Muslim Minority and Institutional Accessibility to Health Care Services in India:Reflections from the field

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Abstract

This paper intends to focus on the relationship between communal violence and it impact on the accessibility of health care institutions among Muslim community. However attempt is also taken to explain the problems of accessibility beyond the dimension of communal violence. The paper is based on the empirical and sociological study of health condition of Muslims in the state erstwhile state of Andhra Pradesh. The study exposes the issues of availability and accessibility of health institution in a socio-cultural and political conditions namely during communal riots or communal outbreaks and at times terrorist attack elsewhere in any region of the Indian society and reveals the discrimination experienced at household level. The issue of access is a complex concept in the debate of public health services and at least four aspects require evaluation. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent to which a population 'gains access' also depends on financial, organizational and social or cultural barriers that limit the utilization of services. This study also tries to understand the availability and accessibility of health institutions across the three regions of erstwhile state Andhra Pradesh, i.e. Telangana, Coastal Andhra and Rayaseema. It is also noted that the availability of health institution in the state is comparatively better than some of the states but the specifically the accessibility with reference to Muslim population is subject of serious concern in the paper.

Keywords: *Minority, Muslim, India, Communal Violence, Health, accessibility.*

1. Introduction

Communal violence refers to a situation where violence is perpetrated across ethnic lines and victims are chosen based upon ethnic group membership. The term *communal violence* is commonly used in south Asia to describe those incidences where results are in the forms of massacres conflict between ethnic communities. Communal violence, as seen in South Asia, typically takes the form of mutual aggression in which members of all involved ethnic groups both perpetrate violence and serve as its victims. The government in India had proposed to pass a Bill against the communal violence as unlawful activities in 2011 called as 'Prevention of Communal and Targeted Violence (Access to Justice and Reparations) Bill, 2011'. This bill had comprised a holistic definition on "communal and targeted violence" as any act or

series of acts, whether spontaneous or planned, resulting in injury or harm to the person and or property, knowingly directed against any person by virtue of his or her membership of any group, which destroys the secular fabric of the nation'. However this law didn't come into reality and with the change in the ruling party, the bill has gone into dust.

This further helps to understand another form of violence which ultimately has its bases into religious manifestation into the larger society. Profoundly speaking, Religious violence in India includes acts of violence by followers of one religious group against followers and institutions of another religious group, often in the form of rioting. Religious violence in India, especially in recent times, has generally involved Hindus and Muslims, although incidents of violence have also been seriously involved Christians. Conflict between different communities, especially those having different religions or an ethnic origin leads to communal violence and these are a commonly described social phenomenon.

Paul Brass [1]a political scientist finds in his research that riots are not spontaneous occurrences which can be facilely explained in terms of mob anger. They are essentially a planned, orchestrated and institutionalized phenomenon. Brass argues that there exists at sites of endemic communal violence an 'institutionalized riot system' which works as a central factor in the genesis and persistence of communal riots. This system, which is nourished and sustained by the discourse of communalism, involves a multiplicity of roles and a network of relations between specific individuals, economic interests, organizations, criminals, politicians, and the police.

Further Brass maintains that there is a close linkage between communal violence and the political process, especially electoral competition and political mobilization. Communal violence has entered a new phase with the Christians and members of other minority religions being made the victims of planned attacks. Communal riots in this recent past decade have been both urban and rural features, but the extent of damage is always greater in the thriving centers of trade and commerce. Tribal population in the rural areas is being forced to get involved in the attacks on Christians and Muslims by bringing them within the Hindutva framework as it has been discussed in some of the past communal violence in different pockets of India. Apart from economic reasons, Rajeshwari [2] writes that call for Hindu unity which is primarily a means to achieve political advantage is the main source for communal violence in this decade.

This idea has taken a worse shape in the contemporary upsurge and bases of communal violence. A.R. Momin reviews how communalism is one of the most destructive forms of damage any human society witnesses. He writes, "It can hardly be disputed that communalism, particularly in its most horrifying manifestation in Hindu–Muslim riots, poses the gravest threat to the cohesiveness and stability of society and state in India. The social, economic and human costs of communal violence are enormous and in fact incalculable" [3]. It is widely argued "there exists at sites of endemic communal violence an 'institutionalized riot system' which works as a central factor in the genesis and persistence of communal riots. This system, which is 106 Ethnicities 6(1) 107 nourished and sustained by the discourse of communalism, involves a multiplicity of roles and a network of relations between specific

individuals, economic interests, organizations, criminals, politicians, and the police. Brass in his book maintains that "there is a close linkage between communal violence and the political process, especially electoral competition and political mobilization" [4].

