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Discrimination in Healthcare: Exploring the Impact of Institutional Communalism on Muslims in India[1]

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Discrimination in Healthcare: Exploring the Impact of Institutional Communalism on Muslims in India

Istikhar Ali

As we conscientiously address the growing issue of institutional communalism within educational institutions (Faisal 2023) and the deteriorating student–teacher relationships, we must not sideline the equally disconcerting matter of strained doctor–patient interaction (DeFrancisco 2015), especially regarding marginalised communities such as Muslims, Dalits, Tribals, etc., regardless of caste, class, or gender. The Sachar Committee (Government of India 2006) and Post-Sachar Committee report (Government of India 2014) highlighted that marginalised communities often face limited access to quality healthcare services and infrastructure, particularly in rural areas. These reports also noted that these communities experience poorer health outcomes compared to the national average (Government of India 2006b, 2014). While each of these aspects demands our unwavering attention and action, I would like to emphasise my expertise in addressing marginalisation and discrimination within the healthcare services, with a specific focus on the India community during the socio-political chaos in India.

Marginalisation acts as a significant barrier to accessing basic services, effectively excluding marginalised communities intentionally (Contractor and Jaitly 2018). This exclusion can be demoralising, discouraging their participation, and even denying them benefits to which they are entitled. According to trends in the National Family Health Survey (NFHS) report, Muslims are reported to be even more disadvantaged than Dalits in terms of health status. Similarly, areas

with a high concentration of Muslims, as per the Sachar Committee Report (SCR), face a lack of basic facilities and amenities, including poor healthcare facilities, which translates into poorer health status (Government of India 2006a).

In my research conducted between 2017 and 2020 in Uttar Pradesh (UP) and Delhi, I employed an ethnographic approach to thoroughly investigate the profound impact of discrimination within the healthcare services against Muslims. This qualitative research method involved engaging in case studies and conducting in-depth interviews to explore the lived experiences of Muslims. Through this research, I uncovered that discrimination extends beyond being a violation of human and civil rights; it significantly impacts overall health outcomes, particularly the mental health of Muslim populations subjected to it (Ali 2022).

This research venture delves deeply into the diverse lived experiences of individuals from various Muslim backgrounds, enabling for an in-depth examination of their interactions within healthcare services with providers and across institutional boundaries. By employing methodologies such as participant observations, comprehensive interviews, and immersive field notes, this ethnographic study seeks to unearth the multifaceted determinants behind discrimination, whether rooted in religious, cultural, or socioeconomic factors. I aim to extract valuable insights into the obstacles faced by Muslim individuals while seeking essential healthcare services by immersing myself in their daily lives and healthcare encounters.Consequently, this research not only illuminates the stark realities of discrimination in healthcare services (Khanday and Tanwar 2013) and institutional communalism (Singh 2015) but also lays the foundation for well-informed interventions and policy reform. These efforts are all geared towards fostering an environment of equitable and inclusive healthcare services for every member of the Muslim community.

In this noble pursuit, the objective is to further illuminate the matter by presenting three distinctive case studies, each offering a unique perspective on the multifaceted aspects and encounters of discrimination while accessing healthcare services. These narratives unveil the experiences of individuals within the community, namely Yusuf, Fatima, and Amir (names

changed to protect their identities), collectively illustrating the intricate nature of this pervasive problem.

Case Study 1: Yusuf's Struggle for Equal Healthcare

Yusuf, a 38-year-old small travel agent from UP, underwent the distressing experience of witnessing or perceiving discrimination and humiliation during his mother's treatment in a prominent public hospital in Varanasi and private hospitals in Allahabad (renamed Prayagraj) in eastern UP, India. His experiences serve as a distressing reminder of the intersectionality of religious and class-based discrimination in healthcare services.

Yusuf's journey began when he accompanied his mother, suffering from a heart-related issue, to a public hospital. Despite being in a public hospital, he perceived that he did not receive the same level of care and attention from the health personnel as others were receiving. This discrepancy could be due to factors such as class, religion, or personal references. The doctors appeared disinterested and avoided providing adequate information about his mother's condition, as he observed.

Expressing his frustration, Yusuf said,

"It was very irritating (*jhallahat*, loosely translated) for me because the doctor's behaviour was not cordial or cooperative at all with me. I was trying to communicate and seeking an update about my mother's health, but the doctor bizarrely made a face and walked away. I acknowledge that he did not utter any inappropriate words, but his gestures and tone were humiliating. Perhaps he did not intend to do it, but I felt that it occurred intentionally because of my Muslim appearance and low economic status" (Interviewed in 2017, UP).

