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Exploring Religious Discrimination Toward Women in Public Health Facilities in Mumbai

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Abstract: The rise in communally driven identity politics in India during the past two decades has led to an increasing number of communal flare-ups in the country, State institutions have been found to be complicit in many cases, raising questions on the secular nature of the state. In the two major instances of communal violence in the past two decades - the 1992-1993 Mumbai riots following the Babri Masjid demolition and the 2002 post-Godhra riots in Gujarat - the involvement of the police force has been explicitly noted by Judicial Enquiry Commissions as well as fact-finding reports. As with the police system, the health system too has displayed biases towards minority communities during communal riots. This departure from a neutral role in times of communal riots points to the extent to which communal elements have seeped into even the health machinery. In addition to this active bias and discrimination perpetrated during communal riots, we at CEHAT (Centre for Enquiry into Health and Allied Themes) hypothesize that discriminatory treatment by health facilities operates in times of peace as well, and women belonging to the minority community face such discrimination on a regular basis. Studies show that the experience of discrimination has an impact on people's health and sense of well-being. Discrimination by health care providers at health facilities results not only in poor health outcomes for vulnerable groups but also reduces compliance with treatment and serves as a barrier to accessing medical care. India is signatory to several human rights treaties that explicitly forbid prejudice and bias in the provision of services. By virtue of being a signatory to these human rights treaties, the Indian State is committed to provide health services and end all forms of discrimination in the health facilities. It therefore becomes important to understand the overt and covert functioning of religious based discrimination in the area of health. Health professionals and health systems need to recognize that women face multiple forms of discrimination based on caste, class and community and therefore take additional steps to ensure unbiased delivery of services.

Keywords: Women, Minorities, Muslims, Discrimination, Communalism, Public Health

1. Introduction

The link between discrimination and health is a close yet complex one. The studies in the West show that the experience of discrimination has an impact on people's health and sense of well-being. Discrimination by health care providers at health facilities results not only in poor health outcomes for vulnerable groups but also reduces compliance with treatment and serves as a barrier to accessing medical care. In the Indian context, discrimination against patients of the minority community has been documented for health systems in times of riots, but how it operates in times of apparent peace has not been understood sufficiently. Further, there is no effort underway to address these communal biases.

A review of literature on Muslim women's health indicates that a substantial proportion is concerned primarily with their fertility and use of contraceptives. There are a few studies that have gone beyond this to understand the overall health of Muslim women. MWS has attempted to understand differences between Hindu and Muslim women in their health seeking behaviour and decision making powers with respect to health care. This survey questioned women about their reasons for not accessing public health facilities, but since it was a quantitative study, the opportunity to explore the role that discrimination plays in deterring access to health facilities was lost. To the best of our knowledge, no study so

far, has examined the way in which discrimination operates in patient provider interactions, and the role that biased behaviour plays in deterring access to public health facilities in times of peace.

CEHAT's experience of training health care providers on the issue of violence against women for the past eight years has revealed that communal biases exist among them. In 2001, when Dilaasa, a public hospital based crisis centre was initiated, exploratory formative research was carried out that sought to understand providers' perspectives towards domestic violence. This study revealed the biases and stereotypes that exist towards the Muslim and bhaiyya communities. The belief that domestic violence was more common among Muslims than among Hindus and that Muslims have big families because they are reluctant to use contraception was prevalent among providers.

As the communal undertones in the country gradually increase, it is of importance that we analyse how these processes play out in the utilization of public services for Muslim minorities. The manner in which communal discrimination from public health institutions operates at a micro level needs to be systematically studied so that appropriate measures may be taken to correct it and thereby improve the quality of services provided to Muslim women.

State institutions have been found to be complicit in many cases, raising questions on the secular nature of the state. In the two major instances of communal violence in the past two decades - the 1992-1993 Mumbai riots following the Babri Masjid demolition and the 2002 post-Godhra riots in Gujarat - the involvement of the police force has been explicitly noted by Judicial Enquiry Commissions as well as fact-finding reports. These include actively being part of the rioting mob, not taking action against rioters, refusal to register police complaints against rioters and even biased investigations. As with the police system, the health system too has displayed biases towards minority communities during communal riots. This departure from a neutral role in times of communal riots points to the extent to which communal elements have seeped into even the health machinery.

A report on the health situation following the Gujarat riots of 2002, [3] describes the lapse in the health professionals' role: It is apparent that while the hospitals have largely been non-discriminatory, they have been unable to mobilize support to protect their non-partisan and humanitarian role. [1] The nature of violence perpetrated against women in the riots and the impact of such violence on women cannot be overstated. Health professionals failed to perform their legal duties in a neutral manner, compromising the hope for justice for the victims. Reports have also highlighted the polarization that has occurred in the medical community as a result of a growing communal identity.

In addition to this active bias and discrimination perpetrated during communal riots, we at CEHAT hypothesize that discriminatory treatment by health facilities operates in times of peace as well, and women belonging to the minority community face such discrimination. CEHAT's [2] work with health care providers in the Municipal Corporation of Greater Mumbai (MCGM) has shown that health care providers do harbour communal biases and stereotypes related to the Muslim community. The Sachar Committee report, based on discussions with representatives from the Muslim community, has reported that Muslim women prefer not to access health facilities due to the unacceptable behaviour that they encounter. [3]

2. Methodology

2.1. Methodological Approach

In an attempt to understand women's experience of religious prejudice during interactions with the health system and their perceptions of how religious identity affects the manner in which health care providers behave with them, we reviewed literature on racial discrimination in health services from the West. Studies have utilised both qualitative and quantitative methodologies to understand and measure discrimination.

