

## Health of Muslims in Maharashtra

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### CEHAT

Structural inequalities have been linked to disease causation as well as poor access to health services. In the Indian context, inequality is sourced in caste, class, religion, gender, among other factors. This paper deals with the inequalities based on religion on a population's health which are evident in various direct and indirect ways.

Maharashtra has about 10.3 million Muslims, who comprise about 10.6% of its population. This makes it the largest religious minority in the state. The deplorable conditions of life and deprivation faced by Muslims have been established in other chapters. Factors such as education, economic status, working and living conditions are important social determinants of health and there are clearly established links between these determinants and health. Poverty in general leads to poor nutrition leading to lower productivity and income. With continued morbidity, assets might need to be sold, consumption spending might reduce and quality of life and housing gets affected. Poverty forces people to use strategies that may either deplete their assets (removing their children from school) or take steps that actually increase their vulnerability (such as taking on debt, prostitution, crime). Education affects health directly in terms of knowledge and information about health problems and ability to absorb health education material. Further, education is a determinant of future employment and income, there by defining a person's socioeconomic status which has an impact on health. Poor working conditions also affect health. Working on the roadside, in unventilated factories, with hazardous chemicals, all affect health and employability. This could lead to looking for work in the informal sector and doing casual labour, where the working conditions are, more often than not, worse. Ill health also leads to decreased immunity and increased requirement for food. With neither is available, and there are poor working and living conditions, there is a high susceptibility to diarrheal diseases and respiratory infections which further spread due to crowded living or working conditions.<sup>1</sup> Studies in the developed countries have clearly established the link between discrimination which is indirectly proportional to poor utilization of health services, increased delays in seeking health care and poor adherence to medical treatment.<sup>2</sup>

The State of Maharashtra has witnessed the highest number of Hindu-Muslim riots post-independence. Displacement and subsequent ghettoization has been a definite impact of communal riots. Ghettoization has made it easier for State authorities to neglect Muslim dominated areas and not provide them with adequate services such as health care, sanitation and education facilities. According to Gayer and Jaffrelot, a ghetto is “a bounded ethnically (or religiously) uniform socio-spatial formation born of the *forcible relegation* of a *negatively*

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<sup>1</sup> Grant U (2005): *Health and Poverty Linkages, Perspectives of the Chronically Poor*, Background Paper for the Chronic Poverty Report 2008 - 09, Chronic Poverty Research Centre.

[http://94.126.106.9/r4d/PDF/Outputs/ChronicPoverty\\_RC/other-grant-health.pdf](http://94.126.106.9/r4d/PDF/Outputs/ChronicPoverty_RC/other-grant-health.pdf)

<sup>2</sup>Casagrande S S, Gary T L, LaVeist T A, Gaskin D J, and Cooper L A “Perceived Discrimination and Adherence to Medical Care in a Racially Integrated Community” *J Gen Intern Med.* 2007 March; 22(3): 389–395.

*typed* population (italics added).”<sup>3</sup> Ghettoization in the context of Muslims, simply reinforces all of the above vulnerabilities, directly and well as indirectly, making them doubly susceptible and sidelined.

### **Methodology:**

The paper is based on analysis of NFHS, DLHS, NSSO data sets. The DHS Maharashtra was approached for data on availability of health services and prevalence of diseases, profile of health workers, etc. However, as disaggregated data is not available, we had to rely on empirical data in order to gain a true picture of health in the Muslim community. In this paper therefore, even as we use these health indicators, we draw upon evidence from primary studies conducted in the Muslims ghettos of Maharashtra, to understand the subject at hand.<sup>4</sup>

### **Limitations of the data**

Firstly, there is a lack of disaggregated indicators based on religion. The Government of Maharashtra does not record any data that is disaggregated by religion. For instance, given the poor living environment which Muslims have been pushed to inhabit, it would be important to know the incidence of Malaria among them. However, the incidence of Malaria is only available for the district level and this says nothing about whether Muslims are more likely to suffer from Malaria than others.

Secondly, comparing ‘Muslims’ to ‘Hindus’ is futile in most instances because both the religious groups have a caste hierarchy within them and so interaction between caste and religion is an important one to consider. What is required is data disaggregated by social groups which into account both religion and caste. However, these are most difficult to find. We also attempted to use the NSSO raw data and create ‘socio-religious categories’ such as ‘upper caste Hindu’, ‘upper caste Muslim’ etc. But the resultant sample sizes in these categories were too small to enable any meaningful analysis.

These limitations in data have crucial implications for policy makers, as they highlight the need to supplement these key indicators with field level information in order to gain a true picture of health in the Muslim community.

## **II.1 Childhood Mortality Rates**

As per the NFHS 3 data, at the state level, Muslims in Maharashtra, fare better than other groups in terms of early childhood mortality rates. They have an infant mortality rate (IMR) of 25.9 which is lower than that for other religions as well as across castes. Neonatal, Child and Under-5 mortality rates (U5MR) for Muslims too is lower than for other groups (Table 1). Similarly, at the district level one finds that districts with a high concentration of Muslims<sup>5</sup> have an infant mortality rate (IMR) that is similar or slightly better than the state

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<sup>3</sup> Gayer L and Jaffrelot C (2012) Muslims in Indian Cities: Trajectories of Marginalization, Hurst and company, 2012.

<sup>4</sup> A baseline study of development indicators in Bhiwandi, Maharashtra (2010-11) (College of Social Work, Nirmala Niketan), Multi-sectoral Development Plan for Malegaon Town, 2011 (Tata Institute of Social Sciences), Multi-sectoral Development – Behrampada, 2011 (RCWS, SNDT University), Multi-sectoral Development – Sion Koliwada, 2011 (RCWS, SNDT University).

<sup>5</sup> 7 districts are being considered as 'Muslim concentrated' based on: (1) top 5 districts that have the highest % population of Muslims as per the 2001 census (Mumbai, Mumbai-S, Aurangabad, Parbhani, Akola) (2) top 5

average. (Table 2) In the context of the marginalization that Muslims face, these numbers seem out of place.

A closer look at data from large surveys however, shows that the generally low IMR and U5MR among Muslims at the state level, is related to their location in urban areas. A look at inter-state variations in IMR through the NFHS 2 reveals that states that have a high percentage of Muslims staying in the urban areas (such as Maharashtra, Karnataka, Andhra Pradesh, Gujarat, Madhya Pradesh, Tamil Nadu) as well as those states where there is a higher percentage of Muslims staying in urban areas of the state than the total population of the state in general (Uttar Pradesh and Bihar) were found to have lower U5MR than the state average. In contrast, those states where the percentage of Muslims in urban areas is less as compared to that for the state (West Bengal, Assam and Haryana), the U5MR is higher for Muslims than the state average. (Table 3)

Table 3: Childhood Mortality Rate and Population in Urban areas for States

State	U5MR (state)	U5MR for Muslims	% of total population in urban areas	% of total Muslim population in urban areas
Uttar Pradesh	135	108	21	36
Bihar	110	99	13.3	15.2
Karnataka	83	66	34	59
Maharashtra	70	42	42.4	70.0
Andhra Pradesh	91	40	27.3	58.1
Gujarat	91	50	37.4	58.7
Madhya Pradesh	145	99	24.8	63.5
Tamil Nadu	71	56	44.0	72.8
<i>West Bengal</i>	<i>71</i>	<i>77</i>	<i>28</i>	<i>16.8</i>
<i>Haryana</i>	<i>79</i>	<i>90</i>	<i>28.9</i>	<i>14.5</i>
<i>Assam</i>	<i>80</i>	<i>87</i>	<i>12.9</i>	<i>6.4</i>

Source: NFHS 2, Basant and Shariff

Therefore when we look at indicators such as under-5 mortality rates by itself for a state, it does not reveal the real performance of Muslims on childhood mortality. Further, we find that within urban areas in Maharashtra, Muslims fare much worse than other groups when it comes to child survival. A special fertility and mortality survey<sup>6</sup> done in 1998 clearly illustrates this. (Table 4)

Table 4: Child Mortality Rates by Religion and Residence

	Muslim	Hindu	Others	Total
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districts that have the highest proportion of the Muslim population in Maharashtra as per the 2001 census (Mumbai, Mumbai-S, Aurangabad, Thane, Nashik)

<sup>6</sup> The survey is of 1.1 million households, data is based on Sample Registration System.

