Chapter 1
INTRODUCTION

1.1 Introduction

The 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, can they enjoy other benefits of life. Health development is essential for social and economic development.

“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” (Kwaak, 1991). Women constitute half of the world’s population. Women’s health is important not only for themselves but also for future generations. Women’s health affects the well being of the household 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.

A report prepared by the U.N 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. It is observed that even in a relatively egalitarian state of Kerala, there exists caste and socio-economic inequalities in women’s health (Haddad, 2006).
As revealed by Ronzio (2004), women are usually vulnerable to malnutrition for both social and biological reasons, throughout their life cycle. As children, 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. Thus there exists an 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, housewife and a distributor of food and she eats whatever is left after feeding the family, which results in malnutrition and ill health.

The health status of Muslim women in Kerala has to be examined on the basis of health scenario of the state. In Kerala, the health scenario is characterized by a paradoxical co-existence of high morbidity rate and low mortality rate. The paradox is that, on the one side, Kerala stands as the state with all indicators of better health care development in terms of Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Perinatal Mortality Rate (PNMR), Birth Rate (BR) and Death Rate (DR), but on the other side Kerala outstrips all other Indian states in morbidity especially in chronic illness.

Though Kerala has made remarkable progress in basic indicators of health, morbidity remains high. Morbidity is an indicator of illness, which denotes any deviation from the state of normal, physical and mental well being. Higher morbidity has significant social, economic and health implications as it directly reduces labour productivity on the one hand and increases medical and non-medical costs attached to it on the other.
A core problem around women’s health is the multi dimensionality of women’s lives. As Patricia Kennedy (1997, 2002) has argued, most women have three roles to carry out in their lives: care giver, earner and life giver. Their responsibilities for caring tend to make them the focal point of a family unit and often the community as well, carrying out childcare, elder care and community based voluntary activities.

Women often neglect their own health because they prioritize their commitment to others. Poverty and lack of access to financial and other resources affect women’s health. Although women live longer than men 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).

Kerala is a multi caste multi religious state and Muslims constitute the second largest religious group in India and they form the largest single minority. As per the Census of 2001, Muslims constitute 24.7 percent of the population (The Hindu, 2004). Malappuram is the only Muslim majority district in Kerala. 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, 2004).
Another quotation highlights the point that Muslims 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. Researchers have found that women’s biology (their genetic make up, physiology or hormones) seems to have more influence on the onset and progression of disease.

The bulk of Indian Muslims suffer grave deprivation in social opportunity because of lack of access to education, health care and other public services and to employment (Frontline, 2006). The literacy rate among Muslims is 59 percent, which is below the national average of 65 percent. Muslim women’s work participation rate is just 9.6 percent. Relationships between socio-economic status and health have been widely studied by many social scientists. Navaneetham et al. (2006) established negative relationship between socio-economic status and prevalence of ailments and also between education and morbidity.

Mel Bartley (2000) who worked on dimensions of inequality in women’s lives comments that “levels of social advantage are expressed in patterns of social interaction… do seem to have a strong effect on life style and the health habits which are known to increase the risk of major diseases such as heart disease and cancer in women.”

In most 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.

In Kerala, though conventional indicators give a better health status of women, there are many grave health problems like somatisation disorder, depression, suicide and gender-based violence. Health status of women in respect of non-conventional indicators presents a dismal picture (Jaya Sree).

1.2 Statement of the Problem

Kerala is a multi caste multi religious state where Muslims constitute the second largest religious minority. Muslims are generally described as economically and educationally backward community. Researchers have reported higher morbidity rates among Muslim community. Higher morbidity has social, economic and health implications because it reduces labour productivity on the one hand and increases medical and non- medical cost attached to it on the other. Though higher morbidity rates are reported among Muslim households, no exhaustive study has been done to analyse the health status of Muslim women. The present study is an attempt to examine the morbidity structure of Muslim households and the health status of Muslim women in Kerala.

1.3 Objectives

The specific objectives of the present study are

(a) To examine the socio-economic characteristics of Muslim households.

(b) To examine the morbidity structure of Muslim households.

(c) To examine the pattern of medical expenditure and method of treatment of Muslim households.
(d) To analyze the health status of Muslim women.

1.4 Hypotheses

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

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

iii) There exists significant variation in the preference for treatment between rural and urban households.