2. **How Communal Violence are understood:**

In her brief analysis on communal violence, Puja Mondal [4] writes, 'communal violence involves people belonging to two different religious communities mobilised against each other and carrying the feelings of hostility, emotional fury, exploitation, social discrimination and social neglect. The high degree of cohesion in one community against another is built around tension and polarization'. Mostly the targets in the violence are the opposite group and community members out of feeling of enmity and hatred against each other. The nature of violence mostly takes a mob violence where no leadership is available that can contain the violence except the intervention of state machinery. The targets of attack are the members of the 'enemy' community. Generally, there is no leadership in communal riots which could effectively control and contain the riot situation. It could thus be said that communal violence is based mainly on hatred, enmity and revenge.

"Inter-group conflict seems to be an in- escapable aspect of public life in heterogeneous societies. Stability of such societies is precarious. The medley of peoples constituting them, in the words of J S Furnival, "mixes but do not combine. Each group holds by its own religion, its own culture and language, its own ideas and ways, as individuals they meet but only in the market place, in buying and selling" [5].
It is a phenomenal to understand that violence in India has been perennial in the name of caste and untouchability, violence against women especially from weaker sections, tribes, and minorities. But the nature and form of communal violence has increased dramatically quantitatively and qualitatively in the history of communal violence in India. Mahatma Gandhi was first victim of communal violence in the process of communalization that was followed intensively after demolition of *Babri Masjid* in December 6, 1992 [6]. The portrayal of communal violence became a regular social and political fact in the post Babri era making one group of people more sensitive and threatened than the others.

India finds various reasons for the outbreak of communalism before and after the independence. The inherent differences between two religious communities (Hindus and Muslims) have also given rise to the emergence of orthodox political parties in counter to each other. The trauma of partition continued for decades in the memories of people suffering the violence, loss of lives and separation from their kith-kin until the jin of Babri Masjid appeared as a social fact. Yet, "the resurgence of communalism is often sought to be explained either as the logical consequence of Muslim separatism, or in terms of the persistent Muslim opposition to changes in the Islamic Personal Law. On the other side, it is explained in terms of the ideology of the "Hindu Rashtra" and the anti-Muslim posture of the Rashtriya Swayamsevak Sangh (RSS)" [7]

The Madan Commission also attributed to the fact that urban is more prone to rural in the repeated outbreaks of communal violence. There are other views that makes responsible for the outbreak of communal violence. For instance, it is also argued that "the contemporary energy of communalism is derived from the landscape of fragmented and uneven capitalist development…….Muslims, in particular, were late entrants in the process because their proximity to the bureaucratic, judicial and economic structure of feudalism made it harder for them to adjust to new profession [8]. In the last thirty years of span, the child who didn't get affected by second phase of communal violence, they are being injected the poisonous communalized political hatred against each other and mostly it against the Muslims and Christian in India. The other attributes are associated to conversion and cow slaughter etc.

While reading carefully the Sachar Committee Report apart from several other studies, it is empirically demonstrated that Muslims are socio-economically and educationally lagging behind Scheduled Castes or Dalits. The continuous backwardness among Muslim is also one of the reasons that allow communalism to rise in this community and a selected few political parties get due benefits [9]. The mass among Muslim still rely on the state machinery to curb any such outbreak of violence and crime that can allow them to continue their everyday activities and lead a minimal household life to survive in the capitalist era of competition and stiffness. The Perception of Dalits towards Muslims have not been full hatred and enmity until the illiterate Dalits, OBCs and Tribes are provoked to follow the deadly act against their neighbours. This was also reflected in the fieldwork among Dalits in the state of Jharkhand and Telangana [10].The social, economic and human costs of communal violence are enormous and in fact incalculable and that has not been scientifically done till date. This is a difficult terrain to attempt and in doing rationale estimation on the damages on the post consequences of communal violence. But the socio-cultural and political gap created due to repeated recurrence of violence has definitely changed the social mapping of the Indian society and its basic fabric. One pertinent reference to be connecting to such recurrence is Ahmedabad where repeated communal outbreak has broken the social fabric between Hindus and Muslims. The continuous segregation between the two communities have become a visible fact in every spheres of human life, including building house sat their own community settlements, opening business units or shops, functioning of schools and private hospitals etc. These instances have ruined the constitutional ethos of secular life in Ahmedabad in Gujarat [11].

