MILLENNIUM DEVELOPMENT GOALS AND MUSLIMS OF INDIA

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ABSTRACT

The United Nation's Millennium Development Goals (MDGs) outline a set of eight development goals, 18 targets and 48 measurable indicators to combat poverty, hunger, illiteracy, gender inequality, diseases and environmental degradation. With the deadline set at 2015, the MDGs seek to ensure a time-bound accelerated pace of development in identified areas of immediate attention. In India, as we draw closer to 2015, an assessment of progress in meeting the stated objectives and targets is called for. Given India's entrenched social hierarchy and complex cultural diversity, it is important to evaluate group-specific performance in assessing the framework's achievements and relevance. The MDGs have been criticised for ignoring the specific vulnerabilities that minorities are faced with: discrimination, susceptibility to majoritarian violence and conditions of powerlessness. This paper studies the performance of India's Muslim population on indices of social development and asses their plausibility of meeting the MDGs by the target year. Drawing from a variety of sources, the paper points at inequities in education, income and health conditions. It recommends addressing security concerns and adopting disaggregated goals that take into account the specificities of disempowerment and marginalisation faced by minority groups.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organisations
CPR	Contraceptive Prevalence Rate
CSR	Child Sex Ratio
HIV	Human Immunodeficiency Virus
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Rates
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MPCE	Monthly Per Capita Expenditure
NFHS	National Family Health Survey
NGO	Non Governmental Organisation
NSS	National Sample Survey
NSSO	National Sample Survey Organisation
OBC	Other Backward Class
SC	Scheduled Caste
SCR	Sachar Committee Report
SRC	Socio-Religious Category
SRS	Sample Registration System
ST	Scheduled Tribe
UNICEF	United Nations International Children's Emergency Fund
UPA	United Progressive Alliance
U5MR	Under Five Mortality
WHO	World Health Organization

SUMMARY

The United Nation's Millennium Summit in 2000 outlined a set of eight development goals, 18 targets and 48 measurable indicators to combat poverty, hunger, illiteracy, gender inequality, diseases and environmental degradation. The Millennium Development Goals (MDGs) were to play a guiding role in the international development agenda and provide benchmarks to measure a country's progress in eradicating poverty.

The MDGs have found reflection in India's development priorities and were mentioned in the United Progressive Alliance's National Minimum Programme before the 2004 elections. However, as the 2015 deadline for reaching the MDGs is nearing, an assessment of progress is called for. Given India's entrenched social hierarchy and complex cultural diversity, it is important to evaluate group-specific performances. The MDGs have been criticised for ignoring the specific vulnerabilities of minorities, such as discrimination, insecurity, and the lack of political empowerment. By failing to make any specific mention of minorities, the MDGs have remained distant to them. Yet, insecurity and social exclusion might adversely affect a country's capability to meet the goals.

The outcomes of India's Muslim population on the MDGs offer a contrasted picture:

- Incidence of poverty among Muslims is 6 per cent higher than national averages in rural areas and 4 per cent in urban areas.
- While the country nearly achieved universal enrolment in primary education according to official data, 35 per cent of Muslim males and 47 per cent of females are illiterate; 19 per cent of Muslim boys and 23 per cent of girls are out-of-school.
- Infant and Under Five Mortality rates are slightly below the national average, with 52 and 70 per 1000 live births against an average of 57 and 74.
- Disaggregated data on maternal mortality is not available, but studies suggest that the incidence of maternal mortality is slightly lower among Muslims than the national average at 212 per 10,000 live births.
- While disaggregated data on tuberculosis and malaria is not available, awareness of AIDS among Muslims, at 55 per cent for women and 82.2 for men, is slightly lower than national averages. However prevalence is lower as well (0.06 for women and 0.22 for men against an average of 0.22 and 0.36). The gap is steepest in contraceptive usage (46 for Muslim women and 46 for men, against an average of 57 and men 84).
- Access to sanitation is poor among Muslims. A UNICEF study estimates that 50 per cent of Muslim households do not have access to individual toilets; tap water coverage is estimated at 36 per cent, 4 points below national averages.

RECOMMENDATIONS

1. The post-MDG framework should focus on the most excluded groups within signatory countries and set monitorable targets to assuage their plight.

2. Group-disaggregated development data should be generated to allow monitoring progress on the MDGs. The dearth of data is one of the major impediments in scrutinising inequities in the distribution of power and resources across communities. The Sachar Committee for instance, recommended transforming the National Data Bank into an independent authority with adequate powers to access data from concerned ministries, departments and implementing agencies.

