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The God Of Death Takes Half Of Our Children: Health Of Women And Children In The Sundarbans Islands

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Abstract: Grassroots level health care workers provided insights into rural women's health concerns at a program development workshop held at Sundarban Islands in West Bengal, India. This report describes these narratives and identifies strategies for potential intervention plans. The narratives suggest layers of disenfranchisement compounded by gender inequality and geographic instability.

Key words: Sundarbans, maternal and child health, girl-child, grassroots-level health care workers, India

The Sundarbans group of islands is home to over three million people where the threat of natural disasters including cyclones and droughts are as common as the daily ebb and flow of water in this land of 18 ebbs and tides.[1] The islands, along with the region under the territory of Bangladesh, form the largest delta in the world at the confluence of the Ganges, Brahmaputra, and Meghna rivers.[2] This island nation is perhaps best known for the Royal Bengal Tigers and other flora and fauna including the now threatened mangrove forest, and species of snakes, spotted deer, and birds.

Despite its rich biodiversity, the people living in the Sundarbans are dually marginalized by virtue of living on the fringes with respect to physical location as well as social and economic isolation historically marked by governmental policies of exclusion and disenfranchisement for this island nation.[3] For families living in the islands, fishing, prawn seed collection, and a single harvest season during the few non-monsoon months constitute the major income-generating activities. Life in the islands is difficult at its best, with people migrating to Kolkata and other urban areas in search of work, leaving behind families with small children and elderly parents. Preventable infectious diseases are common, as are infant and maternal mortality, phenomena explained as the will of Yama, the God of Death, in Hindu mythology.[4]

Two workshops were conducted with community health workers in an effort to understand women's reproductive and child health needs and prioritize interventions within the context of limited resources. The workshops were designed to discuss and identify risk and protective factors of women's health as observed by the community

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health workers during the course of their interaction with the women. The health workers shared their experiences of health care service delivery to women within the parameters of institutional barriers such as gender, religion, caste, social and economic status.[5,6]

As a social work researcher exploring maternal and child health concerns in rural India, and as a person born and raised in this region, I participated in cyclone relief work three weeks after a deadly Cyclone (Aila) had passed through the delta on May 25, 2009. My entry to this region was facilitated by Dr. Amitava Chowdhury, a health care consultant in the Sundarbans. In collaboration with non-governmental organizations, Dr. Chowdhury is spearheading an effort to strengthen maternal and child health outcomes in the area by training women from villages as grassroots-level health care workers, especially working on decreasing maternal and neonatal mortalities, and improving morbidity conditions.

This paper originates from a series of two two-day workshops held on discussing and identifying health priorities for rural women, and follow-up interviews with key informants engaged in maternal and reproductive health care delivery. Sabuj Sangha (literally meaning *the green community*) and Jaigopalpur Gram Vikas Kendra (JGVK), which connotes *Jaigopalpur Rural Development Center*, are two community-based organizations working in the Sundarbans Islands. One of their focus areas is addressing maternal and child health concerns by training groups of women from this rural community, a task assigned to Dr. Amitava Chowdhury. The workshops were held at Sabuj Sangha and JGVK during June 2009, organized and facilitated by me along with Dr. Chowdhury. Dr. Chowdhury is currently involved in conducting series of maternal and child health training of village-level health care workers and has developed, delivered, tested, and evaluated the curriculum. He also works closely with the village-level health care workers every step of the way to ensure that information is updated among health care workers on an ongoing basis.

Why community women as grassroots level health care workers? Women in rural West Bengal are among the most neglected and underserved, even without the added trauma and practical problems of natural disasters.[4] A recently completed family and household survey found that while both boys and girls attend school at an equal rate, girls typically do not complete high school and over half of women in this region marry before they are 18 years old. The fertility rate is 2.5 child per woman in rural households, a practice encouraged by male preference.[7] Teenage pregnancy is higher than national average in West Bengal, particularly in the rural areas where child marriage is still widespread.[8,9] The frequency of high-risk births is increased by low maternal age, poor nutrition, and lack of access to and utilization of antenatal care services; together, these factors push infant mortality rates in the rural areas 19% higher than that of the urban areas in West Bengal.[7]

