Working Paper 226

Maternal Healthcare of Muslim Women in Uttar Pradesh: The Discourse, Experience and Concerns

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Abstract:

Women's health especially of marginalized communities remains a grappling issue for policymakers and social scientists. The papers attempts to understand and map the social determinants of individual's and community's health and well-being. The paper reveals that Muslim women remain vulnerable in terms of access to health benefits. Post-independence Muslim community in general and women in particular have declined in economic sphere entailing poor health accessibility. Muslim women also own fewer assets and have the lowest workforce participation ratio. The first round National Family Health Survey (NFHS) substantiated this vulnerability. On the ground lack of awareness among Muslim women remains a major bottleneck for accessibility to health services. They face still birth, have limited exposure of birth control mechanisms, prefer non-institutional deliveries, and donot avail ICDS facilities. The trends of NFHS 4 and 5, reveals slight improvement, however substantive social and economic improvement demands greater equity in accessibility.

Keywords: Minority, Maternal Health, NFHS, Social Determinants of Health, Uttar Pradesh

Maternal Healthcare of Muslim Women in Uttar Pradesh: The Discourse, Experience and Concerns

The Discourse

Women's issues have evolved gradually since 1848 when Elizabeth Cady Stanton and her friends drafted a 'Declaration of Sentiments,'[1] but it was only in the 1960s and 1970s, during the second wave of feminism that women's health as an agenda became prominent.[2] The women's health movement recognised that males in the patriarchal system used women's bodies as a vessel to mediate their dominance. Feminists advocated improved healthcare for women and the elimination of sexism in healthcare systems. Hence, the right to abortion, access to contraception, safeguarding from marital/sexual violence, and other issues entered the discourse around the women's health movement.

In addition to the above elements, the 'social determinants' approach brought comprehensiveness in the discourse around women's health issues in the 21st century. Someone like Jennifer Nelson (2015) argued that this approach had already been taken during the 1960s and 1970s. She wrote that the New Left Movement was not only talking about access to medicine but also highlighting 'social determinants,' as the root cause of poor health among women. 'Thus, while medication and mechanical intermediation to treat disease is significant, it is also essential to change societal formations and hierarchies that disempowered few groups founded on ethnicity, class, gender, sexual orientation, and culture so that all persons have access to the means to live healthy lives.'[3]

The negative improvement in the health conditions of marginalised sections of women has also brought to fore the 'social determinants' approach across the globe including India. The element of 'condition in which people live' also came up prominently in the Commission on

[1]Elizabeth Cady Stanton used the Declaration of Sentiments as the agenda and linked the budding movement for women's rights directly to that commanding American sign of liberty. The exact accustomed words outlined their urgings: "We hold these truths to be self-evident; that all men and women are created equal; that their Creator endows them with certain inalienable rights; that among these are life, liberty, and the pursuit of happiness."

[2]D. Wardell (1980) dates the women's health movement to early 20th century.

[3]Jennifer Nelson, *More than Medicine*, New York University Press, 2015.

Social Determinants of Heath (2008). The Commission adopted three principles and asked the world to:

- Improve the situations of daily life - the conditions in which persons are born, nurture, live, toil, and age.
- Take up the challenge of biased sharing of power, capital, and resources - the organisational drivers of those situations of daily life - worldwide, nationally, and sub-national level.
- Quantify the challenge, assess action, enlarge the knowledge base, advance a workforce skilled in the social elements of health, and raise community consciousness about the societal determinants of well-being.

Within the social condition, cultural aspects such as religious belief systems and their interface with health utilisation have become a dominant framework. To examine the issue, B.J. McElmurry (1993) noted that 'Cultural position and political system are two important factors of women's health.' Sengupta (2016), while explaining the determinant, brought forth 'cultural belief' as a variable. However, it was Ellen L. Idler (2014) who explained the role of religion as a determinant of health. Idler argued that religion gives warmth and disciplines an individual's life. It controls human behaviour regarding greed, desire, sexual activity, and consumption. Religion can directly be helpful by creating social capital. At the middle level, a bridge between individual and large-scale structures such as State creates healthy societies.

Literature has focused on how the interface between the Muslim minority's cultural beliefs and their health decisions has been taking shape in developed nations. Various studies on Muslim women's beliefs and behaviour toward health systems are now under focus in developed countries. This is due to the widening of the racial base of the population as a result of migration and underdevelopment. Lori M. Walton (2014) argued in favour of 'cultural competency' (CC) concerning Muslim women. He observed: "Within the Muslim religion, unique healthcare beliefs that may impact physical, social, and psychological health need to be integrated into a cultural framework within the western dominant culture of healthcare provisions."

G. F. Al-Jayyousi & K.S. Myers-Bowman (2022), through their study, emphasized the need for CC. Their study revealed that "Mothers' (Muslim) health values were shaped by Islam, culture origin, and the acculturation factor. Mothers shared health values with their adolescent daughters by being available, monitoring their health behaviours, engaging in

healthy communication with them, and modelling healthy behaviours." Sean Tackett (2018) further disaggregated the Muslim or Islamic belief system and how it could impact healthcare utilisation by community women. He noted down the potential barriers for Muslim women as follows.

- Modesty and privacy requirements
- Physical appearance
- Physical touch
- Disclosure of sensitive information
- Gender preference for provider
- Family patterns of caring
- Predestination and fatalism
- Maintaining religious practices during illness
- Fear of stereotype and discrimination
- Health literacy and language proficiency
- Traditional healing practices
- Healthcare access

Ayah Ayesh (2022) too found that variables such as sex, use of contraception, abortion, sterilisation, menstruation and prayers, and medication during Ramzan were influenced by the religious belief system among Muslim women. Although there has been a spurt in research on Muslim women and advocacy for CC, Danielle (2019) has found in a recent study that 93.8 percent of Islamic women stated that their healthcare service providers did not comprehend their ethnic or religious requirements.

