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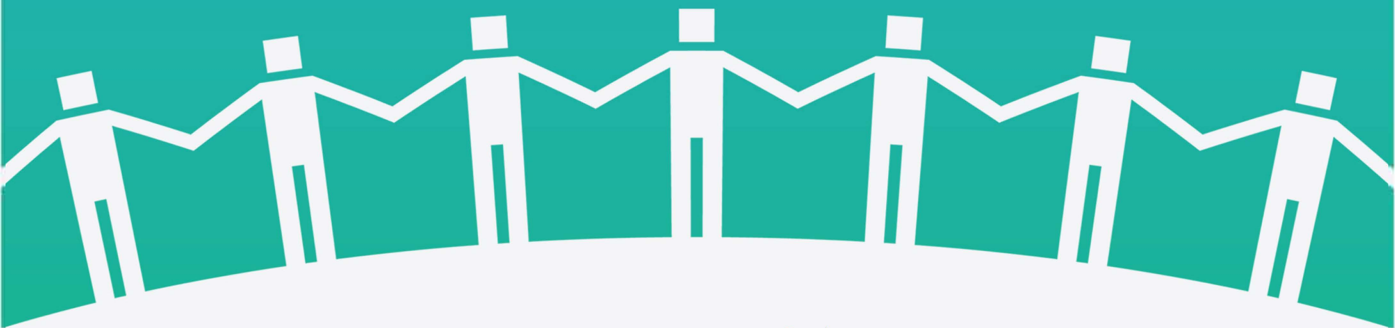

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eSocial Sciences and Humanities (eSSH)
An online journal

Acknowledging the need for quality forums in which research scholars could publish after proper peer-review, eSocial Sciences launches its online journal, *eSocial Sciences and Humanities (eSSH).* The journal hopes to serve as a forum primarily for Indian research scholars to publish in. The journal seeks to devote about seventy percent of its space in every issue to publishing quality work from research scholars across India. eSSH publishes work in all the fields of inquiry within the Social Sciences and Humanities.

eSSH is a part of eSocialSciences and will feature on www.esocialsciences.org which is a project of IKF, Mumbai.

We are grateful to Dr T K Sundari Ravindran and Dr Mohan Rao for organising and guest editing this special issue of *eSSH*

Special Issue
Health Inequities in India

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Social Exclusion and Health of Muslim Communities in Maharashtra

Sana Contractor[1] Tejal Barai-Jaitly[2]

The relationship between social exclusion and health is a complex one. Social exclusion predisposes affected communities to a variety of social and economic vulnerabilities with the potential to jeopardize their health. These result in the community being 'left out' deliberately, discouraging social participation or even actively denying them services. The institutional structures that perpetuate social exclusion differ by gender, class, sexual orientation, race, ethnicity and other similar structures. In India, religious identity is one such structure, and Muslims (a religious minority) is one such socially excluded group.

This paper examines the health status of Muslims in the State of Maharashtra. It describes the socioeconomic context of Muslims and explores how this influences the health of the community. Using secondary data, it also seeks to compare how Muslims fare on key health indicators versus other socio-religious groups in India.

This paper is based on analysis of the National Family Health Surveys, District Level Household Surveys, and the National Sample Survey Organizations data sets. It also draws upon published literature, particularly primary studies commissioned by the Maharashtra State Minority Commission in 2013.

Maharashtra is home to about 12 million Muslims, who constitute nearly 12 per cent of its population (Census, 2011) and their location is largely urban. We found relative disadvantage among Muslim communities in terms of socioeconomic status, education and their work profile. Studies provided evidence of poor access to clean drinking water and sanitation, and poor availability of public health facilities in Muslim ghettoes. In the absence of public health facilities, many communities are forced to access private healthcare providers. Childhood mortality has improved little over the years, and recent data shows child mortality indicators for Muslim children are worse than for other religious communities. While utilization of maternal health services by Muslim women are more or less at par with other communities, there are concerns around respectful care. The data also calls into question myths related to Muslim fertility, arguing for the provision of appropriate methods of contraception to Muslim women. There is evidence of deep-rooted biases amongst health providers resulting in discriminatory behaviour towards Muslim women, which affects access to services.

This paper has examined the socioeconomic context of Muslims in Maharashtra, which conveys marginalization and isolation, and illustrates how this affects the health and well-being of this community. The findings throw up important questions and hypotheses that need to be studied in greater detail if we seek to better understand and address the needs of the minority population in a context-specific manner. We need to uncover and document mechanisms of social exclusion and structural obstructions, with a view to eliminating these.

Keywords : social exclusion, Maharashtra, Muslim communities, marginalisation, isolation

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Inequities between and within countries are among the most pressing concerns of our times. These include not only economic inequities, but also developmental inequities. The Sustainable Development Goals (United Nations [UN], 2015) recognize this reality and call for “leaving no one behind.” Health inequities are being recognized as a significant barrier to the achievement of Universal Health Coverage and several other targets within Goal 3 on ensuring healthy lives and promoting the well-being. Goal 10 of the SDGs explicitly calls for reducing inequalities between and within countries. The framework of social exclusion allows us to examine these inequities in some depth. Rather than viewing inequities as absolute differences among groups, social exclusion provides a framework to understand inequities as the consequence of various social processes and linked to other forms of exclusion including economic, political and cultural.

