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Reproductive Behaviour of Muslims in Uttar Pradesh

M.E. Khan and Bella C. Patel

Introduction

Muslims form the largest minority group in India. According to the 1991 census, they constitute about 12 per cent of the country's population. In absolute terms, Muslims in India totalled 101.6 millions which gives India the distinction of having the second largest Muslim population in the world. The spread of Muslims in different states varies from one per cent in Punjab to 22 per cent in the States of Kerala and West Bengal, except for 64 per cent in Jammu and Kashmir. In Uttar Pradesh, according to the 1981 census, Muslims comprised 15.2 per cent of the total population. Within the State also their concentration varies from 3.2 per cent in tile Hill region to 21 per cent in the Western region. Some districts of the Western region such as Muradabad, Rampur, Shahranpur, Bijnor and Shahjahanpur have a Muslim concentration of as much as 40 per cent.

The growth rate of the Muslim population in India during the last three decades is somewhat higher than that of the non-Muslim population. The exponential growth was around 2.67 as compared to 2.16 for other communities. In Uttar Pradesh too, it has followed the same pattern. Sample surveys [1], [2], [3], [4] carried out by a number of agencies have shown that Muslims have higher fertility and prefer larger families. These observations are sometimes used by a few fanatics of other religious groups to oppose family planning, as they fear that if the present bend persists, Hindus will be eventually outnumbered by Muslims. This proposition, however, has been mathematically examined and rejected by demographers [5]. Even with the worst (and most improbable) scenario of the current growth rate remaining unchanged in future, it is projected that the Muslim population will grow from 11.7 per cent of the country's population in 1981 to 12.8 per cent in 2001 and about 18 per cent in 2081. Even after 200 years post 1981, that is, in the year 2181, the proportion of Muslims will increase only to 26.7 per cent of the total population of India.

The present paper, based on a large sample survey [6] carried out in Uttar Pradesh, compares the reproductive behavior of Hindus and Muslims, and attempts to examine the determinants of their differential fertility and family planning behavior.

Data

Data for the present study were taken from the Uttar Pradesh (UP) baseline survey conducted in 15 districts of the state. The study was sponsored by the State Innovations in Family Planning Service Agency (SIFPSA) and was carried out by eight different research and consultancy organizations. The Population Council, on behalf of SIFPSA, coordinated the survey and provided technical assistance to the consultancy firms on all aspects of the research.

From each of the selected districts, 2,500 households proportionately spread over rural and urban areas were randomly selected. All ever married women 13-49 years of age, in these households, were interviewed. Details of the sample design are given elsewhere [6]. The present paper analyses the baseline survey data from only the Western districts of UP namely Ghaziabad, Meerut, Rampur and Shahjahanpur because these districts have a significant number of Muslims and therefore, have been able to maintain their traditional value system. In other locations where they are in small numbers, under the influence of the dominant caste/religious groups, they tend to lose their value system more easily and adopt the values of the general community in which they reside.

A total of 11,278 ever married women, 13-49 years of age, from 10,377 households in the selected districts were interviewed. Of the 11,278 women, 7,870 were from rural areas and the remaining 3,408 from urban settings.

Findings

Table 1 presents the background information of the women who were interviewed for the survey.

Table 1: Background characteristics of the women by education and religion

	Hindu					Muslim				
	Illiterate	Primary	Matric	Matric+	Total	Illiterate	Primary	Matric	Matric+	Total
Residence										
Urban	22	35	52	81	34	38	54	80	93	43
Rural	78	62	48	19	66	62	46	20	7	57
% educated	63	12	15	10	100	80	13	5	2	100
Mean age	31.0	30.2	29.0	31.0	30.6	30.4	28.1	28.4	30.1	30.0
Age at effective marriage (yrs)										
Mean	16.9	17.3	18.3	19.8	17.5	17.2	17.4	17.9	19.8	17.3
S.D.	1.9	1.9	2.0	1.8	2.1	1.9	1.9	2.0	1.8	2.0
% reporting as housewife	97	97	98	94	97	99	98	97	87	98

No. of estimated women ('000s)	**92**	**174**	**206**	**140**	**1432**	**353**	**60**	**20**	**9**	**442**

The data dearly show a wide gap in the educational levels of Hindus and Muslims 80 per cent of the Muslim women as compared to 63 per cent of Hindu women were illiterate. While, only 7 per cent of the Muslim women had schooled up to the Matriculation (Matric) level or more, the corresponding figure was as high as 25 per cent among Hindu women. Cross tabulation of the husband's and wife's educational level further indicated that both the husband and wife were illiterate among twice as many Muslim couples (51 per cent) as compared to Hindu couples (24 per cent). In contrast, among the Hindus about 24 per cent of both spouses had schooled beyond the primary level; the corresponding percentage among Muslims being only 5 per cent.

An analysis by residence showed that a larger proportion of Muslims (43 per cent) as compared to Hindus (34 per cent) were urban-based. Further, the rural-urban disparity in education was much wider among Muslim women than among Hindu women. For instance, while among Hindu women those who had studied up to the Matriculation level were equally distributed in rural and urban areas, as many as 80 per cent of Muslim women who had attained a similar level of education were concentrated in urban areas. This suggests that the spread of higher education (Matriculation and above) among Hindus is substantial in both rural and urban areas, whereas among Muslims, it remains largely an urban phenomenon.

The two communities did not differ much with respect to their age structure (not given in the table) and age at marriage. The mean age of Hindu and Muslim women were 30.6 and 30.0 years respectively, and their mean age at effective marriage was 17.5 and 17.3 Years respectively. Again, no difference was observed in their participation in the paid labor force: 97-98 per cent of women from both communities were housewives.

Fertility Differences

The paragraphs below present the total fertility rates, average number of live births and living children, and the completed and desired family size of the Hindu and Muslim respondents.

