



INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

Muslim Women Health in India

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Abstract

The present paper highlights the Status of Muslim Women Health in India, paper based on a secondary sources. According to the world Health organization due to biological differences women live longer than men in all regions of the world. If health is defined as a state of complete Physical, Mental & Social well-being and not merely the absence of disease or infinity. It follows that existence is a necessary condition for aspiring for health. The girl child in India is increasingly under threat. In recent decades, there has been an alarming decrease in the child sex ratio (0-4 years) in the country. Accesses to technological advances of ultra sonography and India's relatively liberal laws on abortion have been misused to eliminate female fetuses. From 958 girls to every 1000 boys in 1991, the ratio has declined to 934 girls to 1000 boys in 2001. In some states in western and north western India, there are less than 900 girls to 1000 boys. The sex ratio is at its worst in the state of Punjab, Haryana, Himachal Pradesh and Gujarat. Where severe practices of seclusion and deprivation prevail, The sex ratio 2011 shows an upward trend from the census 2001 data sex ratio as per census 2011 is 940 females per 1000. Women's empowerment is hindered by limited autonomy in many areas that has a strong bearing on development. Their institutionalized in capacity owing to low levels of literacy, limited exposure to mass media and access to money and restricted mobility results in limited areas of competence and control. The family is the primary, if not the only locus for them. However, even in the household domain women's participation is highly gendered. Nationally, about half the women (51.6%) are involved in decision making on their health care. Women's widespread ignorance about matter related to their health poses a serious impediment to their well- being.

Keyword – Muslim Women, Islam, Maternal Mortality, prenatal neonatal, empowerment.

Introduction - Science 1990, the world has experienced uneven progress in reducing the maternal mortality Ratio, defined as the number of maternal deaths during a given period of time period per 100,000 live births. To the end, global leaders from 189 countries signed the millennium Declaration in 2000, promising that all Efforts will be made to reduce the maternal mortality rate (MMR) by 75% from 1990 to 2015, requiring a yearly rate of decline of 5.5% According to estimates by the WHO. UNICEF, UNFPA, The World Bank and the United Nations Population Division, the south region in total has managed to reduce 64% of maternal deaths-from 530 deaths to 190 deaths per 100,000 live births between 1990 and 2013 (WHO 2014). Globally India over 20% of all maternal deaths in 2013. Regional estimates show that hemorrhage and hypertension are responsible for over maternal deaths in South Asia. Indirect causes that includes deaths due to conditions, such as malaria, HIV/AIDS and cardiac diseases, Account for about one fifth of maternal death in the region. (According to Aday and Andersen 1947) “Three crucial components of maternal health care were parameterized: Women having four or more antenatal care (ANC) visits, deliveries conducted by Skilled Health (Rajesh Kumar Rai 2015.) Personnel”. U.N. Secretary-General Ban Ki-moon launched the initiative at the Sustainable Development Goal summit in 2010. The Islamic Development Bank is one of the donors. “It sends a very strong message that Middle Eastern countries are discussing (this issue) among their peers and learning from each other,” said Nana Kuo, Senior Manager at the U.N. Secretary-General’s Every Woman Every Child Initiative on September 27, during a gathering organized by the U.N. Foundation. For instance, the Islamic Republic of Afghanistan plans to increase the use of contraception from 15% to 60% as part of its public spending on health by 2020. Public health and development experts found that taking care of women and children is the cornerstone of a healthy society. Nevertheless, this is a challenge in most Muslim societies as sexual education for non-married adolescents, especially female, remains a taboo. The prevalence of religious laws, namely Islamic legislation, has hindered women and girls’ sexual and reproductive health. Yemen,(365/100,000.2014.) for example, has the highest rate of maternal deaths in the Middle East, according to its National Population Council. Therefore, there is a need for research to study the health beliefs of Muslim women to provide a clinical picture that incorporates the perceived influences of culture on health beliefs and practice in the medical or rehabilitation setting. The relationship of health beliefs to specific constructs is important in determining the outcome regarding access to health care, assimilation of health care practices, and follow through with medical evaluation and (Kamilia Lahrichi 2015.) treatment.