The health care infrastructure in the rural areas such as the Sundarbans is solely dependent on the three level health care delivery institutionalized by the government of India. According to the Indian Public Health Standards established by the Ministry of Health and Family Welfare, the first level of health care delivery is conducted at the Primary Health Center (PHC) which should be available to a population of 20,000. Four PHCs refer cases to a nodal Community Health Center (CHCs) for secondary level of care, assigned to a population of 80,000. The CHCs are supposed to be equipped with

30-bed inpatient care facility providing medical care including obstetrics and gynecology, surgery, and pediatrics.[10]

The National Rural Health Mission (NRHM) was launched by the Ministry of Health and Family Welfare in an effort to strengthen the existing sub-centers.[10] Currently in its seventh year, the NRHM is yet to meet the goals and identifies significant challenges including the need for institutional reforms and strategies of decentralization.[11]

The health care infrastructure at Sundarbans is at its best fragmented largely because of its locale that poses difficulty in accessing the islands. As a result, institutionalized health care in the islands is either non-existent or at best inadequate. This leaves health care choices for the people of the Sunderbans limited to indigenous health care providers using herbal medicinal supplements from forest resources, private for-profit health care providers charging prohibitively exorbitant prices, and health practitioners who are neither qualified, trained, nor licensed to provide medical care, yet practice medicine without supervision.[4,12,13]

Guided by the philosophy of optimal instead of minimal care for rural maternal health, the village-level health care workers are envisaged as a key group of paraprofessionals who are trained, have the knowledge, and can identify, intervene, and evaluate safe pregnancy and motherhood in their villages. The trained grassroots-level health care workers work with pregnant women in their villages throughout the entire gestation period and up to a year after the birth of the child. Ensuring availability and accessibility of adequate antenatal, postnatal, and neonatal care is one of the goals of health care workers. During the gestation period of the mother-to-be, the trained health care workers provide information and education on nutrition, health, hygiene, vaccination, as well as assess possible adverse occurrences such as anemia and preeclampsia (conditions that are treatable).

The training of community health care workers spans over 10 months of bi-weekly, face-to-face group educational sessions with Dr. Chowdhury, the health care consultant. Using multiple teaching methods (including audio-visual aids, lectures, demonstrations and field visits) Dr. Chowdhury provides information and knowledge to enhance skill development and training. The topics range from simple basic rules of health and hygiene to complex anatomy and physiology, and also cover safety and other concerns about the pregnancy and childbirth process. Along with the medical information, the health workers also gain hands-on experience in conducting simple pathological testing to assess hemoglobin levels, urine albumin level, and examination of blood pressure. Perhaps the most important knowledge gained by the community health care workers is the ability to identify accurately at-risk cases that need specialized intervention beyond the capacity of home-based delivery of care, and therefore, advance planning for institutionalized care, if available.

The community health workers, who at present are all women, were recruited and provided with the maternal and child health care training by Sabuj Sangha and JGVK after a call for application was announced in the community. The community health workers are employed by these organization and paid a modest monthly salary of average Rs.800 (approximately USD $20). At the time of participation in this workshop, all health workers had completed their 10-month training with Dr. Amitava Chowdhury and had already started working with their own caseloads. A typical profile of a com-

munity health worker involved in this maternal and child health care work is as follows: a woman from a village geographically close to the relevant community-based organization; with or without a high school diploma but with basic reading, writing, and mathematics skills; in her late thirties or early forties; without childcare or elder care responsibilities that prevent her from traveling and sometimes staying overnight at the training center if need be. Most importantly, the women recruited to be community health workers at either organization are connected to their neighborhood communities and are therefore attuned to the cultural beliefs, biases, and sensitivities of the region such as norms around gender selectiveness favoring the male, social acceptance of dowry, and family violence upholding a patriarchal society.[14,15]