	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
<b>Infant Mortality Rate</b>												
Total	39	55	21	49	52	45	45	41	51	47	52	42
Rural	40	46	34	57	61	53	63	59	67	56	60	52
Urban	38	56	15	28	31	27	28	24	36	31	38	24
<b>Under-Five Mortality Rate</b>												
Total	56	70	41	60	62	58	51	40	63	59	62	55
Rural	53	58	48	70	70	69	77	58	94	69	69	69
Urban	54	73	32	37	42	31	26	25	27	41	50	31

*Source: Special Fertility and Mortality Survey, 1998: Report of 1.1 million Indian households, Sample Registration system. New Delhi: Office of Registrar General, India, p.152*

The data shows that for the State of Maharashtra as a whole, IMR for the Muslim community is 39 per thousand which is lower than other groups (Hindus and ‘others’) and also lower than that for the total population. However, the scenario changes in the urban areas where IMR for Hindus and other groups drops to 28 per thousand as compared to 38 per thousand among Muslims. A similar pattern is seen in case of under-five mortality, which is lower for Muslims than other groups in rural areas, but in urban areas Muslims fare comparatively worse<sup>7</sup>.

What this discussion clearly reveals is the fact that macro – level studies do not explain the survival rates for Muslim children. Nor are they able to explain the reasons for the rates that are prevalent. One can conclude therefore, that child survival rates vary based on location (urban/rural) and also on religion. While child survival rates in urban areas are generally better than rural, within urban areas, Muslims fare much worse than their counter parts in terms of child survival, perhaps owing to their living conditions and lack of access to health care. In Maharashtra, 70 percent of the Muslim population is urban,<sup>8</sup> and so this data takes on greater significance.

## II. 2 Nutrition and anaemia

In Maharashtra, according to NFHS 3, 48 percent of women are found to be anaemic. Looking at percentages on the basis of religion it was found that 43 percent of Muslim women, 49 percent of Hindu women and 53 percent of Buddhist women were found to be anaemic. (Table 5)

**Table 5: Anaemia among Women by background characteristics**

Religion		Mild (10-11.9 g/dl)	Moderate (7-9.9)	Severe (<7)	Any (<12)
	Hindu	33.1	13.9	1.8	48.9
	Muslim	27.8	14.7	0.6	43.0

<sup>7</sup>Although the data is relatively old (from 1998), no such recent analysis is available.

<sup>8</sup>Shaban et. Al. “Survey of Muslims in Maharashtra”, published by Maharashtra State Minorities Commission and TISS.

	Buddhist/Neo-Buddhist	36.3	14.6	2.1	52.9
	Other	31.8	7.6	1.3	40.7
Caste	Scheduled Caste	35.3	14.6	2.1	51.9
	Scheduled Tribe	37.6	18.3	3.0	58.9
	Other Backward Class	31.9	13.3	1.6	46.8
	Other	31.3	13.1	1.3	45.7
Wealth Quintile	Lowest	35	17.7	2.7	55.3
	Second	36.2	15.6	2.4	54.2
	Middle	33.1	15.6	1.9	50.7
	Fourth	32.6	12.9	1.5	47.1
	Highest	30.6	12.0	1.1	43.7
	Total	32.8	13.9	1.7	48.4

Source NFHS 3 - Maharashtra

Secondly, a study on the nutritional crisis in Maharashtra<sup>9</sup> based on NSSO data (04-05, Consumption round), shows that Muslims have the lowest average calorie consumption per capita per day, among all religious groups, in both rural and urban areas of Maharashtra. The consumption in urban areas at 2094 calories/capita/day is lower than it is even in rural areas where it is 2265 calories/capita/day. In the rural areas, Muslims fare better than only Scheduled Castes and in urban areas they are worse off than Scheduled castes (SCs) and Scheduled Tribes (STs). Moreover, Muslims also have high incidence of calorie-poor in the state. In rural areas, Muslims fare slightly better than Buddhists in terms of incidence of calorie poor and in urban areas they have the highest incidence of calorie poor among all groups.

What is plainly obvious, is the diametrically different inferences that can be drawn from the NFHS and NSSO data. Therefore, there is a need to explore reasons for why the nutritional status of Muslim women is generally better than other groups, even though their caloric intake is poor.

### II. 3 Fertility and Contraception

A look at the NFHS data, provides a picture of the changing fertility rate and contraceptive use among Muslims. The Total Fertility Rate (TFR) of Muslims in Maharashtra has steadily reduced from 4.11 in 1992-93 (NFHS I) to 3.3 in 95-96 (NFHS 2) to 2.8 in 2005-06 (NFHS 3). This drop in TFR has been better for Muslims than it has for the state as a whole (Table 6). Contraceptive use among Muslims in Maharashtra has been increasing over the years and stands at 57.4% as per DHLS- 3 (Table 7)

**Table 6: Change in fertility across NFHS surveys**

	Muslim			ALL		
	NFHS	NFHS	NFHS	NFHS	NFHS	NFHS

<sup>9</sup> Nutritional Crisis in Maharashtra SATHI 2009

	3	2	1	3	2	1
Total wanted Fertility Rate	2.11	2.20	2.98	1.66	1.87	2.13
Total Fertility Rate	2.85	3.30	4.11	2.11	2.52	2.86
Difference between TFR and TWFR	0.74	0.90	1.13	0.45	0.65	0.73
Mean Number of Children Ever Born to Women age 40-49 years	4.4	4.58	5.20	3.4	3.77	4.25

Source: NFHS various rounds

However, the percentage of women using contraception is still lower than other women. One of the reasons for this, is the non-availability of the preferred method of contraception (spacing methods). This has been established in other studies across the country<sup>10, 11, 12</sup> and is also likely to be true for Maharashtra. The DLHS-3 data for Maharashtra clearly indicates that as compared to other groups, a smaller percentage of Muslim women use sterilization as a method of contraception. (Table 7)

**Table 7: Current use of contraceptive method by background**

		Any method	Male st	Female st	IUD	Pill	ECP	Condom
Religion	Hindu	65.9	3.1	54.4	1.4	1.6	.2	4.1
	Muslim	57.4	0.7	41.4	2.8	5.2	.5	5.7
	Christian	55.3	1.3	40.1	1.4	1.3	0	4.3
	Sikh	68.8	0	34.7	0	10.2	0	23.8
	Buddhist/Neo Buddhist	64.4	4.5	52.7	0.7	1.2	.2	3.8
	Jain	72.6	0	49.6	3.7	3.6	0	12.8
	Others	63.3	7	49.3	0	1.4	0	2.8
	Maharashtra	65.1	2.9	53	1.9	1.9	.2	4.4

Source: DLHS 3- Maharashtra

<sup>10</sup>Hussain S. "Exposing the Myths of Muslim Fertility: Gender and Religion in a Resettlement Colony of Delhi" Center for Women's Development Studies, 2008.

<sup>11</sup> Jeffrey R, Jeffrey P. (2000) Religion and Fertility in India, Economic and Political Weekly August 26-September 2, 2000.

<sup>12</sup> Elizabeth Chacko "Women's use of contraception in rural India: a village-level study" Health & Place September 2001, 7(3):197-208.

The use of IUDs, Pills and Condoms is greater among Muslims. (Table 7). However, the family planning program in Maharashtra (and in India as a whole) concentrates solely on limiting methods such as sterilization, when Muslim women’s family planning needs are those of spacing methods. As a result, Muslim women have high unmet need and lowest percentage of demand satisfied, while the total demand for contraception is more or less within the range of the rest of the groups. Moreover, because of the prevalent belief that non-use of contraception by Muslim women is rooted in religious beliefs, the focus of policy has been on ‘changing mindset’ of Muslims through awareness campaigns. It is important to note that, in Maharashtra, 77.4% of Muslims have received messages regarding family planning from “any source” (radio, tv, etc), which is much higher than Hindus at 59.2%. (Table 8) Therefore in terms of exposure to family planning messages Muslim women seem to be well aware.

Table 8: Demand For Contraception by Religion

Religion	Unmet need for FP	Met need for FP	Total demand	Percentage of demand satisfied
Hindu	12.2	62.0	74.2	83.6
Muslim	21.9	49.1	71.0	69.1
Christian	12.8	53.2	66.0	80.6
Buddhist/neob	11.4	66.3	77.7	85.3

Source: NFHS 2

It is this mismatch that needs to be remedied even in the state of Maharashtra, so that contraceptive services are able to cater to the needs of people. Making acceptable methods of contraception available to the community should be the focus, rather than imposing one method for all. It also needs to be stated here that in the absence of preferred method of contraception, it is not surprising that Muslim women rely on the private sector for spacing methods (DLHS-3).