Total Fertility Rate

Table 2 gives the total fertility rate (TFR) of the Hindu and Muslim women by district. It indicates that Muslim women had a higher TFR than Hindu women in

all the four districts, ranging between 5.6-5.9 as compared to 4.3-5.2 among the Hindus. On average, a Muslim couple had one child more than a Hindu couple, and the fertility of Muslims was about 16 per cent higher than that of Hindus.

Table 2: Total fertility rate in selected districts, UP

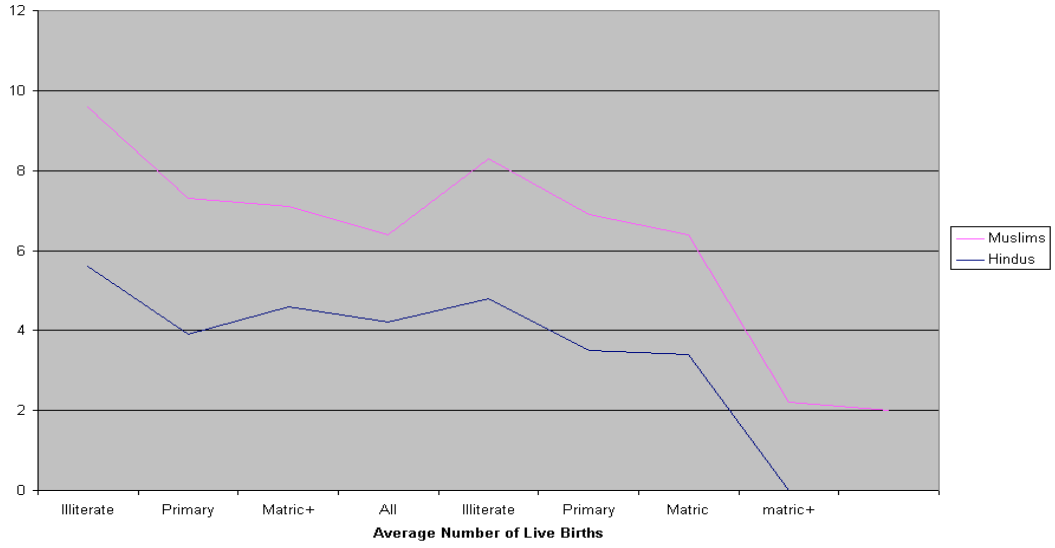
District	Hindu	Muslim
Ghaziabad	4.8	5.8
Shahjahanpur	4.8	5.9
Meerut	4.3	5.8
Rampur	5.2	5.6
Uttar Pradesh*	4.8	5.8

* Source: IIPS, 1994.

Average number of live births and living children

On average, Muslim women, had 4.2 live births and 3.5 living children, which is 16-20 per cent higher than the corresponding, figures of 3.5 and 2.8 among the Hindus (Figure 1). Education appeared to have only a marginal impact on the average number of children among Muslims while among Hindus it showed a consistent negative impact on fertility (Figure 1).

Figure 1: Average Number of Live Births and Living Children by Religion



Completed and desired family size

Completed family size was obtained by adding the number of living children a woman had and the number of additional children she wanted. The analysis showed that Muslim women wanted a somewhat larger family than did Hindu women. For instance, only 13 per cent of the Muslim women aspired for a two-child family, about 18 per cent hoped to have three children, while 58 per cent wanted four or more children. The corresponding percentages for Hindu women were 25, 27 and 45 respectively. The mean completed family size worked out to 3.6 (SD ± 1.2) for Muslims and 3.2 ± 1.1 for Hindus, as presented in Table 3. Among the Muslims, the mean completed family size dropped from 3.7 for illiterate mothers to 3.0 for those who had studied up to Matric and 2.6 for women who had attained higher education. A similar but somewhat sharper decline was observed among Hindu women.

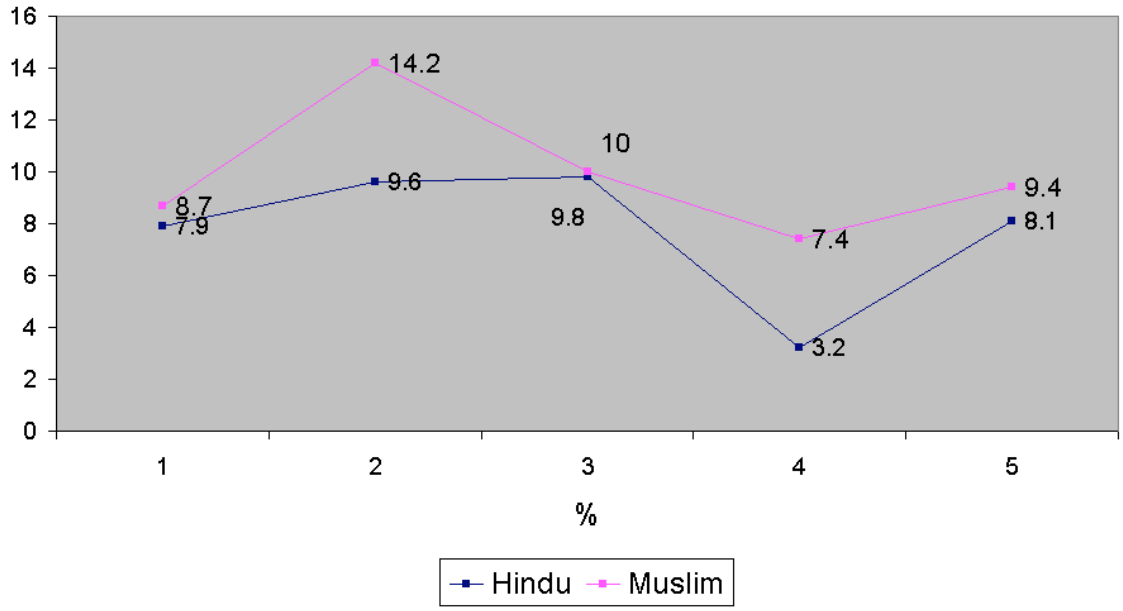
Table 3: % distribution of women by completed family size, education and religion

