Chapter 7

SUMMARY OF FINDINGS AND CONCLUSION

Health of a nation depends on the state of health of women. Health of families and communities are tied to the health of women. It is commonly said that “a woman who prepares the food is the last to eat”. This key sentence encompasses both the physical and social reasons for her poor health.

Kerala is a multi-caste, multi-religious state where Muslims constitute the largest religious minority. As per census 2001, Muslims constitute 24.7 percent of the population. Muslims are generally described as an economically and educationally backward community. They suffer grave deprivation in social opportunity because of lack of education, health care and other public services and employment. Researchers have reported higher morbidity rates among Muslim community. Though higher morbidity rates are reported from Muslim community, no exhaustive study has been undertaken to analyse the health status of Muslim women. Ours is an attempt to study the morbidity structure of Muslim households and health status of Muslim women in Kerala.

7.1 Objectives of the Study

The following are the main objectives of the study.

1. To examine the socio-economic characteristics of Muslim households.

2. To examine the morbidity structure of Muslim households.

3. To examine the medical expenditure and method of treatment of Muslim households.

4. To analyze the health status of Muslim women.
7.2 Hypotheses

1. Education of the head of the household and health status of women are positively related.

2. Income of the household and health status of women are positively related.

3. There exists significant variation regarding preference for treatment between people of rural and urban households.

The study comprises seven chapters. Chapter one presents statement of the problem, objectives, data source, methodology and analytical tools, importance of the study, review of literature and limitations of the study. Chapter two deals with an overview of health status of women at national, state and district level. Third chapter examines the socio-economic characteristics of the Muslim households that satisfy the first objective of our study. Morbidity structure of Muslim households is presented and analyzed in fourth chapter. Medical expenditure and method of treatment are presented in chapter five. Chapter six deals with the analysis of health status of Muslim women. Chapter seven summarizes the findings and conclusions.

7.3 Findings of the Study

While reviewing literature, it is found that higher morbidity rates are reported from Muslim communities. Though higher morbidity rates are reported, no exhaustive study has been done to analyze the health status of Muslim women in Kerala.

An overview of the health status of women is given in the second chapter which reveals that the health status of women in Kerala is better than that of India if assessed on the basis of indicators of health such as sex ratio, literacy, life expectancy, Death Rate, Birth Rate, Infant Mortality Rate, Maternal Mortality Rate, Reproductive
Care, Nutritional Status etc. But the morbidity rate of Kerala is greater than that of India indicating inferior position of women. The health status of Muslim women in Kerala is also better than that of Indian Muslim women. In the sample district Birth Rate, Fertility Rate, Decadal Growth Rate and Infant Mortality Rate is greater than that of the state level showing a backward position. But Death Rate, Maternal Mortality Rate and Life Expectancy are greater than that of the state level.

Examination of the socio-economic status of households on the basis of constructed socio-economic index reveals that 24.7 percent belongs to low level, 31.6 percent come under medium level and 43.7 percent is with high status. The average household size is the lowest among high socio-economic groups (5.1) and the highest in low socio-economic group (6.3). It was found that nature of houses, electrification status and sanitary facilities of households improved with improvement in socio-economic status.

Average income of the household is estimated at Rs.10928. Per capita income is Rs.1906. Pattern of consumption of food articles reveals that Muslim community consumes mainly non vegetarian diet. A comparison with NFHS3 findings show that at the national level, only 6.3 percent of population consumes fish daily, whereas it is 96.6 percent among sample households. Again at the national level, 21.8 percent consumes meat once in a week whereas among sample population it is 27.8 percent. Among sample population 21.9 percent consume egg daily but at the national level it is only 3.5 percent.

The sex ratio of the sample area is 1000:1050. Age and sex wise distribution shows that the proportion of females (11.3) is less than that of males (12.1) in less than five-year group. Under 16-50 and 51-65 age groups, males have slight
dominance. In greater than 65 category, percentage of females (6.4) is greater than that of males (4.5). Examination of autonomy in decision-making power of the sample population reveals that 10.6 percent of women have involvement in obtaining health care and only 9 percent of women have participation in financial matters.

Out of the total women married among the sample population, 76.8 percent were married before reaching 18 years. At the national level, only 17 percent women were married before reaching 18 years. Our sample survey revealed that work participation rate among women is 4.4 per cent whereas it is 6.6 in the district.

