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Health status of deshi Muslims: A case study of goalpara district

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Abstract
Health is a prerequisite for human development and an essential component for the well-being of the mankind (Srivatsa, 2015). Health is an indicator of well-being that has immediate implications for the quality of life as well as for productive capacities and capabilities (AHDR, 2003). In a wider perspective, health is defined in terms of adaptation to changes in nature and society. Here, health includes freedom from pain, stress, discomfort and boredom, and adaptation to social and biological environment (Dubos, 1968). Various studies suggest that sound health is crucial for improved productivity as well as production. A healthy population is a prerequisite for successful development. So health has been considered as a vital indicator of economic development. The present study examines key health indicators such as Crude Birth Rate (CBR), Crude Death Rate (CDR), Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and profiles of communicable and non-communicable diseases prevalent in selected areas of the district.

The Deshi Muslim community is an indigenous ethnic group of Assam (Ali, 2017). The indigenous Muslim people who have been living in the undivided Goalpara district are known as Deshi Muslim (Rahman, 2014). Traditionally, this section of people is rural based and primarily depends on Agriculture and other petty manual works for their livelihood. So, this section of people remains far behind to achieve realizing health facilities. The idea of equality regarding health status among all sections of people seemed questionable in such situation. To observe the reality in grassroots a micro level study is adopted. Therefore, a study entitled "Health Status of Deshi Muslims: A Case Study of Goalpara District" is adopted.

Keywords: health status, crude birth rate, crude death rate, infant mortality rate, maternal mortality rate and deshi muslims

Introduction

Historically, the word health appeared approximately in the year 1000 A. D. Dolfman (1973) [6] and Balog (1978) [3] studied the roots of the concept of health. The term health originally came from Old English and it indicated the state and the condition of being sound or whole. More precisely, health was related not only with the physiological functioning but also with mental and moral soundness as well as spiritual salvation. Though the word health has often been preceded by both positive and negative qualifiers viz; good, bad or poor, it has always been regarded as a positive entity.

For the ancient Greeks, health was always an attribute of paramount importance. The ancient Greeks' apprehension of health and illness was based on the theory of the four 'fluids'(such as blood, phlegm, yellow bile and black bile) that is in its turn premised on the theory of the four elements viz; fire, earth, water and air and their four corresponding qualities like heat, dry, humid and cold. All these theories have as a starting point the number four, which was of great significance for Pythagorean philosophy that dominated the pre-Socratic period (Temkin, 1995) [19]. These theories are also encountered later on in Socratic philosophy. Plato contends that health is a state of being in complete harmony with the 'universe', a universe never affected by old age and disease due to the harmonious synthesis of the four fundamental elements (fire, earth, water and air) providing its substance (Tountas, 2000) [20]. The Greek word 'Ὑγεία' (hygia) does indeed describe a condition of completeness and contentment. A healthy body is a well-balanced body, one that exists in harmony with cosmic laws and order (Ackerknecht, 1982) [1].

The Greeks' ideas of health and illness have undoubtedly exerted a major influence on the Western views of health. However, with advances in the fields of medicine, science, sociology, psychology, and politics, the more philosophical theories of health began to be challenged and substituted by more scientific ones. As suggested by Balog (1978) [3], three major views of health have emerged in more recent time: firstly, the traditional medical concept, secondly, the World Health Organization concept, and finally, the ecological concept.

Firstly, the traditional medical concept indicates the earliest notion of health as a disease-free state. This view of health was largely accepted during the first half of the twentieth century, mainly between physicians and medical personnel. As described by Balog (1978) [3], such a traditional medical concept of health was based on the assumption that health and disease were objective and observable phenomena. Developments in the areas of anatomy, bacteriology and physiology contributed to this view. Rather than representing the presence of certain attributes, health was therefore defined solely in respects of the lack of disease, symptoms, signs or problems. *Secondly*, in the late 1940's, the World Health Organization developed a more holistic concept of health as "a state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity". Rather than restricting health to an absence of illness, health was conceptualized more in terms of the presence of absolute and positive qualities. This holistic and more utopian view of health encompasses and extends the traditional medical view by conceiving health as a positive state of well-being in which physical health is only one of the aspects involved. Along with that, social, psychological, physical, economic and political

aspects were incorporated in the definition of health, and regarded as components of paramount importance for health and well-being. *Lastly*, more ecological and relative notions of health emerged in the 1960s and 1970s. Such perspectives differed from the previous medical and holistic approaches mainly in two aspects: first, by conceiving health as a more relative sort of concept and, second, by placing a greater emphasis on the interrelationships between the environment and the individual's quality of life. These ecological and relative definitions of health tended to base on an evaluation of the person's level of functioning and adaptation to the environment. Within the more function-oriented perspectives, health has been defined either in terms of an adequate functional capacity which allows the individuals to carry out their duties and responsibilities (Oberteuffer, 1960) [12], or in terms of a certain quality of life which enables individuals to live happily, successfully, fruitfully, and creatively (Williams,1946; Bauer & Schaller, 1955; Hoyman, 1962) [4].