Number of living children	Hindu					Muslim				
	Illiterate	Primary	Matric	Matric+	Total	Illiterate	Primary	Matric	Matric+	Total
2 or < 2	15	26	40	62	25	10	17	28	53	13
3	26	30	33	24	27	17	20	26	20	18
4	47	39	26	12	40	50	43	30	11	47
5	8	4	1	1	5	11	11	5	12	11
Non-numeric	3.5	3.1	2.7	2.2	3.2	3.7	3.5	3.0	2.6	3.6
S.D.	1.1	1.1	1.1	1.0	1.1	1.1	1.2	1.2	1.2	1.2
Women estimated ('000s)	912	174	206	140	1432	353	60	20	9	442

The relatively higher fertility among Muslims was also reflected in their family size norms. Thus, on an average, a Muslim couple perceived a four-child family (mean: 3.6 children) as ideal as against a three-child family (mean: 3.0 children) considered ideal by a Hindu couple. This desire for a larger family is well corroborated by [figures 2] on the number of additional children wanted by number of living children. For instance, among Muslim women who currently had 2, 3 or 4 living children, 71, 48 and 19 per cent respectively were desirous of having additional children. The corresponding percentages for Hindu women were only 45,22 and 10 respectively. This pattern persisted even when educational disparity, was controlled. Among Muslims, dependence on fate, God, etc. was much higher (22 per cent) as compared to Hindus (5 per cent); this

religious and fatalistic attitude dropped significantly with education (table not given).

Fig. 2: % women reporting at least one pregnancy as unwanted



Unwanted pregnancy

When asked if any of her pregnancies was unplanned or unwanted, about 8 per cent of Muslim and 9 per cent of Hindu women reported their last pregnancy as an unwanted one. At least 4 per cent of the women in both groups had experienced two or more unplanned pregnancies. The two groups did not differ in their experience of having unwanted pregnancies.

Ideal age at marriage

Table 4: which presents the women's opinions regarding the ideal age at marriage for girls, shows that an almost equal proportion (nearly 30 per cent) of both Hindu and Muslim women reported 17 or less years, 18 years and 19+ years as the ideal ages for marrying their daughters.

Table 4: % distribution of women perception of age at which girls should marry, education and religion

Age at marriage (years)	Hindu					Muslim				
	Illiterate	Primary	Matric	Matric+	Total	Illiterate	Primary	Matric	Matric+	Total
< 17	41	18	7	1	29	35	25	8	3	32
18	29	44	48	40	34	28	35	57	48	30
19+	24	36	44	59	32	27	36	34	49	29
Don't know	6	2	1	-	5	10	4	1	-	9
Average age	17.5	18.3	18.2	19.5	18.0	17.7	17.6	16.9	19.0	18.1
No. of estimated ever married women ('000s)	912	174	206	140	1432	353	60	20	9	442

Among both religious groups, a much higher proportion of illiterate women (35 to 40 per cent) perceived 17 years or less as the ideal age at marriage than did those who had studied up to Matriculation (7 to 8 per cent) or beyond it (1-3 per cent). Further, over a third (36.5 per cent) of the Muslim and 45 per cent of the Hindu women were aware of the correct age at which a girl can legally marry.

Family Planning

This section looks at the awareness, knowledge and practice of family planning and the unmet family planning need as indicated by the study.

Awareness and knowledge of family planning

Knowledge of family planning was nearly universal, both among the Muslim (93 per cent) and Hindu (95 per cent) women. They all were aware of at least one modern contraceptive. Even modern spacing family planning methods were known to a substantially high proportion of women in both groups, through to a somewhat great proportion of Hindu (91 per cent) as compared to Muslim women (88 per cent). Table 5, Panel A, presents this information by their educational level.

To assess the extent of correct knowledge about different contraceptive methods, for each family planning method mentioned by the woman she was asked to indicate who (male or female) could use that method and how it was used or administered. Over three-fourths of the Muslim women had correct knowledge of at least one modern family planning method (79 per cent), and of at least one modem spacing method (73 per cent). The corresponding percentages were

somewhat higher for Hindu women - 87 and 77 per cent respectively (Table 5, Panel A).

Table 5: Distribution of women knowledge and current use of family planning, education and religion

	Hindu					Muslim				
	Illiterate	**Primary**	**Matric**	**Matric+**	**Total**	**Illiterate**	**Primary**	**Matric**	**Matric+**	**Total**
A. FP Knowledge % aware of										
Any FP method	93	98	98	99	95	92	97	98	97	93
Any modern FP method	93	97	98	98	91	86	94	97	97	88
Any modern spacing method	87	95	98	98	91	86	94	97	97	88
% having correct knowledge of										
Any modern FP method	83	93	94	95	87	77	88	89	91	79
Any modern spacing method	71	86	90	93	77	70	84	86	91	73
B. FP use - % using										
Sterilization	16.9	25.2	24.5	20.6	19.4	3.8	4.5	10.3	-	4.1
IUD	1.0	3.0	4.7	6.7	2.4	0.9	1.0	3.0	1.3	1.1
Pill	2.1	2.7	3.5	4.9	2.7	2.3	2.4	5.4	13.9	2.7
Condom	3.1	5.7	10.2	19.6	6.1	4.8	8.5	13.6	13.6	5.9
Any modern method	23.1	36.6	42.9	51.8	30.6	11.8	17.1	32.1	28.8	13.8
All method	27.6	42.3	48.5	59.5	35.6	15.7	23.2	35.0	35.0	18.0
No. of currently married women ('000s)	878	170	201	138	1387	339	57	19	8	423