Status of Muslim Women's Health in India

The intersection of religion, culture, and sex for Muslim women has unique implications for their healthcare provision in India but it's a topic that has remained understudied so far. In the post-independence period, policies addressing women's health in general adopted the birth or population control approach rather than following the impact of social determinants on health.[4] Rosanna Ledbetter (1984), in her review of India's family planning programme after 30 years of independence, observed that through family planning India wished to achieve the Westernised standard of living for its citizens by controlling the birth rate. It was only in the 1990s, according to Matthews Mathai (2007),[5] that the health concerns for women moved from the narrow family planning approach to their reproductive rights and general health. The health sectors of developing nations like India are still grappling with primary health facilities and their universal accessibility. The culturally specific health response proposed as 'CC' is a distant dream. There is no effort yet for adopting the 'Cultural Competency' approach.

The reason for the lack of such an approach is very few studies on health issues among Muslims in general, and fewer still focusing on their women's healthcare in India. The discussion on Muslim health issue is invariably contextualised around the population debate in communal binary. Thus, the discussion on Total Fertility Rate (TFR) has undergone a politico-mythical twist in the country. It needs writings of former chief election commissioner S.Y. Quraishi (2021) to dispel myths around such topics.[6] Although modern

[4]It was argued that social concerns were part of consideration while discussing women's health issues in pre-independent India. Among the most important works in this regard was Margaret I. Balfour & Ruth Young's *The Work of Medical Women* (1929). Balfour and Young captured a wide range of issues, such as social conditions, the history of the struggle of women medical staff in India, and the health of women who were segregated into many communities. These communities had a varied range of traditional practices, which hampered women's health. Purdah, caste, child marriage, and older men marrying younger girls were a few practices affecting all women. Nevertheless, the impact of each practice was different. For instance, purdah was more prevalent among the Muslim community. Due to lack of education and apathy for modernisation, women from this group were at the fag end of the health system. Similarly, Savitri Thapar (1963) argued that women's health and child condition was aligned in national thought. She writes, "The National Planning Committee, (NPC), under the leadership of Pt. Jawaharlal Nehru, set up by the Indian National Congress in 1935, strongly supported family planning through self-control as well as by contraceptives on socio-economic grounds. This was the first committee which…did not ignore the individual's aspect and considered how improvement in the health of the mother, and reductions in high infant and maternal mortality rates and abortion rates could be brought about through birth control, resulting in increasing happiness of the family.

[5] M. Mathai has done a review of 'The global family planning revolution: three decades of population policies and programmes, 2007

[6]S.Y. Quraishi, *The Population Myth: Islam, Family Planning and Politics in India*, 2016, Harper Collins.

healthcare systems have been slow in discussing the interface of religion with healthcare, social determinants such as education, wealth, media exposure, caste, and gender are widely acknowledged.

Muslim women in the last decade of the 20th century were lagging in terms of accessing medical health facilities, education, asset ownership, use of contraception, total fertility rate, etc. Making an important analysis of health accessibility among Muslim women in National Family Health Survey (NFHS) 2 and NFHS 3, Das, Mohanty, and Haque (2016) found that "Muslim women stood behind Hindu women and those of other religious groups concerning maternal healthcare utilisation. There is a substantial gap between the country's average and Muslim females..." N.A. Mondol et al. (2020) has done a situational analysis of maternal health service in the context of Muslim women and found that education, wealth, and media information are important factors for medical utilisation. While recognising the backward health status of Muslim women, Das, Mohanty, and Haque (2016) also pointed out the above-mentioned non-cultural variables as significant determinants.

Unlike the previous study on Muslim women in India, Khan and Shahid (2022) have done pioneering research in establishing a strong religious impact on the health behaviour of Muslim women in the country. Their study has contextualised maternal and child care around the community's belief system and observe that several popular perceptions regarding maternity, antenatal care (ANC), and visiting local faith healers negatively impact the overall outcome.[7]

Status of Muslim Women Healthcare in Uttar Pradesh

To highlight the role of 'social determinants' in health outcomes, we have taken Uttar Pradesh as our case study. According to the World Bank classification and World Health Organisation (WHO), India falls in the Lower-Middle Income category of nations.[8] Within India, Uttar Pradesh is the most populous state with 37.79 percent of its total population being poor. The state stands third in the Multidimensional Poverty Index (MPI) 2021 ranking

[7]Abul Salim Khan & Mohd. Shahid, "Maternal and Newborn care Practices among Muslim slum dwellers in India: Does the Popular Common sense matter?", *The International Journal of Community and Social Development*, 4(4), 426-441, 2022.

[8]Both WHO and World Bank have come up with four types of classification of the countries –Low income, Lower-Middle Income, Upper Middle Income, and High Income. According to the latest World Bank ranking for 2021-22, many countries have been hit by the COVID-19 pandemic. They have shown a decrease in their ranking, such as Indonesia, Iran, Panama, Romania, Mauritius, etc.

by NITI Aayog on three dimensions – health, education, and standard of living. Table 1 show the NITI Aayog's ranking of UP state on various Sustainable Development Goals (SDGs). It shows the state performing poorly on SDG3 which is 'Good Health and Well-Being.' In 2018-19, the state ranked 28thor last and moved to the 27thposition in 2020-21.

Table 1: Year-wise UP's ranking on selected important SDGs

Year	SDG 1 [No Poverty]	SDG 2 [Zero Hunger]	SDG 3 [Good Health & Well Being]
2018-19			
Ranking	24	25	**28**
Index	48	43	**25**
2019-20			
Ranking	25	24	**27**
Index	40	31	**34**
2020-21			
Ranking	25	24	**27**
Index	44	41	**60**

Source: NITI Aayog SDGs Reports

A closer look into the SDG3 achievements in UP as compared to India is provided in Table 2 which shows the state's performance on selected health indicators as compared to the country.

