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xploring Religion based Discrimination in Health Facilities in Mumbai

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Preface

India is signatory to the International Covenant of Economic, Social and Cultural Rights (ICESCR) where the right to the highest attainable standard of health care is enshrined and includes four clear dimensions of this right- that health care must be available, accessible, acceptable and of good quality. Acceptability essentially means that the health services must be "respectful of medical ethics and culturally appropriate" and they 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.

CEHAT's engagement through training of health professionals highlighted that they have several biases and stereotypes about different communities. The belief that domestic violence was more common among Muslims than among Hindus and that Muslims have large families because they are reluctant to use contraception was prevalent among providers. In India, there is existing evidence on inequitable access to health care and health status based on gender, caste, class in India. However, there is limited research done on religion based discrimination in health facilities and its impact on access to health care.

This study is an attempt to explore religion based discrimination in health facilities based on perceptions of women from different communities. The study reports that women accessing health facilities are discriminated on the basis of class, caste, language, region and religion. 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.

There is a need to further study how discrimination operates in public health institutions so that appropriate measures may be taken to correct it and thereby improve the quality of services provided to women from different communities. It is important that we analyse how discrimination plays out in the utilization of public services for those from marginalised communities. We hope that our study is making a useful contribution to this field and more research is conducted on the subject to increase the evidence base.

Padma Bhate-Deosthali
Coordinator, CEHAT

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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
IJ	International Initiative for Justice
MCGM	Municipal Corporation of Greater Mumbai
MWS	Muslim Women's Survey
NSSO	National Sample Survey Organisation
PHF	Public Health Facility
POTA	Prevention of Terrorism Act
YUVA	Youth for Unity and Voluntary Action

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INTRODUCTION

"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."

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, the impact of which has been documented in fact-finding reports. The status of Muslims in India as secondary citizens is much known in view of the several reports published recently, especially the Sachar Committee Report, 2006. The systematic marginalization of Muslims, including Muslim women, has received attention in the national sphere.

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 2002¹, 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."* (Medico Friend Circle, 2002) 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 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 own work with health care providers in the Municipal Corporation of Greater Mumbai (MCGM) has shown that they do harbour communal biases and stereotypes related to the Muslim community. The Sachar Committee

¹ In principle, the Health Profession is neutral and non-discriminatory

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. (Rajinder Sachar Committee, 2005)

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.

India is signatory to several human rights treaties that explicitly forbid prejudice and bias in the provision of services². 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. It is a serious health and human rights issue that warrants exploration so that interventions can be put in place to address it.

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 (Engineer, 1991). Tracing the history of communal disturbance in India, eminent journalist Kuldip Nayar, has recorded 5,000 such occurrences till 1980. 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. 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. (Desai, 1991) This trend has continued and the worst was the 2002 Gujarat

² The ICCPR in Article 26 puts an obligation on the State to ensure that no discrimination occurs on the basis of colour, religion, race, sex, language, political opinion, property or social origin, in representation before the law. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESR) of which India is a signatory guarantees citizens the right to the highest attainable standard of health. The four essential elements of this right are availability, accessibility, acceptability and quality. As a signatory of the Covenant, States are required to respect, protect and fulfil the rights enshrined in it.

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 orphaned³. About 100,000 Muslims and 40,000 Hindus were in relief camps. (Ministry of Home Affairs [MOH], 2005)

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".

The Report named 32 senior and junior police officials, who were accused of biased treatment to Muslims to the extent of killing them. This anti-Muslim bias was also extended to the investigations. In cases where the suspected accused was a Hindu or had Shiv Sainik connections and where there were clear leads in the case, absolute apathy characterised the investigation. The Shiv Sena BJP government in the state actually gave promotions to many police officers who were accused in the Report. (Shri Krishna Commission, 1998)

In addition to communal riots, there have also been other attempts at marginalizing Muslims in the Indian State. For instance, after independence, there were attempts by some Congress leaders headed by Sardar Vallabhai Patel to restrict the appointment of Muslims in the police and security forces and also reduce the use of Urdu in the government. (Jayasekera, 2006) While affirmative action on the basis of caste has been implemented in India, the marginalized status of Muslims has not been addressed in the same way. Bhaumik and Chakrabarty find that, while economic inequalities between SCs/STs and upper castes have reduced during the decade 1989-1999, those between Muslims and non-Muslims have increased. (Bhaumik and Chakrabarty, 2009) The representation of Muslims in the public sector is very poor. The Sachar Committee Report finds that the percentage of Muslims employed in the public sector in India is even lower than that of Hindu OBCs. In recent years, the 'War on Terror' has been used as an additional weapon to marginalize Muslims in India. Muslims have often

³ These figures were reported to the Rajya Sabha by the Union Minister of State for Home Affairs Sriprakash Jaiswal in May, 2005. "Gujarat riot death toll revealed". BBC News Online. 2005-05-11. http://news.bbc.co.uk/2/hi/south_asia/4536199.stm. "BJP cites govt statistics to defend Modi". ExpressIndia. 2005-05-12. <http://www.expressindia.com/fullstory.php?newsid=46626>. PTI (2005-05-11). "254 Hindus, 790 Muslims killed in post-Godhra riots". Indiainfo.com. <http://news.indiainfo.com/2005/05/11/1105godhra-rs.html>.

been the targets of repressive laws such as the Prevention of Terrorism Act,⁴ (POTA) and form a greater proportion of the prison population than is their share in the general population.

Rise of Communalism and Ghettoization in Mumbai

Muslims have lived in Mumbai for about 700 years⁵. Currently, about 17 per cent of Greater Mumbai's 12 million population is Muslim,⁶ 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 (Khan, 2007). 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.⁷

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 ghettos. 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), Kurla, Malvani (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 (Robinson, 2005). Deosthali and Madhiwalla, stated

⁴ The India People's Tribunal on POTA (2004) found that in the State of Gujarat, out of about 280 people arrested under the Act only one was a non-Muslim (a Sikh).

⁵ As per the *Gazetteer of Bombay City and Island* (1909), between 1343 and 1534, Bombay came under the Muslim rule of the Sultans of Gujarat. This period saw the growth of a distinct indigenous Muslim community in Bombay. By the 1800s, the community had grown substantially and several Muslim sects were found in the city.

⁶ As per Census of India 2001, Muslims are the second largest religious group of India comprising 13.4 per cent (138 million) of the population, with nearly a third of them living in urban areas. The proportion of Muslim population in Maharashtra is 10.6 per cent (10 million), see www.censusindia.net.

⁷ As per Census 2001, Greater Mumbai has a slum population of 6.5 million. At least 28.5 per cent of these slum dwellers are estimated to be Muslims (*The Milli Gazette*, September 16-30, 2004).

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. (Deosthali and Madhiwala, 2005)

Even within the mixed slum communities like Dharavi, where for years, Hindus from the South and Muslims from the North lived cordially with the Maharashtrians, a process of ghettoization set in after the riots. (Sharma, 2000). If Muslims were a minority in a Hindu settlement, they moved out, and if Hindus were a minority in a Muslim neighbourhood, they moved out. During the riots a brick and cement wall was built at the end of Naya chawl (Tamil Hindus) and the start of Nawab Nagar (Muslims). Only a narrow gap, just enough for an individual to pass through was left. Six months after the riots ended, the wall was brought down by the Muslims with the aid of the municipality. However, for several years after the riots, Tamil Hindus from Naya chawl moved out of the neighbourhood steadily.

In another mixed slum, Jogeshwari (east), which saw no less than five riots - 1964, 1974-75, 1984, 1990-91 and 1992-93 - in the last four decades of the 20th century, Kothari and Contractor state that with each episode of violence, Muslims in the area were systematically pushed into a smaller and smaller settlement area at the peak of a hill, surrounded by Hindu settlements. Each riot pushed Muslims inwards and ghettoised them further - and now they are limited to an area called Prem Nagar. (Kothari and Contractor, 1996)

Ravinder Kaur points out that communal violence is essentially committed to altering urban spaces. It is in the often neglected aftermath of communal violence that "crucial post violence socio-spatial rearrangements take place". According to Kaur, anti-minority violence does not just keep the traditional community boundaries in place; rather it pushes these boundaries further afar. Thus, "physical violence becomes both the occasion and agency for purifying entire mohallas, or neighbourhoods, of the polluting 'Other'... where undesirable elements - members of the 'other' community, their property and places of worship - are removed and boxed into ghetto-like locations" (Kaur, 2005). It has become virtually impossible for Muslims to find accommodation in areas where they are not in a majority and this has restricted their choices. Such ghettoization ensures that members of the minority community do not socialize with those of the majority community and vice versa by reducing spaces for civic interaction. This deepens the sense of alienation of the minority community.

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.

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.

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 (Kothari & Contractor, 1996). 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.

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, there 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 (2006) and the second is the Muslim Women's Survey (MWS) by Ritu Menon and Zoya Hasan (2004). The Sachar Committee report used data from the 2001 Census of India and the 61st round of the National Sample Survey Organisation (NSSO) to assess Muslims' access to social (education and health facilities) and physical (electricity, piped water, roads, transport, postal services) infrastructure. The data 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 (Vissandjee; Barlow and Fraser, 1997). 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.