Therefore health is a function, not only of medical care, but of the overall integrated development of society- cultural, economic, social and political (ICSSR & ICMR, 1981). In fact, nutrition, environmental sanitation, literacy and other socio-economic factors play a greater role than narrowly defined health care services in determining the physical, mental and social well-being of people, especially in the early stages of development. Historically, health has been considered as a prominent socio-economic indicator of development. In many European countries, the improvement in health status began long before the dawn of modern scientific medicine. It was made possible by higher level of nutrition, improvement in environmental sanitation and adoption of better health care and hygienic practices.

The Deshi Muslims community is an indigenous ethnic group of Assam (Ali, 2017) [2]. The indigenous Muslim people who have been living in the undivided Goalpara district are known as Deshi Muslim (Rahman, 2014) [14, 15]. On the basis of numbers of majority people of Rajbongshi community and social and cultural similarities of Deshi Muslim people with Rajbongshi community, it would like to say that majority of Deshi Muslims people came from Rajbongshi community (Karmakar, 2004) [9]. Physical structure of Deshi Muslims, language-culture, behavior etc. indicates that this section of people was converted from Koch-Rajbonshi, Nath-Kalita or kaibarta etc. communities (Datta, 1995) [5]. Presently, people of this district are from various ethnic groups such as Koch-Rajbangshi, Jogi, Deshi Muslim, Kalita, Kaibartta, Brahman, etc. They all speak in one language regardless of caste, creed and religion, which is known as 'Deshi Bhasa'. The evidence of this reality was found from the research work of eminent Assamese scholar Dr. Birendra Nath Datta (1995) [5], where he indicated this language as a 'Deshi Bhasa'[1] after a depth research on this language.

The Deshi Muslim people were one of the prominent factions of Muslims of erstwhile Kamatapur Kingdom. Contemporarily, the undivided Goalpara district extended to North Bengal, earlier eastern Rangpur and Dinajpur districts (now under Bangladesh). After decades of time gone and administrative reorganization took place, a considerable part of Deshi Muslims remained in undivided Goalpara district (now divided into Dhubri, Bongaigaon, Goalpara, Kokrajhar, Chirang and South Salmara-Mankachar districts) that was under the erstwhile Rangpur district and now most factions of this sections of people are remaining in various places in some part of Bangladesh, North Bengal and different districts of lower Assam.

There is a general feeling that Deshi Muslim community is the most backward than its other counterparts in respect to realizing health facilities. Traditionally, this section of people is rural based and primarily depends on Agriculture and other petty manual works for their livelihood. So, this section of people remains far behind to achieve proper health facilities. The idea of equality regarding health status among all sections of people seemed questionable in such situation. Considering backwardness of Deshi Muslims sect of the Assamese society particularly in Goalpara district, it has become imperative to look into the ground realities in micro level. Therefore, the health status of Deshi Muslims is conceptualized and intended to induct it particularly the Deshi Muslims of Goalpara District of Assam.

Objectives of the study

To achieve the main objective of assessing health status the present paper selects the following objectives:

1. To observe the health condition of Deshi Muslims in grassroots.
2. To identify the factors responsible for poor health condition of Deshi Muslims.

Brief notes on Data Base and Methodology

In pursuance to the objectives and the research design, the study proposes to gather both secondary and primary information. The secondary information were collected from various published sources such as; Governmental reports, Official records, Statistical Hand Book of Assam, Journals, Periodicals, etc. Among government reports- reports of Planning Commission of India, reports of Registrar General of India and reports of various agencies were used for secondary information. Various books containing the issue and various issues of journals and periodicals such as Economic and Political Weekly, Journal of Rural Development, Yojana, Kurukshetra, State Government reports etc. were treated as some sect of sources of secondary data. Moreover, various reports published by different institutions and agencies such as reports of OKDISCD, *Deshi Janagosthiya Mancha*, *Goria-Moria and Deshi Jatiya Parishad*, etc. were used as sources of secondary information.