Table 2: Comparison of India and Uttar Pradesh on selected health indicators (NFHS 4 & 5)

	NFHS 4		NFHS 5	
Indicators	**India**	UP	**India**	UP
Institutional births (%)	78.9	67.8	88.6	83.4
TFR (15-49 age)	2.2	2.7	2	2.4
Family Planning by 'Any Method' by women age 15-49	53.5	45.5	66.7	62.4
Total 'Unmet Need' for FP, Women aged 15-49 years	12.9	18.1	9.4	12.9
Mothers who had at least 4 antenatal care visits (%)	51.2	26.4	58.1	42.4
Average out-of-pocket expenditure per delivery in a public health facility (Rs.)	3197	1956	2916	2300
Births delivered by caesarean section (%)	17.2	9.4	21.5	13.7
U5MR	49.7	78.1	41.9	59.8
Neo-Natal Mortality	29.5	45.1	24.9	35.7
Infant Mortality	40.7	63.5	35.2	50.4
% births delivered in a public health facility	52.1	44.5	61.9	57.7
Prevalence of symptoms of acute respiratory infection (ARI) in the 2 weeks preceding the Survey (%)	2.7	4.7	2.8	3.5
Total children age 6-23 months receiving an adequate diet (%)	9.6	5.3	11.3	6.1
Children under 5 years who are stunted (height-for-age) (%)	38.4	46.3	35.5	39.7
Children age 6-59 months who are anaemic (<11.0 g/dl)(%)	58.6	63.2	67.1	66.4
Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl) (%)	53.2	52.5	57.2	50.6
All women age 15-49 years who are anaemic (%)	53.1	52.4	57	50.4
Women who worked in the last 12 months and were paid in cash (%)	24.6	16.6	25.4	15.5
Ever-married women age 18-49 years who have ever experienced spousal violence (%)	31.2	36.7	29.3	34.8
***Source*:** NFHS 4 & NFHS 5 Factsheet				

Table 2 shows that for many indicators of health there has been considerable improvement in India as well in Uttar Pradesh (UP) between NFHS 4 (2015-16) and NFHS 5 (2019-2021). However, UP remains below the national average on most counts. For instance, the state's performance on child mortality, children's health, domestic violence, total unmet needs (for family planning), women's work and cash payment, and institutional birth are significantly behind the national average. Further, the percentage of anaemic children was higher than the national average during NFHS 4, which reduced below the national average during NFHS-5. Although the proportion of anaemic women in the state is less than the all India average, yet in both NHFS 4 and NHFS 5, more than half the state's women in the 15-49 years age group (both pregnant and non-pregnant) are anaemic.

Socio-Economic Status of Muslim Women in Uttar Pradesh

In NITI Aayog's yearly ranking of the states, UP has remained constantly at the bottom (Table 1). If we deconstruct the category of the poor and their social and economic milieu, it will help us to comprehend the situation better. According to an analysis by Arora & Singh (2015),[9] in comparison to the Hindu population, Muslim households are poorer in rural and urban areas. In 2004-05 the overall incidence of poverty among Muslims was 47.40 percent which fell to 34.88 percent in 2011-12. An analysis based on NSSO (National Sample Survey Office) 61st and 68th rounds of the Consumer Expenditure Survey (CES) also found that overall Muslim poverty incidence had fallen by 1.79 percentage points per annum, which was second to 2.04 percentage points per annum of the Scheduled Castes (SC). In 2011-12, the incidence of poverty among Muslims in rural areas was 34 percent whereas in urban areas it was 36.35 percent (Table 3).

[9] For District-wise details on the incidence of poverty, please see Arora & Singh (2015), EPW.

Table 3: Incidence of poverty by social and religious groups in Uttar Pradesh (in percent)

Areas	Year	Social Groups			Religious Groups	
Rural		**SCs**	**OBCs**	**Upper Caste**	**Hindus**	**Muslims**
	2004-05	56.6	42.18	26.01	41.96	46.85
	2011-12	41.11	30.72	12.47	29.83	34
	Change	-2.21	-1.64	-1.93	-1.73	-1.84
Urban						
	2004-05	44.24	42.73	20.85	27.54	48.43
	2011-12	39.14	32.31	12.77	21.34	36.35
	Change	-0.73	-1.49	-1.15	-0.89	-1.73
Overall						
	2004-05	55.12	42.28	24.26	39.64	47.4
	2011-12	40.87	31.04	12.58	28.37	34.88
	Change	-2.04	-1.61	-1.67	-1.61	-1.79

***Source*:** Arora & Singh (2015), EPW, page 5. Figures of change are in percentage points per annum.

It is seen that the least proportion of upper caste people in the state were poor while the maximum incidence of poverty is among SC or dalits followed by Muslims and Other Backward Classes (OBC). Educationally too, Muslim women are lagging their counterparts in other religious groups according to the Census 2011. Table 4 presents the sex-wise literacy rate of the population in Uttar Pradesh showing educational backwardness among Muslim women.

Table 4: Sex-wise literacy rate in Uttar Pradesh, 2011

Religious Communities	Total			Rural			Urban		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Hindus	69.68	79.73	58.61	66.99	78.12	54.82	81.05	86.44	74.96
Muslims	58.76	66.42	**50.59**	56.79	66.06	**47.04**	61.94	67	**56.44**
Christians	73.63	79.44	67.54	63.7	72.76	53.98	83.67	86.35	80.92
Sikhs	79.35	84.91	73.15	72.78	80.07	64.74	92.39	94.31	90.18
Buddhists	68.59	79.19	57.07	66.62	78.03	54.35	79.57	85.4	72.81
Jains	94.05	95.81	92.16	84.09	89.23	78.37	95.61	96.85	94.27
Other	71.11	80.18	61.3	64.36	76.2	51.84	85.18	88.24	81.72
Total	67.68	77.28	**57.18**	65.46	76.33	**53.65**	75.14	80.45	**69.22**

***Source*:** Census 2011, noted in Mashkoor Ahmad (2018: 555)

In all spheres, urban and rural, Muslim women are lagging substantially, as per data from the 2011 Census. Table 4 highlights that at least 49.41 percent of Muslim women are illiterate. The illiteracy rate of Muslim women is more (52.96 percent) than the community average in the rural areas whereas in urban areas it drops to 43.56 percent, less than the community average which is slightly better. Nevertheless, the latest data suggest an improvement in the educational scenario of Muslim women. However, education attainment is yet to be seen to transform into overall empowerment for them. The data in Table 5 provides an interesting insight into the level of women empowerment in Uttar Pradesh across socio-religious groups.