The paper does understand the limitation for the very fact that the so called 'social fabric' and cohesive society in India has also been a myth in the context of caste question. However the present focuss is on the communal relationship carried and performed between all living religious communities in India is no doubt a social fact of cohesive and performing social structure. For instance these were or could be seen during certain festival at pockets of mutual habitat.

This paper is largely in an attempt of the collected empirical data from the four chosen regions of the undivided Andhra Pradesh during 2012 till December 2014 and second round of fieldwork after the state got separated. The empirical and sociological study of health condition of Muslims in Andhra Pradesh exposes the issues of availability and accessibility of health institution in a socio-cultural and political conditions namely during communal riots

or communal outbreaks and at times terrorist attack elsewhere in any region of the Indian society. It also studied how and what level person experiences the discrimination and exclusion during riots and violence than any of the normal day or condition. The interviews and intensive fieldwork tried to understand the problems and faces of communal violence in the forms of discrimination and deprivation of health care services at large [12].

3. The Question of Accessibility (health care services):

When we talk about economic growth or development we mainly relate these two terms to material well-being of the people and resources, which can either increase or decrease their level of development. But social well-being one of the most important components of any economy, expressed in terms of physical and mental status of the human resource has not received due importance. Therefore good health condition of the population ought to be considered as a fundamental factor of economic development. The same is reflected in the constitution of the World Health Organization, which defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [13]

The issue of access is a complex concept in the debate of public health services. This requires evaluation of at least four different aspects. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent to which a population 'gains access' also depends on financial, organizational and social or cultural barriers that limit the utilization of services.

Since health is influenced by a number of factors such as adequate food, housing, basic sanitation, healthy lifestyles protection against environmental hazards and communicable diseases. The frontier of the health extends beyond the narrow limits of medical care. It is thus clear that "health care" implies more than "medical Care". It embraces a multitude of "service provider to individual or community by agents of the health services or professions for the pose of promoting, maintaining o restoring health. More over Health care is a public right, it is the responsibility of governments to provide health care to all citizens' or people at equal scale of measurement. This principle have been recognized by nearly all governments of the world and enriched in their respective constitutions. In India, health care is completely or largely governments function. There is a huge responsibility initiated to begin the public health care system in such a large population with poor income groups as a core of them. Just before and after the independence several committees were formed namely Health Survey and Development Committee Report' popularly known as the Bhore Committee (1946) under Sir Joseph Bhore as its Chairman; Pandya Committee etc. that laid the foundation of public health care system in India.

4. Issues of Availability:

All health related aspects are influenced by the availability of and the access to health services. They are two sides of a coin. Individual households and the state are the most important stakeholders in health service system. To protect and promote general health, the public health infrastructure must be strong. Public health programs must deliver specific health services to the population (e.g. immunization); promote health behavior; and promote healthy environments and RCH.

In Andhra Pradesh, the availability of (Primary Health Centers) PHCs, (Health Sub-Centers) HSCs and (Community Health Centers) CHCs is relatively better than the all-India average and many states in India, except the south Indian states of Kerala and Tamil Nadu. Below figure is indicating the details of availability of health institutions.

