Religious minorities and their reproductive health in India and Bangladesh

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General overview

This paper is a cross-country comparison to understand the differentials in reproductive health among religious minorities in India and Bangladesh. In the paper attempt is to present the available theoretical and secondary literature on the religious basis to reproductive behaviour. Firstly we explore the differentials in fertility, infant and child mortality among Muslims in India and Hindus in Bangladesh. Secondly we seek reasons for the differentials. Thirdly we test the characteristic hypothesis.

We study religious minorities in India and Bangladesh as in each context the majoritarian religion happens to be the religious minority in the other i.e. Muslims are minorities in India and Hindus in Bangladesh. In India, the Muslims constitute 13 percent (RGI, 2001) and in Bangladesh, the Hindus constitute 11 percent (Census, 2001). The discussion and deliberation on religion based fertility differentials is highly politicized (Basu, 1997). Thus in addition to fertility this paper addresses the least explored research question that is religion based differentials in the infant mortality and child mortality in the two countries. The rational for choosing fertility as an indicator was because it is observed that religious composition of any country has significant role to play in the fertility situation. For instance, when Islam happens to be the majority (numerically higher and /or the state religion) religion then the fertility is almost at replacement level with higher acceptance of contraceptives (Iran, Indonesia, Bangladesh and Turkey) but it is higher when Islam happens to be minority religion (Morgan, 2002). The reason for choosing the infant and child mortality is because in India the infant mortality rates are lower for Muslims than for Hindus and the scenario is the reverse in Bangladesh where Hindus have lower infant mortality.

There are some interesting revelations about the demographic behaviour of the study groups (Muslims in India and Hindus in Bangladesh). There is relatively higher Muslim fertility in both India and Bangladesh. The figures regarding contraceptive behaviour from the Demographic Health Surveys of both countries suggest that contraceptive use (any method of contraception) among currently married Muslim (religious minority) women in India is 28 % against 42 % among Muslim (religious majority) women in Bangladesh. Most striking figures relate to use of any modern *temporary* method: 6 % among Muslim women in India against 27 % among Muslim women in Bangladesh. If we look at the other side of the coin, that is Hindus across border the use of any method is 42 % among Hindu (religious majority)women in India and 54 % among Hindu (religious minority) women in Bangladesh. The use of any *modern* method is 38 % among Hindu women in India and 42 % among Hindu women in Bangladesh, while the corresponding figures for modern *temporary* methods are respectively 5 % and 28 %. Infant mortality (IMR) (as well as under-five mortality) among Muslims in India is much lower than among Hindus in India: respectively 59 per

1,000 live births (Muslims) against 77 per 1,000 live births (Hindus). Thus identity such as religion, majority/minority status and gender influences the reproductive health status.

Research Objectives

1. The specific research objective is to explore the differentials in fertility, infant and child mortality between Hindu and Muslim women in Bangladesh and India.
2. Secondly to identify the reasons for these differentials, specifically regarding the levels of fertility and infant and child mortality.
3. Finally characteristic hypothesis will be tested.

Theoretical arguments for religion based differentials in fertility, infant and child mortality commonly known as hypotheses.

The two main arguments which seek to explain the religion based fertility differentials are the particularistic hypothesis and characteristic hypothesis. The former can be referred to as pure religion effect where religious doctrines and ideologies about marriage, family size, sex roles and birth control provide a system of norms and attitudes that influence child bearing preferences and contraceptive choice (McQuillan, 2004). The latter attributes higher fertility of certain religious group to the socio-economic characteristics. The other views by Goldscheider (1971) suggest minority group status as a possible factor playing important role in shaping fertility behaviour. The marginality, insecurity, and lack of upward mobility associated with minority group status influence contraceptive use and fertility behaviour. Thus in order to maintain their distinct identity these groups abide by large family norm and impose restriction on fertility control and thus resulting in higher fertility rates that the majority group (Goldscheider, 1971). Mishra (2004) introduces program *related hypothesis* where the emphasis is being based on the history of family planning program and he has cited this particular hypothesis with regard to Indian experience. Iyer (2002) brings into attention a hypothesis which is referred to as "*discrimination*" which connotes the different religious groups may have differential access to services such as health and family planning. Finally there is a theory which explains the fertility differentials among religious group through the concept of gender as it is perceived in the South Asian countries. According to Borooah and Iyer (2005) the fertility differentials among Hindus and Muslim can be attributed to the lower 'daughter aversion' among Muslims but almost the same level of 'son preference' along with Hindus. Finally fertility differentials depend on the interaction between the socio-economic levels of the religious groups and the local orientations of these groups toward procreation and fertility control (Chamie, 1981). But in the testing of this hypothesis the characteristic hypothesis has always dominated the research on the issue in the absence of empirical evidence in support of the other arguments.

The theoretical underpinning for the infant mortality scenario is not prominent for religion *per se* but recent researches indicate that religious belief might lead to some neglect in childcare and delivery practices (Asser and Seth, 2005, Kaunitz et al, 1987). The available literature indicates considerable difference in child rearing practices during and after pregnancy among the two religious groups.

Data and Method

For exploring the research objective the respective Demographic Health Surveys of both the countries are analyzed, National Family Health Survey 1998-99 for India and Bangladesh Demographic Health Survey 1999-2000. Thus descriptive, bivariate and multivariate analysis of the co-variates of fertility and infant mortality will be carried out for both the religious groups i.e. Muslims in India and Hindus in Bangladesh. For the analysis the dependent variables are indicators of fertility, infant and child mortality. The independent variables will be age of the women, religion, education, standard of living, exposure to mass media, index of women's autonomy, women's occupation, ethnicity and region. Finally the characteristic hypothesis will be tested.

The research seeks to explore the reproductive health of religious minorities in India and Bangladesh. Firstly this paper seeks to explore the differentials in fertility, infant and child mortality between the religious minorities in the two countries. Secondly to find the reasons for the differentials. Finally characteristics hypothesis will be tested.