Table 5: Decision-making power and asset ownership among women in UP (in percent)

Social & Religious Groups	Women Access to Money & % of women decision to use it	Women Own a house alone or jointly	Women Own land alone or jointly	Number of Women who are Employed for Cash*
Hindu	54.9	52.2	44	1,253
Muslim	52.1	46.8	36.5	174
SCs	51.9	51.3	42.4	476
STs	53	68.4	46.9	27
OBCs	54.7	52	43.4	696
Others	57.1	48.1	41.1	228

***Source*:** NFHS 5; * page no. 183

At 51.9 percent, only SC women are less empowered than their counterparts in Muslim households in having access to money and being in a decision making position on its use. Just about 52 percent of Muslim women are financially empowered as compared to almost 55 percent Hindu and OBC women and 57 percent others (upper caste) women. Muslim women happen to be at the bottom in the list on 'owning a house (46.8 percent) or land' (36.5 percent). They are also in a marginal position in the workforce as only 174 Muslim women are employed for cash as compared to 1,253 of Hindu women. Muslim women are only better than ST women.

Reflection of Muslim Women's Health Status: NFHS Findings

The social and economic determinants are not in favour of Muslim women in Uttar Pradesh. Let us see its impact on their health status in the state from the data in NFHS 5, 2021. In the state, TFR varies across literacy, caste, religion and region. Rural women's TFR is 2.5 against 1.9 for urban women.[10] At existing fertility rates, women with 'no schooling' have an average of 1.1 more children than women with 12 or more years of schooling. Table 6 shows that the TFR rate across all socio-religious groups has been dwindling over the years between NFHS 4 and NFHS 5. The latest NFHS-5 data reflect that Muslims still have higher TFR, which is on the decline.

Table 6: Religion-wise Total Fertility Rate (TFR, Children per woman), UP

Religion & Caste	TFR (NFHS 5)	TFR (NFHS-4)
Hindu	2.29	2.67
Muslim	2.66	3.1
Sikh	1.45	1.38
Other	2.83	1.75
SCs	2.57	3.09
STs	2.72	3.61
OBCs	2.35	2.76
Others	2.03	

***Source*:** Author's collation from NFHS 4 and 5.

[10]2.1 children per woman is the replacement level. Replacement level is *fertility at which a population replaces itself from one generation to the next.*

However, Scheduled Tribes (ST) in Uttar Pradesh have the highest TFR at 2.72 compared to 2.66 of the Muslims. Muslim women have an average of 0.37 more children than Hindu women (a TFR of 2.7, compared with 2.3) and 1.2 more children than Sikh women (TFR of 1.4). Sikh women have the lowest TFR, at 1.45, which is below the replacement value. There has been a slight improvement in Sikh women's TFR between NFHS-4 and NFHS-5.

Table 7: Percentage of women aged 15-19 years who began childbearing, NFHS 4 & 5, UP

Religion & caste	NFHS 4	NFHS 5
Hindu	4.0	2.9
Muslim	3.1	2.7
Sikh	NA	NA
Others	4.5	(0)
SCs	4.5	3.2
STs	8.8	6.7
OBCs	3.8	2.7
Others		2.5

***Source*:** Author's collation from NFHS 4 and 5.

Note: N.A. = Not available. Figure in parenthesis is based on 25-49 unweighted case.

It has been argued for long that early marriage of Muslim girls takes a toll on them and their children's health. However, recent data has shown an encouraging picture concerning childbearing women in their teenage (15-19 years) (Refer Table 7). In the last round of the NFHS 5 between 2019-21, only 2.7 percent teenaged Muslim women in the state had become mothers as compared to 3.1 percent in the previous round in 2015-16. In this context, tribal women (ST) have an alarming record with 6.7 percent women in the 15-19 age groups bearing their first child in the latest data. Inter-community-wise data show that 2.9 percent of Hindu women in age group of 15-19 years have reported childbearing. This is a dismal record compared to Muslim women, which could be attributed to improvement in education attainment among the latter.

Education, however, does not seem to have reversed the traditional preference for sons over daughters in the state, although the desire for male offspring has considerably come down across all socio-religious groups over the period covering the last three rounds of NFHS.

Figures in Table 8 show that both Muslim men and women have shown more preference for son in the latest round of survey.

Table 8:Percentage of male child preference between NFHS 4 and 5, UP

Socio-religious groups	NFHS-5		NFHS-4	
	Women age 15-49 who want more sons than daughters	Men age 15-49 who want more sons than daughters	Women age 15-49 who want more sons than daughters	Men age 15-49 who want more sons than daughters
Hindu	22.1	21.9	30.7	26.9
Muslim	28.1	25.3	33.8	32.4
Sikh	12.6	*	13.0	*
Other	16.2	*	19.1	33.2
SCs	25.2	25.8	35.6	29.8
STs	26.3	34.6	34.5	44.9
OBCs	23.7	22.3	32.2	28.8
Others	18.8	18	24.2	22.1
UP	**23.1**	**22.4**	**31.3**	**27.9**
NFHS 4	**31.3**	**27.9**	**NFHS 3, 33.5**	**NFHS 3, 27.8**

***Source*:** Author's collation from NFHS 4 and 5.

A little over 28 percent Muslim women voiced preference for son over daughter. This is higher than the state's average of 23.1 percent although nearly six percentage points less than their preference in NFHS 4. Overall, the preference for male child among women in the state has come down by eight percentage points between NFHS 5 and NFHS 4 and by ten percentage points between NFHS 5 and NFHS 3. In case of men, Muslims' preference for sons is third at 25.3 percent as compared to 34.6 percent among ST and 25.8 percent among SC. However, among men also the preference for male child has come down across most socio-religious groups over the last three rounds of NFHS.

