Millennium Development Goals: Status of Muslims in India

Shaila Parveen

Abstract

The Millennium Development Goals (MDGs) are a set of commitments made by governments at the 2000 United Nations (UN) Millennium Summit. The collective aim is to use these goals as the frame work for national and international development activities to 2015. The MDGs consist of 8 goals, 21 targets and 60 indicators. The key targets include: the reduction by half of the number of people living in extreme poverty(i.e. on less than US $1 per day); universal access primary education, including for girls; reduction by three-quarters of maternal mortality and by two-thirds of under-5 child mortality; a reverse in the spread of HIV/AIDS and malaria; a reduction by half of the number of people without access to safe water and sanitation; and integration of sustainable development principles in country programmes The pervasiveness of caste, ethnic and religion based social exclusion in India has left specific sections of Indian population suffering from chronic poverty, illiteracy, ill-health, and higher mortality rates. The impoverished conditions of the SCs, STs and Muslims – who together constitute more than one-third of India's population – will undermine the chances of India meeting its MDG targets. In this paper the performance of Muslim communities against the targets identified in the MDGs are assessed .The Report on Social Economic and Educational Status of the Muslim Community in India, which was launched by the Prime Minister's High-level Committee, acknowledged that the Muslim community makes up a relatively large portion of the population in extremely deprived and impoverish States of India. Hence, there is a need for specific policy and programme interventions that target the

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Muslim community to accelerate their progress towards eradication of poverty and the achievement of MDGs.

Key Words: *Minorities, Millennium Development Goals, Poverty, Hunger*

The Millennium Development Goals (MDGs) are a set of commitments made by governments at the 2000 United Nations (UN) Millennium Summit. The collective aim is to use these goals as the frame work for national and international development activities to 2015. The MDGs consist of 8 goals, 21 targets and 60 indicators. The key targets include: the reduction by half of the number of people living in extreme poverty (i.e. on less than US $1 per day); universal access primary education, including for girls; reduction by three-quarters of maternal mortality and by two-thirds of under-5 child mortality; a reverse in the spread of HIV/AIDS and malaria; a reduction by half of the number of people without access to safe water and sanitation; and integration of sustainable development principles in country programmes. Overarching these targets is Goal 8, namely to 'develop a global partnership for development that aims to reform the international trade and financial system'. Donor countries report on their contribution towards the MDGs through international development cooperation, while countries in receipt of development assistance report on their domestic progress in fulfilling the MDGs in periodic MDG Country Reports. The adoption of the MDGs implied that henceforth, individual governments and the international community would be accountable in promoting human well-being. With the deadline set at 2015, the MDGs also sought to ensure a time-bound accelerated pace of development in the targeted areas of immediate attention. A decade later, a review report of the United Nations noted with satisfaction the catalytic role that the MDGs had played in reducing national poverty in many of the developing economies of the world (Govt. of India 2011). Given India's massive share of the world's poorest population, the achievement of the MDGs will largely depend on India's progress in poverty reduction. In India the concentration of poverty is in a particular region, northern and eastern states, social groups such as NT/DNTs, STs, SCs and Muslim community and among them women and children from these social groups (Tanweer Fazala 2013).

The Report on Social Economic and Educational Status of the Muslim Community in India, which was launched by the Prime Minister's High-level Committee, acknowledged that the Muslim community makes up a relatively large portion of the population in extremely deprived and impoverish States of India. Hence, there is a need for specific policy and programme interventions that target the Muslim community to accelerate their progress towards eradication of poverty and the achievement of MDGs. This paper is an attempt to raise public awareness of the MDGs. Essentially, it provides an alternative and independent civil society perspective on the status of MDGs and the Muslim population, who continue to live under extreme poverty and face a number of challenges to attain the MDGs. The paper draws a clear connection between poverty and social discrimination and exclusion. Through community based and people's organizations, the Muslim community can raise their collective voices to call for the government's commitments to the Millennium Declaration signed by the Government of India in September 2000 to achieve the MDGs, has been criticized for ignoring the specific vulnerabilities those minorities are faced with – discrimination, susceptibility to majoritarian violence and conditions of powerlessness. It is argued that by failing to make any specific mention of minorities in any of the eight MDGs, 18 targets and48indicators, the stated goals have remained distant to them. Furthermore, the MDGs do not emphasize on the collection of group-specific disaggregated data to measure progress towards the goals, as a result of which, there is no compelling mechanism to measure the progress of marginalized minorities and performance of signature countries in this regard (C. Lennox, 2010). In 2007, a study presented by the UN Independent Expert on Minority Issues noted that of the 50MDG Country Reports reviewed, merely 19 discussed minorities, though perfunctorily: only four reports specifically mentioned religious minorities, and of these, only two discussed inequalities experienced by religious minorities (Govt. of India 2012). The MDGs fail to acknowledge that religious minorities face cumulative deprivation, which impacts their material life such as access to welfare schemes, modern education, employment opportunities and political offices. It is argue that prevailing conditions of injustice, insecurity and social exclusion against religious minorities might adversely affect a country's capability to meet MDG goals (P.N.Bhat, 2005).