Social exclusion has been defined as “the process through which individuals or groups are wholly or partially excluded from full participation in the society within which they live” (European Foundation for the Improvement of Living and Working Conditions, 1995, cited in deHaan 1998). According to WHO’s Social Exclusion Knowledge Network, social exclusion operates in four critical dimensions – economic, political, social and cultural – and at different levels, individual, household, group, community, country and global. Social exclusion is relevant while discussing health inequities because it results in unequal access to resources, and reduced capabilities and rights, based on social status (World Health Organization [WHO], 2008). When specific groups of people are pushed to the margins of society, there is a power imbalance resulting in ‘discrimination’ against these groups.

The relationship between social exclusion and health is a complex one. On the one hand, social exclusion predisposes affected communities to a variety of social and economic vulnerabilities that have the potential to jeopardize their health. On the other, the status of such communities serves as a significant barrier to accessing services, resulting in ‘leaving them out’ deliberately, discouraging their participation or even denying services. Factors that perpetuate social exclusion differ across contexts. In India, the grounds and sources of social exclusion and discrimination are many – caste, class, religion, gender, and so on. The India Exclusion Report 2013–14 which explores exclusion in four “public goods” – education, urban housing, decent work in labour markets and legal justice concerning anti-terror legislation—finds that Dalits, Adivasis, Muslims and persons with disabilities in India are most consistently excluded from all. The report finds that members of these groups tend to be “excluded on unequal and discriminatory terms compared to other sections of society” (p.8). The present report looks at one such group, the Muslims.

Muslims,A Socially Excluded Community in India

Muslims constitute 14 per cent of India’s population, making them the largest minority group in the country. The exclusion of Muslims however, does not merely come from being a minority. Rather, it is rooted in decades of unrest between them and the majority Hindu community, which has given rise to many communal riots, dating back to pre-independence. In fact, the movement to partition India has, by some, been said to be rooted in this sense of exclusion faced primarily by the Muslim elite who feared further exclusion in a united independent India (Engineer, 2007). Post-independence, two government reports – the Gopal Singh Panel report of 1983 and a report prepared by a committee chaired by S.Vardarajan, a member of the National Commission for Minorities in 1996 - examined the issue of exclusion of Muslims. They reviewed the exclusion of Muslims especially from representation in public services, judiciary, the private sector and banking services,

and found it to be abysmally low compared to the share of the community in the general population. The Gopal Singh Panel Report noted that “there was a “sense of discrimination prevailing among the minorities” and that it “must be eliminated, root and branch if we want the minorities to form an effective part of the mainstream.” (Venkitesh, 2006).This report, however, was never tabled in Parliament and was released only in 1989. Most recently, a high-level panel set up in 2005, by the Manmohan Singh Government headed by Justice Rajinder Sachar (or the Sachar Committee as it is known) to study the social, economic and educational conditions of Muslims in India, provides perhaps the most comprehensive picture of the exclusion of the community in India. The report of the committee, released in 2006, notes that Muslims find themselves facing a “dual burden” – of being labeled anti-national and at the same time, of being appeased. As if countering the misconception that Muslim “appeasement” has led to any positive developments for the community, the report finds high levels of poverty and precarious employment among the community. It also highlights their lack of representation in public and law enforcement services (Government of India [GoI], 2006). Yet, the official discourse on developmental exclusion in India has not, as Hasan argues, always taken religious minorities into account (Hasan, 2009).

As a follow up to the Sachar Committee report, in 2008, the Maharashtra State Minority Commission (MSMC) set up a commission (the Mahmoodur Rahman Committee) to document the conditions of Muslims in the state (Government of Maharashtra, 2013). Various studies were commissioned drawing on primary and secondary data, especially from four Muslim dominated areas including Malegaon, Bhiwandi, Behrampada, and Mumbra. The purpose of doing these studies was to inform a multi-sectoral development plan which would guide efforts towards the development of Muslims in the State. The Center for Enquiry into Health and Allied Themes (CEHAT) was commissioned to carry out a study to synthesize emerging findings related to health from the various reports. This study was published as a chapter of the final report (Contractor & Barai-Jaitly, 2014).[3] The present paper explores the social and economic conditions of Muslims in the state one state of India – Maharashtra – that has relatively good development indicators and links them to the prevalence of health inequities and discrimination towards the community.

Based on this analysis, we hope to draw attention to the need for health research to recognize the presence of inequities and exclusion-based on religion, as well as adopt a more nuanced approach to understanding the processes that affect the health of this socially excluded group in India.

Methods

This paper is based on a previous report commissioned by the Maharashtra State Minority Commission, as part of the Mahmoodur Rehman Committee Report. The data used here is primary and secondary data from various sources. First, we look at key indicators from the published state reports of the National Family Health Surveys (NFHS), District Level Household Surveys (DLHS) and the National Sample Survey Organizations (NSSO), to understand emerging patterns and trends related to the health of Muslims. Second, we draw upon primary studies commissioned by the Maharashtra State Minority Commission and others in Muslim dominated ghettoes in Maharashtra. (Nirmala Niketan, 2011, Poonacha et al., 2011, Shaban, 2011a & Jain, 2014). These studies used a mix of qualitative and quantitative methodologies including sample surveys in the four areas

[3] For a more extended version of the report, please see Contractor S and Barai-Jaitly T (2014) *Health of Muslims in Maharashtra,* CEHAT Mumbai. http://www.cehat.org/publications/1491288467

and qualitative methods such as focus groups, in-depth interviews and key informant interviews to study different aspects of development in these communities such as employment, education, infrastructure, women's issues and health. For the purpose of this paper we have drawn on the findings related to health from these reports. We refer to these studies hereafter as the study from Bhiwandi/Behrampada/Malegaon/Mumbra, respectively. Finally, the report also brings together existing published literature on the health of Muslims in Maharashtra, to add to the analysis emerging from the secondary data and primary studies.