With respect to practising family planning or using contraceptives, Muslims trail other socio-religious groups even though their use within the community has increased over the years.

Table 9: Use of contraception by women aged 15-49 years across socio-religious groups, NFHS-5, UP (in percent)

Socio-religious group	Any Method	Any Modern Method	Any Traditional Method
Hindu	63.5	46.3	17.2
Muslim	56.4	34.3	22.1
Sikh	75.3	67.1	8.2
Other	68	43.4	24.7
SCs	62	45	17
STs	57.1	45.1	12
OBCs	61.9	43.5	18.4
Others	64.6	46.5	18.1
UP	62.4	44.5	18

***Source*:** Author's collation from NFHS 5.

NFHS-4 noted that the lowest use of contraception was among Muslim women. In the category of 'any method' of contraception, 38.3 percent of Muslim women acknowledged using it as compared to 46.9 percent of Hindu women aged 15-49 years. Muslim women were doing better than only ST women (32.4 percent) in the 'any method' of contraception category. NFHS-5 result is no different (Table 9). Rather, Muslim women have the lowest proportion of ladies using 'any method' of contraception at 56.4 percent. Only 34.3 percent of Muslim women respondents said they used 'any modern method' of contraception, which is even lower than SC and ST women. This could be due to the cultural and religious belief systems of the community. A large section of Muslims even nowadays is of the view that contraception is antithetical to Islam. Visiting a medical store to buy contraceptives is considered to be a male prerogative and action that women should avoid. Patriarchy and traditional understanding of Islam on contraception further explain the lowest use of contraceptives among Muslims vis-à-vis other socio-religious groups. These factors help further in decoding the poor performance of Muslims towards' unmet need' of family planning. Table 10 presents the NFHS 4 and NFHS 5 data on the demand-supply gap or 'unmet need' for family planning among currently married women in the 15-49 years age group in UP.

Table 10: Unmet need for family planning among currently married women (15-49 years) in UP (in percent)

Social-Religious groups	Unmet Need for F.P., NFHS-4	Unmet Need for F.P., NFHS-5
Hindu	17.8	12.8
Muslim	19.6	13.2
Sikh	4.5	6.9
Other	8.9	9.1
SCs	18.5	13.3
STs	25.5	14.7
OBCs	18.3	13.1
Others	16.4	11.5
UP	18.0	12.8

***Source*:** Author's collation from NFHS 4 and NFHS 5.

The Muslim women's unmet need for family planning dropped to 13.2 percent in NFHS 5 from 19.6 percent in the previous 2015-16 round. However, this is still above the state average of 12.8 percent. However, at 14.7 percent, ST women have the highest unmet need of family planning. Among religious groups, Hindu women have 12.8 percent of unmet needs of planning while it is the lowest for Sikh women at 6.9 percent.

Patterns on pregnancy outcomes (Table 11) also reveal an interesting fact about maternal health challenges in the state. Live births per 1000 shows that Muslim women are doing better than all other socio-religious communities. Muslim women have the highest proportion of live births at 89.8 percent as compared to 87 percent among Hindu women and 89 percent among ST women. Further, rural women have a better live birth record at 87.9 percent than that of urban women at 85.7 percent. In case of abortions, only two percent of Muslim women reported to have aborted their pregnancy as compared to 3.7 percent of women in the state. Also, Muslim pregnant women had a better chance of completing all the trimesters with a lowest miscarriage ratio. At 10.9 percent, Sikh women have the highest miscarriage rate among all other groups in UP. However, Muslim women are less fortunate with respect to stillbirths which is the highest for them among all socio-religious communities.

Table 11:Pregnancy outcomes among currently married women aged 15-49 years in UP(in %)

	NFHS-5				NFHS-4			
	Live Birth	Abortion	Miscarriage	Stillborn	Live Birth	Abortion	Miscarriage	Stillborn
Urban	85.7	4.6	8.6	1	81.9	6.9	10.1	1.1
Rural	87.9	3.5	7.5	1	85.8	4.6	8.2	1.4
Hindu	87	4.1	8	1	85.0	5.1	8.6	1.3
Muslim	89.8	2	6.9	1.4	84.9	4.9	8.6	1.7
Sikh	85.4	3.7	10.9	0	70.0	17.1	12.9	0.0
Other	92.5	2.2	5.3	0	78.5	4.4	17.1	0.0
SCs	87.4	3.6	7.9	1.2	86.0	4.2	8.3	1.5
STs	89	2.3	7.5	1.3	92.1	2.0	4.8	1.1
OBCs	88	3.6	7.4	1	85.1	5.1	8.5	1.3
Others	85.8	4.6	8.8	0.8	82.5	6.5	9.8	1.2
UP	87.5	3.7	7.8	1	84.9	5.1	8.6	1.4

***Source*:** Author's collation from NFHS 4 and NFHS 5.

During child birth, registered and institutional deliveries are expected to save the life of the mother as well as the new-born. India has come a long way in reducing the death of women during delivery. In 2018-20, Maternal Mortality Rate (MMR) has dropped to 97 per 100,000 live births from 130 per 1,00,000 births in 2014-16. Similarly, Uttar Pradesh has also shown improvement in controlling MMR. In 2015-16, MMR in UP stood at 201, which came down to 167 in 2018-20. However, this is way above the national average of 97. The state has the third highest MMR in the country only lagging Assam and Madhya Pradesh on this count, thus raising serious questions on the status of pre- and postnatal care among pregnant women. Table 12 presents data on antenatal or prenatal care availed by pregnant women in UP across socio-religious groups.