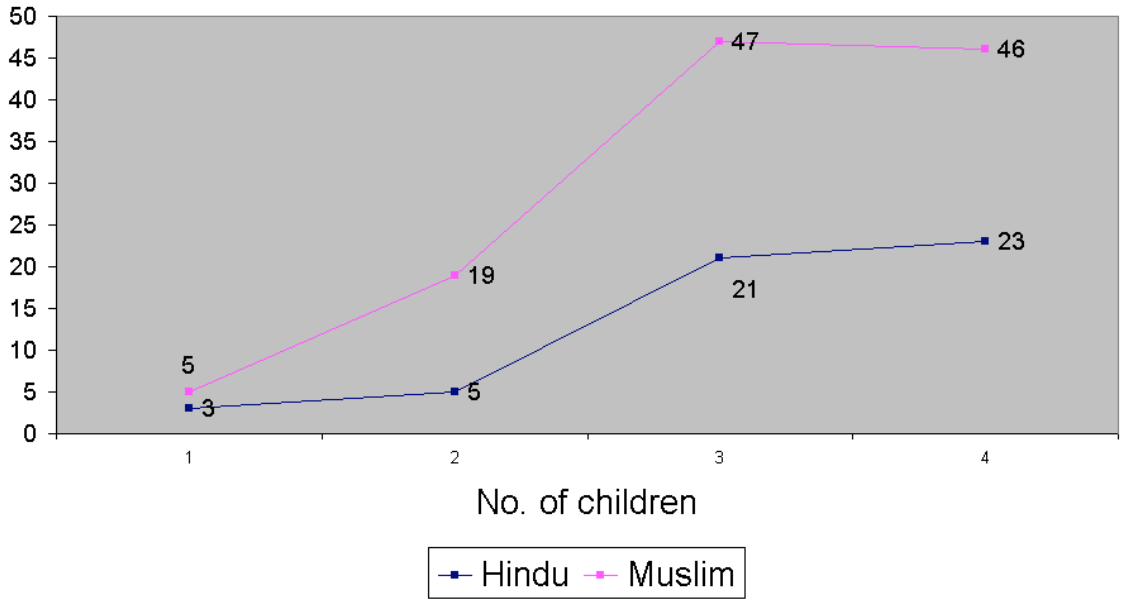
The same pattern was observed for each specific family planning method - a higher proportion of Hindu as compared to Muslim women had correct knowledge about the method (Table 5, Panel A). The disparity was less in the case of the pill and condom (4 per cent points) than the IUD (8 per cent points) or tubectomy (13 per cent points).

Contraceptive use

Contraceptive use among the Muslims was quite low as compared to the Hindus as shown in Panel B of Table 5 and (Figure 3). At the time of survey, only 18 per cent of the Muslim women were practicing family planning; 13.8 per cent were using modem methods and 4.2 per cent traditional methods. The corresponding figures for Hindu women were 36 per cent (modern: 31 per cent; traditional: 5

per cent). Preference for contraceptives methods also significantly differed among the two groups. While the most preferred method among Hindus was sterilization, the condom was more popular among Muslims (Table 5, Panel B). Acceptability of the pill was also greater among the latter than the former suggesting thereby that the promotion of non-terminal methods, particularly the condom and pill, among Muslims, rather than the usual program emphasis on sterilization, may give better results.

Fig. 3: Contraceptive user by no. of living children



The analysis further showed a positive relationship between education and current use of contraception. Differentials in contraceptive use by education were more evident between illiterate Muslim women (16 per cent) and those who had received schooling up to the Matriculation level and higher (35 per cent). Marked differences were also observed in the use of the pill and condom between the illiterate and literate groups (Table 5, Panel B).

Religious differentials in contraceptive use persisted even after controlling for education and age of the women which in a way is also a proxy variable for the number of living children. These findings are presented in Table 6. However, two important points need to be noted. One, that the differential in contraceptive use between the two religious groups reduced substantially with an increase in education. For instance, in the 2534 age group, 55 per cent of Muslim couples

who had attained more than the Matriculation level were practicing family planning; the corresponding figure for Hindu couples was 67 per cent (Table 6).

Table 6: Percent distribution of FP users by age and education

Age (in years)Primary	Matric	Matric+	Total		
Hindu					
< 24	11	19	25	43	18
25-34	33	52	65	67	44
35+	42	63	76	71	51
Muslim					
< 24	9	15	22	21	11
25-34	22	32	49	55	26
35+	21	38	49	28	24

Another point which needs to be underlined is the fact that the differential between the two religious groups is greater in the older age groups of 25-34 and 35+ years than the younger age group (24 years or less). This may indicate that younger Muslim couples are more inclined to adopt contraception than those who are older.