Health in Islam- As a basis for studying health beliefs Muslim women, a general understanding of the Islamic belief system as it pertains to medical ethics is indicated. Muslim derives health guidance by three major sources:

- 1 Quran (Muslim holy book), which outline the five pillars of faith. Shahada (Islamic statement of beliefs in one God), Prayers (Five obligatory prayers), Zakat(Charity), Sawm (Fasting during Ramadan), and the pilgrimage to Mecca (Hajj).
- 2 Sunnah (Example of the prophet Mohammad), and
- 3 Ijtihad (Law of deductive logic).

The health, are saying of the prophet Mohammad (SAW), are also considered as necessary knowledge that my provide guidance to general health care belief and medical ethics.

Certain health beliefs that “Risky behaviors” Have been identified within the Muslim culture as part of the religious belief system. Behaviors such as drinking alcohol, overeating, and intake of harmful drugs are prohibited by the religion of Islam. However, other behaviors, with more subtle influences such as tobacco use, sedentary lifestyle, and stress have negative consequences on Muslim patients and are not explicitly forbidden under the sharia (law) in Islam. According (Luecken, and Gunn 2005.) “Suggest a positive relationship between health beliefs such as prayer, religiosity, concept of forgiveness and lower levels of cortisol in men and (Lori, Fatima, Akram 2014.) Women.

Maternal Mortality Rate – In spite of the growing concern about reproductive health, information on levels and differentials in maternal mortality remains fragmentary for most developing countries. Selective cross-section of the population, for India The national family health survey of 1992-93 was the first to provide a national estimate of 437 maternal death per 100,000 births for the two years period preceding the survey (International institute for population science 1995). Even the national level, the sample inadequacies of the NFHS come into sharp focus when the second round of the survey in 1998-99 produced a maternal mortality estimate of 520, but field to confirm statistically the possible rise in the level of maternal mortality (International institute for population science 2000).

To fill the data gap, the potential of the sample registration system-a dual-record system for collecting data on births and deaths for estimating maternal mortality has also been explored in record time. The source has recorded a maternal mortality ratio of 408 and 407 deaths for 1997 and 1998 India register general (1999-2000).

Maternal mortality levels were lowest in the northwestern zone, which comprises the state of Haryana, Himanchal Pradesh, and Punjab (289 deaths), and in south India (383 deaths). On the other hand maternal mortality was greater than 600 in the eastern zone (Assam, the northwestern state and West Bengal) and north central zone (Bihar and Uttar Pradesh). Nonetheless, this information can be of use because sisters are unlikely to have come from very different socioeconomic background in estimates of maternal mortality are presented according caste, religion education socioeconomic status, and developmental levels of the village. No surprising, the maternal mortality ratio is estimated to be high among women of scheduled tribes (652 deaths) and scheduled caste (584), compare with come of other caste (516). Among the religious group, Hindus, have higher maternal mortality (537 deaths) than either Muslim (384) or women of other religious (428).

The unusually low maternal mortality among Muslim women is a puzzle; it could, part. Reflect the fact that they generally live in larger village than other groups and have batter access to emergency obstetric care. Show the Muslim women maternal mortality for these the loss developed villages have significantly higher maternal mortality (646) than do either moderately developed or well villages (501 and 488 deaths,

respectively). Therefore, access to health care appears to be a factor in the level of maternal (P.N. Mari Bhatt 2002) mortality.

Muslim women domestic violence, perinatal and neonatal mortality-

Between 10 and 64% of women experience life-time physical or sexual violence from male partners. The relationship between domestic violence and perinatal, neonatal and infant mortality, about which evidence is much more limited. Perspectives follow-up study was carried out in 2002-2003 in four Indian states, among a cohort of rural women selected from the 1998-99 National Family and Health Survey data for 3,909 birth outcomes in this four- years period were analyses. After controlling for potentially confounding factors, births to mothers who experienced two or more episodes of recent domestic violence experienced higher perinatal (HR 1.85, 95% confidence interval, CI 1.12-2.79) and Neonatal (HR 1.62, 95% CI, 1.11-2.53) mortality, compared to births to women who reported no violence. Births to women who experienced violence had 68% higher risk of infant mortality compared with the no violence group. A single episode of violence did not lead to higher risk of mortality. Possible reasons for the link between domestic violence and poor birth outcomes include the role of blunt trauma to the fetus, elevated levels of maternal stress, poor physical health of the mother from violence and care-seeking behavior. There should be greater focus on violence prevention within child survival programmed.

