

## Lives without Rights

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Husband of Khuku Mondal (thirty years old) of Uttardanga village in Gosaba (in the Sundarban region, essentially an archipelago of islands which are still in their formative stage and are criss-crossed by a plexus of brackish water rivers, rivulets and creeks in the southern fringe of the Gangetic delta in eastern India, famous for its mangrove forest and Royal Bengal tigers) was threatening to take her out to the core forest to be devoured by a tiger if she again bore him a girl child. To their neighbors, this was quite understandable; Khuku had already given birth to four girls. But ultimately, Khuku was blessed because her fifth pregnancy resulted in a boy and she is perhaps living happily thereafter. Namita of Chhotomollakhali had one boy and three girls. During her fifth pregnancy, she was also suitably warned with appropriate intimidation, which she took in right earnest. So when Namita found her fifth offspring to be a girl, she immediately thrust the placenta down the throat of the baby. However, Namita was not entirely out of luck. Because the tragedy was taking place in the dead of night and as the *dai* (the traditional village midwife) had night blindness, her family readily accepted it to be a case of a stillborn baby without any fuss.

Experiences make people wise. Sabitri Bachhar of Mollakhali will testify to that. She is not only an experienced *dai*, but she also has the uncanny ability of pre-natal sex determination. By observing the signs and symptoms of a pregnant woman, she can determine the sex of the unborn child. Sabitri is not alone. Sumitra Mondal of Kumirmari and Sushama Benia of Masjidbati proclaim similar abilities and all three of these women regularly attend expectant mothers desperately eager to know about the next baby. (While conducting a labour, they can even tell you the likely sex of the next baby by looking at the umbilical cord of the present one!) And what will happen if it is diagnosed to be a female fetus? In that case, Khuku and Namita have to ponder over whether they have any option other than to give birth to a girl child and risk the mother being devoured by a tiger or at least kicked out of her home. So the expectant mothers are 'referred' to 'Dr' Ali of Gosaba or 'Dr' Pal of Mollakhali, or those of their ilk who have specialized in the business of intra-uterine killing. They have improvised their own methods. These 'doctors' thrust inside roots or stems of 'medicinal' plants and inject chemicals into the sac. Here *dais* have a word of caution for womenfolk: come early. Otherwise, if the pregnancy advances beyond three months, not only will each extra month cost them an extra thousand rupees, but chances will be higher that the procedure will also cost their own lives.

### Rights and wrongs

Incredible as this all may sound, it is no fiction. Neither is this a recollection of events of a bygone era. All of this is happening in this twenty-first century. All of these events are still happening even after the experiences of a tumultuous twentieth century to which we owe not only the concept of women's rights, but also the seminal concept that human beings are entitled to certain basic, inalienable rights irrespective of his/her special identity, and that women or marginalized social groups should be able to enjoy their identity-specific rights. These values have not remained purely within the realm of abstract values. To a very significant extent, these

values have been incorporated into the generally accepted norms of a civilized way of life and have even found their place in the statutes of most of the world's countries. Yet, there remains a huge gap between what we generally accept to be morally correct and what the society actually practices. The case of women's empowerment is no exception to this harsh reality. Often, an overwhelming majority of the female populace in our society experiences the lofty ideals of women's liberation in their violation rather than in their realization. This incongruity between precept and practice is one of the most challenging legacies we have inherited from the previous century.

Certainly, we need to understand this incongruity, to understand how and why abstract moral values tend to evaporate when it comes to the lives of women of marginalized peasant families. And what can be a better method of learning than to walk down the dusty village tracks, to accept the warm and modest hospitality in the decrepit mud huts of remote hamlets of Sundarban, and to hear from the womenfolk about their multiple woes? Actually, these women occupy a special position. Most of them are working women from landless or marginal peasant families and because of their very social position, they have to simultaneously bear the burden of a failing agrarian economy and the weight of an oppressively discriminatory social tradition. Hence, these women can be regarded as living testimonies of the process whereby social and livelihood practices frustrate the dream of empowerment to the extent that village women are not in a position to decide upon matters related to their individual selves, let alone to social affairs.

### **Productive practice and reproductive health**

Any sympathetic discussion with the women of these families will reveal the stark reality of their abysmal health standards and the widely prevalent problems regarding their reproductive health - in spite of a plethora of public health programmes.

All of these women have to take part in productive practices, either in agriculture, fishing, or in the stone quarries. They are compelled to be engaged in these strenuous physical activities in addition to the daily burdens of household chores because the mono-crop agriculture of these regions can neither support the households of marginal peasants nor provide wage earning for landless workers throughout the year. Accordingly, the male members of these families have to leave their villages and join either the army of seasonal agricultural workers who flock to advanced agricultural districts like Hoogly or Bardhaman, or migrate to far away states like Gujarat or Maharashtra in search of uncertain wage earning. Thus, the burden of looking after household affairs has to be shouldered by the wife or the mother. This means that women also have to meet the daily or routine expenditure requirements of the family because repatriation of wages earned by emigrant male members is typically uncertain or at best irregular.