The National Sample Survey Office (NSSO) 61st round (2004–05) report indicates that from 1987 to 2005, the overall poverty levels decreased. However, among the Muslim population, the rate of poverty reduction does not appear to be as significant as in other communities (Government of India 2006a, 151–61). Frustrated by the perceived negligence and indifference in the public hospital, Yusuf decided to discharge his mother and admit her to a private hospital in a different district, hoping for better care. Unfortunately, this transition did not bring the relief Yusuf had anticipated. Discriminatory attitudes persisted within the private healthcare facility. Yusuf grieved, "I do not understand why everyone is behaving discriminately; only a Muslim nurse displayed ample cooperation, albeit within the constraints of hospital protocols. While non-Muslim health personnel were not cooperating well." He vividly recalled the unequal treatment meted out to Muslims in both public and private hospitals.

Discrimination extends beyond the public sector, with Sukhadeo Thorat and Paul Attewell (2007) demonstrating that the private sector is also affected. These discriminatory practices are often subtle, making statistical proof challenging. From a sociological perspective, while such discrimination may not always be rooted in communal relations, it is often perceived as such due to communal and ethnic biases (Nasir 2014). Meanwhile, he struggled to accumulate enough money for his mother's treatment. He spent all his savings, and the family's financial strain intensified. He borrowed money from relatives and friends to cope with the escalating medical expenses. Even after two years following his mother's tragic passing, he continues to repay those debts. This loss left Yusuf deeply scarred by the emotional turmoil and financial crisis he experienced.

This case study underscores the sobering reality that both religion and class play a parallel role in accessing healthcare services. Yusuf belongs to a marginalised caste within the Muslim community, exemplifying the complex interplay of identities that dictate healthcare access and health outcomes. He emphasised that he had been discriminated against not only because of his religion but also due to his class, compounded by underlying caste identities. This aspect needs separate attention in future research.

Case Study 2: Discrimination against Muslim Women in Healthcare

Several studies (for example, Gulati and Sharma 2008; Indian Social Institute 2006; Jeffery and Jeffery 2006; Nasir 2007; Sachar 2006) have observed that the Muslim community lags behind other communities in utilising general public healthcare services, particularly reproductive and preventative health services (Nasir 2014, 71). Muslim women in India encounter unique challenges in accessing quality healthcare services (Barnagarwala 2017). Fatima, a 32-year-old practicing Muslim woman from a modest background, faced discrimination during her pregnancy at a government-run healthcare facility in South Delhi.

Fatima's experience during prenatal care at the hospital was marred by condescending attitudes from the medical staff (BeyondHeadlines 2022), primarily due to her hijab. She recalled, “I often overheard derogatory remarks related to my cultural and religious practices, which made me uncomfortable” (Interviewed in 2019, Delhi). Moreover, communication barriers further hindered her access to crucial pregnancy-related information. She expressed, “Sometimes, avoiding access to healthcare services due to humiliation can cause emotional distress.” Her ordeal underscores the pervasive issue of religious discrimination faced by Muslim women within healthcare settings.

Rosina Nasir's studies (2014) delve into the challenges faced by Muslim women when accessing healthcare services. Her research highlights instances of humiliation and inhumane treatment by healthcare providers towards Muslim women. One observation from focus group discussions

illustrates this: “The first childbirth hurts, doesn’t it? If we scream, they shout and slap us. They say: ‘You didn’t feel any shame when you got the thing in there. Why are you screaming when it’s coming out now?’...They don’t give us any information. If they don’t pay any attention, we’re forced to keep quiet and stop asking...The staff abuses us. They insult us for not using a contraceptive. If we get pregnant soon after a delivery, they say dirty things [about us] ...Their behaviour is inhumane; they treat us as if we are redundant...” (Nasir 2014, 79).

Nowadays, life is becoming harsher for every Muslim, but it is worse for practicing Muslim women, particularly those who wear the hijab (Murrar, Baqai, and Padela 2023). It is not only about the hospital but also every public space wherever you go.

“People give a different look and gesture, and even though you can feel it, you avoid dealing with it. The doctor and nurse were murmuring about the number of children produced and the struggle to handle hijabi women. As usual, I avoid it, but this kind of behavior restricts access to better healthcare service or controls our behavior differently.” -Fatima

This broader problem reflects a systemic bias against them, where faith-based choices, such as wearing the hijab, can lead to prejudice and substandard care. Discrimination affects not only patients' physical health but also leaves emotional scars, impacting their overall mental health (Bakshi 2023).

Case Study 3: Discrimination against Muslim LGBTQ+

Discrimination in healthcare transcends religious and class-based biases, extending to include other facets of identity such as gender identity and sexual orientation. Sexual orientation itself is a challenge to deal with in society, and being a Muslim LGBTQ+ makes it worse, dealing with double marginalisation, particularly in healthcare services. When seeking healthcare services, a

person has to deal with physical touch, such as checkups and treatments. It becomes hard to explain, and usually, doctors do not cooperate, and at the same time, they are not comfortable treating an LGBTQ+ patient.