The pervasiveness of caste, ethnic and religion based social exclusion in India has left specific sections of Indian population suffering from chronic poverty, illiteracy, ill-health, and higher mortality rates. The impoverished conditions of the SCs, STs and Muslims – who together constitute more than one-third of India's population – will undermine the chances of

India meeting its MDG targets. In this paper the performance of Muslim communities against the targets identified in the MDGs are assessed.

Goal 1: Eradicate extreme Poverty and Hunger

The first set of MDGs aims to reduce extreme poverty by half in the period between 1990 and 2015. It also aims to bring down the share of population suffering from national hunger in the same period by 50 percent. Extreme poverty in this case is identified as the proportion of population living below a dollar a day. The indicators for measuring success are: the percentage of population earning below a dollar a day (later increased to 1.25 dollar a day); the poverty gap ratio (i.e. the difference between the poverty line and the actual income or consumption of the poor); and the share of the poorest quintile in national consumption. Based on the Tendulkar Committee Recommendations, the Planning Commission of India estimated the all-India poverty ratio at 29.8 per cent for the year 2009-10. It noted a decline of nearly 7.3 from 37.2 per cent in 2004-05. In the same period the rural poverty declined by eight percentage points from 41.8 to 33.8 per cent and urban poverty from 25.7 to 20.9 per cent. Compare this with the status of religious communities; Muslims reported the highest poverty ratio in urban areas (33.9 per cent). In rural areas, the poverty ratio for Muslims stood at 36.2 per cent. It was disproportionately high in the states of Assam (53.6 per cent), Uttar Pradesh (44.4 per cent), West Bengal (34.4 per cent) and Gujarat (31.4 percent). The Sachar Committee, 2006, using the official National Planning Commission methodology (poverty ratio with 365 days reference period) estimated Muslims (31 per cent) as closely following the SCs/STs (35per cent) in reporting incidence of poverty in the year 2004-05. Muslim poverty was more pronounced in urban areas, where nearly half of their population (44 per cent) counted amongst the poorest compared to the national average of 29 per cent. In Uttar Pradesh, Bihar, Assam, West Bengal and Kerala, the states where most of the Indian Muslims live, they along with the SCs/STs constituted the poorest sections of the population. In the rural areas of the country, where the Muslims (33 per cent) appear to be in better state, they continue to lag behind the national average poverty ratio (28 per cent). It is also noteworthy that the rural-urban differential was highest for the Muslims (11 per cent points) compared to any other socio-economic group.

The goal of reducing extreme poverty by half as envisaged in the MDG seems unlikely in the case of Muslims. For instance, in the urban areas, this would require a decline to 23.5 per cent (taking in to account that Muslim urban poverty stood at 47 per cent in the base year 1993-94) by the year 2015. This would require decennial decline of at least 12 per cent points;

but Muslim urban poverty reduced by only 3 per cent points in the period 1993-94 to 2004-05 (44 per cent). In the rural areas, Muslims followed the national trend of recording a sharp decline in incidence of poverty during the same period, however maintaining the same pace in the following decade (2004-05 to 2015) would be daunting (See Appendix: Table1). Unlike in urban areas, where decline in Muslim poverty is the slowest, Muslims in rural areas do hold promises of faster economic recovery. A recent study (using the 1993 official poverty line) suggests a much faster rate of poverty decline (7.6 per cent per annum) among Muslims in the period 2004-05 to 2009-10.7 In urban areas, on the other hand, poverty decline has been the slowest among Muslims (3.1 per cent per annum).Despite a relatively higher decline in rural areas, at the end of the year 2009-10, Muslims counted among the poorest (25.1 per cent) after SCs (30.3) and STs (32.5) while the national average remained at 21.6.8The monthly per capita expenditure (MPCE) computed on the basis of National Sample Survey (NSS) 2009-10 returns Muslims and the SCs/STs amongst the poorest. In the rural areas, 26.2 per cent of all Muslims fall in the poorest quintile, whereas 25.6 percent of the non-Muslim OBCs and 34.2 of the SCs/STs fall in the same bracket of consumption expenditure. Muslims count amongst the poorest with 40.7 per cent of them slightly better than the SCs/STs (at 40 per cent) who occupy the poorest slot.