1.5 Data source

1.5.1 Secondary data

Secondary data were collected from Economic Review, Census Reports, Statistics for Planning 2009, Panchayath level Statistics, National Family Health Survey reports, Sachar Committee report, reports of morbidity studies carried out by researchers and agencies, books, journals and periodicals.

1.5.2 Primary data

Primary data were collected from 320 households. Malappuram, the single Muslim majority district of the state was chosen for the study. The district consists of 6 taluks, 7 municipalities, 14 blocks and 102 Panchayaths. For the present study, one panchayath each from 6 taluks to represent rural households and 2 municipalities to represent urban households were selected.

From each Panchayath and municipality 10 wards were chosen by random method. Four Muslim households each from 10 wards were selected by purposive random sampling method and information collected through structured questionnaire. From each Panchayath and Municipality 40 households were surveyed. The interview
was conducted with the spouse of male head or female head of the households (in case of emigrant households). Our sample consists of 320 households.

1.6 Methodology

For analytical purpose we constructed Socio-economic Index, Environmental Index, Reproductive Index and Health Index according to the general formula used by the United Nation’s Development Program (UNDP) for the construction of Human Development Index. Socio-economic Index is calculated by taking variables like per capita income, level of education of the head of the household, exposure to mass media and type of house.

Environmental Index was calculated by considering variables such as source of drinking water, cooking device used and sanitary facility of the household.

For calculating Reproductive Index, variables like number of children per respondent, adoption of family planning methods, maternal immunization status and place of delivery were used.

Health Index was calculated by considering variables like episodes of illness, physical disability, need for hospitalization and exposure to health awareness. Variables taken for calculating the various indices and scores assigned to different variables are given below.

1.6.1 Socio-Economic Index

a) Income of the household:

Per capita monthly income less than Rs: 1000= 0, 1000-2000=1, Greater than 2000 = 2
b) Level of education of the head of the household:

   Illiterate = 0, Upto IV Standard = 1, V-X Standard = 2, Higher than SSLC = 3

c) Exposure to mass media:

   Regular exposure to mass media = 1, Not regularly exposed to mass media = 0

d) Type of house:

   Thatched = 0, Tiled = 1, Concrete = 2

1.6.2 Environmental Index

a) Source of water:

   Public tap or well = 0, Own well = 1, Well with pipe connection = 2

b) Cooking device:

   Wood burning = 0, Gas and wood burning = 1, Gas alone = 2

c) Sanitary facility:

   Latrine with septic tank = 1, Latrine without septic tank = 0

1.6.3 Reproductive Health Index:

a) Number of children:

   More than 4children = 0, 3-4children = 1, 1-2children = 2

b) Adoption of family planning method:

   Yes = 1, No = 0

c) Maternal immunization status:

   Periodically done = 1, Not done = 0
d) Place of delivery

   Home = 0, Hospital = 1

1.6.4 Health Index

a) Episodes of illness:

   Chronic disease = 0, Acute disease = 1, Absence of disease = 2

b) Physical disability:

   Physically fit = 1, Physically unfit = 0

c) Need for hospitalization:

   Yes = 0, No = 1

d) Exposure to health awareness:

   Yes = 1, No = 0

For any variable of the Socio-economic Index, Environmental Index, Reproductive Index and Health Index, individual index can be computed according to the general formula.

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\text{Component Index} = \frac{\text{Actual Value} - \text{Minimum value}}{\text{Maximum Value} - \text{Minimum Value}}
\]

The value of Socio-economic Index is the simple average of four component indices. Similarly the value of Environmental Index, Reproductive Index and Health Index are calculated by taking the simple average of the respective component indices. All the values range from zero to one, zero shows the worst position and one shows the perfect situation. Each index is divided into three levels, low medium and high.
As health is a qualitative aspect, we have enumerated the health score of 320 women on the basis of their responses to ten questions. Positive 10 marks were assigned for each positive answer and zero marks for negative answer. The health scores were within the range of 0-100. On the basis of health score, women were classified under three groups. Health scores upto 30, 40-60 and 70-100 were included under low, medium and high categories respectively. Households were also classified under 3 groups on the basis of monthly income. By considering education of the head of the household also, these households were classified under 3 groups. Again, on the basis of members of the household, they were classified under 3 categories.

The broad socio-economic characteristics, demographic indicators, number of schools, number of Arts and Science colleges, number of medical institutions and beds in hospitals of the district were collected using secondary data.