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 (Medico Friend Circle, 2002). 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."* (Khanna, 2008). 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 (Rajinder Sachar Committee, 2006). 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

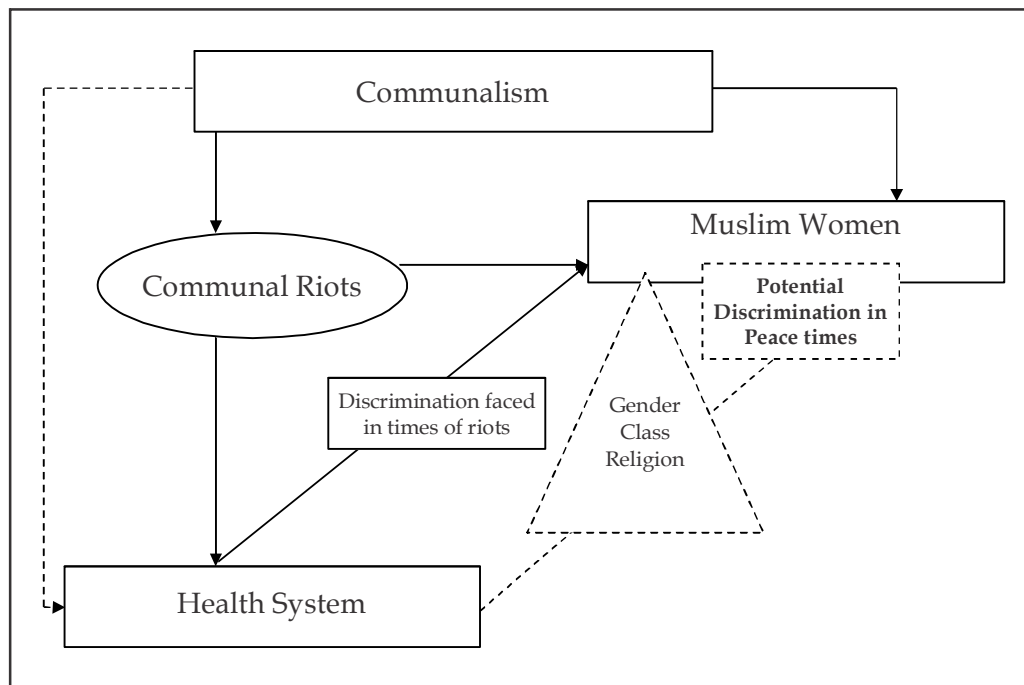
public transport. These statements are based on discussions with various representatives of Muslim communities across the country. The fact that health professionals discriminate against minorities in times of peace, this is indeed possible given the nature of communalization in society as a whole. Such 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 (Physicians for Human Rights, 2003). 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.

CONCEPTUAL FRAMEWORK

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. The figure given below depicts this relationship; the solid lines indicate the established links in literature, while dotted lines indicate linkages the study will explore.

Figure 1: Conceptual Framework for Exploring Religious Discrimination through Women's Experiences of Health Facilities



Rationale for this Study

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 literature on Muslim women's health indicates that a substantial proportion is concerned 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.

Research Objectives

To conduct an exploratory study to understand:

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

Research Questions

- What is the nature of discrimination faced by Muslim women when they access health facilities?
- Does a woman's religious identity affect the manner in which health care providers behave with her?
- What is the role that this discrimination plays in determining decision to access health facilities?

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METHODOLOGY

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.

Quantitative methods to study perceived discrimination have typically employed a survey methodology that uses an index to measure levels of perceived discrimination, and differences between minorities and Whites⁸. Others have administered surveys to physicians after an interaction with patients of different races, and assessed whether they are positive or negative⁹. Still others have utilized 'actors' to understand the differences in the way physicians perceive patients who come to them for care¹⁰.

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. This study used an in-depth interview guide and employed a constructivist approach to understand how African American women perceived the

⁸ Several such indices have been used. The Medical Mistrust Index, for example, is an 11 item scale which was used in one study that found that non-Hispanic Blacks were less likely to trust their physicians than non-Hispanic Whites.

⁹ One study by Doescher et al., on physician's perceptions of patients based on their race, administered questionnaires to physicians after their encounter with white and black patients, and found that physicians were more likely to have negative opinions about black patients. Doescher M P, Saver B G, Franks P, Fiscella K, "Racial and Ethnic Disparities in Perceptions of Physician Style and Trust". Arch Fam Med. 2000;9 (10):1156-1163.

¹⁰ Schulman, for example, utilized videotaped actors who displayed the same symptoms of cardiac disease and found that physicians were less likely to refer black female patients for cardiac catheterization than black males or white patients. Schulman, K.A., Berlin, J.A., Harless, W., Kerner, J.F., Sistrunk, S., Gersh, B.J., Dube, R., Taleghani, C.K., Burke, J.E., Williams, S., Eisenberg, J., Escarce, J.J., Ayers, W. (1999). "The effect of race and sex on physicians' recommendations for cardiac catheterization." New England Journal of Medicine 340:618-626.

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.

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.

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.

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. (Annexure - VI)

Methods of Data Collection

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

Focus Groups Discussions

Our method for exploring women's perceptions of how they were treated in the health facility was Focus Group Discussions (FGDs). We chose FGDs because the information being sought was not about personal experiences per se, but about the experience of minority women as a group. Further, women are more open to talking about their experiences as a collective, especially when the subject is sensitive; when in a group, they tend to be more vocal and share many more experiences than when they are interviewed one-to-one. Eight FGDs were conducted, four with Muslim and four with non-Muslim women. The FGDs lasted for about 45 minutes to an hour.

The tools were piloted in the community by conducting two FGDs, one with Muslim and the other with non-Muslim women. From the two FGDs it became clear that both Muslim and Non-Muslim minority women in this community were facing similar issues while accessing public health system. This was because most of the non-Muslim population in the community were migrants constituting a minority in the city and they too faced discrimination and bias in the health facilities. It was thus decided to conduct an FGD with a Marathi speaking Non-Muslim women's group in the community, to which the experience of the other two groups could be compared.

Sample Size

A total of eight FGDs four from Muslim (44) and four from Non-Muslim (41) communities were conducted with a total of 85* women. Each group had a minimum of eight women. From each FGD it had been decided to conduct a minimum of two in-depth interviews making that a total of about 16 in-depth interviews.

Criteria for selecting women for the FGDs

- Age: 18-30 years (marriage and child bearing age), 31-50 years and 50 plus years
- Access to health facilities: in and around Basta and access to both public and private sectors
- Employment: working and non working women
- Marital status: married and unmarried women
- Education: educated and uneducated women.

Table 1 : Selection Criteria for Research Participants

Selection Criteria for Research Participants				
Age	Health Facilities Public/Private	Educated (minimum)	Employed** (minimum)	Married (minimum)
18-30	2/2	2	4	3
31-50	2/2	2	4	3
51+	2/2	2	4	3

*There will be equal representation of Women from the three communities.

** Employment as we found included work from home and work outside of home. Owing to community differences, not all FGDs could fulfil this. This will become clear in the next chapter when we discuss the nature of work that women are engaged in.

Key informants Interviews

Key Informant Interviews were used to get an overall understanding of peacetime communalism and community context. They were conducted with prominent community members - Municipal Corporator, people from different NGOs and *mahila mandals* (women's collectives) working in the community and some prominent people of the community to understand the history and social make-up of the community. This was felt essential to understand the changing nature of the community during the decade after the communal riots in the city of Mumbai. What are the kinds of changes that have been brought in due to these riots in the city? Has the community undergone any transition as a direct consequence of these incidences? How did/ does the community react to the various incidences taking place in the city? Information generated from the Key Informant Interviews helped the researchers understand the layout and the population distribution of the community.

In-depth Interviews

These were carried out with women identified in the FGDs. Women who were vocal in their sharing in FGDs were contacted for an in-depth interview (IDI). If the research team felt that a particular woman can elaborate on what was shared in the discussion, then that woman was contacted and requested to be a part of the in-depth interview. The in-depth interviews lasted for about an hour and a half. Some of the IDIs had to be conducted in two to three sessions.

The three methodologies of data collection were conducted simultaneously so that they could feed into one another. Transcriptions of the FGDs were carried on simultaneously. Attempts were made to finish transcriptions of one FGD before conducting the second one. In-depth and Key Informant interviews were also conducted in the same manner.

Community Mapping, Rapport Building and Discussions

The initial contact with the community was made soon after the development of the proposal. Three organisations working in the community were contacted to understand the community and to find an inroad into the community. The organisations introduced the team to their focal point women in the community and the *mahila mandal* members, who introduced the team to the community. The team initially spent time walking around the community with the *mandal* members from the organisations making contacts and familiarising themselves with the community. After the initial contacts were established, the team would spend a day or two visiting different parts of the *basti* familiarising themselves with the locality and rapport building. Women for the study were identified during this rapport building phase. The team also participated in *morchas* (demonstrations), celebration of festivals and other programs organised by the NGOs to familiarize themselves with the community.

Potential research participants were identified by the team on the first day itself. The team met groups of women in the lanes and held discussions with them on health issues. Women, both Muslim and non-Muslim, were extremely vocal about their problems with the health facilities, especially the public health facilities. Field notes were made and potential research participants were identified from these discussions. The team visited each area at least thrice before conducting a FGD in that area. Repeated visits were made to maintain the contacts established with the women and also to be able to get a holistic picture of the area by talking to more women.

Throughout the data collection, the team visited the community and spoke to women sitting outside their houses, in and around public places like temples, schools and parks. Discussions were held with both Muslim and non-Muslim women often in groups of three or more. Narratives of bad experiences were collected from these discussions.

Informed Consent

Informed consent was sought from participants before the focus group discussion as well as interviews. An information letter that explained the purpose of the study was given to the participants. Women often had questions about how documentation of such experiences would be useful, and it was clarified that the study would be able to push the government to take cognizance of the problems in the system and address them. Both the information letter and the consent letter clearly explained and requested the women to share only that information that they were comfortable with in sharing with the group. There were also questions and doubts raised about their identities being revealed. Women stated that they did not want to complain against the public health facilities, for fear that the facility would stop providing health facilities to them. A lot of time was devoted to interactions with the women before the FGDs and they were assured that anonymity would be maintained. Enough time was also given before the start of an FGD to answer all the participants' questions. Two things that helped the participants ease out were the fact that the team gave them the information sheet regarding the study and also that the address and the numbers of the organisation were mentioned in each information sheet.

Consent was got from the women at different levels. The first was when the team met the women in the community, informed them about the study and invited them to be part of the research. Then women were collectively informed and told about the study before the start of the FGD. Finally, women were given written consent forms which were read out and then they were requested to sign these.

Analysis

The aim of analysis in this study was to explore the nature of discrimination that exists in health facilities as perceived by Muslim and non-Muslim women, the unit of analysis being a woman. The data we collected was rich in content as it had information that extended beyond the nature of discrimination. Potential first level and second level concepts for the purpose of analysis were developed. Using this approach, analysis was done and second order concepts were organised as chapters in view of the research questions.