In the Indian context, where so little is known about how religious discrimination operates in the patient-provider interaction, what was warranted was an exploratory study rather than one that measured discrimination. The methodology that allowed for this was a qualitative one. We were able to locate a few focus group and in-depth interview studies conducted with minority populations to understand whether they perceived discrimination in the health system, and why. Two focus group studies conducted by the Institute of Medicine and Kaiser Family Foundation are landmark studies in this regard. They chronicle African American and other minority women's experiences with health care providers and are able to portray what made them feel they were discriminated against. Benkert & Peters studied 20 African American women's experiences of racial prejudice in the health setting and explored ways of coping among them. [4] This study used an in-depth interview guide and employed a constructivist approach to understand how African American women perceived the way they were treated at health facilities. We felt that using such a qualitative method would provide the opportunity to delve into women's experiences and perceptions of discrimination and thus chose this over a quantitative approach.

2.2. Religious Discrimination: Operationalization

This study primarily focussed on studying discrimination on the basis of religion. It proceeded with the assumption that discrimination on the basis of gender and poverty exists in health facilities and that there is a need to go beyond this to study discrimination based only on religion. For this purpose, an effort was made to select two communities (Muslim and non-Muslim) as similar as possible in their socioeconomic status. An effort was made to match women of the two communities as closely as possible so that only religion separated them.

2.3. Selection of Research Area

Various areas in Mumbai were explored where Muslims and non-Muslims lived in the same community, but in different pockets. Prominent organisations working in the areas were contacted and communities visited. A community in the western suburbs was finally selected due to its mixed population, as well as its proximity to public health facilities. Prior to fieldwork, the team contacted three different organisations working in the area of health and women's rights, to assess the feasibility of the study. These organisations ran Mahila Mandals (women's organisations) and other advocacy programs in the community and were able to help us mobilize participants for the study. They also played a role in helping us understand the area of study and the experiences of women in public health facilities, which were critical to developing the tool.

2.4. Development of the Study Tool

In the Indian context, because religious discrimination in the health facilities has not been systematically studied, the first task was to uncover the meaning of discrimination as would be understood by the community. Bedh bhav was the term closest to discrimination in Hindi. The next step was to figure how one could elicit/uncover discrimination at the health facilities. The most extreme violation would be denial of services by the health care providers or health facilities, based on religious identity. This extreme form, as we know from experience, is not how discrimination operates, at least in times of peace in the city of Mumbai. Another way to elicit discrimination would be to look at differences in treatment provided to patients based solely on their religious identity. Such differences would be impossible to capture because of poor record-keeping in the Indian context. What we needed to depend on therefore, was women's reports of their experiences of discrimination.

The team carried out an exercise on deconstructing discrimination. Health care providers from the public health system who have been sensitized to the issue of communalism were spoken to, to understand the biases that health care providers tend to harbour towards religious minorities, and how these are demonstrated in interactions with patients. We also interacted with community based organisations working in Muslim communities, to understand the kinds of problems that women from their communities faced when they accessed public health facilities. Based on these conversations and our own understanding, a guide was developed for deconstructing discrimination.

2.5. Methods of Data Collection

Focus Group Discussions, In-depth Interviews and Key Informant Interviews were used as tools for data collection in this study.

2.6. Research Objectives

To conduct an exploratory study to understand:

1. The nature of discrimination in health facilities/the nature of religious discrimination in health facilities
2. How Muslim women experience discrimination in health facilities
3. How discrimination faced by Muslim women influences their utilization of health services.

3. Rise of Communalism in Indian Society

The very origin of the modern Indian State is marred by the occurrence of communal riots. Massive communal riots that broke out post-partition claimed 2 million lives and around 12-14 million people were forcibly driven from their homes. Millions of Muslims were driven out of India, and Hindus and Sikhs from Pakistan, in the violent exchange between the newly formed independent states of India and Pakistan. Post- independence, riots have occurred across the country, although their character has changed. [5] Tracing the history of communal disturbance in India, eminent journalist Kuldip Nayar, has recorded 5,000 such occurrences till 1980. [6] He remarks that communal disturbances have been taking place unabated and are acquiring greater ferocity. Commenting on the change of nature of communal riots in India, A. R. Desai states that during the 1950s communal riots were more a result of sudden outbursts of group violence. [7] From the 1960s they were more systematically engineered. The numbers of lives lost have been increasing. The decade 1950-60s witnessed a death toll of 316, while 301 people died in communal riots in 1967; 1969- 1970 alone saw a death toll of above 800 people. Eminent writers and journalist note that not only was the death toll rising but increasingly the majority of people dying were Muslims and also the destruction of property was more of Muslims than of Hindus. [7] This trend has continued and the worst was the 2002 Gujarat riots which according to an official estimate, saw the killing of 1044 people - 790 Muslims and 254 Hindus including those killed in the Godhra train fire. Another 223 people were reported missing, 2,548 injured, 919 women widowed and 606 children orphaned. About 100,000 Muslims and 40,000 Hindus were in relief camps. [8]

Another trend noted during the riots has been the active connivance or passive inaction of the State, specifically the police force. During riots, the police have failed to do their duty in registering cases against offenders and protecting victims. Referring to the role of the police in the 1992-93 riots in Mumbai, the Sri Krishna Commission Report notes, The bias of policemen was seen in the active connivance of police constables with the rioting Hindu mobs, on occasions, with their adopting the role of passive on-lookers on occasions, and, finally, their lack of enthusiasm in registering offenses against Hindus even when the accused was clearly identified. [9]

4. Review of Literature

4.1. Rise of Communalism and Ghettoization in Mumbai

Muslims have lived in Mumbai for about 700 years. Currently, about 17 per cent of Greater Mumbai's 12 million population is Muslim, who have come from various parts of the country, particularly from the Konkan coast, Gujarat, Uttar Pradesh, Bihar, the Deccan, and Kerala. Historically, much like other communities in Mumbai, Muslims too have tended to live in enclaves. However, many also lived in mixed housing colonies and settlements. [10] Poor Muslims, who form a substantial percentage of the city's slum population, lived in mixed slums and shantytowns in Dharavi, Govandi, Behrampada and Cheetah camp.