It is important to remember that data on fertility has time and again been used to perpetuate the bias that the high fertility rate of Muslims is contributing to India’s population explosion (projecting them as ‘irresponsible citizens’) and inciting fear that soon the population of Muslims will exceed that of Hindus. Even academics have argued that it is the “backward” religious beliefs of Muslims which forbid the use of contraception.<sup>13</sup> The abovementioned data clearly provides evidence to the contrary. However the misconception that Muslims are averse to using contraception is still strongly ingrained within health care providers. In the study conducted by CEHAT<sup>14</sup> in Mumbai, women reported being routinely mocked about the number of children they have. Often health care providers would feel that Muslim women were lying about the number of children that they have, even if the woman may have come for her first pregnancy. These misconceptions propagated over the years are harmful and must be urgently addressed.

<sup>13</sup>Fargues, P (1993): ‘Demography and Politics in the Arab World’, Population: An English Selection, (5), pp 1-20. As quoted in Jeffrey and Jeffrey (2000)

<sup>14</sup> The study was on Muslim women’s experiences of discrimination while accessing health facilities. The study was conducted in a Muslim dominated slum in Mumbai. Eight Focus Group Discussions were conducted with Muslim and non-Muslim women (both Maharashtrian and non-Maharashtrian) to explore their experiences with health facilities.

## II.4.1 Maternal health – Antenatal care (ANC) coverage

**Table 9: Percentage of women who received antenatal check up by background**

		Percentage of women who received any ANC	Percentage of women who received all three ANC visits	Percentage of women (aged 15-49) who received full antenatal care (ANC)
Religion	Hindu	91.1	73.7	35.1
	Muslim	94.9	77	26.4
	Christian	100.0	82.6	44.7
	Sikh	*	*	*
	Buddhist/Neo Buddhist	94.2	77.8	28.3
	Jain	100	97.9	60.2
	Others	80	47.6	31.8
Caste/Tribe	SC	93.5	75.7	30.2
	ST	81.5	60.2	32
	OBC	94.9	80.4	37.2
	Others	94.5	77.7	34.2
Wealth Quintile	Lowest	77.2	52.3	24.1
	Second	88.2	64.5	27.1
	Middle	91.9	72.3	31
	Fourth	95.4	79.3	34.4
	Highest	98.3	90.4	46.3
	Mah	91.8	74.4	33.9

Source: DLHS 3- Maharashtra

**Table 10: Place of Antenatal Check up**

		Any Antenatal Check up	Govt. Health Facility	Private Health Facility	Community Based services
Religion	Hindu	91.1	42.6	46.5	3.2
	Muslim	94.9	45.4	54.9	1.5
	Christian	100	53.6	36.5	8.2
	Sikh	*			
	Buddhist/NeoBuddhist	94.2	55.1	31.9	2.2
	Jain	100	10.3	91.8	2.1
	Others	80	50.6	25.6	19
Castes	SC	93.5	54.4	34.4	2.1
	ST	81.5	49.8	24.7	6.6
	OBC	94.9	44.2	50.5	2.8
	Others	94.5	36.4	57.8	1.9
Wealth Quintile	Lowest	77.2	48.3	19.0	7.1
	Second	88.2	51.3	27.6	3.6



	Middle	91.9	47.4	38.3	3.2
	Fourth	95.4	47.8	48.3	2.1
	Highest	98.3	29.5	74.0	1.8
	Maharashtra	91.8	43.8	46.1	3.1

Source: DLHS 3- Maharashtra

On the basis of the above tables, the following observations can be made –

Both significant percentage of Hindu and Muslim women make it a point to access health facilities for ANC. Muslim women also do marginally better when it comes to receiving all three ANC check-ups. What is significant to note is that despite a higher percentage of Muslim women that access ANC and go for all there check-ups, only 26.4 percent have received total ANC care. This is significantly lower than other groups and also lower than that in the State as a whole (Table 9). Access to TT injections and Iron-Folic-Acid tablets seem to be the two components of ANC that are not received consistently by Muslim women. Moreover, we find that a significant percent of those in the lowest wealth quintile are the ones that are not receiving ANC care. The question therefore is – why are so many Muslim women not receiving total ANC care?

We also find that a higher percentage of Muslim women as compared to Hindu and Buddhists women are accessing ANC from private facilities. (Table 10) It is largely women from higher wealth quintiles that are more likely to access private facilities. This is therefore a cause of concern as it is possible that even poor Muslim women are going to private facilities. This is illustrated through empirical data where Muslim women have said that they do prefer private providers as they feel public providers do not treat them with dignity.

We explore the above two questions based on available literature. The low consistent use of ANC services, may have to do with distance from the health facility and women’s decision making power in the household. Menon and Hasan<sup>15</sup>, in a survey conducted across different regions in India, used a Freedom of Movement Index (FMI) to gauge whether women required permission to carry out certain activities. For both Hindu and Muslim women, they found that women were required to seek permission for attending to their health needs more than for going to work or to the market. This is consistent with findings from several studies on women’s health seeking behavior, which have established that lower priority is accorded to women’s health than to other economic and domestic activity. While the mobility and decision-making power of women in general is low, the survey finds that Muslim women have marginally lower decision making regarding seeking health care (a higher need for obtaining permission). The authors attribute this to the fact that being a poor and marginalized community, the economic implications of seeking health care are probably greater for Muslims than other groups and hence decision-making is curtailed. Therefore, correlating this with the NFHS data, one can infer that Muslim women may end up going for the ANC check up but not be able to afford the injections and tablets.

Further, the push towards private facilities for ANC must also be considered, as there is evidence to state that it may have to do with the quality of services and the behaviour of staff at the public facilities. The study conducted by CEHAT in Mumbai revealed that Muslim women waiting for gynaecological check-ups at the public hospital, found it highly objectionable that they were asked to remove their “shalwar” in the waiting room much

<sup>15</sup>Hasan Z, Menon R, “Unequal Citizens- A study of Muslim Women in India”, Oxford University Press, 2004.

before their turn. Doctors, ward boys and other patients walking in and out of the waiting room made them feel awkward. Because other women were wearing “saris”, they were not subjected to this humiliation. For some, this deterred them from going to the public hospital for ANC visits completely. As a Muslim woman from the ghetto described during a focus group discussion (FGD):

*“When I went for my first delivery to the public hospital, I did not know of anything. I was new and it was my first time. I went in for my check-up. In the women’s waiting room we were asked to take off our shalwars. Most women were wearing saris so they did not have to undress at all. There was still a lot of time for my appointment. I did not feel comfortable taking off my clothes and sitting there naked in front of everyone. There were people walking in and out of the room. I requested the nurse but she was rude and said ‘if you don’t want to take your clothes off then go home.’ I did not know what to do. I was very shy and then I walked out and told my husband that I do not want to go back to that hospital. After that we went to a private doctor for check-ups.”*

In addition to this, as mentioned before, Muslims women are also taunted by health care providers for having too many children. This behaviour at the public hospital may deter women from accessing ANC services there.<sup>16</sup> Those who can afford it would access private facilities, but for those who cannot there is no option.

#### **II.4.2 Place of Delivery**

##### High institutional delivery linked to urban location

The DLHS data show that institutional deliveries among Muslims are higher than other groups and also as compared to the state average (Table 11). The districts with a majority Muslim population are found to have same or higher percentage of women having institutional deliveries, as the State average. This is possible as the majority of Muslims live in urban areas where health infrastructure is more easily available than in rural areas.

The relationship between urban status and prevalence of institutional deliveries is further evident through an inter-state comparison of how Muslims fare vis-a-vis institutional deliveries. In states such as Bihar, West Bengal, Assam and Haryana where Muslims are less urban than general population (percentage urban among Muslims is less than percentage urban among general population), the percentage of births in health facilities among Muslims are lower than state average. States such as Maharashtra, Andhra Pradesh, Karnataka, Kerala, Tamil Nadu, MP, where a greater proportion of the Muslim population of the state is urbanized (as compared to the general population), the percentage of births in health facility is higher than or about the same as the state average. Exceptions are Rajasthan, Gujarat and UP, where even though the Muslim population is more urban, the percentage of births in the health facility are almost equal to state average. Thus, it seems that location (whether urban/rural) is what determines whether a woman gets an institutional delivery. How Muslim women fare versus others within urban areas, however, has not been explored in the survey.