Following training, each community health care worker is assigned an average caseload of 75 to 250 households, depending on population density in the area served. The health care worker intervenes with both individual and cluster-level meetings with eligible women who are classified as pregnant mothers, women trying to become pregnant, or women who have given birth in the last year. Health workers who are undergoing training pair up with a senior health worker who has already undergone the 10-month training and is willing to serve as a mentor. Village-level health care workers follow the progress and outcomes of the pregnant mothers to whom they provide antenatal care, couples who are trying to conceive and who want to receive prenatal care, and mothers and infants who have chosen to receive perinatal care. Many times, the individual and cluster-level meetings are attended by mothers-in-law and other village elders, in an effort to influence current provision of adequate care of women in this rural area which is situated in a largely patriarchal society with distinct preferences for the male child.[16,17]

Using a decentralized model each trained community health care worker is given her caseload of households with eligible couples who are potential or actual recipients of maternal and child health care within the geographical intervention area of the community-based organization.

Village-level health care workers provided an important systemic understanding of women's health beliefs and concerns in an atmosphere of poverty, natural disasters such as cyclone Aila, marginalization, and disenfranchisement.[5] The existing and widely accepted norms of gender inequality in this region extend its bias and male preferences to devalue women's life and livelihood through dowry and domestic violence ensuing a culture of patriarchal terrorism.[18]

Understanding Practice-Based Evidence

Given the health care workers' close ties with the village community, meeting with the health care teams to discuss current issues involving maternal and child health was clearly an imperative. The need for this discussion stemmed from understanding existing health beliefs and interpreting the cultural and social understanding of the following: 1)high fertility rates despite abject poverty, 2)continuing maternal and infant mortality in the region, and 3) the socioeconomic-cultural context in which such health beliefs and health behaviors are embedded. As mentioned earlier, these cultural contexts include positive family and social interactions along with practices such as dowry, domestic

violence, gender selectivity, and underage marriages, which could be detrimental and sometimes fatal, while living with the geographical threat of natural disasters including cyclones and droughts.[4,19] The workshop originated from the idea that while the medical and public health interventions aspire to address safe pregnancy and safe motherhood concerns, contextual factors such as those mentioned here threaten the very core of successful maternal and child health outcomes. In this region, such issues have often been ignored by traditional social and community development approaches.

Workshop participants narrated their experiences of working with women in the Sundarbans by highlighting both facilitating and limiting factors that influence women's health-seeking behaviors. Participants utilized multiple formats to record their observations and group discussion outcomes, and used communicative theater as methods to present social situations needing interventions. The participants came from Pathar Pratima and Basanti blocks of South 24 district of the Sundarbans islands. Sabuj Sangha and JGVK each trained 25 village-level health care workers as maternal and child health paraprofessionals in the area surrounding their villages. At the time of these workshops, the health workers had already completed their training and were out in the field either on their own or under supervision of a cluster coordinator. However, given the continuous nature of recruitment of health workers, there was no uniformity in time frame since completion of training.

The workshops were held over two days at each of the two sites. Participants and facilitators arrived at broad themes of concerns emerging from the question: As a health worker working in Sundarbans, what are your concerns regarding delivery of maternal and child health care to the communities? Using the framework of hermeneutic inquiry,[20] the participants were invited to engage in a dialog providing means to gain information from the lived experiences of these health workers in the islands. Hermeneutic inquiry was deemed appropriate as it allows for a process to unfold and clarify conditions of understanding as shared meaning, in this case, characteristics of maternal and child health and its influences as experienced by village level health care workers.[21,22]

The discussions with the 50 village-level health care workers clearly indicated the insider perspective this team of women had in terms of both medical and cultural understandings about maternal and child health conditions in the region that influences high fertility rates, infant mortality, low birth weight and gender inequality in the region. The socio-cultural realities of maternal and child health in the region became intertwined in this discussion of identifying health priorities.

It is important to note that the stages of a female life cycle were identified by the village-level health care workers in terms of the social roles and responsibilities taken up by women in this region (infant girl, daughter, sister, daughter-in-law, wife, mother, mother-in-law) rather than in terms of such periods as early childhood, middle childhood, and adolescence. The stages of life cycle were identified by the participants in a manner to maximize protection, development, and support of women's agency. In many instances, the paraprofessionals' life experiences illustrated the social realities of women's lives. Intervention areas for the infant girl were identified by the women as follows: Socio-legal conditions, mental health, physical health, and moral development as relevant in this agrarian economy surrounded by water. These factors cut across

genders, but girls are often excluded from some of these basic needs and are the focus here.[23] The following ideas emerged during these discussions.