In a move towards inclusivity and improved healthcare accessibility, Delhi's Dr Ram Manohar Lohia Hospital launched India's first transgender outpatient department (OPD) in September 2023. Professor Ajay Shukla stated, "Transgender individuals were encountering numerous challenges in accessing our hospital's services" (ANI 2023). Furthermore, the All India Institute of Medical Sciences Delhi has revealed plans to establish a specialised Centre of Excellence for Transgender Healthcare on its campus (Express News Service 2023).

Amir, a 30-year-old young Muslim who identifies as LGBTQ+, encountered discrimination when seeking healthcare services at a hospital in Delhi. His experience sheds light on the broader issue of bias against individuals based on their sexual orientation, an aspect that has yet to be thoroughly explored in academia.

Amir shared, "When seeking treatment for a health-related matter, I faced hostility and a lack of understanding from healthcare providers uncomfortable with my LGBTQ+ identity. I was afraid of visiting a female doctor, and I was uncomfortable seeking a male doctor because of issues related to personal boundaries" (Interviewed in 2020, Delhi). On the contrary, Amir endured derogatory comments and judgmental behaviour from medical staff due to his soft voice, leaving him feeling profoundly alienated and discouraged from seeking healthcare services. Amir expressed, "As an LGBTQ+ patient (Arora, Bhujang, and Sivakami 2022), I often struggle with self-confidence and face stereotypical perceptions due to the reactions of healthcare personnel. Their intrusive questions about my identity, family, and religion exploit my emotions and sentiments." The underlying issue is not only about receiving treatment but also about fostering gender sensitisation within the healthcare system.

This situation underscores the urgent need for LGBTQ+ inclusive healthcare policies and practices within the healthcare system. Discrimination based on sexual orientation not only jeopardises physical health but also contributes to mental health challenges, highlighting the imperative of creating an environment where all individuals, regardless of their identity, receive respectful and equitable healthcare.

Escalating Institutional Communalism

One disconcerting trend that emerged from my research is the escalating institutionalised everyday communalism (Menon 2023) within the healthcare system. This unsettling phenomenon is by no means limited to the public sector; however, hospitals, which should ideally be sanctuaries of healing and compassion, are not exempt from its influence. Institutional communalism has, regrettably, been a persistent issue in the country's socio-political fabric, and it is increasingly gaining momentum over time.

In India, institutional communalism has manifested in public and private healthcare services, adversely affecting the Muslim community. Several reports highlight instances where Muslims face discrimination, subtle bias, or outright exclusion when seeking medical assistance (Contractor and Jaitly 2018). This form of communal prejudice not only compromises the principles of equal healthcare access but also perpetuates systemic disparities and forced self-exclusion (Nasir 2014). Nivedita Menon, a writer and a professor of political thought at Jawaharlal Nehru University, Delhi, addresses the issue of institutional betrayal in healthcare.

Discrimination within healthcare settings, coupled with the broader communalistic landscape, results in a pervasive environment of inequity and injustice, further undermining the health and mental health of those already vulnerable due to their religious identity. In India, institutional communalism intensifies the problem, impacting not only Muslims but also other marginalised communities. It has been well-documented during and after the pandemic, and a recent Oxfam

report has explicitly highlighted that Muslims have experienced 33% discrimination in hospitals, compared to 22% for the Schedule Castes (OXFAM 2021). As such, my research underscores the urgent need for systemic change and a commitment to upholding the principles of equality and inclusivity within India's healthcare system. It is essential to acknowledge and address the multifaceted nature of discrimination, which affects individuals and communities based on religion, class, and sexual orientation at least at the institutional level, whether it is public or private. It is also imperative that we approach this issue with the same urgency and commitment as we do with other pressing concerns, as the health and well-being of the Muslim community are equally at stake.

Conclusions and Recommendations

The narratives of Yusuf, Fatima, and Amir unveil the distressing reality of discrimination against Muslims in India's healthcare system, rooted in their multiple identities and practices. Discrimination within healthcare settings is not merely a violation of human and civil rights; it is a stark injustice that amplifies existing health inequalities. Discrimination in healthcare remains a substantial and urgent global concern, casting a long shadow over societies worldwide. This deeply distressing issue takes a toll on those who endure it, leaving indelible marks not only on their physical well-being but also on their mental health. Whether based on religion, class, or sexual orientation, this discrimination carries far-reaching consequences for both physical and mental health.

These narratives shed light on the emerging trend of institutional communalism in India and its adverse impact on healthcare system. They emphasise the urgent need to address discrimination against marginalised communities, particularly Muslims, within the healthcare system. The narratives underscore the immediate need for healthcare systems to adopt inclusive policies and practices that respect and cater to the diverse identities of patients.

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