Alongside the process of discovering concepts, field work for two months was organised, where women in the community and the older contacts were contacted to bridge the gaps. Women who were seen sitting in groups outside their houses were mainly approached for conversation. A detailed understanding of the community was hence, generated.

Challenges

Although in-depth interviews had been chosen as a method of data collection, after conducting six interviews, the research team felt that they were not able to generate as much information as was expected. It was also felt that most women were not as comfortable talking about problems with the health system, as they were during the FGD. The free atmosphere that was attained during the FGDs and the spontaneity was missing in the IDIs. It was observed that women were tense and tried to change topics when conversing about issues on discrimination. Women tended to smile or just maintain silence when asked to expand on things discussed in the FGDs. Out of six in depth interviews, we were able to generate data only from two, and even that went beyond what was discussed in the FGDs. While the women had consented to speak during the in-depth interviews, there lurked the fear of speaking about the discrimination faced and they did not share as much as during the FGDs.

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ABOUT THE COMMUNITY

I. Background

This study was conducted in a *basti* (slum), of Mumbai city spread across a stretch of less than a kilometer, located close to a railway station. About 100,000 families reside in this area, which is divided into several *bastis* - Nada, Bada, Gnagar, Anagar, Kwadi. Politically the area is very vibrant with the presence of BJP, Congress and Samajwadi Party. There are a number of *mahila mandals* and other local community based organisations functioning in the area. They work on various issues including sanitation and hygiene, housing, loans and legal advocacy.

The entire slum rests on marshy land. The construction type of the *bastis* is varied as they developed at different points in time. Among all the *bastis*, Nada and Kwadi are the oldest constructions in the area, which were originally a part of a government scheme initiated in the early 1960s. They are comparatively more structured concrete constructions with wider lanes as compared to Bada, Gnagar, Gabar and other new *bastis* in the area. Kwadi in fact was designed to be a model village in the city. From 1980 onwards, people from within and outside of Maharashtra migrated to this area leading to a gradual vertical and horizontal expansion of habitations. Their legal status is a controversial issue.

Location wise, Nada and Gnagar are located adjacent to the railway station, while Kwadi is located further away. Opposite to Nada, Bada's construction is strictly vertical with lanes just three feet wide. Rawl is a part of Bada. Anagar, which has a *chawl* type concrete construction, is located opposite to Kwadi with about 40 families. It is the most spacious and well constructed among all the *bastis*. Many houses in Anagar have toilets installed unlike those in Bada, Nada, Gabar, Gnagar and Kwadi.

II. Social Character

The slum as a whole has a mixed population of both Muslims and Non Muslims (usually low caste) from different parts of the country mainly Uttar Pradesh, Rajasthan, Bihar, Haryana, Gujarat, Maharashtra, and West Bengal.

It was among one of the worst affected areas in the 1992-93 communal riots. Prior to the riots, the *bastis* had a mixed population of Muslims and Non-Muslims¹¹. Today, the way *bastis* are spatially organised, one can observe that there are clearly defined Muslim majority and non-Muslim majority areas. Nada, Bada and Gnagar are Muslim majority communities with Muslims mainly from Uttar Pradesh, Bihar, Maharashtra, Bengal and other states. Rawl¹², predominantly Muslim is a part of Bada. It has a lane inhabited by only Gujarati families. Kwadi has a majority of non-Muslim, low caste community from Rajasthan and border areas between Haryana and Rajasthan. In Anagar, a Maharsahtrian Boudh community resides¹³. For the purpose of this study, we picked one Muslim community, one non-Muslim Kaj community from Rajasthan and one Maharashtra Boudh community.

While families in Bada and Nada are usually nuclear, those in Kwadi and Anagar have more of a joint set up. These families are related to each other by blood, through marital relations or they belong to the same village. For any financial help, people rely on their relatives or take loans from local businessmen on interest (between 2%-4%). The first choice among both Muslim and Non-Muslim women is to ask for help from their parental homes rather than from their in-laws, depending on the relations with the in-laws and financial standing of the two. Among Muslims, Mosque funds and donations and easy loans from the cloth merchants are the common sources for medical and marital purposes.

III. Education and Marital Age

Educational status of the general population in Basta is low. Women in particular, across the different communities, older women in the age group of 50 above are illiterate while some above the age of 40 have been educated till standard 5 and above. Younger women between 22-35 years of age have studied till standard 10 and above. Many Muslim women have Urdu education. At present, unlike other areas in the community where girls are being encouraged to pursue higher education, girls in Kwadi drop out after standard 8. Women in Kwadi shared with us that when they

¹¹ For instance, pre 1992-93 riots Kwadi had a mixed population of both Muslims and Non-Muslims which has changed to a Non-Muslim dominated locality with a handful of Muslim families.

¹² In Rawl, we were told that it was once a Gujarati majority lane, but over the last ten years, families have moved out. Those who have moved in are mostly Muslims. Some of the Gujarati families presently living there shared with us that they too are likely to move to another place. Two explanations found for this change in composition of community are: First, as people acquire higher incomes, they move out of the slum to better areas. Second, post riots, through a process of ghettoization, Gujarati Hindus have moved out to other areas. Similar changes were reported for Nada, non-Muslim families have moved out. One of our KRIs, who is heading a local organisation expressed that the non-Muslims left out of fear, as there was no one who would take a guarantee of their safety post the riots.

¹³ Some of the owners in this *chawl* have sold their apartments and some have rented them out, not necessarily to Maharashtra for residential and commercial use. Although Kwadi has a dominant Kaj population from Rajasthan and bordering areas of Haryana, one can find several families from Uttar Pradesh and Bihar referred to as *Bhaiyyas* by the Kaj community. For other communities all people from Uttar Pradesh, Bihar, Rajasthan, Haryana are *bhaiyyas*. There are few families from Maharashtra and Gujarat as well living in Kwadi. Originally, Kwadi was meant only for people of Kaj community, but over the years, the original owners have moved out allowing people from different states to stay there either on rent or as owners.

compare girls in their community to girls in their villages, village girls are better educated¹⁴.

IV. Occupation

The occupational profile is varied, with people generally engaged in occupations that require basic or no education such as small businesses (cloth factory etc, utensil store), casual labour, auto-rickshaw driving, tailoring and so on. However, it is interesting to note that the Maharashtra Boudh community has a different work profile, for both men and women. While in all the other areas, women are engaged in home based work or domestic work, the women from Anagar have formal sector jobs like beauticians, accountants etc. Similarly, in the case of men, the ones from Anagar are employed in the service sector. This suggests that the Maharashtra Boudh community is better off than the others in the nature of work that they do.

The kind of work that men and women in these areas are involved in is depicted in the table below.

Table 2: Respondents' Occupations Area-wise

Area	Men	Women
Nada	Wholesale garment shops, tailoring, auto-rickshaw drivers, informal labourers.	Domestic workers
Kwadi	Collect and sell hair for the purpose of making hair wigs; segregate plastic from waste; make tyres and chappals, few are white-collar workers in the railways and other jobs	Home-based work of necklace making
Bada	Making Tiffin, outsourcing embroidery, batik printing, dyeing and tailoring, small businesses	Home-based work like sewing buttons, stitching nightgowns, bindi making and other piece rate work, domestic help.
Rawl	Make flower garlands	Make flower garlands, papads and tailoring
Anagar	Service sector clerks, lawyers, doctors	Beauticians, accountants, compounders

¹⁴ Reason cited for this difference is that families in Kwadi are afraid that by sending their girls to educational institutions, chances of their getting into intimate relationships with boys increase significantly.

V. Profile of the Sample

Respondents of the study are women who are primarily married with children living in small spaces, belonging to the lower class, not well educated and majorly dependent on the incomes of their husbands.

Table 3: Women's Education, Work Status and Marital Status

Category	No. Of Women (Muslim)	No. Of Women (Non- Muslim)	Total
	Education		
Educated	32	23	55
Uneducated	12	18	30
Total	44	41	85
	Work Status		
Working	13	21	34
Non-Working	31	18	49
Studying	0	2	2
Total	44	41	85
	Marital Status		
Married	38	22	60
Widow	6	17	23
Single	0	2	2
Total	44	41	85

Total number of women in our sample was 85, 41 Non Muslim and 44 Muslim women. Non-Muslim women in our sample belonged to Gujarat, Maharashtra, Rajasthan and Uttar Pradesh, while Muslim women belonged to Maharashtra and Uttar Pradesh primarily (few came from Delhi, Bangalore, Chennai, Hyderabad and Ahmedabad).

Respondents' occupations ranged from Beautician, making garlands, *papads*, tailoring, bead work to small businesses such as a dairy, ferry business and so on.

Table 4: Occupation of Women

Occupation	No. of Women
Milk Dairy	1
Beautician	1
Garland Making	2
Stitching	8
<i>Papad</i> Making	1
Ferry Business	1
Crochet	1
Small Cloth Business	1
Mandal Member	5
Domestic Help	7
Bead Work	4
Health Worker	1
Religious Tuitions	1
Total	34

While on most socio-demographic indicators, Muslim and non Muslim women were similar, it is interesting to note that although a greater proportion of Muslim women were educated, there were more working women in the non-Muslim groups. This suggests that mere access to education did not ensure that women were able to work outside the home and have financial resources.

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AVAILABILITY AND ACCESS TO HEALTH SERVICES

This chapter analyses the availability of health services for women in the community. It attempts to capture factors that determine Muslim and non-Muslim women's access to health care services.

In the year that the research team spent in the community, women both Muslim and non-Muslim shared their experiences about health and health facilities. From the data that emerged we were able to get a sense of health issues of women, health facilities available and those accessed. There were several similarities as well as differences between the two groups, which provides a context to exploring experiences of discrimination in health facilities. This chapter begins with reporting the health issues of women in the community, availability of services, factors that affect women's choice of services and change in availability and preference of facilities over the years.

