Health of Muslims In Maharashtra

Sana Contractor and Tejal Barai – Jaitly

Cehat

Centre for Enquiry into Health and Allied Themes

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PREFACE

The report "Health of Muslims in Maharashtra" is an outcome of a project commissioned to CEHAT by the Maharashtra State Minorities Commission. It is based on a systematic review of existing studies and analysis of secondary data sources.

What is evident is that a large percentage of Muslims in Maharashtra live in a context of alienation, deprivation and insecurity. The prejudice against the community, everyday experiences of discrimination and harassment impacts their overall well being, quality of life and access to public institutions. The poor availability of health facilities, poor access to clean drinking water and sanitation in the Muslim dominated pockets or ghettos reflects the systematic neglect by the state. Living in such conditions itself is a violation.

Mere examination of general health indicators do not accurately reflect the health status of Muslims especially the impact of the acute deprivation and discrimination. In fact these raise a lot of questions that need further exploration. There is evidence of deep rooted biases amongst health providers about Muslim fertility and this must be addressed by the health system and medical education. The family planning services must acknowledge the needs of the population and make acceptable methods of contraception available to the community rather than impose one method for all.

With respect to religious minorities in India, there is a need to study the linkages between discrimination and health. There is also a need to understand how discrimination affects health outcomes and health seeking behaviour.

We hope that the report will provide direction to the Government of Maharashtra's efforts in addressing the needs of this minority population. An edited version of the report is published as chapter 7 of the Report on "Socio-economic and Educational Backwardness of Muslims in Maharashtra" published by the Government of Maharashtra.

Padma Bhate-Deosthali
Coordinator, CEHAT

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ABBREVIATIONS

ANC	-	Antenatal Care
ATS	-	Anti Terrorism Squad
CMO	-	Chief Medical Officer
DHS	-	Directorate of Health Services
DLHS	-	District Level Household Surveys
EPA	-	Environment Protection Agency
FMI	-	Freedom of Movement Index
FP	-	Family Planning
HCP	-	Health Care Providers/Professionals
HCR	-	Head Count Ratio
ICDS	-	Integrated Child Development Services
IFA	-	Iron Folic Acid tablets
IMR	-	Infant Mortality Rate
IUD	-	Intra-uterine Device
JSY	-	Janani Suraksha Yojana
MP	-	Member of Parliament
MPCE	-	Monthly per capita Expenditure
MSMC	-	Maharashtra State Minority Commission
NFHS	-	National Family Health Survey
NNMR	-	Neonatal Mortality Rate
NSSO	-	National Sample Survey Organization
POTA	-	Prevention of Terrorism Act
RSBY	-	Rashtriya Swasthya Bima Yojana
SRG	-	Socio-religious Groups
TB	-	Tuberculosis
TMR	-	Total Mortality Rate
TT	-	Tetanus Toxoid
U5MR	-	Under-5 Mortality Rate
WHO	-	World Health Organization

SECTION I

INTRODUCTION

SOCIAL EXCLUSION AND HEALTH

Social exclusion has been defined as "the process through which individuals or groups are wholly or partially excluded from full participation in the society within which they live". It is an important concept to understand 'deprivation' in any society, beyond just looking at 'poverty' or income inequality as a reason and form of deprivation (Dehaan & Dubey, 2004). According to WHO's Social Exclusion Knowledge Network, it operates in four critical dimensions – economic, political, social and cultural – and at different levels, individual, household, group, community, country and global. Social exclusion is relevant while discussing health, because it results in unequal access to resources, reduced capabilities and rights, based on social status (WHO, 2008). When certain groups of people are pushed to the margins of society, there is a power imbalance resulting in 'discrimination' against these groups which may lead to 'leaving them out', deliberately, discouraging their participation or denying them access to services.

The institutional structures that perpetuate social exclusion differ from context to context. They include gender, class, sexual orientation, race, ethnicity and many more. In the United States and the United Kingdom for instance, it has been well documented that racism is a strong source of exclusion that affects both health status and health care. Research from the United States has linked the poor status of African Americans' health to a host of different institutional, individual and provider factors. Lifetime experience of racial discrimination has also been identified as a stressor that contributes to various negative health outcomes among racial and ethnic minorities (Meyer, 2003). Experience of racial discrimination has been associated with poor utilization of health services, increased delays in seeking health care and poor adherence to medical treatment (Casagrande et. al., 2007).

Many studies also focus on the role of racial discrimination by health professionals and the manner in which it affects health outcomes. There is evidence that racial and ethnic minorities tend to receive sub-standard treatment 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) when compared to whites. The disparities increase mortality and morbidity among African Americans. These disparities have been attributed to systemic problems, biases and stereotyping prevalent among health care providers and certain patient factors such as refusal for treatment. Patients belonging to racial and ethnic minorities tend to delay treatment and refuse treatment more than whites. This could be because of lack of trust in the provider, negative experiences with the health system or a "poor cultural match between providers and patients" (Nelson, 2002).

We cite the above literature in this report, to emphasize the extent to which social exclusion and discrimination can jeopardize the health of a large proportion of a population. In the Indian context, the grounds and sources of social exclusion and discrimination are many – caste, class, religion, gender, and so on. The present report looks at one such axis, religion, and in this context looks at the health status of Muslims in Maharashtra.

Muslims in Maharashtra

Maharashtra is home to about 10.3 million Muslims, who constitute about 10.6 per cent of its population. This makes it the largest religious minority in the state. The state stands fourth as far as absolute size of Muslim population is concerned (after Uttar Pradesh, West Bengal and Bihar) and twelfth in terms of percentage of total population in the State. Muslims are concentrated in the central belt of Maharashtra. Certain blocks of the districts of Parbhani, Nashik, Aurangabad, Nanded and Raigarh have a significant Muslim population. Muslims are also concentrated in the highly urbanized areas of Mumbai, Mumbai (Suburban) and Thane. Mahajan and Jodhka observe that Muslims have perhaps been the most marginalized groups in Maharashtra (Mahajan & Jodhka, n.d.). Yet, the official discourse on developmental exclusion in India has not, as Hasan (2009) argues, always taken religious minorities into account. It has largely revolved around issues of caste-based discrimination. Affirmative action to address caste - based discrimination has included reservations in employment and education, and efforts have been made to enable caste groups to access and utilize these benefits (Hasan, 2009). However, until now, religious groups have not been part of these efforts. Bhaumik and Chakrabarty argue that in the period between 1989 and 1999, while economic inequalities between Scheduled Castes/Scheduled Tribes (SC/ST) and upper castes have reduced, those between Muslims and non-Muslims have increased (Bhaumik & Chakrabarty, 2006).

This report has found instances of discrimination, bias, negative experiences in the health sector, segregation of living spaces as well as unequal access to education and livelihoods,, and health care in particular.

A. SOURCES OF DATA

The Maharashtra State Minority Commission (MSMC) has made an effort to understand the conditions of Muslims in the state and has taken up the task of addressing the problems through multisectoral development plans. This report is an effort to understand the health status of Muslims in Maharashtra. It is hoped that it will provide direction to the Commission's plan for addressing the health issues of Muslims in the state in the coming years.

The report is based on analysis of National Family Health Surveys (NFHS), District Level Household Surveys (DLHS) and the National Sample Survey Organizations (NSSO) data sets. It also draws upon secondary data and literature, particularly primary studies commissioned by the MSMC and others in Muslim dominated ghettoes in Maharashtra.[1]

The Directorate of Health Services (DHS) Maharashtra was approached for data on the availability of health services and prevalence of diseases, profile of health workers, and so on. However, such disaggregated data based on religion was not available. We also attempted to use the NSSO raw data to create 'socio-religious categories' such as 'upper caste Hindu', 'upper caste Muslim' etc. But the resultant sample sizes in these categories were too small to enable any meaningful analysis. Disaggregated data on religion sourced in context is very critical to address health problems. For instance, post riots in Mumbai, a large percentage of Muslims have been pushed to inhabit poor and congested ghettos; it would be important to know the incidence of malaria among them. However, the incidence of malaria is only available at the district level. This is an important lacuna which must be addressed as it has implications for planning and implementation of policies and programs.

Moreover, comparing 'Muslims' to 'Hindus' in large datasets should be done with caution, as both the religious groups have a caste hierarchy within them, which would have an impact on the overall indicators. Therefore, where studies were available, we have tried to support such comparisons with field data. The interaction between caste and religion is an important one to consider, and certainly warrants more exploration in research.

This report is divided into the following sections - Section I provides a background to the problem, Section II looks at the context of Muslims in Maharashtra, the social determinants of health and the evident structural violence. Section III looks at their health indicators in the context as reflected in Section II. Section IV is the conclusion that we have drawn from our analysis, followed by recommendations.

[1]Primary studies done in Bhiwandi, Malegaon, Behrampada & Sion Koliwada, commissioned by Maharashtra State Minority Commission with College of Social Work Nirmala Niketan, Tata Institute of Social Science & Research Centre for Women's Studies, SNDT Women's University. References of these report are given in end of the report.

SECTION II

MUSLIMS IN MAHARASHTRA - EVIDENCE ON SOCIAL DETERMINANTS OF HEALTH

According to the World Health Organization (WHO), the social determinants of health care are mostly responsible for the disparities that exist within countries and amongst countries. Conditions under which people are born, live and work are an expression of the freedom that they have in order to live the life the way they want to. In order to understand the health status of a population, it is essential to understand their living conditions, resources, economic disparities, disparities in terms of power and working conditions. This section portrays the context by presenting the nature of structural violence faced by Muslims in Maharashtra as well as the state of social determinants, often a consequence of structural violence. The social determinants explored here are poverty, work profile, education, residential segregation (ghettoization) and living conditions (within these ghettos).

A. Poverty and Marginalization

Maharashtra has one of the highest levels of per capita income among the states of India, whereas the Muslim community in Maharashtra has among the lowest monthly per capita expenditure (MPCE). Amongst the states with a high Muslim population, rural Muslims in Maharashtra fare relatively better. However, in the case of Muslims staying in the urban areas of Maharashtra, the MPCE is dismally low at 68.14 (Table 1). The urban-rural differences in MPCE in Maharashtra are very high, indicating wide disparities in the conditions of Muslims across the state in rural and urban areas. This is important considering that 70 per cent of the Muslim population in the state lives in urban areas.

Table 1: Index Numbers of Average MPCE by Religious Groups (Hindu=100)

State	Rural	Urban
Uttar Pradesh	96.94	73.24
Bihar	98.63	77.65
Maharashtra	101.11	68.14
West Bengal	86.63	90.54
Andhra Pradesh	102.32	75.35
Tamil Nadu	118.41	144.79
Karnataka	107.64	72.04
Kerala	90.13	80.34
India	**96.3**	**78.22**

(Source: National Sample Survey Organization, 1999-2000, Adapted from John and Mututkar, 2005)

This disparity also holds true also for Head Count Ratio (HCR, proportion of population living below the poverty line).

Table 2: Head Count Ratio Muslims across States (proportion of population that is classified as poor)

State	Rural	Urban
Uttar Pradesh	30.84	42.17
Bihar	44.24	45.88
Maharashtra	14.94	44.86
West Bengal	36.96	22.49
Andhra Pradesh	5.65	38.10
Tamil Nadu	13.03	32
Karnataka	12.30	37.96
Kerala	11.51	31.09
India	**27.01**	**36.62**

(Source: National Sample Survey Organization, 1999-2000, Adapted from John and Mututkar, 2005)

Here again, Muslims in rural Maharashtra fare much better than Muslims in the urban areas of the state. Interstate comparison reveals that Muslims in rural Maharashtra are better off than their counterparts in underdeveloped states such as Uttar Pradesh and Bihar. They also fare better than Hindus in these states (Hindus: 22.65 per cent and Muslims: 14.94 per cent). However, when you compare the Muslims in the rural areas of Maharashtra to those in the rural areas of better developed states such as Andhra Pradesh, Kerala, Karnataka and Tamil Nadu (Table 2), they seem to fare more poorly. The state of urban Muslims in Maharashtra is worse than that of their counterparts from many underdeveloped states such as Uttar Pradesh and West Bengal, let alone those in developed states such as Andhra Pradesh, Tamil Nadu, Karnataka and Kerala. The Head Count Ratio for Hindus in the urban areas of the state is 21.61 per cent as against a high of nearly 45 per cent for Muslims. In a well-developed state that contributes to 13 per cent of the country's GDP; it is quite clear that the development of the state has not accrued the same benefits for the development of Muslims.[2]

[2] John and Mututkar have used the poverty line as laid down by the Planning Commission. While a debate on the same is not relevant to the present paper, it must be said that despite the government's having set the poverty line at an unacceptably low level, there is a very high proportion of poor Muslim population in Maharashtra. What the poverty estimate for Muslims in particular would be, if the poverty line were revised is unfathomable.