Goal 2: Achieve universal primary education

This is to be achieved by ensuring that by 2015 children, boys and girls, alike will be able to complete a full course of primary school. Net enrolment ratio in primary education, proportion of pupil starting at grade I who reach grade II, and literacy rate of 15-24 age group are the indicators proposed to measure success in achieving the set goals. The Census 2001 figures returned Muslims as least literates among all religious communities. The recent NSSO 2007-08 educations round further confirmed a high proportion of Muslims as illiterates. The proportion of illiterates among Muslim males is at par with the SCs/STs and higher than the OBCs. Muslim women (47.3 per cent) count amongst the most illiterate segments of the society, their status comparable only with SC/ST (53.2) women (See Appendix: Table 2). In terms of levels of educational attainment, nearly one-fourth (23.1 per cent) of all Muslim males and one- fifth (20.1) of females were merely literate. A substantial proportion of Muslims—male (18 per cent) and female (15.4) had attained only primary education. Meanwhile at the higher levels of education, upper primary and above, Muslim proportion was significantly lower than that among all other SRCs including SCs, STs and OBCs.

The NSS (2007-08) also provides data on current attendance for the age group between 5-29 years. A significantly large section of the Muslims (16.5 per cent males and 24.7 females) never attended any educational institution. Nearly one-third of them (34.5 per cent males and 31.9 females) dropped-out after having enrolled in one of them. Only 47.7 per cent of Muslim males and 42.1 per cent of females – lower than all other SRCs – were enrolled in primary level of educations and above. The educational deprivation of Muslims is further compounded by the fact that even in the current school going age group (6-14 year),enrolment of Muslims remains poor as more than one-fifth (20.7 per cent) were estimated to be out of school. The All India Survey of Out-of-School Children found a very high proportion – 7.67 per cent of Muslim children in the age group 6-13 reporting out of school. The corresponding figure for SCs, STs and OBCs was 5.96, 5.60 and 2.67 per cent respectively. (See Appendix: Table 3)

Goal 3: Promote Gender Equality and Empowerment

The MDGs rest on education as the major tool to bring about gender equality. It therefore emphasizes on eliminating gender disparity in primary and secondary education, and at all subsequent levels of education. Correspondingly the ratio of literate women to men in the 15-24 age groups is one of the indicators for measuring success in instituting gender equality. Apart from educational data, the share of women in Wage Employment and proportion of seats held by women in the national legislature are other measurements proposed in the MDG scheme. In India, across all social groups, gender disparity at various levels of education appears insurmountable. According to the 2011 Census, 65.5 per cent females and 82.1 per cent of males—a gap of nearly 17 percent points—were considered as literates. Due to an improvement in female literacy, the gender gap in literacy closed by nearly 5 per cent points in the period 1991-2001. However in the ensuing decade of 2001-2011, the gender gap reduced by only a further 3 per cent points indicating a slowing down of the process. Going by crude literacy figures, Muslim women (50.1 per cent, 2001 Census) closely followed the national average (53.7 per cent female literacy), though they lagged behind Muslim men by a margin of 17.5 percent. In the absence of comparative figures from the 1991 and 2011 Census exercises, estimation based on general progress in female literacy does not suggest a healthy trend.

It is observed that Muslim girls, both in urban and rural areas, have a very high proportion of those who never attended school or any educational institution. The female bias

in the data on 'never attended' is true for most other SRCs. However, the gender gap is considerable amongst Muslims at 8 per cent points.

Nonetheless, having entered an educational institution once, the probability of dropping-out was more among Muslim boys when compared with girls. The drop-out rate was a significant 4 per cent points lower among Muslim girls. Variation across caste and residence was minuscule in this regard. Further, the difference between male and female enrolment in primary education (or above) was also found to be low among Muslims (5 per cent points) when compared with the all-India average (9 per cent points in rural and 2.3 per cent points in urban areas). This highlights the desire among Muslim girls to take to education. The task however is to get them enrolled in schools first. This is particularly true among all SRCs; Muslims (both boys and girls) have the highest figures for having never attended school (higher than SCs and STs). They also have the least numbers for those enrolled in primary or above level. Going by the current figures, therefore, it is unlikely that gender disparity at various levels of education will be mitigated by the target year 2015.

Although gender disparity persists among Muslims in so far as educational indicators are concerned; Muslims do return a better figure on other accepted indicators of the status of women. Census 2001 indicates that a majority of Muslim girls are married only after attaining 18 years (56.9 per cent), which is higher than the national average (56.5 per cent) and that the incidence of child marriages (below 10years) is minimal (2.2 per cent). Then also, the Muslim sex ratio (936) is higher than the national average (933), and among religious communities they fare better than the majority Hindus as well as the Sikhs. They however lag behind the Christians (1,009), Buddhists (953), Jains (940) and others (992). A comparison with 1991 figures indicates that barring Christians, and to some extent Sikhs, it is only among Muslims that the sex ratio has shown signs of progress. (See Appendix: Table 4) A look at the child sex ratio (CSR) further confirms this trend. While the all-India pattern suggests a declining child sex ratio (927 in 2001), the trend is reversed in the case of Muslims who report a further improvement in the CSR (950).9 The decline in CSR is usually attributed to the practice of sex selection and preference for male children at birth. Given the background, does a higher CSR among Muslims indicate a better position of Muslim women, in contrast with those from other religions?