3. The post-MDG framework should draw on the UN Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (1992). The Declaration makes it mandatory on states to frame policies that ensure a fair participation of minority groups in the economic development of their countries. With the plausible drying up of external aid, a challenge for the post-MDG phase is to ensure a committed share of national incomes towards meeting development goals. The post-MDG declaration could make it mandatory for governments to guarantee adequate budgetary allocation to minority communities and other excluded groups.

4. The signatory states should be encouraged to enact laws empowering minorities and addressing their security related concerns. Violence against religious minorities impact their performance on targets such as alleviating poverty or enhancing school enrolment – those of women notably. The security of vulnerable populations, therefore, becomes intrinsic to the evolving agenda of human development. A measurable target in this regard could focus on the decline in reported cases of anti-minority violence.

1. INTRODUCTION

The United Nation's Millennium Summit of 2000 outlined a set of eight development goals, 18 targets and 48 measurable indicators to combat poverty, hunger, illiteracy, gender inequality, diseases and environmental degradation. With as many as 189 countries, India being one of them, pledging to adopt the goals and their targets in their respective national planning frameworks, the Millennium Development Goals were set to form the core of the international development agenda and benchmark to measure a country's progress in terms of eradicating poverty and ensuring an equitable human development.

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 world.[1]

In India, as we draw closer to 2015, an assessment of progress in meeting the stated objectives and targets of MDGs is called for. The MDGs imply a uniformity of approach in setting targets and measuring progress; but, given India's entrenched social hierarchy and complex cultural diversity, it is all the more important to evaluate group-specific performance in assessing its achievements and relevance. The goals and principles embodied in the MDGs have found reflection in India's development priorities. They have been particularly embodied in the 11th Plan that went a step further in adopting "inclusive growth" as the mantra of planned economic development in India. In consonance with this, the vision document of the 11th Plan declared; 'the central vision of the 11th Plan is to build on our strengths to trigger a development process which ensures broad-based improvement in the quality of life of the people, especially the poor, Scheduled Castes (SCs), Scheduled Tribes (STs), other backward classes (OBCs), minorities and women.'[2] In quantifiable terms, the inclusive growth strategy involved identifying 27 targets at the national level that were placed in six major categories namely: (i.) income and poverty; (ii.) education; (iii.) health; (iv.) women and children; (v.) infrastructure; and (vi.) environment.

[1] Government of India (2011), "India Human Development Report, 2011", Institute of Applied Manpower Research, Planning Commission, Delhi: Oxford University Press, p. 2.
[2] C. Lennox (2010), "Religious Minorities and the Millennium Development Goals", in P. Taneja (ed.), State of the World's Minorities and Indigenous Peoples, London: Minority Rights Group International, p. 31.

2. MDGS AND RELIGIOUS MINORITIES

The MDGs have been criticised for ignoring the specific vulnerabilities that 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 and 48 indicators, the stated goals have remained distant to them. Furthermore, the MDGs do not emphasise 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 marginalised minorities and performance of signatory countries in this regard.[3]

Although in the UN's Millennium Declaration (2000), states expressed their commitment 'to strengthen the capacity of all…countries to implement the principles and practices of democracy and respect for human rights, including minority rights', operationally this call has failed to translate into concrete and monitorable action. In 2007, a study presented by the UN Independent Expert on Minority Issues noted that of the 50 MDG 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.[4]

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.[5] In such a climate, religious minorities are neither active participants nor generators of economic growth. Processes internal to the community such as sensitivity towards religious codes, women's participation in the job market, intolerance towards divergent groups, might further impede the community's possibility of meeting MDGs. In India for example, poor work participation of Muslim women can be attributed to cultural factors, some of which are discussed below.

[3] Ibid., p.32.
[4] Government of India (2012), "Press Note on Poverty Estimates, 2009-10", Delhi: Planning Commission.
[5] To ensure consistency, the study draws on the 1993 poverty line used before the recommendations of the Tendulkar Committee.

