notion of quality of life in a holistic manner. The concept of health started with the biomedical viewpoint, which includes the traditional notion that health is the "absence of disease". Biomedical concept is based on "germ theory disease", which has dominated medical thought at the turn of the 20^{th} century. This concept has minimized the role of environment, social, psychological and culture on health. The

biomedical model, for all its spectacular success in treating disease, is found inadequate to solve some of the major health problems of humankind (e.g; malnutrition, chronic diseases, drug abuse, mental illness, environmental pollution, population explosion, etc.) by medical technologies (Park 2007). Developments in medical and social sciences led to the conclusion that the biomedical concept of health is inadequate and this gives rise to another concept that of the ecological concept.

The ecological concept has viewed health, as a dynamic equilibrium between man and his environment and disease is the result of maladjustment of the human organism to environment. Ecological concept explains health as a relative of pain and discomfort and a continuous revision and adjustment to the environment to ensure optimal function. Human ecological and cultural variations determine not only the occurrence of disease but also the availability of food and the population explosion. The ecological concept raises two issues, viz; imperfect man and imperfect environment.

Contemporary developments in social sciences is revealed that health is not only a biomedical and ecological phenomenon, but also one, which is influenced by social, psychological, cultural, economic and political factors of the people concerned. These factors must be taken into consideration in understanding, defining and measuring health. The cultural and sociological perception is useful for understanding the response to health seeking behavior and its consequences. Development of attitudes and perceptions regarding health or health seeking behavior is often a portrayal of the cultural perception.

The holistic concept is the synthesis of all concepts which implies that all the sectors must be considered for measuring health. It recognizes the strength of social,

cultural, economic, political and environmental influence on community. This concept corresponds to the view that health implies a sound mind in a sound body in a sound family and in a sound environment.

In recent years, philosophy of health acquired some new concepts. It includes health as a fundamental human right, which is the essence of productive life and not the result of ever-increasing expenditure on medical care. Since, health is central concept of quality in life; it involves individuals, state and international responsibility. Health and its maintenance are a major social investments and a worldwide social goal. It is note that this social investment is integrally linked to the health and well-being of women in particular.

The socio-economic well being of a society depends on the health of the members of that society. Only when people have an acceptable level of health, they can enjoy other benefits of life. Development of health sector is essential for socio-economic development of the country. Health is a crucial aspect in human life. Health problems can affect the regular activities, which ultimately would be harmful for the socio-economic life of the individual as well as family, and in broader sense, it would be harmful for the society as a whole.

"A woman's health is her total well-being, not determined solely by biological factors and reproduction, but also by effects of workload, nutrition, stress, war, and migration among others" (Vender, 1991). Women's health is important not only for themselves but also for future generations. Women's health affects the well being of the households and that of the society. The health of families and communities are tied to the

health of women. The illness or death of a woman has serious and far-reaching consequences for the health of her children, family and community. Though women play the most important role of the society but they are neglected in the society in all respect. They are suffering a lot of problems in their everyday life from their childhood to till death. Health problem is one of the serious problems among these problems that they are suffering in their day-to-day life. Health problems of the women can directly affect the household production function. It is observed from many studies that the women morbidity rate is comparatively higher than men morbidity rate. Due to the biological changes in their different phases of life, the morbidity rate of the women is different for different phases. The morbidity rate increases after their marriage and the rate of increase of morbidity goes up according to their increase in age. Indian women have high mortality rates particularly in their reproductive age. The morbidity also varies due to different religion.

A core problem around women's health is the multi dimensionality of women's lives. Kennedy (1997, 2002) has argued that most women have three roles to carry out in their lives: caregiver, earner and life giver. Women often neglect their own health because they prioritize their commitment to others. Poverty, negligence on themselves and dedication to the family members affect women's health. Though women live longer than men but almost everywhere they suffer more illness and disabilities throughout their lives. The World Health Organization notes "gender disparities in health care are often striking. Families may invest less in nutrition, health care, schooling and vocational training for girls than boys. Sex discrimination and low social status of girls and women frequently result in poor physical and mental health" (WHO, 2004).