Goal 4: Reduce the under-five mortality

Reduce the under-five mortality rate by two-thirds between 1990 and 2015 Under-five mortality (U5MR), infant mortality rates (IMR), and immunization rates are also indicators

that measure success in reaching MDG targets by 2015.The findings of the Sachar Committee, based on various surveys and estimates, show infant (under one year) and childhood mortality (under-five years) to be lower than the average among the Muslims of India.

The 1981 and 1991 Census (indirect) estimates, and the 1992-93 and 1998-99 National Family Health Survey (NFHS)-1 and 2 estimates show this consistently.10 The NFHS-3 (2005-06) finding confirm the continuation of lower infant and child mortality among the Muslims of India compared to the national average. It is argued that lower than average child mortality among Muslims is partly on account of their higher urbanisation. Strictly speaking, Muslims – both in urban and rural areas – have lower mortality (both infant and under five) than the national average in the 1992-93 as well as 1998-99 surveys. In the NFHS-3, however, mortality of Muslim children in rural areas showed a similar frequency as the rest of the population which indicate that the decline in child mortality was slowly being arrested in the case of Muslims. (See Appendix: Table 5, 6)

As far as meeting the MDG goal is concerned, taking the 1992-93 survey (IMR 86 and U5MR 119) as the base year, India needs to reach a two-thirds reduction in infant and under-five mortality by the 2015 survey (IMR of 29.6 and U5MR of 39.6). Going by the survey data of 2005-06, India reported IMR of 57 and U5MR of 74.3. Therefore in the 12-year intervening period, IMR declined by 33.7 per cent and U5MR by 37.8 per cent. During the same period, the IMR and U5MRof Muslim children declined from 77 and 106 in 1992-93 to 52.4and 70.0 in 2005-06, a decline of 31.9 per cent and 33.9 per cent respectively. Going by the current pace of decline in IMR and U5MR, it is unlikely that India will be able to meet the MDG goal of 29.6 IMR and 39.6 U5MR by 2015. Even Muslims, who register a below average child mortality are unlikely to reach the MDG target. A concerted and massive expansion in health facilities, improvement in child nutrition, awareness campaigns and an enhanced capability to combat infectious diseases would be required if India were to meet the MDG targets by 2015.

The immunization of Muslim children remains weak among all SRCs. The NFHS-3 discovered only 49.6 percent of the Muslim children in the age group of 12-23 months having been vaccinated of measles as compared to 58.8 per cent being the national average. Vaccination of Muslim children for all basic vaccines was also reportedly poor with only 36.3 per cent of them having benefitted as against 43.5 per cent being the national average. (See Appendix: Table 5)

The reason could be poor popularization of the immunization drives among the Muslims. Cultural impediments do not seem to play much role here as vaccination against Polio, a priority scheme of the World Health Organization (WHO) and Government of India, has an overwhelming response from the Muslims, no different from other segments of the population.

Goal 5: Improve maternal health

The target includes reducing by three-quarters, the maternal mortality ratio (MMR) in the period between 1990 and 2015. The indicators include MMR and proportion of births attended by skilled professionals.

The MMR is a measure of the number of women aged 15-49 years dying from maternal causes per 100,000 live births. While various methods of estimation of MMR have been deployed by scholars, there is unanimity on a very high ratio of maternal deaths in India. According to one estimate, MMR stood at 398 in 1997-98, reduced to 327 in 1999-20019 and 301 in the period 2001-2003.13 The Sample Registration System (SRS)– India's main source of information on fertility and mortality indicators – reported a further drop in MMR to 212 in the years 2007-09.14 However, despite a noticeable decline, it is unlikely that India would be able to reach the targeted MMR of 109 deaths by the end of 2015. This is because the actual rate of progress in reduction of maternal mortality remains at 2.60 per cent per annum as against the required rate of progress of 4.69 per cent per annum. Although the SRS does not provide religion disaggregated MMR data, various surveys do indicate a lesser occurrence of maternal mortality amongst Muslim women. The Reproductive and Child Health Survey-2 indicated a slightly lower percentage of maternal deaths for Muslims.15 Of the 611 deaths reported, only 10 percent of them included Muslim women despite their share in the survey population being 12.2 per cent. The MMR among Muslims was the least at 384 while Hindus reported a much higher figure of 573.17 (See Appendix: Table 8).