Care-seeking for post-partum morbidity, rural India –

Despite high morbidity and the danger of maternal death, women in low-resource settings frequently fail to seek post-partum care from formal providers. 2,114 mothers were interviewed through a household survey in February 2008 in the rural of India, in order to elucidate factors influencing care seeking behavior for post-partum health problems. 929 (43.9%) women had post-partum morbidity in the six weeks after delivery, of whom 5.8% did not seek any care, 49.2% sought care from informal providers, and 45.0% sought care from formal providers. Factors associated with seeking care from a formal rather than informal provider included being from a more educated household ($p < 0.05$), delivering at a health facility ($p < 0.001$), having a severe post partum complication ($p < 0.05$), and being Muslim rather than Hindu ($p < 0.01$). Women who did not seek any attention appeared to be most influenced by distance to a health care facility and whether they had had an institutional delivery, which underscores the importance of trying to increase rates of institutional delivery in order to improve post-partum care as well as delivery and birth outcomes. The finding that Hindu women were less likely to seek care than Muslim women should be investigated (Taylor & Francis 2010) further.

Discussion and Conclusion-

This study used the nationally representative Demographic and Health Survey data of India (2005–2006), to assess the associations. This study identified a number of factors,

Including place of residence, women's education, partner's education, age at birth, birth order, and wealth quintile, as being significantly associated with the utilization of selected maternal health care services

by Muslim women in India. Muslim women living in urban areas were more likely to utilize maternity care compared to their rural counterparts.

The lower utilization of maternal health-care services among rural women could also be linked with their lower socioeconomic status, along with contextual factors such as the distance to the nearest health center, lack of adequate transportation, and bad roads that can restrict proper and timely access to existing health facilities. The study empirically examined the positive impact of education, specifically Muslim women's education, on maternal health-care utilization. The positive association between women's education and utilization of healthcare services has always been hypothesized and manifested in various studies, especially developing countries (According to Magadi et al.2007) "suggest that educated women's make independent decisions and influence their in-laws' decisions regarding their own and their children's health, leading to higher utilization of modern health care facilities. Like women's education, all three components of maternity health care service among Muslim women were affected by their husband's educational attainment. This was associated with the husband's involvement in the wife's reproductive and maternal health care needs.

(According to Bloom et al.2000), "Public health literature has long argued that healthy reproduction only happens if the individual, utilization of health care services."

Economic status was found to be another significant factor affecting of the maternal health-care in India. (According to Equity Analysis et al.2008) The Muslim women belonging to the richest households were more likely to use maternity care, compared with women from the poorest household. That the poor-rich gap in the utilization of maternal and child health-care services have widened and programmed is barely reaching the poor section of society. This is probably because poor household do not have the resources for health care expenses, as their priority is to meet their basic daily needs, whereas wealthier household can spend a higher proportion of their earnings on health care (Monthay and Sarivastva 2013). Though the estimates on (MMR) by religious groups are not available in India, there is a pronounced indication that the likelihood of utilization of maternal health-care services in India is better than their neighbors. The programs and policies formulated towards improvement regarding maternal health-care utilization need to be understood in depth across the countries.

For example under the ambit of (NHRM), the government of India launched a broad conditional cash transfer scheme (JSY) in April 2005, to encourage women of low socioeconomic status to give birth in health facilities. (Ministry of Health and Family Welfare, Government of India 2011) According to JSY guidelines after delivery in one of these facilities, the eligible women would receive in urban areas 600 and rural areas 700 rupees. It is worth mentioning that the JSY scheme under NHRM was not focused on the Muslim population, the programs and policies formulated for improvement of maternal health-care utilization need to be understood in depth these countries.

In conclusion, to amplify maternal-health-service utilization, emphasis needs to be placed on the determinates of coverage, including policies and health system, financial flow, and health inequities existing

across different socio-economic groups as demonstrated through this study. In addition, the “generation of authentic statistics, evidence-based and targeted evaluations, as well as interventions, can reduce inequities related to socioeconomic behavior and demography in maternal health care service utilization” (Rai and Tulchinsky 2012).

Awareness regarding maternal health care must be strengthened to maximize utilization, by enhancing community involvement and improving coordination among health care system. Advancing maternal health-care utilization to bring necessary behavioral change among different religious group.

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