I. Illnesses reported

In our study, the profile of illnesses found in the Muslim and Non-Muslim areas is similar. In both communities women distinguish between serious (*badi bimari*) and non-serious illnesses (*choti bimari*). Non-serious illnesses include cough, cold and fever which are commonly reported. Serious illnesses include non-communicable illnesses such as heart ailments, diabetes, cancer, kidney stones and genito-urinary illnesses, as well as communicable diseases such as prolonged fever, malaria, jaundice, typhoid and tuberculosis. These diseases are related to the poor living conditions in the slums which have inadequate sanitation, waste disposal and ventilation. Apart from these illnesses, emergencies were also reported by women, which include accidents, burns, high fever or any other such ailments or delivery as well. (Refer Table 5 for list of illnesses prevalent in the community).

II. Available Health Facilities

The area of study is populated by both public as well as private health services. Private services include local providers, charitable clinics and also big hospitals. Public health facilities are run by the Municipal Corporation of Greater Mumbai (MCGM) and include a health post and dispensary. There are two Municipal hospitals located nearby, one in the western part of the suburb (B) and another in a neighboring suburb (V). The most popular public facility used for deliveries was K Maternity Home located in the area. It has, however, been closed for renovation and women have had to access other public hospitals in the vicinity, such as B. Constant comparisons were

made between B and K, the latter being praised for its services to the extent that women expressed that if K were converted into a full-fledged hospital, once it re-opened, it would take away the load from B. The Closure of K resulted in women moving to other facilities. . Non-Muslim women moved to N, a public facility. On the other hand, many Muslim women moved to B. They had either never heard of N or not made the effort to visit it.

III. Choice of Facility based on Illness

Women reported accessing different facilities based on the illness reported. There were similarities between both communities; for example, both did not access public health facilities for non-serious illnesses and the reasons were the same. On the other hand, both accessed public health facilities for serious illnesses and emergency situations. There were however, a few differences between the two groups - specifically around the financial ability of Muslim women to access private facilities, and the stress that Muslim women placed on the behaviour of health care providers, which determined their preference for private providers vs. others. These differences are depicted in the table below.

Table 5: Reasons for accessing or not accessing Health Facilities, based on Type of Illness: Differences between Muslim and Non-Muslim Women

Type of facility	Type of Illness	Muslim	Non Muslim
Public	Non - serious	Not accessed because in any case medications etc have to be bought from outside – cost is as much as going to private	
	Serious	<ul style="list-style-type: none"> • Cost of services not as much as in private, so accessed • Women have less access to resources in the family than non-Muslim women, and therefore not able to access private facilities 	<ul style="list-style-type: none"> • Usually do not access public facilities as women can afford – have more access to resources
	Pregnancy and Delivery	<ul style="list-style-type: none"> • Muslim women cannot afford to go to private hospitals as they have lesser access to resources. Because behaviour of staff in public facilities is bad, many reported going back to villages for delivery or going for home deliveries. 	<ul style="list-style-type: none"> • Do not access as behaviour of providers is bad, except in case of complications. • Can afford to access private facilities.

	Emergency	<ul style="list-style-type: none"> • Accessed because guaranteed to get services, quality of doctors is good 	
Private	Non - serious	<ul style="list-style-type: none"> • Closer to access, not much time is lost • Cost is lower than accessing public facility because travel is not much and in any case in public hospitals, medications have to be bought from outside • Behaviour of local doctors is better than those in public hospital 	<ul style="list-style-type: none"> • Closer to access, not as much time is lost • Cost is lower than accessing public facility because travel is not much and in any case in public hospitals, medications have to be bought from outside • Quality of services, effectiveness of medication is more
	Serious	<ul style="list-style-type: none"> • Prefer to access private as quality of services is perceived to be better 	
	Pregnancy and Delivery	<ul style="list-style-type: none"> • Accessed for ANC, but not for delivery as cost is too high. 	<ul style="list-style-type: none"> • Prefer to access private as behaviour of providers is better • Able to choose female doctor – prefer female doctor – Reported only by Kaj women.

Another difference that was noted was that non-Muslim women were more aware of the various private facilities available in the area, but the Muslim ones were not. While non-Muslim women listed many private (HF¹⁵, BC, Gu Hospital, S, Po, I) and public facilities (B, Ke, W, Vd, Si, N, C), facilities listed by Muslim women were few (Private-HF, Su, Ga and Public- B, Ke, K). This raises a question about different awareness levels of women from these two groups and the extent of their interaction with one another.

IV. Factors affecting Choice of Health Facilities

The factors that play a role in this choice of health facility are discussed in detail below.

¹⁵ HF hospital is another private hospital that is frequented by women as a local NGO group offers them discount in the hospital.

1. Financial Factors

Costs associated with accessing a facility are one of the primary determinants of health access for both groups of women.

Local Doctors vs. Hospital

In case of everyday illnesses such as fever, costs involved in travelling and seeking treatment at a bigger facility are almost the same or higher as compared to treatment costs at the local level. The local doctor's fees which includes medication for 2-3 days are at par with the overall cost of treatment at the bigger facility.

Just give it a thought, we do not get charged for the fee of the doctor (at a public health facility), other than that all the medicines and the tests that they give, are from outside (of the hospital). So we think that, we spend on the rickshaw 30 - 30 rupees then spend 60 rupees on the medicines and then the waiting time. Calculating all that, we feel that we might as well spend 60 rupees here only and get the medicines.

With this kind of a clear comparison, local doctors are the first point of contact for women for all kind of health issues/illnesses. Unfortunately, there are no functioning public facilities close by that women could access, and they invariably have to go to the big hospital to get any sort of treatment. The nearest public hospital is located 5 km from the community and the only way to reach there is by auto-rickshaw, which is expensive, or by bus, which is time consuming. Private providers, on the other hand, are located less within a 500m radius and therefore automatically become the preferred option.

Public vs. Private

In case of serious illnesses, which require prolonged treatment and pregnancies, the choice of a facility is critically dependent on the financial status of the family. Women stated that those who can afford the expenses associated with treatment in a private facility prefer it over public. For deliveries, if a family could spare only about 2000-3000 rupees, then they access the public hospital and if they have around 5,000-10,000 rupees, they access any private facility.

Muslim women explained that in most Muslim households there was usually just one earning member. Whereas in most non-Muslims households, both husband and wife were working and once the children were of an age, they also pitched in to the earning of the family. A comparison of the profiles of the respondent of our study showed that most women from the non-Muslim community were engaged in some form of employment, whether from home or outside. This was not the case with Muslim women.

Further, in private facilities, the moment the patient ran out of money, he/she was denied services, irrespective of the person's religion. This motive acts as a discouraging factor for Muslim women (who are unable to gather resources) to access private facilities, as women have shared experiences of being embarrassed and put to shame due to delay in payment. Such a situation is less likely to arise in public facilities.

Even for the women who went to private facilities for treatment of serious ailments, over a period of time, they were forced to lean back on public facilities for want of money. While accessing private facilities to get specialized treatment, costs accumulate especially for prolonged treatment. In order to bear this cost, women seek financial support from their parental home and other relatives and such help is dependent on the latter's financial status. In most cases, the financial status of those who provide help is not significantly better/higher than the help seekers, hence the financial support is withdrawn after a while. Because the illness is serious and cannot be ignored, women end up going back yet again to the public health system. If treatment there too does not seem to be effective, they are left with no choice but to seek help from local doctors in the area or any other doctors. These are often based on recommendations of neighbours/relatives.

2. Quality of Services

Private facilities were clearly considered to be of better quality than public ones by all women. Quality was defined by women as availability of treatment and services, ease of navigating the facilities, quality of food and general ambience of the facility. In terms of ease of navigating procedures in the facilities, women explained that although there are queues at the private clinic, the approach is more methodical than it is in public health facilities. For example, patients are given numbers based on which they get to see the doctor. The crowd is not as big as that in the public hospital. They have to pay money at one place and get medicines from there itself, unlike the public hospital, where one has to run around in order to get medication, only to find that it is unavailable and therefore needs to be procured from outside. Further, the behaviour of staff was better. While both groups stressed on the systematic procedures at private facilities, Muslim women seemed to value the behaviour of providers greatly. They expressed that at private facilities they feel cared for and respected, especially during deliveries. On the other hand, the experience of delivery in public hospitals was described as demeaning, "*where all one wants is to get over with the delivery and go home*". Details of the nature of bad behaviour are explored in the chapters that follow.

3. Women's Decision making Powers and Mobility

Women's position in their family and the restrictions on their mobility emerged as two significant factors influencing health care access.

Health as a non-priority

Most women in the study, perceived their health as a secondary issue. If their treatment did not yield results in the expected time, the cost was perceived to be unworthy, as that money could be used to finance more important things in their family. This was seen in the narratives of both sets of women irrespective of the religion that they belonged to. The following case study demonstrates the relegation of women's ailments to a secondary status, if they are not considered 'serious'.

This however did not apply to *mandal* members from all the communities, because owing to their position in the *mandal*, they were active in decision making in the household and contributed significantly to their family decisions.

Nilopher suffered from a skin ailment which caused swelling in her body parts which eventually spread to her face. She sought treatment from a local doctor, then from a larger public facility and then finally from a doctor recommended by relatives. The problem has lasted for almost 9 months and she was required to pay Rs.600 for the specific treatment. Between her and her husband, they came to the conclusion that with this money, they could fund their younger one's school fees for three months, and so the treatment was not sought. She says, "Aisa to nahi ki koi zyaada badi bimaari hai ki jaan to khatra ho" (it is not as if it is a serious ailment which is threatening my life).

Access to Finances in the Family

For Muslim women and women from the Kaj community, the access to finances was far more limited than it was for other non-Muslim women as very few women from these communities were engaged in formal work. Among Muslim women, very few worked. In the Kaj community too, barring *mandal* members, none of the women worked as domestic help or engaged in any other work that required them to step out of the confines of their community.

