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UNHEARD VOICES OF THE 'CHARUAS' : BARRIERS TO EFFECTIVE HEALTH DELIVERY IN THE CHAR AREAS OF ASSAM

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Abstract

Health is a major area concerning development for countries like India which is yet to be able to provide universal and basic health care services to its entire population. Among the major health issues confronting the country are increasing disease burden, maternal health and child health issues etc. With one of the most complex demographic scenarios in the country, the northeastern state of Assam is facing a huge challenge as of today. The geographical terrain, socio-religious beliefs etc. of the state contributes significantly to the variability seen in socio-economic data; accessibility is thus a major issue in implementing various government schemes. There are certain areas which have chronically suffered from lack of adequate health infrastructure – the char areas of the river Brahmaputra may specially be mentioned here. In this article it is argued that the char areas of the Brahamaputra river have been a classic case of neglect by the state government. Even though demographic challenges are present, the poor living condition of people cannot be justified in this day and age; appropriate measures need to be taken to uplift the lives of the charuas.

Keywords: Health, Accessibility, Brahmaputra, Chars, Assam

Introduction: The 'Char Areas'

The riverine areas (island) of the river Brahmaputra, locally known as "Char/ Chapori" cover about 3.60 lakhs hectares of land and population of approx. 24.90 lakhs (as per Socio Economic Survey 2002-03). Chars are the riverine islands created on the river Brahmaputra in the Northeastern state of Assam. During monsoons, these char areas are victims of flood and other disaster and as a result suffer from lack of infrastructure and access to adequate healthcare services. There are 2,251 villages in the char areas and only 52 Primary Health Centres exist which are not

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sufficient enough to cover the entire population. (Socio-Economic Survey 2002-03) Due to floods, it is difficult to construct permanent infrastructure in the char areas, also the people residing in these areas frequently change their base after every six months.

These remote areas have not seen the fruits of development in any significant manner, because of limited accessibility and consequent administrative and other constraints. While certain districts of the state have been declared as "Backward" for the purpose of providing special incentives to attract industries, but in these districts, there was no systematic plan to remove backwardness to bring them at par with the rest of state. The physical, sociological and institutional constraints on development of Char Areas are many and complex. Such as virtual absence of all weather communication with the main banks, reliable means of intra and inter char mobility, inadequate growth of transport and basic infrastructure like surface roads, health and drinking water, delivery systems for farm inputs, marketing, agro-services electricity and education.

Two benchmark surveys were conducted during 1992–1993 and 2002–2003 by the Assam State Char Areas Development Authority (the Authority was later elevated to a full-fledged government directorate). The survey provided worrying statistical pointers. The density of population of chars is twice than that of the state, chars dwellers comprised 9.37 per cent of the state population although chars accounted for only 4 per cent of the state's cultivable land, chars had a high rate of illiteracy and, in some districts, the literacy rate fell between the two surveys (Chakraborty, 2012, p. 23).

In contemporary times the state government, National Health Mission Assam (NHM), NGOs (Non-Governmental Organizations) and innovative PPP (Private Public Partnership) models like the Boat clinics has tried to take sustained health care to lakhs of persons on the islands, with a special focus on women and children, who are the most vulnerable in difficult conditions. But the effective implementation of these development schemes have been patchy, at best.

The Charuas: A brief history and colonization of the chars

Contrary to the popular perception, all char inhabitants are not Muslims of East Bengali origin. In the eastern part of state, a number of tribal groups, riverine communities like the kaibartas, have been dwelling on chars. A migrant community—the Nepali grazers—also inhabits chars in central and eastern Assam. On the whole, however, it won't be wrong to surmise that most char dwellers are of East Bengali origin. They migrated to the province over a period of many decades. They were induced to migrate by a colonial state which wanted to harness the so-called "wasteland" of the recently annexed province to generate revenue. By 1911, as many as 118,000 migrants had settled down in Goalpara district, making up 20 per cent of the district population (Weiner, 1983, p. 283).

More than a hundred years later, the lasting impression of the colonial policy is present in terms of neglect and backwardness of char dwellers. It appears that many things, besides the channels of the Brahmaputra, separate the chars from rest of Assam—which is itself considered to be a neglected territory of Indian republic.