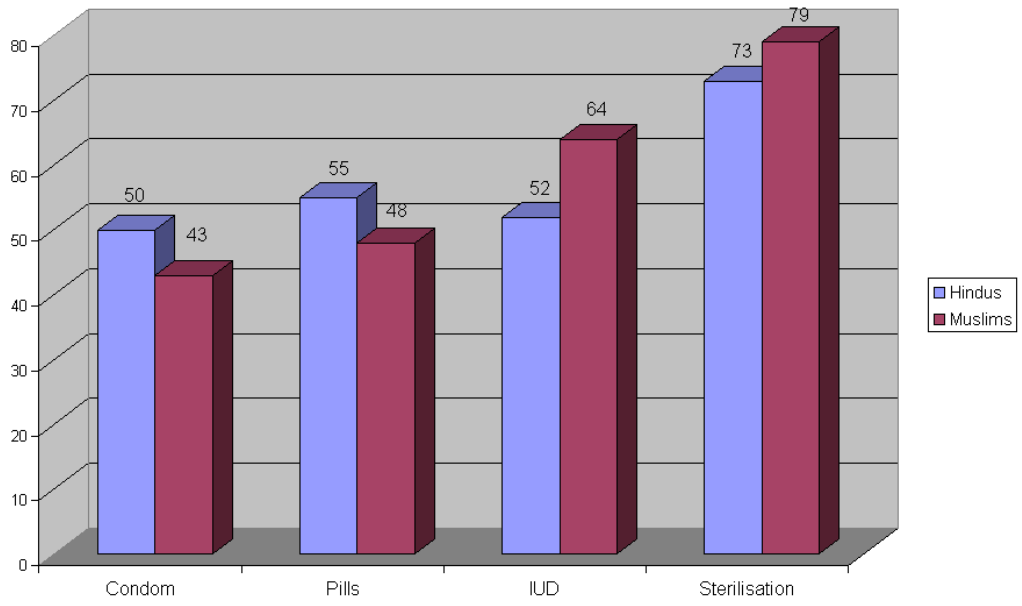
Figure 3 shows a positive association between the number of living children and contraceptive use. Contraceptive use increased steadily from 3 per cent among Muslim women who had no living children to 23 per cent among those with four or more living children. The same pattern was evident among Hindu women - increasing from 5 per cent among women with no children to 46 per cent among those with four or more living children. Except in the case of a childless couple, at all levels of family formation, contraceptive use among Hindus was two to three times higher than among Muslim.

Source of contraceptive supply

Two-thirds of the sterilizations and slightly more dm half of the IUD insertions were performed in primary health centers and other government institutions (Figure 4). However, in the case of non-terminal methods (the pill and condom) less than half of the acceptors were observed to depend on government sources. A comparison of the sources of supplies among the two religious groups showed that for clinical methods a higher proportion of Muslim women (64-79 per cent) depended on public clinics as compared to Hindus (52-73 per cent). In case of non-clinical methods however, the dependence of Muslim women on government clinics was much lower (43-48 per cent) than that of Hindu women

(50-55 per cent) indicating thereby that in the provision of contraceptives, and particularly of non-clinical methods, private facilities and other outlets play a significant role. Perhaps more Muslim couples could be reached by increasing contraceptive availability from private facilities through the social marketing and CBD approaches.

Figure 4: Percent of Current Users Utilising Public Clinics as Source of Service



Level of unmet need

The unmet need for family planning is defined, as the proportion of couples who wish to delay or avoid the next pregnancy but are not using any contraceptive. All currently non-pregnant eligible women who wished to delay their next birth by two or more years and were yet not practicing contraception were grouped into the category of "unmet need for spacing". Similarly, those who wanted no more children and were yet not using any family planning method were grouped as "unmet need for limiting childbearing". The total unmet need among Muslim women was much higher (56 per cent) than among Hindu women (42 per cent). The unmet need for spacing and stopping childbearing for the two religious groups was estimated at 24 and 32 respectively for Muslims against 17 and 25 per cent respectively for Hindus. The differential in unmet need between the two communities persisted even after controlling for education (Table 7).

Table 7: Level (%) of Unmet Need by Religion and Education

Levels of Education	Hindu						Muslims					
	Unmet need			Total demand for Contraceptives	% of Contraceptive demand Met	Estimatd CNN (000's)	Unmet Need			Total demand for Contraceptives	% of contraceptive demand met	Estimated CNN (000's)
	Spacing	Limiting	Total				Spacing	Limiting	Total			
Illiterate	20	29	48	71	32	878	24	35	59	71	17	339
Primary	16	22	39	76	49	170	22	24	46	63	27	57
matric	15	16	30	73	59	201	22	21	43	75	43	19
Matric	8	18	26	78	67	138	17	13	30	59	49	8
All (%)	17	25	42	73		1387	24	32	56	70		423

The unmet need for family planning was negatively associated with female education. Thus, illiterate and less educated women expressed a much higher level of unmet need for family planning as compared to their more educated counterparts. Conversely, the percentage of contraceptive demand that was satisfied increased from 17 per cent for illiterate Muslim women to 49 per cent for women with schooling above the Matriculation level. The corresponding figures were much higher in the case of Hindu women, being 32 and 67 per cent respectively.

'Opposition from husband or other family members' (10 per cent) and 'use of contraception is against religion' (38 per cent) were the main reasons for the unmet need among Muslim women. Fear of the operation, failure, fear of side effects or a dislike of the existing methods were mentioned by another 5 to 6 per cent of the women as reasons for not using contraception.

Obstacles to the acceptance of family planning

This section presents information about the major barriers to family planning acceptance namely access to information through exposure and the attitude of the couple to family planning. The nature of client provider contact and quality of services offered are discussed subsequently.

Access to information

In a traditional society like that of rural Uttar Pradesh, the main sources of information about sexuality and family planning include the mass media,

husband, friends and other peer groups. However, data on the exposure of women to mass media and husband-wife communication on desired family size showed that Muslim women have less access to information than Hindu women. For instance, as evident from Table 8, over three-fourths (64 per cent) of the Muslim women were not exposed to any mass media viz. newspaper, radio, TV and cinema as against almost half of the Hindu women. Among both religious groups, such exposure was positively associated with the level of education. For instance, only 29 per cent of illiterate Muslim women had been exposed to at least one of the mass media as against 88 per cent of those who had studied up to Matriculation and above.