A lower rate of maternity-related deaths among Muslims is difficult to explain. The NFHS-3 (2005-06) data on ante-natal care reveals substantial variation by religion of the likelihood of women having received ante-natal care (See Appendix: Table 9). Muslim women rather lagged behind other women in receiving ante-natal care from a recognized health care provider. Compared to 73 per cent of Muslim women, 78 per cent of Hindu and 90 per cent of Sikh women received ante-natal care. Christians and Jains outscored all others in receiving care from a qualified doctor. Visit to the doctor was found to be least among Muslims (48 per cent) when compared with women of other communities.

Thus, more than a quarter of Muslim women, during the course of their pregnancy, have no access to any ante-natal care. In fact the likelihood of having received ante-natal care at all, as well as ante-natal care from a doctor, increases sharply with the household's wealth index. Among mothers in households with the lowest wealth quintile, 59 per cent received ante-natal care of which only 23 percent received it from a doctor. By contrast, among mothers in households in the highest wealth quintile, 97 per cent received antenatal care of which 86 per cent received it from doctors.18 More than half of all births take place in a woman's own home and nearly 9 per cent at her parents'.. Births to Muslim mothers (33 per cent) are least likely to take place in a health facility.

Goal 6: Combat HIV/AIDS, Malaria and other Diseases

The MDG envisages halting the spread of preventable diseases such as HIV-AIDS, malaria and tuberculosis and reversing the trend by the year 2015 – crucial to the general health of the population. At stake are HIV prevalence among young pregnant women, the rate of condom use in the contraceptive prevalence rate (CPR), prevalence of deaths associated with malaria and tuberculosis.

6.1 AIDS

The NFHS-3 collected information regarding the awareness of HIV-AIDS among the men and women in the age group 15-49 years. It noted with satisfaction that knowledge of the disease was more widespread in the survey year (2005-06) as compared to NFHS-2 (1998-99). However, awareness of the disease was least among the Muslims of India, men and women including. Only 55 per cent of the Muslim women interviewed had heard of the disease compared to 61 per cent of Hindu, 85 per cent Christian, 76 per cent of Sikh, 84 per cent Buddhist and 94 per cent Jain women. The awareness was considerably higher among Muslim men with 82.2 per cent of them confirming knowledge of it. However, when it came to knowledge of methods of prevention, the numbers fell down drastically. Only four out of 10 women and seven out of 10 men knew of the prevention methods. (See Appendix: Table 8 ,9)

According to the National AIDS Control Organization's Annual Report (2009-10), the spread of HIV in India displays a stable trend. The adult HIV prevalence in the year 2008 stood at 0.29 per cent which was much lower than 0.45 per cent in the year 2002. The prevalence of the disease among pregnant women in the age group 15-24 years also showed a declining trend. HIV prevalence was found low for all social groups in India. The NFHS-3

data revealed a very negligible frequency of occurrence of HIV among Muslim women at 0.06 per cent when compared with the average of 0.22. Muslim men too reported a very low prevalence of the disease at 0.22 as against the average of 0.36. A growing need and adoption of family planning techniques is observable across SRCs in India. The CPR for currently married women in India rose to 56 per cent in the period 2005-06, up from 48 per cent in 1998-99. Even as the CPR has increased, female sterilization has steadily declined from 71 per cent reported by NFHS-2 to 37 per cent during NFHS-3. Contraceptive use among married women varies markedly by education, religion, caste, and wealth. Just over half of women with no education (52 per cent) use any method, compared with 62 per cent of women with 12 or more years of education.). Muslims displayed the lowest CPR of 45.7 per cent, however when compared with the NFHS-2 (37 percent), they do demonstrate a growing adoption of contraceptive techniques. (See Appendix: Table 11,12,13,14)

6.2 Malaria

Among infectious diseases, malaria is one of the big causes of mortality among children. India achieved spectacular gains in malaria control during the 'Eradication Era' in the 1950s till the mid-1960s when reported cases were reduced to 64,000. However, since the 1990s, there has been a rise in the reported cases of the disease with figures ranging from 1.5 to 2.6 million per annum. Conservative estimates suggest 666-1,000 deaths per annum caused by malaria. Since it is a major cause of death in infancy and childhood in many developing countries, the so-called presumptive treatment of fever with Anti-malarial medication is advocated in many countries where malaria is endemic (Tanweer Fazal, 2013). The NFHS-3 (2005-06) data on malaria treatment found a very small proportion of children (below five years) suffering from fever being administered anti-malarial medication (8 per cent). The treatment through anti-malarial drug was found to be least among Muslims (4.9 per cent) and highest among Buddhists (19.8 per cent).