Table 12:Professional antenatal care (ANC) of women across socio-religious groups in UP(in percent)

Socio-religious groups	Doctor	ANM/Mid wives/LHV	ICDS worker	Village HW	ASHA	No ANC
Hindu	46.7(35.6)	34.6(36.4)	5.4(1.7)	0.2(0.1)	7.2(1.8)	5.2(23.9)
Muslim	52.4(41.5)	29.7(31.8)	5.1(1.2)	0.2(0.0)	5.8(1.2)	5.9(23.5)
Sikh	65(75.9)	29.6(20.8)	1.2(1.5)	0(0)	0(1.7)	4.2(0)
Other	61.8(57.3)	25.9(37.9)	2.1(0)	0(0)	7.9(4.8)	2.3(0)
SC	42.7(28.4)	36.7(38.9)	6(2.3)	0.2(0.1)	7.9(2.4)	5.7(27.4)
ST	36.6(20.4)	29.5(25.4)	8.4(2.3)	0.1(0.1)	11.6(2.7)	11.3(49.9)
OBC	47.9(36.3)	33.9(36.1)	5.3(1.5)	0.2(0.1)	6.9(1.7)	5.1(23.8)
Others	55.8(51.4)	29.1(30)	4(0.9)	0.1(0.1)	5.5(0.9)	4.7(16.2)
UP	47.8(36.8)	33.7(35.5)	5.3(1.6)	0.2(0.1)	7(1.7)	5.3(23.7)

***Source*:** Author's collation from NFHS 5 and NFHS 4.
Note: Figures in parentheses are NFHS-4 data.

It is seen that 5.9 percent pregnant Muslim women did not access any ANC from a healthcare provider in NFHS 5. While the figure is the second highest among all communities, there appears to have been some progress in this regard as almost 23.5 percent pregnant Muslim women in the state had not availed any ANC during NFHS-4 in 2015-16. With the substantial decrease in 'No ANC' care in NFHS 5, Muslim women only lag ST women in UP, 11.5 percent of whom did not avail ANC in the latest round. However, out of the remaining pregnant Muslim women, majority them 52.4 percent accessed doctor-attended ANC as compared to 41.5 percent Muslim women in 2015-16, who accessed doctor-attended ANC services in the state. In comparison, 46.7 percent pregnant Hindu women accessed doctor-attended ANC. Further 29.7 percent Muslim pregnant women were attended by ANM/mid-wives/Lady Health Visitors (LHV). The proportion of ICDS (Integrated Child Development services) representatives and ASHA workers attending on Muslim women has also improved over the years (Table 12).

There has been an overall improvement in accessing ANC across various communities over the years. The progress along various indicators of ANC during NFHS 5 is given in Table 13.

Table 13: Antenatal care indicators during pregnancy in previous 5 years, NFHS-5, UP

Socio-Religious Groups	% with 4 or more ANC visits	% with ANC in 1st Trimester	% who have 2 or more T.T. injections in Pregnancy	% whose last live birth was protected against neonatal Tetanus	% who were given IFA	% who took IFA at least for 100 days	% who took IFA at least for 180 days	% who took an intestinal parasite drug
Hindu	42.3	62.3	81.2	92.1	84.8	22.2	9.8	32.2
Muslim	42.4	63.1	81.4	91.9	81.6	22.4	9.2	30.6
Sikh	38.1	56	82	93.1	92.9	32.8	9.7	28.6
Other	60.8	73.7	81.7	88	87.4	24.4	19.4	41.2
SCs	39.4	61.9	80.8	92	84.6	19.8	8.5	32.3
STs	28.7	55.5	72	83.4	78.8	15.4	7.9	38.8
OBCs	42.4	61.8	81.2	92.1	84.2	21.8	9.2	32.4
Others	47.6	66.1	82.6	93	84.8	28.1	13.1	29.6
UP	**42.4**	**62.5**	**81.2**	**92.1**	**84.3**	**22.3**	**9.7**	**32**

Source: Author's collation from NFHS 5 data.

It is observed that during NFHS-5, 42.4 percent of Muslim pregnant women have undertaken four or more ANC visits while 81.4 percent of Muslim women have taken two or more Tetanus Taxied (TT) injections for protection against tetanus. However, 81.6 percent Muslim pregnant women were administered Iron-Folic Acid (IFA) tablets, which is less than the state average of 84.3 percent. ST women are the lowest consumers of IFA tablets during pregnancy at 78.8 percent. Therefore, they along with SC women are also the group with the lowest consumption of IFA for at least 100 days at 15.4 percent and 19.8 percent respectively. Further, the progress on pregnancy registration and issuance of Mother and Child Protection (MCP)cards in the state has been substantial in the state across all socio-religious groups in general, and among Muslim and ST women in particular (Table 13).

Table 13:Pregnancy registration and MCP card in UP across socio-religious groups

	NFHS-5		NFHS-4	
	% of pregnancies that were registered	% of mother's given an MCP card	% of pregnancies that were registered	% of mother's given an MCP card
Hindu	91.7	95.9	80.5	81.4
Muslim	90.8	94.7	76.2	72.8
Sikh	89.4	96.5	100	80.5
Other	82.2	96.4	90.3	73.3
SCs	91.6	96.2	79.5	82.8
STs	89.3	88.4	57.1	81
OBCs	91.7	95.8	80.1	79.4
Others	90.8	95.1		
UP	**91.5**	**95.7**	**79.7**	**79.8**

***Source*:** Author's collation from NFHS 4 and NFHS 5.

Data in Table 14 show that only 79.8 percent deliveries of Muslim women were institutional. Of these, just 50.7 percent of Muslim women approached public health facilities for delivery, which is way below the state average of 57.7 percent. In accessing institutional delivery services, Muslim women are ahead of only ST women at 74.7 percent. A significant 29.1 percent of Muslim women accessed private health facilities for their deliveries as compared to 24.8 percent of Hindu women.