Figure 1 Health Infrastructure in Andhra Pradesh (erstwhile) and India

Health infrastructure in Andhra Pradesh and In India

Perticulars		Andhra Pradesh	Karnataka	Kerala	Tamilnadu	All India
Sub-Center	Requred	11699	7369	4761	7057	158792
	in position	12522	8143	4575	8706	14709
	Short fall	_		186		19590
Primery Health Centers	Requred	1924	1211	4761	293	6491
	in position	1570	2193	4575	256	4535
	Short fall	354		186	37	2115
Community Heath Centers	Requred	481	302	197	293	6491
	in position	167	325	233	256	4535
	Short fall	314			37	2115
Multipurpose Workers (female) ANMat sub-center	Requred	12522	8143	4575	8706	147069
	in position	22140	8822	3418	8635	166202
	Short fall			1157	71	10793
Health workers(Male)MPW at subcenter	Requred	12522	8143	4575	8706	147069
	in position	6127	3762	1285	959	52774
	Short fall	6395	4381	3290	7747	94337
Health Assistanat (Female)LHV at PHC	Requred	1570	2193	813	1283	23673
	in position	1564	2266	795	868	17034
	Short fall	6		8	415	7275
Health Assistant(Male)at PHCs	Requred	1570	2193	813	1283	23673
	in position	1920	658	633	1895	16563
	Short fall		1535	180		10029
Doctors at PHCs	Requred	1570	2193	813	1283	23673
	in position	2212	3198	1122	2268	25870
	Short fall					2433
Obstetrician Gynaecologist at CHC	Requred	167	325	233	256	4535
	in position	260	233	NA	0	1939
	Short fall		92	NA	256	2949
Physicians at CHCs	Requred	167	325	233	256	4535
	in position	20	192	NA	256	1165
	Short fall	147	133	NA	0	2949
Paediatrician at CHCs	Requred	167	325	233	256	4535
	in position	90	192	NA	0	1311
	Short fall	147	133	NA	256	2991
Total Specialist at CHCs	Requred	668	1300	932	1024	18140
	in position	480	726	774	0	6781
	Short fall	188	574	158	1024	11361
Radiographs	Requred	167	325	233	256	4535
	in position	65	51	10	98	1817
	Short fall	102	274	223	158	2724
Pharmacist	Requred	1737	2518	1046	1539	28208
	in position	1614	2054	1014	1159	21688
	Short fall	123	464	32	380	7655
Lboratory Technicians	Requred	1737	2518	1046	1539	28208
	in position	1363	1344	268	870	15099
	Short fall	364	1174	778	669	14225
Nurse/Midwife	Requred	2739	4468	2944	3075	53390
	in position	4056	4309	3383	4287	44940
	Short fall		159			18017

Source: RHS Bulletin, March 2010, Ministry of Health, Family Welfare, Government of India

The large scale study conducted in the Muslim Ghettos at the pockets of Muslim population in Andhra Pradesh shows that the availability of health institution is one of the questions needs to be addressed. The physical from the health institution to the population to be catered is serious concern. The average distance of the government health center is more than 3 km in most of the above discussed areas. It is found that 68 percent of the study population who visits government health institution travels more than 3 km of a distance. The Primary Health Centers (PHCs) and Community Health centers (CHCs) are found to be comparatively located at far distance in Muslim populated areas. In the records of the institutional delivery, the advantages results into disadvantages to the Muslim population who are poor and in real need to public health services. Further is found that only 13 percent study population are within one Kilometer distance.

Figure 2 Distance to health centers and the study population.

District	Distance of Health Centre				Total
	0 to 1 km	1 to 2 km	3 and above	NOT APPLICABLE	
HYDERABAD	10	32	176	7	225
	4%	14%	78%	3%	
NIZAMBAD	9		202		211
	4%		96%		
GUNTUR	5	78	131		214
	2%	36%	61%		
KURNOOL	91	15	83	29	218
	42%	7%	38%	13%	
Total	115	125	592	36	868
	13%	14%	68%	4%	100%

Source: Field Survey (2014-2016)

However the availability of health centers is better in the average of the all India level. But when it is critically observed for the Muslim Population there is scarcity and lack of availability. The most profound feature and trend reflected in this study is that Muslim communities have shown larger dependency and initiative to access on the public health services. When Muslim families prefer Government Health institutions for treatments, it is very important to see the availability and accessibility of the health centers.

The reason behind choosing health institution varies from availability to accessibility. Muslim population in the study preferred government health institution due to the fact that it is relatively less expensive and the pockets of such patients are not emptied for treatments. The incidence of poverty is higher more among Muslims in general. According to Sachar committee report, Andhra Pradesh was reported to have poverty level among Muslims is 35% among Urban in comparison to other Minority groups. The poverty levels in the rural areas

among Muslims are seven percent whereas 4% are other minority groups. As compared to rural areas, Muslims face much higher relative deprivation in urban areas. Over time changes in poverty level also show that the economic conditions of Muslims in urban areas have not improved as much as Other SRCs [14].