On the basis of primary data, socio-economic characteristics of the sample households and population were examined in the following manner.

General socio-economic characteristics of the household such as family structure, average size of households, nature of houses, electrification status, sanitary facility and provision for disposal of waste water were examined on the basis of constructed Socio-economic Index. Area of houses, land ownership, source of drinking water, income of the household, cooking fuel used and ownership of consumer durables were examined. Pattern of consumption of various food items of the households were examined and the findings were compared with the NFHS 3 findings. Demographic characteristics such as sex ratio, age structure according to sex, literacy level, marital status, age at marriage of women, birth interval, fertility rate and contraceptive use were examined. Autonomy in decision-making power,
exposure to mass media, work participation and involvement in political and social organizations of women were also examined.

To examine the morbidity structure, diseases were classified under two groups, acute and chronic ailments. Different types of infectious diseases, respiratory diseases, gastrointestinal diseases and others were included in acute diseases. The major chronic ailments considered are diabetes, hyper-tension, cardiac problems, asthma, cancer, varicose vein problem, gynecological problems, arthritis, osteoporosis, psychic disorders, kidney disorders, thyroid disorders etc. Morbidity rate is defined as the number of ailments reported during the reference period per 1000 persons. Reference period for acute diseases was taken as 15 days prior to the survey. For chronic diseases reference period of 12 months prior to the survey was used. Morbidity rates among rural households and urban households were estimated. Morbidity rates for acute and chronic diseases, morbidity rates across socio-economic groups, per capita income groups, according to gender and age groups, family structure, education groups, emigrant and non-emigrant households etc. were estimated. Percentage of people with multiple diseases in different age groups was estimated. Percentage of chronic, acute and all diseases according to area, number of members of the family and sex were calculated. Percentage of acute and chronic diseases of emigrant and non- emigrant households were estimated. Association between morbidity and income of those suffering from acute and chronic diseases were examined using Chi-square test. Association between education and morbidity, occupation and morbidity, socio-economic status and morbidity, environmental status and morbidity, nature of family and morbidity, emigration and morbidity, age and morbidity were also examined using Chi square test.
Using z test, it was examined whether the proportion of morbidity rates of rural and urban households, acute and chronic diseases of males and females, different per capita income groups and socio-economic groups were equal or not.

Average monthly medical expenditure and per capita monthly expenditure of different socio-economic groups, emigrant and non-emigrant households were estimated. Medical expenditure per person per episode of illness for acute and chronic diseases under different systems of medicine was calculated.

The methods of treatment for acute and chronic diseases of the households were estimated. Using Chi square test, it was verified whether the systems of treatment for different socio-economic, environmental, occupational and educational groups were uniform or not. Variation in the preference for treatment among rural and urban households for acute and chronic diseases and among males and females were verified using z test.

To analyze the health status of women, association between Socio-economic Index and Health Index, Environmental Index and Health Index, Reproductive Index and Health Index were examined using Chi-square test. On the basis of calculated health score of women, we examined the association between health score and income, health score and education and heath score and size of family by using Chi- square test. A study of mean and standard deviation of different indices of different educational groups, income groups and of different family sizes were made. Variations in different health index values among different educational, income and family groups were examined using ANOVA. To compare the reproductive details of younger women and older women of the households, we classified women under two groups, women with less than 40 years and greater than 40 years of age. Average
number of children, types of delivery, number of abortions occurred, number of stillbirths etc. of the two groups of women were calculated. Using Chi square test we examined the association between educational status of mothers and their number of children and association between education and immunization of children.

1.7 Importance of the Study

Though numerous studies are available on the status of women, no exhaustive study has been done to analyse the health status of Muslim women in Kerala. As Muslims form a quarter of the total population and belong to backward community and the morbidity rates reported from them are relatively higher, a study of this kind seems to be highly important. 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.

1.8 Plan of Study

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 the national, state and district level. Third chapter examines the socio-economic characteristics of the sample households. Morbidity structure of Muslim households are presented and analysed 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.
1.9 Review of Literature

Health is defined by W.H.O as “a complete state of physical, mental and social well being and not merely an absence of disease or infirmity.” In this sense health is multi dimensional and each dimension is influenced by numerous factors.

Health scenario of the state is characterized by a paradoxical co-existence of high morbidity and low mortality rates. An examination of the health status studies in Kerala is done initially, before going into health status studies of women.