Table 14:Type of institutional deliveries and post-natal care, NFHS-5, UP

Social and Religious Groups	% of births delivered in a public health facility	% of births delivered in a private health facility	% of births delivered in a health facility	% of deliveries assisted by health personnel	% of women with postnatal checkup	% of women with postnatal check within two days of delivery
Hindu	59.3	24.8	84.2	85.2	81.4	78.4
Muslim	50.7	29.1	79.8	82.6	84.8	81.5
Sikh	32.7	58	90.8	90.8	79.2	79.2
Other	55.5	40.8	96.3	85.5	96	94.9
SCs	61.2	19.8	81	82.8	80.9	77.8
STs	58.5	16.3	74.7	77	72.8	69.3
OBCs	58	25.4	83.4	84.9	82.2	79.2
Others	51.4	36.8	88.2	88.2	84.1	81.1
UP	**57.7**	**25.7**	**83.4**	**84.8**	**82.1**	**79**

***Source*:** Author's collation from NFHS 5

Table 15 highlights the Out-of-Pocket Expenditure (OoPE), which was expected to be 'no expenditure' while visiting public health facilities during the last two rounds of NFHS. However, it is seen that the state average OoPE in public facilities is Rs. 2,300 in 2019-21 as compared to Rs. 1,956 in the previous NFHS-4 survey. Rs. 20,135 is the state average OoPE for visiting private health facilities. Earlier Tables show that most Muslim women have been visiting public health facilities. Table 15 also shows that Muslims on an average pay higher amounts, i.e. Rs. 2,370 while visiting government facilities. However OoPE for Sikh women is found to be the highest at public health care facilities at Rs 12,623.

Table 15: 'Out of Pocket Expenditure' for institutional deliveries across socio-religious groups in UP (in INR)

Socio-religious groups	Public Health Facility	Private Health Facility	Any Health Facility	% who received Financial Assistance Under JSY
Hindu	2,281 (1,916)	20,502(15,618)	7,932(6,585)	44.7 (50.7)
Muslim	2,370(2,169)	18,379(13,573)	8,400(7,179)	37.9(40.3)
Sikh	12,623(1,652)	37,278(19,693)	29,377(17,653)	7.6(8.7)
Other	1,141(1,159)	20,755(18,188)	8,650(11,149)	44.5(29.3)
SCs	2,010(1,698)	17,705(13,798)	6,040(4,765)	48.8(59.2)
STs	1,795(2,427)	14,538(11,669)	4,789(4,411)	50.2(53.5)
OBCs	2,325(2,844)	19,943(14,590)	7,912(6,362)	43.7(49.0)
Others	2,793(2,844)	22,658(17,188)	11,350(9,996)	35(35.7)
UP	**2,300 (1,956)**	**20,135 (15,189)**	**8,043 (6,718)**	**43.5(48.7)**

***Source*:** Author's collation from NFHS 4 and NFHS 5
Note: Figures in parentheses correspond to NFHS-4

Table 15 also points to some interesting data pertaining to the Janani Suraksha Yojana (JSY).[11] Between NFHS-4 and NFHS-5, the percentage of beneficiaries getting financial assistance under the JSY scheme across all socio-religious groups has gone down from 48.7 percent to 43.5 percent. The non-payment of JSY has been across caste and religion. Among Muslim women, 37.9 percent received monetary benefits under JSY during NFHS-5 as compared to 40.3 percent in NFHS-4.

[11] JSY is a Union government financed programme that integrates monetary help with delivery and post-delivery care. The Yojana (programme) has mentioned Accredited Social Health Activists (ASHA) as an operational links between the system and pregnant women.

Data in Table 16 provides information on community-wise utilisation of ICDS facilities accessed in NFHS-5. Muslim women availed lesser ICDS facilities during pregnancy and breastfeeding as compared to other socio-religious groups, except ST. Further, 65.1 percent of Muslim women availed 'Any Benefit' during pregnancy from ICDS compared to 69.4 percent of Hindu women. On this count, Muslim women lagged the SC and OBC women in seeking any ANC benefits. Also, 58.3 percent of Muslim women accessed supplementary food from ICDS during pregnancy as compared to 65.2 percent of Hindu women. Even SC, ST, and OBC women have better utilisation of ICDS for supplementary food. The trend is similar with respect to health check-ups in ICDS during pregnancy. Muslim women are behind Hindu, SC, and OBC women insofar as the utilisation of ICDS facilities during breastfeeding is concerned.

Table 16: Indicators of utilization of ICDS services from AWCs by women during pregnancy (P)& breastfeeding (BrF) across socio-religious groups in UP, NFHS 5

Socio-religious groups	Any Benefits (P)	Suppl. Food (P)	Health Check-ups (P)	Health & Nutrition Education (P)	Any Benefits (BrF)	Suppl. Food (BrF)	Health Check-ups (BrF)	Health & Nutrition Education (BrF)
Hindu	69.4	65.2	63	56.4	65.6	62.6	58.8	54.1
Muslim	65.1	58.3	59.9	54.2	61.9	56.8	56.5	51.9
Sikh	41.8	37.2	37	33.2	37.9	37.9	30	30
Other	53.1	37.5	49.6	40.3	43	39.8	40.8	32.8
SCs	72.7	68.6	66.5	58.9	68.4	65.3	61.9	56.7
STs	63.7	60.3	56.4	51.1	59.6	56.9	53	49.1
OBCs	68.5	64.1	62.4	56	64.9	61.7	58.2	53.5
Others	62.8	56.3	56.7	51.5	59.4	54.9	53.4	49.5

***Source*:** Author's collation from NFHS-5.

Notwithstanding lesser utilisation of ICDS facilities during and after pregnancy, Muslim women are at par with women from other social and religious groups with respect to prevalence of anaemia or iron deficiency. Data on incidence of anaemia across socio-religious groups in UP (Table 17) indicate that only 1.8 percent of Muslim women are afflicted with severe anaemia as compared to 2.2 percent of Hindu women. The incidence of severe anaemia is highest among Sikh women at 3.3 percent followed by SC and ST women at 2.3 percent. Overall, since NFHS-4, there has been a decline in the prevalence of anaemia among women across all communities.