##### More likely that institution for delivery is private

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<sup>16</sup> PLEASE ALSO SEE SECTION ON II,8 UTILISATION OF PUBLIC AND PRIVATE HEALTH FACILITIES

Further it is interesting to note that unlike other religious groups, Muslims are more likely to deliver in private health facilities. As per the NFHS 2, in Maharashtra, 42.7% of Muslims delivered in private health facilities as compared to 24.2% Hindus. (Table 12)

Table 12: Place of Delivery (Public, NGO, Private, Home, Parents Home, Other) by Religion

Religion	Public	NGO/Trust	Private	Own Home	Parents' Home	Other
Hindu	22.6	0.9	24.2	27.8	23.9	0.7
Muslim	28.2	0.6	42.7	15.0	12.5	1.0
Christian	(20.3)	(10.2)	(48.9)	(0.0)	(20.7)	(0.0)
Buddhist/Neo-Buddhist	42.3	0.0	18.7	23.6	15.1	0.3

Source: NFHS 2 - Maharashtra

A deterrent to delivering in public hospitals, and towards a higher use of private health care, is the bad behaviour of health care providers in labour wards of public hospitals is well known. The experience of having to deliver at a public hospital is extremely dehumanizing. The study conducted by CEHAT Error! Bookmark not defined., showed that while both Muslim and non-Muslim women, reported being treated badly during labour. Muslim women particularly reported being called names such as 'landiyabai' which was derogatory and clearly alluded to their religious identity. Moreover, health care providers routinely passed remarks about how Muslims have many children and are irresponsible.

This behaviour plays a role in pushing Muslim women away from accessing public health facilities. For those who are able to afford it, private health care is an option. But for the others, they may be left with no choice but to deliver at home. Evidence suggests that many Muslim women, even in cities, are having home deliveries. Primary studies show that home deliveries among Muslim women still persist. In Bhiwandi, it was seen that of the 100 home deliveries that took place in the year of the study, 97 were of Muslim women and only 3 were of other religions. Despite its close proximity to hospitals, Behrampada also shows instances of home deliveries. The study reveals that that one of the reasons is the government policy of charging for delivery of a third child. The study reports that not all of these home deliveries are even assisted. As per the prevailing government rules, ante-natal and post-natal care is free at public hospitals for the first two children. However, the birth of a third child entails a payment of Rs.700 from the woman. While the fertility rate is reducing, there are still families who have more than two children, and such conditionalities reduce their access to institutional delivery in public hospitals. Given the fact that the government is unable devise a family planning programme that suits their needs, priorities and perspectives, such conditionalities seem even more harsh.

#### Poor utilization of JSY despite high utilization of pvt sector

Despite the high percentage of Muslims utilizing the private sector for deliveries, it is surprising to note that the percentage of Muslim women accessing benefits under the Janani Suraksha Yojana (JSY) is extremely low for Muslims at 2.9% as compared to 8.8% for Hindus, 10% for SCs, 16% for STs, and 7% for OBCs. (Table 13)

**Table 13: Percentage of women receiving government financial assistance for delivery care (JSY)**

		Govt Financial Assistance for Delivery Care
Religion	Hindu	8.8
	Muslim	2.9
	Christian	2.9
	Sikh	*
	Buddhist/NeoBuddhist	10.9
	Jain	3.7
	Others	0
Castes	SC	10.1
	ST	16.3
	OBC	7.0
	Others	3.6
	Maharashtra	8.3

Source: DLHS 3- Maharashtra

If people are forced to access expensive private services, it is only logical that they utilize such schemes to offset the cost. The poor utilization of the scheme therefore, may have to do with the fact that several documents such as a ration card, BPL certificate are required for accessing JSY which Muslims have trouble accessing. As per a survey conducted by Shaban et al<sup>8</sup> in Maharashtra, one fifth of Muslims in the State do not possess a ration card, which serves as a barrier to accessing government schemes.

## II. 6. Child nutrition and Immunization

### Child Nutrition

In terms of nutrition of children, we find that while fewer Muslim children are under weight and wasted, a greater percentage of them are stunted (height for age). (Table 14)

Table 14: Percentage of Children under age 5 years (for NFHS-2 children below age 3 were considered) classified as malnourished, Maharashtra

	Weight for Age(Underweight)		Height for Age (stunting)		Weight for Height (thin / wasted)	
	% Below -3SD	% Below -2SD	% Below -3SD	% Below -2SD	% Below -3SD	% Below -2SD
2005-06						
Muslim	7.9	29.1	22.0	42.0	4.1	12.2
Hindu	12.5	38.5	18.3	46.1	5.3	16.8
Total	11.9	37.0	19.1	46.3	5.2	16.5
1998-99						
Muslim	13.7	45.2	11.2	35.7	1.2	17.8
Hindu	19.4	51.4	15.4	41.8	3.1	22.8
Total	17.6	49.6	14.1	39.9	2.5	21.2

*Source: NFHS 2005-06 and 1998-99*

The percentage of children with the more severe stunting (-3SD) is greater for Muslims than Hindus as well as the state average. This is a cause of concern, since stunting is an indicator of sustained long term deprivation or repeated illnesses. Children can be “underweight” if they have suffered from an illness just prior or during the survey. Therefore while stunting is a cause for concern for children in general, it is more so for Muslims since they have higher percentage of children suffering from more serious level of stunting.

### Immunization

DLHS-3 data shows that vaccination among Muslims is higher than that for the entire state and comparable to that among other communities (Table 15). In Muslim concentrated districts too, the rates of immunization are generally higher than the state average, barring Nashik and Aurangabad (Table 16). Data from the primary studies in Bhiwandi, Behrampada and Sion-Koliwada also show that immunization coverage among the Muslim population is fairly good, with 80-90 percent of children having been immunized (Table 17). Yet, there seem to be misconceptions about acceptance of immunization by Muslims. According to the CMO of the IGM hospital in Bhiwandi, immunization of children was a big challenge because a majority of the Muslims refuse to administer their children the vaccinations including polio drops since they believe that the vaccine contains the genes of pigs. The study conducted in Bhiwandi, however, shows that 93.5% of children below 5 years were immunized! Among those who were not immunized, the fears were related to fear of getting their child immunized, due to illness among children during immunization drives and lack of time. Thus there is a dissonance between what the health care providers perceive as reasons for non-immunization and the actual reasons for the same. Similarly in Behrampada, even though the survey data showed that more than 80% children in the 2-5 year age group had been immunized, the Public Health Supervisor at the Health Post felt that there was a lack of awareness among Muslim mothers about immunization, which needed to be remedied.

Utilization of ICDS services such as availing anganwadi/balwadi facilities and supplementary food was poor among Muslims in the primary studies. For example, in Malegaon only about 16% Muslim households report any help from ICDS schemes.<sup>8</sup> In Bhiwandi, women from only 3 families availed the ICDS scheme and children from about 26% families (primary survey data and FGDs) attended the anganwadis/balwadis (Table 18). The reasons for poor utilization of these facilities needs to be explored and addressed.

### **II.7 Availability of Public and Private Health care**

A picture of Muslim-concentrated areas is provided by studies commissioned by the Minorities Commission in 4 highly populated Muslim areas –Bhiwandi, Mumbra, Malegaon, and Behrampada. The paucity of health facilities in these Muslim-majority pockets or ghettos clearly emerges from the data in these four primary studies. As per the standards proposed in the National Urban Health Mission, one Urban Health Post is required to cater to a population of 25,000-50,000 persons. In stark contrast to this, the findings from the studies are as follows (Table 19):

- Bhiwandi has 10 health posts and only one Government hospital catering to a population of about 7 lakh residents. Residents have mentioned that the hospital is unable to provide any specialized care. Only normal deliveries are performed and no

C-sections. They also mentioned that the hospital does not even have emergency facilities, ambulances or blood banks. There are no multi-speciality or tertiary care facilities and people are dependent on Mumbai or Thane for any kind of surgery.

- In Mumbra, there are 3 Urban Health posts and one maternity home that cater to a population of 8 lakh persons. Further, the few urban health posts are only open for 2 hours, 6 days in a week at a time that is inconvenient for people, which makes access extremely difficult. The only hospital is located in Kalwa and for issues that cannot be addressed there, residents have to go to Mumbai or Thane
- Malegaon with a population of 4.7 lakhs has 4 municipal dispensaries, 3 maternity homes, and 2 Municipal hospitals, along with a district hospital. However, the study mentions that the municipal hospitals largely cater to paediatric and child needs, whereas the district hospital provides very limited services.
- The study from Behrampada showed that the area had no health post for a population of 49,829 and residents had to access the health post located in Kherwadi for their needs.