Goal 7: Ensure Environmental Sustainability

A dismal pattern is produced at the level of housing marked by high and growing ghettoization and unemployment. Poor Muslims live in hovels without electricity. Only 19 percent have piped water supply. The poor quality of drinking water and sanitation in Muslim localities is a grave concern. Absence of proper civic amenities and infrastructure facilities is marked. Poor roads and lack of proper transport, sanitation, water, electricity and public health facilities pervade Muslim localities. 60.2 percent of Muslims do not have any land in

rural areas compared to the National average of 43 percent. Only 2.1 percent Muslim farmers have tractors. Just 1 percent own hand pumps. No *anganwadis,* ration shops and government schools are found in Muslim localities. Low participation of Muslims in local self government bodies resulted in development benefits failing to reach Muslims. There is clear and significant inverse association between the proportion of the Muslim population and the availability of educational infrastructure in small villages. Villages with a concentration of Muslims are not well served with *pucca* approach roads and local bus stops. The concentration of Muslims in States lacking infrastructure facilities implies that a large Proportion of the community is without access to basic services. In both urban and rural areas, the proportion of Muslim households living in *pucca* house is lower than the total population. Muslims are better off compared to OBCs and SC/STs though the proportion of Muslims in *pucca* houses is lower than those of Hindus in both areas. Overall the access of Muslims to toilet facilities is low but better than that of both SC/STs and OBCs. Almost half of the Muslim households in India lack access to toilets. Access is low but better than those of SC/ STs and OBCs probably because of greater concern among Muslims for privacy especially among women. The absence of facilities among Muslims in villages is summarized in Table 19.Muslims, like SC/STs, live in large numbers in villages that are least electrified. They have the least access to piped potable water. Compared to all other groups, Muslim households have reported poor use of clean fuel. Disparity is wide in urban areas. The non-use of modern fuels such as LPG, electricity or kerosene for cooking increases as the share of the Muslim population and village size increases. Muslim population seems to be close to average in terms of housing structure and better placed in terms of toilet facilities but ranks poorly in water availability, electrification and cooking fuel facilities. (See Appendix: Table 15)

Conclusion

An audit of the performance of the Indian Muslim community in terms of meeting MDG goals, does not present a bright scenario. While there is a general progress in India in terms of poverty decline, improved enrolment, decrease in gender gap in literacy, a noticeable decline in MMR, infant and child mortality rate, stability in terms of AIDS prevalence, there is much left to be desired in so far as meeting MDG targets by the year 2015 is concerned. From the perspective India's of socially excluded communities, particularly Muslims, meeting MDG goals remains a distant dream. This is true even in the case of variables in which Muslims for a variety of reasons have returned above average figures such as maternal, infant and child mortality. Lack of a group specific approach, could be the plausible reason for

dismal performance of the excluded group as well as the general drag in the overall progress.MDG Country Reports urgently need to be revised to incorporate discussion of the legal framework for protection of religious minorities and national measures to ensure that religious minorities are benefiting equally from progress towards the MDGs. The silence on these points in MDG Country Reports to date is chronic. The collection of disaggregated data for religious (and other) minorities needs to be prioritized by international and national development actors alike. Opportunities for religious minority actors to influence and implement MDG-related initiatives should be implemented.

There is great scope to use the minority rights framework to improve the effectiveness of MDG policy interventions. This is not only good practice and fiscally responsible but is also a fulfilment of state obligations under international human rights and minority rights standards. If religious minorities are excluded from the MDGs, not only will the purpose of the goals be undermined, but the conditions for their long-term sustainability will seriously be in doubt. Investing in the human capital within religious minority communities and ending persecution and discrimination on the basis of religion will contribute to better development for all.

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Appendix Tables

Table 1: Poverty Ratio By Social Groups And Residence: all India Selected Status

	All India			All Hindus			SC/STs			Muslims		
Urban poverty	2004-05	1993-94	1987-88	2004-05	1993-94	1987-88	2004-05	1993-94	1987-88	2004-05	1993-94	1987-88
All India	29	33	38	27	31	36	46	51	55	44	47	53
Uttar Pradesh	32	35	45	27	31	33	46	57	49	43	46	58
Bihar	42	34	53	38	31	52	70	52	62	57	46	57
West Bengal	24	23	33	21	20	29	41	37	48	44	41	57
Assam	7	8	17	5	6	17	7	14	22	13	22	21
Kerala	23	24	45	24	25	44	41	32	61	31	27	56
Rural poverty												
All India	28	37	39	28	36	40	41	50	54	33	45	43
Uttar Pradesh	34	42	45	33	43	45	45	59	60	37	43	47
Bihar	42	58	58	41	56	57	64	71	71	52	67	62
West Bengal	28	41	46	24	38	45	31	49	55	36	48	47
Assam	23	45	35	16	40	32	18	42	36	38	55	51
Kerala	13	25	25	13	24	24	24	37	36	17	32	37