Table 17: Prevalence of anaemia among women aged 15-49 years across socio-religious groups in UP (in percent)

Socio-religious groups	NFHS-5				NFHS-4			
	Mild	Moderate	Severe	Any Anaemia	Mild	Moderate	Severe	Any Anaemia
Hindu	24.3	23.9	2.2	50.4	38.9	12.5	1.1	52.4
Muslim	24.6	24	1.8	50.5	38.5	12.8	1.2	52.6
Sikh	25.5	25.7	3.3	54.5	41.5	9.5	3.0	54.0
Other	22.6	18.4	1.8	42.9	33.2	11.0	0.4	44.7
SCs	24.4	23.8	2.3	50.5	39.0	13.6	1.2	53.9
STs	24.3	24.5	2.3	51	41.1	15.3	1.2	57.6
OBCs	24.1	23.7	2	49.8	38.8	12.4	1.1	52.3
Others	24.7	24.8	2.4	51.9	38.5	11.6	1.0	51.0

***Source*:** Author's collation from NFHS 4 and 5.

Like the utilisation of ICDS and benefits of JSY, Muslims, both men and women, figure lower in the list of those having health insurance coverage in Uttar Pradesh (Table 18). Just 6.8 percent of Muslim women have health insurance cover as compared to 8.7 percent of Hindu women. In contrast, SC women with health coverage are 12.3 percent while there is 7.2 percent health insurance coverage among OBC women and 7.8 percent among ST women. Similar is the trend for Muslim men on health insurance, as they figure just above ST and OBC men in this regard.

Table 18:Sex-wise health insurance cover across socio-religious groups in UP (in percent)

Socio-religious groups	NFHS-5		NFHS-4	
	% of Women covered by any Health Insurance (No. of Women)	% of Men covered by any Health Insurance (No. of Men)	% of Women covered by any Health Insurance (No. of Women)	% of Men covered by any Health Insurance (No. of Men)
Hindu	8.7 (76,981)	10.9 (9,431)	2.9	3.8
Muslim	6.8 (15,784)	8.2 (1699)	1.5	1.7
Sikh	6.5 (173)		3.1	*
Other	16.2 (186)		5.6	5.7
SCs	12.3(23311)	15.9 (2714)	2.8	3.2
STs	7.8 (12,84)	6.8 (122)	2.4	8.6
OBCs	7.2 (49,514)	8.6 (6022)	2.2	2.9
Others	6.9 (18,870)	9.3 (2286)	3.3	4.7

***Source*:** Author's collation from NFHS 4 and 5.

Data in Table 19 attempts to provide an insight in the level of empowerment among women in Uttar Pradesh vis-à-vis health-related decisions. A perceptible improvement has been recorded in the status of Muslim women in terms of decisions taken by them with respect to their health. On this count, they are almost at par with Hindu women. However, here the condition of ST women lags all other communities. On the issue of facing violence during pregnancy, the plight Muslim women has worsened since the previous survey in 2015. During NFHS-4, 4.1 percent of women responded that they had faced violence during pregnancy. That figure has risen to 4.6 percent in NFHS-5. Each community has recorded a positive decline regarding violence, except Muslims.

Table 19: Healthcare decisions and violence faced by women across socio-religious groups during pregnancy in UP (in percent)

Socio-religious groups	NFHS-5		NFHS-4	
	% of women 15-49 age making decisions alone or jointly on their Health care	Women age 18-49 experience violence during Pregnancy	% of women 15-49 age making decision alone or jointly on their Health care	Women age 18-49 experience violence during Pregnancy
Hindu	81.7	3.5	73.1	4.4
Muslim	81	**4.6**	**72.5**	**4.1**
SCs	81.5	4	73.6	5.6
STs	76.3	3.1	80.8	7.1
OBCs	81.2	4	71.7	4.2
Others	82.9	2.2	74.8	3.1

***Source*:** Author's collation from NFHS 4 and 5.

CONCLUSION

The overall situation of maternal healthcare in Uttar Pradesh has improved between the two surveys, NFHS-4 and NFHS-5. Some of the indicators on maternal health, such as MMR, registered births, professional attendants, and supply of IFA tablets, are closing in on the targets set in Sustainable Development Goals (SDGs). However, the state still has a long distance to cover in the field of maternal healthcare as compared to other states in the country as pointed out by the NITI Aayog. The discourse also indicates that at the international level the concepts of 'Cultural Competence' (CC) and 'Gender Medicine' has figured prominently in the discussion, especially when dealing with religious or ethnic minorities. However, India is still in the race to provide essential medicine accessibility and utilisation to women. The importance of religious beliefs and its impact on maternal health is an area that policymakers need to consider to have better health outreach among minorities.

Within the state, socio-religious group-wise analysis of maternal healthcare reveals that although the Muslim women's conditions have improved on many indicators yet they are lagging other communities. Their health situation has been conditioned by general or common factors such as lack of education, poverty, lack of information, and a patriarchal society. However, Muslim women's health is also impacted by religious beliefs, as pointed out by a few studies. Use of contraception, number of children, early marriage, visiting health facilities independently, privacy and physical touch by male doctors, abortion, use of medicine during Ramzan, are issues which are highly impacted by religious beliefs. A focused evidence based study is a must to ascertain the link between the religious beliefs of Muslim women and their health indicators. Along with that, this paper argues that the element of 'Cultural Competence' must be introduced in policy and healthcare institutions along with making healthcare accessibility affordable for them.

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