**Table 19: Available health facilities in the 4 areas of primary studies**

	Population	Health Post/ Dispensaries	Maternity Home	Govt. /Mun. Hospital	Private
Bhiwandi	711329*	10 health posts		1	75 private hosp/nursing homes.
Malegaon	471006*	4 dispensaries	3	1 District + 3 Municipal	
Behrampada (H/E Ward)	663742 (ward) 49, 829 (Behrampada)	6 dispensaries+ 8 health posts	1	1	38 pvt nursing homes/ 254 practitioners
Mumbra	8 Laks approx	3 Health posts	1	None	18 pvt nursing homes and private hospitals

- Source: Primary Studies done in Malegaon, Bhiwandi, Mumbra and Mumbai, commissioned by the MSMC
- \*Data from Census 2011

It appears therefore, that the abovementioned Muslim concentrated ghettos have been systematically neglected by the state. This is also consistent with the findings of an empirical study across 17 states, including Maharashtra, which revealed that there is a high *possibility* of “existence of statistical discrimination in the outcomes of the allocation process on the basis of caste and religion. A higher proportion of Muslims in the rural area of a district leads to a lowering of the public input.”<sup>19</sup> The same study also revealed that “outcomes of the allocation process are characterized by *selectivity against* scheduled castes and Muslims who

<sup>17</sup>Betancourt R and Gleason S (1999 ): *The Allocation of Publicly Provided Goods to Rural Households in India: on Some Consequences of Caste, Religion and Democracy*, page 18. downloaded on 12/10.12 from (<http://www.econweb.umd.edu/papers/betancourt9901.pdf>)

live in rural areas of a district” (italics added).<sup>18</sup> While this study has been done in urban areas, it is likely that the same phenomenon also operates in urban areas, particularly since the representation of Muslims in the municipal corporations of these cities/towns is poor.

#### Flourishing of private health facilities

The primary studies from Muslim-concentrated areas suggest that private facilities are more in number. In Bhiwandi for instance, there were 75 private hospitals/nursing homes. According to the Survey Report of private medical practitioners in Bhiwandi, (Civic health centre, 2006-2007) amongst the private medical practitioners, over a third are Unani doctors, followed by Homeopathic and Ayurvedic, while about a tenth are allopathic doctors with an MBBS degree. Similarly in Behrampada, there were 16 private practitioners in the area, most of them having a BUMS or BHMS degree. These doctors are not qualified to provide allopathic treatment and cannot do justice in cases of emergency or acute cases. There were no specialists or super-specialist facilities available nearby (Table 19). Similarly in Mumbra, there is a severe dearth of public health facilities and a mushrooming of several private providers in the area. Because of the convenience of accessing these facilities, they are by and large the first point of seeking support. However, the cost of the facilities is quite high which people cannot afford, and they discontinue treatment unless it is something that is likely to be fatal.

### II.8 Utilization of Public and Private Health Facilities

In Maharashtra as a whole, over the years, there has been a decline in use of the public sector and an increase in utilization of the private sector. This is more so for outpatient care, than inpatient care. As per the 60<sup>th</sup> round of the NSSO, only 11 percent of urban and 16 percent of rural outpatient care and 28 percent of inpatient care is managed by the public sector.<sup>19</sup>

Data from primary studies shows that people choose to go to private or public facilities based on availability and ease of access. Bhiwandi and Mumbra have a gross dearth of health facilities and so people are left with no option but to access the private sector. In Bhiwandi for instance, almost 90% of people with minor illnesses (cough, cold, stomach problems) sought treatment from a private provider and almost 70% in case of major illnesses (malaria, TB, typhoid, asthma, heart problems, diabetes etc). In Mumbra, 76% of people reported in the survey that they access local private providers for minor illnesses. However for major illnesses they preferred to go to public health facilities located outside Mumbra (in Kalwa or Thane city), or even if they were as far as Mumbai. This probably has to do with the fact that treatment for major illnesses would be unaffordable to most people in the private sector (Table 20 & 21).

In contrast, Behrampada and Malegaon where there are some public health facilities, the studies show that, a greater number of respondents reported accessing the government health facilities. This is not, however, because they prefer the services of public health facilities, but because they cannot afford to access private facilities. In Malegaon there are Municipal dispensaries, maternity homes, and Municipal hospitals (largely paediatric and gynaecology). Government health facilities mainly include Health posts, a Rural hospital and a District

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<sup>18</sup>Ibid 24 pg. 18

<sup>19</sup> Government of Maharashtra (2002): *Human Development Report Maharashtra*, 2002.  
[http://planningcommission.nic.in/plans/stateplan/sdr\\_pdf/shdr\\_maha02.pdf](http://planningcommission.nic.in/plans/stateplan/sdr_pdf/shdr_maha02.pdf)

hospital. Other health facilities include Private General and Private Specialist clinics (mainly gynaecology and paediatric). Those who can afford private treatment avoid government health facilities. About 70% of the population in the town uses government facilities but the use among Muslims is higher than non-Muslims. Table 22 highlights the stark difference between the access for private and government health facilities between Muslims and other SRCs. This has to do with their poorer economic status which makes it difficult for them to afford even the cheapest private facilities.

A similar finding is reported in a study conducted in Mumbai slums<sup>20</sup> (See box) which found that even within the slum, the poorest people in the slum access public health facilities more than those that are better off (within the slum population itself). While religious groups were not used as an indicator in the study, socioeconomic status was classified using quartiles of standardized asset scores amongst 48 vulnerable slum localities. Of the total population studied, there were 47% Hindus and 46% Muslims. Of the 47% Hindus, only 32% were in the 1<sup>st</sup> quartile (the poorest) and 57% were in the 4<sup>th</sup> quartile. On the other hand, of the 46% Muslims in the sample, a whopping 65% were in the 1<sup>st</sup> quartile and only 34% in the 4<sup>th</sup> quartile. This means that even within the slum, the Muslims form the 'poorest of the poor' and therefore they are more likely to access public health facilities than others.

Table 23: Characteristics by cluster socio-economic quartile group of women who gave birth in urban slum communities of Mumbai (select indicators only)

Quartile groups	All (%)	1 <sup>st</sup> (%)	2 <sup>nd</sup> (%)	3 <sup>rd</sup> (%)	4 <sup>th</sup> (%)
Hindu	47	32	46	54	57
Muslim	46	65	49	36	34
Other	7	3	5	10	9

This makes the condition of the public health system extremely relevant while talking about the health care services available to Muslims. Respondents from all three studies, in Bhiwandi, Behrampada and Sion-Koliwada mentioned facing several problems at the government facilities, even as they acknowledged that this was where they accessed services. Problems such as negligence, long waiting periods, lack of medicines and pathology services were reported. In Bhiwandi respondents mentioned that government hospitals were not able to deal with even simple surgeries and they were often referred to Thane or Mumbai for treatment. Medicines were always prescribed to be bought from outside. Even for diseases like Malaria and typhoid, medicines were made available only at the time of an epidemic. The study conducted by CEHAT in Mumbai showed similar results. Women complained that although treatment was to be provided free, they routinely had to buy medicines from outside. Public health facilities also involved waiting for long periods of time. Women also reported corruption and favouritism among the staff at public hospitals. Therefore, although the women used the public health facilities, it was evident that they were not happy with the services and it was only lack of financial capacity to afford private facilities that pushed them to public facilities.

<sup>20</sup> Neena S More, Ujwala Bapat, Sushmita Das, Sarah Barnett, Anthony Costello, Armida Fernandez and David Osrin (2009): Inequalities in maternity care and newborn outcomes: one-year surveillance of births in vulnerable slum communities in Mumbai, International Journal for Equity in Health, from <http://www.equityhealthj.com/content/8/1/21>



It is pertinent to note that such problems are reported by people from all communities. There is an obligation of the State to make the Public Health System stronger and more responsive not just to Muslims, but to all those who use it – largely those who are economically deprived.

In a study conducted in Mumbai slums<sup>20</sup> examined care and differences in outcomes, between more and less deprived groups. Vulnerability was identified by social risk indicators (such as unemployment, substandard housing etc); environmental indicators such as (open drains, informal water supply etc) and health service utilisation indicators (such as infrequent interaction with community health volunteers, etc).

The data revealed that the woman who is relatively better off than her more poorer counterparts in the slums performs better across all indicators. She is more likely to be literate, less likely to be married below the age of 20, has a higher likelihood of being over 20 years of age at the time of her first pregnancy, more likely to have received antenatal care (including tetanus toxoid injections and IFA tablets). A woman in a slum who is relatively better off than the other families in the slums itself is also more likely to have received postnatal care and there were higher chances for her receiving private medical care. Thus even within the less better off in a city slum, the ones in the comparatively “better off” strata access public health facilities less than the more disadvantaged ones. Moreover, even within this narrow range of socio-economic advantage and disadvantage within the slum population, even the neonatal mortality rate differs with the women in the higher 4<sup>th</sup> quartile (least poor) faring better.

What is important to note is that a disproportionately large percentage of those in the poorest quintile were Muslims. Putting it across this way, the above indicators could clearly reflect the state of Muslims in urban slums, and that they are worse off than Hindus staying under similar conditions. Therefore, with “the environment” remaining the same, giving a level playing field in terms of access to employment, education, health facilities, etc; why are the Muslims still faring worse off than the Hindus? Why are they more vulnerable? Is this because of discrimination? Is it that the fact that they live in ghettos led to increasing their vulnerability? Is it because these opportunities and services are not in tune to their needs and culture and therefore require more proactive efforts? Or is there simply a lack of mutual trust that required confidence building measures?