Table 8: % distribution of women by exposure to mass media, education and religion

	Hindu					**Muslim**				
	Illiterate	**Primary**	**Matric**	**Matric+**	**Total**	**Illiterate**	**Primary**	**Matric**	**Matric +**	**Total**
Exposed to at least one of the mass media	35	66	83	95	51	29	53	85	88	36
Discussed desired family size with husband	54	70	82	92	64	46	56	67	82	49
No. of currently married women ('000s)	912	170	201	138	1387	339	57	19	8	423

Similarly, the extent of husband-wife communication on desired family size was lower among Muslims as compared to Hindus. Half of the Muslim couples and a third of the Hindu couples had never discussed the number of children they should have with their spouse. As expected, inter-spousal communication was also positively associated with the educational level of the women (Table 8). A comparison of the two religious group further indicated that the impact of education on husband-wife communication was much sharper and steeper among the Hindus as compared to the Muslims. This could be because the Muslim who are socially and economically more backward than the Hindus, hold on to their traditional values more strongly than do Hindus.

Attitude of couples to family planning

An analysis of the women's own attitude towards family planning and their perception about their husbands' attitudes on the subject showed that among the Muslims only 57 per cent of both spouses as compared to 82 per cent among the Hindus, approved of family planning (Table 9).

Table 9: Percent distribution of women by attitude to family planning and religion

Attitude to FP	Hindu	Muslim
Both spouses approve	82	57
Wife approves, husband disapproves	3	12
Wife disapproves, husband approves	4	9
Both spouses disapprove	2	9
Wife unsure, husband approves	8	11
Wife unsure, husband disapproves	1	2

Among all Muslim women, 69 per cent approved, 18 per cent disapproved and 13 per cent were uncertain whether contraception should be approved. The corresponding percentages among the Hindu women were 85, 6 and 9 respectively. The percentage age of women reporting disapproval of contraception by heir husbands was much higher (23 per cent) among the Muslims than among the Hindus (6 per cent).

Contact, with the family welfare program and service quality

According to the government norm an ANM who caters to a population of approximately 5,000, is expected to visit each household in her work area at least once in two months. The frequency of the provider's contact with the prospective clients particularly during the postpartum period, the quality of such interactions, and details of the information provided about various contraceptive methods are important elements of service quality and play a significant role in the acceptance and continuation of contraception as well as in the utilization of health services.

Level of contact with the program

The findings indicated an extremely poor level of contact between the beneficiaries and the program (table not given). Only around 10 per cent of the

women, both Muslim and Hindu, were visited by the PHC/SC workers during the three-month period prior to the survey. Further, about 16-17 per cent of the women had themselves contacted a health worker for various reasons. Even when both these contacts were considered together, at most, only about a fourth of the currently married Muslim and Hindu women reported to have had any contact with a health worker during the last three months.

Choice of contraceptive

The most common family planning methods mentioned by the health workers as reported by Muslim women were the pill and tubectomy (65-66 per cent); the condom and IUD were reported by a slightly lesser number of the women (56-57 per cent), while even fewer - about 19 per cent and 4 per cent had been informed about the safe period and withdrawal respectively (Table 10).

Table 10: Percent distribution of women by quality of counseling and follow up visits

	Hindu	**Muslim**
% who reported FP method mentioned by health worker*		
Sterilization	76	65
IUD	46	56
Pill	50	66
Condom	40	57
Withdrawal	5	4
Safe period	11	19
% who mentioned both advantages and disadvantages of the method*		
Sterilization	22	18
IUD	14	15
Pill	13	19
Condom	9	11
Withdrawal	1	1
Safe period	1	1
Number of women reporting visit by PHC/SC staff ('000s)	188	49
% users visited by the health worker within one month of adopting FP method**	11	4
% users informed about type of precautions	68	50

to be taken after adopting the method**		
% users told when to make a revisit**	41	26
% users visited by the health worker within one month of adopting FP method	11	4
Estimated number of current FP users ('000s)	474	76

* = Base is those who were visited

** = Base is number of current FP users.

In the case of Hindu women, sterilization was reported to have been most mentioned to them by the health workers (76 per cent) while a lesser proportion (as compared to the Muslims) had been informed about non-terminal methods. These findings suggest that family planning workers tended to offer a greater choice of contraceptives to Muslims than to Hindus perhaps because of the general perception that the former are less inclined to accept sterilization. Further probing into the quality of counseling revealed that only a small proportion of the women, both Muslim and Hindu, had been informed about the advantages as well as the possible side effects of contraceptives. While this shows poor quality of counseling by family planning workers, it does not show any difference in their approach by religion. Further, when analyzed by educational level, more illiterate and less educated women were found to have received information about the advantages and disadvantages of sterilization and condoms while other spacing methods were emphasized more among better educated women.

Advice to acceptors on precautions and revisits to clinic

One-half of the Muslim acceptors as against 68 per cent of the Hindu acceptors reported that they had been informed about the precautions to be taken after adopting the method (Table 10). Similarly, only a quarter of the Muslim women who were currently using contraceptives said that they had been told when to make a revisit as compared to 41 per cent of their Hindu counterparts. More qualitative research using indepth case studies and participant observations during the actual delivery of services are required to look into the differential behaviors and counseling pattern of service providers with women from different communities. It is possible that the providers felt more comfortable with their Hindu clients and were therefore able to give them more time and complete information.

Follow-up visits by the workers

As in the case of home visits, follow up visits by the workers to family planning acceptors was also very low. As indicated in Table 10, only around 4 per cent of Muslim acceptors and 11 per cent of Hindu acceptors had been visited by a worker within one month the acceptance of contraception. The study thus shows that though frequency of contact between the women and the family welfare workers was equally poor in the case of both the communities, the quality of services provided to Hindu women was relatively better than that provided to Muslim women.

Maternal and child health care

The following section looks at the differentials in the utilization of mother and child health services by the women.