Findings

Socioeconomic Context of Muslims in Maharashtra

Maharashtra is home to about 12 million Muslims, who constitute nearly 12 per cent of its population (Registrar General of India [RGI], 2011), making them the most numerous religious minority in the state. The state stands fourth as far as absolute size of the Muslim population is concerned (after Uttar Pradesh, West Bengal, and Bihar) and 12th in terms of percentage of total population in the State. Muslims are concentrated in the central belt of Maharashtra. Specific blocks of the districts of Akola, Parbhani, Nashik, Aurangabad, Nanded, and Raigarh, as well as the highly urbanized areas of Mumbai, Mumbai (Suburban) and Thane, have a significant Muslim population (Government of Maharashtra, 2013). Muslim communities in Maharashtra are not homogenous – they include various sects and castes, in addition to wide variations in class. A few communities such as the Bohras and Khojas are relatively wealthy, but these do not represent the average. While there is a range of social determinants affecting health, in this paper, we present three critical areas for which data are available. These are economic conditions (including poverty and unemployment), education, and neighbourhoods (ghettoization of Muslims), which in turn demonstrate a link to social exclusion of the community.

Economic conditions

About 70 per cent of Muslims in Maharashtra reside in urban areas, and 60 per cent of these in slums (Shaban, 2011b). The Muslim community in Maharashtra has among the lowest monthly per capita expenditure (MPCE). Muslims residing in the urban areas of Maharashtra have a dismally low MPCE of Rs. 68.14 (derived from the table in John & Mututkar, 2005). Muslims also face higher unemployment than Hindus, and their work participation ratio (WPR)[4] is lower than Hindus both in Maharashtra as well as at the national level. (See Table 1) The proportion of Muslims employed in the unorganized sector is more than any other socio-religious group. The most significant share of the Muslim workers in Maharashtra is in 'other works,' particularly in urban areas. Included in 'other works' are occupations such as carpentry, masonry, fabrication, mechanics, hawking, pulling rickshaws, etc. (Shaban 2011b).

[4] Worker population ratio is defined as the number of persons employed per thousand persons. WPR= No. of employed persons x 1000. /Total population. Worker Population Ratio is an indicator used for analyzing the employment situation in the country.

Table 1: All India Worker Population Ratio (WPR)*, NSSO 66th Round (2009 – 10)

Region	Hindu	Muslim	All religions
Maharashtra	608	496	593
India	568	497	599

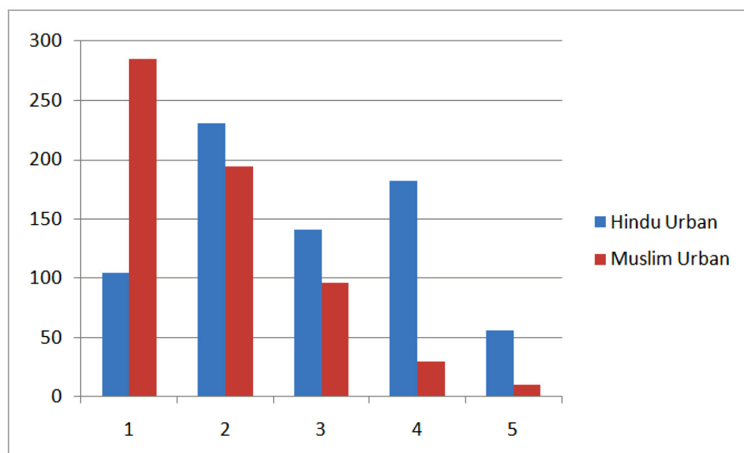
* According to Usual Status (ps+ss) Among Persons of Different Categories of the Major Religious Groups (Urban and rural, male and female, 15 years and above)

Source: Ministry of Statistics Planning and Implementation [MOSPI], 2013

Education

Census data shows that the literacy rate among Muslims was more than 80 per cent in Maharashtra. In this regard, Muslims fare better than Hindus in the state and better than their counterparts in India as a whole as well (Directorate of Economic and Statistics, 2015-16). However, concerning actual educational attainment, the picture is somewhat bleak. The NSSO 66th Round (2009 – 10) indicates a high enrolment ratio of Muslims, but this is followed by sudden dropouts, even in urban areas where access to of higher education institutions is expected to be better (see Figure 1).

Figure 1: Distribution of Level of Education Across Religions in Urban Maharashtra,
NSSO 66th Round (2009 – 2010)



X-Axis: Literate up to Pre-primary (1), Secondary (2), Higher Secondary(3), Graduate (4) and Post Graduate(5).
Y-Axis: Per 1000 distribution of persons of age 15 years and above.

A state-wide survey (Shaban, 2012) showed that only 2.2 per cent of Muslims were graduates or more, and among women, this rate was even lower. Evidence shows that reasons for drop out range from monetary problems and the imperative to start earning, poor quality of schools, and discrimination in the labour market. (Jain & Shaban, 2009). Further, lack of availability of higher educational institutions is a concern. Maharashtra is amongst the top eight states in the country with the highest number of colleges and has a high college- density of more than 25 (number of colleges per lakh eligible population in the age-group 18-23 years) (National Sample Survey Organization [NSSO], 2009 -10). However, Bhiwandi, an area where Muslims constitute 56 per cent of the population has only three colleges for a population of more than seven lakhs. Discrimination has also been reported in schools. During the focus group discussions in the primary study in Behrampada, parents talked

about the biases of teachers against their community. One parent said 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.