B. Work Profile

With India's increasing growth rate, informalization has not only increased, but there are also increasing linkages between the informal and formal sectors. A report by the National Statistical Commission[3] shows how the unorganised and the informal sector in our country form a pivotal part of the Indian economy. More than 90 per cent of the workforce and 50 per cent of the national product are accounted for through the informal sector. It is recognised that a high proportion of the informal workforce is constituted by the underprivileged sections of the population (Government of India [GOI], 2008).

The extreme vulnerability of these underprivileged sections of the population, particularly in the context of Muslims, as a result of a large proportion of them working in the informal sector, is evident from Table 3.

Table 3: Percentage Distribution of Expenditure Classes by Social Identity, Informal Work Status and Education (2004 – 2005)

S. no.	Economic Status	Social Categories (percentage share in own total)				% of unorganised workers
		STs/SCs	All OBCs (except Muslims)	All Muslims (except STs and SCs)	Others (of 15 years & above) and without STs, SCs, OBCs and Muslims)	
1	Extremely poor	10.9	5.1	8.2	2.1	5.8
2	Poor	21.5	15.1	19.2	6.4	15.0
3	Marginally poor	22.4	20.4	22.3	11.1	19.6
4	Vulnerable	33	39.2	34.8	35.2	38.4
5	Middle Income	11.1	17.8	13.3	34.2	18.7
6	High income	1	2.4	2.2	11	2.7
7	1 + 2	32.4	20.3	27.4	8.5	20.8
8	3 + 4	55.4	59.6	57.1	46.3	57.9
9	7 + 8	87.8	79.9	84.5	54.8	78.7
10	5 + 6	12.2	20.1	15.5	45.2	21.3

(Source: National Commission for Enterprises in the Unorganized Sector, Government of India, 2008)

[3] A Commission set up by the Government in January 2000 under the chairmanship of Dr. C. Rangarajan reviewed the statistical system and the entire gamut of Official Statistics in the country. http://mospi.nic.in/Mospi_New/site/inner.aspx?status=2&menu_id=122.

Nearly 87.8 per cent of SCs/STs, 79.9 per cent of Other Backward Classes (except Muslims) and 84.5 per cent of Muslims constitute the most poor and vulnerable category of unorganised workers. These are the category of workers who have been completely left out and neglected in India's growth story. The report further revealed that vulnerabilities are exposed according to socioreligious groups. While the SC/ST population is protected to some extent by affirmative action by the government, Muslims are not. They are overwhelmingly concentrated in the unorganised sector and in self–employment activities to meet their livelihood needs.

The workers in the unorganised sector (reiterating here that 84.5 per cent of Muslims constitute the most poor and vulnerable category of unorganised workers) survive at a bare subsistence level, with no security, working under unhygienic and miserable conditions despite the economic growth our country since the 1990s. The Indian growth story has been characterised by a rapid growth of the middle class and the rich. But this growth has clearly excluded Scheduled Tribes, Schedules Castes, OBCs and Muslims.

The level of educational attainment is a determining factor in terms of sector or nature of work. The level of education also seemed to have an effect on entry into the organised sector. Amongst the regular unorganised workers, STs and Muslims, on an average, had higher levels of education than their counterparts in the organised sector, but still found themselves in unprotected jobs. Low educational attainment was most prominent among ST, Muslim and OBC men and women and unorganised non-agricultural workers (GOI, 2008).

Hindu men and women are more likely to be in the organised sector. Even in the case of Hindus in the unorganised sector, they are more likely to be regular workers or self-employed workers. In the case of Muslim men and women in the unorganised sector, in both urban and rural areas, they are more likely to be self-employed workers (GOI, 2008). Lower levels of education and lack of access to land among Muslims could be the factor affecting their labour market position.

In Maharashtra, the scenario is replicated. In the urban areas, the proportion of Muslim workers employed in the unorganised sector is significantly higher than in the case of any other socio-religious group. According to the 2001 census, in Maharashtra the total work participation rate for Muslims is 32.4 per cent, which is lower than that for Hindus (44.2 per cent). This difference is particularly evident in the case of women wherein the work participation rate for Muslim women is 12.7 as compared to 33.6 for Hindu women. The largest share of the Muslim workers in Maharashtra is in 'other works', particularly in urban areas. This includes work like carpentry, masonry, fabrication, mechanics, hawking, pulling rickshaws etc. It is important to note that the participation of women in 'other works' among Muslims is lesser than that among cultivators, agricultural labourers or household industries (Table 4).

Table 4: Work Participation among Muslims in Maharashtra

		Work Participation Rate	Cultivators	Agricultural Workers	Household Industry Workers	Other Workers
Total	Male	50	6.4	11.7	2.6	79.4
	Female	12.7	15.7	43.8	8.0	32.5
	Total	32.4	8.1	17.6	3.6	70.7
Rural	Male	49	20.9	35.5	2.6	40.9
	Female	26.7	23.4	61.6	4.2	10.8
	Total	38.1	21.8	44.4	3.2	30.6
Urban	Male	50.4	0.7	2.2	2.5	94.6
	Female	6.3	0.7	9.8	15.4	73.9
	Total	30	1.0	2.9	3.8	92.6

(Source: Census 2001, as presented in Shaban, 2011.)

As regards the nature of employment, a survey of Muslims conducted across Maharashtra in 2009 finds that the share of casual workers and self-employed among Muslims is very high. In the age group 15-65 years, the survey shows that 29 per cent of Muslims are self-employed, about 29 per cent are salaried/wage employed and 28 per cent are casually employed. The major activities that engage the male self-employed include hawking, tailoring, rickshaw/taxi driving or running a shop. Among females, most are engaged in tailoring, hawking, embroidery or running a shop (Table 5).

Table 5: Current Activity Status of those in the Labour Force by Sex in the Age Group 15-65

	Self employed	Regular salaried/ wage employed	Casually employed	Unemployed
Male	29	32.3	28.8	9.9
Female	30.6	18.5	28.7	22.2
Total	29.4	29.2	28.7	12.7

(Source: Socio-Economic and Educational status of Muslims in Maharashtra: A state report, Shaban, 2011.)

In rural areas, only 21.8 per cent Muslims are cultivators. More Muslims work as agricultural labourers, suggesting that they do not own much land. This fact gets reinforced for the state of Maharashtra (Table 6) when we look at the table below. For the state of Maharashtra, the Index of land deficit is 45.9 (NSS, 55th Round).[4]

[4] The negative value indicates that the share of land cultivated by Muslims is lower than the share of Muslims in total rural households, and therefore in this case it being much lower. Bose, Himanshu and Bose, Prasenjit. (2006, December 31). Economists explode ET Report. People's Democracy, XXX (53), Retrieved from, http://pd.cpim.org/2006/1231/12312006_rejoinder.htm

Table 6: Index of Land Deficit

State	Share of Muslim Households in Total Rural Households (%)	Share of Land Cultivated by Muslims in Total Land Cultivated (%)	Index of Land Deficit
	A	B	C
Madhya Pradesh	2.6	2.8	8.7
Rajasthan	6.3	6.2	-1.4
Himachal Pradesh	1.3	1.2	-8.3
Kerala	20.0	16.7	-16.3
West Bengal	30.9	25.6	-17.4
Assam	27.7	21.5	-22.4
Jammu & Kashmir	40.4	30.3	-25.1
Uttar Pradesh	12.3	8.0	-35.1
Bihar	12.6	7.9	-37.9
Gujarat	3.2	1.8	-43.4
Karnataka	6.0	3.3	-45.5
Maharashtra	4.9	2.7	-45.9
Andhra Pradesh	3.9	2.1	-46.3
Orissa	1.3	0.6	-51.8
Tamil Nadu	2.3	1.1	-53.1
Haryana	5.4	0.9	-83.9
Punjab	0.9	0.1	-91.1

(Source: National Sample Survey Organization, 55th Round 1999 - 2000.)

Maharashtra with a sizeable Muslim population fares poorly in terms of their overall vulnerability because majority work in the unprotected neglected unorganised sector. This not only leads to economic insecurity of Muslims, but has consequences on the overall quality of their life and health.

B. i. Impact of Riots and Ghettoization on Work and Livelihood

Riots and consequent ghettoization have affected the work and livelihoods of Muslims, and therefore their physical and mental health, particularly in Maharashtra. The state has seen perhaps the highest number of communal clashes. It is the daily wage earners or the small traders and businessmen, particularly in the informal unorganised sector that suffer the most. Already marginalized, loss of jobs, property, business and daily wages affect them drastically. While the impact of riots and ghettoization on Muslims in Maharashtra is dealt with later, the work profile in two Muslim ghettos in Mumbai is given here.

In Bhiwandi, where majority of the population is Muslim, it was found that 94.67 per cent of those employed were working in the unorganised sector, which includes power loom workers (unskilled power loom labouresr making up for 45.16 per cent of the total population employed), casual labourers, domestic workers and self-employed. Majority of those employed in Bhiwandi in the unorganised sector are not covered by any employment regulations; consequently, there is no security of employment and it is irregular, employers do not need to follow any statutory obligations, infrastructure and working conditions are poor, trade unions are absent and wages are low, based on piece rate or given as daily wages. More than 80 per cent of Muslims who did not have bank accounts said that they did not have a bank account because what they earned would be spent. There was no scope for any kind of savings (Maharashtra State Minority Commission [MSMC] & College of Social Work Nirmala Niketan, Research Unit, 2011).

In another study (Table 7) conducted in the Muslim dominated slum of Beharampada (239 of the 250 respondents in the study were Muslims), majority of the respondents were in the unorganised sector. Unemployment rates were high (45.2 per cent). Nearly 20 per cent of the population of the slum worked as skilled workers. The self-employment rate in this slum was 10.80 per cent. Despite having more than one earning member, the total monthly family income was between Rs. 5,001 and Rs. 10,000 for majority of the study population. About 25 per cent of them had a monthly income below Rs. 5,000, which is inadequate for a city like Mumbai (Poonacha, 2012).

Table 7: Work Profile – Behrampada

S. No.	Occupation of the Respondent	Percentage
1	Self-employed (garment shops, shoe shops, grocery stores, butchers, telephone booths, etc)	10.80
2	Government job (Railway canteen, BMC, etc.)	1.20
3	Private company job (security guards, supervisors, contractors, etc.)	6.40
4	Skilled labour (electricians, tailors, welders, zari workers, metal fabricators, drivers, and carpenters)	20.00
5	Daily wage work (construction workers, helpers, etc.)	4.00
6	Piece rate home based work	2.80
7	Unskilled labour (domestic servants, loaders, etc.)	8.00
8	Unemployed persons	45.20
9	Professionals (teacher, social workers)	1.60

Moreover, studies commissioned by the Maharashtra State Minorities Commission in Malegaon and Bhiwandi[5] show that Muslims have difficulty accessing bank credit due to discrimination by banks.

B. ii. Child Labour in Maharashtra

Child labour includes working children (not necessarily earning) and children out of school. These children might not be earning, but they might be engaged in household responsibilities such as taking care of the siblings and the elderly or they may have been taken out of school to cut costs. They also represent a potential labour pool. These out of school children, earning as well as non-earning, who make up 18 per cent of children, (15 per cent boys and 21 per cent girls) constitute child deprivation. Nine states have been identified in the Indian Human Development Report (2011) with a high incidence of child labour. Maharashtra is one of them. The link between economic and social deprivation and child labour is well known. There is a negative association among the per capita household expenditure and incidence of child labour and out of school children. The incidence of child labour and child deprivation was high among Muslims, higher than that among Hindu SCs. In fact the Report (2011) has categorically stated that Muslims have the highest incidence of child labour, and the pace of decline in child labour is also the slowest amongst them (Goverment of India [GOI], 2011).

C. EDUCATION

One of the important social determinants of health identified by the WHO is education, which affects health directly in terms of knowledge and information about health problems. Further, education is a determinant of future employment and income, thereby defining a person's socioeconomic status which has an impact on health. It is for this reason that education is an important factor to consider while describing the health of a population.

The literacy rate among Muslims according to the 2001 census was 78 per cent in Maharashtra, which was slightly higher than the state average. It is interesting to note that Muslim women too tend to have a higher literacy rate than other socio-religious groups in Maharashtra (Table 8). Despite this high literacy rate, Muslims do not fare very well in terms of higher educational attainment. The 2001 Census showed that only 2.6 per cent of Muslims in Maharashtra were graduates or above. A state-wide survey (Shaban et al, 2011) shows that only 2.2 per cent of Muslims were found to be graduates or more, and among women, this rate is even lower. The pattern of educational attainment varies across regions with the eastern region of Maharashtra showing a high rate of drop outs after high school, while in the western region a greater proportion pursue higher education. The Census also shows that the percentage of Muslims completing primary level schooling is significantly higher than other socio-religious groups (SRCs), but after that, they are unable to keep pace.