## **II.9 Morbidity related to Living Conditions**

The environment, in which we live, quite obviously, affects health in several ways. Ventilated, safe housing, good sanitation and adequate drinking water are some of the basic prerequisites for a healthy life. In this context, it is important to address the living conditions of Muslims in Maharashtra and the impact it is likely to have on their health.

### **Living Conditions in the Ghettos**

At the outset, it would be pertinent to point out that a disproportionately large number of Muslims live in slums. According to the evidence put out by Shaban et al, 70% of Muslims in the state of Maharashtra live in urban areas; about 60% of these stay in slums and another 30% in lower caste areas (Table 24). While there are no estimates about what proportion of the Muslim population live in ghettos and what proportion of these ghettos are slums, it would be safe to assume from this data that it would be a large percentage.

**Table 24: Distribution of Muslim Households by type of Neighbourhood in Urban Areas**

Type of neighbourhood	Slum	Low Income Area	Middle Income Area	High Income Area	Mixed
% of households	57.7%	31.3%	9.1%	1.6%	0.3%

*Source: Shaban 2011, Sample Survey, 2009.*

In this section we draw on data from the primary studies in Malegaon, Mumbra, Bhiwandi and Behrampada, as well as the survey conducted by Shaban et al to describe the living conditions in the areas where Muslims are concentrated. We simultaneously also make an effort to understand how these living conditions may impact health.

The general appearance of the slums and amenities, as described in the primary studies, provides a stark picture of deprivation and neglect. In Malegaon, Muslim localities have narrow roads and congested houses. The houses consist mostly of kuccha houses. In Behrampada, the housing consists of several huts with one storey perched precariously on the other – some times as high as 4 storeys – a clear safety hazard.

*Water problems:* With respect to drinking water, Shaban finds that a substantial percentage (12-13 percent) of households in Mumbai, Thane and Nashik rely on purchased water for their daily needs. This is because there is inadequate supply of potable municipal water. In Bhiwandi (with 50 percent of the population being Muslims) for instance, the estimated current supply is 110 mld per day, while, with a population of 10 lakhs, it should be at least 150 mld per day. This indicates that there is a shortfall of more than 25%. In the survey which covered 14 slums, none of the communities had municipal water connections and had to make do with private connections. Only 28% of respondents reported getting water from a public municipal tap and the water that comes through the municipal taps comes only late in the night. Most communities surveyed in the city therefore relied on private connections, public taps or private tankers for water, the potability of which was suspect particularly in the monsoons. Similarly in Behrampada, there are only six communal taps for about 60,000 families, and they too get water pressure only between three and five am. Further, most water pipes run through open sewers, making it easy for contaminants to seep in.

*Sanitation:* In Bhiwandi, current system of drainage covers only 30% of the city, rest lacks proper drainage. Waste management systems are inadequate in the city and there is a conflict over the place where waste is to be deposited. Also, no biomedical waste management facility is there in Bhiwandi and all waste is transported to Kalyan for treatment and disposal. The slaughter houses have no waste management facility – the Maharashtra Pollution Control board has objected to the absence of a waste management facility and has also filed a criminal case against the municipal corporation under provisions of the EPA. However no action has been taken.

In Malegaon, a large part of the city does not have underground sewage system, most of it is open and prone to blockage. There is frequent flooding even with little rainfall and the water logging causes breeding of mosquitoes. Similarly, Behrampada is surrounded and intercepted by open gutters, which provides fertile ground for breeding of mosquitoes.

*Toilets:* In Bhiwandi and Behrampada there is a dearth of toilets and so children as well as adults often have to defecate in the open or in the gutters. In Behrampada 21% of the

households had private toilets attached to their houses, 76.80% used public toilets, and 2% used paid public toilets. The number of toilets is inadequate, particularly for women who have to leave early in the morning and wait in long queues. Fights over use of the toilets were reported to be common. Condition of toilets is filthy due to clogging of drains. Further, the same area also has to be used for washing of utensils.

#### Impact on health as a result of poor living environment

The picture emerging from the abovementioned studies shows that the condition of Muslim dominated ghettos vis-à-vis water, sanitation and housing facilities is extremely poor in the state of Maharashtra. The poor living environment in the ghettos provides a breeding ground for several communicable diseases. In the primary studies from Malegaon, Bhiwandi, Behrampada and Sion-Koliwada, it was seen that between 60 to 90 percent of respondents reported having suffered from a minor illness in the past year. Common minor illnesses included viral fever, cough, cold and stomach problems. Most commonly occurring serious illnesses in all four studies were Malaria and Tuberculosis. The prevalence varied across regions, however. In certain areas like Bhiwandi, 30 percent of the families reported having a member who suffered from Malaria in the past year and one in ten reported a case of Tuberculosis in the family. In Behrampada, malaria was reported by about 10 percent of the families and tuberculosis by less than 5 percent (Table 25). Other serious illnesses included jaundice, typhoid, and non-communicable diseases like diabetes, asthma and cardiac problems. The high prevalence of infectious diseases like malaria and TB has been attributed to the congested living environments which are a feature of most slums in which urban Muslims reside. Lack of sanitation, and systematic neglect by municipal authorities results in easy spread of infections.

Living environment and lack of potable water can also be linked to the fact that in places like Malegaon, 45.4% of total recorded deaths among Muslims are in the age group below 5 years and these are largely due to pneumonia and diarrhoea. Indeed, in Maharashtra, as per the NFHS 2, percentage of children having suffered diarrhoea in the two weeks prior to the survey was 35.7% among Muslims, as compared to 23.4 among Hindus and 23.1 among Christians. It is further important to note that this percentage was even greater than the percentage of children with diarrhoea in Mumbai's slums. Interestingly, the percentage of children with diarrhoea in slum and non-slum areas of Mumbai does not vary by more than 2 percentage points, but that of Muslims with diarrhoea is certainly higher than both these. This evidence, coupled with other problems such as malnutrition (among infants (<1 year), in Malegaon, malnutrition was the major cause of death) also provides some explanation for why the Infant Mortality Rate among Muslims in urban areas is higher than it is for other groups.

#### **Occupational hazards:**

As has been discussed before, at the national level, 84.5% of Muslims constitute the most poor and vulnerable category of unorganised workers. While the SC/ST population is protected to some extent by affirmative action by the government, Muslims on the other hand are overwhelmingly concentrated in the unorganised sector and in self – employment activities to meet their livelihood needs. The workers in the unorganised sector survive at a bare subsistence level, with no security, working under unhygienic and miserable conditions. This trend is replicated in Maharashtra as well. In Bhiwandi and Malegaon, most people are employed in powerlooms/hand-looms where there is no proper ventilation and breathing lint

causes respiratory problems. In Malegaon, Tuberculosis is the major cause of death among women persons aged 6-14 years, 15-35 years, and the third most common cause of death among women aged 36 to 55 years. Among men, Tuberculosis was the cause of death mostly in the 15-35 and 36 to 55 years age group. Similarly in Bhiwandi, TB was the cause of deaths in 11.5 percent of individuals. In Mumbra, the two Urban Health Centers together reported about 250 new cases of Tuberculosis every year. Coupled with occupational issues, the high prevalence of TB could also be attributed to the congested living environment.

Further, it is also important to note that Muslims have one of the highest incidences of child labour in India. Nine states have been identified in the report with a high incidence of child labour. Maharashtra is one of them. Maharashtra, however, does not figure in the states with the highest percentage of out of school children. Child deprivation on the other hand is more pervasive, and is significant across all states except Kerala, TN and HP. The link between economic and social deprivation and child labour has been clearly established, and given the deprivation that Muslims face, this is not surprising. In fact, the incidence of child labour and child deprivation is high in Muslims, higher than Hindu SCs. In fact the Human Development Report (2011) has categorically stated that the pace of decline in child labour is also the slowest among Muslims.<sup>21</sup> One of the sectors where children work in Maharashtra are in the balloon factories of Dahanu. While there is no estimates of how many are Muslims, it is suffice to say that there are children working in this hazardous industry. In these factories includes mixing rubber with chemicals, colouring balloons and testing each balloon with gas. The factories are cramped and poorly ventilated. They work 9 hours a day and 6 days a week. The children are exposed to ammonia, fumes of acetic acid and French chalk. Health hazards include burning of the respiratory lining leading to pneumonia, bronchopneumonia even heart failure. Visitors are advised not to enter due to fear of choking in the fumes and children as young as 8 years are found to work here<sup>22</sup>.