Neighbourhoods

The socioeconomic context of Muslims in Maharashtra appears to belinked in many ways to ghettoization. A disproportionately large number of Muslims live in slums; 70 per cent of the Muslims in the state of Maharashtra live in urban areas, and about 60 per cent of these stay in slums and another 30 per cent in lower income areas (See Table 2). The Mahmoodur Rehman committee report notes that 90 per cent of Muslims live in Muslim-majority areas, eight percent live in mixed neighbourhoods and just two percent live in areas where there are very few Muslims (Government of Maharashtra, 2013).

Table 2: Distribution of Muslim Households by type of Neighbourhood in Urban Areas in Maharashtra

Type of neighbourhood	**Slum**	**Low-Income Area**	**Middle Income Area**	**High-Income Area**	**Mixed**
Proportion of households	57.7 per cent	31.3 per cent	9.1 per cent	1.6 per cent	0.3 per cent

Source: Shaban 2011b.

Shaban (2012) notes that the segregation of settlements in Mumbai along religious lines is not new. 'Enclaves' of communities such as that of Parsis in Wadala, Bohris in Dongri, Maharashtrians in Dadar, Gujaratis in Johri Bazar, and so on existed from earlier. However, these established a 'horizontal social order' of communities and were not considered better or worse than the other. However, this changed in recent times with increasing fear and insecurity. Maharashtra has witnessed a number of Hindu-Muslim riots post-independence, and this contributed to the ghettoization. The first communal riot dates back to 1893. In 1967 riots broke out in Malegaon; in 1970, there were riots in Bhiwandi, Jalgaon and Mahad, and in 1984 in Bhiwandi again and in parts of Mumbai. In recent years, (particularly 1992-93) Mumbai, Malegaon, Aurangabad, Bhiwandi, Pune, Nagpur and Dhule are some of the areas of the state that saw a large number of riots that caused displacement of people on an unprecedented scale, affecting Muslims largely. Large numbers of families were forced to leave the places where they had lived all their lives. Increased polarization, failure of the state to control riots and its possible participation in riots (see, for instance Sabrang Communication 1998), led to a feeling of insecurity that resulted in a situation where people choose to live among those of their own community, i.e. ghettoization. Asghar Ali Engineer describes the process as follows:

> Many people are unable to return to their homes even now not just for imaginary fear. When they returned to get the panchnamas made, or just to survey their lost homes, they found their neighbours uncommunicative. In some cases, walls had been erected and boards put up saying, 'Minorities not wanted'. All of them want to sell their rooms and 'live with members of their community if possible', even if it means, as Shahabuddin of Pratiksha Nagar said, 'Living in third class surroundings compared with my A-class area'. Shahabuddin is not alone in his sentiments. There has been distress sale of properties on both sides, i.e., Muslims selling off properties in the Hindu area and vice versa. Thus, in a way, communal divide is complete. (Samiti, 1993)

This led to formation of areas with high concentration of Muslims, and discrimination in the housing market forces led even those who were not victims of riots, to live in 'Muslim areas'.

Living Conditions and Health in Muslim Dominated Areas

Housing, Water, and Sanitation in Muslim Ghettos

The living conditions in Muslim-dominated areas appear to be poor in terms of access to basic amenities including housing, water, and sanitation. In Bhiwandi for instance (where 25 per cent of the population resides in slums), 25 out of 27 slum pockets were Muslim dominated. Nearly 50 per cent of the residents lived in *kuccha* houses. The houses of 44 per cent of the respondents measured 100 square feet or less; almost 90 per cent did not have separate kitchens. Some Muslim dominated slums were also located on forest land and therefore remained neglected by the Municipal Corporation. Because they were considered to be 'illegal,' they were not provided with basic amenities (Nirmala Niketan, 2011). In Malegaon too, Muslim localities consisted mostly of *kuccha* houses (Shaban, 2011a). In Behrampada, the housing consisted of several huts with one storey perched precariously on the other – sometimes as high as four storeys – a safety hazard (Poonacha et al., 2011).

As for drinking water, Shaban (2011b) found that a substantial percentage (12-13 per cent) of households in Mumbai, Thane, and Nashik relied on purchased water for their daily need (Shaban, 2011b). In Bhiwandi city, the survey which covered 14 slums, found that none of the communities had a municipal water connection and had to make do with private connections or tankers for water, the portability of which was questionable particularly in the monsoons. Another common feature of the areas studied was the lack of adequate sanitation (Nirmala Niketan, 2011). In Bhiwandi and Behrampada, there was a shortage of toilets and children as well as adults often had to defecate in the open or in the gutters. In Behrampada, only 21 per cent of the households had private toilets attached to their houses, 77 per cent used public toilets, and two percent use paid public toilets. The number of toilets was inadequate, particularly for women, who had to leave early in the morning and wait in long queues. Fights over the use of the toilets were reported to be common, and the condition of toilets was said to be filthy due to the clogging of drains. Further, residents used the same area for washing utensils (Poonacha et al., 2011).

The picture emerging from the studies mentioned above shows that the condition of Muslim-dominated ghettoes in Maharashtra vis-à-vis water, sanitation, and housing facilities is extremely poor. The residential segregation of Muslims is evident, which directly and indirectly impacts their health.