The story of human development at the Chars

Located at the margin of the margin, chars have registered a lacklustre record of human development. The Assam Human Development Report 2014 estimated that char areas have the highest multidimensional poverty among all regions of the state (GoA, 2016, p. 198). Economic backwardness limits char dwellers' livelihood options. Severe floods adversely affect char areas and further restrict their economic opportunities. When the char residents migrate to mainland Assam, they face discriminations (Chakraborty, 2012, p. 23).

These migrants from East Bengal introduced better techniques of cultivation in Assam, greater crop variety (including a number of vegetables hitherto unknown in Assam), and multiple cropping, the last of which was not practised in Assam till the arrival of the immigrants (Weiner 1978; Madhab 2006). Moreover, immigrants settled on all available land, even on land previously thought uncultivable like the chars (sandbars) of the Brahmaputra (Goswami 2007).

Muslim char dwellers, or charuas as they are called unflatteringly, are a minority community in Assam on account of their religion. Many of them have taken to identify themselves as Na-Asamiya (the New Assamese). As Bhaumik (2011) remarks, it remains an open question whether adoption of a new identifier has succeeded in abating the hostility they face from the everyday chauvinism.

The problems in the Char Areas are unique in nature, due to constant threat from flood and erosion during the rainy season. No mega developmental schemes can be taken in these areas. The land mass is segregated and cut off from each other, making it very difficult for taking any major scheme for road communication, irrigation, Power supply or setting of educational institutions. (Directorate of Char Areas Development)

Initially the Char Areas Development Authority was created in the year 1984. But however, then the Char Areas Development Authority had declared this Directorate of Char Areas Development Assam as a full fledged one in 1996 under Welfare of Minorities and Dev. Deptt. Govt. of Assam

The main purpose of creating this Directorate was to improve the socio-economic conditions of the people living in char/chapori areas of Assam through affirmative action and inclusive development so that every citizen has equal opportunity to participate actively in building a vibrant state and to facilitate an equitable share to minority communities in education, employment, economic activities and to ensure their upliftment. However, these promises remain on paper till date.

The Boat Clinics

Pioneering the concept Private-Public partnership (PPP) in the country and to address a few of these health related challenges faced by the char residents, the State Government of Assam in partnership with for North East Studies and Policy Research C-NES started the concept of Boat Clinics. People residing in these outreached areas lack basic health facilities and it is difficult for them to travel to reach the health centre seeking for health care services.

The boat clinic initiative of C-NES started in 2005 with *AKHA – the ship of Hope* with aid from UNICEF. Encouraged by its success NRHM entered into an agreement with C-NES to provide

health service to the island communities of the state. C-NES came forward to spread the initiative to other parts of the State. With this partnership NRHM has been able provide preventive and curative services to these communities in 13 districts of the State with funding from NRHM. These units not only provide access to basic services of health care but also provide essential knowledge and information on the kind of services under the umbrella of NRHM to the residents in the island who have no access to health care. (C-NES Annual Report 2014-16)

Each district has 15 staff headed by the District Programme Officer (DPO) who is the key person in organizing district plans and coordinating among the team, district health departments, district administration, NHM and the community. His or her team includes two Medical Officers and paramedical staff including two ANMs, a GNM, a pharmacist and one laboratory technician besides three community workers and a four member boat crew. The work of the boat clinics has led to remarkable results: On an average, 18,000-20,000 people are treated every month in the districts, individuals who were earlier beyond the reach of government programmes because no doctors or paramedics would go on a regular basis. Till March 2019, over 2.7 million basic health services have been provided.

It started small in Dibrugarh, in partnership with the district administration. Later, following a similar strategy, it expanded its services to Dhemaji and Tinsukia. UNICEF then came into the picture to build capacity and training. The National Rural Health Mission, Government of Assam, then proposed a collaboration seeing this as a major opportunity to give sustained health care to those millions who have been beyond 'normal' reach. A unique Private Public Partnership was signed on January 2008 with NRHM. The Boat Clinics work in 13 districts of the state — Dibrugarh, Tinsukia, Dhemaji, Jorhat, Lakhimpur, Sonitpur, Morigaon, Kamrup, Nalbari, Bongaiaon, Barpeta , Bongaigaon and Dhubri. A total of 15 Boat Clinics are operating along the river, Barpeta and Dhubri having an additional unit each to cater to a larger population.