[5] Primary studies done in Bhiwandi & Malegaon, commissioned by Maharashtra State Minority Commission with College of Social Work Nirmala Niketan, Tata Institute of Social Science.

Table 8: Literacy Rate of Muslims vis-à-vis other SRCs in Maharashtra

		Rural	Urban	Total
Maharash-tra	All	70.4	85.5	76.9
	Male	81.9	91.0	86.0
	Female	58.4	79.1	67.0
Muslims	All	72.9	80.3	78.1
	Male	83.2	85.1	84.5
	Female	62.2	74.7	70.8
Hindus	All	70.0	86.3	76.2
	Male	81.7	92.1	85.8
	Female	58	79.6	65.9
SCs	All	67.9	78.3	71.9
	Male	80.6	87.6	83.3
	Female	54.7	68.4	60
STs	All	52.3	74.2	55.2
	Male	64.5	83.0	67.0
	Female	39.9	64.7	43.1

(Source: Census 2001, as presented in Shaban 2011.)

The traditional discourse around low rates of educational attainment among Muslims has suggested that Muslims continue to be educationally backward because they are conservative and place a higher value on religious education in madrasas over secular education. It has also been suggested that Muslim women, particularly, are not sent to schools if they are co-educational or do not have women teachers (Ruhela, 1998). Evidence does not support this argument.

The survey by Shaban (2011) of Muslims in Maharashtra finds that only 4 per cent of Muslims are educated in madrasas. Moreover, the studies in Maharashtra show that the decisions made while accessing and continuing education are far more complex and not necessarily rooted in conservatism. A survey by Jain and Shaban in Mumbai in 2009 found that. The most common reason for dropping out of school (reported by half the respondents) was the lack of information about the next level of education, followed by monetary problems. About 12 per cent of the respondents had to start working and so they dropped out of school and another 12 per cent reported that they dropped out because they had to get married.

The quality of schools and education, particularly municipal schools in Muslim concentrated areas, is wanting in many ways. The Sachar Committee report findings too concur with this fact. There is a high teacher-pupil ratio, absentee teachers, poor quality teaching, lack of hostel facilities and unwillingness towards renting residential places out to Muslim students. A study conducted in Bhiwandi revealed the dismal state of municipal schools. The teachers ask the children to do their personal work and at times, even clean the school. There is one teacher for a class of about a hundred students, and that too students from different standards. A respondent revealed that her son who studied till standard 3 in a municipal school could neither read nor write. The cost of private education is high, which most cannot afford. The school was situated in a Muslim ghetto of Bhiwandi (MSMC & College of Social Work Nirmala Niketan, Research Unit, 2011). The study revealed that there were no institutions for secondary and higher studies and so several students dropped out of school and some started working. This was particularly true for girls; as safety was considered to be an issue, they were not sent to college, which was some distance away.

There is a sense of discrimination by the labour market (particularly in government and private sector jobs) and even though some Muslims are able to afford higher education, they do not see any prospects of returns. This is evident from the earlier discussion, which states that even with high levels of education, Muslims still find themselves in unprotected jobs. This is also evident from the Section below on the representation of Muslims in public sector jobs.

The Muslim community has been often stereotyped, which leads to disheartenment and therefore acts as a deterrent. This has been reported in the studies commissioned by the MSMC. During the focus group discussions in one such study done in Behrampada, a Muslim ghetto in Mumbai, parents reported the biases of teachers against their community. "One parent reported that when her son went to school after an absence of a day, the teacher snidely remarked that he must have gone to attend his father's second marriage, and hence he did not come to school." (Poonacha, 2012).

Muslim students also face discrimination (see Case Study 1). This not only acts as a constraint and leads to discouragement, but studying in a discriminatory environment, is like swimming against the tide.

Case Study 1: Education and Discrimination

"My friend and I had to leave class because we were non-Marathi, I don't want sympathy. But is this fair?" Farhana asked.

When Farhana was in college, she found that many students could answer their examinations in Marathi. She and her Muslim friends asked if they could answer the questions in Urdu. They were refused. There was this other time when she and her neighbour, Tabassum, had to leave class when the teacher announced that all non-Marathi speaking students should leave class. There was no reason given. While Farhana does not expect sympathy because she is a Muslim, she does not want to be discriminated against. This discrimination is unconstitutional. The Constitution of India grants equality and forbids any discrimination based on religion, race, caste, sex or place of birth.

(Source: Adapted from Menon, M. (2011): Riots and After in Mumbai: Chronicles of Reconciliation, Sage Publications)

D. GHETTOIZATION

According to Gayer and Jaffrelot, a ghetto is "a bounded ethnically (or religiously) uniform socio-spatial formation born of the forcible relegation of a negatively typed population." Gayer and Jaffrelot (p. 22) have further identified the characteristics of a typical ghetto[6]–

1. An element of social and/or political constraint over the residential options of the given population (as a result of riots for instance).
2. There are class and caste diversities within these localities, which regroup population from different social backgrounds on the basis of ethnic or religious ascribed identities.
3. The neglect of these localities by state authorities leading to lack of basic infrastructure in terms of health (in terms infrastructure, outreach, etc.), education, water, sanitation, etc.
4. The estrangement of the locality and its residents from the rest of the city. This could be a result of poor, difficult or even relatively public transport; limited options of employment opportunities outside aggravated by the cost, time and effort for commute thereby negating the potential benefits, home based employment, or even insecurity, etc. Where business has been uprooted as a result of moving into ghettos, it results in loss of livelihoods where even people might be forced to leave their original work or employment.
5. The subjective sense of closure of residents, related to objective patterns of estrangement from the rest of the city. This again is very common in ghettos since there are often clear demarcations marked as "borders" and sometimes ghettos also turn into walled communities.

D. i. Ghettoization as a consequence of Communal Riots

Maharashtra has witnessed the highest number of Hindu-Muslim riots post-independence and this has contributed to the socioeconomic deprivation of Muslims in the State. The first communal riot dates back to 1893. In 1967 riots broke out in Malegaon; in 1970, there were riots in Bhiwandi, Jalgaon and Mahad, and in 1984 in Bhiwandi again and in parts of Mumbai. In recent years, (particularly 1992-93) Mumbai, Malegaon, Aurangabad, Bhiwandi, Pune, Nagpur and Dhule are some of the areas of the state that have seen a large number of riots that caused displacement of people on an unprecedented scale, affecting the Muslims largely.

Displacement has been the impact of communal riots. Large numbers of families were forced to leave from the places where they had lived all their lives. Increased polarization

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[6] The authors of the present report have added some elaboration on the points made by Gayer and Jaffrelot. Gayer, L. and Jaffrelot, C. (2011). Muslims in Indian Cities: Trajectories of Marginalization, Columbia University Press, Retrieved from, http://books.google.co.in/books?id=Z7J8ITgtkosC&printsec=frontcover&dq=gayer+and+jaffrelot&hl=en&sa=X&ei=A3C-nULftMYbYrQf17oCIAw&ved=0CCwQ6AEwAA

and a feeling of insecurity have resulted in a move wherein people choose to live among those of their own community, leading to ghettoization. This has led to the formation of areas with high concentration of Muslims, such as Malegaon in Nashik District, Bhiwandi and Mumbra in Thane district and Behrampada, Shivaji Nagar, Kurla and Jogeshwari in Mumbai. The extent of discrimination in the housing market forces even those who have not been victims of riots, to live in 'Muslim areas'.

D. ii. Impact of Ghettoization

A study by Action Aid and the Indian Social Institute, New Delhi, compares two Muslim ghettoes – one in Delhi and the other in Ahmedabad – vis-à-vis the conditions and perceptions of its residents (Ali & Sikand, 2006). The Ahmedabad ghetto was newer and almost 83 per cent of people had migrated in the last decade (which can be correlated with the stark changes that have occurred in the city after the Gujarat carnage of 2002), while the one in Delhi was much older with only 33 per cent having migrated in recent times. Nearly 52 per cent of respondents in the Ahmedabad sample reported a decline in economic conditions post migration. Many also reported that their new localities were not as well endowed with infrastructure as compared to the place from where they had migrated, assigning this to apathy on the part of government authorities. Riot victims from Mumbai have narrated similar experiences, especially of economic losses as a result of riots. Not only have victims lost lakhs in property and not received proportional compensation, but their uprooting has also jeopardized livelihoods as described earlier (also see Case Study 2) (Menon, 2011).

Case Study 2: Impact on Livelihood

"We were forced to move, to leave our property, our jobs....we lost so much. What could we do?"*said Ahmed.*

Ahmed was forced to move to Kasaiwadi, a ghetto, from Masjid Compound, which had a mixed population. His whole family was involved in making brushes for a factory. Once they moved into a ghetto, the brush company refused to send them the material since they now lived in a "Muslim area" and feared that their material would be looted. His family had to start afresh. Ahmed had studied till Standard 10 and managed to get a job as a night watchman and worked during the day as a supervisor in a building. He then got into selling cassettes and soon managed to buy a small shop. The riots have affected him and his family badly. Besides uprooting them, they lost Rs. 3-4 lakhs in property. They had to sell it for a meagre amount of Rs. 60,000. The government compensation amounted to a shameful Rs. 5,000.

People are displaced as a result of communal riots and moving into ghettos affects their livelihoods. Small businesses are uprooted and often, they cannot do the work that they originally did.

(Source: Adapted from Menon, M. (2011): Riots and After in Mumbai: Chronicles of Reconciliation, Sage Publications.)

Moreover, ghettoization reduces spaces for civic interaction and members of the minority community do not socialize with those of the majority community and vice versa. The term, "border", is used to "demarcate" the Muslim from the Hindu areas. Meghwadi, for instance, which was the epicentre of the Mumbai riots in Jogeshwari (East) in 1992-93, is referred to as the "border" even today (Menon, 2011). Another example is that of Naya Nagar in Mira Road, Mumbai which is a Muslim ghetto. A broad road outside Mira Road, referred to as the "border", separates Naya Nagar and Shanti Nagar (a Hindu ghetto) from other areas. The use of such terms to segregate Muslims by Hindu ghettos deepens the sense of divisiveness between the communities. For example, in the study by Ali and Sikand quoted above, a large number of respondents in the Ahmedabad ghetto said that their relationship with Hindus had worsened after migration; only 3 per cent of respondents reported having cordial relations with Hindus. Simultaneously, such segregation makes the demonization of minorities in the minds of majority communities much easier for communal forces.

D. iii. Living Conditions in the Ghettos

As discussed earlier, residential segregation has been identified as a fundamental cause of health inequities among racial and ethnic minority groups in the States. Williams and Collins discuss the many ways in which residential segregation affects the social determinants of health as well as living conditions. It restricts access to good employment opportunities, educational attainment, and in turn results in income disparities among racial groups, particularly disadvantaging African Americans. Segregated neighbourhoods are also likely to have poorer quality housing, fewer municipal and transport amenities and environmental hazards. (Williams and Collins, 2001).

Even availability of health facilities and pharmacies in segregated areas is likely to be less than in other places (Williams & Collins, 2001). We see these characteristics in Muslim ghettos as well.

A disproportionately large number of Muslims live in slums; 70 per cent of the Muslims in the state of Maharashtra live in urban areas and about 60 per cent of these stay in slums and another 30 per cent in lower caste areas (Table 9).

Table 9: Distribution of Muslim Households by type of Neighbourhood in Urban Areas

Type of Neighbourhood	Slum	Low Income Area	Middle Income Area	High Income Area	Mixed
% of Households	57.7%	31.3%	9.1%	1.6%	0.3%

(Source: Shaban 2011 & Socio-economic and Educational Status of the Muslims of Mumbai and Its Suburbs 2009.)

When we study typical ghettos, we find a lot of commonalities amongst them. Thus, while there is an overall neglect of slum areas, the neglect of human and infrastructure development is particularly apparent in those slums that are dominated by minorities. Consider Bhiwandi, it is known as the "Manchester of India" for its handlooms and power looms. The decline of Mumbai's textile industry spurred the growth of Bhiwandi's economy and it became the largest power loom centre in the country. At present, there are 25 handlooms and more than 5,000 power looms. More than half the population of Bhiwandi is directly or indirectly dependent on the looms for its livelihood (Williams & Collins, 2001). Muslims constitute nearly 50 per cent of Bhiwandi's total population (Census, 2001).