Importantly, Muslim women have articulated their inability to generate income and hence are able to access only the public health system for health complaints. They access it because it is low cost, although they face many problems. They compared themselves to non-Muslim women who were engaged in some form of employment, and who could therefore choose among the options of facilities available given their ability to generate income. A Muslim woman stated: "*In their households there are always two to three earning members, while we are not allowed to work; in our families there is one working member and five to seven people dependent on his single income. How far will the money last?*"

Restrictions on Mobility

In general, women want to access services which are located close to their residence. Most women consult their families especially their husbands for decisions to access facilities, other than local doctors. As the local doctors are nearby, the need to travel does not arise and women can visit them without having to take permission from their family members. Besides, the doctors' fees are minimal. However, for any treatment that requires going to the hospital, the permission of the husband is required. The following case study demonstrates how women too perceive this restriction of mobility as a 'concern':

The geographical access of the Muslim group and women from the Kaj community was more restricted compared to that of the non-Muslim group. In other words, the non-Muslim Marathi speaking group spoke about accessing far off facilities, while the Muslim group and non-Muslim Kaj women rarely spoke about accessing facilities which are located farther away from B.

Seema very lovingly stated that her husband took such care of her that he even bought the groceries for the house. All that she had to do was to bring her children home from school. "My husband loves me so much that he does not let me even buy vegetables for the house. If it were up to him he would bring the children also home from school". She stated that she did not know many routes in the area despite having been born in the locality. Talking of changing times, she stated that when she was a small girl in her maternal house, she was never allowed out even in her own lane. When she spoke to her neighbours, her brother would be around. She stated that it was after marriage that she was able to go out a bit. Yet, if she needed to go anywhere and her husband was not free, he would ask her to take someone with her or else postpone her visit till it was convenient for him to accompany her.

4. Characteristics of Health Care Providers

Doctors' Approach and Behaviour of Staff

Muslim women gave a lot of importance to the fact that in private facilities, the doctors were better behaved than in public facilities and they emphasized the hospitable approach of their local doctor. They said they went to those private doctors with whom they had a close bond. This factor as a reason for preferring private facilities over public ones was not reported by non-Muslim women, suggesting that it is an important consideration for Muslim women. The local Muslim doctors, they say, have a positive and warm approach towards them, in a manner that "Marathi" doctors at the public health facility receive patients of their own community. This reflects that the lack of comfort or the perceived difference in doctor's behaviour at a public health facility becomes a factor influencing women's preference of a health service.

Women do not mind waiting in the queues because when they do get their turn, the doctor spends time in listening to them unlike doctors in bigger hospitals such as B. The doctor may only help with one out of all the problems that women list, but they feel better just being able to discuss it with them. They continue to go the doctors who pay attention to them, treat them as people rather than just as patients. For instance, just greeting the patient and showing interest in their lives is appreciated by them. This becomes significant when placed against the indifferent or rude approach of doctors in bigger public health facilities towards Muslim women. Behaviour as a factor remained a constant in Muslim women's responses while accessing facilities for conditions ranging from non-serious to serious. For the non-Muslim group, behaviour emerged as a factor in responses surrounding deliveries.

Muslim women clearly distinguished between the attitude and behaviour of staff in private facilities and public facilities. We observed that when Muslim women described the way the staff spoke to them, there was a change in their tone to demonstrate the difference between public and private. Description of private staff's behaviour '*pyaar*' (love, affection) reflected care and concern in constant comparison to the lack of it in B.

With regard to deliveries, women expressed that the lower level staff in public hospitals used derogatory language to inform or explain anything to them. Some said that they also faced physical abuse. Women expressed that the language used was so despicable that they felt ashamed to repeat those words. They were sensitive to the staff's comments: "Why do you scream now, why didn't you scream when you were having intercourse with your partner?" Women who delivered once at B did not have the courage to deliver there again, they would rather deliver at home or at a private facility. Women from the Kaj community expressed disgust and disappointment at the behaviour of the lower staff and the way women had to deliver in the ward without any side screens or curtains.

There were also instances when pregnant women in labour pain were refused admission in hospitals on the pretext that there was still considerable time left for the delivery and this resulted in delivery occurring in their homes or outside the hospitals or en route. Further, C-sections were advised without explaining the real need for it. (medical mistrust can be mentioned here.) Some Muslim women stated that they would prefer giving birth at home but they had to choose institutional deliveries for the birth certificate that was issued by the hospital. For those who could afford it, delivery at a private facility was definitely preferred.

Sex of the Doctor

For Muslim women and Kaj women, the availability of female doctors was important, particularly for deliveries. Both groups expressed apprehension about the presence of male doctors in the delivery ward. They expressed discontent with the fact that

male doctors were allowed to conduct checkups and suture after delivery. Women were unable to choose doctors in the government hospitals. They had to consult the one available in the facility. Women found this a big drawback, and most Muslim women stated discomfort in consulting a male doctor for pregnancy checkups and deliveries. In an interview with a gynaecologist who runs a maternity hospital in the area, this dimension was validated. She told us that one of the reasons that 99 per cent of her patients were Muslims despite being located in a non-Muslim area, was that there were no males in her hospital. All her staff were female.

Doctors' Religion

From the responses of women, it is clear that the religion of the doctor does not play a role in deciding which facility to access, and what women are looking for, are female doctors (in the case of Muslims and the Kaj community) who are sensitive. Both groups spoke about going to doctors of the opposite religion and religion per se did not emerge in any of the responses relating to access of facilities. The non-Muslim group who spoke of going to two Muslim doctors were from Rawl. According to the women, these two doctors are well qualified and known in the area. Similarly, Muslim women accessed services from non-Muslim doctors as they have been practicing in the area for many years and hence there is a certain level of comfort that they feel with them.

V. Changes in Availability and Preference of Facilities over Time

As our respondents consisted of women from different age groups, it was also possible to capture women's understanding of the changes they have seen in the health facilities, as well as changes in their preferences of a health facility.

Availability: Overall availability of health services in the area had increased significantly. Older women spoke about using B and K in their time (public facilities), and there were no private clinics. But the younger women identified a number of health services available including a sizeable proportion of private practitioners and local clinics.

Quality: Older women tended to compare the current low quality of health care provided in B to the good quality care that was provided when they were in the process of giving birth to their children. They perceived a serious decline in the quality of services ranging from availability of medicines and good quality food, behaviour of staff, hygiene and cleanliness standards and the general ambience in B. They spoke about K hospital (which is closed at the moment) along similar lines, constantly placing it above B in terms of easy availability of quality care in the vicinity. They displayed satisfaction with B's services as long as it was a small hospital, and maintained that ever since it was converted into a big hospital, most services had degraded. This view reported by women is disturbing as B was upgraded from a small hospital to a super

specialty hospital implying that the quality of services available at the hospital should have improved. With respect to this, while women perceived a decline in quality, they also perceived an exponential increase in population, which, to them, has left B overcrowded. This points to an understanding that women have developed over time in order to cope with the problems they encounter at B. There were other recurring criticisms of B, such as increase in cost and rise of corruption. It was also reported that lack of medicines and material despite their availability and the demand for money by the *ayabais* was never a problem in their time (people willingly gave whatever they wanted, now they are forced).

VI. Conclusion

Women access different facilities for different reasons. Cost, as expected, is a common factor which determines access among both Muslim and non-Muslim groups, but the choice of facilities available to the women from the two groups varies greatly, given their access to financial resources and decision making powers in the family. Access of Muslim women's group and non-Muslim Kaj women's group to health facilities is also restricted geographically, while non-Muslim women are able to travel greater distances to obtain health care. In terms of awareness about the services available, Muslim women seem to be not so well informed when compared to non-Muslim women. Among both the groups, *Mahila Mandal* workers were very active.

The doctor's approach and behaviour of staff are significant factors that women value, particularly Muslim women. However, they are not always able to access private facilities given the financial and other limitations that they face, and are compelled to seek services from public health facilities. The fact that the behaviour of doctors and other staff have been a recurring theme in Muslim women's responses while speaking of access to a facility, opens up a window to explore elements of discrimination. The exact components of this "approach, attitude and behaviour" are explored in the following chapter.

WOMEN'S EXPERIENCE IN PUBLIC HEALTH FACILITIES AND DISCRIMINATION BASED ON RELIGION AND REGION

After talking to women about where they accessed medical services and the reasons for choosing these, we went on to discussing their actual experiences in public health facilities. 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 angry 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.

In this section, we begin with describing the various types of bad behaviour that were reported by both Muslim and non-Muslim women. We then go on to describing the experience of both minority communities - non-Maharashtrian non-Muslims as well as Muslims, with respect to the *burqa* and *purdah*. Finally, we discuss the specific kinds of religion-based discriminatory behaviour that Muslim women spoke of in the study.

The Table below depicts the various kinds of behaviour that have been reported by Muslim and non-Muslim women.

Table 6: Description of Behaviour towards Muslim and non-Muslim Women

Nature of Discrimination	Description	Actor
Stated by all women	<ol style="list-style-type: none"> 1. Rude language 2. Corruption to jump the queue 3. Abuse in labour ward – made to clean floors, physical and verbal abuse, no privacy 4. Denial of treatment, delay of treatment 5. Behaving badly towards accompanying persons 6. HCPs use English which is not understood by the patient population 	<i>Ayabais, ward boys</i>
Comments on the <i>burqa</i> and <i>purdah</i>	<ol style="list-style-type: none"> 1. Asked to remove veil even before the turn for examination 2. Biases that <i>burqa</i> clad women steal children. 3. Taunted as dramatic women because of inhibitions to remove <i>burqa</i>. 	Nurses, <i>Ayabais</i>
Discrimination specifically reported by Muslim women	<ol style="list-style-type: none"> 1. Use of derogatory remarks about women married to circumcised men, “<i>Landiyabaika</i>” 2. Being singled out as “<i>Musalman aurat</i>” creating a negative impression 3. Refusal to understand and comprehend Urdu names 	Nurses, <i>Ayabais</i>
Stereotypical remarks	<ol style="list-style-type: none"> 1. Muslim women have many children 2. Muslim people are uneducated 3. Muslim women refuse to use contraception 4. Muslim people are dirty 	Doctors, nurses, <i>ayabais</i>

I. BAD BEHAVIOUR REPORTED BY BOTH MUSLIM AND NON-MUSLIM WOMEN

1. Rude Behaviour

One of the biggest criticisms of the hospital was the language used by the staff of the hospital. Women, whether Muslim or non-Muslim, were equally perturbed by the tone and manner of the language used by the staff. Women reported that the staff shouted at patients including children to maintain silence even when they were in acute pain. While this manner of being spoken to was demeaning in itself, being insulted in front of other people was even worse, to the extent that women felt like that the staff did not think they had any feelings. Such rude behaviour was reported by both groups of women; however,, there was a difference in the articulation by Muslim women and non-Muslim Kaj women. Muslim women specifically stated that they found it extremely dehumanizing and felt as though they had no *izzat* (honour) whatsoever. They also stated that the staff tended to treat them as they would treat a stray dog entering the premises of the hospital. Muslim women used terms like "*jhidki*", which connotes rude language and "*tawajja nahi detay*" indicating disinterest of the staff towards the patients. "*As though we are holding the staff prisoners forcing them to treat us,*" is what these women said. This dejected expression of 'not feeling human' was reflected in the narrations of Muslim women and Kaj women. The non-Muslim women, on the other hand, expressed anger.