However, after the riots of 1992-93 in which over a thousand people, mainly Muslims, were killed in mob rioting and by the police, the city's social geography underwent a radical change. The feeling of extreme insecurity following the riots resulted in the exodus of Muslims from mixed communities into homogenous ghettoes. Members of the minority community moved into groups where their community predominated, particularly safe areas where riots did not take place, in order to gain a sense of security after the State failed to protect them. This uprooting took place mostly from the border areas between Hindu and Muslim localities to the inner areas of the community that were perceived to be safer. There was also an influx of Muslim families from other parts of the city into these areas. Aside from the thousands of Muslims who left the city never to return, other Muslims, so also Hindus, who lived in mixed areas or housing colonies where they were in substantially smaller numbers consciously chose to move to neighbourhoods dominated by their community in order to feel more physically secure. Some moved into the already dense Muslim dominated neighbourhoods of south and central Mumbai - Nagpada, Madanpura and Bhendi Bazaar - others moved outwards to Jogeshwari (west), Curl, Melvin (Malad) and Govandi. Middle-class Muslims were attracted to the Millat Nagar complex in Andheri West, while poorer Muslims sought refuge in the Bharat Nagar slums in Bandra East. Still others went to live in the extended suburbs of Mira Road in north-west Mumbai and Mumbra in Thane district [19]. Deosthali and Madhiwalla, stated that there was a continuous influx of people into a Muslim dominated area in Kurla because this area remained unharmed during the riots. Although Kurla was largely affected, this particular area maintained peace. Safety was a major reason for choosing this area for settlement by the communities. [11]

It should have been the responsibility of the State to try to reinstate the faith of the minority community in its institutions after such gruesome communal riots, but it has failed miserably in this regard by allowing such segregation to take place, and more by failing to provide adequate infrastructure and services such as health care, sanitation and education. Despite the conditions of extreme squalor and the negative impact that ghettoization has on their economy, Muslims continue to live in these areas because of the feeling of insecurity and lack of faith in the State to protect them.

Connecting the present with the past, in her preface, the M. Mennon observes: Today it is common to hear the word ghetto and to think of Muslims as the other and terrorists; in fact, many Muslims are denied jobs because of who they are; for them jobs are hard to come by and a sense of alienation is evident. The popular perception about Muslims is that all Muslims are not terrorists but all terrorists are Muslims. The situation has become worse after the Babri Masjid demolition and the riots in Mumbai in 1992-93—the worst it has possibly ever seen. [12]

Further discussing the impacts of displacement, Menon observes, Living in a ghetto, often not out of choice, in that sense, has narrowed their focus, restricted their aspirations, and created a longing of the life they once knew…They live up with a split image of the city—one that existed in the past, which now only exists in their imagery and reality of the present. And the biggest loss in these violence, after losing loved ones and trust over 'another' community, is the loss of livelihood. Moving to a ghetto for safety reasons has also led to the community being further marginalized. Perceptions about Muslims have changed and often those in jobs face some kind of discrimination. Those who move to ghettos often feel this more than the others.

4.2. Muslim Women and Communalism

In the context of communalism, because religious identity takes precedence over other identities, struggle for women's rights becomes difficult, larger problems of the community become more important than internal problems of women. Chhachhi in her paper, Forced identities: the state, communalism, fundamentalism and women in India, uses the examples of the well known Shah Bano case and the unwavering defence of widow immolation by right-wing Hindu parties to illustrate how women's rights become the political battleground for communal wars. She points to how women's bodies are considered repositories of communal identity and how the inability to protect them becomes a matter of shame for the community involved. [13]

It is for this reason that in the frequent and intense communal riots in recent years, women have systematically been targeted and become victims of sexual violence. The intensely patriarchal communal ideology portrays them as the bearers of honour of a particular group. In addition to the short-term impact of riots on life, physical health, psychological well-being and disruption of life, the long term consequences for women are even more debilitating. The International Initiative for Justice (IIJ) report describes the restrictions placed on women's mobility after the riots in Gujarat in 2002, which hampered their access to employment, education and participation in public life. The report summarizes the impact, Right-wing politics thus not only directly attacks and marginalizes those considered as the other, but also forecloses all spaces for demands from those marginalized within the other communities.

Although communities ghettoize in order to gain a sense of security, the impact on women is highly deleterious. Safe

spaces for women get redefined as those within the ghetto. One study conducted in Jogeshwari (east), a suburb of Mumbai looked at the phenomenon of ghettoization following riots that occurred in this area in the 1990s [14]. Nearly 72 persons who had migrated as a result of the riots were interviewed in order to understand how dispossession impacts the lives of those affected. As far as the impact on women is concerned, the study found that the fear psychosis caused by communal riots put further restrictions on women's mobility. This often resulted in girls being taken out of school if it required for them to go beyond the boundaries of the ghetto. It also puts a dual burden on Muslim women - in addition to their struggle for gender equity within their communities, they now have to deal with the struggle for rights as minorities.