A report by Nirmala Niketan College of Social Work maintains that the transport system within Bhiwandi and its connectivity to the city are rudimentary. Poor basic amenities such as water, sanitation, electricity, housing indicates the abysmal/wretched quality of life of the people here. Most of the people are manual labourers, skilled and unskilled labourers or hawkers. There is no affordable housing and therefore they are forced to stay in slums under inhuman conditions. In fact, Bhiwandi is declared as a slum town because 25 per cent of its population resides in slums (Williams & Collins, 2001). Out of the 27 slum pockets, 21 are recognised by the government and 25 are Muslim dominated. Nearly 50 per cent of these people live in *kuccha* houses. It is significant to note that nearly 80 per cent of the respondents have lived in Bhiwandi for more than 15 years. Nearly 90 per cent of the respondents are Muslims; this implies that even after settling in one place for a decade and a half, the quality of their homes and their lives has not improved. The houses of 44 per cent of the respondents measure 100 square feet or less; nearly 90 per cent do not have separate kitchens. The living conditions are unhygienic and crammed. Some live where they work.

Some Muslim dominated slums are also located on forest land and therefore remain neglected by the Municipal Corporation as they are considered 'illegal' and not provided with basic amenities. Instead of provision of alternative housing options, the people staying in these slums have not only been given eviction notices and demolition dates, but also told that the money spent on the demolition of the houses would have to be compensated by the people staying in the slums (Williams & Collins, 2001). Since Bhiwandi is a migrant town with a floating population, its government is far less accountable and gets away with negligence.

In Malegaon too, Muslim localities consist mostly of *kuccha* houses. Room density is higher among Muslims than among non-Muslims according to the study[7]. In Behrampada, the housing consists of several huts with one storey perched precariously on the other – some times as high as four storeys – a safety hazard. Here too, the room density is high and ventilation poor. There are distinct differences in amenities between Hindu and Muslim areas. Muslim areas have narrow roads and congested houses (Shaban, 2011).

[7] number of persons in a house per unit habitable room

Water Problems

With respect to drinking water, Shaban (2011) finds that a substantial percentage (12-13 percent) of households in Mumbai, Thane and Nashik rely on purchased water for their daily needs.In Bhiwandi city, there is a shortfall of water; the estimated current supply is 110 mld per day, while, with a population of 10 lakhs, it should be at least 150 mld (Mega Litre or 10^6 litre) per day. This indicates that there is a shortfall of more than 25 per cent. In the survey which covered 14 slums, none of the communities had municipal water connection and had to make do with private connections. Only 28 per cent of the respondents reported getting water from a public municipal tap, while 55 per cent reported that the water was insufficient. The water that comes through the municipal taps comes late in the night. Most communities surveyed in the city relied on private connections, public taps, hand pumps of private tankers for water, the potability of which was suspect particularly in the monsoons.

In Malegaon, the survey shows that 49 per cent of the respondents stated that the water supply is inadequate to meet their daily consumption needs. In Behrampada, there are only six communal taps for about 60,000 families, and they too get water pressure only between 3 am and 5 am! Further, most water pipes run through open sewers, causing contaminants to seep in.

Toilets and Sanitation

In Bhiwandi, currently, the system of drainage covers only 30 per cent of the city. Waste management systems are inadequate in the city and there is a conflict over the place where waste is to be deposited. Besides, there is no biomedical waste management facility, and all waste is transported to Kalyan for treatment and disposal. The slaughter houses too have no waste management facility – the Maharashtra Pollution Control board has objected to the absence of a waste management facility and filed a criminal case against the municipal corporation under provisions of the Enviornment Protection Agency (EPA). However, no action has been taken. A large part of Malegaon does not have an underground sewage system, most of it is open and prone to blockage. There is frequent flooding even with little rainfall and the water logging causes breeding of mosquitoes.

In Bhiwandi and Behrampada, there is a dearth of toilets and children as well as adults often have to defecate in the open or in the gutters. In Behrampada, only 21 per cent of the households have private toilets attached to their houses, 76.80 per cent use public toilets, and 2 per cent use paid public toilets. The number of toilets is inadequate, particularly for women, who have to leave early in the morning and wait in long queues. Fights over use of the toilets are common. The condition of toilets is filthy due to the clogging of drains. Further, the same area is also used for washing utensils.

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

E. LAW ENFORCEMENT

According to the Sachar Committee report, many Muslims believe that there is a feeling of hostility that the law enforcement agencies harbour towards Muslims. Discussions with representatives from the Muslim community, conducted by the Sachar Committee also threw up issues of discrimination by these agencies - that the presence of police in Muslim localities is more than that of health facilities and educational institutions. The Tata Institute of Social Sciences (TISS) survey by Shaban (2011) found that almost 50 per cent of Muslims believe that the police are biased against them. Muslims have often been the targets of repressive laws and form a considerable proportion of the prison population. The representation of Muslims in the police force too is negligible, less than 5 per cent. This situation presents a very strong sociopolitical context to the health status of Muslims, particularly mental health.

E. i. Discriminatory Behaviour during Riots

The discriminatory role that the police have played in communal riots has fuelled Muslim's lack of trust in law enforcement agencies. During riots, the police have also failed to do their duty in registering cases against offenders. Referring to the role of the police in the 1992-93 riots in Mumbai, the Sri Krishna Commission Report says, "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 was shown in investigation. To award these atrocities carried out by the police officials, the Shiv Sena BJP government in the state actually gave promotions to many police officers who were accused in the Report (ShriKrishna, 1998).

Vibhuti Narain Rai, ex-DIG of the BSF, in his book, *Perception of Police Neutrality during Hindu-Muslim Riots in India,* has exposed revealing truths from the viewpoint of an insider controlling riots. He had intensive interviews with victims of riots and also policemen and police officers. He openly states that "no riot can continue for more than 24 hours unless the state wants it to continue". The interviews have shown that the Hindus look at the police as their friends, whereas the Muslims look upon the police as their enemies. This tendency has been seen in the gruesome killings of youth in the Hashimpura, Meerut and Bhagalpur riots. "In all the riots discussed in this particular study, the police did not act as a neutral law enforcement agency but more as a 'Hindu' force". (Sikand, 1999).

E. ii. Repressive Laws

The "National Tribunal on the Atrocities against Minorities in the Name of Fighting Terrorism" organised by ANHAD in Hyderabad in 2008, found that all over the country

Muslim youth were being victimised by police on allegations of being involved in various terrorist acts. The tribunal recorded this phenomenon in Maharashtra, Gujarat, Madhya Pradesh, Andhra Pradesh and Rajasthan though it prevailed in other states too ("Police victimizing minorities", 2008). The Indian Peoples Tribunal on Prevention of Terrorism Act (POTA) 2004 reported that in Gujarat, out of a total of 280-plus people arrested under the Act, only one was a non-Muslim (a Sikh). This law has been used as an instrument of harassing the minorities by picking up relatives of suspects, detaining and torturing them on baseless evidence ("A reality check", 2004). Meena Menon, in her book, describes an incident in Behrampada, wherein several Muslim men were picked up by the police in a combing operation allegedly because they were involved in carrying out terrorist activities. An investigation revealed no evidence of such activity and they were eventually released. These arbitrary arrests of Muslims by the state police are probably the reason why there are a large number of detenues and undertrials in Maharashtra's prisons.

Case Study 3 "I fail to understand why"

"I don't have a criminal record and the police know that, but every time something happens in the city, I find the police at my door. I have been detained and questioned by the ATS and the local police three times so far. I fail to understand why," says Dr. Tipu Sultan, a BHMS doctor from Shivaji Nagar, doesn't like to talk about his involvement with the police.

Sultan was picked up first after the 2002 Ghatkopar blast, again after the 7/11 train blasts, and for the third time following the Malegaon blasts. *"The police came to my clinic and ransacked it,"* says Sultan. *"When I asked why, I was told to keep quiet. They thought I was a conspirator in the Malegaon blasts. Yes, I have relatives in Malegaon and had been there just before the blasts, but that doesn't make me a terrorist."* After searching the clinic, the police took Sultan to the police station in a van. *"I was pulled out like a criminal,"* he says. *"People from the area had gathered. I cannot forget the way they stared at me. All I wished was that the ground would open up and swallow me."* At the Anti Terrorism Squad (ATS) office, Sultan was questioned for nearly four hours. Eventually, a delegation of doctors met the ATS chief and the police commissioner, and Sultan was released.

The next few days were very difficult. *"I had to face my clients and neighbours," he says "For them I had been arrested which meant I had done something wrong. More than the police, the media blemished my image. But now things have died down and life proceeds as it has to."*

(Source Akela, Sayed and Sadhwani (2010), adapted from Shaban 2011.)

That several acts of terror perpetrated by Hindus have not been investigated at all is evidence of the bias of the police against Muslims! For instance, two Bajrang Dal workers died while making bombs in a Nanded Bajrang Dal Branch in April 2006. On the basis of evidence unearthed by the police and anti-ATS, it was established that the place was used for making bombs and that one of the persons who was injured confessed to this as well. However, the leads of this case were not used to investigate other cases of bomb blasts in Maharashtra. Similarly, in the Malegaon blasts that took place in 2009, the ATS found Sadhvi Pragya and others to be associated with the case. Yet, the perception that terror attacks are largely perpetrated by Muslims continues (Puniyani, 2012).

E. iii. Over-representation in Prison Population

Probably the most obvious evidence for the State's repression of Muslims in Maharashtra, and the discriminatory attitude of the police, is the fact that Muslims form a disproportionately large proportion of the prison population in the state. While Muslims form just over 10 per cent of the state's population, their share in the prison population is much higher. According to the prison statistics, from 2000 to 2007, over 20 per cent of the convicts in Maharashtra have been Muslims (Shaban, 2011). This is comparable to the US wherein African Americans form 13 per cent of the total population, but 34 per cent of the prison population (Marc & Ryan, 2007). Among undertrials, the condition is worse. About 30 per cent of the undertrial population in Maharashtra's jails are Muslims (Table 10). In 2000, this figure was as high as 39.3 per cent. Among detenues (Table 11), the percentage is sometimes as high as 47 per cent, more than thrice their share in the population! The over-representation of Muslims among undertrials and detenues is particularly disturbing. Perhaps it is likely to have more to do with inability to secure a good defence, rather than high rates of crime among Muslims.

Table 10: Undertrials in Maharashtra Jails by Religion

	2000	2001	2002	2003	2004	2005	2006	2007
Percentage								
Hindu	50.9	63.8	60.1	61.3	61.7	67.8	64.2	65.0
Muslim	39.3	31.5	28.9	30.6	33.1	26.2	27.3	28.3
Sikh	1.7	1.0	1.4	1.1	1.0	0.8	1.3	0.8
Christian	3.0	1.7	2.1	1.7	1.4	2.1	1.7	1.1
Others	5.2	2.0	7.4	5.3	2.8	3.2	5.5	4.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(Source: Prison Statistics India (various years), as quoted in Shaban 2011.)

Table 11: Detenues in Maharashtra Jails by Religion

	2000	2001	2002	2003	2004	2005	2006	2007
Percentage								
Hindu	34.9	46.6	40.1	45.0	48.2	48.1	63.5	54.6
Muslim	30.7	40.8	35.2	47.6	41.8	41.7	32.1	36.2
Sikh	4.6	0.5	1.3	1.6	2.4	1.3	1.1	0.7

Christian	14.7	3.3	12.1	1.6	2.9	2.1	1.5	5.3
Others	15.1	8.8	11.4	4.2	4.7	6.8	1.8	3.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(Source: Prison Statistics India (various years), as quoted in Shaban 2011.)

The general mistrust of the police and law enforcement agencies among Muslims is a cause for concern, as it deters people from registering complaints when they genuinely need to. Moreover, the constant harassment by the police and tarnishing of the image of the community has resulted in Muslims living in constant fear of being picked up and charged on flimsy counts. It clearly has an impact on their day-to-day functioning, their mental health and their job prospects. This impact needs to be documented more systematically to understand the burden that such discrimination is likely to have on one's mental health and general well-being.

F. PARTICIPATION IN GOVERNANCE AND POLICY-MAKING

Muslims in India are not visible in the three core seats of power– the judiciary, the administration and the police. In 2002, of the total number of High Court Judges in the country, less than 7 per cent were Muslims. Significantly, there is not even one Muslim judge in the Maharashtra High Court. Representation continues to remain low. Of the 5,000 IAS officers in the country, less than 3 per cent are Muslims. Muslims constitute only about 4 per cent of the more than 3,236 IPS officers (Gayer & Jaffrelot, 2011).

Muslims are on the periphery of our political system. In the 1980s, the proportion of Lok Sabha Members of Parliament (MPs) was in proportion to their share in the population. According to the 1981 census, Muslims constituted 11.4 per cent of India's total population and 9 per cent of the MPs in the Lok Sabha were Muslims. The proportion of Muslims in the Lok Sabha has since then dwindled. Today, Muslims represent only 5.5% of the Lok Sabha MPs. It is important to note that there is not even one sitting Muslim MP from the state of Maharashtra! (Gayer & Jaffrelot, 2011). Besides, the percentage of Muslims employed in the public sector across India is also very low, drastically lower than even Hindu OBCs (Table 12) (Goverment of India [GOI], 2006).