3. MUSLIMS IN THE DEVELOPMENT DEBATE IN INDIA

The Report of the Prime Minister's High Level Committee (popularly Sachar Committee, 2006) on the 'social, educational and economic status of Muslims' propelled the community to the centre of the development debate. The Sachar Committee Report (SCR) outlines that Muslims across most parts of India, as a community are deeply impoverished and suffer from huge illiteracy, a high drop-out rate, depleting asset base, below average work participation and lack of stable and secure employment. Their deplorable situation is further compounded by their limited access to government schemes and programmes, poor credit flow from public banks and other financial institutions and meagre share in public employment. Regional variations notwithstanding, Muslims, as a whole, have performed only a shade better than scheduled castes and tribes (SCs/STs) on most indices of development, while they have lagged behind the Other Backward Classes (OBCs). A year later, the report of the Commission on Linguistic and Religious Minorities (Ranganath Misra Commission, 2007) also reached a similar conclusion regarding the status of Muslims.

As a follow up exercise, the United Progressive Alliance (UPA) government at the Centre had introduced a series of ameliorative measures – especially educational and financial – to address the development deficits faced by Muslims, in particular, and religious minorities at large. Measures such as Multi-Sectoral Development Programme, scholarship schemes for pre-matric, post-matric and technical education, enhanced credit flows to minorities through public sector banks, strengthening National Minorities' Development and Finance Corporation, Madarsa Modernisation Scheme, Prime Minister's 15 Point Programme were initiated. In quantifiable terms, the above mentioned schemes have fallen short of meeting the laudable aims with which they were launched. However, there singular achievement have been in presenting Muslims and religious minorities as units of analyses, policy making and state induced development thinking in India.

4. THE MDGS AND MUSLIMS OF INDIA

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 study the performance of Muslim communities against the targets identified in the MDGs are assessed. The task is two-fold: to assess them in terms of key development indicators identified in the MDGs, and the extent to which goals and targets correspond to the needs of the Indian Muslim community. In doing so, certain caveats are in order. The Muslims of India, despite popular portrayal, defy cultural, doctrinal, social or political homogeneity. They display remarkable variation in terms of regions, castes and gender to the extent social development is concerned. For the purpose of this study, the research parameters are confined to pan-India patterns, without missing out on any significant discrepancy in the regional analysis. Another point to note: the paucity of development data on religious communities holds up comparative analysis. For example, the Census of India has begun publishing religion disaggregated work participation and literacy data since 2001 and therefore an analysis of progress since 1991 on these counts remains speculative. Finally, while the burden of implementing MDGs across individuals and communities solely lies on the shoulders of government functionaries, the cultural impediments emerging from the internal dynamics of the community should not be missed.

4.1. 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 per cent. 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.

In India however, the standards for measuring poverty have differed with much debate around the fixing of the percentage of population living below official poverty line. 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 41.8to 33.8 per cent and urban poverty from 25.7 to 20.9 per cent. Compare this with the status of socially excluded groups such as the SCs, STs and Muslims. In rural areas, the highest level of poverty was reported by the STs (47.4 per cent) followed by the SCs (42.3 per cent), while in the urban areas, the SCs were the poorest (34.1 per cent) followed by STs (30.4 per cent).

Among religious communities, Muslims reported the highest poverty ratio in urban areas (33.9 per cent). In rural areas, the poverty ratiofor 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 per cent).[6]

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 (35 per cent) in reporting incidence of poverty in the year 2004-05. Muslim poverty was more pronounced in urban areas, were 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 ration (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-Religious Category (SRC) (See Appendix: Table 1).

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 a 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 21.6.8

The 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 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 more than the SCs/STs (at 40 per cent) who occupy the poorest slot (See Appendix: Table 2).

4.2. 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

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[6] See for instance: P. N. Mari. Bhat, A. J. Zaviera (2005), "Role of Religion in Fertility Decline: The Case of Indian Muslims", *Economic & Political Weekly*, 40(5), pp. 385-402.
[7] Ibid., p. 229.
[8] N.P. Das, et.al. (2009), "Emerging Causes and Determinants of Maternal Mortality in India: Based on Large Scale Surveys since the 1990s'", Population Research Centre, M.S University, Baroda, p. 8.

in achieving the set goals. The Census 2001 figures returned Muslims as least literates among all religious communities. The recent NSSO 2007-08 education round further confirmed a high proportion of Muslims as illiterates. The proportion of illiterates among Muslims 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 3).

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 (See Appendix: Table 3).

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 4).

4.3. GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The MDGs rest on education as the major tool to bring about gender equality. It therefore emphasises 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 group 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 per cent 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 per cent. 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 (See Appendix: Table 4).

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 10 years) 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. 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?

4.4. GOAL 4: 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) findings 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.[11] 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 indicates that the decline in child mortality was slowly being arrested in the case of Muslims.[12]

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[9] Ibid., p. 3260.
[10] International Institute for Population Sciences (2007), "Key Findings, National Family Health Survey-3, 2005-06", Mumbai: IIPS., p.194.
[11] Ibid., p. 209.
[12] Ibid., p. 323-4.