4.3. Muslim Women and Health

A majority of the academic discourse on Muslim women's health concerns itself with their fertility. Much of this literature is based on analysis of secondary data and suggests that religious beliefs of Muslims forbid the use of contraception, which accounts for their high fertility rate. However, research and commentaries published in the last decade have rigorously studied the reasons for low use of contraceptives among Muslims and found that it can be attributed to non-availability of the preferred method of contraception, insecurities related to the minority status of Muslims and lack of information regarding methods of contraception.

In recent times, their have been two large studies that have gone beyond Muslim women's fertility to study the health conditions of Muslims. The first of these is the Rajinder Sachar Committee [2] and the second is the Muslim Women's Survey. [15] The Sachar Committee report showed that the availability of medical facilities in the village (a health sub- centre, dispensary or primary health centre) reduced with a rise in the proportion of Muslims, particularly in larger villages. According to the report, of all the villages without medical facilities, 16 per cent are located in Muslim concentrated areas. When stratified by the state, it is seen that the infrastructural conditions of Muslim concentrated villages are not much worse than the others, but the fact that states with poor infrastructure such as Assam, Uttar Pradesh, Bihar and Jharkhand have a large Muslim population indicates that a large proportion of the community does not have access to such infrastructure. Similarly, MWS with reference to access to basic amenities states, Clearly, there are disparities in access to services and programmes along rural and urban lines and possibly along socio-economic status and community lines, reflecting discrimination in their provision on the basis of caste and religion.

While there is a general lack of health facilities and other infrastructure available to Muslims in rural areas and some urban areas such as ghettos, in most urban areas, it is the accessibility to these services that is difficult. Accessibility has various dimensions, which include physical accessibility, economic accessibility, non-discrimination and information accessibility. Both mobility of women and their decision making power in the household contribute to whether they can access health services. Studies exploring the utilization of health services have suggested that the inability to travel alone, purdah restrictions and the opportunity costs of time taken to travel to the facility are significant predictors of poor utilization among Muslim women. [16]The MWS found that the most important reason for Muslim women not going to the health center was the distance, followed by lack of adequate facilities. The two factors that get highlighted even more with ghettoisation of communities as has happened in Mumbai.

4.4. Discrimination in Health Facilities

There is little information about the kind of discrimination that Muslim women encounter at the health system in times of peace, but fact-finding reports from riot investigations have highlighted certain aspects. A report on the public health situation after the 2002 riots in Gujarat found that Muslim patients were targeted in health institutions by mobs, injured patients were not allowed to enter the gates and their relatives were terrorized. [1] The report mentions that cases of sexual assault were not registered by doctors even when there were obvious signs of the same. Post mortems were often not done and when they were, they failed to note injuries caused due to police firing. Dying declarations were also not recorded. All these failures on the part of the health system left victims with no evidence to seek justice.

Renu Khanna writing on the Godhra riots states that past incidents of attacks on Muslim patients in certain hospitals deterred Muslims from accessing those hospitals. Given the climate of insecurity, hospitals took certain measures to deal with the situation, such as discharging Muslim patients prematurely, segregating patients based on community and providing leave to staff from the minority community. These measures might have been taken in good faith, yet the reports point out that it may threaten the secular character of health institutions and lead to accentuation of polarization within the profession. [17] In such a scenario, doctors failed to perform their ethical duty and maintain medical neutrality. This must be viewed seriously by the profession.

What the report highlights is the polarization that has occurred within the medical profession as well as among the voluntary agencies providing health care. It was largely Muslim doctors and organizations that responded to the needs of the victims, quite unlike the numerous relief efforts that were initiated following the earthquake in Kutch in January 2001. At the same time, doctors and other health professionals, who were members of the VHP, also participated in the violence against Muslims. These professionals have neither been questioned nor booked for their involvement in such violence. The report notes that the manner in which segregation of health professionals took place along religious lines is worrying, particularly when there has been no attempt to reinforce the values of neutrality against communal ones.

In India, the discrimination encountered by Muslim

women from health professionals has been mentioned in the Sachar Committee Report. The report states that Muslim women are deterred from accessing public health institutions because of the unacceptable behaviour that they encounter. [3] It further states that due to this discrimination, they prefer going to providers from their own community, even if they are not suitably qualified, and end up receiving substandard treatment. It also pointed out that Muslim women wearing the burqa feel that they are not treated well in public facilities such as hospitals, schools and public transport. These statements are based on discussions with various representatives of Muslim communities across the country.

The fact that health professionals discriminate against minorities in times of peace, this is indeed possible given the nature of communalization in society as a whole. Such discrimination (based on race and ethnicity) has extensively been documented in the West in recent times. For instance, a report by the Institute of Medicine in 2002 found that racial and ethnic minorities tend to receive sub-standard treatment as compared to whites for a large spectrum of chronic and infectious diseases, even after adjusting for socioeconomic factors, type of insurance coverage and type of clinical setting (private, public, teaching or non-teaching). Similarly, another systematic review conducted by Physicians for Human Rights in 2003 found that the quality of treatment provided to racial and ethnic minorities is inferior to that provided to whites. [18] Both reports have attributed the disparities to systemic problems, biases and stereotyping prevalent among health care providers and certain patient factors such as culturally held beliefs, lack of trust in health facilities and physicians, and reduced satisfaction with treatment provided.