The Power of the God of Death

The threat or actual instances of female infanticide remains a reality in this region, and many of the participants identified registration of birth to be a viable means of accounting towards both identifying live births and monitoring health of infants, especially girls. Prevalence of infant mortality in this region is countered by equally high child-bearing rates.[24–26] To a health services professional the high level of infant mortality is apparent from the suboptimal levels of prenatal care and multiple pregnancies in this region, along with poverty and food insecurity, and the well-established associations between young maternal age and adverse neonatal outcomes.[27,28] However, such concerns are felt to be subsumed under the all-encompassing will of the God of Death (Yama) who aids women's efforts in making meaning of the tragedy of losing a child.[29,30] The predominant health belief at the forefront is the accepted notion of Yama taking half of all children born as his share, therefore justifying multiple pregnancies. Similar confidence in the will of Yama was also shared with reference to immunization of neonates. The village-level health care workers emphasized vaccination for girls and keeping meticulous record of vaccination as a priority to ensure healthy infants and also as an additional measure to count live births in an effort to counter infanticide practices.

The most glaring example of gender inequality culminating in female infant deaths was illustrated by a workshop participant who lamented Yama's gender preference when it came to taking his share. While infant boys were more likely to survive neonatal health conditions than girls, the health workers had already identified Yama's preference for female infants when he came to take his share. Once again, the workshop discussion revealed the underlying gender inequality at play and therefore the need for awareness and protection for the girl child was emphasized by the participants.

Hence, where infant mortality was previously seen as a benign manifestation of the will of Yama the God of Death, the workshop discussions facilitated critical analysis and understanding of the gendered nuances of it where it seemed no longer plausible for Yama to covet only female infants without active participation from the mortals.

Male Gender Preference

Perhaps the most illuminating example used to signify the cultural beliefs of families responding to the birth of a girl was shared by this participant: "When a child is born to a family we know it is a boy from the blowing of the conch shells in celebration; in contrast when a girl is born, not even a pradeep [Sanskrit: *light*; in the West Bengal small oil lamps called *pradeep* are lit in celebration of a joyous occasion] is lit to welcome the new born, households seem to be deserted and shrouded in darkness from mourning the birth of the girl child." Birth of a boy is celebrated with the similar joy and splendor marked with the birth of Krishna, a much revered Hindu God, widely accepted as an incarnation of Vishnu, part of the holy trinity of Hindu religion. According to the discussant, parents of a male child are congratulated as "Lord Krishna has come home

to them." Workshop participants discussed possibilities of announcing the birth of a girl as a visit from Lakshmi, a Hindu goddess of wealth and prosperity equally revered to Krishna, to consciously compare this traditional welcome. However, introducing this altered message within the social-cultural realities requires new communication skills, a barrier that still must be overcome.

Registering new births for a ration card as required by the public distribution system in India to distribute food grains was recognized as another important identifying document for the girl child. With the cyclone submerging houses, many people in the villages lost their ration cards which are considered as primary identification document sources. The need for ration cards was identified as a concern by the village-level health care workers given the importance of this identification document in accessing food, water, and other relief material, especially in times of crisis. Participants identified rights to health, education, and property as basic rights and emphasized the extension of them to both girls and boys instead of the cultural practice of favoring boys.

Information and Education

In addition to prioritizing safe and healthy pregnancy and delivery of the child, the participants identified optimal prenatal care as key to avoiding congenital abnormalities including fetal distress and negative birth outcomes. Early intervention was suggested to diagnose and treat any physical and mental health anomalies, along with education and awareness generation about the same among family members. Male preference also manifests itself in treatment of boys and girls in critical areas of early childhood development. Boys and girls get differential access and exposure to everyday conditions of nutritious food, health, education, health care and treatment, as well as opportunities for play, exposure to the outside world, and age-appropriate recreation. This supports research in the delta as well as in rest of India about the nutritional status of women where girls had lower likelihood of receiving nutritious food than boys.[31,32]