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 52.4 and 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 immunisation of Muslim children remains weak among all SRCs. The NFHS-3 discovered only 49.6 per cent 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. The reason could be poor popularisation 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.

4.5. 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 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 per cent of them included Muslim women despite their share in the survey population being 12.2 per cent. All other religious groups such as Hindus (84.3 per cent of deaths, 82.4 population share) and Christians (3.9 per cent deaths, 2.3 population share) as well as social groups such as SCs (26.7 per cent deaths, 18.9 population share) and STs (16.7 per cent deaths, 8.8 population share) reported a higher share of maternal

[13] International Institute for Population Sciences (2007), "Key Findings, National Family Health Survey-3, 2005-06", op. cit., p. 393.
[14] Ibid., p. 122.
[15] Ibid., pp. 119-22.

deaths compared to their share in population.16 Economist P. N. Mari Bhat used the 1994 National Council of Applied Economic Research -Human Development Institute Survey data to compute caste and religion differentials of MMR. It was estimated that in rural India, among social groups, STs had the highest MMR of 652, followed by the SCs at 589. The MMR among Muslims was the least at 384 while Hindus reported a much higher figure of 573.[17]

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. Muslim women rather lagged behind other women in receiving ante-natal care from a recognised 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'. By religion, births to Jain mothers (93 per cent), Buddhist/Neo-Buddhist mothers (59 per cent), Sikh mothers (58 per cent) and to a lesser extent Hindu mothers (39 per cent) are most likely to take place in a health facility. Births to Muslim mothers (33 per cent) are least likely to take place in a health facility.

4.6. 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.

4.6.1. 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. Differentials in knowledge of prevention methods by caste and religion indicate

[16] Ibid., p. 238.
[17] United Nations International Children's Emergency Fund and World Health Organization, (2012), "Progress of Drinking Water and Sanitation", New York: UNICEF, WHO, pp. 45-47.
[18] S. Sachar, et al. (2006), "Social, Economic and Educational Status of the Muslim Community of India", op., cit., pp. 146-7.

that ST women and men are least aware of each of the three means of HIV/AIDS prevention and Muslim women and men are less likely to be aware of different means of HIV/AIDS prevention than women and men in other religious groups.

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. Amongst men, Christians at 0.56 per cent, Sikhs at 0.45) and Buddhists at 0.65 reported above average prevalence of HIV. However owing to the very small size of the sample that tested positive, religious differentials need to be spelt with a degree of caution.

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 sterilisation 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. Contraceptive prevalence is highest among Jains (75 per cent), followed by Buddhists/Neo-Buddhists (68 per cent) and Sikhs (67 per cent). Muslims displayed the lowest CPR of 45.7 per cent, however when compared with the NFHS-2 (37 per cent), they do demonstrate a growing adoption of contraceptive techniques.

The use of condoms as a means of contraception seemed less preferred across the population. Urban married women demonstrated a greater preference for condoms (9.8 per cent) compared to those in rural areas (3.2 per cent). The choice of condoms varied with educational and wealth status with women of higher educational level and wealthier women making a preference for condoms. Among religious groups, Muslims (6.8 per cent), Jains (15.8 per cent) and Sikhs (19.7 per cent) displayed above average (5.2 per cent) preference for condoms.

4.6.2. 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. 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).

4.7. GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

While much of the focus in goal 7 is regarding physical environmental concerns such as the spread and expansion of forest coverage, carbon dioxide emission, and the use of solid fuels, concerns such as access to sanitation, improved water source and conditions of slum-dwellers have a direct bearing on sections of the human population. The tangible targets, in this context, are to bring down by half the proportion of population without sustainable access to safe drinking water and sanitation. The other target: bring about tangible improvements in the lives of the slum-dwellers by 2020.