Morbidity Related to Living Conditions

The living environment and lack of water and sanitation described above were bound to result in the spread of communicable diseases. In places like Malegaon, 45.4 per cent of recorded deaths among Muslims are in the age group below five years and are primarily due to pneumonia and diarrhea (Shaban, 2011a). In the primary studies from Malegaon, Bhiwandi, Behrampada, and Sion-Koliwada, 60 to 90 per cent of the respondents reported having suffered from a minor illness in the year preceding the study. Common minor illnesses included viral fever, cough, cold and stomach problems. The most commonly- occurring serious illnesses in all four studies were malaria and tuberculosis, the prevalence of which varied across the regions (Poonacha et al., 2011). In certain some areas like Bhiwandi, 30 per cent of the families reported the presence of a member who suffered from malaria in the year preceding the study while one in ten reported a case of tuberculosis in the family (Nirmala Niketan, 2011). In Behrampada, malaria was reported by about 10 per cent of

families and tuberculosis by less than 5 per cent. 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 tuberculosis was attributed to the congested living environment, a feature of most slums in which urban Muslims reside (Poonacha et al., 2011).

Reproductive Health

Fertility and Contraception: The fertility rate of the Muslim population in India, in general, is an intensely politicized issue, and has been used by politicians to stoke majoritarian fear. (See for instance, Outlook Web Bureau 2018). A look at the data, however, shows a very different picture. Foremost, various rounds of the NFHS provide a view of the declining fertility rate among Muslims. The Total Fertility Rate (TFR) of Muslims in Maharashtra steadily reduced from 4.11 in 1992-93 (NFHS 1) to 3.3 in 1995-96 (NFHS 2), to 2.8 in 2005-06 (NFHS 3), and to an almost replacement level fertility rate of 2.33 in 2015-16 (NFHS 4). This drop in TFR was better for Muslims than for the whole state (International Institute for Population Studies [IIPS] & ORC Macro, 2001, IIPS & Macro International, 2008, IIPS & ICF, 2017).

Table 3: Demand for Contraception by Selected Socio-religious groups, NFHS -4, Maharashtra 2015-16

Religion	Any modern method	Unmet need for family planning		Met need for family planning (currently using)		Percentage of demand satisfied
		For spacing	For limiting	For spacing	For limiting	
Hindu	63.1 per cent	4.2 per cent	5.1 per cent	4.9 per cent	60.2 per cent	87.5 per cent
Muslim	55.9 per cent	4.7 per cent	6.6 per cent	6.5 per cent	52.0 per cent	83.8 per cent
Schedule Caste	26.1 per cent	4.6 per cent	6.1 per cent	4.6 per cent	59.7 per cent	85.7 per cent
Schedule tribe	15.5 per cent	4.7 per cent	4.6 per cent	4.4 per cent	58.5 per cent	87.1 per cent

Source: IIPS and ICF, 2017

Contraceptive use among Muslims in Maharashtra was also found to have increased over the years but dropped slightly in the last decade from 57.4 per cent in NFHS 3 (2005-06) to 55.9 per cent in NFHS 4 (2015-16). Data from NFHS 4 also suggests that Muslims prefer the use of spacing methods such as pills and condoms. The use of condoms among Muslims is 16.8 per cent as compared to 11 per cent for the state, and oral contraceptive pills is 3.7 per cent as compared to 1.4 for the state. (IIPS & ICF, 2017) Similarly, in the primary study in Behrampada, community health workers reported that women were not averse to using contraception, but preferred spacing methods rather than sterilization (Poonacha et al., 2011). Since the family planning programme in India is focused mainly on permanent methods of contraception, it is possible that the low utilization of contraception among Muslim may be the result of this skewed focus and the poor availability of spacing methods in the public health system. Other studies have reported that non-availability of the preferred method of contraception as one of the barriers to accessibility of family planning services among Muslim women. (Hussain, 2008, Jeffrey & Jeffrey, 2000, Chacko, 2001). As a result, Muslim women have a high unmet need for family planning, and the lowest percentage of demand satisfied, while the total demand for contraception is more or less within the range of the rest of the groups (see Table 3).

Therefore, there is a clear mismatch in what Muslim women need and what is provided by public health services, thereby resulting in their potential exclusion from services, or pushing them to access these services from the private sector.

Maternal health

With regard to maternal health, no disaggregated data by religion is available in recent times. However, the utilization of services by different socio-religious groups provides some indication of maternal health in the Muslim community. As per NFHS 4, Muslim women are as likely to utilize maternal health services as women from other communities (IIPS & ICF 2017). In the previous round, i.e., NFHS 3 (IIPS & Macro International, 2008), the proportion of Muslim women who had institutional deliveries and went for antenatal checkups was greater than other communities, but this gap has reduced with an overall improvement in these indicators for all communities over the last ten years. However, despite utilization being almost the same as the majority community, concerns over the quality of care exist. For instance, as per NFHS 4, about as many Muslim women (70 per cent) as Hindu women (72 per cent) are likely to go for 4 or more antenatal checkups. However, only 28 percent of Muslim women received all components of antenatal care, as compared to 32 per cent of Hindu women (IIPS & ICF 2017). The reasons for this warrant exploration as they may reflect systematic unavailability of services in Muslim dominated areas or may be related to untrained providers. Similarly, almost an equal proportion of Hindu and Muslim women deliver in health facilities. However primary studies show that, despite residing in the urban areas with proximity to health facilities, some women do have their child delivery at home. Instances of home births were seen in Bhiwandi as well as in Behrampada, which is located not more than 7kms from a health facility (Nirmala Niketan, 2011 & Poonacha et al., 2011). The Behrampada study also reported that not all of these home deliveries were assisted, indicating high risk to lives of the mother and child. The study reported that one of the reasons for not approaching the health facility was that as per prevailing government rules, only first two deliveries were conducted free of charge. Further, women reported bad behavior of staff towards them, discrimination and higher expenses, as reasons for not going to the hospital (Poonacha et al., 2011).