Instead of its faraway distance 60% of the total study population visits government hospitals during illness and again the main reason to prefer public health institution is being less expensive. There is a general perception about Muslim population that they depends upon the traditional healing methods for treating diseases but the study showed only 1 person in total study population depend upon this method. There is a large awareness among the study population about health care and its importance. The given chance they wanted to live healthy life. The figure shows the preferences of different health Institutions among the Muslim minority group in both the states.

Figure 3 Health practitioner and Hospitals

Districts	Government Hospital	Private Health Institutions	RMPs	Traditional Practitioners / Healers	Govt. and private hospitals	Total
HYDERABAD	133	55	32	1		225
	26%	22%	37%	100%		26%
NIZAMABAD	133	26	46			211
	26%	10%	53%			24%
GUNTUR	166	42	6			214
	32%	17%	7%			25%
KURNOOL	87	126	3		2	218
	17%	51%	3%		100%	25%
	519	249	87	1	2	868
Total	60%	29%	10%	0%	0%	100%

Source: field survey

Since accessibility is behavioral aspect we cannot measure it in terms of availability of the institutions to the population. Choice of the health care institution and treatment preferences are influenced by the behavioral aspects of the doctors and medical staff of the health institution. In present study Muslims are visiting Government institution only when they don't have other alternative in terms of availability of other institution or there is no required amount for treatment. But given chance they are prefer other private health institutions which again leading them into financial burden.

5. Exclusion and Effects of Communal violence:

The above figure gives details of the preferences people made for treatment. The basic reason behind the choice is the cost of the treatment. Since poverty among Muslims is more it is the

obvious choice for government health institution for treatment. But when we study the exclusionary factors among Muslim Community it is relieved that Muslims are facing more behavioral discrimination at heath institution than the any other institution. Since Health institutions are like day to required institution it is alarming that the more discrimination is happening there. Discrimination starts from the set-up of the government health institution to the behavior of the staff. When we saw the Muslim populated areas and the government health centers to the locality, we found the setup discriminationary, mostly the health centers are other end of the locality otherwise it may be less distance to these localities. When it comes to the behavioral aspects of the staff and doctors, this begins from the very step of interaction between patients and health personnel; firstly, in the initial introductory interaction before listening the detail symptoms and problems related to illness, the staff and a few doctors already have preconceived notions and they associate their perceptions about the patient onto patients' living condition and cultural traits than examining the reasons for their illnesses. These uncountable behaviours of the doctors and staff have created the huge gap between availability and accessibility of the health institution indirectly.

The following figure 4 shows the details of discrimination at various institutions. Fourty four percent have faced different forms of discrimination at health institutions, it is more when compare to other types of health institutions; namely private and non-government managed health institutions. Since health institutions are vital for well-being of the society, discrimination at these places push the community for less advantageous social situations. Top of the ten, Muslim are enforced to realize the larger narrative that they are minority and they have to face similar consequences in every front of societal life.

Figure 4 Discrimination faced at various Institutions

Districts	Public/ Govt. health centers		Banks		Education Institutions			In providing Municipal Infrastructure			At work place		
	Yes	No	Yes	No	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
HYDERABAD	115	110	34	191	44	175	6	78	141	6	25	194	6
	51%	49%	15%	85%	20%	78%	3%	35%	63%	3%	11%	86%	3%
NIZAMBAD	99	112	37	174	35	176		101	110		33	178	
	47%	53%	18%	83%	17%	83%		48%	52%		16%	84%	
GUNTUR	120	94	28	186	50	136	28	56	130	28	1	185	28
	56%	44%	13%	87%	23%	64%	13 %	26%	61%	13%	1%	86%	13%
KURNOOL	51	167	6	212	8	210		11	207		6	212	
	23%	77%	3%	97%	4%	96%		5%	95%		3%	97%	
Total	385	483	105	763	137	697	34	246	588	34	65	769	34
	44%	56%	12%	88%	16%	80%	4%	28%	68%	4%	8%	89%	4%