Religion disaggregated data on amenities is scanty. The NFHS collects data on drinking water and sanitation but does not provide the religious distribution of these facilities. According to the UNICEF-WHO Report on 'Progress of Drinking Water and Sanitation, 2012', India witnessed an improvement in water and sanitation facilities between 1990 and 2010. Sanitation facilities expanded marginally, from 51 to 58 per cent in 2010 in the urban areas, while in rural areas, the expansion noticeably, was just from just 7 per cent in 1990 to 23 in 2012. In total, the access to improved sanitation rose from 18 to 34 per cent in 2010. Thus, suggesting a vast majority of Indian population deprived of modern sanitation. In this regard, the availability of improved drinking water has enhanced more substantially with an overall rise from 69 to 92 per cent coverage. The figures could also be misleading as in the case of piped drinking water within premises, where there has been no worthwhile improvement. In 1990, 49 per cent of the urban population had access to piped drinking within premises; twenty years down the line, the coverage remains at 49. In the rural areas though, a marginal rise of 5 per cent in coverage – from 7 per cent in 1990 to 12 in 2010 could be noticed. The overall expansion in piped drinking water till the premises is negligible – from 18 per cent in 1990 to 23 in 2010.

The Sachar Committee, 2006 found almost half the Muslim households in India lacking access to toilets. The proportion in rural areas was much higher. In urban areas, the proportion of Muslim households who have flush toilets was significantly lower than the proportion for the whole urban population. A larger section of Muslim households have access to public/shared flush toilets or own pit toilets. Over all, the access of Muslims to toilet facilities was low but was slightly better than SC/ST and OBC communities. Citing the NSSO 60th Round, the Committee also highlighted the absence of tap/piped water facility in a large proportion of Muslim homes. Over all, urban areas were better served (60-70 per cent) with tap water but in rural areas, only one-quarter of the populace had access to tap water. Invariably, Muslims were having least access to such facilities both in urban as well as rural areas.

5. 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.

5.1. RECOMMENDATIONS

1. The MDGs are a global construct that set uniform targets for countries while remaining oblivious to the structural make-up of such societies. The monitorable targets that were identified look at aggregate populations thus ignoring the differentials of religion, region, gender, tribe or caste. Thus a country's overall progress on certain MDGs doesn't necessarily indicate its distribution across its various socially excluded groups. For instance, India seems to have made significant advance in poverty alleviation, however, its benefits have rarely reached the SCs, STs or religious minorities who continue to count amongst the most poorest. The post-MDG framework must take note of this limitation in the MDG scheme and make suitable amendments to ensure that the fruits of development reach the most deprived and marginalised. One of the effective measures could be to focus on the most excluded groups within signatory countries and set monitorable targets to assuage their plight.

2. In adopting minority focused targets, the post-MDG framework could draw strength from international instruments such as UN Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (1992) signed by all the member states. The Declaration, besides a host of other commitments, makes it obligatory on the states to frame policies so as to ensure fair participation of minority groups in the economic progress and development of their respective countries. With the plausible drying up of external aid that the MDGs were dependent upon, a challenge in the post-MDG phase is to ensure a committed share of national incomes towards meeting development goals. The post-MDG declaration could make it obligatory on signatory states to guarantee adequate budgetary allocation towards development of minority communities and other excluded groups.

3. The adoption of group-specific targets and differentiated goals necessitates generation and maintenance of group-disaggregated development data to ensure monitoring of progress. The

dearth of such data is one of the major impediments in scrutinising inequities in the distribution of power and resources across communities. To address the data deficit, the Sachar Committee for instance, recommended the institution of National Data Bank as an independent authority with adequate powers to access data from concerned ministries, departments and implementing agencies.

4. The universal framework that the MDGs adopt is a top-down approach towards setting goals and targets. In the absence of a consultative process involving state functionaries, civil society organisations and grass-root NGOs and CBOs, the development behaviour of social groups such as religious minorities and their specific needs are usually missed. For instance, situations of actual or palpable violence against religious minorities might seriously impact their performance in terms of meeting MDG targets of alleviating poverty or enhancing school enrolment. This could be particularly debilitating for the women belonging to such communities. Security of vulnerable populations, therefore, becomes intrinsic to the evolving agenda of human development. The signatory states could be encouraged to enact laws empowering minorities and addressing their security related concerns. A measurable target in this regard could be a substantial decline in the reported cases of anti-minority violence and hate crimes within a given time-frame.