Child Health

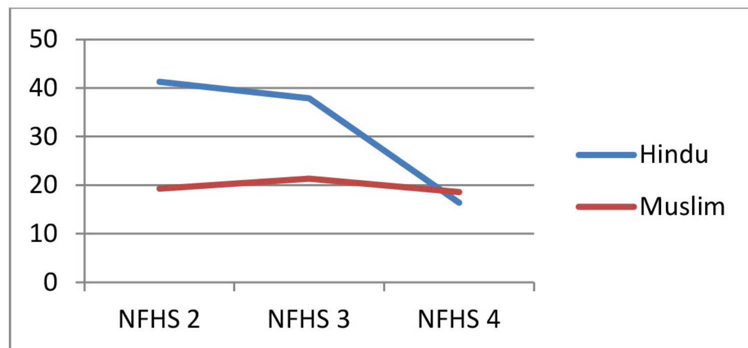
Child Mortality: NFHS 2 and NFHS 3 suggested that the neonatal mortality rate, infant mortality rate, child mortality rate and the under-5 mortality rate of Muslim children were better than for Hindu children (Contractor & Barai-Jaitly, 2013). The relatively better childhood mortality rates among Muslims in India, despite their poorer education and wealth status, are a subject of much debate. Better sanitation (Geruso & Spears, 2014) and urban location of Muslims (Contractor & Barai-Jaitly, 2013) are some of the hypotheses proposed to explain this relative advantage. However, NFHS 4 shows a very different picture. It appears that while childhood mortality rates dropped overall in Maharashtra, for Muslims, they remained constant. As per NFHS 4, childhood mortality for Muslims in Maharashtra was higher than that for Hindus and the state as a whole (See Figures 2, 3 and 4).

It is pertinent to note that as per NFHS 4 (2005-06) Infant Mortality Rate, Neonatal Mortality Rate and Under-5 Mortality Rate are all lower in urban areas than rural areas in Maharashtra (IIPS & ICF, 2017). Muslims being located in urban areas should, therefore, be at an advantage but this does not appear to be the case. The reasons for this must be explored. Infant mortality rates are reflective of a large number of contextual factors such as literacy, socioeconomic status, nutrition (of the pregnant woman and children), and importantly availability and utilization of health facilities. The reasons why childhood mortality rates did not improve for Muslims as compared to Hindus in Maharashtra,

may perhaps be related to these factors, especially the poor living conditions of Muslims, which overshadow the urban advantage.

Figure2: Neonatal Mortality Rate Trends for Muslim & Hindu children, Maharashtra,

NFHS 2, 1999; NFHS 3, 2005 – 06; NFHS 4, 2015 – 16



*Y-axis indicates the neonatal mortality rate

Source: IIPS & ORC Macro, 2001, IIPS & Macro International, 2008 & IIPS & ICF, 2017

Immunization: Along with changing trends in child mortality indicators, it is also important to point out the changing trends in immunization. At the time of NFHS 2 (1998-99), there were wide gaps in immunization coverage with 35 per cent of Hindu children receiving all vaccinations as compared to 26.3 per cent of Muslim children. At the time of NFHS 3, the gap decreased to 59.8 per cent of Hindu children receiving all immunizations against 54.8 per cent of Muslim children. However, at the time of NFHS 4, the gap appears to be widening again with 59.3 per cent of Hindu children receiving all vaccinations as compared to only 45.6 per cent of Muslim children. While there has been a general trend on reduction in coverage in the last decade, it seems to have had a significant negative impact on Muslim children, and the gap is wider than that of NFHS 2 (1998-99) in terms of complete vaccinations (IIPS & ORC Macro, 2001, IIPS & Macro International, 2008 & IIPS & ICF, 2017).

Availability of Public and Private Healthcare

The paucity of health facilities in Muslim-majority ghettoes emerges from the data in the four primary studies. (Nirmala Niketan, 2011, Poonacha et al., 2011, Shaban, 2011a & Jain, 2014) 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:

- Bhiwandi has ten urban health posts and only one public hospital catering to a population of about 7 lakh residents. Residents 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 have emergency facilities, ambulances or blood banks. There are no multi-specialty or tertiary care facilities and people travel to Mumbai or Thane for any surgery.
- In Mumbra, there are three urban health posts and one maternity home that caters to a

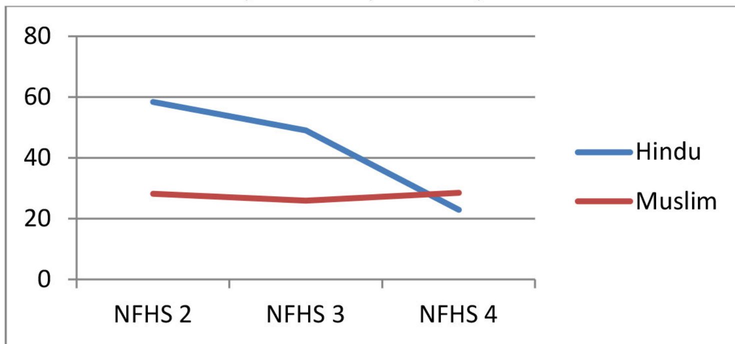
population of 8 lakh people. Further, the few urban health posts are only open for two hours, six days in a week at a time that is inconvenient for people, which makes access extremely difficult. The only hospital is located in Kalwa, and for conditions that cannot be addressed there, residents travel to Mumbai or Thane

- Malegaon with a population of 4.7 lakh has four municipal dispensaries, three maternity homes, and two municipal hospitals, along with a district hospital. However, the study mentioned that municipal hospitals largely cater to paediatric and child needs, whereas the district hospital provided limited services.
- The study from Behrampada showed that the area had no health post for a population of 49,829 and residents accessed health post located in Kherwadi for their needs.