The morbidity rate of Muslim households is 548. Among rural households it is 569 and 490 among urban households. Morbidity rate of males is 400 whereas it is 688 among females. Morbidity rate of acute diseases is 130. Among rural households it is 144 whereas, it is 90 among urban households. Acute morbidity rate of males is 85 and that of females is 172. Morbidity rate of chronic diseases is 418. Among urban households it is 400 and 425 among rural households. Chronic morbidity rate among males is 315 and 516 among females. Morbidity rate among rural households was found to be greater than that of urban households. Acute and chronic morbidity rate of females is greater than that of males among rural and urban households.

Morbidity rate among low, medium and high socio-economic groups was 537, 571 and 538 respectively. The acute morbidity rate among low, medium and high socio-economic groups was 193, 152 and 75 respectively. The acute morbidity rate was found to be decreasing with improvement in socio-economic status. The chronic morbidity rate among low, medium and high socio-economic groups was 344, 420 and 463 respectively. Here, the morbidity rate decreases with improvement in socio-economic status. Morbidity rate calculated according to family structure shows that it
is 470 among joint families and 572 among nuclear families. Both acute and chronic morbidity rate was found to be low among joint families. It is 119 and 351 among joint families whereas is 133 and 438 among nuclear families. Morbidity rate of emigrant households is 579 and 534 for others.

Acute and chronic morbidity rate of emigrant households were 149 and 431 whereas it is 122 and 412 among others. The number of multiple diseased persons was found to be high among 50-65 age groups. The percentage of chronic and acute diseases was found to be high among families with small number of members among rural and urban households. Chi square test showed that the association between acute diseases and income are not significant whereas the association between income and chronic diseases is highly significant. Again, association between socio-economic status and morbidity and environmental status and morbidity were found to be significant. Association between nature of family and morbidity is also significant.

The main chronic diseases that we came across in the study were arthritis, hyper- tension and diabetes. Percentage of people affected with arthritis, hyper-tension and diabetes is 11.6, 10.2 and 9.1 respectively.

Average monthly medical expenditure of the household is Rs.762. It is Rs.916 for emigrant households. Average health care expenditure of low, medium and high socio-economic status groups was Rs. 582, Rs. 792 and Rs. 873 respectively. Per capita monthly expenditure of different socio-economic groups is Rs.94, Rs.137 and Rs. 155 respectively. For emigrant households per capita monthly expenditure is Rs. 156 and Rs.123 for others. The average medical expenditure per episode of acute illness under Allopathic system, Ayurveda and Homeopathy is Rs.173, Rs. 145 and Rs.53 respectively. For chronic diseases the average medical expenditure per episode
of illness under Allopathic system is Rs.346, Rs.301 under Ayurveda and Rs.106 under Homeopathy.

For the treatment of chronic diseases, 88 percent depends on Allopathic system, 3 percent on Ayurveda and 9 percent on Homeopathy. Out of 88 percent depending on Allopathic system for the treatment of chronic diseases, 25.7 percent approaches Government hospitals and 62.3 percent on private sector. Out of 9 percent depending on Homeopathy, the share of private and government sector is 3.2 percent and 5.9 percent respectively. For Ayurveda treatment, 1.7 percent depends on government sector and 1.2 percent on private sector. Altogether 30.7 percent depends on government for the treatment of chronic diseases and 69.3 percent depends on private sector.

For the treatment of acute diseases 68.5 percent depends on Allopathic system, 4.6 percent on Ayurveda and 26.8 percent on Homeopathy. Altogether, 39 percent depends on government sector and 61 percent on private sector for the treatment of acute diseases.

System of treatment is not uniform among different per capita income groups. But the system of treatment is uniform among people of different environmental, socio-economic and educational levels.

Z test shows that there is significant difference in the preference for treatment among rural and urban households for chronic diseases like diabetes, hyper-tension, arthritis and piles. There is significant difference in preference for treatment among males and females for chronic diseases like diabetes, asthma, arthritis, osteoporosis,
varicose vein problem, psychic disorder and thyroid disorders. Among acute diseases also there is significant variation for preferences among rural and urban households.

The distribution of households and women on the basis of constructed indices to analyze the health status are as follows. In the case health index, the percentage of low, medium and higher status groups is 3.4, 18.4 and 78.1 respectively. The percentage of low, medium and high groups according to socio-economic index is 24.7, 31.6 and 43.7 respectively. In environmental index, 28.4 percent comes under low level, 29.4 percent belongs to medium level and 42.2 percent comes under high level. The percentage of women with low, medium and high reproductive index values is 20.3, 25.6 and 54.1 respectively.