Health and well-being is a concept related to the substantial differences between women and men in their access to sufficient nutrition, healthcare and reproductive facilities; and issues of fundamental safety and integrity of person. According to the World Health Organization, 585,000 women die every year, and over 1,600 every day, from causes related to pregnancy and child birth (Srivastava et al., 2008). A report prepared by the United Nations at the time of International Development Decade of Women points out that women constitute half of the world's population, do two thirds of the world's work hours but receive only a tenth of world's income and own less than a hundreds of the world's property (Rao 2000). The health of women is highly linked to their status in society. As in any other domain of development, gender based discrimination is inherent in health also. According to Ronzio (2004), women are usually vulnerable to malnutrition for both social and biological reasons, throughout their life cycle. In some parts of the world, girls are discriminated against in access to health care, to food and education and in other ways. As teenagers, they suffer from early pregnancy and are at a greater risk of retarded growth than boys. Reproductive aged women are subject to numerous stresses affecting their health and well-being. Elderly women in many societies are deprived too. There exists inter generational cycle of growth failure for women. Lower status of women is the result of lower education and social position. Tradition idealizes a woman's role as a mother, homemaker and a distributor of food who eats whatever is left after feeding the family, which results in malnutrition and ill health.

Women look after their entire family with giving less self attention. It has been reported that women receive less health care then males (Chatterjee 1990). In most of the Muslim societies, men play a paramount role in determining the health needs of a woman

(Shaikh and Hatcher 2004). Power or control in family decision-making is exercised more often by husband than by wives (Piet-Pelon et al, 1999). Since men are decision makers and in control of all the resources, they decide when and where woman should seek health care. The low status of women prevents them from recognizing and voicing their concerns about health needs. Many studies have reported that women are deprived of the basic health information and holistic health services (Mohapatra and Mohanty 2002; Malhotra; 2004 and Srivastava et al; 2008). In this context, the situation in Muslim society is no better (Piet-Pelon et al. 1999). Utilization of medical care in all societies has been found less among the women in comparison to the men. Health problems of Indian women are primarily related to their social status in society. The lower status of women in comparison to men does not enable them to utilize medical services as much as men (Sathyamala et al., 1992). Moreover, it is asserted that ill health among women is not taken seriously (Bhandari, 2004).

The health problem is more acute for Muslim women compare to Hindu women as Muslim women are belonging to different social structure in India. In terms of overlooked health disparities, Muslim women are fast growing, less educated and undeserved population. 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). Muslim women carry more of the work burden of the household and hence have little time to seek out health care services, thus putting themselves at a disadvantage relative to men in their access to and utilization of health care services. Rural Muslim women give birth at a very young age, usually quite

soon after their first menstrual period. Work opportunities for Muslim women are very limited. The majority are forced to restrict themselves to home-based labour. The average age of girls at marriage is 15 years. By 19 years, they have had at least two or three children. With the majority of girls not being allowed to complete schooling, the likelihood of their acquiring marketable and employable skills is remote. Muslim women face various constraints on their mobility, so that they need permission from their in-laws or husbands to visit the market or a place of worship. With large number of Muslim households below the poverty line, there are fewer chances of girls being allowed to continue with their education. An additional factor is that there are no sex-segregated schools to which these girls can be sent.

There are 64 million Muslim women in India which are the largest female Muslim population in world (Hassan 2011). However, they have made very few gains in field of economical and social development. Muslim women are conspicuous by their absence in politics, bureaucracy, university, public and private sectors. They are neither opinion maker nor decision maker. They are educationally disenfranchised, economically vulnerable and politically marginalized. It is really shameful that after 64 years of independence still Muslim women do not have access on health and education facilities, they are ruthlessly exploited for decades. Muslim girls are among the least educated section of Indian society. Muslim women are deprived of equality in their own society by mullah. The government is treating Muslims as a vote bank. That is why they form committees but never implement their recommendations.