The present study focuses on the development issue of general health practices and safe motherhood in particular through the efforts of various health schemes. Rural healthcare comprises of multiple topics like nutrition, sanitation, immunization of children, treatment of diseases, infant and maternal mortality, etc. It is notable that all of these issues are linked to each other, often one being the cause or effect of the other. Hence it is important that each of these problems is tackled in coherence with action taken for other problems. This is where the scope of participatory communication, of having dialogue and discourse among members of community comes into the forefront. According to Niti Aayog's Report Assam's Mortality Ratio is 237 as compared to India's 130 during 2014-16. Hence, the study aims to explore the ways in which participation can be implemented in the present organizational set up of these health delivery services.

The limited number of studies that exist on chars paints a grim picture. The growth of population is high and so is the density (690 per sq. km in 2002–2003). Grinding poverty and poor socio-economic indicators characterize char areas. Between 1992–1993 and 2002–2003, the percentage of people living below the official poverty line rose from 48.89 per cent to 67.89 per cent in chars. In contrast, in Assam as a whole, the poverty rate was 36.09 per cent in 2002 (Chakraborty, 2012, p.

23). There has been a continuous decline of per capita land in chars. Goswami (2014) found that more than half of the char dwellers were illiterate. The total fertility rate was 4.56 among the surveyed households, much higher than the state average which was 2.4 according to Government of India (GoI; 2014). Also, 91 per cent households did not have access to clean water. Only 1.4 per cent household had the facility of sanitary latrine. Mortality rate in the char areas was 8.6 per thousand and higher than the state average. Maternal Mortality Rate (MMR) is the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management.

Theoretical framework

The study focuses on the principles of community participation in the context of participatory development communication. Until the 1960s, economic theories explained the lack of development as being a consequence of industrial and technical backwardness, while sociological theories attributed a lack of development to the cultural backwardness of the illiterate masses. Accordingly, it was believed that the quickest solution for development would entail the borrowing of the modernisation strategies of the Western societies which were deemed to be developed societies. This resulted in the emergence of development communication during the modernisation paradigm in terms of which specialists and advisors in development advised the poorer countries (Kumar, 1994:76).

In contrast, participatory development communication assumes that individuals should be active in development programmes and processes; they could contribute ideas, take the initiative and articulate their needs and problems while, at the same time, asserting their autonomy (Baofo, 2006). Therefore, emphasis is on the process of planning and the utilisation of communication resources, channels, approaches and strategies in programmes which are designed to bring about some progress, change or development, as well as the involvement of the developing community in the change efforts. With the abovementioned shift in focus from the linear mode of communication during the modernisation era to full participation of the developing community, there is no longer an attempt to disseminate information to communities, but rather to involve the communities fully in both identifying their needs and taking ownership of activities and information.

Paulo Freire, an educational theorist, incorporates participation as a key concept in his philosophy and he indicates that participation is based on the notion that the historical vocation of human beings is to be free from anything in life that does not provide for the involvement of people in the processes of change. Freire's theory focuses on the premise that, in order for communication to be effective, it is essential that it be participatory, dialogic and reciprocal (Freire, 1970:101)

Health and Communication:

Communication plays a vital role in the prevention and control of diseases and improving health in a society. Proper communication is very important especially in rural areas as per development activities are concerned (Nwosw, 1987). Simpson- Hebert and Wood (1998) puts emphasis on starting a successful advocacy by identification of groups that are to be influenced

upon and he also suggests finding out the most appropriate manner to communicate the message. But in order to know the meaning of health communication or define it one must first know the meaning of 'communication' (RenataSchiavo, 2014; R.K. Thomas, 2006).