1.9.1 Health Status Studies

Panicker and Soman (1984) attempted to relate socio-economic factors and public policy measures to health. They pointed out that morbidity in Kerala remains high and mortality decline has been significant.

Dumont (1986) examined the influence of magic and other beliefs in the health status among South Indian sub castes.

Kumar et.al (1988) reported high morbidity rates in Kerala on the basis of comprehensive analysis.


Kannan etal (1991) conducted a study in rural Kerala regarding the linkage between socio-economic status and health status based on the data surveyed in 1987. They argued that the high morbidity in Kerala is a manifestation of its continued backwardness and poverty of the masses.
Kutty et.al (1993) analyzed birth and death rates as calculated from sample of 9440 households with respect to variables such as region, religion and socio-economic status taking into account income, education, housing condition and land ownership.

Krishnan (1994) brought out the possible reasons for high morbidity in Kerala and offered certain explanations to the health paradox of Kerala. He attributes morbidity in Kerala to three factors:

i. Inadequacies of human environment

ii. Inherent factors of natural environment

iii. Ageing and life style changes of the population.

Murray (1994) attributes higher morbidity to changing perception of illness and health, the ageing of population due to demographic transition, falling fertility rates etc.

Sharadamoni (1994) reported that ageing has become an issue-exploring question in Kerala and our state is classified as an ageing state.

Ramamani Sunder (1995) examined the state of morbidity in Kerala covering both urban and rural areas and found that total morbidity rate of Kerala is 194.8 per 1000 and 183 per 1000 for the urban areas. Corresponding figures in India is 106.7 and 103 respectively.

Kabir et.al (1998) mentioned that in spite of all the favorable health indicators used to illustrate achievement of Kerala, a substantial part of the population still suffers from morbidity rooted in air and water borne infection.
Borell et.al (1999) described social class inequalities in health status and use of services, both curative and preventive in Barcelona, in a country with a National Health Service. Their findings are sufficient to defend the understanding of equitable health policies especially in providing access to preventive care for the entire population.

Kunjhikannan et.al (2000) confirmed that Kerala had made remarkable advances in basic indicators of health status and reported sharp increase in medical expenditure.

Dileep (2002) using 52nd NSSO Round Data examined the prevalence of ailments and hospitalization in Kerala. He found that age and seasonality had considerable effects on the morbidity of individuals and the burden of ill health was higher in rural areas than in urban areas. He opined that people who were more likely to have a better life style had higher level of morbidity and hospitalization and factors like physical accessibility of health care services and capacity to seek health care could create artificial differences in morbidity and hospitalization among different sub groups of the population of Kerala.

Saseendran et.al (2003) pointed out that though health status of Kerala has improved, morbidity remains very high and tertiary diseases are on the rise in Kerala.

Krishna Swami (2004) observed that morbidity pattern of the state has been undergoing major changes due to ageing of the population, migration of young adults to Gulf and other countries.

Nayar et.al (2005) made a comparison of Kerala and Bihar on the basis of health indicators and showed that Kerala has attained much improvement in health
sector and was due to skillful support to the social sectors such as education, health and other social arrangements.

According to Gangadharan (2007) Kerala is under the octopus hold of both communicable and chronic diseases.

1.9.2 Studies relating to Health Status of Women

Bhattachargee (1981) argues that in developed countries females have chances of surviving right from childhood to old age. But in India, females are suffering from bad mortality conditions compared to males and the major reason is poor nutrition, housing and sanitary condition and inadequate medical facilities. Banerji (1982) examined the role of caste and religion in the specific behavior of individual groups and related this to their health culture.

Dyson et.al (1983) pointed out that the North Indian kinship system undermines the cultural worth of females much more than the kinship system of the South and its impact on health.

Cullen et.al (1984) reported that women experience greater levels of long-term poverty, which leads to more illness.

Hilary (1984) reported that more number of women have neurotic and depressive disorders. Admission rates to psychiatric hospitals are 33.3 percent higher for women than men. Wallace (1987) reviewed the health and major health needs of developing countries. They include high fertility, high maternal mortality, inadequate maternity care, unsafe abortion and poor nutrition.

Daly (1989) also mentioned the influence of poverty on the illness of women.
Aras et.al (1990) examined the problem of adolescent mothers and reported that they are more likely to give birth to low weight and pre term babies.

Ascadi et.al (1990) reported malnourishment and limited access to health care among females from birth onwards.