## **II.10 Prejudice among health care providers**

The behaviour of health care providers in the public health system is generally known to be insensitive. Various studies conducted in Maharashtra have noted that the behaviour of staff at hospitals is rude. Patients have reported that health care providers speak without any respect for patients. Doctors often speak in English and do not explain what ailment women are suffering from, nor do they explain the medications that need to be taken. Further, incidents of verbal and physical abuse in the labour ward have also been reported; women are beaten and scolded to make them bear down the pain. Such behaviour encountered by people at public health facilities is in itself highly objectionable. The right to health includes the aspect of acceptability and quality – health services must not just be available and accessible, but also respect the dignity of patients.

In addition to this pervasive insensitivity of health care providers, there is an added layer of prejudice towards people from the Muslim community. Evidence from the primary studies conducted particularly in Bhiwandi, Behrampada and the CEHAT study in Mumbai show that there are deep rooted religion-based prejudices among health care providers. Focussed

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<sup>21</sup> GOI (2011): *India Human Development Report*, Institute of Applied Manpower Research, Planning Commission, Government of India, accessed on 21/10/2012 from [http://www.pratirodh.com/pdf/human\\_development\\_report2011.pdf](http://www.pratirodh.com/pdf/human_development_report2011.pdf)

<sup>22</sup> Combating Child Labour Legal Approach, Volume 4 By S Walbooks. [google.co.in/books?isbn=8176256366](http://google.co.in/books?isbn=8176256366)

group discussions showed that women felt that they were treated differently from women of the majority community. Muslim women reported that the manner in which they were spoken to at the health facility was different from how health care providers spoke to people of their ‘own’ community. This feeling of ‘otherness’ was perpetuated by the fact that HCPs would refuse to pronounce or spell Muslim names correctly.

Muslim women have also reported that they are called names with a derogatory connotation, such as ‘landiyabai’ (wife of circumcised man) at health facilities. They are referred to as ‘ladaku log’ (aggressive people) if they refuse to remove the burqa.

Moreover, women have expressed that it is the wearing of the burqa that brings about a change in attitude of the hospital staff.

*“They look at the veil and they make a face; feel irritated. They feel that we are dirty underneath the veil. They ask us to remove it the minute we enter the hospital. Nowadays in certain hospitals they do not allow women with veils. They say that women in veils steal children. Someone may have done it, but is it right to label the entire community because of one act?”*

The women were very aware of the stereotypes that health care providers had about them – that Muslims have too many children, they are dirty and uneducated. Indeed, these misconceptions are common among health care providers. In Behrampada, one health worker mentioned that Muslims tend to have more TB because they eat beef which may result in transmission of Bovine TB!

Table 26: Experiences of women while accessing public health facilities

<b>Faced by</b>	<b>Description of behaviour</b>
All women	<ol style="list-style-type: none"> <li>1. Rude language</li> <li>2. Corruption to jump the queue</li> <li>3. Abuse in labour ward – made to clean floors, physical and verbal abuse, no privacy</li> <li>4. Behaving badly towards accompanying persons</li> <li>5. Health care providers use English which is not understood by the patient population</li> </ol>
Muslim Women	<ol style="list-style-type: none"> <li>1. Use of derogatory remarks about women married to circumcised men, “Landiya baika”</li> <li>2. Being singled out as “ Musalman aurat” creating a negative impression</li> <li>3. Refusal to understand and comprehend Muslim names</li> <li>4. Asked to remove veil even before the turn for examination</li> <li>5. Taunted as dramatic women because of inhibitions to remove burqa</li> <li>6. Biases that Burqa clad women steal children.</li> <li>7. Stereotypical remarks               <ol style="list-style-type: none"> <li>a. Muslim women have many children</li> <li>b. Muslim people are uneducated</li> <li>c. Muslim women refuse to use contraception</li> <li>d. Muslim people are dirty</li> </ol> </li> </ol>

*Source: The above table is based on data collected as part of a study exploring Muslim women’s experiences of discrimination while accessing public health facilities. The study was*

*on Muslim women's experiences of discrimination while accessing health facilities. The study was conducted in a Muslim dominated slum in Mumbai. Eight Focus Group Discussions were conducted with Muslim and non-Muslim women to explore their experiences with health facilities.*

These experiences have deterred women from accessing public health facilities, and therefore should be a cause of worry. This ignorance and acceptance of such misconceptions among health care providers needs to be addressed urgently. Such experiences have also been reported by Muslims with other public institutions. For instance, during the focus group discussions in the study done in Behrampada, parents reported the biases of the teachers against their community. "One parent reported that when her son went to school after an absence of a day, the teacher snidely remarked that he must have gone to attend his father's second marriage, and hence he did not come to school."

The linkages between discrimination and health are only just beginning to be explored in the Indian context, but evidence from the West suggests that the lifetime exposure to discrimination is associated with poor health outcomes, as well as poor health seeking behaviour (increased delays in seeking health care and poor adherence to treatment regimes) and poor utilization.<sup>23</sup> With respect to religious minorities in India, these are some areas that need further exploration as the behavior of providers with people from these groups has been reported in studies. The impact that it has on their health seeking behaviour and health status needs to be considered more seriously and remedied.

Further, it is not just prejudice based on religion, but also that based on caste that needs to be checked. Non-discriminatory, dignified, acceptable health services are a right of people from all communities and the State must make efforts to ensure that providers are culturally competent and respectful to people of all faiths. In fact, the National Commission for Religious and Linguistic Minorities mandates that in regions where more than 30% of a population speaks a specific language, all persons employed in public services must also speak the language. This means that in places like Bhiwandi where 50% of the population is Urdu speaking, health care providers (by virtue of being public sector employees) must also be fluent in the language. This is one of the many ways in which health services can be made culturally sensitive to the needs of the Muslim community.

## **II.11Mental Health**

The mental health of Muslims in Maharashtra and religious minorities in India, in general has received little attention in literature. Given the marginalization, discrimination, bias that this group faces, it is likely that mental health has suffered both as a direct impact of riots as well as day-to-day experiences. While Maharashtra has witnessed several riots in which Muslims have been targeted, the long-term impact on mental health has not been studied. However, the mental health impact has been reported anecdotally. A team of psychiatrists who visited Gujarat in the period immediately following the pogrom of 2002 report that people commonly complained of insomnia, startle reactions, fearfulness, intrusive memories and sadness. The commonest coping method, they found, was prayer.<sup>24</sup> There has been no study

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<sup>23</sup>Casagrande S S, Gary T L, LaVeist T A, Gaskin D J, and Cooper L A *Perceived Discrimination and Adherence to Medical Care in a Racially Integrated Community*; J Gen Intern Med. 2007 March; 22(3): 389–395.

<sup>24</sup>Shetty H (2002): "Response of mental health professionals in Gujarat", *Issues in Medical Ethics*; 10 (3).

to examine the long term impact of such incidences on the mental health of people, nor any remedial measures implemented.

In addition to the impact of riots, the constant harassment by the police and tarnishing of the image of the community has resulted in Muslims living in constant fear of being picked up and charged on flimsy counts. This clearly has an impact on their day-to-day functioning and their mental health.

This impact needs to be documented more systematically, as it has in the West, to understand the extent of this discrimination and the true burden that such discrimination is likely to have on one's mental health. In the United States, for instance, a study examined associations between abuse or discrimination and psychological distress, level of happiness, and health status among Arab American adults after September 11, 2001.<sup>25</sup> It found that Personal bad experiences related to ethnicity were associated with increased psychological distress and reduced happiness. Perceptions of not being respected within US society and greater reported effects of September 11 with respect to personal security and safety were associated with higher levels of psychological distress.

### **III. Recommendations**

What the paper has clearly established is this fact – a large percentage of Muslims in Maharashtra live in a strong context of alienation, deprivation and insecurity. This has affected their lives and prospects in every aspect; health, education, livelihood; pushing them into the spiralling cycle of more deprivation and ill-health. The mainstream indicators of health by themselves in no way capture any of this. On the contrary they actually expose the inadequacies of the state and the health system to understand and address the needs of the minority population.

At the start of this paper, we highlighted the link between social determinants and health. Throughout the paper we have made an attempt to make sense of the indicators on the basis of the prevailing context of the Muslims. In order to achieve health equity in general and for Muslims in particular, efforts need to be put into improving the conditions of daily life – the conditions and circumstances under which people are born live and work. It is also essential to develop a knowledgebase and expertise on the social determinants of health to enable addressing the same<sup>26</sup>.

In order that the conditions of daily life for Muslims be improved, it is essential that Muslim ghettos and their development receive special focus. Living in such debilitating conditions is itself a violation. They are forced to live in ghettos and are not living there as a matter of choice. Therefore, state must take concrete steps towards improving the living environment through ensuring better housing, clean surroundings, better drainage and access to potable water.