The crucial point here is that while, to a significant extent, the appalling health standards can be traced back to the poor material - including economic - condition of the women's living, it is clearly also a function of their position as women in a social milieu which is a heady mix of patriarchal domination, archaic traditions, and entrenched taboos. The average woman has to follow the extant rituals and practices regarding child birth, birth control and child health. Even the health workers, when they are present, fail to make much headway with their repertoire of

scientific health awareness programmes. This is primarily because the women whose health is at stake are not supposed to make a choice. In other words, a woman does not have the right to determine her own reproductive functions; it is the husband who will decide about childbearing. He, not she, will determine the need and nature of contraceptive. Ante natal care will be in accordance with beliefs held by the mother-in-law. And whether the mother will be entitled to rest before and after child birth will be determined by the economy.

The story is complex, yet revealing. It reveals the interrelated nature of the issues of empowerment and economy, health and social practice, reproductive health and productive activities.

When these women participate in strenuous activities in paddy fields or as stone crushers, they are already heavily burdened by their multiple woes. To begin with, they are chronically malnourished. It is widely known that marginal, peasant families are plagued by semi-starvation and endemic malnourishment. Within these peasant families, women traditionally bear a greater share of that hunger. Even girl children are no exception. Chanda Hansda and Karan Hembram, local medicine men of Mallarpur, have claimed that each of them attend to 150-200 malnourished children (thin wasted limbs, distended abdomen, dry skin) every month who are brought to their clinics by mothers. According to Hansda and Hembram, the majority of these malnourished children are girls. This should surprise no one. In a social milieu where the girl child itself is unwanted and where there is so much anxiety and cruelty aimed at pre-empting the birth of a girl child, it is difficult to expect that care would be taken about her nutrition.

These girls, hamstrung by malnourishment ever since birth, will be married off when they are still in their adolescence. Women of these villages have emphasized that almost without any exception, girls are married off at the age of fifteen or sixteen, if not earlier. Usually, these girls discontinue school education after class two or three. Children of these families often find it difficult to continue with their schooling because both of their parents are engaged in earning livelihoods and they too are required to lend their help. When it comes to leaving the school, naturally girls will have to leave first. Thus, they get married at fifteen or sixteen and become mothers at sixteen or seventeen years.

But why should they become mothers at the early age of sixteen, and even after such wide spread campaigns about birth control? It cannot be denied that the public health system has made contraceptives and birth control advice available in most of the villages. The same cannot be said about other essential health services. In other areas, clinics run by non-government organizations have stepped in and ubiquitous medicine shops are always there with a supply of contraceptives. Actually, the problem lies elsewhere. Women here are not supposed to take a decision in matters regarding their own physiological functions. It is the husband who will decide on the need or method of contraception. The majority of married males don't like all the fuss surrounding birth control before the birth of their first baby. So girls in these villages are destined to become mothers in their teens.

Neither is there any dearth of campaigns on the need for adequate nutrition for expectant mothers. There are even targeted programmes to take care of the nutritional needs of pregnant women. However, there remains a huge gap between the intent and implementation of

programmes like the Integrated Child Development Services scheme (ICDS) and it is difficult to cite specific instances in these villages where they have successfully and persistently taken care of the nutritional demand. There are hardly any instances of pregnant women in these families taking milk, fish, eggs or fruits regularly. Most of the families simply cannot afford such luxuries. There are other problems too. Widely held beliefs in these areas will tell you that a woman will have a large sized baby if she eats a lot and that is never desirable because home delivery supervised by an untrained local *dai* is the rule rather than the exception (again due to the yawning gap between the policy emphasis on institutional delivery and the appalling state of requisite infrastructure), and the *dai* finds it difficult to manage large babies. Consequently healthy babies are considered to be potentially hazardous and low birth weight is desirable! Due to similar reasons, women often refuse to take tablets containing ferrous sulphate and folic acid regularly. They are scared by the black stool- that is a common side effect - and the prospect of a large baby!

Then there is the question of rest. Scientific advice suggests that pregnant women and women in their early post partum period should take adequate rest. But the household chores of impoverished peasant families themselves demand a lot of work and hardly allow womenfolk any respite. Beyond this, the prevailing state of the economy has made pregnant women busy harvesting in the field or carrying head loads in a 'job site', a common sight. There is also no respite even after childbirth. Usually, the women have to return to their grueling schedule, both within and outside the home, within three to four weeks of confinement. Needless to say, no one is too bothered about nutrition of the lactating mothers also. As a matter of fact, nutrition after childbirth gets worse, again due to peculiar taboos. For one week, the mother will be given only dry food and very little water. This is supposed to ensure healing of the baby's umbilical stump. The mother must also be frugal while taking meals lest the baby has a stomach upset!