Chatterjee (1990) reported low levels of education and formal labour participation among Indian women and pointed out that they have little autonomy and all these factors exert negative impact on the health standards of Indian women.

Gulati et.al (1990) examined women’s status in developing countries and stressed the need for development programs for raising the status of women by increasing ‘investment in women’ such as family planning, improvement in health services, education and training facilities.

Kapil (1990) mentioned the early onset of child bearing as the reason for reproductive health problems among women.

Luthra et.al (1991) pointed out that the cultural norms and taboos associated with sexuality and reproduction are barriers for women to seek health care for reproductive morbidities.

India’s Maternal Mortality ratio is estimated as 400 to 500 per 100000 live births. It is about fifty times higher than that of many industrialized nations and six times as that of Srilanka (UNICEF, 1991).

Freeman et.al (1993) pointed out that “a shamefully large number of girls and women die each year because of unique risk inherent in being female in a world where females are second class citizens.”
Disease burden per 1000 population in India is much more on women than men. In all other countries including Sub Saharan Africa, males have a higher burden of disease than females (World Development Report, 1993).

Gupta (1994) revealed that in large parts of India, marriage plunges a woman into a highly vulnerable part of her life cycle, especially where exogamy is practiced, they find themselves as members of the household in which they are strangers, and their sources of social support are thin. This makes them ill equipped to protect their health at a stage in their lives when they are most burdened by the reproductive health risk of pregnancy, contraception, abortion and childbirth.

Bhatia et.al (1995) reported that education, economic status and religion are significant determinants of maternal service utilization.

Doyal (1995) also pointed out that poverty and lack of access to financial and other resources adversely affect women’s health. Indu et.al (1995) observed that 80-85 percent of women suffer from reproductive tract infection and infertility rate in India is 3 percent. About 42 percent of women reported reproductive health problems, which is higher than the national average of 39 percent.

Vissadjee et.al (1997) examined the influence of education, income and family structure on women’s health and pointed out that they are significant determinants.

Victoria et.al (1998) observed that mother’s education is highly correlated with high level of malnutrition among children.

Moulasha et.al (1999) reported higher fertility rates among Muslim women compared to Hindu women.
Adler et.al (1999) reported that breast cancer and malignant melanoma rates are higher among upper socio-economic groups. Mukhopadhyay (1999) pointed out that the dual role of women in the family and workplace make them more tensed and they perform family responsibilities and duties attached to their job at the expense of their physical and psychological health.

Zachariah et.al (1999) reported that migration has caused nearly a million married women to live away from their husbands and ‘gulf wives’ had experienced extreme loneliness and got increasingly burdened with added responsibilities.

Vinod et.al (2000) examined the effect of mother’s education and other demographic and socio-economic factors in the nutritional status of children and exposed that more than half of all children under age four are malnourished children growing in low educational background with lower nutritional status.

Bhaskaran (2001) pointed out that the Disability Adjusted Life Years (DALY) due to effects of malnutrition is around 15.5 million in India and more among women.

Duraiswamy (2001) revealed that morbidity is relatively higher among children and aged and sickness is more common among females.

Griffiths et.al (2001) reported that poor quality of public health care services compelled women to adopt home delivery in rural Maharashtra.

Gulati et.al (2002) highlighted that women empowerment factors like education, gainful employment etc play a significant and promotive role towards reproductive health status improvement. These factors also help in fertility reduction, high contraceptive usage, lowering age at marriage, higher utilization of reproductive health care and children’s immunization.
Mohammed et.al (2002) revealed more psychiatric morbidity among women in rural and urban areas and among different religious groups.

Asokan (2004) mentioned caste, religion, socio-economic status and type of head of household as significant determinants of childbirth in rural Kerala.


Thampi (2004) argues that Muslim women have significantly less autonomy compared to Hindu women, which affects their well being.

Sreenivasan (2005) examined the relation between religiosity and health and reported that less educated people were having more disciplined life compared to highly educated people.

Yadava (2005) observed that heart attack, stroke and other cardiovascular diseases are devastating in the case of women also.

Thresia (2006) reported higher morbidity rates among women, which are poverty and occupation related along with reproductive health problems.

Indu (2006) pointed out that women are more prone to suffer from mental problems because of the multiple roles they have to perform. Lack of decision making capacity, poor status at the family and community level, sexual abuse, gender discrimination, malnutrition, overwork etc. made them vulnerable to mental health problems.
Manju (2006) highlighted that the state had been witnessing a demographic transition with the elderly constituting more than 50 per cent of population and having a number of economic social and health problems.