In order to tackle the problems rooted in biases of health care providers, the United States as well as other countries in the European Union have instituted cultural competence trainings into their syllabi in order to make health professionals more accessible to minority populations. In Europe too, such problems have been recognized and attempts made to correct them. The European Union Against Racism, in a seminar in 2005 made several recommendations to eliminate discrimination in health facilities, including the fact that health care providers must be educated to understand such discrimination, male and female doctors should be present in all facilities, hospitals must be aware of dietary guidance and they should not have religious symbols. In the Indian context however, even though some evidence does exist about communal attitudes among providers, no effort has been made to study it in detail, nor address it through interventions.

The literature cited above provides a picture of the relationship between communalism and women's status and health, and this is the conceptual framework in which we place this study. Rising communalism in society has affected the status of Muslim women and has also had an impact on how health systems respond to Muslims in times of active conflict. However, how this operates in times of peace is what this study seeks to explore.

5. Discussion on Women's Experience in Public Health Facilities and Discrimination Based on Religion and Region

It is worth noting that both Muslim as well as non-Muslim women perceived the public health facilities to be unfriendly and hostile, owing to the fact that they were free services. Private facilities, on the other hand, were said to be better because they were paid for. When asked if they were treated differently from others, it was interesting to note that both Muslim as well as some non-Muslim women perceived being treated differently. While this was expected in the case of Muslim women due to religious discrimination, among non-Muslim women such sentiments were expressed by women from the migrant Kaj community. This suggests that in addition to the religious bias in the way health care providers deal with patients, there also seems to be regional differentiation.

All women were very emotional and angryry while sharing their experiences in public health facilities. They were either extremely loud while talking about their experiences or they would become inaudible - an indication of their emotions. The anger was especially directed towards the staff of the hospital like the nurses, the ayabais and the ward-boys. The women were mostly forgiving towards the doctors. They spoke about the rude behaviour of the staff towards them. The corruption and the favouritism that existed in the hospitals overall and specifically in the labour wards. The prevalent abuse in the labour wards were that they were made to clean floors, physical and verbal abuse, no privacy, denial of treatment/delay in treatment, unavailability of medicines, behaving badly towards accompanying persons etc.

5.1. Abuse in Labour Ward-Made to Clean Floors, Physical and Verbal Abuse, No Privacy

Women across communities revealed the cruel and inhuman ways in which they had been treated or had seen others being treated in the labour ward in public hospitals. The class four employees, ayabais, verbally and physically abused women while they were in labour. Verbal abuse included derogatory remarks, abusive language and comments on sexuality. Comments on women's character and sexuality were passed with an intention to discourage reproduction. Such comments were targeted at all women, both Muslim and non-Muslim, while the remarks on the former referred specifically to their religion. This can be attributed to the reproductive notions/bias against Muslims that exist in society and find their way into health facilities as well.

This bias took different forms. Pregnant women were often made to clean dirty floors and were not offered water. During recovery, patients were asked to clean their utensils without concern for their health.

Women were slapped on their thighs and across their faces to stop them from screaming or doing anything else that

inconvenienced the ayabais. The doctors too ignored such abuse. That this form of abuse has been continuing for generations is evident from the experiences that both older women and women of the present generation shared. However, women distinguished between those women who faced abuse and those who did not. Women facing physical and verbal abuse were necessarily those women who screamed out loud while in labour. Some women, having seen the horrific nature of ayabais, refrained from making any noise and therefore escaped abuse. What is more disturbing to women about such experiences is the presence of male doctors/ward boys; they felt humiliated because they had been shamed in front of the opposite sex. The experience of abuse revolves around pregnancy or reproduction reflecting on the gendered nature of such experiences.

One must consider that experience of such abuse has resulted in women having pulled out of a public health facility while others continued to negotiate. Muslim women and women from the Kaj community who experience abuse at present, are those whose families cannot afford deliveries in a private facility. They are also the women who have accepted the reality by telling themselves that the abuse is only going to last a few days, so they may as well bear with it.

Women spoke about the positioning of the beds in the labour ward and the lack of curtains or the lack of usage of the provided curtains. Women often mentioned how they were all lying there facing one another in bare minimums without the curtains drawn to give them some sense of privacy. Women found this very humiliating as not only were they just left there but also they were in full view of whoever passed through the ward. They found it highly objectionable because there were ward boys and doctors on rounds and anyone could see them lying there. Clearly this was not so for women accessing private facilities.

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5.2. Discriminatory Behaviour Specifically Directed at Muslim Women

The first thing that the Muslim women said while talking about the differential treatment in the hospitals was the fact that the medical staff got irritated looking at them and their naqaab. Musalman ko dekhe ke aisa lagta hai shaayad unko chidh hoti, aisa lagta hai. They further felt that the moment the hospital staff sees a woman in a burqa they start behaving differently, they become difficult with them. Burkha dekhte hai to jyaada hi natak karte hai (they make a fuss the minute they see a burqa).

1. Asked to remove veil even before their turn for examination

The insensitivity of the medical staff toward Muslim women came through very clearly when women spoke of the fact that they were asked to remove their burqa even while they were waiting their turn to be examined. Women clearly stated that they understood the need to remove the burqa during examination, yet they did not understand the need to remove it before their turn with the doctors. They felt humiliated. Muslim women normally are uncomfortable removing their veil in front of strangers and would prefer to keep it on till their turn came. Further, Muslim women waiting for a gynaecological check up

found it highly objectionable that they were asked to remove their salwar (trousers) in the waiting room much before their turn. They found this extremely humiliating, especially as the non-Muslim women did not have to go through this exercise as they were wearing sarees. The women said that no one knew how long it would take for their turn and yet they are asked to remove their trousers and sit semi-naked in front of all kinds of people (including ward boys and male doctors) walking in and out of the waiting rooms.