Antenatal care

The findings presented in Table 11 show that, in general, a lesser proportion of the Muslim women had received antenatal care than had Hindu women. For instance, only 47 per cent of the Muslim women who had conceived during the last two years had received tetanus toxoid (TT) injections and even fewer (23 per cent) had been supplied with iron and folic acid tablets. The corresponding figures for Hindu women were 56 and 35 per cent respectively.

Further analysis by controlling for education showed that education had a major impact on the utilization of antenatal services. For instance, only 43 per cent of illiterate Muslim women as compared to 70 per cent of those who were educated (Matriculation and above) had received a TT injection. Similarly, 21 per cent of the illiterate women as against 67 per cent of the educated ones had received iron and folic acid tablets. A similar pattern was observed among the Hindu women as well.

Place of delivery and assistance during delivery

A majority of the mothers, more than 94 per cent Muslims and 87 per cent Hindus, reported to have delivered at home (Table 11, Panel A). Only 2-4 per cent among both religious groups had used a put for her delivery. Education appeared to have direct bearing on institutional delivery. Only 4 per cent of illiterate Muslim women had institutional deliveries as compared to 27 per cent of those who had studied up to Matriculation and 57 per cent of those with higher education. A similar trend was observed among Hindus where the corresponding figures were 4,26 and 61 per cent respectively.

Only 23 per cent of the deliveries among the Muslim women and 27 per cent of those to Hindu women were assisted by a doctor, a nurse or a trained dai. Again, the mother's education had a significant effect on the assistance sought during delivery. Only 20 per cent of those who had studied up beyond this level reported trained birth assistance. A similar trend was also observed among their Hindu counterparts, the corresponding figures being 18,44 and 70 per cent respectively.

Postpartum contact with health workers

Table 11, Panel A also shows a very low level of contact of women who had delivered during the last two years with the grassroots health worker even during the postnatal period (within two months of delivery) when the women require various health services and contraceptive advice. Only 5-7 per cent of the women in both groups who had delivered during the last two years reported to have been visited by a PHC/SC worker within two months of delivery while only 8 to 11 per cent, of the women had sought assistance from the health workers during the postpartum period.

As Panel A of Table 11 shows, only 10 per cent of the Muslim women and 15 per cent of Hindu women had had any contact (worker visited the women or women visited the worker) with the health worker during the postpartum period. The mother's education did not affect this, and the same pattern was observed among the Hindu women as well.

Table 11: Coverage of MCH services received by mothers children by education and religion

	Hindu					**Muslim**				
	Illiterate	**Primary**	**Matric**	**Matric+**	**Total**	**Illiterate**	**Primary**	**Matric**	**Matric+**	**Total**
A. Women										
% received TT injection	48	67	73	84	56	43	60	71	77	47
% received iron & folic acid tablets	27	38	55	74	35	21	24	53	67	23
Estimated no. of women pregnant in last two years ('000s)	433	73	87	50	643	206	36	9	3	254
% delivers assisted by	18	31	44	70	27	20	24	68	50	23

trained person										
Contact with PHC/SC worker within two months of delivery	15	18	15	20	15	10	11	10	10	10
Estimated no. of women delivered in last two years ('000s)	429	72	86	50	637	204	36	9	3	252
B. Children										
Immunized fully	26	40	52	67	34	17	24	39	100	20
No Immunization	38	26	7	6	30	50	44	35	-	48

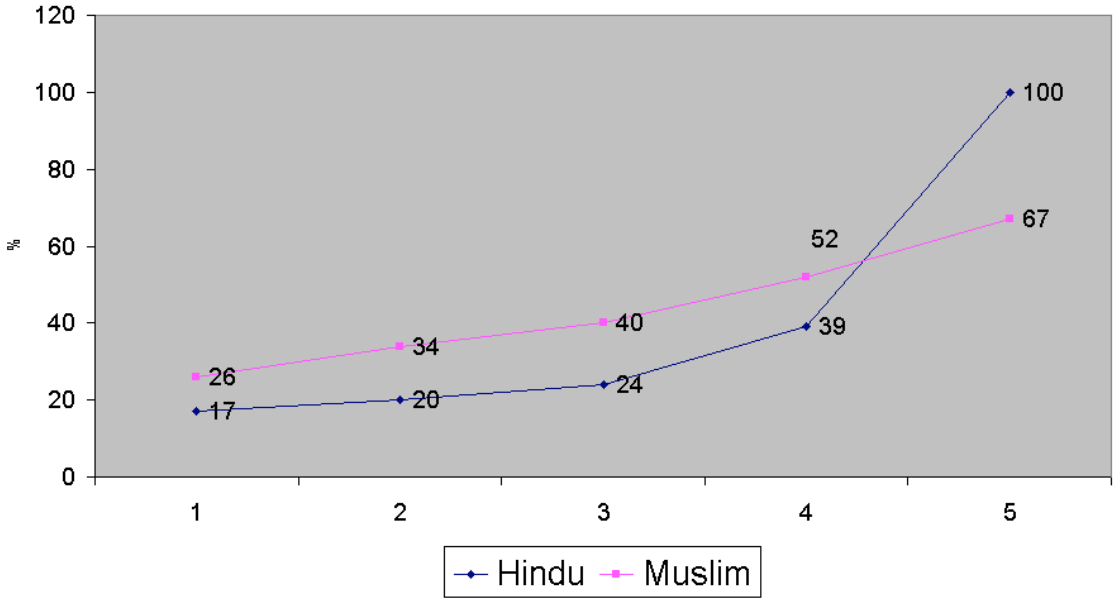
The study thus shows that though utilization of pre and post natal care was poor in both the communities, Hindu women were slightly better served than Muslim women.