Table 12: Share of three Social Religious Categories in the Public Sector (%)

Public Institution	Hindu OBC	Muslim non – OBC	Muslim OBC
Railways	9.3	4.5	0.4
PSUs	7.3	2.7	0.6
University teachers	17.6	3.9	1.4
Non-teaching personnel at universities	24.9	3	1.7

In Maharashtra, at the local levels even where Muslims are in a majority, their representation is not proportionate. For instance, in the Municipal Corporation of Bhiwandi-Nizampur. Muslims constitute nearly 50 per cent of the population in Bhiwandi, but only about 7 per cent are part of the Municipal Corporation. Hindus constitute nearly 35 per cent, whereas nearly 60 per cent of employees are Buddhists (MSMC & College of Social Work Nirmala Niketan, Research Unit, 2011).

It has been argued that Muslims are not often found in higher level or formal organised sector jobs due to their backwardness and lack of education. However, this was also the case with SCs and STs. A study of the Indian Administrative Services revealed that earlier, the SC and ST quotas were rarely filled. However, positive intervention by the state subsequently changed the scenario (Dalal, 2008). This has not been done for Muslims.

In India, the state governments are responsible for provision of public services down to the local level. They control most of the financial resources that have been dedicated to these activities. Elected members of state legislatures play a key role in these allocations. Absence of Muslims from these arenas, therefore is likely to affect the quality of public services they receive. An empirical study across 17 states, including Maharashtra, revealed that there is a high possibility of the presence of statistical discrimination in the outcomes of the allocation process on the basis of caste and religion. The high proportion of Muslims in the rural areas of a district has been attributed to the lowering of the public input (Betancourt & Gleason, 1999). The same study reveals that outcomes of the allocation process are characterised by selectivity against Scheduled Castes and Muslims who live in the rural areas (Betancourt & Gleason, 1999).

INFERENCES

The above sections have made an attempt to throw some light on the life and circumstances of Muslims in the state. Two facts have been clearly established. One, that structural violence affects the growth and future of an entire population and has a direct impact on health, both physical as well as mental (Section I). Second, that the Muslims in Maharashtra face structural violence at various levels (Section II). This section reflects on the socio-economic disparities, discrimination, residential segregation, lack of opportunities, poor living conditions, poverty; that is, structural violence in general. The Muslims are thus a significantly deprived population in the State. In terms of housing, income, work profile, education there are major challenges that the community has to face. The negative image of the community that is projected by law enforcement agencies further complicates matters, making them more vulnerable to discrimination and neglect. Frequent communal riots in the state have not only had an immediate impact on their lives, but in the long run served to reinforce and propagate their marginalization. In addition to the direct impact of the riots in the form of loss of life, property, livelihood and displacement, the phenomenon of ghettoization has pushed the community into an isolated corner, both physically as well as socially. The living conditions in these ghettoes are abysmal with poor and precarious housing, inadequate access to potable water supply, lack of sanitation, drainage and garbage disposal.

The evidence presented in Section I shows how structural violence faced by Muslims in Maharashtra has a serious impact on the physical and mental health of the entire population in the state. It is a vicious cycle, from which it would be very difficult to emerge, without positive intervention from the state. It is against this background, this reality, within which we have to understand and contextualize their health status as witnessed from various data sources mentioned in the following section.

SECTION III

HEALTH AND HEALTH CARE

Health care is an important determinant of physical and mental well-being and every government is obliged to meet the health needs of its citizens **without any discrimination.** In a landmark judgment, the Supreme Court of India expanded the scope of Article 21 of India's Constitution (Right to Life) and ruled that "Right to Health" is integral to the Right to Life. According to the World Health Organization (WHO), the determinants of health of a community include the social and economic and physical environment and a person's individual characteristics and behaviour.

A. Childhood Mortality Rates

According to NFHS III data, Muslims in Maharashtra, fare better than other groups in terms of mortality rates in children. They have an infant mortality rate (IMR) of 25.9 which is lower than that for other religions as well as across castes. Neonatal (NNMR), Child and Under-5 mortality rates (U5MR) for Muslims too is lower than for other groups (Table 13). Similarly, districts with a high concentration of Muslims[8] have an infant mortality rate (IMR) that is similar or slightly better than the state average (Table 14). In the context of the marginalization that Muslims face, these numbers seem out of place.

Table 13: Childhood Mortality Rates by Background Characteristics

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

(Source National Family Health Survey - III Maharashtra, 2005 – 2006.)

[8] Seven districts are being considered 'Muslim concentrated' based on: (1) top 5 districts that have the highest % population of Muslims as per the 2001 census (Mumbai, Mumbai-S, Aurangabad, Parbhani, Akola) (2) top 5 districts that have the highest proportion of Muslim population in Maharashtra as per the 2001 census (Mumbai, Mumbai-S, Aurangabad, Thane, Nashik).

Table 14: District wise Infant Mortality

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

(Source: Maharashtra State Health Systems Resource Centre (SHSRC) Report, 2007.)

A closer look at data from large surveys shows that the low IMR and U5MR among Muslims at the state level could be because a large proportion of Muslims in the state reside in urban areas. A look at inter-state variations in IMR through the NFHS II reveals that states that have a high percentage of Muslims staying in urban areas (such as Maharashtra, Karnataka, Andhra Pradesh, Gujarat, Madhya Pradesh, Tamil Nadu) as well as those states where there is a higher percentage of Muslims staying in urban areas than the total population of Muslims in the state in general (Uttar Pradesh and Bihar) were found to have lower U5MR than the state average. In contrast, those states where the percentage of Muslims in urban areas is less compared to that for the state (West Bengal, Assam and Haryana), the U5MR is higher for Muslims than the state average (Table 15).

Table 15: Child Mortality Rate and Population in Urban Areas for States

State	**U5MR (state)**	**U5MR for Muslims**	**% of total population in urban areas**	**% of total Muslim population in urban areas**
Uttar Pradesh	135	108	21	36
Bihar	110	99	13.3	15.2
Karnataka	83	66	34	59
Maharash-tra	70	42	42.4	70
Andhra Pradesh	91	40	27.3	58.1
Gujarat	91	50	37.4	58.7
Madhya Pradesh	145	99	24.8	63.5

Tamil Nadu	71	56	44.0	72.8
West Bengal	71	77	28	16.8
Haryana	79	90	28.9	14.5
Assam	80	87	12.9	6.4

(Source: National Family Health Survey - II 1998 - 99, evolved from Basant and Shariff.)

Further, we find that within urban areas in Maharashtra, Muslims fare much worse than other groups when it comes to child survival. A special fertility and mortality survey[9] conducted in 1998 clearly illustrates this (Table 16).

Table 16: Child Mortality Rates by Religion and Residence

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

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

The data shows that the for the State of Maharashtra as a whole, IMR for the Muslim community is 39 per thousand, which is lower than other groups (Hindus and 'others') and also lower than that for the total population. However, the scenario changes in the urban areas where IMR for Hindus and other groups drops to 28 per thousand as compared to 38 per thousand among Muslims. A similar pattern is seen in the case of under-five mortality, which is lower for Muslims than other groups in rural areas, but in urban areas Muslims fare comparatively worse.[10]

What this discussion clearly reveals is that though macro level studies reflect better survival rates for Muslim children, it is not so for the majority of the population. In Maharashtra, Muslims are more concentrated in urban areas (70 per cent of the Muslim population is urban (Shaban, 2011) and an urban-rural break up clearly reflects the poor survival rates for Muslim children despite being in urban areas. This is significant - first, it clearly shows that despite being concentrated in the urban areas in Maharashtra,

[9] The survey is of 1.1 million households, data is based on Sample Registration System.
[10] The data is relatively old (from 1998) as no recent analysis is available.

Muslims are unable to benefit from the higher concentration of health services. Second,, it opens up the possibility of the nexus between the circumstances of the Muslims (the social determinants of health and the structural violence as elaborated in the earlier sections) and their health status.

B. Nutrition and Anaemia

According to NFHS III, 48 per cent of women in Maharashtra are found to be anaemic. Looking at percentages on the basis of religion, it was found that 43 per cent of Muslim women, 49 per cent of Hindu women and 53 per cent of Buddhist women were found to be anaemic (Table 17). There is not much difference in terms of the percentage of women being anaemic among the poorest of the poor and the population in the second wealth quintile. Common sense would suggest that the poorest of the poor would have a much higher percentage of those anaemic. There are no explanations that can be sought without a more detailed study.

Table 17: Anaemia among Women by Background Characteristics

Religion		Mild (10-11.9 g/dl)	Moderate (7-9.9)	Severe (<7)	Any (<12)
	Hindu	33.1	13.9	1.8	48.9
	Muslim	27.8	14.7	0.6	43.0
	Buddhist/ Neo-Buddhist	36.3	14.6	2.1	52.9
	Other	31.8	7.6	1.3	40.7
Caste	Scheduled Caste	35.3	14.6	2.1	51.9
	Scheduled Tribe	37.6	18.3	3.0	58.9
	Other Backward Class	31.9	13.3	1.6	46.8
	Other	31.3	13.1	1.3	45.7
Wealth Quintile	Lowest	35	17.7	2.7	55.3
	Second	36.2	15.6	2.4	54.2
	Middle	33.1	15.6	1.9	50.7
	Fourth	32.6	12.9	1.5	47.1
	Highest	30.6	12.0	1.1	43.7
	Total	32.8	13.9	1.7	48.4

(Source National Family Health Survey - III Maharashtra, 2005 – 2006.)

What adds another dimension to the above observations is the fact that a study on the nutritional crisis in Maharashtra (Sardeshpande, Shukla & Scott, 2009) based on National

Sample Survey Organization (NSSO) data (2004-05, Consumption round), shows that Muslims have the lowest average calorie consumption per capita per day, among all religious groups, in both rural and urban areas of Maharashtra. The consumption in urban areas at 2094 calories/capita/day is lower than it is even in rural areas where it is 2265 calories/capita/day. In the rural areas, Muslims fare better than only Scheduled Castes and in urban areas they are worse off than Scheduled Castes (SCs) and Scheduled Tribes (STs). Muslims also have a high incidence of calorie-poor in the state. In rural areas, Muslims fare slightly better than Buddhists in the incidence of calorie poor and in urban areas, they have the highest incidence of calorie poor among all groups.

Thus, diametrically different inferences can be drawn from the NFHS and NSSO data. Therefore, the nutritional status of any population or community cannot be ascertained without a detailed context based study.

C. Fertility and Contraception

A look at the NFHS III data provides a picture of the changing fertility rate and contraceptive use among Muslims.

Table 18: Change in Fertility across NFHS Surveys

	Muslim			ALL		
	NFH-SIII	NFH-SII	NFHS I	NFHS III	NFHS II	NFHS I
Total wanted Fertility Rate	2.11	2.20	2.98	1.66	1.87	2.13
Total Fertility Rate	2.85	3.30	4.11	2.11	2.52	2.86
Difference between TFR and TWFR	0.74	0.90	1.13	0.45	0.65	0.73
Mean Number of Children Ever Born to Women age 40-49 years	4.4	4.58	5.20	3.4	3.77	4.25

(Source: National Family Health Survey, various rounds)

The Total Fertility Rate (TFR) of Muslims in Maharashtra has steadily reduced from 4.11 in 1992-93 (NFHS I) to 3.3 in 95-96 (NFHS 2) to 2.8 in 2005-06 (NFHS III).This drop in TFR has been better for Muslims than for the state as a whole (Table 18). Contraceptive use among Muslims in Maharashtra has been found to be increasing over the years and stands at 57.4 per cent as per DHLS- 3 (Table 19).

Table 19: Current use of Contraceptive Method by Background

		Any method	Male st*	Female st*	IUD	Pill	ECP	Condom
Religion	Hindu	65.9	3.1	54.4	1.4	1.6	.2	4.1
	Muslim	57.4	0.7	41.4	2.8	5.2	.5	5.7
	Christian	55.3	1.3	40.1	1. 4	1.3	0	4.3
	Sikh	68.8	0	34.7	0	10.2	0	23.8
	Buddhist/Neo Buddhist	64.4	4.5	52.7	0.7	1.2	.2	3.8
	Jain	72.6	0	49.6	3.7	3.6	0	12.8
	Others	63.3	7	49.3	0	1.4	0	2.8
	Maharashtra	65.1	2.9	53	1.9	1.9	.2	4.4

(Source: District Level Household Surveys - 3 Maharashtra, 2007-2008)

Note: st*- sterilization

While it is often reported (and accurately so) that the overall percentage of Muslim women using contraception is low, it would be important to point out that the use of condoms is higher among Muslim women, as also the use of IUDs (twice as much) and oral contraceptive pills (three times greater), than that among Hindu women. In other words, the use of spacing methods is preferred by Muslim women and one of the reasons for the low overall utilization of contraception among Muslim women, is likely to be the non-availability or poor availability of spacing methods in the public health system. This has been established in studies across the country (Hussain, 2008; Jeffrey & Jeffrey, 2000; Chacko, 2001). It is also important to note that, in Maharashtra, 77.4 per cent of Muslims have received messages regarding family planning from "any source" (radio, television, etc), which is much higher than Hindus at 59.2 per cent (NFHS 3).) In terms of exposure to family planning messages, Muslim women seem to be well aware. However, the family planning program in Maharashtra (and in India as a whole) leans more towards limiting methods such as sterilization, when Muslim women's family planning preferences are those of spacing methods. As a result, Muslim women have high unmet need and lowest percentage of demand satisfied, while the total demand for contraception is more or less within the range of the rest of the groups (Table 20).