Source: Sachar Committee Report, 2006

Table 2: Distribution of Persons by MPCE Quintiles

Rural- MPCE						
Group	1	2	3	4	5	Total
ST/SC	34.2	23.6	18.8	14.3	9.1	100.0
OBC	23.0	21.9	20.9	19.5	14.8	100.0
Other non-Muslims	10.6	16.5	20.3	22.9	29.7	100.0
OBC Muslims	25.6	26.0	19.3	16.3	12.8	100.0
Other Muslims	26.4	26.4	19.9	17.1	10.2	100.0
All Muslims	26.2	26.3	19.5	16.8	11.2	100.0
Total	24.8	22.0	20.0	18.1	15.2	100.0
Urban- MPCE						
Group	1	2	3	4	5	Total
ST/SC	40.0	24.6	16.9	11.1	7.5	100.0
OBC	28.7	25.6	20.6	16.0	9.0	100.0
Other Non-Muslims	12.3	16.2	22.2	23.9	25.4	100.0
OBC Muslims	46.4	25.3	16.0	7.4	4.9	100.0
Other Muslims	35.6	28.5	17.4	12.5	6.2	100.0
All Muslims	40.7	27.0	16.7	10.1	5.5	100.0
Total	26.8	22.4	19.9	17.0	14.0	100.0

Source: NSSO 2009-10

Table 3: Educational Attainment of Socio-Religious Categories

All Males							
Education level	ST/SC	OBC	Other non-Muslims	OBC Muslims	Other Muslims	All Muslims	Total
Not literate	35.6	26.9	15.9	37.6	32.2	34.7	27.9
Below primary	21.6	20.0	15.1	22.5	23.6	23.1	19.8
Primary	18.0	17.5	15.0	16.7	19.1	18.0	17.1
Upper primary/middle	12.8	15.7	15.6	11.6	11.3	11.4	14.3
Secondary/Higher secondary	9.3	15.3	24.1	9.4	10.6	10.0	14.9
More than Higher secondary	2.7	4.6	14.3	2.2	3.2	2.8	6.0
All Females							
Education level	ST/SC	OBC	Other non-Muslims	OBC Muslims	Other Muslims	All Muslims	Total
Not literate	53.2	45.1	26.9	51.7	43.5	47.3	43.7
Below primary	18.4	17.7	14.7	19.5	20.5	20.0	17.5
Primary	14.1	15.2	16.4	12.1	18.1	15.4	15.2
Upper primary/Middle	7.9	10.7	13.7	8.8	8.7	8.7	10.3
Secondary/Higher secondary	5.4	9.0	18.8	6.6	7.5	7.1	9.9
More than Higher secondary	1.0	2.3	9.6	1.2	1.7	1.5	3.4

Source: NSSO 2007-08

Table 4: Current Education Statuses

All males					
SRC	Never attended	Dropped out	Currently attending non-formal (including pre-primary)	Primary & above	Total
ST/SC	13.5	34.5	0.9	51.1	100.0
OBC	8.3	34.9	0.9	55.9	100.0
Other non-Muslims	3.5	36.1	1.2	59.1	100.0
OBC Muslims	20.1	31.4	1.4	47.1	100.0
Other Muslims	13.1	37.5	1.1	48.4	100.0
All Muslims	16.5	34.5	1.2	47.7	100.0
Total	9.9	35.0	1.0	54.1	100.0
All Females					
group	Never attended	Dropped out	Currently attending non-formal (including pre-primary)	Primary & above	Total
ST/SC	24.3	30.7	0.9	44.1	100.0
OBC	17.5	33.1	0.8	48.7	100.0
Other non-Muslims	6.4	39.1	0.9	53.6	100.0
OBC Muslims	30.7	27.3	1.3	40.7	100.0
Other Muslims	19.5	35.9	1.2	43.5	100.0
All Muslims	24.7	31.9	1.3	42.1	100.0
Total	18.2	33.4	0.9	47.5	100.0

Source: NSSO 2007-08

Table 5: Vaccination among Muslim Children, NFHS-III, 2005-2006

% of children aged 12–23 months with specific vaccination,2005–06											
	DPT			Polio							
BCG	1	2	3	At birth	1	2	3	Measles	Basic vaccines	No vaccine	No. of children
69.7	67	58.3	47.8	45	90	84.5	77	49.6	36.3	7.3	1,814

Table 6: Early Childhood Mortality among Muslim Children NFHS, III, 2005-06

Neonatal	Post neonatal	Infant	Child	Under five
34.1	18.2	52.4	18.5	70.0

Table 7: Prevalence of Anemia in Muslim children

% of children age 6–59 months classified as having anemia,NFHS-III,2005–06				
Anemia status by hemoglobin level				
Mild	Moderate	Severe	Any Anemia	No. of women
38.3	15.1	1.3	54.7	15,340