This further exemplifies the lack of public health facilities available in these densely populated areas, which has a bearing on the health of the community.

Figure 3: Infant Mortality Rate Trends for Muslim & Hindu children, NFHS 2, 1999;

NFHS 3, 2005 – 06; NFHS 4, 2015 – 16



**Y-axis indicates infant mortality rate*

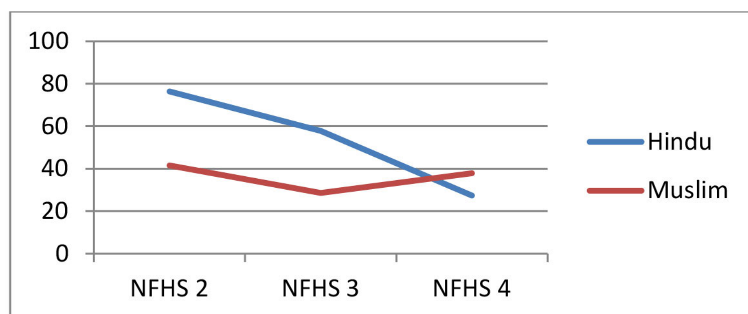
Source: IIPS & ORC Macro, 2001, IIPS & Macro International, 2008 & IIPS & ICF, 2017.

Flourishing Private Health Facilities

The non-availability of public health facilities in Muslim ghettoes may have led to the flourishing of private health facilities. In Bhiwandi, for instance, there were 75 private hospitals/nursing homes as compared to one municipal hospital and ten health posts. According to a survey report of private medical practitioners in Bhiwandi, (As cited in Chief Minister's Study Group Government of Maharashtra, 2013) over a third of private medical practitioners were Unani doctors, followed by Homeopathy and Ayurveda, while about a tenth were allopathy doctors with a bachelor's degree (Nirmala Niketan, 2011). Similarly, in Behrampada, there were 16 private practitioners in the field area of the study, most of them with an Unani or Homeopathy degree. There were no specialists or super-specialist facilities available (Poonacha et al., 2011).

Figure 4: Under - 5 Mortality Rate Trends for Muslim & Hindu children,

NFHS 2, 1999; NFHS 3, 2005 – 06; NFHS 4, 2015 – 16



**Y-axis indicates the under-5 mortality rate*

Source: IIPS & ORC Macro, 2001, IIPS & Macro International, 2008 & IIPS &ICF, 2017.

Prejudice among Health Care Providers

The prejudiced behaviour of health care providers was reported in the primary studies conducted particularly in Bhiwandi and Behrampada, where women specifically said that they did not like going to health facilities because they felt discriminated against by the hospital staff (Poonacha et al., 2011 & Nirmala Niketan, 2011). This finding is supported by the Sachar Committee report which found that Muslim women are deterred from accessing public health institutions because of the "unacceptable behaviour" that they encounter, and 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 points out that Muslim women wearing the burqa feel that they are not treated well in public facilities such as hospitals, schools, public transport, etc (Government of India, 2006). Another study in Mumbai (Khanday & Tanwar, 2013), found that Muslim women felt that they were treated differently from women of the majority community. Muslim women reported that the manner in which health care providers spoke to them 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 providers would refuse to pronounce or spell Muslim names correctly. Muslim women also reported that they were called derogatory names, such as *'landiyabai'* (wife of circumcised man) at health facilities. They were referred to as *'ladaku log'* (people who tend to fight) if they refused to remove the burqa. Moreover, women have expressed that it is the wearing of the burqa that brings about a change in the attitude of the hospital staff (Khanday &Tanwar, 2013).

> "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?"(Khanday & Tanwar, 2013).

Table 4: Available Health Facilities in Four Areas of Primary Studies

Area	Population	Health post/ dispensaries	Maternity Home	Public/ municipal Hospital	Private
Bhiwandi	7,11,329*	10 health posts		1	75 hospitals/nursing homes.
Malegaon	4,71,006*	4 dispensaries	3	1 District + 3 Municipal	
Behrampada (H/E Ward)	6,63,742 (ward)				
49,829 (Behrampada)	6 dispensaries & 8 health posts	6 dispensaries & 8 health posts	1	1	38 nursing homes/ 254 practitioners

**Data from Census 2011.*

Source: Nirmala Niketan, 2011, Shaban, 2011a & Poonacha et al., 2011

The prevalence of stereotypes and myths among health care providers is also evident. The study by Khanday and Tanwar highlighted various stereotypes that health care providers harbor about Muslim women– that Muslims have too many children, they are dirty and uneducated. Other subtle forms of stereotypes were also evident in the primary studies. For instance, in the Behrampada study, one health worker while speaking about the high prevalence of tuberculosis in the community, remarked that Muslims tend to have more TB because they eat beef leading to the transmission and spread of Bovine TB (Poonacha et al., 2011). Similarly, in Bhiwandi, according to the Chief Medical Officer, 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. This, despite the fact that 94 per cent of the children under 5 in the area were immunized, as per the primary survey (Nirmala Niketan, 2011). These perceptions cast Muslim communities as backward, stringent followers of religious *diktats* no matter how harmful, and resistant to change. They also reinforce the “otherness” of communities (see Table 5).