Table 20: Demand for Contraception by Religion

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

(Source: National Family Health Survey - III Maharashtra, 2005-06)

Therefore, there is a clear mismatch in what is needed and what is provided. Because of the prevalent belief that non-use of contraception by Muslim women is rooted in religious beliefs, the focus of policy has been on 'changing the mindset' of Muslims through awareness campaigns rather than making a 'basket of choices' available for contraception. As a result of the poor availability and promotion of the preferred method of contraception by the state, it is not surprising that Muslim women rely on the private sector for spacing methods (DLHS-III). There is a need to address the mismatch between needs and what is provided by the state as well as the prevalent biases, so that contraceptive services are in tune with priorities and preferences of the people.

Data on fertility has often been used to perpetuate the bias that the high fertility rate of Muslims is contributing to India's population explosion (projecting them as 'irresponsible citizens') and inciting fear that soon the population of Muslims will exceed that of Hindus. Even academics have argued that it is the "backward" religious belief of Muslims that forbids the use of contraception (Fargues, 1993). The misconception that Muslims are averse to using contraception is still strongly ingrained in health care providers. The above mentioned data clearly provides evidence to the contrary. In the study conducted by CEHAT[11] routinely mocked about the number of children they have. Often health care providers would feel that Muslim women were lying about the number of children they have, even if the woman may have come for her first pregnancy. These biases and misconceptions propagated over the years are harmful and must be addressed.

D. Maternal Health – Antenatal care (ANC) Coverage

A significant proportion of both Hindu and Muslim women make it a point to access health facilities for ANC. Muslim women also do marginally better when it comes to receiving all three ANC check-ups.

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

Table 21: Percentage of Women who received Antenatal Check up by Background

		Percentage of women who received any ANC	Percentage of women who received all three ANC visits	Percentage of women (aged 15-49) who received full antenatal care (ANC)
Religion	Hindu	91.1	73.7	35.1
	Muslim	94.9	77	26.4
	Christian	100.0	82.6	44.7
	Sikh	-	-	-
	Buddhist/Neo Buddhist	94.2	77.8	28. 3
	Jain	100	97.9	60.2
	Others	80	47.6	31.8
Caste/ Tribe	SC	93.5	75.7	30.2
	ST	81.5	60.2	32
	OBC	94.9	80.4	37.2
	Others	94.5	77.7	34.2
Wealth Quintile	Lowest	77.2	52.3	24.1
	Second	88.2	64.5	27.1
	Middle	91.9	72.3	31
	Fourth	95.4	79.3	34.4
	Highest	98.3	90.4	46.3
Maharashtra		91.8	74.4	33.9

(Source: District Level Household Surveys - 3 Maharashtra, 2007-2008)

Despite a higher percentage of Muslim women who access ANC and have undergone all three check-ups, only 26.4 per cent have received total ANC, that is, receiving tetanus toxoid (TT) injections and Iron-Folic-Acid tablets; these seem to be the two components of ANC that are not received consistently by Muslim women. This is significantly lower than other groups and also lower than that in the State as a whole (Table 21).

Moreover, we find that a significant percentage of those in the lowest wealth quintile are the ones who are not receiving ANC care. The question therefore is, why are so many Muslim women not receiving total ANC care despite completing three ANC visits? Does it reflect poor ANC care based on discrimination? This needs to be seen in the light of the fact that that a higher percentage of Muslim women, as compared to Hindu and Buddhist women, are accessing ANC from private facilities (Table 22).

Table 22: Place of Antenatal Check up

		Any Antenatal Check up	Government Health Facility	Private Health Facility	Community Based Services
Religion	Hindu	91.1	42.6	46.5	3.2
	Muslim	94.9	45.4	54.9	1.5
	Christian	100	53.6	36.5	8.2
	Sikh	-	-	-	-
	Buddhist/ NeoBuddhist	94.2	55.1	31.9	2.2
	Jain	100	10.3	91.8	2.1
	Others	80	50.6	25.6	19
Castes	SC	93.5	54.4	34.4	2.1
	ST	81.5	49.8	24.7	6.6
	OBC	94.9	44.2	50.5	2.8
	Others	94.5	36.4	57.8	1.9
Wealth Quintile	Lowest	77.2	48.3	19.0	7.1
	Second	88.2	51.3	27.6	3.6
	Middle	91.9	47.4	38.3	3.2
	Fourth	95.4	47.8	48.3	2.1
	Highest	98.3	29.5	74.0	1.8
Maharashtra		91.8	43.8	46.1	3.1

(Source: District Level Household Surveys - 3 Maharashtra, 2007-2008)

It is common knowledge that women from higher wealth quintiles are more likely to access private health facilities. This needs to be seen in the light of empirical data that reveals that Muslim women have said that they prefer private providers as they feel public providers do not treat them with dignity. Therefore, it is a cause for concern that even poor Muslim women are going to private facilities. They are found to be sourcing contraceptives from private providers. Thus, it is clear that despite having followed up the relevant number of times for ANC, Muslim women do not get complete care and this could be the primary reason why they access private facilities.

It has been argued that Muslim women have lower decision making power in the household. However, Menon and Hasan (Hasan, 2004), in a survey conducted across different regions in India, used a Freedom of Movement Index (FMI) to gauge whether women required permission to carry out certain activities. For both Hindu and Muslim women, they found that women in general were required to seek permission for attending to their health needs more than for going to work or to the market. This is consistent with findings from several studies on women's health seeking behaviour, which have established that lower priority is accorded to women's health than to other economic and domestic activity. While the mobility and decision-making power of women in general is low, the survey finds that Muslim women have marginally lower decision making power regarding seeking health care (a higher need for obtaining permission). The authors attribute this to the fact that being a poor and marginalized community, the economic implications of seeking health care are probably greater for Muslims than for other groups and hence decision-making is curtailed. Despite the high poverty rates and lower decision making power, what is it that motivates or forces these women and their families to seek private ANC which they could receive free otherwise?

The study conducted by CEHAT in Mumbai revealed that Muslim women waiting for gynaecological check-ups at the public hospital, found it highly objectionable that they were asked to remove their "shalwar" in the waiting room much before their turn. Doctors, ward boys and other patients walking in and out of the waiting room made them feel awkward. Because other women were wearing "saris", they were not subjected to this humiliation. This deterred them from going to the public hospital for ANC visits completely. A Muslim woman from the ghetto described her experience during a focus group discussion (FGD). (Khanday & Tanwar, 2013)

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

D. i. Place of Delivery

The DLHS data show that institutional deliveries among Muslims are higher than among other groups and also as compared to the state average (Table 23). In districts, where the Muslim population is in majority, the percentage of institutional deliveries is the same as the State average or higher. This is possible as the majority of Muslims live in urban areas where health infrastructure is more easily available than in rural areas.

Table 23: Profile of Women delivering in Health Facility

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

(Source: District Level Household Surveys - 3 Maharashtra, 2007-2008)

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

D. ii. Greater Utilization of Private Sector for Delivery

As is the case for ANC, Muslims are more likely to deliver in private health facilities. According to the NFHS II, in Maharashtra, 42.7 per cent of Muslims delivered in private health facilities as compared to 24.2 per cent Hindus (Table 24).

Table 24: Place of Delivery (Public, NGO, Private, Home, Parents Home, Other) by Religion

Religion	Public	NGO/Trust	Private	Own Home	Parents' Home	Other
Hindu	22.6	0.9	24.2	27.8	23.9	0.7
Muslim	28.2	0.6	42.7	15	12.5	1
Christian	(20.3)	(10.2)	(48.9)	(0)	(20.7)	(0)
Buddhist/ Neo-Buddhist	42.3	0	18.7	23.6	15.1	0.3

(Source: National Family Health Survey - III Maharashtra, 2005 - 2006)

This higher use of the private sector for deliveries can perhaps be attributed to the callous behaviour by the hospital staff in government facilities. The experience of having to deliver at a public hospital is dehumanizing. The study cited earlier, by CEHAT, showed that both Muslim and non-Muslim women, reported being treated badly during labour. Health care providers routinely passed remarks about how Muslims have many children and are irresponsible. This behaviour plays a role in pushing Muslim women away from accessing public health facilities. The private sector, affordable or not, might be the only option for some. For others, they may be left with no choice but to deliver at home. (Khanday & Tanwar, 2013)

Evidence suggests that many Muslim women, even in cities, are having home deliveries. In a study in Bhiwandi, it was seen that of the 100 home deliveries that took place in the year of the study, 97 were Muslim women and only 3 were from other religions. Despite its proximity to hospitals, Behrampada, a Muslim ghetto, also shows instances of home deliveries. The study reports that not all of these home deliveries are assisted, risking the life of the mother and the child. A possible reason for this could be that as per the prevailing government rules, delivery care is free at public hospitals for the first two children. However, the birth of a third child entails a payment of Rs.700 from the woman. Such conditionalities reduce women's access to institutional delivery in public hospitals. Moreover, the need to reduce fertility rates should not lead to disincentives or policies that can lead to endangering the mother and the child.

D. iii. Poor Utilization of Janani SurakshaYojana (JSY)

Despite the high percentage of Muslims utilizing the private sector for deliveries, it is surprising to note that the percentage of Muslim women accessing benefits under the Janani Suraksha Yojana (JSY) is extremely low for Muslims at 2.9 per cent, as compared to 8.8 per cent for Hindus, 10 per cent for SCs, 16 per cent for STs, and 7 per cent for OBCs (Table 25).

Table 25: Percentage of Women receiving Government Financial Assistance for Delivery Care (JSY)

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

(Source: District Level Household Surveys - 3 Maharashtra, 2007-2008)

The poor utilization of the scheme therefore, may have to do with the fact that documents such as ration card and BPL certificate are required for accessing JSY. According to the survey conducted by Shaban (2011) in Maharashtra, one fifth of the Muslims in the State do not possess a ration card, which serves as a barrier to accessing government schemes.

E. Child Nutrition and Immunization

In terms of nutrition of children, we find that while fewer Muslim children are under weight and wasted, a greater percentage of them are stunted (height for age) (Table 26).

Table 26: Percentage of Children under age 5, Classified as Malnourished, Maharashtra

	Weight for Age (Underweight)		Height for Age (stunting)		Weight for Height (thin / wasted)	
	% Below -3SD	% Below -2SD	% Below -3SD	% Below -2SD	% Below -3SD	% Below -2SD
2005-06						
Muslim	7.9	29.1	22.0	42.0	4.1	12.2
Hindu	12.5	38.5	18.3	46.1	5.3	16.8
Total	11.9	37.0	19.1	46.3	5.2	16.5

(Source: National Family Health Survey - III Maharashtra, 2005 - 2006)

The percentage of Hindu children who are underweight and wasted is higher. However, this could be because of an immediate illness prior to the survey, particularly in the case of underweight children. However, the percentage of children with the more severe stunting (-3SD) is greater for Muslims than for Hindus and is greater than the state average as well. This is a cause for concern, since stunting is an indicator of sustained long term deprivation or repeated illness. This clearly validates the argument in section - III.B on nutrition wherein the calorie intake of Muslims was much less than that of the general population and reiterates the need for a multi-layered context based study and analysis. It would be simplistic to say that less Muslim women have anaemia and that more Hindu children are underweight. DLHS-3 data shows that vaccination among Muslims not far behind the average state level (Table 27).

Table 27: Vaccination among Children below Six Years

Religion		% of children who received full vaccination
	Hindu	69.4
	Muslim	63.9
	Christian	47.1
	Sikh	
	Buddhist/Neo-Buddhist	76
	Other	64.7
Caste	Scheduled Caste	69.9
	Scheduled Tribe	52.2
	Other Backward Class	74.5
	Other	75.0

Wealth Quintile	Lowest	43.2
	Second	57.5
	Middle	69.4
	Fourth	72.7
	Highest	80.7
	Total	69

(Source: District Level Household Surveys - 3 Maharashtra, 2007-2008)

Data from the primary studies in Bhiwandi, Behrampada and Sion-Koliwada also show that immunization coverage among the Muslim population is fairly good, with 80-90 per cent of children having been immunized (Table 28).