Many definitions try to capture the true meaning of health communication. The Centre for Disease Control and Prevention (2011) defines health communication as *"the study and use of communication strategies to inform and influence individual decisions that enhance health".*
According to the same organization the definition of health communication, as given in the previous year, ought to give emphasis to changing behaviour of receivers of health messages by 'influencing' and 'motivating' them.Even though there are numerous definition of health communication but they ultimately aim to impact the vulnerable and underserved populations. As Schiavo (2014) states "yet, the broader mandate of health communication is intrinsically related to its potential impact on vulnerable and underserved populations"

Health communication draws from several definitions and theoretical fields such as Sociology, Anthropology, Psychology, Marketing, Mass Communication etc. and it has been acknowledged by many scholars (WHO& UNICEF, 2012; Bernhardt, 2004; Kreps, Query, and Bonaguro, 2007). Health communication relies on various types of communication like interpersonal communication, mass communication, new media communication, mobilization of the community, engagement with the public, communication in medical field, constituency relations and strategic partnerships, strategic public communication and public advocacy (WHO, 2003; Bernhardt, 2004; Schiavo, 2008).

Health Communication by NHM Assam

The Information, Education & Communication (IEC) strategy of NHM aims to create awareness and disseminate information regarding the benefits available under various schemes/programmes of the Ministry and to guide the citizens on how to access them.
IEC BCC (Behaviour Change Communication) plays a crucial role in the successful implementation of any developmental program, especially health programs. The objective is also to encourage build-up of health seeking behaviour among the masses in keeping with the focus on promotive and preventive health. The IEC strategy caters to the different needs of the rural and urban masses through the various tools used for communication. Through various IEC-BCC campaigns NHM is constantly striving to inform all the community about various healthcare services with an aim to improve the demand for these services, and also to encourage health-seeking behaviours.

These include spreading information on the preventive and promotive healthcare for the adolescents, newly married couples, expectant mothers, lactating mothers, newborns and children. The districts along with the state and all stakeholders have to ensure to make it a big success in creating enhanced awareness and inculcating a health seeking behaviour in the masses. Though RMNCH+A (Reproductive, Maternal, Newborn, Child and Adoloscent) and communicable diseases continue to remain in the prime focus, NCDs (Non Communicable diseases) are increasingly contributing to higher disease burden awareness/health camps be done at the grassroots level. And

to address the these issues the concept of Health and Wellness Centre (HWCs) that provide comprehensive primarily care including prevention and platform for health promotion.

The National Health Mission, envisages attainment of universal access to equitable, affordable and quality health care services in the State of Assam. A lot of efforts have been given for ensuring quality in services of health which is one of the important mandates under the National Health Mission. Another important aspect of NHM, Assam is strengthening of community participation in health service delivery system. Supportive supervision and monitoring system is an integral mandate of NHM, Assam. Generating demand by creating awareness is also given equal emphasis. NHM as of gives a lot of emphasis in reaching the unreached, viz. the population living in char and tea garden areas well as the urban slum. The ASHA programme, considered to be the foundation of NHM, Assam is rendering laudable voluntary services covering all the villages and urban population.

Conclusions:

Geographical remoteness, the pandemic and subsequent lockdown have threatened the livelihood of char dwellers. This has led to a decline in income, food insecurity, and health concerns that have aggravated the inequalities of the charuas. Their remote geographical location, poor health infrastructure, malnutrition, and existing morbidities make them more susceptible to COVID-19. In addition to that, colonial exploitation and continuing deprivation still continue to characterize the char areas. The 'welfare' measures of the post-independent state have failed to address the deep divide and exclusion they experience in society.

The charuas have since time immermorial been 'othered' and 'alienated'. The larger Assamese society, and particularly the elites, have reproduced the idea of 'otherness' visa-vis the charuas in the public sphere. They often attribute the problems faced by the charuas to the socio-economic arrangements of their geographical remoteness and hence as an extension of the history of coloniality.

There is a need to ensure basic healthcare facilities in each of the PHCs with required staff, essential drugs, and routine vaccinations for the upkeep of their well-being. Imparting of employability training skills to char dwellers will improve their skills and empower them to look for other income-generating opportunities. Employment creation via small and medium enterprises should be encouraged by engaging the char dwellers to make local products. The promotion of agricultural produce in collaboration with the concerned ministry of the state government will prove beneficial for both parties in the long run.

Furthermore, universal basic income (UBI) can be introduced for the char dwellers where they can be provided with a fixed monthly income to meet their urgent needs and help them escape from falling deeper in the clutches of poverty.

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