To achieve the core objective of the study primary information were gathered through purposive multi-stage random sampling technique. The sample survey technique adopted to collect primary information can be elaborated as follows.

Collection of Primary Information

In the first phase of the survey, Goalpara district of Assam was chosen purposively as the area of the study because mostly the Deshi Muslims inhabit in this district of Assam.

The district has 829 Revenue Villages, 5 Revenue Circles and 8 Community Development Blocks (CDBs), where Deshi Muslims are a major fraction of the society. In the second phase of the survey, 3 (Three) administrative blocks have been chosen randomly from the total of 8 Community Development Blocks such as; Rangjuli, Matia and Lakhipur Community Development Blocks. Deshi Muslim Villages are situated in a stretch amounting to 11 in Ranjuli, 11 in Matia and 10 numbers in lakhipur CD Blocks respectively. In the third phase

of the survey, 12 villages were chosen from each of the Blocks randomly from a total of 32 villages adopting a specific procedure of about 8:3 in each village. The study adopts the selected households as sample units. In the fourth phase, a pilot survey was conducted through which the selected households were identified followed by visits to them with a questionnaire schedule. The questionnaire schedule was tested with the objectives of the study followed by its finalization during this phase. In the fifth stage of the survey, the pre-tested questionnaire schedules were used to collect required primary data which included a sample size of 250 households. The size was justified because it was about 10 per cent of total Deshi Muslim households inhabiting in the selected blocks of Rangjuli, Matia and Lakhipur comprising 83, 83 and 84 respectively.

Health Status of Sample Households

Health status of sample Deshi Muslims of Goalpara district is at a very poor status. The health status of sample households of the Rangjuli, Matia and Lakhipur community Development blocks are reflected by key indicators such as Crude Birth Rate (CBR), Crude Death Rate (CDR), Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), which is shown in the table 1

Table 1: Health Status of Sample Households

Blocks	Health indicators			
	CBR (per 1,000 live births)	CDR (per 1,000 live births)	IMR (per 1,000 live births)	MMR (per 1,00,000 live births)
Rangjuli Community Development Block	16 (35.80)	6 (13.42)	2 (125)	1 (781.25)
Matia Community Development Block	15 (32.05)	7 (14.96)	2(133)	1 (833.33)
Lakhipur Community Development Block	22 (48.67)	9(19.91)	3 (136)	1 (840.34)
Total	53 (38.77)	22 (16.09)	7(131)	3 (818.31)

Notes: CBR→ Crude Birth Rate, CDR → Crude Death Rate, IMR → Infant Mortality Rate, MMR → Maternal Mortality Rate. The figures in brackets represent percentages to total sample size.
Source: Field survey.

The above table 1 shows that the most significant health indicators such as IMR and MMR are much more higher at 131 per thousand and 818.31 per lakh in the study area, whereas CBR and CDR also quite high at 38.77 and 16.09 per thousand respectively. These statistics shows a poor health status of Deshi Muslims. The prominent health indicators of Deshi Muslims are elaborated below.

Crude Birth Rate (CBR)

The Crude Birth Rate is one of the internationally considered vital indicators of health status. It is generally defined as the ratio of total live births to total population in a specified community or area over a certain period of time. The birth rate is often expressed as the number of live births per thousand of the population per year. The CBR of the Deshi Muslims is at 38.77 per cent as revealed in table 1. It is higher than the state as well as national rates of 22.5 per cent and 21.6 per cent respectively. The finding implies that despite the government policy provisions for control of birth, it remained at a higher rate. The high rate of CBR is due to the prevalence of high illiteracy, child marriage, sustenance of poverty and the belief of the people about more hand for more earnings.

Crude Death Rate (CDR)

Crude Death Rate is another crucial health indicator of any given community. It signifies the number of deaths happening among the individuals of a given geographical area during a calendar year, per 1,000 mid-year total population of the same area in the same period. It is found that the CDRs of Deshi Muslims in selected blocks such as Rangjuli, Matia and Lakhipur community development blocks are at 13.42 per cent, 14.96 per cent, 19.91per cent respectively. The variation of CDR is prevailed among the selected blocks of the district. Differences to accessibility to health centers are accounted for the variation in CDR values in various blocks.