2. Corruption and Favouritism

Most women, both Muslim and non-Muslim, spoke of the staff's favoritism and offering special privileges to their relatives. While talking of the difference in behaviour towards people in the hospitals, women stated that relatives and friends of the staff were the only ones who got special treatment. Not only did they not have to wait in the queues but medicines would always be made available for them.

Women also felt that the reason for the staff's rude behaviour towards them was to extract extra money from them. In many narratives, women maintained that if they were willing to pay some extra money to the staff, then things eased out and all their difficulties and rude behaviour of the staff vanished. "*The nurses can get you to jump the queue, get you hot water and clean sheets on beds if you pay them some extra money.*" *Ayabais* especially demanded money at the time of the birth of the child Rs.100 for a girl and the amount could go up to Rs.500 for a boy. The women particularly disliked this habit of the staff as they felt that it was unfair for the staff to demand the money. When the patient and their family gave willingly, why demand it? Besides, not all patients could afford it. What was more bothersome was that if someone did not give the money, the staff said rude things to the newborn. Most women stated that they made provisions for this money as they did not want to hear abuses heaped on their child.

3. Abuse in the 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.

4. Poor Services in the Public Hospital

Denial of Treatment/ Delay in Treatment

In a number of cases, pregnant women were refused admission in the labour ward despite being in labour or being in a critical condition due to pregnancy complications. They were asked to return later as there was time left for delivery. For instance, a Muslim pregnant woman who was bleeding was denied admission to the labour ward for this reason. There was great resentment expressed at being refused admission in a state where both the woman and child were at risk if not attended to immediately. In another experience, a woman shared her daughter's plight. She was refused admission twice the same day, despite being in tremendous pain. According to the mother, the doctors who refused admission were trainees and did not realise the urgency of the situation. After a lot of pleading, her daughter was finally admitted. It also reflects the insensitivity of the health system towards pregnant women.

Women also complained of the fact that there were times, especially in the labour and the emergency wards, when patients were admitted and left for hours without any attention. A non-Muslim pregnant woman shared her experience of how she was bleeding and in immense pain but was not attended to. She was told that she would need an abortion and therefore had to wait. When she could not bear the pain, she complained to the higher staff. This forced the staff to initiate her treatment. In one case, a pregnant woman who was bleeding was not attended to for three hours. In yet another one, a woman shared that she was lying unattended during delivery and had delivered without any assistance. The doctor came to see her after she had delivered, only after she confronted the sister to call the doctor. These narratives indicated that such negligence and delay in treatment is inhuman and unacceptable.

Women from both communities often complained of medical facilities not being available during emergencies. Their experiences in emergency have often been lengthy procedures for admissions and first-aid, lack of proper treatment and very often, they were asked to consult the out-patient department the following morning. They questioned, *"If it is an emergency, then shouldn't all the tests and procedures be conducted? How can a patient go back in pain and return the next morning to endure the wait and go through the entire process again in OPD?"* Procedures can wait in an emergency. The patient should be attended to first and then the paper work completed." At nights especially women have found that doctors on duty are missing and when contacted are not willing to come. These problems are deterrents to receiving timely health care access.

Unavailability of Medicines

Further, in spite of being treated in a public hospital, women stated that they had to purchase everything required for a delivery from outside. To give an example, they stated that everything including cotton swabs had to be purchased from outside. Women had doubts whether the medicines and other materials purchased were being used for them. Nurses often refused to give back the extra medicines stating that they would be used for the next patient. They suspected that the staff was selling the medicines and other material bought. Medicines were never available with the pharmacist. Women maintained that if the doctor prescribed four of a kind, they got only two. Ointments were always out of stock. Women questioned angrily about the missing medicines.

Unhygienic Hospital Environment

Women from both communities conveyed that in their experience, hospital surroundings were unhygienic, including beds in the ward. Sheets were not changed for days. They were given stained gowns to wear. The change of clothes that women were provided for deliveries were torn and not in a wearable state. But they had little option but to wear it and suffer it.

5. Behaving badly towards accompanying Persons

In the facilities, women accompanying patients also had to face disrespectful behaviour by the lower level staff. The staff expected them to be there only to take care of the patient without using even the basic facilities for themselves such as drinking water. They were not allowed to sit on the chairs and stools in the ward and not even allowed to use the toilets.

6. Not being able to understand instructions or navigate Health Facility

Both Muslim and non-Muslim women complained that they could often not understand instructions given by doctors. In larger public health facilities, services are located in different buildings, on different floors and involve different procedures. Women who access such facilities for the first time naturally cannot find their way around easily. They invariably had to face the indifference of providers and no answers to their questions. According to them, the staff was unwilling to give the correct information and often made people run around even to get basic information. In the case of treatment, women were not informed about the procedure, why it was being done, the risks involved and the precautions to be followed. What most of them found specifically disturbing was not being informed about the reasons for which a caesarean section (C-section) was required. Having information about the rationale for medical procedures, and being able to make a decision about undergoing them are the rights of women as health care seekers, but these are routinely violated.

II. INSENSITIVE ATTITUDES TOWARDS WOMEN WEARING BURQA/GHUNGHAT

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.

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 hai*

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). Interestingly, this hostility was also reported by non-Muslim Kaj women who wore a ghunghat (veil). The sense of being an outsider for these women came from the way they dressed and they felt that they were treated differently because of it.

"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."

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 any unpleasant experiences.

III. DISCRIMINATORY BEHAVIOUR SPECIFICALLY DIRECTED AT MUSLIM WOMEN

1. 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 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.

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.

2. 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.

3. Spoken to 'differently'

Many of the Muslim women felt that there was a difference in the way the staff at the PHFs spoke to them when compared to how they spoke to people belonging to their caste, religion. The nurses especially seem to become polite and explain things in a detailed manner to people of their caste and religion. The respondents said, *"hum ko dekhke unka lehza badal jaata hai"*. Their tone and body language changes when they see us, they said. One of the Muslim participants specifically stated that the *ayabais* resented the fact that they had to clean "our dirt."

It must be noted that irrespective of the intention of the doctors, if the patient perceives a difference in their behaviour, they are being discriminatory.

4. Stereotypical Remarks

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.

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.

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.

When we go to register our pregnancy the nurse will rudely ask us how many children we have. They always ask for the number of children we have. It does not matter even if it's a first time delivery. They will always comment on the number of children and say that we have two to three children at home and are lying. There are women who do hide the number of children they have but that does not mean that all women are hiding.

5. Not knowing Marathi or English

Muslim and Kaj women too often said that the lack of knowledge of Marathi was a barrier in communicating with hospital staff and left them feeling like they did not understand as much as the other patients. Muslim women were often educated in Urdu medium schools and hence were not conversant with the local language.

We have a problem where most of us have studied in Urdu medium or not studied at all. We feel at loss when we are not able to understand what is being said and we keep looking at them like fools. Also when we go to the hospitals the staff feels we are dirty and uneducated and so don't talk properly to us. There are times when we feel if we knew a bit of English we would be able to give it back to them and then not feel as small as we do now.

IV. ACTORS OF DISCRIMINATION

Nurses, *Ayabais* and ward boys were the ones towards whom most of the women's wrath was directed. Whether it was the verbal and physical abuse in labour wards, being taunted, being asked to remove *burqas*, use of derogatory language - all of these were reported as being perpetrated by either nurses or Grade IV staff. As the women stated, the behaviour of the staff was bad towards them as they were the ones who had to do all the work. The doctors came for five minutes to check and write down the course of treatment. The actual work is done by the Grade IV staff of the hospital. The feeling was that because they were the ones doing the work, they were pressurized and hence the treatment towards the patients.

In both communities, doctors were often looked at with a different lens. There was very little criticism from either community. They often stated that doctors came to do their work and then it was up to the rest of the staff to look after them. The one criticism they had with the doctors was their short consultation time which became shorter when the doctors lingered at tea breaks.

This does not necessarily mean that doctors do not have biases, just that they do not spend a lot of time with patients and hence it is not as evident. However, the fact that doctors merely watched and never took action against the bad behaviour of staff, was never raised as a concern by the women themselves.

V. PERCEIVED REASONS FOR DISCRIMINATION

When talking to women about difference in treatment in hospitals on the basis of religion, there were very few women who commented or agreed to it. In their instant response, women often stated that bad treatment in the hospital was common to all. They also stated that the hospitals were usually so crowded that no one had the time to look at who they were shouting or screaming at. However, the very character of 'bad behaviour' as reported by Muslim and non-Muslim women is different, and a religious bias is clearly evident. In this section, we discuss women's own perceived reasons for why they are treated badly.

1. Growth in Population and Overworked Staff

Growth in population was considered the biggest reason for the bad behaviour of the staff in the hospital. People justified the reasoning by comparing the facilities to those of yesteryears. The public hospital that the community accesses has been there for generations and the older women recollect the good facilities available during their times. The women who had used the facilities for their deliveries no longer wanted their daughters and daughters-in-law to use them. According to them, the lack of facilities and medicines now is because the population of the country is increasing and the hospitals cannot cope. They are always overcrowded and this makes the

doctors and other staff stressed, which is why they behave badly.