When I went for my first delivery to the public hospital I did not know of anything. I was new and it was the first time. I went in for my check-up. In the women's' waiting room we were asked to take off our salwars. 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 did not want to go back to that hospital. We went to a private doctor for checkups.

2. Taunted as dramatic women because of inhibitions to remove burqa

When women found it difficult to comply on occasion, they were taunted for being too dramatic (boltay hain ke Musalman bai natak kartey hai). Women expressed that they were not trying to be difficult, but they felt that removing the veil at the doorstep made them uncomfortable and that the staff was doing it to harass them. The staff was unable to appreciate their inhibitions in taking off the burqa, that their culture was different, and the women found this behaviour insensitive. We will remove it when it is our turn. But the ayabais often start shouting at us and ask us to remove it the minute we enter the facility. And if we do not listen then they ask us to leave the facility.

3. Biases that Burqa clad Women steal Children

Recently, women are being made to take off the burqa at the gate of the hospital as there have been incidents of children being stolen. This has been used against Muslim women consistently, which hurt them as they were looked at with suspicion all the time, despite the fact that they were in the hospital to seek care.

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

Both the communities seemed to put in an effort to merge with the larger population. The fact that most of the experiences of discrimination came from women in burqas or women in ghunghats, shows that as long as one is not able to identify a person by her appearance, she does not face unpleasant experiences.

4. Stereotypical Remarks

Muslim women often spoke about the various stereotypes that health care providers harbour about them, which were dehumanizing. The Muslim women felt that the staff seemed to be judging them on the basis of their preconceived notions, that Muslims are dirty, uneducated, violent and have a number of children. How these stereotypes are expressed are discussed in detail below:

There is a common stereotype of Muslims in Mumbai - that they are uneducated and poor, and the health care providers harbour them too. Women reported that they often heard statements like where do these people come from; they have nowhere to go and so they come here. Muslim women stated that the reason they were accessing public health facilities was that they were poor and could not afford a better place. No rich person comes to PHFs. But there was no need for the staff to humiliate them on the basis of their financial conditions and ill-treat them.

At no point did the non Muslim respondent mention this.

That Muslim women have a high fertility was the other most prevalent stereotype that they encountered. They reported that when they reached the public hospital for deliveries, they were always doubted upon on the number of children they had. Deliveries in PHFs cost very minimal especially the first two, after which one has to pay for a delivery. The bias that the hospital staff carry, is that Muslim women lie about the number of children they have to avail themselves of labour facilities at a low cost.

Again a point never mentioned by non-Muslim respondents. What is interesting here is that there are enough and more non-muslim women with more than two children and numerous Muslim women with two or less than two children, yet it is only the Muslim respondent who mentioned this and mentioned it repeatedly!

Muslim women stated that some women may have to do so because of financial constraints. Often this is done to save them the extra charges they have to pay for having more than two children and also to save themselves from hearing the derogatory remarks by the staff. But even if it was the woman's first delivery, she was subject to the same taunts and abuses by the staff. The staff further taunted them that they enjoyed themselves while having sex and now at the time of delivery they were screaming. They clearly stated that a lot of non-Muslim women had more than two children but felt it was unfair on the part of the staff to make general derogatory comments.

5. Use of derogatory Labels to refer to Muslims

Muslim women were acutely aware of the derogatory labels that were used to refer to them. They were labelled as trouble makers and fighters (ladaku aurat) and often called landiya baika, meaning wife of a circumcised man. The sexual connotations of such labels are quite evident, particularly when they are used in labour rooms. Women found such behaviour extremely embarrassing and humiliating. They could not understand the need to be addressed in a manner that was so derogatory to a community. The question often asked was, why could they not be addressed in a manner similar to the other female patients in

the hospitals? What made the staff so hostile towards them?

Women stated that they were referred to as Musalmaan Aurat which was used to single them out and isolate them on purpose. They said that the tone used was one of ridicule or malice. The Muslim women objected to this as they did not like being singled out as Musalmaan and said that they would like to be treated like the rest of the women visiting the hospital.

They look at us and say Musalmaan bai troubles us a lot. All people in the hospital are under pressure and tend to be a little rude. But why isolate us? Why are we picked on? Not all of us are the same.

6. Refusal to understand and comprehend Urdu Names

Muslim women also expressed their concern over the fact that the staff in public hospitals are not able to understand and write their names correctly. Clerical errors during registrations at the public health facility (PHF) were often mentioned by Muslim women. Correcting names during registration seems to have become a norm with them. As stated by them, they are extremely vigilant during the registrations as one mistake can lead them to a lot of hardships. As one woman explained, When I gave my husband's name for registration instead of Kareem they wrote Kishore. If I had not been careful I would have got the papers in the wrong name. The Muslim women defended the hospital staff sitting at the registration counter, by justifying the difference between their languages and Urdu, which was different in pronunciation and had many alphabets not found either in Hindi or Marathi. But it brought about a sense of feeling like an outsider. The fact remains that Muslims have been visiting these facilities for generations and the staff has not managed to get used to the names.

5.3. Reactions of Women to Bad Behaviour

Marginalisation and Discrimination was further expressed between Muslim and non-Muslim women's articulation of how they reacted to the bad behaviour encountered at the health facility. The feeling of entitlement was clearly missing within the Muslim women.

Among non-Muslim women, and even the minority community among them, the reaction to bad behaviour was that of anger and disgust. They questioned the behaviour of providers, stating that the providers did not have the right to treat them with disdain even if they were poor. Women demanded that the poor had the right to avail themselves of government health services and that they should not be discriminated against because of their economic status. Some have confronted a nurse if she was harsh with the patient while administering an injection and have told the staff to provide proper and timely services to patients and call the doctor. They have asserted their rights by saying that HCPs are paid for their services and that they must talk to the patients and their attendants in a decent manner. Women shared that they have confronted doctors for undue delay in treatment and for not explaining the procedure of treatment and have gone to the extent of telling the doctor that he would not be consulted ever again at any cost.