Table 8: Total Fertility Rate (TFR) in India and among Muslims, NFHS-III, 2005-06

	TFR	Mean no. of children ever born to women age 40–49 years
Muslims	3.09	4.60
India	2.68	4.00

Table 9: Antenatal Care among Muslim Women, NFHS-III, 2005-06

% distribution of Muslim women with recent live birth by antenatal care									
Doctor	ANM/ nurse/ midwife/ LHV	Other health personnel	Dai/TBA	Anganwadi/ ICDS worker	Other	No one	Missing	Total	No.
48.2	21.3	2.2	0.7	0.5	0.2	26.8	0.1	100	6,486

Table 10: HIV Prevalence among Muslim, NFHS-III

Percentage HIV positive women and men age 15–49 who were tested					
Women		Men		Total	
% HIV+	No.	% HIV+	No.	%HIV+	No.
0.06	7,285	0.21	5,626	0.1	12,912

Table 11: Health Problems among Muslims NFHS-III

No. of women and men aged 15–49 per 100,000 with disorders, 2005–06							
No. of women per 100,000 with				No. of men per 100,000 with			
Diabetes	Asthma	Goitre	Total	Diabetes	Asthma	Goitre	Total
1,037	2,024	1,090	16,936	1,237	2,218	481	8,747

Table 12: Knowledge about AIDS

Source of knowledge about AIDS	Percentage
Radio	37.2
Television	75
Cinema	4.9
News Paper, Magazine	23.5
Poster, Hoarding	8.4
Health Worker	2.9
Adult Education Programme	0.7
Friend, Relative	30
School Teacher	1.1
Other Sources	3.1

Source: NFHS-II, 1998–99.

Table 13: Contraceptive Prevalence Rate NFHS-II 1998-99

(Percent of couples of Reproductive Age Practicing Contraception)		
	Group	
India State	Muslims	All
India	37	48
Andhra Pradesh	47	60
Assam	34	43
Bihar incl. Jharkhand	9	25
Gujarat	58	59
Haryana	-	64
Jammu & Kashmir	46	49
Karnataka	44	58
Kerala	48	64
Madhya Pradesh incl. Chhattisgarh	46	44
Maharashtra	49	61
Punjab	-	67
Rajasthan	25	40
Tamil Nadu	49	52
Uttar Pradesh incl. Uttarakhand	21	28
West Bengal	56	67

Source: PMHLC Report, 2006.

Table 14: Current use of Contraception among Muslim (modern method)

% distribution of currently married women by contraceptive method used, NFHS-III							
		Modern method					
Any method	Any Modern method	Female sterilization	Male sterilization	Pill	IUD	Injectibles	Condom/ Nirodh
45.7	36.4	21.3	0.6	5.7	1.8	0.3	6.8

Unmet need for family planning			Met need for family planning			Total demand for family planning		
For spacing	For limiting	Total	For spacing	For limiting	Total	For spacing	For limiting	Total
8.6	10.2	18.8	6.8	38.9	45.7	15.4	49.2	64.6

Table 16: Current use of Contraception among Muslim (traditional method)

% distribution of currently married women by contraceptive method used, NFHS-III					
	Traditional Method				
Any traditional method	Rhythm	Withdrawal	Folk Method	Not currently using	Number of women 100%
9.3	5.6	3.4	0.3	54.3	12,288

Table 17: Number of Villages without Basic Facilities, 2001

	Small (Less than 1000 Population)			Medium (1000–2000 Population)			Large (More than 2000 Population)		
	With Muslim Population Share of								
Facilities	< 9%	10–39%	40% +	< 9%	10–39%	40% +	< 9%	10–39%	40% +
All India									
Education	44,542	4,676	4,240	3,667	1,186	1,078	906	423	382
Medical	1,93,640	13,051	11,193	56,813	9,435	7,130	18,181	6,191	4,680
Post	1,68,088	11,670	11,013	43,838	7,959	7,111	11,194	4,398	4,448
Bus Stop	1,72,048	12,410	10,547	53,199	10,336	7,898	22,519	8,859	6,717
Approach Road	1,33,063	8,496	7,910	34,124	5,749	4,970	10,627	3,644	3,502
Total Vill.	2,42,549	16,525	13,840	1,03,175	15,648	11,149	68,537	18,895	11,763
% of All Population	87.7	6.8	5.5	23.2	2.6	74.2	26.7	3.3	70.0
% of Muslim Population	8.8	23.3	67.9	13.8	7.4	78.9	14.9	8.2	76.8

Source: PMHLC Report, 2006.

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