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APPENDIX

MDGS, TARGETS AND ACHIEVEMENTS BY SOCIO-RELIGIOUS CATEGORY

MDGs	Monitorable target	Data source	All India			Muslims			SCs/STs		
Eradicate extreme poverty and hunger	Halve between 1990 to 2015 the proportion of population whose income is below $1 a day	Data Source: Sachar Committee, Planning Commission, NSSO 2009-10	09-10	04-5	93-4	09-10	04-5	93-4	09-10	04-5	93-4
			29.8 (Tendulkar Comm. 2009-10)	29 (Sachar)	33	Rural 36.2 Urban 33.9	44	47	Rural ST 47.4 SCs 42.3 Urban STs 30.4 SCs 34.1	46	51
			MPCE poorest quintile: 24.8% in rural & 26.8% in urban			MPCE poorest quintile:26% in rural & 40.7% in urban			MPCE poorest quintile:34.2% in rural & 40% in urban		
Achieve universal primary education	Ensure that by 2015 children everywhere, boys and girls alike, complete full course of primary education	NSSO 2007-08, Sachar Committee	Illiterates 35.6% percentage (6-14) out of school: 12.6% Drop-outs (5-29): 34.3%			Illiterates :40.8% percentage (6-14) out of school: 20.7% Drop-outs (5-29): 33.3%			Illiterates 44.2% percentage (6-14) out of school:15.9% Drop-outs (5-29): 32.7%		
Promote gender equality and women's empowerment	Eliminate Gender Disparity in Primary and Secondary Education and at all levels of education	NSSO 2007-08, Sachar Committee	Illiterates: Males 27.9%, Females 43.7% Current enrolment in primary & above (5-29): Male 54.1%, Female 47.5% Out of school (6-14): Males 11.1%, Females 14.3%			Illiterates: Males 34.7%, Females 47.3% Current enrolment in primary & above (5-29): Male 47.7%, Female 42.1% Out of school (6-14): Males 18.7%, Females 23%			Illiterates: Males 35.6%, Females 53.2% Current enrolment in primary & above (5-29): Male 51.1% Female 44.1% Out of school (6-14): Males 13.9%,Females 18.2%		
Reduce under-5 mortality rate by two-thirds by the year 2015	Reducing U5MR and UMR by two-thirds	NFHS 3 (2005-06)	1992-93 IMR 86 U5MR 119 2004-05 IMR: 57, U5MR : 74.3			1992-93 IMR: 77 U5MR: 106 2004-05 IMR: 52.4 U5MR: 70			1992-93 **SCs** IMR 107 U5MR 149 **STs** IMR 91 U5MR 135 2004-05 **SCs** IMR 66.4 U5MR 88.1 **STs** IMR 62.1 U5MR 95.7		
Improve maternal health	reducing by three-quarters, the maternal mortality ratio (MMR)	Sample Registration System, various studies	92-3	98-9	07-09	No data by religion available. Various studies suggest a slightly lower MMR for Muslims			Data by caste not available. Various studies suggest a higher than average MMR for SCs and STs		
			543	466	212						
Combat HIV/ AIDS, malaria and other diseases	halting the spread of HIV-AIDS and reversing the trend by the year 2015	NFHS-3(2005-06)	Awareness of AIDS (Women 57% and men 83.6%) AIDs prevalence (0.22 for women and 0.36 for men) Contraceptive Usage CPR 56% for women & 50.1% for men			Awareness of AIDS lowest (55% of women and 82.2% men) AIDS prevalence lowest for Muslims (0.06 for women and 0.22 for men) Contraceptive Usage CPR: 45.7% for women & 46.2% for men			Awareness of AIDS SCs: 55.3% women & 80.8% Men STs: 38.6% women & 63.9% men AIDS Prevalence SCs: 0.23 women & 0.34 men STs: 0.12 women & 0.39 men Contraceptive Usage CPR: 55% for SC women & 49.4% for men 47.9% for ST women & 40.3% for men		

MDGs	Monitorable target	Data source	All India	Muslims	SCs/STs
Ensure Environmental Sustainability	To bring down by half the proportion of population without sustainable access to safe drinking water and sanitation.	UNICEF (2012) Sachar Committee Report (SCR, 2006) Human Development report, 2011	Coverage of improved sanitation from 18% in 1990 to 34% in 2010 HDR, 2011: 50% of Indians without toilet facilities Coverage of improved drinking water from 69% to 92% in 2010 (UNICEF) Tap water coverage: 40.1% (HDR)	Religious distribution not provided by UNICEF SCR found 50% of Muslim households lacking access to toilet facilities. HDR, 2011 reports 1/3rd of households without toilets No UNICEF data by religion Tap water coverage: 36% (lowest among all rel. com)	Caste distribution not provided by UNICEF HDR, 2011 reports 2/3rd of households without toilets No UNICEF data by caste Tap water coverage: SCs 38.4%, STs 24%

TABLE 1: POVERTY RATIO BY SOCIAL GROUPS AND RESIDENCE: ALL-INDIA AND SELECTED STATES

	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 STATUS

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

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