Table 28: Immunization and ICDS Rates as per Primary Studies

Place	Immunization	Birth Registrations	ICDS Coverage/ No.of women Monitored
Malegaon			155 functioning centres (16% households covered)
Bhiwandi	93.46	91.13%	3
Behrampada	>80%	88.52%	6
Sion-Koliwada	>80%	100%	3

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

Yet, there seem to be misconceptions about acceptance of immunization by Muslims. According to the Chief Medical Officer (CMO) of the Indira Gandhi Memorial (IGM) Hospital in Bhiwandi, immunization of children was a big challenge because majority of the Muslims refused to administer their children the vaccinations including polio drops since they believe that the vaccine contains the genes of pigs. The primary study conducted in Bhiwandi referred to earlier, however, shows that 93.5 per cent of children below five were immunized! Among those who were not immunized, the fears were related to illness among children during immunization drives, and lack of time. There seem to be no religious undertone to the reasons given for children not being vaccinated. Thus, there is a dissonance between what the health care providers perceive as reasons for non-immunization and the actual reasons for the same. Similarly in Behrampada,(Poonacha, 2012) even though the survey data showed that more than 80 per cent children in the 2-5 year age group had been immunized, the Public Health Supervisor at the Health Post felt that there was a lack of awareness among Muslim mothers about immunization, which needed to be remedied.

Utilization of Integrated Child Development Services (ICDS) such as availing *anganwadi/ balwadi* facilities and supplementary food was poor among Muslims in the primary studies. For example, in Malegaon, only about 16 per cent of the Muslim households reported any help from ICDS schemes (Shaban, 2011) In Bhiwandi, women from only three families availed themselves of the ICDS scheme and children from about 26 per cent of families (primary survey data and FGDs) attended the *anganwadis/balwadis* (MSMC & College of Social Work Nirmala Niketan, Research Unit, 2011). The reasons for poor utilization of these facilities need to be explored and addressed.

F. Availability of Public and Private Health care

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

- Bhiwandi has 10 health posts and only one Government hospital catering to a population of about 7 lakh residents. Residents have mentioned that the hospital is unable to provide any specialized care. Only normal deliveries are performed and no C-sections. They also mentioned that the hospital does not even have emergency facilities, ambulances or blood banks. There are no multi-speciality or tertiary care facilities and people have to go to Mumbai or Thane for any kind of surgery.
- In Mumbra, there are three Urban Health posts and one maternity home that cater to a population of 8 lakh persons. Further, the few urban health posts are only open for two hours, six days in a week at a time that is inconvenient for people, which makes access extremely difficult. The only hospital is located in Kalwa and for issues that cannot be addressed there, residents have to go to Mumbai or Thane
- Malegaon with a population of 4.7 lakhs has four municipal dispensaries, three maternity homes, and two Municipal hospitals, along with a district hospital. However, the study mentions that the municipal hospitals largely cater to paediatric and child needs, whereas the district hospital provides very limited services.
- The study from Behrampada showed that the area had no health post for a population of 49,829 and residents had to access the health post located in Kherwadi for their needs.

It appears therefore, that the above mentioned Muslim ghettoes have been systematically neglected by the state. This is also consistent with the findings of an empirical study across 17 states, including Maharashtra, which revealed that there is a high possibility of "existence of statistical discrimination in the outcomes of the allocation process on the basis of caste and religion. A higher proportion of Muslims in the rural area of a district leads to a lowering of the public input." (Betancourt & Gleason, 1999). The same study also revealed that "outcomes of the allocation process are characterized by selectivity against Scheduled Castes and Muslims who live in rural areas of a district". (Betancourt & Gleason, 1999). While this study has been done in urban areas, it is likely that the same phenomenon also exists in urban areas, particularly since the representation of Muslims in the municipal corporations of these cities/towns is poor. This is evident from the picture of health infrastructure in districts with a significant Muslim population as well as in the Muslim ghettos of Mumbai that emerges from Tables 29 and 30.

Table 29: Availability of Health Infrastructure by District

	Population Per Sub Centre	Population Per PHC	Population per Rural Hospital
Thane	5443	34333	133899
Nashik	6522	36533	129756
Parbhani	5570	38452	149002
Aurang-abad	7887	44008	169262
Akola	6577	39022	195110
Norm	**5000**	**20000**	**120000**

(Source: Government of Maharashtra, Directorate of Health Services)

Table 30: Available Health Facilities in the four areas of Primary Studies

	Population	Health Post/ Dispensaries	Maternity Home	Govt. /Mun. Hospital	Private
Bhiwandi	711329*	10 health posts		1	75 private hosp/ nursing homes.
Malegaon	471006*	4 dispensaries	3	1 District + 3 Municipal	
Behrampada (H/E Ward)	663742 (ward) 49, 829 (Behrampada)	6 dispensaries+ 8 health posts	1	1	38 pvt nursing homes/ 254 practitioners
SionKoliwada (F/N Ward)	524393	6	1	1	54 pvt nursing homes/3 large private hospitals

(Source: Primary Studies done in Malegaon, Bhiwandi and Mumbai, commissioned by the MSMC)
*Data from Census 2011.

F. i. Flourishing of Private Health Facilities

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

F. ii. Utilization of Public and Private Health Facilities

In Maharashtra, over the years, there has been a general decline in the use of public sector health facilities and an increase in utilization of those of the private sector. This is more so for outpatient care than inpatient care. According to the 60th round of the NSSO, only 11 per cent of urban and 16 per cent of rural outpatient care and 28 per cent of inpatient care is managed by the public sector (National Sample Survey Organisation, 2004).

Data from primary studies show that people choose to go to private or public facilities due to availability and ease of access. Muslim ghettos have a dearth of public health facilities, leaving a larger scope for proliferation and utilization of the private sector. Moreover, the bias against Muslims in the public sector makes them more open towards accessing the private sector, despite the cost and the debt that it might lead to. Bhiwandi and Mumbra have a gross dearth of health facilities and so people are left with no option but to access the private sector. In Bhiwandi for instance, almost 90 per cent of people with minor illnesses (cough, cold, stomach problems) sought treatment from a private provider and almost 70 per cent in the case of major illnesses (malaria, TB, typhoid, asthma, hearth problems, diabetes etc). In Mumbra, 76 per cent of people reported that they accessed local private providers for minor illnesses. However, for major illnesses they preferred to go to public health facilities located outside Mumbra (in Kalwa or Thane city), even if they were as far as Mumbai. This probably has to do with the fact that treatment for major illnesses would be unaffordable to most people in the private sector (Tables 31 and 32).

Table 31: Preferred Treatment for Non-serious Illnesses

	Behrampa-da	Sion-Koliwada	Bhiwan-di
Govt	77%	21.7%	11%
Private	36%	33%	88%
Private and public	25%	---	---
Other	0.5%	5%	3%

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

Table 32: Preferred Treatment for serious Illnesses

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

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

In contrast, Behrampada and Malegaon where there are some public health facilities, the studies show that a greater number of respondents reported accessing the government health facilities. In Malegaon there are Municipal dispensaries, maternity homes, and Municipal hospitals (largely paediatric and gynaecology). Government health facilities mainly include Health posts, a Rural hospital and a District hospital. Other health facilities include Private General and Private Specialist clinics (mainly gynaecology and paediatric). Those who can afford private treatment avoid government health facilities. About 70 per cent of the population in the town uses government facilities but the use by Muslims is higher than by non-Muslims. Table 33 highlights the stark difference between the access for private and government health facilities between Muslims and other SRCs.

Table 33: Health Facility accessed by People in Malegaon, by Religion

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

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

A similar finding is reported in a study conducted in Mumbai slums (More et al., 2009) - that even within the slum, the poorest people in the slum access public health facilities more than those that are better off (within the slum population itself). The study examined care and differences in outcomes between more and less deprived groups. Vulnerability was identified by social risk indicators such as unemployment, substandard housing and so on, environmental indicators such as open drains, informal water supply etc., and health service utilisation indicators such as infrequent interaction with community health volunteers.

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

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

While religious groups were not used as an indicator in the study, socioeconomic status was classified using quartiles of standardized asset scores amongst 48 vulnerable slum localities. Of the total population studied, there were 47 per cent Hindus and 46 per cent Muslims. Of the 47 per cent Hindus, only 32 per cent were in the first quartile (the poorest) and 57 per cent were in the fourth quartile. On the other hand, of the 46 per cent Muslims in the sample, a whopping 65 per cent were in the first quartile and only 34 per cent in the fourth quartile (Table 34). This means that even within the slum, the Muslims form the 'poorest of the poor' and therefore they are more likely to access public health facilities than others. It would be a matter of safe assumption that for the poorest of the poor, quality of services, rude behaviour and bias might not be matters for consideration as a result of the lack of choice.

Table 34: Characteristics by cluster Socioeconomic Quartile Group of Women who gave birth in Urban Slum Communities of Mumbai (select indicators only)

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

This makes the condition of the public health system relevant while talking about the health care services available to Muslims. Respondents from all three studies, in Bhiwandi, Behrampada and Sion-Koliwada mentioned facing several problems at the government facilities, even as they acknowledged that this was where they accessed services. Problems such as negligence, long waiting periods, lack of medicines and pathology services were reported. In Bhiwandi, respondents mentioned that government hospitals were not able to deal with even simple surgeries and they were often referred to Thane or Mumbai for treatment. Medicines were always prescribed to be bought from outside. Even for diseases like malaria and typhoid, medicines were made available only at the time of an epidemic. The study conducted by CEHAT in Mumbai showed similar results. Women complained that although treatment was to be provided free, they routinely had to buy medicines from outside. Public health facilities also involved waiting for long periods of time. Women also reported corruption and favouritism among the staff at public hospitals. Therefore, although the women used the public health facilities, they were not happy with the services and it was only lack of financial capacity to afford private facilities that pushed them to public facilities. (Khanday & Tanwar, 2013)

It is pertinent to note that such problems are reported by people from all communities. The State is obliged to make the Public Health System stronger and more responsive not just to Muslims, but to all those who use it – largely those who are economically deprived. A study by Chowdhury revealed that urban Muslims were found to be the most vulnerable to the medical poverty trap for whom the head count ratio increased by more than 8 percentage points due to out-of-pocket payments for health care in 2004 (Chowdhury, 2012). Casual labourers too were found to be amongst the most vulnerable, and a large proportion of Muslims happen to be casual labourers. A household might have to dis-save, borrow (therefore indebtedness), accept contributions, sell assets, reduce other non-discretionary expenditure like food (immediate cutting of costs), education (eventual cutting of costs and increase in working children), to finance treatment cost. They are thus not only most likely to be pushed into a poverty trap, but will also find it increasingly difficult to be able to come out of it because of depleted short term (for example, sold assets) and long term resources (for example, education of children). With the bias and stereotyping about Muslims, the scenario only gets more difficult and complicated.

G. Morbidity related to Living Conditions

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

It would be pertinent to reiterate that a large number of Muslims live in slums. According to Shaban (2011) 70 per cent of Muslims in the state of Maharashtra live in urban areas; about 60 per cent of these stay in slums and another 30 per cent in lower caste areas (Table 9) While there are no estimates about what proportion of the Muslim population lives in ghettos and what proportion of these ghettos are slums, it would be safe to assume from this data that it would be a large percentage.

The living conditions in these slums are inhuman, to say the least, and have been described in some detail earlier section - II.D.iii. In general, the poor living environment in the ghettoes provides a breeding ground for several communicable diseases.

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

In the primary studies from Malegaon, Bhiwandi, Behrampada and Sion-Koliwada, it was seen that between 60 to 90 per cent of the respondents reported having suffered from a minor illness in the year preceding the study. Common minor illnesses included viral fever, cough, cold and stomach problems. Most commonly occurring serious illnesses in all four studies were malaria and tuberculosis (TB). The prevalence varied across regions, however. In certain areas like Bhiwandi, 30 per cent of the families reported having a member who suffered from malaria in the year preceding the study and one in ten reported a case of tuberculosis in the family. In Behrampada, malaria was reported by about 10 per cent of the families and tuberculosis by less than 5 per cent. Other serious illnesses included jaundice, typhoid and non-communicable diseases like diabetes, asthma and cardiac problems. The high prevalence of infectious diseases like malaria and TB has been attributed to the congested living environment, which is a feature of most slums in which urban Muslims reside. Lack of sanitation and systematic neglect by municipal authorities lead to easy spread of infection.