2. Poverty

Women in the study always stressed on the importance of money as a determinant of how one was treated in a health facility. They stated that if you had the money, then you could buy good treatment and behaviour even in public hospitals, which otherwise mistreated people who looked poor. Women were aware of how the health care providers treated other poor people. *"The hospital staff is not even willing to touch people who live on the streets. They are made to run around from one place to another."* Women also said that if one were to dress appropriately and go to the hospital, they were treated differently. They spoke of the fact that women in western clothes looking wealthy were always spoken to politely and often made to jump queues.

Money could often buy good treatment even from the *ayabais* and the nurses. If one paid a little money, then your case file was moved ahead. The staff spoke properly to you and better care and service was provided to you during delivery. Naeema said emphatically, *"If you are poor you are treated like a dog in the PH; the staff believes that you are coming to a PHF because you do not have any money and they have to work for you which they resent."*

VI. CONCLUDING REMARKS

From these vivid descriptions of behaviour of staff that women reported, the various axes of discrimination that play out are evident. First, all women owing to their poverty report being treated with disdain in the public health facilities. They sometimes justify this behaviour of the staff attributing it to increase in population, overwork and stress. However, they also recognise that had they been better educated or better dressed, they would have been treated with more respect. The second realm of disadvantage that is faced by women is due to their gender. Not only do they have to overcome several barriers in order to merely access health care, but there is a clearly gendered nature of abuse that they are subjected to in the health facility. Particularly in labour wards, the behaviour is not just insensitive but abusive. This is perhaps done with the objective of shaming women whom the health providers believe are 'reproducing irresponsibly'. The third axis of discrimination that women in the Muslim community come face to face with is due to their religion. The various stereotypes of being poor, uneducated, dirty and having too many children constantly come up, even in routine interactions with the health facility. They are made to feel like outsiders and sense that they are not treated the same as others. Non-Muslim immigrant women too express such sentiments and the discrimination based on 'region', therefore is evident.

WOMEN'S RESPONSES TO BAD BEHAVIOUR OF STAFF

It was evident that on several occasions, women expressed a desire/will to control their circumstances while asserting their rights. It can be observed that Muslim and non-Muslim women's response to circumstances encountered within and outside health facilities have been dealt by them very differently. While both groups of women faced bad behaviour in the health facilities, their reactions and efforts to address the problems show a marked difference. In this section, we will discuss how women process the behaviour that is meted out to them, how they feel and what their coping mechanisms are.

The table below depicts women's varying reactions to the bad behaviour encountered in public health facilities and actions taken by them

Table 7: Reactions of Women to the Behaviour meted out to them in Health Facilities

	Muslim	Non-Muslim
How women feel	<ul style="list-style-type: none"> • Feelings of shame and hurt, helplessness • Explain behaviour based on overcrowding, population growth, lack of time for providers and so on 	<ul style="list-style-type: none"> • Feeling of anger, being violated and wronged • Question behaviour of providers, why facilities are not up to the mark and so on
Actions taken by women	<ul style="list-style-type: none"> • No confrontations about stereotypical remarks made on the basis of religion • Bribe staff for services • Withdrawal from facilities, going to others • Avoiding behaviour that invokes violence-not screaming in labour room, withholding information about the number of children they have • Being vigilant 	<ul style="list-style-type: none"> • Confront providers • Bribe staff for services • Withdrawal from facilities, going to others • Efforts to integrate by changing dress - Kaj women have stopped wearing lehenga-choli as it is considered backward
Reasons for not taking action	<ul style="list-style-type: none"> • Fear of reprisal • Dependence on facilities 	

I. REACTIONS OF WOMEN TO BAD BEHAVIOUR

There was a clear difference between Muslim and non-Muslim women's articulation of how they reacted to the bad behaviour encountered at the health facility. 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.

II. 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.

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.

Bribing

What both Muslim and non-Muslim women have gathered is that if a staff member is given some money, the quality of services improves. Both groups of women have resorted to this in order to make their experience in the hospital more bearable, at least in the short term. From everything as small as jumping the queue, to getting better food, to getting clean linen, bribing they found could be a solution.

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.

Accommodating, changing way of Dress

Non-Muslim Kaj women said that they traditionally wore *lehenga-cholis* when they 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 identity¹⁶. (Robinson, 2010)

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.

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.

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.

¹⁶ A study from Gujarat, for instance, discusses how the division of society along religious lines and consequent ghettoization following violence puts minority women under strict surveillance of the men in their community, who try to control women's movements, behaviour and dress.

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.

III. CONCLUDING REMARKS

This study shows that Muslim and non-Muslim women react to the bad behaviour of providers in different ways and that the actions taken by them are also very different. 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.

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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 Chapter Five, where we have discussed 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.

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.

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.

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Introduction Letter for Participation of Community Women for FGDs

Dear Madam/ Sir,
Greetings!

My name is....., I am a member of the research team from the Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai.

CEHAT (Centre for Enquiry into Health and Allied Themes) is the research centre of Anusandhan Trust. It was established in 1994. We are involved in research, training, service and advocacy on health and allied themes. CEHAT undertakes socially relevant research and advocacy projects on various socio-political aspects of health. It tries to establish direct services and programs to demonstrate how health services can be made accessible, equitable and ethical and disseminate information through databases and relevant publications. During the 15 years of its existence, it has been able to establish a creditable reputation with regards to the quality of its work and the ethical principles that have guided such work.

We are conducting a study in Mumbai to explore discrimination based on religion in health facilities. This study will explore if women from the minority (Muslim and Non Muslim) communities face any negative experiences in the health facilities, be they public or private. How do these negative experiences affect the women and can these negative experiences be termed as discrimination?

We would like to request your consent to participate in the study. If you agree to participate, you will be asked to participate in a group discussion about your experiences in the various health facilities that you visit. The group will consist of about eight to ten women from your community. The discussion will be held in two parts unless the group decides to go ahead with one sitting. The two discussions will be of about 45 minutes each. In case of a single discussion, it may last up to an hour and a half. Your responses will be recorded on paper and tape, (if the group agrees on tape as well). There will be no monetary compensation for your participation in the study.

To make sure that no one learns about any information discussed by you in this project, your name will not appear on any document or other materials associated with the project. Your name will also not appear on any FGD records used for computers, or on any recording of conversations. FGD notes will be kept in a safe place under lock and key and only authorized persons designated by us will have access to them. The identity of the participant will remain confidential. The tapes

will be destroyed after the information has been noted down on paper. Your name will be removed from all records and your record will be given a unique code. The research team will not be able to control the sharing of the participants in the group by the group members outside the group. Hence we would request you to only share that information which you are comfortable with. We are not seeking any information that is personal in nature. We would request you to draw upon your experiences.

Your participation in this study is voluntary; you may decline to participate without consequence. If you decide to participate, you may withdraw from the study at any point in time.

You can withdraw during the time that the team is conducting the research in the community or and even after the research team has withdrawn from the community. Complete contact information of the research team will be provided to all the participants.

You can choose to participate in the study even if you do not wish to sign the consent letter. In that case, verbal consent will be sought. In case you need any further information or clarification on any issues, you can contact the Research Team members.

The contact details have been mentioned at the beginning of this form.

Research Team: Zamrooda Khanday, Yavnika Tanwar, Priyanka Jasson and Namita Khot.

Informed Consent Form

CEHAT

Centre for Enquiry into Health and Allied Themes, Anusandhan Trust

Sai Ashray, Aram Society Road

Vakola, Santacruz (East)

Mumbai-400054

Ph: 02-226673154/ 226673571

I have read/been explained about the objective of the study and organisations conducting the study and my queries have been answered to my satisfaction. I agree to participate in the study voluntarily and to respond to the questions. I understand the purpose, nature, and length of my involvement in the study. I understand that there will be no monetary benefit for participation in the study. I understand that my identity will remain confidential while sharing information given by me and the report will not mention any names or identities. I understand that I may choose not to participate at the beginning of the project or at any time during the project without penalty.

I am aware that in case I need any further information or clarification on any issues, I can contact the addresses at the top of this form.

I consent to participate in this project voluntarily.

Date Signature of Respondent

In case of Verbal Consent

I, the undersigned, have explained to the volunteer in the language he/she understands, the procedure to be followed in the study, and the risks and benefits involved.

Date Signature of Research

Investigator

Name of the Research Investigator

FGD Protocol for “Exploring Religion Based Discrimination in Health Facilities”

I. Introduction of the Research and the FGDs

II. Brief Personal History of the Participants

- Name of respondent
- Age
- Sex
- Address
- Marital Status
- Religion
- Education
- Occupation

III. Health Profile of the Community

- What health problems are common in your locality?
- What are the health care facilities available around your locality? Local doctors, private and public, hospitals, clinics etc.
- Out of these facilities which ones are used for what kind of illness? Please elaborate.
- What are the health facilities that people from the locality go for reproductive health problems, pregnancies and deliveries?

IV. Experiences at the Health Facilities

- What has been your experience of seeking treatment at a health facility? Describe. (The various facilities that women report and seek their experiences in those in terms of comfort, quality of treatment, and overall satisfaction)
- Have you or people from your locality faced any problems during your visits to any health care facility or when admitted for treatment?
- What kinds of problems do you face
 - Procedural-waiting time, paper work, lack of medicines, shortage of doctors etc) Probe for OPD and IPD both? (From registration, Diagnosis, referrals, treatment, admission,)
 - Kind of behaviour from the staff - probe for all staff starting from the watchmen at the gate, nurses, doctors, technicians, assistants, lab boys and *ayabais* etc
 - Remarks and statements that they do not like - probe for not liking the remarks.
- Are these problems faced by everyone? If not, who faces it?

- Who is most affected by this kind of behavior - probe for slum dwellers, uneducated, women, religion/caste.