Rights of Girls

The workshop attendees shared experiences from the villages where breastfeeding time was shorter for infant girls, as well as delay in introducing nutritious food to girls as elements of inequity that needed to be addressed. This mirrors decade-old family and health survey results, conducted in India where strong sex differences put girl children at a disadvantage in childhood feeding, accessing health care, and overall nutritional status.[33] In addition to food and nutrition, participants also emphasized enhancing family members' knowledge and education about vaccinations. The participants stressed vigilance in extending equal health care to girls as a need of the community that also included skincare, dental hygiene, cleanliness, prevention of communicable diseases, and due diligence in providing timely treatment and care of minor diseases and ailments. Preparing children for school and quality education was of utmost importance as many noticed the practices of sending boys to schools while girls were left alone at home to help with household chores. A critical area of intervention noted was to educate the

entire family about the needs of children, irrespective of gender as an important step towards enhancing equal access and treatment of girls.

The prevailing culture of patriarchal dominance in this Indo-Bangladeshi delta region has also led to an unchallenged acceptance of multiple pregnancies in pursuit of a boy, a practice exacerbated by the culture of dowry which puts parents of girls at severe economic disadvantage, thus endangering both maternal and child health.[23,34,35] Any discussion of reproductive and child health therefore must address the concerns related to safety, security, priority, and protection of women's lives and rights and acknowledge the imbalance caused by the patriarchal system.

Consistent with experiences of gender inequality nationally in India, instances where multiple pregnancies do not result in birth of the preferred boy, women could be exposed to threats of family violence in forms of emotional and verbal abuse, threats of or actual abandonment, and in extreme cases, physical battery and sexual violence.[36]

Moving Forward: An Agenda for Action

The discussions reported here about the concerns for the health and well-being of girls on two islands, caught between diminishing resources and gender inequality, are in all likelihood representative of this island nation in its entirety.[23,34,35] As the women in the workshop narrated their experiences of survival and work with relief efforts in the aftermath of cyclone Aila, it was apparent that this large scale destruction not only uprooted trees and drowned the islands, but also unmasked the urban-rural divide, gender inequality, politicking and politics of relief and reorganization efforts, and the hierarchy of social class and creed.[5] The lawlessness and the lack of organized relief efforts following the cyclone also accentuated the vulnerability of women and children whose immediate risks involved hunger, water-borne diseases and homelessness, with systemic risks of abandonment, falling prey to human trafficking, and prostitution, as history has shown.[37] The workshop culminated when participants identified skills needed by health care workers to challenge some of the prevalent traditional practices such as child marriage, dowry, and preference for sons, among others. The participants identified and prioritized those issues that are most sensitive and opted to role play in groups in an effort to practice facilitating such discussions in real life situations. The role-plays acted as a forum to bring up issues that were of importance to the health workers based on their experience in the field, and provided a learning platform for communication styles and how to challenge some of these traditional practices. All community workers participated and gave feedback to each other's group presentations. The workshop ended with a decision to go beyond addressing only clinical information and beginning to address socio-cultural realities within which these health conditions prevail.

An untapped area for research is exploring the effectiveness and impact of the village-level health care workers intervention to curb maternal and infant mortality rates. Part of the failing public health infrastructure in Sundarban is also the inadequate antenatal and neonatal care, including immunization.[13] The enormous challenge posed by that is illustrated by the fact that till February 2012 West Bengal continued to be one of

the four states in India that had yet to eradicate poliomyelitis, and had in fact gone on record to promise strengthen its polio eradication plan especially in its southern parts, where Sundarbans lie.[38]

Individual level concerns of health and survival in this region depend not only upon community and organizational decisions and capacities, but also to the moon phases and the tides that determines safety, security, and livelihood of the individual. Just the way the tide guides individuals' and groups' entry and exit to the river for fishing, the community's conviction in not taking from the forest out of greed also determines how that fishing yield is sold and distributed.[39] The deep-seated culturally embedded health beliefs that guide the people of this island nation contribute significantly to the health and lives of women, men, and children. Any intervention that is designed to have an effect on lives of individuals must take into consideration the historical, social, and cultural contexts within which individuals and the communities interact.

Notes

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