On the other hand, Muslim women expressed humiliation and shame. They felt hurt that they were not being treated like humans. They feel that if they cut our veins we will not bleed said one respondent and this brought home the extent of hurt. Particularly when talking about being faced with stereotypical remarks, women felt that it was unfair that everyone should be labelled. The nature of abuse (sexually coloured remarks) and misconceptions (having too many children, being dirty) heaped on them make them feel ashamed and low rather than angry.

However, they did not express anger rather, they rationalized the health care providers behaviour by saying that they were over worked, perhaps not paid well, and hence they behaved badly. The difference in these responses may be rooted in fear of repercussion. It may also be rooted in a feeling of helplessness on the part of Muslim women - they do not expect any kind of entitlements from the health machinery and are resigned to the fact that they will be treated as inferiors.

5.4. Actions Taken by Women in Response to the Discrimination

There were also differences in the actions that women took to deal with the bad behaviour of health care providers.

1. Confrontation, but not by Muslim Women

Non-Muslim women reported confronting health care providers for undue delay in treatment. They have asserted their rights by saying that providers are paid for their services and that the staff must talk to the patients in a decent manner.

It is important to note that Muslim women never confronted a staff member for saying something that reflected a religious bias. No woman ever reported questioning a provider for using the term landiyabai or for alleging that she was lying about the number of children she had. To reiterate, the reason for non-confrontation among Muslim women was perhaps fear of repercussion and abuse or that they may be denied services.

2. Withdrawing from the Facility

Both Muslim and non-Muslim women reported that they had stopped going to the health facility because of bad behaviour. They would often move to the service of local private providers or if they could afford it, to private nursing homes and hospitals. Several women said that once they were done with child bearing, they had never gone back to the public hospital and would never do so again. Non-Muslim minority women said that they preferred going back to their villages for childbirth rather than go to the public hospital. Others have used certain improvisations to avoid using a large public facility. For instance, following a negative experience, a woman who had been prescribed injections bought them from the market and asked the local doctor to administer them. However, because of financial constraints, several Muslim had little option but to continue going to the public health facilities.

3. Accommodating, changing way of Dress

Non-Muslim Kaj women said that they traditionally wore

lehenga-cholis when then came to Mumbai, but over a period of time, realizing the nature of discrimination that they faced and the taunts, they shifted to wearing sarees. They stated that they gave up their traditional dress to merge into the city to make their lives easier.

Women's clothing, has been identified as a reason for discrimination by Muslim women too, however they have not addressed this tangible characteristic (veil) of their community. In fact in our conversations with women, we found that the veil has been adopted by the younger Maharashtrian Muslims as well, which was not originally a part of their attire. Over the years, the veil has become a contentious issue and it is not easy to question it. While the non-Muslim Kaj women have easily been able to change this aspect, Muslim women are not able to do so. There are geo-political reasons for why this has been difficult for Muslim women. Globally as well as in India, there is growing evidence which suggests that the anti-Muslim sentiment in society is asserting its identity in various ways, one of which is by controlling women's dress, which is a marker of identity. [19]

At the societal level, both groups of women have undertaken measures for maintenance of hygiene and sanitation. Muslim women in particular have engaged in confrontations with people in society about long term measures such as education, as they feel these will change the behaviour of staff and society towards them.

4. Taking Precautions to not trigger bad Behaviour

Muslim women have shared information on some peculiar actions taken by them. Some who have witnessed and experienced abuse in the labour ward revealed that they made a deliberate attempt not to scream during labour to avoid any form of abuse. Second, they were vigilant about how they spelt their names, and third, they were hesitant to disclose the actual number of children they had.

The sheer nature of these steps undertaken by Muslim women also suggests that these actions have been learnt over time as women have understood the dynamics of a public health facility.

Thus, Muslim women's actions were precautionary unlike Non-Muslim women's responses which were more confrontational. This too reflects the dependence of Muslim women on public facilities as they take steps to avoid any negative experiences, while Non-Muslim women bribe, confront and withdraw.

5. Registering Complaints

With regard to a question on registering a complaint with the authorities for the bad behaviour faced by women, non-Muslim women felt that they should make group complaints about what was happening in health facilities. Though Muslim women's reaction was unanimous in that they all wanted something to be done, they were apprehensive about initiating any action for fear of repercussions. They also believed that complaining about the conduct of the HCPs made the situation worse for them as the staff would turn hostile and future use of the facility would be hampered. In fact, many Muslim women expressed that they had to listen and suffer in silence as there were times when the staff threatened them of dire consequences, of not giving medicines and not giving the discharge papers. Women were categorical that these were the facilities that they needed, hence, there was no point in spoiling their relationships with the staff.

The difference in the reactions between Muslim and non-Muslim women implied that Muslim women's dependence on the facility demanded that they do not raise their voices and that they suffer in silence. The willingness to question the behaviour of providers on the part of non-Muslim women suggests a certain sense of entitlement, which is clearly missing among Muslim women. Muslim women are also more reluctant to confront bad behaviour or register complaints against the facility for fear of facing worse conditions on the rebound.