H. Occupational Hazards

As has been discussed before, at the national level, 84.5 per cent of Muslims constitute the most poor and vulnerable category of unorganised workers. While the SC/ST population is protected to some extent by affirmative action by the government, Muslims are overwhelmingly concentrated in the unorganised sector and in self-employment activities to meet their livelihood needs. The workers in the unorganised sector survive at the bare subsistence level, with no security, working under unhygienic and miserable conditions. This trend is replicated in Maharashtra. In Bhiwandi and Malegaon, most people are employed in power looms/handlooms where there is no proper ventilation and breathing lint causes respiratory problems. In Malegaon, this may be one of the reasons why tuberculosis is the major cause of death among persons aged 6-14 years, 15-35 years, and the third most common cause of death among women aged 36 to 55 years (Shaban 2012). Among men, tuberculosis was the cause of death mostly in the 15-35 and 36-55 years age group. Similarly in Bhiwandi, TB was the cause of death in 11.5 per cent of individuals. In Mumbra, the two Urban Health Centers together reported about 250 new cases of tuberculosis every year. Coupled with occupational issues, the high prevalence of TB could also be attributed to the congested living environment.

It is important to note that Muslims have one of the highest incidences of child labour in India. Nine states have been identified in the report with a high incidence of child labour. Maharashtra is one of them. Maharashtra, however, does not figure in the states with the highest percentage of out of school children. Child deprivation on the other hand is more pervasive and is significant across all states except Kerala, Tamil Nadu (TN) and Himachal Pradesh (HP). The link between economic and social deprivation and child labour has been established, and given the deprivation that Muslims face, this is not surprising. In fact, the incidence of child labour and child deprivation is high among Muslims, higher than that among Hindu SCs. The Human Development Report (2011) has categorically stated that the pace of decline in child labour is also the slowest among Muslims (Government of India [GOI], 2011). One of the sectors where children work in Maharashtra is the balloon factories of Dahanu. Work in these factories includes mixing rubber with chemicals, colouring balloons and testing each balloon with gas. The factories are cramped and poorly ventilated. The children work nine hours a day, six days a week and are exposed to ammonia, fumes of ascetic acid and French chalk. Health hazards include burning of the respiratory lining leading to pneumonia, bronchopneumonia and even heart failure. Visitors are advised not to enter due to fear of choking in the fumes and children as young as eight years are found to work here (Wal, 2006). There are no estimates about how many are Muslim children and how many are not, but it is suffice to say that for all children, this is unacceptable.

I. Mental Health

The mental health of Muslims and discriminated groups in India has received little attention in literature. This is a significant gap in research, considering the fact that there is both large scale violence as well as daily 'micro-aggressions' perpetrated against them. Anecdotal evidence suggests that this violence has had a detrimental impact on mental health. A team of psychiatrists who visited Gujarat in the period immediately following the pogrom of 2002 report that people complained of insomnia, startle reactions, fearfulness, intrusive memories and sadness. The commonest coping method they found was prayer (Shetty, 2002).

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

Studies on the impact of violence and discrimination have been undertaken in the West. In the United States, for instance, a study examined associations between abuse or discrimination and psychological distress, level of happiness and health status among Arab American adults after September 11, 2001 (Padela & Heisler, 2010). It found that personal bad experiences related to ethnicity were associated with increased psychological distress and reduced happiness. Perceptions of not being respected within US society and fear of personal security and safety were associated with high levels of psychological distress.

Given the marginalization, discrimination and bias that this group faces, it is likely that their mental health has suffered as a direct impact of riots and day-to-day experiences. The long term impact of riots on mental health has neither been studied in our country nor have any remedial measures been implemented.

J. Prejudice among Health Care Providers

The behaviour of health care providers in the public health system is generally known to be insensitive and often rude, a fact supported through various studies cited herein. Doctors often speak in English and do not explain what ailments women are suffering from, nor do they explain the medications that need to be taken. Further, incidents of verbal and physical abuse in the labour ward have also been reported; women are beaten and scolded to make them bear down. Such behaviour encountered by people at public health facilities is in itself highly objectionable. The right to health includes the aspect of acceptability and quality – health services must not just be available and accessible, but also the dignity of patients has to be respected.

In addition to this pervasive insensitivity of health care providers, there is an added layer of prejudice against people from the Muslim community. This is supported through evidence from the primary studies conducted particularly in Bhiwandi, Behrampada and the CEHAT study in Mumbai. Focussed group discussions showed that Muslim women felt that they were treated differently from women of the majority community. Muslim women reported that the manner in which they were spoken to at the health facility was different from how health care providers spoke to people of their 'own' community. This feeling of 'otherness' was perpetuated by the fact that HCPs would refuse to pronounce or spell Muslim names correctly. (Khanday & Tanwar, 2013)

Muslim women reported that they were called derogatory names, such as *'landiyabai'* (wife of circumcised man) at health facilities. They were referred to as *'ladaku log'* (people who have a tendency to fight) if they refused to remove the *burqa*. Moreover, women have expressed that it is the wearing of the *burqa* that brings about a change in attitude of the hospital staff.

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

The women were very aware of the stereotypes that HCPs had about them – that Muslims have too many children, they are dirty and uneducated. In Behrampada, one health worker mentioned that Muslims tend to have more TB because they eat beef leading to the transmission and spread of Bovine TB!

Box: Experiences of Women while accessing Public Health Facilities

Faced by	Description of Behaviour
All women	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. Behaving badly towards accompanying persons
	5. Health care providers use English which is not understood by the patient population
Muslim Women	1. Use of derogatory remarks about women married to circumcised men, "*Landiyabaika*"
	2. Being singled out as " *Musalmanaurat*" creating a negative impression
	3. Refusal to understand and comprehend Muslim names
	4. Asked to remove veil even before the turn for examination
	5. Taunted as dramatic women because of inhibitions to remove burqa
	6. Biases that Burqa clad women steal children.
	7. Stereotypical remarks
	a. Muslim women have many children
	b. Muslim people are uneducated
	c. Muslim women refuse to use contraception
	d. Muslim people are dirty

(Source: Khanday, Zamrooda and Tanwar, Yavnika. (2013). Exploring Religion based Discrimination in Health Facilities in Mumbai. Mumbai: CEHAT.)

The study was conducted in a Muslim dominated slum in Mumbai. Eight Focus Group Discussions were conducted with Muslim and non-Muslim women to explore their experiences with health facilities.

The linkages between discrimination and health are only just beginning to be explored in the Indian context, but evidence from the West suggests that lifetime exposure to discrimination is associated with poor health outcomes as well as poor health seeking behaviour (increased delays in seeking health care and poor adherence to treatment regimes) and poor utilization (Casagrande et al., 2007). With respect to religious minorities in India, these are some areas that need further exploration as the behaviour of providers with people from these groups has been reported in studies. The impact that it has on their health seeking behaviour and health status needs to be considered more seriously and remedied.

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

SECTION IV

RECOMMENDATIONS

That a large percentage of Muslims in Maharashtra live in a strong context of deprivation, alienation and insecurity has been clearly established by this study. These conditions have affected their lives health education, livelihood, pushing them into the spiralling cycle of more deprivation and ill-health. The mainstream indicators of health by themselves in no way capture any of this. On the contrary, they actually expose the inadequacies of the state and the health system to understand and address the needs of the minority population in a context based manner.

At the start of this paper, we highlighted the link between social determinants and health. Throughout the paper we have made an attempt to make sense of the indicators on the basis of the prevailing context of the Muslims. In order to achieve health equity in general, and for Muslims in particular, efforts need to be put into improving the conditions of daily life – the conditions and circumstances under which people are born, live and work. It is also essential to develop a knowledge base and expertise on the social determinants of health to enable addressing the same (WHO, 2008).

In order that the conditions of daily life for Muslims be improved, it is essential that Muslim ghettos and their development receive special focus. For reasons of safety and absence of choices, they live in ghettos. Living in such debilitating conditions is in itself a violation of human rights. Therefore, the state must take concrete steps towards improving the living environment through ensuring better housing, clean surroundings, better drainage and access to potable water.

Recommendations for the Health System

1. There is a clear need for disaggregated context based data on health and key indicators in order to improve the health status of any population. In the absence of this, any policy or program would clearly be deficient and its impact ineffective or incomplete.
2. Availability of Public Health Facilities: Urbanization of Muslims has not helped them to have better access to health services or infrastructure in Maharashtra. Public health facilities including basic services are virtually absent in areas such as Bhiwandi and Mumbra and people are left with no option but to access the private sector or travel long distances. Even antenatal care (ANC) coverage, which is part of the essential public health package, is poor. Specific measures in terms of setting up new services and deploying human resources are required urgently.
3. There are biases/prejudices against the Muslims, particularly amongst healthcare providers (HCPs), for instance, the belief their non-acceptance of family planning methods and immunization, having four wives and multiple children, not taking a daily bath, being aggressive/terrorists and so on. The biases are so strong

that the health officials have actually said that immunization and family planning indicators in these specific areas are poor even though the figures provided by them show the opposite. These biases get translated into discriminatory and rude behaviour towards Muslims. This is a matter of serious concern as it acts as a deterrent for Muslims to access government facilities. In addition to these biases, there are reports of derogatory behaviour against Muslim women. This leads to a serious situation. Their living conditions and poverty make them vulnerable to various diseases and they need to rely oftentimes on the private sector (higher costs and unreliable quality) for treatment, which pushes them further into the poverty trap. This forms a vicious circle. The Directorate of Medical Education and Research must address these stereotypes and biases of their staff at all levels through sensitization of health care providers and providing channels for redress.

4. There is need to improve access to health related schemes such as the Janani Suraksha Yojana, Rashtriya Swasthya Bima Yojana (RSBY) and others to help prevent the poverty trap due to health costs. The causes for poor utilisation of the scheme among Muslims need to be explored and addressed.

   The disincentive for third and more deliveries reduces access to public health facilities for maternal care. It is a known fact that women have limited decision making power in general. Such disincentives, therefore, only serve to harm the women. The family planning services offered need to be in keeping with the needs of the population. Muslims have the highest unmet need indicating that not only is there a need to explore the form of family planning most desired by them (spacing versus limiting), but also deliver these is a culturally acceptable and sensitive manner.

5. Primary studies have provided evidence of hazardous working conditions in most areas such as Bhiwandi, Malegaon (for those working in power looms) and Behrampada (for those working in the garment and zari industries) leading to adverse health conditions. Specific interventions to address these are required particularly in the context of the large proportion of the population in the informal sector and the related health and financial risks associated with this sector. There also needs to be aggressive and concerted efforts to address child labour in the state.

6. There is also evidence of minimal Integrated Child Development Services (ICDS) coverage and poor outreach of *Anganwadi/ Balwadi* centres. Efforts must be made to increase this as it impinges on the health of the community.

7. Urban areas are dominated with a huge private sector which remains inaccessible to the poor and marginalized mainly due to the costs involved, and where they are accessed by the poor, it is accompanied with poor returns in terms of quality of health care for the costs incurred, leading to further impoverishment. Urban health planning is essential and a well-developed referral system with a focus on

primary health care is essential. There is also the need to regulate the private sector and hold it accountable.

At this juncture, it is essential to reiterate some issues that have emerged from this study. Section I has clearly established that there is a dose-response relationship between structural violence and discrimination in particular and health outcomes, self-reported illnesses and health seeking behaviour in general. A lifetime experience of discrimination has also been associated with poor utilization of health services, increased delays in seeking health care and poor adherence to medical treatment (Casagrande et al., 2007). It has also been evidenced and documented that negative behaviour on the part of health care providers leads to lack of trust, and therefore, poor utilization of health services. The marginalization of Muslims and the evidenced deprivation makes them most vulnerable to the medical poverty trap. The allocations of resources by the state have also indicated a bias against Muslims and lower castes.

General health indicators do not explain nor do they accurately reflect the health status of Muslims, especially the impact of the acute deprivation and discrimination of a large proportion of them that is evident in the contexts that they live in. For instance, why does the infant mortality rate of the Muslims not get the advantage of their being urbanized? Or what explains the dichotomy between these two - the better nutritional status of Muslims as reflected in the NFHS data and the NSSO data, which clearly reflects them as being highly calorie deficient? The negative image of the community, everyday experiences of discrimination from various quarters and harassment by law enforcement agencies are bound to have an impact on their mental health, but there is little focus on this aspect.

In order to achieve health equity in general and for Muslims in particular, efforts need to be put into three core principles of action. First, to improve the conditions of daily life – the conditions and circumstances under which people are born, live and work. Second, there is a need to tackle the inequitable distribution of power, money and resources. Third, develop a knowledge base and expertise on the social determinants of health to address the same (WHO, 2008).

Finally, conditions under which people are born, live and work are an expression of the freedom that they have in order to live the life the way they want. No citizen of this state and country, belonging to any religion, should be denied or deprived of this basic right of the freedom to live the life they aspire to, and health is a big component as well as an outcome of this freedom. When a government fails to address these chronic problems, it should be seen either as an inadequacy of the state or a lack of will. In either case, it has to be redressed.

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सेहत

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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.

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