### **Recommendations for the Health System:**

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<sup>25</sup>Padela A and Heisler M (2010) “The Association of Perceived Abuse and Discrimination After September 11, 2001, With Psychological Distress, Level of Happiness, and Health Status Among Arab Americans” *Am J Public Health*. 100(2): 284–291.

<sup>26</sup> WHO (2008): *Closing the gap in a generation*, from [who.int/publications/2008/9789241563703\\_eng.pdf](http://who.int/publications/2008/9789241563703_eng.pdf) on 18.10.2012.

1. Availability of Public Health Facilities: Urbanization of Muslims has not led them to have better access to health services or infrastructure in Maharashtra. Public health facilities in areas such as Bhiwandi and Mumbra, are virtually absent and people are left with no option but to access the private sector. The public health services are clearly inadequate to provide services to these pockets. Specific measures in terms of setting up new services, deploying human resources are urgently required. Even for basic health services, the Muslim population has to rely on the private health sector due to absence of any public health facilities. Even ANC coverage which is part of the essential public health package, is poor with a large number of Muslim women registering at the private health sector.
2. There is strong evidence that HCPs carry biases/prejudices against the Muslims, such as non-acceptance of family planning methods and immunization, having four wives and multiple children, not taking bath, being aggressive/terrorists and so on. This is a matter of serious concern as it acts as a deterrent for Muslims to access government facilities. The biases are so strong that the health officials have actually said that immunization and family planning indicators in these specific areas are poor even though the figures provided by them show the opposite. The Directorate of Medical Education and Research must address these stereotypes and biases of their staff at all levels by providing concrete evidence. In addition to these biases, there are reports of derogatory behaviour against Muslim women. All of these need to be addressed through sensitization of health care providers and providing channels for redress.
3. The family planning services offered too need to be in keeping with the needs of the population. Not only are services offered not culturally sensitive (providing only sterilization services when spacing is what people want), but health care providers harbour several biases against the Muslim community.
4. There is a need to improve access to health related schemes such as the Janani Suraksha Yojana is required. The causes for poor utilization of the scheme among Muslims need to be explored and addressed.
5. The disincentive for third and more deliveries reduces access to public health facilities for maternal care and should be abolished.
6. Primary studies have provided evidence of hazardous working conditions in most areas such as Bhiwandi, Malegaon (for those working in power looms) and Behrampada (garment and zari industry) leading to adverse health conditions. Specific interventions to address these are required. There also needs to be aggressive and concerted efforts to address child labour in the state.
9. There is also evidence of minimal ICDS coverage and poor outreach of Anganwadi/Balwadi centres. Efforts must be made to increase this as it impinges on health of the community.
8. Urban areas are dominated with a huge private sector which remains inaccessible to the poor and marginalised mainly due to cost. And where they are accessed by the poor, it is accompanied with poor returns in terms of health care for the costs incurred, leading to further impoverishment. Urban health planning is essential and a



well-developed referral system with a focus on primary health care is essential. There is also the need to have the private sector more accountable.

Nagging questions/unanswered question: General health indicators do not explain the status of Muslims especially the impact of the acute deprivation of a large proportion of them that is clearly evident in the contexts that they live in. For instance, why does the infant mortality rate of the Muslims not get the advantage of them being urbanized? Or what explains the better nutritional status of Muslims as reflected from the NFHS data, versus the NSSO data which clearly reflects as them being highly calorie deficient? Other aspects of impact of religious discrimination on health too need to be explored, for instance, mental health. The negative image of the community, everyday experiences of discrimination from various quarters and harassment by law enforcement agencies are bound to have a poor impact on mental health, but there is no focus on this aspect of health at all.

## ANNEXURE

**Table 1: Childhood Mortality Rates by background characteristics**

		NN	IMR	Child Mortality	U-5 MR
Religion	Hindus	37.9	49.0	9.3	57.8
	Muslims	21.3	25.9	2.8	28.6
	Buddhist/Neo-buddhist	43.8	51.7	10.3	61.5
	Other				
Caste	SC	35.8	45.2	5.2	50.2
	ST	32.5	51.4	19.4	69.8
	OBC	39.4	50.6	7.6	57.8
	Other	34.3	40.5	7.1	47.4
Wealth Quintile	Lowest	71.6	95.6	23.5	116.8
	Second	32.5	37.1	6.33	43.1
	Middle	41.3	52.3	6.2	58.1
	Fourth	26.7	36.4	5.6	41.8
	Highest	22.9	27.4	6.4	33.6
Total	Total	35.6	45.3	8.5	53.4

NFHS 3 - Maharashtra

**Table 2: District wise Infant Mortality**

	IMR
Thane	29
Nashik	28
Aurangabad	35
Akola	32
Parbhani	32
Mumbai (2007)	33
State	31

Source: Maharashtra SHSRC report

**Table 11a: Profile of women delivering in health facility**

Religion		% of women who delivered in a health facility
	Hindu	61.0
	Muslim	78.6
	Christian	67.3
	Sikh	*
	Buddhist/Neo-Buddhist	68.1
	Jain	97.9
	Other	44.3
Caste	Scheduled Caste	67.2
	Scheduled Tribe	34
	Other Backward Class	70
	Other	74
Wealth Quintile	Lowest	26.3
	Second	44.1
	Middle	58.4
	Fourth	73.7
	Highest	91.5
	Total	63.5

Source: DLHS 3- Maharashtra

**Table 11b: Place of Delivery by District**

Dist	percentage of women who had institutional deliveries
Thane	71.7
Nashik	63.5
Parbhani	64.6
Aurangabad	65.8
Akola	74.3
Mumbai Suburban	93.5
Mumbai	92.1
Maharashtra (15-	

49)	63.5
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Source: DLHS 3- Maharashtra

**Table 15: Immunization among Children below six years**

Religion		% of children who received full vaccination
	Hindu	69.4
	Muslim	63.9
	Christian	47.1
	Sikh	
	Buddhist/Neo-Buddhist	76
	Other	64.7
Caste	Scheduled Caste	69.9
	Scheduled Tribe	52.2
	Other Backward Class	74.5
	Other	75.0
	Lowest	43.2
Wealth Quintile	Second	57.5
	Middle	69.4
	Fourth	72.7
	Highest	80.7
	Total	69

Source: DLHS 3- Maharashtra

**Table 16: Immunization by district**

	Percentage of children aged 12-23 months who received full vaccination
Akola	72.6
Aurangabad	61.8
Nashik	68
Parbhani	71.6
Thane	73.6
Mumbai - Suburban	84.7
Mumbai	76.7
Maharashtra	69

Source: DLHS 3- Maharashtra

**Table 17: Immunization and ICDS rates as per primary studies**

Place	Immunization	Birth registrations	ICDS coverage/ No. Of women monitored
Malegaon			155 functioning centres (16% households covered)
Bhiwandi	93.46	91.13%	3
Behrampada	>80%	88.52%	6
Sion-Koliwada	>80%	100%	3

Source: Primary Studies done in Malegaon, Bhiwandi and Mumbai, commissioned by the MSMC

**Table 20: Preferred treatment for non-serious illnesses**

	Behrampada	Sion-Koliwada	Bhiwandi
Govt	77%	21.7%	11%
Private	36%	33%	88%
Private and public	25%	---	---
Other	0.5	5%	3%

Source: Primary Studies done in Bhiwandi and Mumbai, commissioned by the MSMC

**Table 21: Preferred treatment for serious illnesses**

	Behrampada	Sion-Koliwada	Bhiwandi
Govt	71%	47%	22%
Private	24%	43%	69%
Private and public	--	---	8%
Other	5%	10%	1%

Source: Primary Studies done in Bhiwandi and Mumbai, commissioned by the MSMC

**Table 22: Health facility accessed by people in Malegaon, by religion**

	Private	Public	Other
All religions	30.5	69.4	0.1
All Muslims	25.9	74	0.1
Muslim OBCs	28.9	71	0.1
Non-Muslims	49	51	0

Source: Primary Study done in Malegaon, commissioned by the MSMC

**Table 25: Common and serious illnesses reported**

	Behrampada	Sion-Koliwada	Bhiwandi
Common illnesses	90%	99%	62%
Serious illnesses	22%	12%	43%
Malaria	9%	9.2%	30.6%
TB	4%	---	4%
HIV	0.4%	---	---
Asthma	1.2%	0.04%	1.4%
Heart Problem	2.8%	0.04%	1.8%
Diabetes	1.6%	0.04%	1.6%
Others	3.6%	1.6%	6.5%

*Source: Primary Studies done in Bhiwandi and Mumbai, commissioned by the MSMC*