Most of the women believe that they will not conceive as long as they are breast-feeding and that they don't need any contraceptives until their menstrual cycle starts again after confinement. Hence, it is only natural that they become pregnant again within a year. And the same story of nutrition and rest repeats itself. This cycle goes on because as has already been pointed out, decisions regarding contraception remain the husband's prerogative. Men typically abhor the idea of using contraceptive methods themselves and tend to dictate the method women should or should not use. For example, 'copper T' is not allowed. The 'Pill' is usually – though not always – allowed, but rarely are these women able to maintain the cyclical regularity and so it often fails. Women themselves often discontinue the 'pill' out of fear of the side effects (she will blame the 'pill' for any ailment that she may suffer while taking it.) The option of tubectomy is for all practical purposes, non-existent for similar reasons. Prevailing wisdom says that the 'ligation' operation will rob the woman of her strength and vigour. Also, the all too frequent incidences of infant and child mortality dissuade mothers from crippling their fertility permanently. At any rate, the dilapidated public health facilities available in these villages rarely offer the service. Thus, other unsafe methods are tried – almost never successfully, for obvious reasons. The upshot of all this is that before completing their third decade, these women have multiple pregnancies along with a few harrowing experiences of feticides.

These repeated, successive, and mostly unwanted pregnancies have made criminal incidences of illegally and crudely performed feticides alarmingly prevalent. The strong and entrenched bias

against the girl child has added insult to injury. Whenever they are pregnant, the women are anxious to know whether they are going to have a daughter. For this, they mostly depend upon a set of ill omens and few dubious physical signs because clandestine sex determination facilities are neither available nor affordable. Beliefs in allegedly ominous portends are so strong that if a pregnant woman has a nightmare of being bitten by a tortoise she will take it as a sure sign that she is carrying a female fetus and will submit herself for the ghastly ordeal of feticide in the hands of 'Dr' so and so.

### **The vicious cycle**

It is not surprising, then, that these malnourished and worn out creatures will be host to a multitude of maladies. Unfortunately, it is difficult to measure statistically the prevalence and incidence of those worrisome problems because in most of these remote areas, the presence of a public health care system itself is limited. Yet, records of the clinics run by non-government organizations are sufficient to underscore the problem.

The most widely prevalent complaints of women attending the clinics are those due to malnutrition. Almost all of them complain about weakness or reeling of the head. Almost every one has anaemia. Many suffer from night blindness. Most of the children – particularly girls – have wasted limbs, protruded bellies, dry skin and coarse hair. Mothers complain that these babies are irritable and are always crying. With their frail health and endless chores always waiting for their attention, mothers find it impossible to look after nagging irritable children and often sedate them with opium.

After malnutrition, pelvic inflammatory disease is the most common cause of complaints. Pain in the lower abdomen, white discharge, and irregular menstruation are reported by almost everyone. While malnutrition is one of the causative factors, poor hygiene is another. They usually take baths in the dirty water of nearby ponds. The toiling women of Sunderban often spend hours in waist deep brackish water in search of prawns. The prevalence of sexually transmitted diseases is also on rise because the males of Sunderban have to migrate away from their villages in search of wage earning and often bring those afflictions home. Thanks to vigorous campaigns on AIDS, women are aware of this danger. However, this awareness has not really helped them because they are never in a position to compel their partners to use condoms. In other words, they are not entitled to protecting themselves. Rather, because the AIDS campaigns tell them more about the threat and not as much about the signs and symptoms of AIDS, they add to their already awesome burden of anxiety.

What may appear to be surprising is the significant prevalence of cases of genital prolapse among these women. Here also, specific data is not available. However, according to the records of these clinics, more than ten percent of women complain that their uterus comes down whenever they strain for defecation or try to lift some weight. And again, surprisingly, they develop this problem quite early. Madhabi Mondal and Soma Mondal had attended the clinic in Parasmoni village on the same day. Madhabi is twenty seven and Soma is twenty four years old. Both of them have been diagnosed with first-degree uterine prolapse.

When considered against the backdrop of the life cycle just described, it is not difficult to locate the causative factors behind this higher prevalence of genital prolapse. Malnourishment, early pregnancy, successive pregnancies with short intervals in between, crude home deliveries in utterly unhygienic conditions, early resumption of heavy physical activities after confinement, repeated horrific abortions – there are so many assaults to a woman’s reproductive organs. And from there begins another story of suffering and humiliation. Heavy physical activities and lifting heavy objects become difficult and embarrassing (because uterus will come down) but she won’t have any respite from those requirements. This often leads to the unbelievable tragedy where a middle aged woman with second degree uterine prolapse is compelled to use a torn piece of cloth as a binder before she begins her day as a wage labourer in paddy field. But, then, tragedy doesn’t end there. For a woman it is not enough to earn wages. At the end of the day she has to satisfy her husband’s lust, for which she is equally unfit. In such cases husbands are quite understandably annoyed and take recourse to their sovereign right to coerce their wives into subjugation.

Where are they to go from here? No light is apparently visible at the end of the tunnel, particularly as the problem of genital prolapse cannot be cured by medicines. It needs surgery. A major surgery that cannot be done in villages. So they have to come to the city. That needs time and money. Who is going to expend that? Are they worth it?

Thus the tragedy goes on. Endlessly, it seems. It takes the ultimate toll on the psyche of these humble souls; a lot of them attend the clinics with insomnia, anxiety, depression and so on. They have hysterical fits. They are frequently ‘taken by ghosts’!

Where human society fails, perhaps only ghosts dare.

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*(Names have been changed for obvious reasons.)*

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