6. Conclusion and Recommendations

In this report, we have looked at the status of Muslims in India, specifically Muslim women, the rise in communalism and its impact on Muslim women, and the manner in which this manifests in times of peace in interactions between health care providers and Muslim women. The study has been able to highlight the various barriers that Muslim and non-Muslim women face in accessing health services and the factors that affect their decision-making. The behaviour of staff is one such factor, which Muslim women consider when preferring one provider over another. We looked at the kind of behaviour that all women encounter in health facilities, and how the experiences of Muslim women are different from those of non-Muslim women. The triple burden of being poor, female and Muslim is apparent in how Muslim women are discriminated in health facilities. The playing out of different stereotypes that health care providers harbor about Muslim women, and the manner in which it affects Muslim women has been clearly highlighted in the study. Differences between Muslim and non-Muslim women's reactions to this behaviour of health care providers too have been discussed, including the fact that Muslim women prefer not to confront providers or take action against them for fear of repercussion.

Though women have devised numerous strategies to cope with circumstances in health facilities and society, they cannot be left to it. Health facilities and health care providers should acknowledge that women accessing health facilities are feeling discriminated on the basis of class, caste, language, region and religion and acknowledge that these women who have been forced to pull out of a facility and yet others who stay on because they do not have an option, have rights. Their right to unbiased quality health care has to be honoured.

The right to the highest attainable standard of health care is enshrined in the International Covenant of Economic, Cultural and Social Rights. It has further been elaborated upon in General Comment 14 and at the very minimum, four clear dimensions of this right have been described - health

care must be available, accessible, acceptable and of good quality. India, being a signatory to the ICESCR has a responsibility to ensure that it is able to provide such health care to all its citizens. While the aspects of availability and accessibility are well recognised, there is need to dwell more on that of 'acceptability'. Acceptability implies that the health services which are provided must be respectful of medical ethics and culturally appropriate. In section 18, General Comment 14 states that health care related goods and services must be free from discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status. It is further stressed that discrimination in health care can be accomplished with even minimum resources. [25]

This study has brought to light the many ways in which discriminatory behaviour of health care providers manifests in Muslim women's interactions with the health system. There is need to put several mechanisms in place to ensure that such behaviour is checked and to instill sensitivity among health care providers towards women from the Minority community.

Recommendations

From the perspective of medical neutrality and ethics, we make the following recommendations to the health facilities and health care providers.

1. At the level of medical and nursing education, a basic understanding of social, economic and cultural inequities in health care in India must form part of undergraduate medical education. It will help build a sense of empathy between patients and providers, and enable providers to understand the socioeconomic conditions of their patients, which has an impact on their health status. This is essential in order to ensure that false stereotypes are not perpetuated by health care providers towards any community.

2. The health system must address these stereotypes and biases of their staff at all levels through sensitization and providing channels for redress. In- service training for existing staff is essential too.

3. There is need to include modules on communication skills into medical education. Behaviour of staff towards all women (both Muslim and non- Muslim) suggests that there is a great need for more respect and dignity on the part of health care providers while dealing with patients.

4. Strict action must be taken to prevent any form of verbal or physical abuse against women. Mechanisms to redress grievances must be strengthened and provisions must be made to ensure that reporting is anonymous and there is no backlash on the complainant.

5. Hospital staff should be more aware of and sensitive to the cultural differences among their patients. Using language that patients understand, taking time to explain procedures and being sensitive to their needs are essential to ensure that patients feel respected.

6. Male and female doctors must be present at all times in hospitals, so that patients can choose to be treated by the gender they prefer.

7. The health system must be cognizant of the various ways in which it excludes persons from discriminated groups, including the presence of religious symbols in public spaces, language used by providers and so on.

Local Words: Translations/Glossarys

Basti: community

Berahmi–Behaviour: without any consideration, not caring for, without understanding, lacking emotion and displaying hatred.

Bhaiyya community: people from Uttar Pradesh and Bihar

Bimari: illness

Chidh/jhunjlahat: Frustration and irritation

Dava khanas: clinics

Dandiya: traditional folk dance of Gujarat

Gali: small lane

Ghaghracholi: traditional dress consisting of a long skirt, a blouse and a dupatta

Ghungat: veil

Jalan: not used in its true meaning which means being jealous. Used on the same lines as Chidh.

Jhidki: snub, talk rudely. For instance, if you are unaware and you ask a question to the staff, they tell you something and you don't understand. You ask again and they reply rudely saying why do you come here if you don't know, don't ask the same question again and again. It is similar to the word jhadak in Hindi which means to say or do something rudely intended to shut up or shun away someone.

Kaum: People of the same religion.

Khichav: used in the context of facilities. It means that due to the increasing number of patients in the hospitals, there is pressure on the providers which manifests in their behaviour towards patients.

Mangal Sutra: necklace worn by married women

Mahila Mandal: a cooperative of women

Mohallas: neighbourhoods

Morchas: demonstrations

Tawajja: paying attention to what is being said by someone. For instance, if one is asking a question or is expressing something, the other persons reaction is Tawajja. If he/she is listening or just hearing or completely ignoring what is being said. If one says ki unka tawajja theek nahi hai, it means that they don't listen or react in way that is encouraging to the person. Women explained that it means that they don't care about what we say or express.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CEHAT	Centre for Enquiry into Health and Allied Themes
C-SECTION	Caesarian section
FGD	Focus Group Discussions
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
ICESR	International Covenant of Economic, Cultural and Social Rights ICFI International Committee of the Fourth International
IDI	In-depth Interviews
IIJ	International Initiative for Justice
MCGM	Municipal Corporation of Greater Mumbai
MWS	Muslim Women's Survey
NSSO	National Sample Survey Organization
PHF	Public Health Facility
POTA	Prevention of Terrorism Act
YUVA	Youth for Unity and Voluntary Action

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