To study the condition of Muslims in India, the govt. of India constituted several committees viz; Gopal Singh committee (1983), Sachar committee (2006), Rangnath

Misra committee (2009). They found Muslims condition is worst than Dalits. Share of Muslim in public employment is less than three per cent. Obviously, the Muslim women are further skewed towards the bottom. Privatization of health and education has worst impact on Muslim women. They are worst victim of communal fascism. Ruling class for last 64 years has no interest to improve the condition of Muslim women.

Married women in every society not only face the burden of domestic work, but also reproduction and work outside of home (productive labour). Chatterjee (1990) finds that females are worse off than males in terms of mortality up to the age of 35 years. This pattern is inversely related to women's social and economic value. Their prospect improves when they pass the reproductive stage, become established earners, and have social status as mother-in law. In case of health related problems, women are exposed in the same way as men. However, they get attention much later than man does, if at all they do. In many cases, they are likely to be treated at home rather than by a doctor or at a medical centre. Thus, women are more likely to face serious consequences including death.

Muslims represent the second largest religious group in India, and they form the largest single minority. Muslims are described and observed to be poor and marginalized groups. The conditions of Muslims are reflected in the following quotation that is worth noting. "Muslims are not only poor, there is also poor understanding of their human conditions, which has more long lasting effect, for a change can come from knowledge and understanding" (Shariff et al, 2004). Muslims also suffer double discrimination by virtue of being both Muslims and poor (Aravind 1992). Higher morbidity rates are reported from Muslim communities (Asokan et.al, 2007). As women live longer than

men, they suffer from more illness and disabilities throughout their lives. The bulk of Indian Muslims suffer severe deprivation in social opportunity because of lack of access to education, health care and other public services and to employment (Frontline, 2006). In most of the developing countries women have subordinate status, which affects their health as well as their rights. Women may not be permitted to make health related decisions or visit doctors without the permission of their husbands. Improvements of health status of women remain an unmet challenge, with great disparities between low and high-income countries.

1.2 Statement of the Problem and Relevance of the Study

Women represent half of the world's population and contribute greatly to the functioning of society. Their poor nutritional status presents adverse health and socio-economic consequences in society. The potential consequences include poor reproductive health outcomes such as maternal death during and or after childbirth (Gemeda et. al. 2013). Women's nutritional status does not only affect them but the family at large especially the young children. For example, the nutritional status of babies and infants is closely linked to the health status of their mother before, during and after pregnancy (Smith and Haddad 2000). However, little attention has been put to address the causes of women malnutrition as other development challenges have been viewed as more important thus given priority (Loaiza, 1997). Women's health thus needs to be improved so that they are able to lead a productive and healthy life. Low level of understanding about the determinants of malnutrition is one of the challenges faced in addressing the problem of women malnutrition.

Health concerns are regulated by religion (Ahmed 2005; Scheinberg 2006; Hasan 2008). Muslims are generally described as economically and educationally backward community. Many researchers have reported in their research work that the morbidity rate is higher among Muslim community. Higher morbidity has social, economic and health implications because it reduces labor productivity on the one hand and increases medical and non-medical cost attached to it on the other hand. The health problem is more acute for Muslim women compare to Hindu women as Muslim women are belonging to different social structure in India. In terms of overlooked health disparities, Muslim women are fast growing, less educated and undeserved population. Though higher morbidity rates are reported among Muslim households, but no exhaustive study has been done to analyze the health status of Muslim women. A study on the health status of Muslim women and the morbidity structure enables to find major health issues faced by the community and the findings may be useful to planners and policy makers while formulating future health care policies and strategies.

Women generally ignore their health problems until their problems touch at serious levels and become too sick. The rural women are regularly facing different health related problems viz; anemia, gastrological problem, calcium deficiency, high fertility, thyroid problem, breast cancer, low blood pressure, heart disease, hair falling, menstrual and white discharge problem etc. which need to be monitored. But, these problems are quite often ignored both by family member and the women herself. These problems arise mainly due to lack of lack of nutritional consumption, poverty, lack of awareness, improper family planning and so on.