Table 5: Experiences of Women while Accessing Public Health Facilities

Faced by	Description of Behaviour
	• Rude language • Corruption to jump the queue • Abuse in labour ward – made to clean floors, physical and verbal abuse, no privacy • Behaving badly towards accompanying persons • Health care providers use English which is not understood by the patient population
	• Use of derogatory remarks about women married to circumcised men, “Landiyabaika.” • Being singled out as “Musalmanaurat” creating a negative impression • Refusal to understand and comprehend Muslim names • Asked to remove veil even before the turn for examination • Taunted as “dramatic” women because of inhibitions to remove burqa • Biases that Burqa-clad women steal children. • Stereotypical remarks o Muslim women have many children o Muslim people are uneducated o Muslim women refuse to use contraception o Muslim people are dirty

Source: Khanday & Tanwar, 2013

Despite this poor behavior and discrimination encountered at public health facilities, Muslim women continued to access them. Given that dignified treatment is a core component of quality of care and a human right, this aspect of provider behavior needs more attention.

Discussion

The literature on religion-based inequalities, discrimination, and exclusion of Muslims vis-à-vis health, in India, is scarce. For instance, a recent comprehensive review on inequities in maternal and reproductive health in India found only one article specifically about the Muslim population and pointed out that while some studies included data on religion, they did not explore the linkage between health status and being part of the Muslim community (Sanneving et al., 2013). Nevertheless, over the past decade, some studies and reports have attempted to highlight the health conditions of Muslims and their relative disadvantage. The Sachar Committee report (GoI, 2006), released in 2006, showed that of all the villages without medical facilities, 16 percent were located in Muslim concentrated areas. The availability of health facilities in the village declined with a rise in the proportion of Muslims in the population, particularly in larger villages. Similarly, concerning access to basic amenities, Menon and Hasan (2004) state,

> Clearly, there are disparities in access to services and programmemes along rural and urban lines and possibly along socio-economic status and community lines, reflecting discrimination in their provision by caste and religion.

Where inequalities around the religious community are reported, the studies are largely around maternal and reproductive health. A study reported that Muslim women (among slum populations) were less likely to have a birth attended by a trained birth attendant (Hazarika 2010). One study found that Muslims (along with other disadvantaged communities like SCs and STs) were more likely to report poor self-rated health (Bora & Saikia, 2015). The greater likelihood of receiving antenatal care (in Madhya Pradesh) and accessing post-natal care (in West Bengal) by Muslim women was reported (Jat, Ng & Sebastian, 2011, Tuddenham et al., 2010).

The present paper attempts to look beyond religion as an individual characteristic which determines health status and instead seeks to establish the disadvantaged socioeconomic conditions of Muslims in Maharashtra, drawing linkages to discrimination against the community and the historical impact of violence that pushed them into ghettoes. Located largely in urban areas, Muslims should have had an advantage, but indicators reveal a mixed picture. In case of childhood mortality rates, it appears that despite being located in urban areas, Muslims have not benefitted from the fall in mortality rates in the state over the past decade. Similarly, although utilization of maternal health services among Muslim communities is at par with the majority community, there are concerns around discrimination in accessing care. The findings of this paper are in no way conclusive, but rather indicate the need for exploring in greater detail, the mechanisms that explain differences in indicators as well as uncover the experiences of Muslims in the state.

That said, it is also important to note that considering Muslims as one group is not always helpful, as there are huge class, caste, gender and geographic differences between them. Intersectional analysis seeks to uncover the unique experiences of these different sub-groups and is therefore essential. The experiences of Muslim women or Dalit Muslims are likely to be quite different owing to additional layers of marginalization to which they are subjected. To be able to understand this, both qualitative and quantitative studies are required. These differences are insufficiently explored in the literature

and, the paucity of large datasets further makes it difficult to conduct a detailed examination of these differences.

In this context, evidence from some western countries suggests that 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 regimens) and poor utilization (Casagrande et al., 2007). The trust deficit between the State and the Muslim community is bound to play out also in its interactions with the health system, as has been reported in an ethnographic study from rural Uttar Pradesh which explores how widespread lack of trust in the public health system affects women's access to institutional delivery care. This warrants more context-specific, qualitative studies which can uncover these experiences, especially since we know from other contexts that such discrimination affects health. The impact that behaviour of providers, reported in this paper and other studies, has on people's health-seeking behaviour and health status needs to be considered more seriously and remedied. Similarly, the stark context of residential segregation of Muslims in the state and its impact on the health of the population also requires more serious investigation. Residential segregation has been identified as a fundamental cause of health inequities among racial and ethnic minority groups in the United States (Williams & Collins, 2001). Even the availability of health facilities and pharmacies in segregated areas is likely to be poorer than in other places (Williams & Collins, 2001). We see these characteristics in Muslim ghettos as well.

Finally, this paper only examined certain health issues for which literature and data were available. The general condition of Muslims, the stresses they face in everyday life also warrants more research into the impact of everyday micro aggressions faced by Muslims on their mental health. Similarly, the evidence on the Muslim community's precarious employment in the unorganized sector also warrants more research on occupational health hazards that the community faces.

Conclusion

The findings reported in this paper indicate that a large proportion of Muslims in Maharashtra live in relative isolation and are subject to relative disadvantages vis-à-vis poverty, employment, education and living conditions. These conditions affect their health and well-being, as explored in this paper. The findings throw up important questions and hypotheses that need to be studied in greater detail if we seek to better understand and address the needs of the minority population in a context-specific manner. It is, therefore, important that the mechanisms of social exclusion and structural obstructions are uncovered and documented so that they may be eliminated.

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