Source: Field survey

In order to arrive at scientific data, several intensive group discussions were conducted throughout the fieldwork. The group discussion reveals that this kind of discrimination gets intensified and aggravated during the abnormal condition or any outbreak of communal violence anywhere in India and more particularly in Andhra Pradesh and Telangana State. The manifestations of invisible discrimination appears tangible and felt by the people in all forms of institutions including educational set ups. This type of behavioural discrimination and perceived segregation not only happened in affected areas but also far from the region. Where ever these types of disturbances occurred, it affect the community at large. The worse to the life of innocent and less educated Muslim mass is that even a terrorist attacks anywhere in India fuels the intensity and types of discrimination in Andhra Pradesh and Telangana State. The study has primarily located the efforts to measure the discrimination at health care institutions in both the Telugu speaking states, however the above analysis of felt discrimination due to communal violence is newer forms of social and institutional discrimination. A study report titled "Communal violence, long an issue in India, has remained at consistently high levels in the past five years. Official data shows more than 700 outbreaks of communal violence in 2016 alone, with 86 killed and 2,321 injured. However, the actual figures are likely to be considerably higher as many incidents go unreported" [15].

6. Conclusion:

Communal violence affects the social fabric at large scale, so it has affected the states of Andhra Pradesh and Telangana. There is no doubt that the aftermath impacts in socio-cultural and economic aspectsare more fatal than during the communal violence. The discrimination at health institutions adversely affect the communities to get benefits and uplift there social conditions. The community studied in the long duration of period have repeatedly reported to have faced social and economic discrimination that disadvantages them in terms of access to resources and basic needs which is reflected in poor health outcomes. The intensive fieldwork in the research field and during the interviews of case study does highlight the importance of communal violence and consequences as economic and social loss. The community member has also felt very strongly about the discussion on communal violence and also affects the health care accessibility of the urban backward Muslims and Dalits.

The dimension of social exclusion does include how the manifestations are witnessed in the social life of the people and communities. A lot has been researched in the lines of caste and segregation but a few studies are found to be focusing on communal violence and access to health care institutions. Discrimination and exclusion of marginalized groups are issues that are increasingly receiving the attention of social scientists of late. This is now widely accepted that developments in state and society in post independent India have not conformed to the expectations as discrimination and exclusion still persists in our society [16]. The question of Muslim being subjugated to social discrimination is also similar to other communities and social groups in India and worldwide but the distinctness of reflected in case of Muslims are never absolutely similar. The first identification of the person with their name as being is the first marker of differentiating this community from the rest.

An unpublished dissertation titled 'Reimagining 'Good Muslim, Bad Muslim': Public Theologies of Citizenship and Belonging in the Republic of India" is apt to examine where Meghan Koushik [17] analyses how Muslims are seen as other and bad than being good. The

attempt of Paul Brass [18] is a landmark study to see through the narratives on the issues of ethnic and religious violence in contemporary India. The title, 'Theft of an Idol Text and Context in the Representation of Collective Violence' brings qualitative aspects of violence in the context of urban and rural contextualization while showing urban public violence, including police-public confrontations and Hindu-Muslim riots. Therefore various forms of violence have always helped the narrative to grow as mega narrative and consequently affecting the Muslims everywhere in India including the two southern states like Andhra Pradesh and Telangana States.

I profoundly argue that the studies on sociology of religion be based not merely describing the religious ethos of varieties rather make the empirical studies part of the discussion and discourse across the syllabus and curriculum of educational institutions. Studying Muslim as minority community would provide value addition to the already established social dimensions known to the social sciences and more particularly in Indian context and spheres. There is a growing threat perceived among Muslim households in relation to accessibility to health care services as well. The feeling of exclusionary process is likely to heighten and intensify in case of the percolation of prejudice and stereotypes in doctor-patient relationship. This would be most crude form of discrimination faced by any community in the most advanced state of society's development where doctors-patients relationship is influenced by the fact that there is continuous outbreak of religious tensions-communal violence. The accessibility to public health institutions are already declining due to various other reasons, the manifestation of communal tones and prejudices on religious lines would worsen the national desire to increase institutionalization of health care services including the target to reduce maternal mortality, infant mortality and morbidity too. There is scope to assume the picture of this form of discrimination getting worse in the northern and western states of India which has got strong colour of communalized way of living everyday life. A new form of discrimination is established though the research data is limited to two southern states of India.

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Note:

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