Getting good health care facilities for maintaining their good health is a fundamental human right. It is the responsibility of the government to provide health care to all people in equal proportions. The health status of a country depends largely on the availability of health-related infrastructure. At the same time to maintain a sound health, access to safe drinking water, toilet and housing is also essential. The Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005. The aim of NRHM is to bring about significant improvement in the health system and the health status of the people. The primary focus of the mission is to improve access to health care for the rural people. It seeks to provide equitable, affordable and universal access to rural people, especially women and children. 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 non-availability of skilled man-power and infrastructure, the purpose of setting up of health care centers is not successfully achieved in the rural area.

The present study is an attempt to understand the health status and nutritional status and its determinants of Muslim married women in the study area and also to find out the traditional preventive cares, which they used for health problems. The study also attempts to find out the availability of rural health infrastructure and their demand for getting health care services in rural area.

1.3 Area of the Study

The study focuses on the Muslim married women belonging to the rural area of the Cachar district. Cachar district is located in the southern part of the state Assam. The total geographical area of the district is 3,786 Sq. Km. Administratively the district is

divided into two sub-divisions viz; Silchar (Sadar) and Lakhipur. There are five revenue circles and fifteen community development blocks (CD) in the district. There are seven Assembly constituencies in this district, viz; Silchar, Sonai, Dholai, Udharbond, Lakhipur, Barkhola, and Katigorah. According to the 2011 census, Cachar district has a population of 1,736,319. The district has a population density of 459 inhabitants per square kilometer which is higher than the state average 397. Out of the total population, 18.17 per cent population lives in urban regions and 81.83 per cent lives in rural areas of the district.

1.4 Objectives of the Study

The main objectives of the study are following:

- To examine the general and disease-wise health status of the rural Muslim married women in Cachar district.
- To identify the socio-economic factors influencing the health status of the rural Muslim married women of different age groups in Cachar district.
- To examine the accessibility of health care facilities and schemes for the rural Muslim women in Cachar district.
- To investigate the traditional preventive measures taken by the rural Muslim married women to escape from health problems what they are facing.
- To examine the demand for health care facilities and to identify the determinants of this demand.

1.5 Hypotheses of the Study

On the basis of the above mentioned objectives the following hypothesis can be framed.

- The health status of rural Muslim married women in Cachar district is very poor.
- The health status of Muslim married women in Cachar district is poor due to lot of socio-economic problems.
- There is lack of rural health care facilities available in Cachar district.
- Muslim married women depend largely on the traditional measures to get relief from the health problems.
- There is high demand for health care facility among the Muslim married women.

1.6 Data Sources

The study is based both on primary and secondary data. Primary data are collected from the field by preparing scheduled questionnaires. A three-stage stratified random sampling technique is used for collecting the data. The methodology for the collection of primary data (sampling design) is discussed in detail in Chapter 3.

Secondary data are collected from Census Reports of India, Year Book issued by the Department of Family Welfare of the Ministry of Health and Family Welfare, Govt. of India, Hand Book of Health Statistics of Assam, District Statistical Hand Book and Statistical Abstracts of India and Assam, Medical Bulletins National Family Health Survey (NFHS), National Rural Health Mission etc. Some information has to be collected from the medical personals.

1.7 Outline of the following Chapters

This introductory chapter is followed by following chapters.

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

Chapter 3 consists of theoretical and conceptual frameworks and methodology of the study.

Chapter 4 examines the health status of rural Muslim married women both with the help of morbidity and BMI (Body Mass Index) analysis. This chapter also consists with the socio-economic determinants of health status of the women.

Chapter 5 deals with health infrastructure and health care facilities in Cachar district.

Chapter 6 deals with the traditional preventive measures that the rural Muslim married women are taking for different health problems and their demand for health care facilities and its determinants.

Chapter 7 depicts the summary, conclusion and policy suggestions and limitation of the study and further scope for research.