Infant Mortality Rate (IMR)

Infant Mortality Rate is another prime indicator of health status. It is represented as the probability of a child dying before he/she attains the age of one year and is calculated per 1,000 live births. As per 1991 census, the IMR of Goalpara district was 106, in comparison with 99 per 1,000 live births in the state level. The IMR of the Deshi Muslims is at 131 per 1,000 live births, which is higher than the IMR of the state as well as national rates at 55 and 42 per 1,000 live births, respectively. The finding implies that despite government intervention in policy provisions to stabilize IMR, it remained high. This high rate of infant mortality is caused by the higher fertility, lack of awareness etc. This finding conforms to the findings of Murthi, Guio, and Drèze (1997) [10] that there is an association between women literacy and infant mortality rate. In case of the sample area the women literacy is at 60.52 per cent (table 1) and IMR is at 131 per 1000 live births.

Maternal Mortality Rate (MMR)

Maternal Mortality Rate (MMR) is another crucial indicator of health status. MMR indicates the number of maternal deaths in a given period per 1, 00,000 women of reproductive age during the same time period. The study finds that the MMR of Deshi Muslims is high at 818.31 per 1, 00,000 live births (refer table 1) which is higher than the state (390 per 1, 00,000 live births) as well as national rate (212 per 1, 00,000 live births) respectively. The high rate of MMRs is caused by low level of medical facilities.

Disease occurrence of Sample Households

Health awareness and the availability of health facilities believed to reduce the incidence of illness of people. Lacking of both aspects regarding Deshi Muslims is among the reasons of high incidence of various diseases prevail to this section of people. Table 2 shows the levels of disease occurrences of the sample households in the selected areas of Goalpara district.

Table 2: Details of Disease Occurrence of the Sample Households (Total Sample Households 250)

Blocks	Types of Disease							
	Malaria	Jaundice	Typhoid	Diarrhea	BP (H/L)	Arthritis	Others	Total
Rangjuli CD Block	14 (16.87)	15 (18.07)	12 (14.46)	10 (12.05)	13 (15.66)	14 (16.87)	5 (6.02)	83 (100)
Matia CD Block	15 (18.07)	11 (13.25)	13 (15.66)	11 (13.25)	10 (12.05)	17 (20.48)	6 (7.23)	83 (100)
Lakhipur CD Block	13 (15.48)	15 (17.86)	14 (16.67)	9 (10.71)	12 (14.29)	16 (19.04)	5 (5.95)	84 (100)
Total	42 (16.81)	41 (16.39)	39 (15.60)	30 (12.0)	35 (14.0)	47 (18.80)	16 (6.4)	250 (100)

Notes: The figures in the brackets represent percentages to total sample size.
BP→Blood Pressure; H/L→High/Low
Source: Field survey.

Table 2, shows the disease occurrence of sample area comprising of Rangjuli, Matia and Lakhipur community Development blocks of the Goalpara district of Assam. The paucity of health facilities is found to be responsible for the prevalence of various communicable diseases in the study area. It is found that 16.81 per cent, 16.39 per cent and 15.60 per cent respectively of Deshi Muslims are affected by the communicable diseases like Malaria, Jaundice and Typhoid. Besides, about 12 per cent Deshi Muslim children are reported to be infected by the non-communicable disease like Diarrhea. Health hazards arising out of Blood pressure, arthritis problem etc. among Deshi Muslims are common and it is found that about 14 per cent and 18.80 per cent respectively are affected by such sufferings (refer table 2).

Conclusion and Recommendation

The study on "Health Status of Deshi Muslims: A Case Study of Goalpara District" brings forth into the record the 'health condition of Deshi Muslims inhabited in specific areas of Goalpara district of Assam'. The holistic approach of inclusive growth is seemed to remain untouched to this section of people. Even after seven decades of independence, Deshi Muslims in Goalpara district are lagging behind than other community in terms of health status. The Deshi Muslims are primarily concentrated in rural areas. Since Deshi Muslims inhabit mostly in rural areas, they are not received proper health facilities. The high rate of CBR, CDR, IMR and MMR of the Deshi Muslims along with the presence of communicable and non-communicable diseases, scanty of pure drinking water and unhygienic living condition reveal this section of people in a condition with poor health status.

The results of this study necessitate certain policy initiatives to transform the poor health condition of Deshi Muslims in Golapara district. Therefore the state government as well as central government is urged upon to implement strategically the following recommended polices.

The health situations among Deshi Muslims must be improved. Therefore, to increase the health situation the following measures are recommended.

- Health centers must be increased for easy accessibility of Deshi Muslims in Goalpara district.
- The standard norms for availing one doctor per ten thousand people must be initiated.
- The number of health workers such as nurses, health educators, and village health workers must be increased so as to improve health awareness.
- Pure drinking water facilities must be provided.

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