Immunization status of children 12-23 months

(Figure 5) shows the status of children aged 12-23 months, the age by which they should be fully vaccinated. Complete immunization coverage of children was only 20 per cent among Muslims as against 34 per cent among Hindus. The percentage of children who had not received any vaccine was also higher (48 per cent) among Muslim than Hindu children (30 per cent). Except for BCG and the first dose of polio and DPT vaccines received by 37 to 48 per cent of Muslim children, all the other doses of all vaccines were received by less than a third of the Muslim children. As against this, 57 to 65 per cent of Hindu children had received BCG and the first dose of polio and DPT vaccines and 40 to 50 per cent had received higher order does of these vaccines (Table 11, Panel B).

The mother's educational level had a definite influence on the completion of the immunization schedule of the children both among Hindu and Muslim women. For instance, only 17 per cent of children of illiterate Muslim mothers had received complete immunization as compared to 39 per cent of those whose mothers had attained Matriculation. Among Hindus, the corresponding percentages were 26 and 67 per cent. As Figure 5 illustrates, even after controlling for mother's education, the immunization status of Muslim children remained consistently lower than that of Hindu children.

Fig. 5: Complete immunization coverage of children (12-30 months) by religion



Further, as Table 11, Panel B shows, as many as 50 per cent and 38 per cent of Muslim and Hindu children of illiterate mothers respectively had not received even a single dose of vaccine whereas all the children of mothers with higher education had received at Least one dose. The number of children who had not been immunized at all decreased to 6 per cent among Hindus and zero among Muslims with an increase in the educational level of the mother.

Discussion

The findings of the study thus indicate that as commonly believed, Muslims have a relatively higher fertility than Hindus. At the end of their reproductive age, on an average, Muslim couples have one more child than Hindus. This could be because of various socio-cultural factors: Muslim women have poorer access to information than their Hindu counterparts; their traditional values do not allow them to discuss their reproductive goals with their husbands and seek their cooperation to achieve their desired family size which is invariably smaller than the finally achieved family size. Moreover, a substantial proportion of Muslim males disapprove of family planning, hence their waves, are not able to use any contraception inspite of not wanting any more children. Their limited knowledge about the existing health and family planning facilities coupled with restrictions on free movement outside the home do not allow them to avail of even MCH care. The present study supports this observation as a much lower proportion of

Muslim women as compared to Hindu women had received antenatal care and only a small proportion of children were protected against infectious diseases.

What is shaking is that inspite of controlling for education, many of the observed differentials among the two religious groups, both in terms of fertility and contraceptive use on the one hand and utilization of MCH services on the other continued to persist though the gap reduced with the increase in the educational level of the women. One of the possible reasons for this relatively high fertility and low level of contraception among Muslims could be community pressure; because of a feeling of insecurity, they try to reside in dusters where the majority are still illiterate, poor and tradition-bound. In such residential concentrations, for small proportions of relatively young men and women, who have received some education, it is not easy to bring about rapid changes in lifestyle. Because of the community influence, they continue to carry their traditional values and this is well reflected in the disapproval of contraception by 23 per cent of the males (as against 6 per cent among Hindus). In such localities, the segregation of women and restrictions on their mobility outside the home is much greater than in localities in which people from different communities reside.

All this reduces access to information, new ideas and utilization of available services including prenatal care and immunization of children. To bring about any major social change among Muslims who live in such concentrated and often segregated localities, a practice which helps in breeding a culture of poverty, will be not only a slow process but also difficult.

The limited impact of education on their reproductive behavior perhaps could also be explained in terms of the quality of education they receive and the social and educational environment of the institutions where they go for schooling. Because of poverty and backwardness, Muslim couples are unable to send their children to better centers of learning as they are expensive and difficult to get admission in. As a result, they often end up 'm schools or madrasas run by Muslim Trusts or declared as minority institutions. Though such institutions get some grants from the Government, their overall infrastructural facilities including the buildings, seating arrangement, play ground and laboratory facilities, quality of teachers and the student-teacher ratio are far poorer than in other public and private educational institutions. The products of these Muslim institutions, in their orientation, learning and overall personality development are quite different from the majority of those coming out from institutions/schools run by the government and particularly by private agencies. The overall environment of these institutions helps in the continuation of their traditional values, and thus, retards the process of social change among the Muslim youth. However, it is also important to underline the fact that in the absence of other viable alternatives, these institutions provide at least some

opportunity for schooling; if they did not exist, the chances of these children getting 'education' would have been further -reduced. In order that these centers of learning become a source of social change and orient Muslim youth towards a modem way of life, closer to the mainstream of the country, they need special attention, both in improving their infrastructural facilities and quality of education.

Discussions with various health and family planning providers also indicated that they feel insecure to visit localities predominated by Muslims. Further probing revealed that more often than not, these feelings are based on their perceptions of not being accepted in the community rather than on actual experience. Similar observations have been reported in other studies. Therefore, program mangers have to plan special strategies that motivational and educational campaigns do not leave these localities unserved. Involving local community members both for motivational work as well as for providing services could be one possible intervention initiative, which could be seriously considered. Examples of some such initiatives could include community based distribution programs, increasing contraceptive outlets through social marketing in Muslim localities, involvement of local health practitioners in the provision of family planning services, using NGOs run by Muslim community members for advocacy and for launching educational campaigns and so on.

The issues are thus much broader and Muslim fertility or their acceptance of family planning cannot be discussed in isolation. They need special programs both for educational and economical upliftment on the one hand and confidence that they are safe and secure even in localities which are not predominantly Muslim. Similarly, innovative approaches have to be planned, tested and implemented to ensure their access to information, contraceptive methods and reproductive health services. Unless the Muslim population is properly segmented, their needs are assessed and appropriate educational packages and family welfare services planned, the decline in Muslim fertility will be limited and a slow process. The earlier this is realized by program managers, the better it will be for the country as well as for the Muslims themselves.

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