Sheela (2006) mentioned that low income countries are at risk because of high fertility, anemia, immune deficiency, malnutrition, poor transport facilities, lack of blood transfusion facilities, deliveries by untrained personnel, illegal abortions etc.

Mishra (2006) revealed some illusions and realities of women’s health in Kerala. She opined, indicators of longer life span of women in Kerala, lower family size and contraceptive use were used to portray a positive picture of women’s health but health of elderly women was ignored at the policy level.

Stephenson (2006) examined the influence of religion on the adoption of female sterilization and reported religion as a strong predictor of the decision to adopt sterilization.

Navaneetham et.al (2006) reported that life style diseases are on the rise in Kerala and morbidity rate is greater among females. Mohindra et.al (2006) reported that women from lower castes (SC/ST) and other backward castes have higher prevalence of poor health than women from forward caste. They concluded that even in a relatively egalitarian state in India, there are caste and socio-economic inequalities in women’s health.

Gangadharan (2006) seeks to identify the major factors contributing to poor health status of women and children in the urban areas of Kerala.
Veni (2006) examined the mental health status of women workers in Handloom Industry. The study revealed that mental health status is not influenced by marital status, age and total years of service.

Asokan and Ibrahim (2007) mentioned caste as a significant determinant of morbidity in Kerala. They reported higher chronic morbidity rates among females and particularly among Muslim households.

Irudaya Rajan et al. (2007) reported a 200 percent increase in the population of elderly adults and among them majority were women. They reported hyper tension/BP, diabetes, arthritis, asthma, emphysema or bronchitis and heart problem as the common chronic illnesses among the elderly in Kerala.

Dwivedi et al. (2007) examined the influence of migration on the nutritional status of women in India. The study revealed that women who migrated from rural to urban areas and staying there for upto five years were more malnourished than non-migrant rural women.

Ramesh (2007) reported that the probability of reporting contraceptive morbidity is high among Muslims and women with 1 to 5 years of schooling.

Kumar et al. (2007) examined the influence of socio demographic factors in the treatment seeking behavior for gynecological morbidity among women of different regions. The study revealed that south Indian women are more conscious about their health compared to north Indian women. In south India, the highest rate of treatment seeking was among Muslim women.

Radhakrishnan et al. (2007) reported low maternal socio-economic status as the principal determinant of low birth weight babies. Rajini (2007) examined the effect of
female education on the health status of households and established a positive relationship between them.

Simon (2007) examined the relationship between health care accessibility and socio-economic groups.

Sandhya Rani (2008) pointed out that the indicators that determine the status of women such as demographic trends, education, work participation, health and justice are not at the satisfactory level in our country.

Ramesh et.al (2009) reported that women who are daily consumers of fruits chicken, meat or fish were more likely to be overweight or obese than those who ate them occasionally or rarely.

Moli et.al (2012) examined the extent of overweight and obesity among adult women and the association between overweight and diseases like diabetes and thyroid disorder and established significant association.

Different studies have revealed that Kerala has the highest morbidity rates in India. The morbidity pattern of the state has also been undergoing change in Kerala. Life style diseases are on the rise in the state. The State has undergone an epidemiological transition. Diseases like heart attack, diabetes, liver disorder, asthma, hypertension, mental disorders etc. are increasing.

While reviewing the literature related to this topic, it has come to be known that studies on the health status of Muslim women is lacking here. As Muslims belongs to backward community and morbidity rates reported from them are relatively higher, a study of this kind seems to be highly relevant.
Amartya Sen observed that “the expansion of women’s capabilities not only enhances women’s own freedom and well-being, but also contribute substantially to the lives of all people—men as well as women, children as well as adults.” The capabilities of women could be improved only by giving due consideration to health. The metaphor ‘Health is Wealth’ is completely true and recognizing its importance in the true spirit, we are proceeding to study the health status of Muslim women.

1.10 Limitations of the Study

The sample survey conducted for the study is a one-time survey and therefore does not explain the seasonal fluctuations in morbidity rate. For measuring chronic morbidity a recall period of twelve months was used, which might have affected the quality of information. The sample size of 320 is relatively small. The entire data collected from the sample is not quantifiable. However the researcher with utmost care recorded the pieces of information from respondents.