On the basis of calculated health score of women it is found that 11.5 percent women are with low score, 36.9 per cent with medium score and 51.6 per cent with high score. On the basis of education of the head of the households, 29 percent come under low status, 59.4 with medium status and 11.6 per cent with high status. On the basis of income 41.3 percent come under low level, 18.1 percent under medium level and 40.6 percent come under high income. On the basis of size of family, 27.2 percent belongs to small family, 43.4 percent was with medium sized family and 29.4 percent with large families.

Chi square test establishes significant association between socio-economic index and health index. The association between environmental index and health index is not significant. The association between reproductive index and health index is also significant. Chi square test also confirms strong association between health score and income, health score and education and health score and size of family.
A study of mean and standard deviation of various health indices according to education shows that environmental index, reproductive index and health index improves with improvement in education. Variation in the index value between different educational groups verified by using ANOVA shows significant variation.

Mean and standard deviation of various health indices according to per capita income also shows that health index, reproductive index and environmental index improves with improvement in income. ANOVA procedure shows that the variation in index values between different income groups are highly significant.

Mean and standard deviation of different indices according to size of the family shows that reproductive index and health index improves with increase in size of the family. Environmental index decreases with increase in family size. Variation in index values examined by using ANOVA shows that in health index and reproductive index, the variation is significant whereas the variation is not significant in environmental index.

Comparison of the reproductive details of younger and older women on the basis of number of children, percentage of home deliveries, abortions occurred, number of still births etc. shows that they are more among older women. The average (median) number of children among older women is 4 and 2 among younger women. Chi square test shows that association between education of mothers and number of children and education and immunization given to children are dependent.

The study of mean and standard deviation of various health indices according to education establishes positive relation between them. ANOVA shows significant variation between groups.
Positive relation between income and health status is also proved to be valid by the study of mean and standard deviation of health index according to per capita income and ANOVA procedure.

7.4 Conclusion

Health status of women in Kerala is remarkably good in all strata of society, when compared with their counterparts in other states. General health indicators such as life expectancy, Infant Mortality Rate, Maternal Mortality Rate etc. are favorable to Kerala, but the morbidity rate show a negative picture. Kerala has the highest morbidity rate of all states in India.

Available health indicators reveal that the status of Muslim women in Kerala is comparatively good compared to other states. Sachar Committee report revealed the fact that Kerala Muslims are far ahead in literacy rates, children’s health status and life expectancy. The fertility rates among Muslims are reported to be higher than that of other communities. Micro level studies revealed higher morbidity rates among Muslims.

Health status of Muslim women is influenced by socio-economic status of the household. The income and education of the head of the household exerts positive influence on the health status of women. Health status of women is also influenced by the size of the family.

Examination of the socio-economic characteristics of the sample population reveals that patriarchal ideology that prioritizes marriage and domesticity of women, limited autonomy in decisions making, low work participation, early child bearing etc. are the constraints that Muslim women experiences in Kerala.
The morbidity rates of Muslim households are very high compared to the earlier estimates of morbidity in Kerala. The female morbidity rate of Muslim households is higher than that of males. The higher morbidity rate reported seems to be an overstatement because morbidity depends upon perception factor, which is culturally conditioned. Some individuals report even minor ailments as illness. Higher rates of morbidity reported from nuclear families, families with less members and families of high socio-economic status indicates the influence of perception factor in deciding morbidity. The three major chronic diseases among Muslim households are arthritis, hypertension and diabetes, all are related to the sedentary lifestyle of individuals.

Considerable difference is noticed in the average monthly medical expenditure and per capita monthly medical expenditure among households of different socio-economic status groups and of general and emigrant households. Allopathy is the dominant system of treatment and private sector is the major health care provider. System of treatment depended on is more or less uniform among different socio-economic groups. Significant difference is observed in the preference for treatment among rural and urban households for the treatment of all acute diseases. Among chronic diseases significant difference in the preference for treatment is noticed between rural and urban households for the treatment of diabetes, hypertension, arthritis, osteoporosis, gynaec problems and piles.

Higher morbidity rates reported from Muslim households and high prevalence of diabetes, hypertension and arthritis throws light on the need for effective health awareness among them. Over dependence on private sector for the treatment is another problem seen among Muslim households.
7.5 Suggestion

1. Effective health awareness programs to change the perception of illness of Muslim households.

2. Improving the public sector health facilities to reduce the burden of medical expenditure of households.

3. Measures to improve the work participation rate of Muslim women are needed.

4. Measures to promote the involvement of Muslim women in social and political activities are desirable.