V. Discrimination at Health Facilities

- How do you understand discrimination?
- How does it take place in the health facilities?
If needed examples stated in the above discussion will be used to flag off discrimination (religion/caste based).
- Why do you think you are treated differently from the other people in the health care facility?
- Do you face similar problems at all health care facilities: public and private?
- Do you feel that behaviour of hospital staff has changed over the years?
- How has the behaviour changed? Can you give some examples or describe the change that you have experienced over the years.

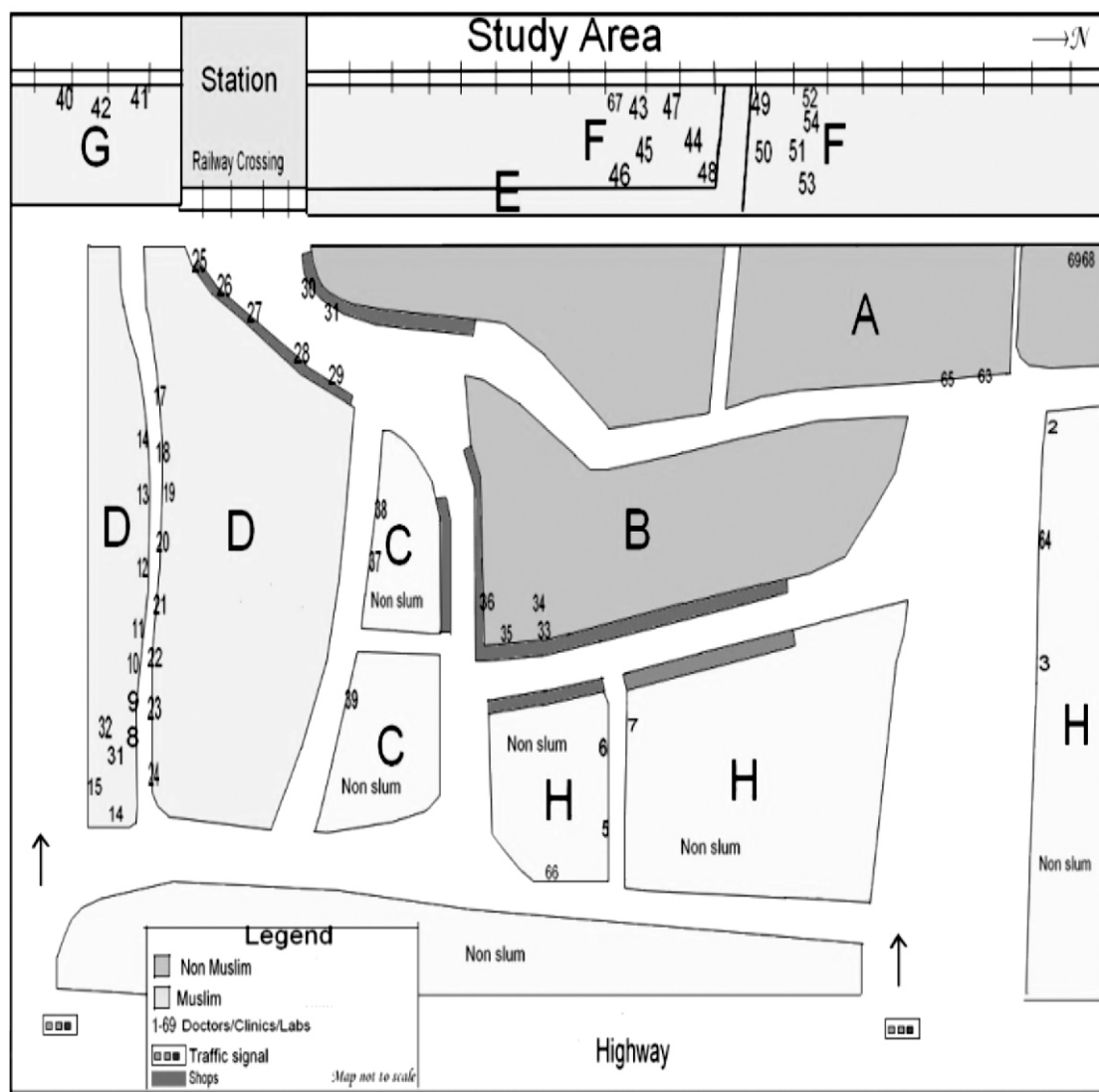
VI. Reactions to the Discrimination

- What do you do about the discrimination? Talk, internalise, ignore?
 - Have you done anything about this experience?
 - Talked to anyone at home, in the locality, complained to authorities in the health facilities or to any influential person/organisation in and around your locality?
 - If you had complained was any action taken regarding your complaint? Elaborate.
If not, why do you think action was not taken?
 - Does this discrimination in any manner influence your choice of health facility? (Change in health facility, ignore medical qualifications of the practitioners, preference of practitioner by religion, shift towards traditional practitioners etc.
 - Is there any way to stop this discrimination?
- Moderator of the FGD ends the discussion with a summary of the key points.

Interview Protocol for Key Informants

- Name
- Age
- Organization
- Position in the community
- What is the nature of work that you do here?
- For how long have you been working here?
- Can you tell us a little bit about the history of this community?
- When did the first settlers come to the community
- Has the composition of the community changed since then?
- What changes have come about?
- What are the reasons for these changes?
- What are the common health problems faced by the community?
- What do they do about their health problems?
- What kinds of health services do people access?
- What kinds of health facilities are available here? Comment on adequacy and quality.
- How are the people from the community treated in the health care facilities?
- Do you see any difference in treatment in health care facilities towards
 - Women
 - Poor people
 - Different religions in the community
- What do you think is the reason of this differential treatment towards women, poor people and Muslims/Hindus?
- How do these factors interplay with each other at the health care facility?
- Do you think this discrimination in any way affects the lives of the Muslim people in the community, especially the women?
- Have there been any complaints about the manner in which people are treated at the health facilities?
- Is there a need to address cases of religious discrimination?
- Has your organisation handled any complaints of religious discrimination, what action has been taken (elaborate)?

Map of Study Area



Operationalization of Discrimination for Health Facilities

I) Physical Appearance

- How do people react to the *burqa*?
- Do you get any comments because you are wearing a *burqa*? Are you denied information, made to wait longer, denied entry if you are accompanying the patient?
- Are you treated differently because of your dress?
- Do you find people behaving differently when you come near them? Do people move away from you, try and find a different seat, do not give you a place to sit, hold their kids back from you?
- Do you cautiously do anything about your dress...remove it when you reach hospital?

II) Name

- How do people at the health services react to your name?
- When you say your name what is the kind of reaction that you get- do they ridicule the name? If yes, what do they say?
- Do HCPs write your full name or short form on case papers?
- Do you try to hide your name in any manner?

III) Communication

i) Body language

- Are people comfortable with you standing or sitting next to them in the waiting room of the hospital?
- Do the HCPs hesitate in any way to talk to you?
- Do they hesitate in touching you?
- How comfortable are you approaching a doctor and or a nurse?

ii) Language

- Is there a difference in the HCPs' tone when they talk to you?
- Do they use certain words or phrases which are community specific and derogatory?
- "*Jumma ke Jumma nahatey ho!*" Have a bath once a week.
- "*Itne bacche kyon paida kartey ho!*" Why do you give birth to so many children?
- "*Yeh log meat bohat khatey hain, takat ata hai or phir baccey paida kartey hain. Aur koyi kaam nahin hain!*" These people eat too much non vegetarian food, gain strength and keep producing kids; they have no other work.
- Do they taunt you at any time about cleanliness etc.?
- Is general behaviour of the community made specific to an individual?
- Are HCPs willing to talk and explain things in Hindi if you do not follow Marathi?

IV) Treatment

- When do you visit the doctors? What makes you wait so long to visit a HCP?
- Why do you think this was so?
- Can you freely talk to your doctor?
- Do you ever feel that your doctor is giving you medicines that may not be tested clinically- using you for research?
- Do the doctors ever offer you free medicines?
- Do they refer you to the social worker?
- Are you informed about the poor box?
- Are you given equal treatment vis-a-vis other communities for getting the poor box benefits?
- Did you at any time feel that the doctor was not listening to what you were saying?
- Do you feel that the doctor patiently explains the health ailment to you and clarifies your doubts viz-a-viz women from other communities?
- Did you ever feel that the time spent with you by the HCP was less than what he/she would spend with another patient?
- How is the treatment of the HCPs during delivery?
- Is this any different from the treatment meted out to women from other communities? If yes, describe.
- What is the treatment you get when you come for an MTP without your husband and why is this so?
- What is the treatment you get when you come for tubal ligation without your husband and why is this so?
- Do you feel that the doctor lacks basic understanding of your culture vis-a-vis your health issues?
- Do you ever feel that right knowledge of your culture or language would help the HCP treat you better?
- Are you informed about the vaccination schemes of the government?
- Does the government staff visit you for vaccinations, especially polio vaccines?
- Do you trust the HCPs in the hospital for your treatment?
- Do you feel that you have to be more proactive and aggressive in order to get quality health care?
- Did you at any point feel that the treatment given to you was not the correct treatment?
- Are health awareness camps held in your community? Are you given information on the role of disease prevention and health promotion?
- Are you given immediate attention in emergencies?

V) Health Care Providers

- What are your thoughts towards a Muslim patient - do you think she is intelligent, violence prone, less deserving in any manner?
- What are the issues you face while dealing with Muslim women patients?
- What is your experience with Muslim women vis-a-vis family planning?
- What is your experience with Muslim women on responsiveness to treatment?
- Do you emphasise on preventive care with your patients?

Local Words: Translations/Glossary

- *Basti*-community
- o *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
- o *Chidh/jhunjlaha*- Frustration and irritation
- *Dava khana*-clinics
- *Dandiya*- traditional folk dance of Gujarat
- *Gali*- small lane
- *Ghaghraoli*- traditional dress consisting of a long skirt, a blouse and a dupatta
- *Ghungat*-veil
- o *Jalan*-not used in its true meaning which means being jealous. Used on the same lines as Chidh.
- o *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.
- o *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
- o *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.



Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.

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